LITERATURE REVIEW

Health Services and Gender-Based Violence

For:

Southern Chiefs' Organization Inc.

July 20, 2022

LOMBARD LAW

Integrity. Respect. Empowerment.

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I. INTRODUCTION

1. Statement of Objectives

We are engaged by SCO Inc. to provide a review of available health care and system data, statistics and supports for those who have experienced gender-based violence (GBV) at the community level or locally in southern Manitoba. This will include an examination of how health care systems respond or fail to respond to the experiences of community members with respect to GBV. Therefore, this review seeks to identify both opportunities and deficits in health care services for Indigenous survivors of GBV.

The first step in this review is to examine the work already done in this area that identifies the role of health care supports for those experiencing GBV at the community or local level. The second step is more qualitative, providing a discussion of how the various health care supports identified respond to the lived experience of survivors of GBV. These two lines of inquiry are interrelated: if health care supports for GBV are lacking, then they are necessarily not responsive to the lived experience of GBV survivors. Indeed, as explained further below, we find that in general there are no specific supports targeting GBV, which has multifaceted impacts and manifestations, and that survivors tend to face the same barriers to effective treatment of GBV that Indigenous people generally face in the field of emergency health care treatment, addictions, and mental health support.

2. Methodology and Organization

Analysing the available literature is an important step in developing policy and practices that are robust and grounded. Literature reviews assist by uncovering gaps: they help answer the question "what is missing from this picture?"

A gap analysis, the practical outcome of a literature review, serves to highlight gaps in three primary areas: logic/structure, data/evidence, and relevance/meaning. A logical or structural gap exists where two concepts are not connected through causation in either or both directions. Data gaps arise by examining the kind of data supporting each causation. Finally, assessing for a gap in meaning, or relevance, asks if the examined studies were undertaken with, and by, the right people or stakeholders. A broader group of stakeholders, in general, results in a better mapping exercise, which in turn solidifies the identified gaps.[1]

At the outset, it is important to note that a data gap will exist in many, if not all, studies on GBV in Indigenous communities. This is because experiences of GBV, in its various forms, often go unreported. In particular, sexual assault is "prone to high levels of underreporting and low case

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[1] Steve Wallis & Bernadette Wright, "Gap Analysis for Literature Reviews and Advancing Useful Knowledge" (6 February 2020), online: Research to Action <www.researchtoaction.org/2020/06/gap-analysis-for-literature-reviews-and-advancing-useful-knowledge> accessed 12 May 2022.

retention in the Canadian criminal justice system."[2] The reasons for underreporting of GBV among Indigenous women, girls, and 2SLGBTQ+ people are complex; they include mistrust of police and the criminal justice system due to systemic racism, a lack of access to culturally appropriate resources, inaccessibility of support services, and concerns about confidentiality in the justice system.[3] The gap is likely wider with respect to GBV against Indigenous 2SLGBTQ+ people due to failures to collect and disaggregate data based on gender identity.[4] We draw attention to this well-known gap in order to contextualize existing data on GBV in Indigenous communities: reported cases are the tip of the iceberg. A fulsome and effective health care response to GBV must be prepared to address the magnitude of the issue and the need among community members, which may not be captured in existing figures. Given that a lack of culturally appropriate and accessible services is cited as a reason for underreporting, improvements in service delivery for Indigenous women, girls, and 2SLGBTQ+ people may well begin to encourage survivors to come forward to access supports.

Fortunately, much work on the issues identified in the scope of work has been undertaken and compiled. We rely on four (4) groupings of sources in our analysis:

1. A completed literature review developed on the issue of missing and murdered Indigenous women and girls and provided by SCO Inc.;

2. A completed literature review by the National Inquiry on Missing and Murdered Indigenous Women and Girls (NIMMIWG) and the final reports of the NIMMIWG;

3. The Royal Canadian Mounted Police's data and reporting on GBV, including the number of referrals it and other institutions made to services and supports off reserve; and

4. Literature reviews and sources developed in the course of my graduate work, which includes jurisprudence and secondary sources focusing on the intricacies of systemic racism in health care and the role of intersectionality in addressing the same.

For ease of reference, our findings, analysis, and conclusions are presented in turn, followed by an appendix with summaries of each of the sources reviewed. Our conclusion contains an evaluation and critique of the existing literature. We offer recommendations for next steps for

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[2] Christine Rotenberg, "From Arrest to Conviction: Court Outcomes of Police-Reported Sexual Assaults in Canada, 2009 to 2014" (2017) 37:1 Juristat 1-57 at 4 <www150.statcan.gc.ca/n1/en/pub/85-002-x/2017001/article/54870-eng.pdf?st=jzBTSPCF> accessed 16 May 2022.

[3] Loanna Heidinger, "Violent Victimization and Perceptions of Safety: Experiences of First Nations, Métis and Inuit Women in Canada" (2022) 42:1 Juristat 1-40 at 4 <www150.statcan.gc.ca/n1/en/pub/85-002-x/2022001/article/00004-eng.pdf?st=hdTph00x> accessed 16 May 2022.

[4] Canada, National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report the National Inquiry into Missing and Murdered Indigenous Women and Girls, vol 1a* (Vancouver: Privy Council, 2019) at 452 [NIMMIWG Final Report, vol 1a].

research to address the identified gaps and build on strengths and opportunities in order to improve health care and system supports for Indigenous survivors of GBV.

3. Definitions and Parameters

The United Nations has defined violence against women by using the concept of GBV in a way that we believe appropriately captures the breadth of the actions that the SCO seeks to describe:

> [T]he term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[5]

To be clear, GBV is any type of violence, mental, physical or sexual, attempted, threatened or actual, perpetrated against a woman, girl, or 2SLGTBQ+ person. Importantly, 2SLGBTQ+ persons' experiences of GBV are distinct and varied. The umbrella term captures a wide range of gender identities. For Indigenous 2SLGBTQ+ people, discrimination based on race and gender is combined with homophobia, transphobia, and other forms of gender discrimination, which also exist within Indigenous communities.[6] At a principled level, it is important to note that those who live through various manifestations of gender phobias in their communities are also survivors of GBV.

While the health care system is often understood as responding to GBV through treatment and care, it is important to note that the health care system can also be a site where GBV is perpetrated. The mainstream health care system has enacted GBV against Indigenous women, girls, and 2SLGBTQ+ people through coerced sterilization and other forms of interference with their reproductive rights.[7] Indigenous 2SLGBTQ+ people report that the lack of access to gender-affirming health care, mental health counselling, and anti-violence services causes further marginalization and makes it difficult for them to get the support they need.[8] "The intentional act of misgendering is a form of severe psychological and emotional abuse"[9]; misgendering and erasure occur routinely when 2SLGBTQ+ people seek health care services.[10]

While we are aware that the SCO is particularly interested in the constituents of the SCO, exclusive focus on the SCO population or region is too narrow for the purposes of this literature review. We

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[5] United Nations, *Declaration on the Elimination of Violence Against Women*, GA Res 48/104, UNGAOR, 48th Sess, UN Doc A/48/104 (1993) <www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.21_declaration%20elimination%20vaw.pdf> accessed 8 March 2022.
[6] NIMMIWG Final Report, vol 1a at 59 and 458.
[7] Yvonne Boyer & Judith Bartlett, *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women* (2017) [Boyer & Bartlett, *External Review* (2017)].
[8] NIMMIWG Final Report, vol 1a at 450.
[9] NIMMIWG Final Report, vol 1a at 451.
[10] NIMMIWG Final Report, vol 1a at 453.

understand that community members of the SCO's constituting First Nations have experienced GBV at the community or local level. Community members are defined as those registered, or entitled to be registered, as members of the SCO's constituting Indian Bands (per section 2 of the *Indian Act*), or otherwise recognized as citizens of the Nations according to instruments or customs arising from inherent, treaty, and/or self-governing powers. The SCO includes 34 Anishinaabe and Dakota Nations and more than 81,000 citizens in what is now called southern Manitoba,[11] straddling Treaty territories 1, 2 and involving the Dakota Nations which are not bound by the numbered Treaties. Though a sizeable population and geographic spread, it is unlikely that this area has been the focus of targeted study on GBV or related issues, and it makes sense to widen the review parameters to capture more general studies which may be applicable to this region. While the health care system of southern Manitoba certainly has unique features, we understand that the intention of this work is to look more broadly at work done on the national level regarding GBV and the health care system as a first step. We can assuredly undertake a more southern-Manitoba-specific analysis that builds on this work at a later date.

Finally, we would like to note the definition of 'available' that we employ. Available to us means free and available to do something at a particular time; qualified or willing to do something at a particular time. The definition implies that the service or system support is capable of delivering a useful benefit to the user. Ensuring the availability of health care services for rural and remote Indigenous communities is required for service delivery to be equitable and effective. As such, though health care services for survivors of GBV may exist in certain forms, they may not be qualified or willing to provide services to Indigenous women, girls, and 2SLGBTQ+ people.

4. Central Findings

Upon our review of an extensive amount of work done on GBV, it is clear that GBV has not been addressed in a serious and systemic way in health care systems, and that the systemic discrimination that Indigenous people face in accessing and benefitting from public health care systems in Canada also plague the experience of Indigenous GBV survivors. Indigenous women, girls, and 2SLGTBQ+ persons disproportionately experience these barriers.

Information about service-specific availability requires interviewing key informants with expertise in the area and on the ground knowledge of primary health care in the subject region.

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[11] Berens River First Nation, Birdtail Sioux Dakota Nation, Black River First Nation, Bloodvein First Nation, Baaskaandibewiziibing Ojibway Nation, Buffalo Point First Nation, Canupawakpa Dakota Nation, Dakota Plains Wahpeton Oyate, Dakota Tipi First Nation, Dauphin River First Nation, Ebb and Flow First Nation, Gambler First Nation, Hollow Water First Nation, Keeseekoowenin Ojibway First Nation, Kinonjeoshtegon First Nation, Lake Manitoba First Nation, Lake St. Martin First Nation, Little Grand Rapids First Nation, Little Saskatchewan First Nation, Long Plain First Nation, O-Chi-Chak-Ko-Sipi First Nation, Pauingassi First Nation, Peguis First Nation, Pinaymootang First Nation, Pine Creek First Nation, Poplar River First Nation, Rolling River First Nation, Roseau River Anishinabe First Nation, Sagkeeng Anicinabe First Nation, Sandy Bay Ojibway First Nation, Skownan First Nation, Swan Lake First Nation, Tootinaowaziibeeng Treaty Reserve, and Waywayseecappo First Nation.

