Table of Contents

Reflections on Acts of Allyship from a Collaborative Pilot of Dried Blood Spot Testing

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ABSTRACT

Allyship with Indigenous Peoples is defined as characteristics or actions that actively support social justice with an aim to reduce inequities experienced by non-dominant groups. Métis-specific perspectives on allyship are very limited. This article presents a reflection upon allyship within a multi-partner, dried blood spot testing (DBST) pilot with Métis communities in Alberta.

METHODS: Using a case study approach, we reflected on our experience working within the collaborative DBST pilot and considered supplemental data from interviews with three DBST providers, meeting minutes, observational notes, and notes from team debriefs for themes related to allyship.

RESULTS: Seven distinct themes were identified. Within this DBST pilot initiative, individuals from partnered organizations who demonstrated allyship: established regular communication with community representatives; listened openly and without judgement (in order to reduce tensions); developed a positive working relationship; deferred decision-making (wherever possible) to those who represented the community; acknowledged past and present history of colonialism and poor relationship(s) with the Métis community; acknowledged the right of Indigenous communities to self-determine their health services; and challenged the status quo.

CONCLUSION: These themes provide guidance and suggest promising practices for building relationships as allies with Métis communities. Allyship between Métis communities and health service providers and policy makers can play an important role in fostering and supporting Indigenous, community-led interventions targeting HIV, HCV and other STBBI. Based on our reflections, we present lessons learned for consideration by those partnering with Métis communities in health and/or social contexts.

KEYWORDS (3-10): Allyship; Métis; HIV; STBBI; dried blood spot testing; Métis research; Indigenous

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INTRODUCTION

> No one is perfect. An ally's compass in their conduct and personal decolonization journey should include a combination of conscience, values, and a commitment to staying open to constant self-evaluation and self-correction, without ego. Decolonization is not an act of isolated self-creation. It is a messy process of relational in-the-world becoming and, as such, is often a difficult task (Irlbacher-Fox, 2014, p. 156).

This paper explores acts of allyship demonstrated through a multi-partner collaboration to pilot dried blood spot testing (DBST) within the Métis community in Alberta in the fall of 2019. Although allyship is a complex context that may elude a single definition (Jaworsky, 2019), for the purposes of exploring how multiple partners can come together to work towards a common goal of supporting Indigenous Peoples to self-determine their own HIV/STBBI testing interventions, we adopt Brown and Ostrove's (2013) definition of allyship. Brown and Ostrove (2013) characterise acts of allyship as actions that actively support social justice with an aim to reduce inequities experienced by non-dominant groups. This occurs through the development of meaningful relationships with these communities and focuses on shifting social accountability onto dominant groups (Brown & Ostrove, 2013; Smith, Puckett, & Simon, 2016). Specifically, allies are individuals who are willing to take action to address health and social issues and inequities rather than solely expressing minimal or no prejudice towards certain groups (Brown and Ostrove, 2013). Essentially, allyship is about supporting the work of those within the communities who face inequities to work to address self and community-identified priorities, rather than taking a leadership role in defining and directing these (Brown & Ostrove, 2013; Hyett, Marjerrison, & Gabel, 2018; Nixon, 2019; Smith et al., 2016). Allyship with Indigenous communities is similar to allyship with other groups, but should be informed by the current and historical contexts of Indigenous communities (Swiftwolf, Shaw, & Montreal Urban Aboriginal Community Strategy Network, 2019). However, there is little literature addressing Métis perspectives or community experiences with allyship in healthcare or health policy. This article presents a reflection on allyship experienced by the DRUM & SASH (D&S) team, which included Métis academic trainees, project coordinators, and health services providers, as well as other Indigenous and non-Indigenous team members during a multi-partner collaboration to pilot DBST within the Métis community.