II. QUALITATIVE ANALYSIS

The SCO has asked for an analysis of existing sources focused on how health care systems respond to the experiences of community members with respect to GBV. The existing sources show health care supports to be piecemeal, subject to systemic racism, and wholly unresponsive to the experiences of Indigenous women, girls, and 2SLGBTQ+ people. We have no reason to believe this reality is different for the members of the SCO constituent communities. Because this answer was demonstrated in the reviewed materials, we will instead dedicate this analysis portion to exploring the key ways in which the health care system has failed to adequately address GBV, and point to areas in which additional research could be undertaken.

The literature reviewed below show that GBV has complex impacts on health and, consequently, on health care needs. In particular, GBV gives rise to immediate and longer-term physical injuries that may require treatment, but may also gravely impact mental health, addictions, and/or substance use issues. These non-physical aspects may present as both contributing factors to vulnerability to GBV and the result of GBV, and are part of the legacy of colonial and intergenerational trauma that continue to plague Indigenous communities. In order to effectively address GBV in a holistic and systemic way, underlying issues of marginalization, poverty, and intergenerational violence must be addressed. Looking more narrowly at GBV in the health care system, more targeted measures may help to tackle its impacts. We will analyse the three areas of GBV impacts in health care, provide an overview of the issues revealed in our source review, and offer suggestions for follow-up work.

1. Holistic Conception of Health and Companion Systemic Overhaul to Meaningfully Address the Root Causes of GBV

As a preliminary point, we would like to acknowledge the conception of health put forth in the NIMMIWG Final Report. Contrasted with the Western medical conception of health as the absence of illness, the NIMMIWG presented a view of health as *wellness*, involving spiritual, cultural, and emotional health and social safety as well as physical and mental health.[12] Relatedly, it takes a broad view of the right to health as connected to clean water, adequate infrastructure, shelter and food security, matters that are often taken for granted in mainstream Canadian society but which remain live issues for many Indigenous people. In this way, the colonial legacy of displacement, oppression, and subjugation which have led to poverty, the breakdown of social relationships, and high rates of trauma in Indigenous communities are very much part of the health conversation. Solutions to address inadequate health care must be rooted in a wider strategy to address this legacy and context, otherwise they risk providing a band-aid to deeper and more intractable issues. This is best framed by Globe and Mail health columnist Andre Picard:

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[12] NIMMIWG Final Report, vol 1a at 416.

> The indigenous community is young and the fastest growing by far – more than 50 percent of indigenous people in Canada are under the age of 15. This is the time to stop generation after generation of disaster, poverty, isolation, addiction and suicide – we've created all that. We have an apartheid system designed to oppress people and it's given the exact results it was designed to produce. Take away their culture, their language, their ability to earn money, their ability to have land, and then, oh, we're surprised they're the most unhealthy people in our country? It's not a surprise at all.[13]

The sources resoundingly find that inequitable service delivery and gaps in services for Indigenous women, girls, and 2SLGBTQ+ people result from funding inadequacies, lack of collaboration, and overburdened service providers.[14] Challenges associated with inadequate and flawed funding models, service gaps, a lack of culturally appropriate services, and inequitable services are heightened in rural and remote communities.[15]

The literature identifies the following as necessary components of appropriate and effective responses to GBV:

- prevention at the health service level;
- equal access to services and opportunities for healing on a long-term basis;
- collaboration among service providers;
- the stable commitment and collaboration of community members, social health practitioners, and government; and
- attention to root causes, including underlying socioeconomic factors.[16]

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[13] NIMMIWG Final Report, vol 1a at 422.

[14] Quebec Native Women, *Nānīawig Māmawe Nīnawind. Stand With Us: Missing & Murdered Indigenous Women in Quebec* (Kahnawake: QNW, 2015) [QNW, *Nānīawig Māmawe Nīnawind* (2015)]; Four Worlds Centre for Development Learning et al, *Aboriginal Domestic Violence in Canada* (Ottawa: Aboriginal Healing Foundation, 2003) [Four Worlds Centre, *Aboriginal Domestic Violence* (2003)].

[15] Canada, Parliament, House of Commons, *Special Committee on Violence Against Indigenous Women*, 41st Parl, 2nd Sess, No 1 (March 2014) (Chair: Stella Ambler); British Columbia, *Stopping Violence Against Aboriginal Women: A Summary of Root Causes, Vulnerabilities and Recommendations from Key Literature* (Ministry of Children's Services, 2011); Pacific Association of First Nations Women, BC Women's Hospital and Health Centre & BC Association of Specialized Victim Assistance and Counselling Programs, *The "Start of Something Powerful": Strategizing for Safer Communities for BC Aboriginal Women* (2003); P Moffitt & H Fikowski, *Northwest Territories Research Project Report for Territorial Stakeholders: Rural and Northern Community Response to Intimate Partner Violence* (Northwest Territories: Aurora College, 2017).

[16] QNW, *Nānīawig Māmawe Nīnawind* (2015); Ontario, Office of the Chief Coroner, Verdict of Coroner's Jury and Recommendations (28 June 2016) <https://ocaarchives.files.wordpress.com/2019/01/jury-verdict-and-recommendations.pdf>; Ontario Native Women's Association & Ontario Federation of Indian Friendship Centres, *A Strategic Framework to End Violence Against Aboriginal Women* (2007) [ONWA & OFIFC, *A Strategic Framework* (2007)]; Wanda D McCaslin & Yvonne Boyer, "First Nations Communities at Risk and in Crisis:

On the last point, much of the literature points to the need for social/health determinants models to be applied to ensure that root causes of GBV are addressed effectively.[17]

Importantly, the sources reviewed highlight the need to address colonialism and racism as systems that enact harm against Indigenous women, girls, and 2SLGBTQ+ people. In particular, the systemic nature of colonialism, including its gendered impacts, must be addressed through decolonization.[18] Widespread racism and stereotyping fuel the denial of services and treatment on the assumption that Indigenous patients are intoxicated or otherwise lack at least a measure of capacity, implying that they are partially, or fully responsible, for their circumstances.[19] Shame and judgment by health care workers also play a significant role in driving Indigenous survivors of GBV away from health care services despite sometimes desperate and dire circumstances.

Control over land and resources can also inform how, when, and where GBV is experienced. The literature draws critical linkages between resource development projects and violence against Indigenous women, girls, and 2SLGBTQ+ people. As the NIMMIWG observed, resource extraction projects can lead to increased GBV perpetrated by non-Indigenous men as well as increased violence within Indigenous communities. Issues related to transient and temporary workers, harassment, assault in the workplace, rotational shift work, substance use and addictions, and economic insecurity often accompany such projects.[20] First Nations in Manitoba have raised specific concerns for women's safety in environmental assessment processes.[21] A regional cumulative effects review by the Manitoba Clean Environment Commission revealed that the arrival of a large transient workforce in northern Manitoba resulted in Indigenous women being targeted for racial and sexual violence.[22] These gendered impacts of resource development highlight the importance of a holistic conception of health, one that considers the health of the land and the community. While the incidence of GBV in areas impacted by resource development has received some attention, specific health care supports and services to address the problem have not been specifically examined.

The literature also draws important connections between the health and justice sectors. A lack of transparency and accountability in policing and justice system responses to GBV are identified as primary aggravating factors. These institutional failures to respond to survivors' needs

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Justice and Security" (2009) 5:2 Journal of Aboriginal Health 61 [McCaslin & Boyer, "First Nations Communities at Risk and in Crisis" (2009)].

[17] ONWA & OFIFC, *A Strategic Framework* (2007).

[18] McCaslin & Boyer, "First Nations Communities at Risk and in Crisis" (2009).

[19] QNW, *Nānīawig Māmawe Nīnawind* (2015).

[20] NIMMIWG Final Report, vol 1a at 584.

[21] Manitoba, Clean Environment Commission, *Report on Public Hearing: Keeyask Generation Project* (2014).

[22] NIMMIWG Final Report, vol 1a at 586.

exacerbate the health gap, systemic racism, and adverse differential treatment experienced by Indigenous women, girls, and 2SLGTBQ+ people.[23]

Some of the literature[24] cites the Aboriginal Healing and Wellness Strategy (AHWS) as a beneficial policy framework in Ontario which successfully addresses "family violence and health issues within an Aboriginal context" for Indigenous women. Literature based in Ontario advocates for an integrated approach to violence against women, which has been lacking in Ontario, and nationally. The AHWS framework could merit a deep examination to explore its potential benefits as at least an initial structure for the new health authority.

Canada's own institutions[25] and other organizations[26] have examined violence against Indigenous women and made findings in reports that present themselves as collaborative efforts with Indigenous women. The reports speak to the need for a coordinated holistic approach to GBV. Further, they acknowledge the heavy burden of discrimination in health services experienced by Indigenous women, pointing to a deep need for the stable provision of culturally safe and relevant health services and holistic healing services designed and implemented by Indigenous peoples. Integrated services, including those specifically targeted towards those most at risk (such as young vulnerable mothers with young children) formed part of the recommended pathways.[27] All such services touch upon the themes examined in the below sections.

2. Physical Injury

Physical injuries are conceptualized in this work as including but not limited to chronic pain, gastrointestinal issues, sexual health, pregnancy and injuries arising from incidents of family and intimate partner violence. The literature reviewed found that racism in health care has led to disappearance and even death.[28] As noted above, systemic racism in health care has also led to

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[23] The Honourable Michael H Tulloch, *Report of the Independent Police Oversight Review* (Queen's Printer for Ontario: 2017) [Tulloch Report of the Independent Police Oversight Review (2017)].
[24] ONWA & OFIFC, *A Strategic Framework* (2007).
[25] Canada, Parliament, House of Commons, Standing Committee on the Status of Women, *Interim Report: Call into the Night: An Overview of Violence Against Aboriginal Women*, 40th Parl, 3rd Sess, No 14 (March 2011) (Chair: Hedy Fry).
[26] AMR Planning & Consulting, *Collaboration to End Violence: National Aboriginal Women's Forum: Report on Outcomes and Recommendations from Working Sessions* (2011) [AMR Planning & Consulting, *Collaboration to End Violence* (2011)].
[27] AMR Planning & Consulting, *Collaboration to End Violence* (2011).
[28] Provincial Court of Manitoba, *Re Brian Lloyd Sinclair, Deceased*, (12 December 2014) <www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf > accessed 12 May 2022; J Géhane Kamel, Investigative Report: Law on the Investigation of the Causes and Circumstances of Death for the Protection of Human Life concerning the Death of Joyce Echaquan (Québec Coroner's Office, 2020) (Translated from French).

interference with the reproductive rights of Indigenous women, girls, and 2SLGBTQ+ people in form of coerced sterilization, another manifestation of GBV.[29]

The Inquiry addressing Pickton's reign of terror in the Downtown Eastside of Vancouver,[30] although not directly related to the provision of health care services, is indisputably the most tragic in terms of examining the impacts of physical injuries, mostly death, of Indigenous women. The report discussed health inequalities that affect women living in Vancouver's Downtown Eastside and the challenges these women faced in accessing health care due, in part, to the judgment they experienced, and distrust of such institutions based on their lived experiences in accessing services. The report found that these serious inadequacies contributed to the women's vulnerability to GBV and serial predation. In sum, the report points to the need for enhanced collaboration between impacted sectors, as discussed in the above section, including health, social, police, and justice. The web of interrelationship between sectors is tightly woven in its production of inequities and discrimination, and requires a holistic approach directed by anti-racism and systemic reform.

Dr. Barry Lavallee's testimony before the NIMMIWG explains that Indigenous women enter the health care system as a stereotype.[31] Because triage and other health professionals often assume that an Indigenous patient suffers from substance use and addictions, underlying issues are not explored, as was the tragic case for the late Joyce Echaquan.

Dr. Lavallee shared that there is a general reluctance to prescribe or provide opioids because of addictions concerns. Such concerns arise even where the patient's medical history and records provide no indication of substance use. Further, birthing Indigenous women are less likely to be offered the same type of pain management medications on account of misguided beliefs that they are more "robust" and do not experience pain in the same way that non-Indigenous birthing mothers do.

Conversely, root causes are sometimes not address and replaced with superficial treatment resulting in a heavy medication to quell symptoms accompanied by discharge with no follow-up. In cases involving GBV, this can send survivors back to sometimes dangerous situations as they must return home where the violence causing their injury resides.

One of the most troubling failures among health care professionals treating Indigenous survivors of GBV is a failure to believe the patient, wholly or in part. For example, the NIMMIWG heard from a woman whose mother who was badly beaten and resultingly had a broken hip. The first responders kept trying to prop her up, thinking she was intoxicated. As she kept falling, the

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[29] Boyer & Bartlett, *External Review* (2017).
[30] British Columbia, *Forsaken: The Report of the Missing Women Inquiry* (Victoria: Missing Women Commission of Inquiry, 2012).
[31] NIMMIWG Final Report, vol 1a at 462.

health professionals laughed.[32] In another instance, a woman sustained a brain injury in a fight. The police assumed she was intoxicated and brought her home, where she soon thereafter died. In yet another situation, a woman who had sustained blunt force trauma to head was treated by emergency responders as though she was intoxicated and fell downstairs when in fact that was not the case.[33] The assumption that Indigenous women are incompetent, based on a series of racial stereotypes, chronically results in a failure to conduct follow-up interviews and provide appropriate care.

3. Mental Health

The literature recognizes inadequacies in how mental health and GBV issues are handled, and roundly recommends better integration with health services as a fundamental requirement to improving the situation.[34]

Our review suggests that a predictor of mental illness is the experience of violence as a child.[35] Experiencing violence as a child is a knock-on effect of GBV, in many instances, and gives rise to cyclical and inter-generational challenges. A program known to the writer, called "Sacred Child", originally designed by the Aboriginal Women's Support Centre in Ottawa, Ontario in the 1990's, has been positively evaluated for decades in assisting Indigenous children to work through the family violence they witnessed. While the children attend the program, their mothers attend separate programming to learn about what their children are experiencing and how to support them in their therapy. Because the Support Centre has a shelter in a covert location, its programming, including "Sacred Child", is offered to all residents of the shelter and the Centre alike – its reach is significant. "Sacred Child" continues to exist to this day and is lauded by the Indigenous community in Ottawa as a cornerstone of GBV prevention and early mental health treatment for young witnesses of GBV. It was designed and implemented by Indigenous GBV survivors with children who went through the program.

Indicators of mental health conditions may manifest in early forms of isolation, self-harm, and suicidal ideation. Data on suicide and attempted suicide in the Indigenous community as a whole is indicative of an epidemic. Suicide rates in the Indigenous community dwarf mainstream statistics and have long since been considered as a crisis, with geographic and demographic ebbs and flows depending on a series of variables, including outside factors such as the pandemic, the Indian Residential School Settlement Process, the discovery of unmarked graves at former Indian Residential School sites, and others. These, again, point to underlying root causes, both offensive and defensive in nature, that require holistic address by the health care system.

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[32] NIMMIWG Final Report, vol 1a at 469-470.
[33] NIMMIWG Final Report, vol 1a at 470-471.
[34] Tulloch Report of the Independent Police Oversight Review (2017).
[35] NIMMIWG Final Report, vol 1a at 438.

The literature identified many anecdotes describing circumstances in which survivors of GBV were not believed by health care professionals. In one such scenario, a woman's therapist only believed her after six months and independent corroboration of her experiences, resulting in the woman leaving treatment.[36] Biased mental health treatment can do more harm than good in that people who need it the most can be turned away. This harkens Allan Wade's testimony before the NIMMIWG in relation to the "colonial code of relationship" in mental health services.[37] It is also relevant, as noted in the NIMMIWG's Final Report, that mammoth delays associated with acquiring mental health services serves as, first, a dissuasion from seeking those services and, later, a deep disappointment when those long-awaited services turn out to be inadequate. A sense of desperation in the survivor of GBV inevitably ensues.

4. Addictions / Substance Use

The cycle of substance use and addictions exists as both a coping mechanism for survivors of GBV and an exacerbating factor. It is a symptom of a root cause, not the cause itself. Intergenerational trauma and a lack of services and treatment facilities exacerbate vulnerability to GBV. Though undertaken in a different context, the Coroner's Inquest into the RCMP's shooting death of Rodney Levi significantly recommended the establishment of residential treatment centres on or near reserve-based communities to increase the accessibility and cultural relevance of treatment. The literature unanimously recommends the establishment and provision of treatment facilities close to Indigenous communities to curb the health service deficit and the justified avoidance by GBV survivors of seeking health care services away from their communities.[38]

Of course, substance use and addictions are a symptom of root causes, examined in the first section of this review's qualitative analysis.

III. CONCLUSIONS

[36] NIMMIWG Final Report, vol 1a at 467.
[37] NIMMIWG Final Report, vol 1a at 467.
[38] Ontario, Office of the Chief Coroner, Verdict of Coroner's Jury and Recommendations (28 June 2016) <https://ocaarchives.files.wordpress.com/2019/01/jury-verdict-and-recommendations.pdf>.

This paper has shown that, despite extensive research into the causes and impacts of violence against Indigenous women, there has been no focused study on how GBV has been dealt with by the health care system. Studies that have touched upon the issue have revealed the deeper systemic problems at play in the treatment of Indigenous people by Canada's health care system. Further, few studies have examined the distinct experiences of Indigenous 2SLGBTQ+ people with respect to GBV, let alone health care responses. More attention needs to be paid to the health consequences of GBV, to be sure, but that attention needs to reflect that the health care system itself is imbued with systemic discrimination such that GBV will not be adequately addressed until Indigenous patients are treated with the same objectivity as other groups in society. Only then will the real reasons for physical *and* mental injuries be given due attention and appropriate referral, and Indigenous patients will not simply be patched up and returned to dangerous situations.

The collective literature reviewed stands for the unquestionable proposition that there are critical and deeply harmful gaps between needs and available services in the health system's address of GBV.[39]

One key to GBV-focused change to the system may be in its governance. The NIMMIWG Final Report noted, almost in passing, that federal health care structures engage with First Nations through "established leadership structures," which means the Assembly of First Nations and elected chiefs.[40] It noted that, "for some women, testifying from a grassroots perspective, this is tantamount to complete exclusion."[41] As the survivors of GBV, it makes sense for solutions to be at least vetted, if not developed and driven, by women and 2SLGTBQ+ people.

For accountability purposes, the design and inclusion of an internal ombudsperson's office has proven effective in other systems and should be considered.

As the health transformation proceeds, it is for SCO to develop structures in which women's voices are heard on matters that are relevant to them.[42] We note that maintaining a high degree of discretion in the physical location and availability of health services designed for GBV survivors and their families, as appropriate, is critical for security and safety purposes. Where it is the health system itself perpetrating the GBV, it is evident that deeper localized grassroots research is required to identify needs and gaps in service provision. This will be essential to design a health authority that is responsive to the needs of the community members who experience GBV and require health care services, including women, girls, and 2SLGBTQ+ people.

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[39] *Inter alia*, Four Worlds Centre, *Aboriginal Domestic Violence* (2003).
[40] NIMMIWG Final Report, vol 1a at 420.
[41] NIMMIWG Final Report, vol 1a at 420.
[42] UN General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UNGAOR 61st Sess, Supp No 49, UN Doc A/RES/61/295 (2007) at Articles 18-19 <www.refworld.org/docid/471355a82.html> accessed 23 April 2022.