Métis peoples are one of the three Indigenous groups in Canada who experience significant disparities in health status compared to non-Indigenous peoples in Canada and who also experience gaps in social and health services (Monchalin & Bourassa, 2019). Few Métis-specific health and social services exist that are reflective of the unique cultural identities of Métis peoples, especially for HIV, Hepatitis C (HCV), and/or sexually transmitted and blood borne infections (STBBI) prevention, testing and treatment (Canadian Aboriginal AIDS Network, 2005; Evans, Anderson, Dietrich, Bourassa, Logan, Berg, & Devolder, 2012; Monchalin & Bourassa, 2019). Métis communities are usually ineligible to apply for federal funding streams which are available to First Nation and Inuit communities through First Nations Inuit Health Branch. Research has shown that Métis people experience racism and/or discrimination when accessing mainstream health services, which are often not culturally responsive (Monchalin, Smylie, & Nowgesic, 2020). Additionally, geographic barriers play a role in access to health services, especially regarding HIV (Canadian Aboriginal AIDS Network, 2005; Traversy, Austin, Ha, Timmerman, & Gale-Rowe, 2015). Métis-specific or Métis-informed services can improve the cultural safety of services offered, thus improving access to care (Monchalin, Smylie, Bourgeois, & Firestone, 2019).

Although not yet formally adopted in Canada for STBBI testing, DBST has recently been identified as an appropriate method for screening for STBBI within the context of developed countries such as Canada and the UK (Ashworth, Douthwaite, Mullender, Cunningham, & O'Shea, 2015), has shown to be useful in resource limited settings, such as rural and remote locations, and has proven cost-effective in other contexts (Chevaliez & Pawlotsky, 2018). Due to its portability, DBST may reduce geographic barriers to testing, and can be performed in environments unsuitable for venous blood collection (Tait, Stephens, McIntyre, Evans, & Dillon, 2013). Given its portability, DBST can potentially be used to increase access to testing in small and remote Métis communities, such as the Métis settlements in Alberta. DBST can be administered by individuals who work outside of the health field, provided they receive training, making it potentially suitable for communities with limited health services, or for individuals who feel more comfortable obtaining STBBI testing outside of a clinic setting.
Piloting DBST within the Métis community in Alberta required significant collaboration and cooperation between multiple individuals and organizations. Shining Mountains Living Community Services (Shining Mountains) was responsible for leading the pilot of DBST within the Métis community on behalf of the Métis Nation of Alberta (MNA) at the request of their staff and leadership team. Shining Mountains is a service agency which provides some of the only Métis-specific services and resources regarding HIV, HCV, and STBBI in Alberta, although they provide services regardless of Indigenous identity or status (R. St. Denys, personal communication, January 15, 2020). DBST was identified by service providers at Shining Mountains as one way of addressing inequities and potentially improving the availability of culturally relevant, Métis-specific testing services. Shining Mountains received planning and implementation support from the DRUM & SASH (D&S) Project (described further in Methods). The Public Health Agency of Canada's National HIV Reference Laboratory Services (NHRLS) supported this pilot through an agreement with Shining Mountains. They provided test strips, DBST training, and analysis services. An agreement that detailed expectations and protocols was signed between the NHRLS and Shining Mountains at the outset of the relationship. The Alberta Health Services (AHS) supported the DBST pilot from a health service and feasibility assessment standpoint in order to integrate the test requisition and reporting into

their existing provincial public health system to ensure linkage to care. The Red Deer Sexual Health clinic provided support at the first testing event by providing administrative staff support and a nurse practitioner who was designated "the most responsible person" (MRP) and could requisition DBST for those interested in obtaining a test.

Given the lack of existing culturally safe healthcare services for Métis people, it was important this DBST pilot was evaluated using culturally relevant approaches, drawing upon the voices of Métis people who received or provided DBST during this pilot. Although the primary purpose of this research was to evaluate DBST, the aim of this paper is to identify and reflect on acts of allyship that were experienced in this multi-partner collaboration.