We recommend the following steps be taken in the development of further research and companion materials to address the gaps clearly identified in the literature review:

1. Adopt a distinctions-based approach by including 2SLGBTQ+ in the purview of all GBV components and conduct a review of available information in that realm;

2. Adopt a continuum of care distinctions-based approach with a focus on community-based health care services and conduct a review of available information in that realm;

3. Identify areas of programming interest, conduct interviews with key informants locally and nationally and with experts from SCO's GBV Advisory Circle;

4. Conduct review of program evaluations associated with programs of interest to include the incidence of brain, intergenerational, and other, trauma with victims of GBV within other governmental initiatives and consider the involvement of the SCO on those committees;

5. Conduct review of provincial ombudsperson's offices in health and consider suitability and adaptability for use by the SCO's emerging health care architecture; and,

6. Undertake and produce a discussion paper implementing approaches and providing findings arising from items 1-5 above, and conduct a qualitative analysis of perceived suitability/adaptability, if appropriate, for local implementation within the offerings of the future health authority.

A.R.L.

IV. APPENDIX: LITERATURE REVIEW SUMMARIES

It is clear that there has been no focused study of GBV and correlating health care supports in the form of targeted services and treatment for Indigenous women, girls, and 2SLGBTQ+ people. The studies that do touch upon the issue demonstrate that there have been no coordinated and meaningful responses to GBV in the health care system. Finally, it is apparent that the piecemeal response to GBV in the health care system has been tainted by the same factors that limit the ability of Indigenous people to obtain effective health care in general, namely, systemic discrimination. This discrimination impacts how GBV is treated in terms of its symptoms as well as its underlying causes.

Below, we summarize the pertinent literature and emphasize findings relevant to the primary purpose of this review. The sources are organized chronologically.

1. Canada, Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples* (Ottawa: The Commission, 1996)[43]

The report is a comprehensive examination of the relationship among Aboriginal peoples, the Canadian government, and Canadian society as a whole. It spans five volumes and includes 440 recommendations. Volume 3, Gathering Strength, and Volume 4, Perspectives and Realities, contain recommendations on addressing family violence and violence against Aboriginal women.

The report recommends that self-directed community healing initiatives be affirmed and supported and that the vestiges of colonial domination and external control that impede community initiative be dismantled immediately (vol 3, 77). The report envisions family violence being addressed effectively through an integrated strategy to achieve whole health, which includes restructuring service delivery through healing centres and lodges under Aboriginal control (vol 3, 78). Perpetrators of violence also have needs and should have access to culturally appropriate treatment (vol 3, 73). Counsellors have found that addictions among Aboriginal people are part of a circle of oppression, despair, violence, and self-destructive behaviour that must be addressed as a whole; the most successful alcohol treatment programs developed by and for Aboriginal people have tackled related problems of physical and sexual abuse, loss of self-esteem and cultural identity, lack of personal opportunity, and marginalisation (vol 3, 148).

The report states that two of the four priorities for change raised by Aboriginal women were (a) health and social services that are culturally appropriate, with a priority focus on healing, and (b) the vulnerability of women and children to violence (vol 4, 20). The report recommends that Aboriginal governments and organisations provide for the full and fair participation of Aboriginal women in the governing bodies of all Aboriginal health and healing institutions (vol 4, 56).

[43] www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx

2. **Manitoba, Public Inquiry into the Administration of Justice and Aboriginal People, *Report of the Aboriginal Justice Inquiry of Manitoba*, vol 1, *The Justice System and Aboriginal People* (Winnipeg: The Inquiry, 1999)[44]**

The inquiry was tasked with examining the relationship between Aboriginal peoples in Manitoba and the province's justice system. Chapter 13 of Volume I of the inquiry's report is entitled "Aboriginal Women." The discussion on supports for abused Aboriginal women is focused on shelter services and making it safe for women to stay in their homes. The report states that there is a provincial toll-free crisis line which provides immediate and culturally sensitive counselling and referrals to women in abusive situations. The inquiry heard that Aboriginal women wanted assistance from programs designed and delivered by Aboriginal people. The inquiry noted that Aboriginal women were uncomfortable with counselling that excluded the abuser from any treatment process and stressed the necessity of the woman leaving her husband. The inquiry stated that Aboriginal women believed that Aboriginal services would focus on the whole person and emphasize healing within the family and keeping the family together within the community. While short-term crisis intervention is often needed, Aboriginal women communicated their desire to be able to transition toward treatment for the family as a unit. The inquiry recommends that where jail does not appear to be the best answer, abusers be required to attend culturally appropriate treatment programs with other members of the family. The report outlines the example of the Hollow Water Resource Group, established to deal with sexual abuse through healing and restitution, rather than punishment.

3. **Kimberly Dreaddy, *Moving Toward Safety: Responding to Family Violence in Aboriginal and Northern Communities of Labrador* (Provincial Association Against Family Violence, 2002)[45]**

This report has four objectives in relation to responding to family violence in Aboriginal communities: to describe current practices, to explore existing models of service delivery, to identify alternatives to traditional shelter services, and to recommend elements of a framework for effective preventative measures (4). The report notes that a single community on Labrador's north coast may receive health services from more than one system, which leads to overlaps and increased costs (12). Efforts to address family violence are typically limited to sporadic public awareness sessions and piecemeal crisis intervention by public health nurses, additions counsellors, and mental health workers (12). The report identifies the following elements of successful approaches to family violence: a holistic approach, community-based and community-driven design and delivery, culturally appropriate design and delivery, active involvement of women, multi-sectoral collaboration and effective coordination, and 24-hour crisis response (18). With respect to collaboration and coordination, the report emphasises the need for a continuum of service delivery, with the ultimate goal of a holistic, well-organised approach to family violence

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[44] www.publicsafety.gc.ca/cnt/rsrcs/lbrr/ctlg/dtls-en.aspx?d=PS&i=1446357
[45] www.gov.nl.ca/vpi/files/movingtowardsafety.pdf

response and prevention (20). Included within the report's proposed model are community-based family violence response teams, which may include mental health workers, community health nurses, and addictions counsellors, among others (30-31).

4. **Four Worlds Centre for Development Learning et al, *Aboriginal Domestic Violence in Canada* (Ottawa: Aboriginal Healing Foundation, 2003)[46]**

This report maps out the complex web of factors that create and sustain family violence and abuse in Aboriginal communities and articulates a comprehensive framework for intervention (ix). The report notes that varying degrees of post-traumatic stress disorder is the fundamental impact of abuse in individual victims (40). The capacity and orientation of professional and community support services can impact the patterns of family violence and abuse: confidentiality, proper protocols, accessibility, and coordinated responses are important (55-56).

The report notes that current programs tend to focus on crisis services for victims and limited rehabilitation for offenders, rather than on the whole range of healing, learning, and support they require; short-term funding contributes to this problem (65-66). Further, current program responses tend to ask communities to respond to pre-determined program criteria and guidelines, rather than facilitate the development of community-based and community-driven programs (66). Funding for programs and services is inadequate and inflexible; communities have difficulty funding long-term, integrated healing and nation-building work, though that is what is required (67). The types of programs that exist are a reflection of the type of funding that is available (81). A paradigm shift related to funding for Aboriginal family violence and abuse is required (81).

There are critical gaps between the needs and available services. Social and mental health services are fragmented, forcing people to interact with many different agencies, each with their own narrow eligibility criteria; this causes clients to become demoralised, confused, and frustrated (80). Many small communities have virtually no services for victims or perpetrators of abuse, which forces people to leave their communities and support systems (80). Many services, especially those in urban centres, are culturally inappropriate; however, the report notes that government sponsored health services have made efforts to be more culturally sensitive and a growing number of Aboriginal organisations in urban centres have developed innovative programs to address gaps and offer more culturally sensitive alternatives (80).

The report proposes a framework for intervention with four components: building an adequate community response system, healing the root causes, transforming the family and community systems that enable and perpetuate abuse, and building adequate support and service systems for long-term healing and community development (83). The work of community response teams

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[46] www.ahf.ca/downloads/domestic-violence.pdf

should include developing and managing healing plans as well as early detection and intervention that is integrated with mental health and other services (85-86).

5. **Pacific Association of First Nations Women, BC Women's Hospital and Health Centre & BC Association of Specialized Victim Assistance and Counselling Programs, *The "Start of Something Powerful": Strategizing for Safer Communities for BC Aboriginal Women* (2003)**[47]

This report is a summary of a forum directed at increasing Aboriginal women's health and safety within the context of sexual assault and relationship violence (5). In terms of issues, gaps, and barriers, the forum identified three themes: violence and racism in Aboriginal women's lives, inadequate and/or inaccessible anti-violence and related services for Aboriginal women, and lack of provincial representation for Aboriginal women (6). Poverty frequently prohibits Aboriginal women from travelling to larger centres to access necessary services, including counselling and health care (7). Aboriginal women are clear that their healing cannot occur in isolation from the healing of Aboriginal men, children, and their communities; anti-violence services must include services for men and youth (8). Anti-violence services that are designed, developed, staffed, and managed by Aboriginal women are vital to Aboriginal women's safety and healing (14). A coordinated provincial Aboriginal women's organisation should be established and funded; this organisation would provide policy makers with expertise and knowledge (15). Staff of both Aboriginal and non-Aboriginal anti-violence, health, and related services require specialised anti-violence training and education that addresses the historical context of violence against Aboriginal women and people (15). Aboriginal organisations must receive core, rather than project-based, funding for anti-violence and health related services (16). Funding based on population ratios is flawed and does not reflect the additional burdens carried by women in rural, remote, and isolated communities (16). Funding for anti-violence services must be accessible, relevant, and equitable to Aboriginal women and peoples (16).

6. **Wilton Littlechild et al, *Creating Healthy, Just, Prosperous and Safe Communities in Saskatchewan* (Saskatoon: Commission on First Nations and Metis Peoples and Justice Reform, 2004)**[48]

Commission on First Nations and Metis Peoples and Justice Reform was established in 2002 by the Saskatchewan government to consider all the components of the criminal justice system and their interaction with Indigenous peoples. Wilton Littlechild was appointed Commissioner, along with four others. The first volume of the final report puts forth an "agenda for change" and 122 recommendations; chapter two focuses on "community promotion," an idea to improve the quality of living of all Saskatchewan through community-based, -driven, and -championed initiatives spanning everything from education to poverty-reduction to housing, as a measure to reduce crime

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[47] https://endingviolence.org/files/uploads/SaferCommforBCAboriginalWom.pdf
[48] www.securitepublique.gc.ca/cnt/rsrcs/lbrr/ctlg/dtls-en.aspx?d=PS&i=23876180

in general. Health care is implicated in this approach, as an area that requires greater access and resources for Indigenous people (2-17). The report particularly notes the need for more resources for addictions (2-14) and for fetal alcohol spectrum disorders, which cause enormous community harm (2-9; 2-13). While these topics are addressed generally, focused on criminal justice and not violence against women in particular, they remain relevant for all forms of violence, including GBV.

7. **Pacific Association of First Nations Women, BC Women's Hospital and Health Centre & BC Association of Specialized Victim Assistance and Counselling Programs, *Researched to Death: B.C. Aboriginal Women and Violence* (2005)[49]**

This report reviews ten studies and one book relating to Aboriginal women and violence and provides a summary of each. It shows that all of these reports bear striking similarities and contends that Aboriginal women know what needs to be done, but there has simply not been the political willpower to do it (6). The report consolidates the recommendations found in these reports, and several are relevant to health care provision. The first is that that needs to be provincial

Aboriginal women's organizations that train and educate Aboriginal women, and which also have a mandate to provide input to policy makers in the development of relevant and effective policy and programs (17). The second is to develop culturally relevant programming and services designed, delivered and implemented by Indigenous community members, including a counseling component specific to intergenerational trauma issues, and a holistic approach to healing (17-18).

8. **Policy Forum on Aboriginal Women and Violence, *Summary of the Policy Forum on Aboriginal Women and Violence: Building Safe and Healthy Families and Communities* (2006)[50]**

The forum was organised around three themes: raising awareness, access to programs and services, and policy and research. The report notes the need for programs and services to be culturally appropriate, to be focused on the family and community, and to incorporate traditional healing and practices (ii). In order to ensure a continuum of services for Aboriginal women and their families, a holistic approach to program and service development and delivery, that is grounded in the culture and traditions of the particular community being served, must be taken (ii). A continuum of services would include awareness, prevention, and post-crisis services (19). Equitable, consistent, multi-year, and sustainable funding for programs and services is required (ii). There is a need for mandatory cross-cultural awareness and cultural sensitivity training for service providers, including health workers (14). With respect to a national awareness campaign, family violence should be understood as a health care issue, requiring the same provisions as other health

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[49] https://endingviolence.org/files/uploads/FinalReportSeptember2005.pdf

[50] https://evaw-global-database.unwomen.org/en/countries/americas/canada/2006/policy-forum-on-aboriginal-women-and-violence-building-safe-and-healthy-communities

issues (16). A policy shift toward providing more support for healing rather than short-term intervention is required, particularly on the part of Health Canada (28).

9. Lheidli T'enneh First Nation et al, *The Highway of Tears Symposium Recommendations Report* (2006)[51]

The report makes recommendations under four headings: victim prevention, emergency planning and team response, victim family counselling and support, and community development and support (12). With respect to victim family counselling and support, the report outlines developing and implementing a permanent regional First Nation Crisis response plan as a short-term goal (16, 28). As a long-term goal, the report calls for increased local, culturally-sensitive, long-term counselling and support services to Aboriginal families who have experienced a traumatic event (16). Ensuring that essential health and social services are available locally is important to reduce the need for travel as it is one source of vulnerability (25). The report recommends that a roster of fully qualified Aboriginal mental health therapists, grief counsellors, critical incident stress counsellors, and other counsellors with relevant expertise be developed (29). In addition, a qualified First Nations crisis response team should be assembled, receive training, and be ready for deployment (29). The report also recommends that qualified Aboriginal agencies or First Nations provide long-term counselling and support to Aboriginal victims' families at their request and direction, and that the transition from short-term emergency support to long-term support be seamless (30).

10. Ontario Native Women's Association & Ontario Federation of Indian Friendship Centres, *A Strategic Framework to End Violence Against Aboriginal Women* (2007)[52]

This report was produced by the Ontario Native Women's Association and the Ontario Federation of Indian Friendship Centres after a summit on this issue attended by provincial and federal officials. It proposes a framework based on 11 principles to end violence against women. The report outlines eight strategic directions as part of a strategic framework to end violence against Aboriginal women. The report advocates for a social/health determinants model to be applied to ensure that the causal issues of violence are addressed (5). All activities aimed at addressing violence against Aboriginal women must be directed, designed, implemented and controlled by Aboriginal women (5). The report calls for the development of a comprehensive, multi-faceted policy to address violence against Aboriginal women, which would require proactive policy integration and coordination in the areas of justice, health and healing, education, employment, training, housing, and social services at all levels of government (10). The report states that the Aboriginal Healing and Wellness Strategy in Ontario has been very successful in addressing family violence and health issues within an Aboriginal context, but does not have a specific focus on ending violence against Aboriginal women (10). The report recommends that governments and

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[51] www.turtleisland.org/healing/highwayoftears.pdf
[52] www.oaith.ca/assets/files/Publications/Strategic_Framework_Aboriginal_Women.pdf

Aboriginal organisations work collaboratively to develop a continuum of care to address issues of violence against Aboriginal women (17).

11. United Nations Committee on the Elimination of Discrimination against Women, *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Canada*, CEDAW/C/CAN/CO/7 (7 November 2008)[53]

This report is the "report card" of the Committee on the Elimination of Discrimination against Women on Canada's progress towards fully upholding and implementing the Convention on the Elimination of All Forms of Discrimination against Women, and is issued at regular intervals based on Canada's own reporting and the input of civil society. The Committee expressly notes that Canada must do more to combat violence against women, and recommends the criminalization of domestic violence. With respect to Indigenous women, it states that their needs to be addressed specifically, with respect to shelter and all services (para 30). With respect to health, the Committee recommends that Canada "carefully monitor" health service delivery in order that it may respond in a gender-sensitive women's health concerns, and ensures that a gender perspective is integrated into all health policies and programs (para 42). Finally, it notes that Indigenous women continue to face discrimination in health care, inter alia, and recommends Canada develop a plan to address the particular conditions affecting Aboriginal women's health (paras 43-44).

12. Canada, National Clearinghouse on Family Violence, *Aboriginal Women and Family Violence* (Ottawa: Public Health Agency of Canada, 2008)[54]

This report explores the issue of family violence in Aboriginal communities in a broad sense, with very little discussion of the health care system. The report recommends cultural sensitivity training for all first responders, including health care professionals (6). First responders indicate that the impact of intimate partner violence on women is primarily felt in their physical and emotional health, which can radiate into other areas of their lives such as their ability to function at work or their role as parent or community member (18).

13. New Brunswick Advisory Committee on Violence Against Aboriginal Women, *A Strategic Framework to End Violence Against Wabanaki Women in New Brunswick* (2008)[55]

This report provides both contextual information on the issue and potential actions in the areas of capacity building, prevention and education, and service delivery in order to address violence against Wabanaki women in New Brunswick (3). The report notes that while Aboriginal women are at a higher risk for substance abuse than Aboriginal men, they represent only 40% of the Aboriginal population in alcohol treatment centres; this may be due to the lack of culturally or

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[53] https://digitallibrary.un.org/record/834098?ln=en
[54] https://publications.gc.ca/collections/collection_2009/aspc-phac/HP20-10-2008E.pdf
[55] www.gnb.ca/0012/Womens-Issues/wabanaki-e.pdf

women-centred facilities, the impact of violence, and the lack of access to child-care (10). Treatment centres that use holistic, culturally based methods have generally shown the best results for Aboriginal women dealing with addiction (10, 22). The following barriers with respect to health, mental health, and addiction services are noted: racism among workers, lack of awareness about services available off reserve, gaps in services as a result of jurisdictional issues, lack of availability of interpreters, and long waiting lists (22). The report notes a lack of awareness or distrust of traditional Wabanaki approaches to healing among the general population in the province, resulting in some service providers not linking their clients with these options (22). Of the report's 49 recommendations, seven relate to health, mental health, and addiction service delivery. These include cross-cultural training for service providers, identifying and addressing jurisdictional gaps and inconsistencies, outreach and education on options and services available to women dealing with abuse and violence, increasing the number of Wabanaki health professionals, and increasing capacity and reducing wait times for services (22-24).

14. Ontario Federation of Indian Friendship Centres, *The Summit III to End Violence Against Aboriginal Women: Final Report* (Toronto: OFIFC, 2009)[56]

This report focuses on how programs and services funded by Ontario's Ministry of Community and Social Services can be improved to support Aboriginal women and families who are working to end violence in their lives (5). Unresolved personal, emotional, or health issues and the lack of resources to address them leaves women extremely vulnerable (22). The report sets out providing Aboriginal specific counselling programming as a goal (26). This includes funding counselling within and outside of shelters, using strength-based approaches, providing counselling in Indigenous languages where possible, and broadening the idea of acceptable counsellors (ex. social workers, traditional healers, Elders, community helpers) (26). Counselling programs should reflect the diversity of First Nations culture and teachings through different models and approaches, as well as by supporting a diversity of cultural programming (26). Counselling should take place in the context of a holistic approach, where counsellors may make referrals and ensure financial support is there for other services (26). The report also includes ensuring counselling and other healing services are available in the community for each family member and the whole family as a goal (27). The report emphasises knowledge and information sharing on best practices and available culturally appropriate programs as well as ensuring consistent quality of care and support for all services (27). The latter requires cultural sensitivity training for mainstream organisations (27).

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[56] www.oaith.ca/assets/files/Strengthening-the-Circle-Report-Final-July09.pdf

15. Wanda D McCaslin & Yvonne Boyer, "First Nations Communities at Risk and in Crisis: Justice and Security" (2009) 5:2 Journal of Aboriginal Health 61[57]

This article argues that models for the future must address the systemic structures of colonialism and offers five decolonising recommendations. To mount an effective response to domestic violence, the ongoing commitment and collaboration of community members, social health practitioners, and all levels of government is required (75). In the long term, culturally appropriate mechanisms are the best way to resolve domestic violence, and this is consistent with the traditional practice of communities holding themselves collectively responsible for the well-being of the community and its members (75-76). This includes a responsibility to support healthy relationships moving toward appropriate balance between men and women (76). Crisis factors must be approached in a proactive, rather inactive or reactive, approach; this could include community health plans and community justice plans (79). The article suggests engaging the Circle as a model and process for a wide range of community activities, which can include health care and justice (79-81). Crisis prevention, response, and crisis aftermath initiatives, including those in health care, must be based on holistic understandings (81). The article also emphasises the importance of developing collaborative relationships to respond to violence, including relationships with governments, community organisations, and neighbouring First Nations (82).