METHODS

The DBST pilot and this opportunity to reflect on allyship arose out of an ongoing partnership between the Métis Nation and D&S. D&S is a five-year, CIHR-funded Implementation Science team grant that is working with communities to develop shared models of care within First Nations and Métis communities in Alberta. The D&S team is comprised of a diverse group of First Nation, Métis, and non-Indigenous CBR researchers, clinicians, health service providers, Elders, and knowledge users. As noted previously, within the context of the D&S study, Métis service providers at Shining Mountains identified the opportunity to provide DBST, with the support of NHRLS, as a method to increase testing for HIV/HBV/HCV/syphilis among Métis peoples. D&S worked with Shining Mountains to facilitate the relationships and the development of provincial lab pathways and testing protocols required to pilot DBST within the Métis community.

The D&S approach is rooted in the principles of community-based research (CBR) (Israel, Schulz, Parker, & Becker, 1998). CBR is a partnership approach to research that focuses on equity and capacity building within research-community relationships (Israel et al., 2010). The principles of CBR are: recognizing community as a unit of identity; building on strengths and resources within the community; facilitating collaborative partnerships in all phases of research; integrating knowledge and action for mutual benefit of all partners; promoting a co-learning and empowering process that addresses social inequities; utilizing a cyclical and iterative process; addressing health from both positive (strengths-based) and ecological perspectives; and disseminating findings and knowledge gained to all partners (Israel et al., 1998). These principles have informed the D&S approach to working with communities, which focuses on meeting communities where they are at (DRUM & SASH, 2020). CBR is a research approach which is congruent with allyship, because at its core, CBR is about restoring power and control throughout the research process by addressing community-identified concerns (Hyett, Marjerrison, & Gabel, 2018). This is similar to the way allies support the work of communities, rather than taking a leadership role within them, and reflects the definition of allyship provided by Brown and Ostrove (2013).

The D&S research approach is strongly informed by Indigenous worldviews and practices (Hart, 2010) and by the Principles of Ethical Métis Research (Israel et al., 1998; NAHO: Métis Centre, 2010). The Principles of Ethical Métis Research emphasize the building of reciprocal

relationships based on mutual respect; the creation of safe and inclusive environments for Métis peoples; and efforts on the part of researchers to have a full understanding of Métis history and context (NAHO: Métis Centre, 2010). Additionally, many principles of CBR overlap or are reflective with Indigenous worldviews in research, which emphasize Indigenous control over research, reciprocity and accountability, respect, reflective non-judgement, and self-awareness when engaging with Indigenous communities in research (Hart, 2010). Thus, using CBR, Indigenous worldviews and Métis Principles, the D&S team members strive to work with communities in a respectful way, engage and act upon their priorities and initiatives, and support the work to integrate cultural practices into STBBI initiative development and evaluation. After many meetings with the partners to develop the pathways and protocols for DBST, results notification, and linkage to care, DBST was piloted at two community events: the Métis D&S community launch, and the annual provincial Métis Health Forum. The Métis D&S community launch was a community event which took place in Red Deer, AB, at the Bower Ponds venue on September 19th and 20th, 2019. Métis community members in Red Deer, Shining Mountains employees, as well as partners involved with the implementation of DBST (employees from Alberta Health Services, Public Health Agency of Canada, the Red Deer Street Clinic, and D&S research team members), and representatives of other local service organizations and government, were invited to attend. The second event in which DBST was offered was the Métis Health Forum, which is hosted annually by the MNA. The corresponding health fair held several dozen booths which featured information on training programs, resources, and services geared towards Métis people. Corresponding activities took place at the Métis Health Forum, which included presentations. The Health Forum took place on November 30, 2019 and drew a broad audience of over two hundred individuals comprised of Métis people from Edmonton and surrounding areas who were either working in or interested in the field of health.

Using a CBR approach (Israel et al., 1998), combined with a case-study approach (Crowe Cresswell, Robertson, Huby, Avery, & Sheikh, 2011; Yazan, 2015), we grounded this paper in reflections based on our team's experience working within all phases (from project formulation to evaluation) of this DBST pilot. We examined supplemental data from interviews with DBST providers, meeting minutes that were taken during planning meetings between collaborators, observational notes from meetings and testing events, the collaboration agreement between Shining Mountains and NHLRS, and notes from debriefs amongst D&S and Shining Mountain team members. Crow and colleagues (2011) identify a case study as a "research approach that is used to generate an in-depth, multi-faceted understanding of a complex issue in its real-life context," and thus is often used to explore a single phenomenon in-depth (p. 1). Because a case-study approach fosters an in-depth examination of a single phenomenon or case and its flexibility allows it to be used in a wide variety of contexts, we identified it as an appropriate methodology for this analysis; this type of reflective work is also congruent with Métis ways of understanding. In this research, the case was the planning and implementation process of a DBST pilot in and with the Métis community. Reflecting on data collected, we identified acts of allyship that occurred throughout our experience in this multi-partner collaborative pilot. This process allowed us to identify seven themes relating to allyship within the context of this DBST pilot experience, and three lessons learned for consideration by those aiming towards allyship with Métis communities and peoples working to address HIV and STBBI within their own communities and contexts.

RESULTS: REFLECTIONS ON ALLYSHIP

Based on our reflections on the contexts and processes of the DBST pilot, seven actions and approaches were identified as promising practices related to allyship. These are: established regular communication with community representatives; listened openly and without judgement in order to reduce tensions; developed a positive working relationship; deferred decision-making (wherever possible) to those who represented the community; acknowledged past and present history of colonialism and poor relationships with the Métis community; acknowledged the right of Indigenous communities to self-determine their health services; and challenged the status quo. Each of these observations will be briefly introduced here and further elaborated upon in the discussion section.

Established regular communication with community representatives

Within this pilot, project partners met on a regular basis via conference calls, and communication was demonstrated by speaking openly and honestly with Shining Mountains and the D&S team members who were supporting this pilot. When partnered agencies experienced internal challenges with approval processes or delays, they shared the reasons behind these challenges openly with the team. For example, a complex laboratory pathway for the handling of test strips, specific to the DBST pilot, needed to be created by AHS and the Provincial Labs. Sharing the details of this complex pathway and process for handling of the DBST strips helped our team to understand the internal challenges involved with piloting DBST, and also showed that the pilot was taken seriously by AHS staff members who wanted to prevent any potential losses of DBS test strips or results and ensure appropriate and timely linkage to care. As challenging as it can be to find time within busy schedules, the commitment to providing regular project updates helped to build trust with project partners, and thus contributed to the development of a positive relationship.

Listened openly and without judgement (in order to reduce tensions)

During the process of planning for the pilot of DBST, there were differences of opinion about a number of issues. Some policy-related disagreements arose related to whether nurse practitioners were qualified to be the "most responsible person" for authorized DBS collection (which included requisitioning tests and following up with clients); whether Shining Mountains could or should collect DBST samples through their office; and whether venous blood tests for STBBI were "better" than DBST for pregnant individuals. These differences of opinions became sources of tension and disagreement for some partners within our team because it was seen as potentially disrespectful of Métis ways of decision-making within healthcare contexts. Some partnered individuals within AHS understood this tension and seemed sensitive to it, whereas others did not. Those who demonstrated this understanding did their best to mediate this tension by rephrasing the intention and wording of their colleagues.

Developed a positive working relationship

For the NHLRS, working toward a positive relationship with the Métis community in this pilot began with the co-development and signing of an agreement. This agreement explicitly stated

that community values, perspectives and knowledges would be honored by the NHLRS throughout their collaboration. The agreement also identified principles of ethical collaboration, which included respect for First Nation, Inuit and Métis right to self-determination; the jurisdiction to decide about testing in their communities; the right to follow cultural codes of conduct and community protocols, and to have these incorporated into the testing process; and the explicit ownership of their data outside of the federal and provincial regulated reporting systems. Staff from the NHLRS acted as allies by attempting to educate their colleagues in AHS about the importance of signing a research agreement (or collaborative memorandum of understanding) with the Métis communities. In response, AHS staff highlighted their existing legal right to collect health information and data within the province without a research agreement or memorandum of understanding in place. Ultimately AHS opted to not develop a research agreement for this project. Taking the time to co-develop and sign this agreement indicated that staff from the NHLRS intended on developing their relationship with the community 'in a good way', regardless of legal imperative.