16. Aboriginal Affairs Working Group, *A Framework for Action in Education, Economic Development and Violence Against Aboriginal Women & Girls* (Ministry of Aboriginal Relations and Reconciliation, 2010)[58]

This report examines how governments and National Aboriginal Organisations can work more effectively to improve outcomes for Aboriginal peoples, with a focus on education, economic development, and violence against Aboriginal women (5-6). The social determinants of health must be considered when examining violence against Aboriginal women, including the need for adequate health services (50). The report identifies improving the socio-economic well-being, including mental health, of Aboriginal peoples as an area for further collaboration between governments and national/regional Aboriginal organisations (54). The report highlights the importance of an integrated and coordinated approach (54, 56). Culturally relevant gender-based analysis (CRGBA) is a tool used to understand specific issues related to Aboriginal women; it is used by NWAC, the AFN, and governments (69-70).

17. British Columbia, *Stopping Violence Against Aboriginal Women: A Summary of Root Causes, Vulnerabilities and Recommendations from Key Literature* (Ministry of Children's Services, 2011)[59]

[57] https://caid.ca/FNComRis2009.pdf
[58] www2.gov.bc.ca/assets/gov/environment/natural-resource-stewardship/consulting-with-first-nations/first-nations/report_aboriginal_affairs_working_group.pdf
[59] www.deslibris.ca/ID/243924

This paper provides an overview of the root causes of and vulnerabilities associated with violence against Aboriginal women and girls, as well as a synthesis of recommendations for addressing the issue (3). Systemic racism creates barriers to Aboriginal people accessing the supports they need from the health care system (3). There is a lack of services and supports for women seeking help with family violence situations, especially in rural and remote communities; the services that are available are rarely staffed by Aboriginal women and are not necessarily culturally appropriate (4). Integration and coordination between services is lacking (4). The report reiterates previous recommendations for an expansion of culturally appropriate, community-based services across the prevention, intervention, and post-incident continuum and mandatory cultural sensitivity training for health care professionals (5, 29). Funding for health services for Aboriginal women should be accessible, relevant, and equitable (27). Adequate, sustainable, multi-year funding for programs and services that address Aboriginal health and well-being, including initiatives to deal with the impacts of the residential school system is required (16). Government funding for the promotion of Aboriginal holistic approaches to healing and wellness should also be provided, including dialogue between Aboriginal healers and non-Aboriginal health care providers (20-21). Permanent regional First Nation crisis response plans should be developed and implemented for First Nations communities and families experiencing a traumatic event (38). A roster of Aboriginal mental health therapists, grief counsellors, critical incident stress counsellors, and other counsellors with relevant expertise should be developed (38). A qualified First Nations crisis response team should be assembled, receive training, and be ready for deployment (38). There is a need for more long-term and relapse prevention services for men who abuse (41-42).

18. Canada, Parliament, House of Commons, Standing Committee on the Status of Women, *Interim Report: Call into the Night: An Overview of Violence Against Aboriginal Women*, 40th Parl, 3rd Sess, No 14 (March 2011) (Chair: Hedy Fry)[60]

The report presents the findings of a study on violence against Aboriginal women. The goal of the study was to gain a better understanding of the extent and nature of the violence, examine the root causes of the violence, and recommend solutions collaboratively with Aboriginal women (3). The report states that a coordinated, holistic approach to violence against Aboriginal women is required (9). The committee heard evidence of widespread discrimination in health services (10, 29-30). Fear of intervention by the child welfare system often prevented women who were victims of violence from seeking help from health service organisations (11). Witnesses emphasised that long-term funding for culturally relevant and holistic healing services that are designed, delivered, and implemented by Aboriginal people is required (20, 23). These services include community healing, counselling services, and supports to deal with addictions (20-22). With respect to addictions, there is a need for better post-addiction treatment and family treatment centres so that women do not have to leave their children behind (23).

[60] www.ourcommons.ca/DocumentViewer/en/40-3/FEWO/report-14

19. AMR Planning & Consulting, *Collaboration to End Violence: National Aboriginal Women's Forum: Report on Outcomes and Recommendations from Working Sessions* (2011)[61]

The report presents the outcomes of a forum on addressing violence against Aboriginal women and girls (i). The report recommends that a holistic continuum of programs and services that assist women and girls who are at risk of or have experienced violence and their children, families, and communities, should be available and accessible throughout a person's life and available in every community (9). These programs and services should draw on culture and tradition (9). The report recommends that public health funding should be directed towards individuals at particularly high risk, such as young vulnerable mothers with very young children (11). Women's access to services that are designed and delivered by Aboriginal women should be increased (12). The report recommends improved networks of resources and services so that women can connect to integrated services through a single point of access (14-15). This may include local or regional crisis response teams, with social workers, nurses, Elders, mental health workers, and other professionals (14). Funding must be coordinated, timely, and capable of meeting community needs (19).

20. British Columbia, *Forsaken: The Report of the Missing Women Inquiry* (Victoria: Missing Women Commission of Inquiry, 2012)[62]

As the focus of this inquiry was on policing and justice, there is limited discussion of the health care system and no recommendations are directly relevant. In Volume I, the report discusses health inequalities that affect women living on the Downtown Eastside of Vancouver and the difficulties these women face in accessing health care, due in part to judgment and distrust of institutions as a result of their lived experiences (vol I, 85-86). The report includes further discussion of the health care system in Volume III. With respect to taking action to directly address women's vulnerability to violence and serial predation, the inquiry heard about the need to take a comprehensive approach to treatment and after-care and build strong networks of social and health care programs (vol III, 14). The inquiry received submissions recommending training for health care workers to support the health and safety of people involved in the sex trade (vol III, 15). The report takes notice of the many health conditions experienced by family members as a result of a missing or murdered loved one, and that many of these conditions are long-term (vol III, 41). The report states there is a need for enhanced collaboration between sectors, including health, social, police, and justice (vol III, 89).

21. Canada, Parliament, House of Commons, Special Committee on Violence Against Indigenous Women, *Invisible Women: A Call to Action: A Report on Missing and*

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[61] www2.gov.bc.ca/assets/gov/environment/natural-resource-stewardship/consulting-with-first-nations/first-nations/report_collaboration_to_end_violence_forum.pdf
[62] https://missingwomen.library.uvic.ca/index.html%3Fp=30.html

***Murdered Indigenous Women in Canada*, 41st Parl, 2nd Sess, No 1 (March 2014) (Chair: Stella Ambler)**[63]

This report seeks to identify practical, action-oriented solutions to increase the safety of Aboriginal women and girls across Canada (4). These solutions must be tailored to the unique circumstances of each community; communities themselves are in the best position to identify local priorities and develop tailored solutions (5). The committee's study was organised around three themes: violence and its root causes, front-line assistance, and prevention (6). The report acknowledges that the root causes of violence against Aboriginal women and girls are varied, complex, and interrelated, and identifies a lack of prevention services such as mental health services as one of the factors (17). Witnesses described barriers such as the lack of culturally appropriate services for Aboriginal women in urban areas, lack of services in rural and remote communities, and jurisdictional gaps (20-21). The report states that programs and services that work well are often the result of a collective vision. An interdisciplinary team model used in Prince Albert, SK enables the police force, social services, health services, and the education system to work together to serve and support vulnerable people (26). Increased human and financial resources for programs and services that support Aboriginal women and girls are required, including long-term funding for community initiatives on reserve (25-26). A coordinated and accessible approach to program funding is also required (26-27).

22. Manitoba, Clean Environment Commission, *Report on Public Hearing: Keeyask Generation Project* (2014)[64]

This report was produced by the Clean Environment Commission after its review of the Keeyask Generation Project proposal and public hearings spanning four months. The primary project proponent was Manitoba Hydro, but four First Nations joined with Manitoba Hydro to form a partnership. Among the four major areas of potential concern arising from the project was potential social and public safety impacts arising from the influx of a large number of temporary workers (xv). The Commission concluded that mitigation measures for the influx of workers were well designed to prevent adverse effects (xvi). The Commission recommended the project be approved with conditions (xiii). In the course of the project review, Tataskweyak Cree Nation and War Lake First Nation identified the influx of construction workers as creating increased risks of GBV, substance use, and a greater need for policing and security (50). In its own environmental assessment of the project, Fox Lake Cree Nation highlighted the impacts on human health and wellness of past hydro development, some of which resulted from racism, violence, and social tension that followed the influx of outside workers (57). Members of Fox Lake Cree Nation cited incidents of harassment, racist comments, abuse, sexual assault, and paternal abandonment that occurred as a result of prior hydro development in the region; they

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[63] https://publications.gc.ca/site/eng/9.579319/publication.html
[64] www.cecmanitoba.ca/cecm/archive/pubs/commission%20reports/keeyask%20web%20final2.pdf

emphasised the need to protect First Nations women in the project area and to take steps to prevent abusive actions and a hostile environment for women (114).

23. Canada, *Action Plan to Address Family Violence and Violent Crimes Against Aboriginal Women and Girls* (Ottawa: Her Majesty the Queen in Right of Canada, 2014)[65]

This report presents a five-year plan to take action under three pillars: prevention violence by supporting community level solutions, supporting Aboriginal victims with appropriate services, and protecting Aboriginal women and girls by investing in shelters and continuing to improve law enforcement and the justice system (1). The plan recognises the importance of taking coordinated action to end violence against Aboriginal women and girls and the key role of the provinces through service provision, including health care (4). It states the federal government's role is to support and coordinate efforts, share information and best practices, and continue to strengthen the law and criminal justice system (4). The federal government has programs to address specific risk factors related to violence, including mental health supports, addiction and suicide prevention, addictions treatment, and crisis response services (6). The plan states that Health Canada is working with key partners to strengthen existing programming through a First Nations Mental Wellness Continuum Framework (6).