Deferred decision-making (wherever possible) to those who represented the community

While deferred decision-making was explicitly acknowledged in the agreement signed by Shining Mountains and the NHLRS, this was not explicitly the case with all partners. Partners in the collaborative pilot provided balanced views with pros and cons to support team-based decision-making, which was reflective of Métis community values and ways of doing things. For example, AHS proposed to limit the number of possible DBS tests collected at the Métis Health Forum and provided a balanced viewpoint for doing so. With some discussion about potential problems and solutions within this scenario, Shining Mountains agreed to limit collection of DBS tests to 50. Although this is more of an example of collaborative decision-making, this discussion process helped partners to understand some of the internal policy and HR contexts within AHS which influenced the collaborative decision to limit tests to 50.

Acknowledged past and present history of colonialism and poor relationship(s) with the Métis community

According to one Métis DBST provider, the relationship between Métis communities and the AHS had not been a positive one in the past. This was acknowledged by an individual within AHS; this individual also expressed their wish to improve upon the relationship between AHS and the MNA. This seemed to strengthen the relationship between team members and the AHS, as there was an interest on the part of some AHS staff in working collaboratively with the Métis community further, whether through DBST or through other projects.

Acknowledged the right of Indigenous communities to self-determine their health services

The research agreement between Shining Mountains and NHLRS explicitly identifies the right of Indigenous communities to self-determine their health services. For instance, the NHLRS, respecting the Métis community's right to self-determine their health services, asked the community to determine the proper protocol around disposal of the test strips after results had been communicated to DBS test recipients. In addition to respecting the community's right to self-determination, this demonstrated an understanding and acknowledgement that some

Indigenous communities place a cultural and/or spiritual importance upon biological samples. Upon partnering with the Métis community, the NHLRS was willing to return samples upon request, in order to respect community protocols. In this case, however, the Métis community leadership determined that destroying the test strips after testing was appropriate.

Challenged status quo

There was some discussion and debate over who could act as the most responsible person and requisition tests. Shining Mountains proposed that nurse practitioners would act as the most responsible person; however, having nurse practitioners designated as the most responsible person at the pilot testing events was challenged and discouraged by some individuals working within the health system who felt that nurse practitioners may have a harder time following up with test recipients. Challenging the status quo was demonstrated by partnered health service providers who advocated that it was within the scope of practice and established protocols for a nurse practitioner to order DBST requisitions and be responsible for communicating results to individuals.

DISCUSSION

Piloting DBST with the Métis community gave our team considerable experience partnering with individuals and institutions that demonstrated actions/acts of allyship, and also with those who are still early on in their journey toward allyship-informed work in the health field. Some institutional partners showed that they were willing to take steps toward acting as allies, in allyship. Some demonstrated acts of allyship within their own systems that directly challenged the actions of others who were less informed about working in allyship with Métis communities. These actions served to increase the comfort level of community partners and may potentially have increased awareness among their colleagues. Others who were part of the DBST pilot would benefit from more education around allyship, systemic racism within health institutions, and coaching in more critical internal dialogue about how to act as accomplices within their respective institutions.

Most of the themes we identified in this analysis have been discussed in the literature in the fields of Indigenous studies and allyship. Here we reflect upon how these acts of allyship may strengthen partnerships with Métis and other Indigenous communities which aim to address HIV, HCV and other STBBI.

Established regular communication with community representatives

Clear and frequent communication was a characteristic of the DBST pilot process. Building trust is an important first step in demonstrating the tenets of allyship (Smith et al., 2016). Effective communication is key to fostering good relationships and establishing trust with Indigenous communities. Open communication about project details is integral to developing a positive relationship with community partners (Ball & Janyst, 2008). Regular, open communication has previously been identified as a wise practice in CBR research (Israel et al., 1998).

Listened openly and without judgement (in order to reduce tensions)

Partners who were effective collaborators within this pilot often listened openly and without judgement, particularly during tense situations. Although it is a simple concept, listening with an open mind and without judgement is an observation about allyship which bears repeating. At the core of Indigenous allyship is understanding that the "conversation" is not about allies; rather it is about Indigenous communities. Listening to community members is an essential aspect of allyship (Smith et al., 2016; Swiftwolf, Shaw, & Montreal Urban Aboriginal Community Strategy Network, 2019). Ideally, when one is working towards allyship, potential conflicts should be navigated gently using open and honest communication. Where possible, decision-making should be deferred to the community partners or a shared or consensus-based decision-making model should be used, as this supports self-determination within the community (Jull, Giles, Boyer, Stacey, & Minwaashin Lodge, 2015).

Developed a positive working relationship

Partners within this pilot study who demonstrated actions of allyship were dedicated to forming respectful and productive relationships with counterparts in community. Establishing meaningful relationships with Indigenous communities is a key aspect of demonstrating allyship with Indigenous peoples (Smith et al., 2016). Building relationships with Indigenous Peoples requires time and patience; workings towards allyship also requires consistent effort, time, and active self-reflection (Kluttz, Walker, & Walter, 2020). Developing a relationship can require going above and beyond what some might typically deem "necessary". For example—signing a research agreement. While not a legal necessity on behalf of AHS, particularly since AHS was not involved in this pilot in a research capacity, relationships with Indigenous communities can benefit from formalized agreements, especially those that outline the explicit responsibilities of organizations/institutions involved. Evans and colleagues (2012) suggest that as part of an ethical approach to engaging in research with Métis communities, research agreements should be required. Additionally, relationships should be grounded in a distinctions-based approach, which requires one to recognize and understand the differences between First Nation, Inuit and Métis Peoples, and utilizes a different approach which is reflective of the unique identities and cultures within each group. Ethical approaches to conducting research with Métis or Indigenous communities also include developing relationships with the community—this is not a one-off task, but a lifelong commitment to relationship building and meaningful collaboration (Leung & Min, 2020).

Deferred decision-making (wherever possible) to those who represented the community

Deferring decision-making to community representatives was a practice modeled by some partners in this collaborative pilot. Deferred decision-making has been identified as a good practice to be used for those working toward allyship, as it attempts to level the power imbalance between Indigenous and non-Indigenous peoples and communities (Swiftwolf et al., 2019). Non-Indigenous people are in a position of power in relation to Indigenous Peoples, and therefore every action (or arguably, inaction) has serious implications (Smith et al., 2016). To strive towards allyship is to work alongside Indigenous Peoples rather than standing in front (Smith et al., 2016). It also requires solidarity which can be demonstrated by amplifying the voices and

perspectives of community members and supporting their self-identified solutions to health problems (Kluttz, Walker, & Walter, 2020). In this case, DBST was an intervention identified by community members to address HIV and STBBI within their community. Meaningfully involving and deferring decision-making to community members is a central tenet of CBR. Community-based approaches to research recognize that there is a power imbalance between researchers and communities; researchers should acknowledge that power dynamic and reflect on how it impacts their work with Indigenous communities (Snow, 2018). Using a CBR approach can facilitate and support acts of allyship with Indigenous communities (Hyett et al., 2018). Although methods for addressing power imbalances exist within research, these types of power imbalances are yet to be sufficiently acknowledged or addressed within health service or health policy contexts.

Health researcher Stephanie Nixon (2019) writes of the impact of power, privilege, and oppression on health and health services. Nixon (2019) challenges us to think critically about who holds expertise on health issues. She argues that within the health sphere, those who hold the decision-making power and money to develop programs, policy, and services affecting those who are 'marginalized' tend to be individuals who hold a certain amount of privilege, and often have less experience with the issues Indigenous communities are attempting to address. Those who are on the "bottom of the coin" (i.e., those who experience oppression) have first-hand experience with these health issues, and are often the most knowledgeable on these topics (Nixon, 2019, p. 3). Fostering and deferring decision-making to community delegates, who are experts in their communities and their needs, supports self-determination of communities.