24. Provincial Court of Manitoba, *Re Brian Lloyd Sinclair, Deceased*, (12 December 2014)[66]

The purpose of this report is to determine the circumstances under which Mr. Sinclair's death occurred; to determine what, if anything, can be done to prevent similar deaths from occurring in the future with regard to, but not limited to, the following: (a) reasons for delays in treating patients presenting in Emergency Departments of the Winnipeg Regional Health Authority hospitals; and, measures necessary to reduce the delays in treating patients in Emergency Departments.

The report examines the last days of Mr. Sinclair's death, along with a contextual review of the circumstances that led him to attend to the ER on the day prior to his death, his treatment there as ascertained from video security footage, staff and family interviews, and other documentary sources of information.

The causes of violence here were determined to be medical negligence, systemic racism, general negligence. This report contains 63 recommendations targeting the circumstances of vulnerable indigenous persons seeking health care services such as homelessness, an Aboriginal Health Services section, adaptations to organizational structures in order to integrate culturally specific

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[65] https://cfc-swc.gc.ca/fun-fin/ap-pa/action-eng.pdf
[66] www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf

safeguards and spur institutional accountability through the creation of adequate and objective patient-focused ER intake processes.

25. Billie Allan & Janet Smylie, *First Peoples, Second Class Treatment: the Role of Racism in the Health and Well-being of Indigenous Peoples in Canada*, (Toronto: Wellesley Institute, 2015)[67]

First Peoples, Second Class Treatment explores the role of racism in the health and well-being of Indigenous peoples in Canada. We begin with an overview of the historical and contemporary contexts of racism, and the ways in which racism is fundamentally responsible for the alarming disparities in health between Indigenous and non-Indigenous peoples. We examine Indigenous responses to racism including individual, family and community level strategies and resiliencies; health service-level responses (including Indigenous and non-Indigenous led services); efforts directed at the training of health professionals; and provincial, territorial and national-level policies and recommendations.

Indigenous peoples' experiences are too often omitted in discussions of racism and anti-racism (Lawrence & Dua, 2005). The reasons for these omissions typically include a rationale that argues for recognition of the unique histories, policies and contemporary circumstances shaping the lives of Indigenous peoples (Nestel, 2012; Levy et al., 2013). While this recognition is important, these omissions may contribute to a continual "writing out" or "writing over" of Indigenous experiences of racism, marginalization and violence, along with the strategies used to address and resist these same realities. The authors emphasize the importance of context,

> For example, epidemiological data is often gathered, analyzed and shared without the inclusion of adequate context related to the historical and present-day impacts of colonial policies on the social determinants of health for Indigenous peoples. In addition, this data can be shared in the absence of the voices and perspectives of Indigenous people themselves (Smylie, 2014).

The authors explain their methodology as including indigenous tellings of indigenous stories, and further explore themes such as racism and colonialism, the impacts of colonialism on the social determinants of health, the Indian Act as a primary institutionalization of colonial policies impacting the social determinants of health, while taking a distinctions-based approach, residential schools, the sixties scoop and contemporary child welfare and the gendered impact of colonial racism.

The discussion paper further examines that which is known about the magnitude of racism experienced by Indigenous Peoples in Canada and its impact on health, well-being and access to

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[67] Discussion paper: https://sac-oac.ca/sites/default/files/resources/Report-First-Peoples-Second-Class-Treatment.pdf; Executive summary: www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf

to health services. The lived experiences of racism in health care is examined, and also located withing unspecified health care services themselves. The discussion paper further explores racism, health care in terms of responses and interventions. Under this guise, the authors examine individual, family and community strategies of resilience in dealing with colonial racism in the health care system, health care and service delivery responses, including those directed by Indigenous peoples, indigenous interventions at the level of mainstream health institutions, and other promising interventions and training programs. The piece also examines national, and provincial or territorial policy responses to colonial violence in health care.

In terms of critical next steps, the discussion paper premisses its position on transforming the conversation about race and health in Canada. In so doing, it sets the course by strongly recommending the improvement of Indigenous health data collection in order to address racism as a driver of Indigenous health disparities.

26. **United Nations Committee on the Elimination of Discrimination against Women, *Report of the Inquiry concerning Canada of the Committee on the Elimination of Discrimination against Women under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, CEDAW/C/OP.8/CAN/1 (30 March 2015)[68]**

This report is the product of an inquiry undertaken by the at the request of the Feminist Alliance for International Action and the Native Women's Association of Canada into violations by Canada of rights under the Convention on the Elimination of Discrimination against Women by virtue of the high levels of violence experienced by Indigenous women and girls. CEDAW representatives undertook a visit to Canada to conduct their inquiry, and found, inter alia, that "women victims of violence often avoided seeking help from health or social service organizations for fear that their children would be apprehended by child welfare authorities." (para 113) They noted the structural inequalities experienced by women in health, and included in their recommendations that Canada improve the socioeconomic conditions of Indigenous women as a holistic response to GBV. One recommendation in particular noted the need to increase access to health services, including mental health supports and drug dependency in particular (218(c)).

27. **Canada, Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (Winnipeg: The Commission, 2015)[69]; Canada, Truth and Reconciliation Commission of Canada, *The Final Report of the Truth and Reconciliation Commission of Canada, vol 5, Canada's Residential Schools: The Legacy* (Montreal: McGill-Queen's University Press, 2015)[70]**

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[68] https://digitallibrary.un.org/record/836103?ln=en
[69] https://publications.gc.ca/collections/collection_2015/trc/IR4-7-2015-eng.pdf
[70] https://publications.gc.ca/collections/collection_2015/trc/IR4-9-5-2015-eng.pdf

These reports focus on the history and legacy of residential schools and its survivors in Canada, and in that context documents one of the sources and root causes of the ongoing epidemic of violence in Indigenous communities, including against women. It documents both the experiences of children and their families in the residential school system, and the intergenerational harm it wrought through the destruction of families and communities and the perpetuation of intergenerational trauma.

In terms of health care, the report also documents the horrific health conditions inside of residential schools, and the inadequate health services for Indigenous people in general, and how it has resulted in inadequate health services today. It acknowledges the health gap, and calls on all levels of government to close it for all Indigenous people, and to measure progress in this regard. It details the funding cuts to important Indigenous health care services in recent years, including to community healing programs and the National Aboriginal Health Organization. It recognizes that Indigenous people must be involved in designing the health care systems that treat them, and that medical personnel require training in Indigenous health issues and anti-racism, amongst other things. It also calls for healing centres for Indigenous people to provide holistic treatment for the effects of residential schools, including on addictions and mental health support, and in line with Indigenous practices.

28. Quebec Native Women, *Nānīawig Māmawe Nīnawind. Stand With Us: Missing & Murdered Indigenous Women in Quebec* (Kahnawake: QNW, 2015)[71]

This report was produced by Quebec Native Women to explore the issue of missing and murdered Indigenous women in Quebec. It addresses root causes of violence, the need for more preventative services for Indigenous women, equal access to services and opportunities for healing on a long-term basis, and the need for more collaboration between service providers. Health care services are part of the suite of services that the report finds are inequitably delivered on account of funding inadequacies, lack of collaboration and overburdened service providers.

This report also noted that racism and stereotyping can imbue service provision and fuel denials of service, particularly in the assumption that Indigenous people are intoxicated (36). It provides an anecdote of an accusation of rape in which the nurse or doctor did not believe the woman accuser because she smelled of alcohol. It also notes that shame and judgment can and do drive women away from seeking out help, even in desperate situations.

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[71] www.faq-qnw.org/wp-content/uploads/2016/11/Naniawig-Mamawe-Ninawind-Stand-with-us-Oct-2016-engl-FINAL.pdf

29. Canada, *FPT Justice Framework to Address Violence Against Indigenous Women and Girls* (Federal-Provincial-Territorial (FPT) Ministers Responsible for Justice and Public Safety, 2016)[72]

This "Framework" is intended as a strategic document, which identifies principles and priorities that will help to guide the focus of federal, provincial and territorial ministers of justice and public safety as they take action with Indigenous peoples and other key partners to improve how the justice system prevents and responds to the violence experienced by Indigenous women. Though it focuses on crime prevention, law enforcement, courts, corrections, victim services, and other justice services, it acknowledges the connection between violence and systemic issues or barriers within our current social system, such as poverty, lack of employment, systemic racism and difficulty accessing services including health care. These factors contribute to the stress in families that may contribute to violence, and may also lead to departures from communities to seek better opportunities and access, leaving women isolated (3, 4). The Framework advocates for a holistic approach that aligns all socioeconomic, health and public safety work on this issue (4, 13). It specifically mentions the need to enhance access addictions treatment in the health system, and the mental health needs of a GBV response (10). It also notes that respondents to a survey indicated that they experience insensitive or racist comments and behaviour when trying to access justice, as well as health, education and social services (14).

30. National Roundtable on Missing and Murdered Indigenous Women and Girls, *Outcomes and Priorities for Action to Prevent and Address Violence Against Indigenous Women and Girls* (2016)[73]

This document contains the conclusions arrived at by the 3nd Roundtable on MMIWG, which brought together families of MMIWG, Premiers, federal, provincial and territorial ministers, Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, Native Women's Association of Canada, Pauktuutit Inuit Women of Canada, and Les Femmes Michif Otipemisiwak / Women of the Métis Nation in Winnipeg, Manitoba on February 26, 2016. It identifies the important role of the health care system, amongst other social services, in the prevention and response to violence against women, setting as a priority fair access to health systems *inter alia* as a preventative measure (2). It also notes mental health and addictions challenges, and identifies the need for culturally-appropriate tools to respond them (2) as well as more robust access to treatment (3). It also calls for the expansion of Indigenous healing centres and holistic healing programming, including post-traumatic programming (4).

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[72] www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/publications/fpt-justice-framework-english.pdf

[73] www.mmiwg-ffada.ca/wp-content/uploads/2019/05/1.-MMIWG-OUTCOMES-AND-PRIORITIES-FOR-ACTION-FINAL.pdf

31. Ontario, Office of the Chief Coroner, Verdict of Coroner's Jury and Recommendations (28 June 2016)[74]

This report is the verdict of a Coroner's inquest into the deaths of seven Indigenous youth in Thunder Bay, convened under the *Coroner's Act*. It acknowledges the multifaceted root causes of these deaths, which were by mostly by drowning and substance abuse, and makes 145 recommendations directed to Canada, Ontario and First Nations governing bodies to underlying socioeconomic factors that led to these deaths.