Acknowledged past and present history of colonialism and poor relationship(s) with the Métis community

In this DBST pilot, one AHS staff member acknowledged poor relationships with Métis community in the past. Learning about the history of colonization and educating oneself rather than relying on others to educate are key to acting as an ally (Smith et al., 2016). For researchers, this educating of oneself should include reflecting on one's privilege and examining how the history of Indigenous health research has shaped the current Indigenous research environment and its governance (Hyett et al., 2018; Jaworsky, 2019; Landy et al., 2016). It is not enough to simply know the history of Canada and its oppressive and colonial origins; allied researchers and partners need to understand the historical contexts, as well as present-day contexts of the specific communities they are working with (Hyett et al., 2018; Jaworsky, 2019). Understanding and acknowledging how historical and current contexts have impacted relationships from both sides (i.e., Indigenous communities and Western governments/institutions) is essential to developing relationships and should also inform the development of health policy and services.

Acknowledged the right of Indigenous communities to self-determine their health services

Acknowledging the right of Indigenous communities to self-determine their health services was explicitly stated in the research agreement with NHLRS. Interfering with the ability of a community (or individual) to self-determine is the opposite of allyship as it reinforces colonial structures and relations that exist to oppress Indigenous Peoples (Smith et al., 2016). Physician researcher Denise Jaworsky (2019) writes, "In addition, specific Indigenous communities may

have developed their own protocols for research and self-determination in research and it is the responsibility of non-Indigenous researchers to be respectful and adherent of local protocols for conducting research" (p. 8). Self-determination has been acknowledged by some as the most important determinant of Indigenous people's health as it influences all other determinants of health. Self-determination in health requires equal participation in planning and decision-making of health services (Loppie Reading & Wien, 2009). In order to address health equity, self-determination of Indigenous communities' health services must take place. Individuals working towards allyship can support the self-determination of communities by supporting their self-identified needs and deferring decision-making to community members and leaders.

Challenged the status quo

In this pilot, individuals who demonstrated the principles of allyship were not afraid to challenge the status quo. Challenging the status quo involves using position and privilege to listen, shift power dynamics, speak up (even when its uncomfortable) and take action (Swiftwolf et al., 2019). Some challenge the status quo by integrating Indigenous knowledges into seemingly very clinical fields (i.e., pharmacists and pharmacy educators) through a process of integrating Indigenous knowledge experts such as Elders, to provide guidance in re-designing health services in ways which are more appropriate and relevant to Indigenous communities (Leung & Min, 2020). As mentioned earlier, allyship is considered by many to be a means to an end in order to address health inequities. Complacency is a major threat to allyship and to addressing health inequities (Leung & Min, 2020).

In 2001, First Nation ethicist Willie Ermine wrote about the *Ethical Space of Engagement*; a space which is formed when two very different societies and worldviews engage each other. Ermine (2001) writes:

> Engagement at the ethical space triggers a dialogue that begins to set the parameters for an agreement to interact modeled on appropriate, ethical and human principles. Dialogue is concerned with providing space for exploring fields of thought and attention is given to understanding how thought functions in governing our behaviours. It is a way of observing, collectively, how hidden values and intentions can control our behaviour, and how unnoticed cultural differences can clash without our realizing what is occurring. Attentive work on these issues has not occurred in Indigenous-West relations, nor has there been a framework that enables this discussion to happen. (p. 203)

In this quote, Ermine highlights the hidden values we hold, and how these can impact the way we as humans and cultural beings work with others within this ethical space. He also emphasizes that this type of deeper, thought provoking work of dialoguing with counterparts has yet to take place in Indigenous-West relations. In order for "human-to-human" dialogue to occur within this ethical space, one must be able to approach this ethical space openly, and "detach from the cages of our mental worlds", or in other words, cast off our pre-conceived notions of the other (Ermine, 2001, p. 202). Therefore, demonstrating the principles of allyship requires one to discard prejudices and approach the ethical space openly when working with Indigenous communities.