The equitable provision of health care and other services that impact health, such as housing, water sanitation and sewage systems, and safety, feature prominently in the recommendations. While GBV is not particularly addressed, the report makes clear that inequity in health care delivery is pervasive in the communities of northern Ontario, and calls out access to mental health supports as well as substance abuse and addictions programs in particular as required to address high suicide and death rates amongst Indigenous teenagers. Health care focused on mental health and addictions is clearly deficient for youth in northern Ontario as elsewhere.

32. P Moffitt & H Fikowski, *Northwest Territories Research Project Report for Territorial Stakeholders: Rural and Northern Community Response to Intimate Partner Violence* (Northwest Territories: Aurora College, 2017)[75]

This report studied intimate partner violence (IPV) in remote and rural communities in NWT, where the rate of violence against women is nine times the national rate. It found three social processes at work causing and perpetuating violence against women in NWT: putting up with violence, shutting up about violence, and getting on with life. The causal conditions of intimate partner violence has grown out of the context of the history of colonization and the intergenerational impact of residential schools, and has been normalized. This has been exacerbated by limited resources for Indigenous women experiencing violence, including by lack of access to health services, *inter alia*, which can further isolate them.

The report labels intimate partner violence as a public health concern in Canada, owing to the damaging health effects for women and their children, and as a major cause of child maltreatment and of the significant over-representation of Indigenous children in the child welfare system. The report is based on five years of data collection and generated a model of the needs of women, gaps in the system and community responses to intimate partner violence. Immediate needs were for safety and shelter, but the health care system is implicated in the longer-term needs of communities to combat violence. Insufficient addiction services, including residential treatment programs, were cited as a gap in this context.

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[74] https://ocaarchives.files.wordpress.com/2019/01/jury-verdict-and-recommendations.pdf
[75] https://nwtresearch.com/sites/default/files/intimate_partner_violence_-_final_report.pdf

The scarcity of resources including health services was a major factor in the cycle of violence. The lack of a shelter, much less victim services, in small communities led to the perpetuation of violence. Both the remoteness of these communities as well as their small size, limited resources and recruitment challenges played a role here.

Further, the report notes the disjointed and piecemeal responses to IPV offered by social and health services systems. Various departments that are responsible for part of the response to IPV do not collaborate, and the failure to plan at a higher level renders the response less effective than it could be. In terms of health care, Health and Social Services has responsibility for case planning for women who have experienced violence, but local health authorities play a role in the foster care system and social services, but they do not coordinate with each other or those who run the shelters or victims services in the justice system. There are clear gaps in providing a consistent and effective response to women who are survivors of IPV and its many knock-on consequences (29). In a nutshell, "[p]articipants described their delivery of services and use of other services available to them as ineffective, crisis-oriented, short term and stand alone" (29).

Finally, the report notes some specific deficiencies with the health care response to IPV, stemming in part from the piecemeal approach to this issue. The report describes nurses refusing to leave their nursing stations to provide care to victims of GBV in their homes, citing their policies regarding safety (32, 36). Differential policies amongst various service providers, as well as policies not adapted to the context, pose barriers to an effective response to IPV.

The report puts forth a positive model for change in addressing IPV in NWT, based on disseminating knowledge of the issue and taking proactive education and awareness programs, as well providing stable and adequate funding for a coordinated responsive strategy. This involves joint planning, communication between services, the development of protocols to ensure consistent and ongoing responses, and sharing resources such as telehealth for victims' services. The circumstances in NWT are unique, with the size and number of remote communities and their respective distances, but these lessons are useful in general. The report also suggests specific tools such as common case management systems, and IPV screening used across social services to proactively identify and address victimized women. Finally, it notes that survivors need long term support regarding the psychological and socio-economic impacts of IPV.

33. The Honourable Michael H Tulloch, ***Report of the Independent Police Oversight Review*** (Queen's Printer for Ontario: 2017)[76]

Ordered by the Ontario government in the wake of public demonstrations of dissatisfaction with policing and police oversight, this review examined Ontario's three civilian police oversight bodies: the Special Investigations Unit, the Office of the Police Review Director, and the Ontario

[76] https://wayback.archive-it.org/16312/20210402050708/http:/www.attorneygeneral.jus.gov.on.ca/english/about/pubs/police_oversight_review/

Civilian Police Commission. It was undertaken by the Honourable Michael Tulloch of the Court of Appeal of Ontario, who made recommendations to improve the transparency, accountability, and effectiveness of those bodies, including through enhancing their "cultural competency" when interacting with Indigenous people. The recommendations are wide-ranging and not directly related to health care.

There is one chapter of the report dedicated to Indigenous peoples which touches upon health care indirectly. Mr. Tulloch canvasses the history and present context of Indigenous-police relations, and recommends cultural training, the recruitment of Indigenous police officers, proactive outreach and relationship-building in Indigenous communities, and more effective civilian oversight of policing in First Nations communities. Of relevance to our purposes is the review's acknowledgement that the oversight bodies did not always understand gender-based violence and issues relating to mental health in many contexts. It recommends ongoing training and evaluation approaches. It also recommends the collection of demographic data, including on Indigenous status and on mental health, for better analysis and evaluation. It notes that data will assist on "research on the social determinants of health" (recommendation 11.1 and para 56). This is an acknowledgement that the police in Ontario have been insufficiently attendant to mental health and GBV issues, and that better integration with health services is required.

34. Yvonne Boyer & Judith Bartlett, *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women* (2017)[77]

The purpose of the report was to conduct a review of the reports from Indigenous women in the Saskatoon Health Region (now the Saskatchewan Health Authority) who report having been sterilized in hospital without their free, prior and informed consent. The report found that the SHR's hospitals and staff impose pervasive structural discrimination and racism in the health care system in general, despite their effort to remedy these.

Causes for violence were determined to be medical malpractice, systemic racism, medical negligence and situational opportunism. The report issued 10 calls to action directed to the SHR targeting requirements in Canadian law, cultural training, Education, restructuring, the creation of an advisory council with authority, ensuring the implementation of a previous report containing a strategic workplan on change, coordination of other supports in and around Saskatoon, reparation, a reproductive center and intensive support center and policy revisions.

35. United Nations, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, "Preliminary

[77] www.saskatoonhealthregion.ca/DocumentsInternal/Tubal_Ligation_intheSaskatoonHealthRegion_the_Lived_Experience_of_Aboriginal_Women_BoyerandBartlett_July_22_2017.pdf

Observations - Country Visit to Canada, 5 to 16 November 2018" (16 November 2018)[78]

The purpose of the observations were to report on the implementation of the right to health in Canada. Canada's shortcomings in terms of prioritizing the right to health for the more vulnerable (particularly Indigenous women) requires renewed commitment and resources. Causes for violence were determined to be systemic racism, systemic negligence, failure to adopt a holistic and culturally relevant human rights-based approach to the right to health.

Remaining challenges in Canada show the need to apply a human rights-based approach. Investments with adequate financial and human resources in health are important and Canada is doing rather well in this regard; so the crucial issue is the direction and prioritizing of resources, as well as rights-based conditions for federal health-related transfers. Cross-cutting to this is the issue of investing in the public health priorities of modern times, namely the so-called "new morbidities" in children and adults such as mental health, underlying determinants of health, addressing drug use issues, adolescent and youth health related issues, including monitoring mechanisms to make sure that all the elements of an analytical right to health framework are in place. The SR's focus on the amplification of the challenges for indigenous GBV survivors was evident.

36. **Mary Ellen Turpel-Lafond, *In Plain Sight: Address Indigenous-Specific Racism and Discrimination in B.C. Health Care, Addressing Racism Review Summary Report* (Government of British Columbia, November 2020)**[79]

This report was the initiative of the B.C. government's appointment of an independent reviewer (Dr. M.E. Turpel-Lafond (Aki-Kwe)) to conduct a review of Indigenous specific racism in the provincial health care system.

This report discusses several findings associated with the experiences of Indigenous Peoples in the BC Health care system and chronicles the lived experience of Indigenous patients in their hospitals in exchanges with their staff. Findings, supported by interviews and statistics, reveal that Indigenous peoples are less likely to attend at the hospital to avoid racism until it is absolutely necessary, accounting for the greater representation of Indigenous patients at the ER proportionately to non-indigenous patients.

Causes for violence were identified as medical violence, medical negligence, systemic racism, stereotyping. The report examines specific incidents of obstetric violence and general negligence and racism in the subject health care system.

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[78] www.ohchr.org/en/statements/2018/11/preliminary-observations-country-visit-canada-5-16-november-2018
[79] https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

This report contains 24 recommendations targeting systems, behaviours, beliefs and implementation of recommendations.

37. J Géhane Kamel, Investigative Report: Law on the Investigation of the Causes and Circumstances of Death for the Protection of Human Life concerning the Death of Joyce Echaquan (Québec Coroner's Office, 2020) (Translated from French)

This report is an investigation into the circumstances and cause(s) of death of Ms. Joyce Echaquan, a wife and mother of 7 children including a one-year-old, in a Quebec Hospital in late 2020 upon her admission for shortness of breath and severe chest pain.

The Coroner, who is also a Quebec Superior Judge, heard from Ms. Echaquan's family, attending health professionals who have since been terminated, and other medical professionals with an expertise in the medical condition from which Ms. Echaquan suffered before and immediately prior to her untimely death after being racially berated, ignored and physically restrained by attending nurses. According to the expert cardiological evidence by a qualified expert, Ms. Echaquan's death could have been prevented if she had been treated for her serious cardiological condition instead of dismissed and restrained. Although the Coroner made a series of recommendations relating to under-resourcing and staff over-extension, she found that Ms. Echaquan's death was due in large measure to racism in the delivery of health care services in the emergency care unit. Racism and stereotypes blinded the attending health professionals from identifying the medical crisis which the deceased was experiencing immediately before her death, found as the attitudinal cause of death in circumstances where treatment would have saved the deceased life.