The *Indigenous Ally Toolkit* (Swiftwolf, Shaw, & Montreal Urban Aboriginal Community Strategy Network, 2019) identifies three important roles within allyship: that of ally, accomplice, and/or co-resistor. The role of an ally is centered around the disruption of oppressive spaces and the status quo through education. The role of accomplice involves working within systems to directly challenge institutionalized/systemic racism and colonization. The role of co-resistor involves standing together (with Indigenous peoples) in resistance against oppression by combining theory and practice, establishing relationships and being deeply involved within a community that informs how one listens critically, understands an issue, and influences how they disrupt oppressive institutions and systemic systems. The authors of the Indigenous Ally Toolkit highlight that all three roles are equally important and are necessary to create positive change for Indigenous peoples. All three of these roles within allyship play an important role in navigating Ermine's (2001) ethical space when it comes to working with and for Indigenous Peoples. The *Indigenous Ally Toolkit* reminds us that "being involved in any kind of anti-oppression work is about recognizing that every person has a basic right to human dignity, respect, and equal access to resources" (Swiftwolf, Shaw, L., & Montreal Urban Aboriginal Community Strategy Network, 2019 p. 3). It is important to highlight the right to 'equal access to resources': within a healthcare context, research has demonstrated that Indigenous peoples do not have access to the same level or quality of healthcare as non-Indigenous Canadians, and in the case of Métis individuals, often experience culturally-unsafe care within the system (Monchalin, 2019; Monchalin & Bourassa, 2019). Therefore, working to resolve health inequities in the field of HIV and STBBI testing and care could be considered one way to demonstrate allyship within health services or public policy.

Involvement in anti-oppressive work requires one to question one's own motivations for involvement in a partnership (Snow, 2018). In this pilot, some partners were more clear regarding their motivations for being involved in the pilot (i.e., demonstrated a clear love for the work and desire to help Indigenous communities address health inequities in the field of HIV testing and care), while the motivations for others were less clear. Those who aim to demonstrate allyship should maintain an awareness of any personal agendas, and actively work to minimize them when working with Indigenous communities.

Physician researcher Denise Jaworsky (2019) has developed an allied research paradigm for epidemiology research with Indigenous Peoples. Although the primary purpose of the DBST pilot was not to generate epidemiological data, many of the foundational aspects of her allied research paradigm are reflective of our findings on allyship and can be useful to those who aim toward allyship. Jaworsky's allied research paradigm is comprised of six principles: reconciliation, relationships, perspectives, positionality, self-determination, and accountability. Relationships, perspective (listening to self-identified issues and research questions of the community), positionality (participating alongside Indigenous peoples), and self-determination are also reflected within our findings. Jaworsky (2019) also highlights Shawn Wilson's (2008) work on relational accountability, using this concept to "begin your own path to reconciliation", which Jaworsky also identifies as a core element when working toward allyship.

CONCLUSION

Allyship, which was reflected through those who supported and facilitated the DBST pilot in the Métis community, was key to the success of this DBST pilot. Non-Indigenous health workers can demonstrate allyship for Métis communities by advocating for policy changes that better support adequately funded, Métis-specific and Métis-administered HIV and STBBI services and can strive to integrate the seven themes into their actions when working with Métis communities. We have summarized these promising practices for building relationships as allies with Métis communities into three lessons learned. These lessons learned can be considered key takeaway messages for individuals or organizations that are currently working with (or considering working with) Métis communities and aim to reflect allyship in their work and ways of being:

1. Take time to foster a positive working relationship with community representatives – this working relationship is built on open and honest listening, regular communication, and the development of trust.
2. Educate yourself on the specific current and historical contexts of the community with whom you are working. Embark upon a learning journey, which includes exploring concepts related to Indigenous self-determination, Indigenous understanding of health and wellness in HIV, HCV and STBBI contexts, and the root causes of Indigenous health inequities. Use your talents to support community-identified, planned, and implemented interventions.
3. Critically reflect on how you can challenge the status quo to the benefit of Métis communities. Ask yourself: is the status quo currently serving the needs of this community? Challenge not only your own, but also your colleagues' ways of thinking and conducting work. Don't be afraid to 'push the envelope'.

We suggest these three lessons learned as an introductory way for you, the reader, to consider how you can work in a more effective and respectful way with Métis communities. By striving to adopt these lessons learned into your work and ways of being, you will benefit community, and grow and learn in allyship.

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