

Improving the Response to Intimate Partner Violence Experienced by First Nations People in the
Primary Care Setting: Provider Perspectives on Manitoulin Island

by

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Abstract

Indigenous women and men living in Canada experience disproportionately high rates of intimate partner violence (IPV) compared to non-Indigenous women and men, which is best explained within a colonial context. Despite the wide range of adverse physical, sexual and psychological outcomes of IPV, a coordinated approach to the phenomenon has yet to be established in the healthcare and social services system on Manitoulin Island, a region in Northeast Ontario. This project was aimed to address that gap at the primary care level through community based participatory research. Using a Grounded Theory and qualitative research approach, primary care providers (n=31) participated in focus groups and interviews to discuss their perceptions of what is required to improve the response to IPV in the primary care setting. The analysis focused on elucidating the barriers and facilitators that exist within current practices, those of which prevent or ease the delivery of care to First Nation patients who are experiencing IPV. Suggestions for culturally relevant improvements at a health care provision and community level are discussed. Further studies should include knowledge translation back into the communities on Manitoulin Island as well as the perspectives of the survivors of intimate partner violence and their perception of what can be improved within current provider practices.

Keywords: Northern Ontario; Indigenous Peoples, First Nations; intimate partner violence, primary care providers, community based participatory approach

Co-Authorship Statement

Dr. Marion Maar

Dr. Maar is the supervisor of this project and her much larger scale community based participatory study. She was heavily involved in every aspect of this project, including the research design, data collection and analysis. Dr. Maar provided ongoing feedback and revisions for this document and will be listed as co-author for the publishable papers of this integrated thesis.

Dr. Maurianne Reade, Dr. Roger Pilon, & Dr. Lorrilee McGregor

Dr. Reade, Dr. Pilon and Dr. McGregor are the committee members on this project. They individually provided feedback and revisions on this paper and will be given the opportunity to co-author on the publishable papers in this integrated thesis.

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“So, whatever you do, whether you eat or drink, do all to the glory of God”

{ 1 Corinthians 10:31 }

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Chapter 1: Introduction

1.1 Reflexivity: Situating Myself

The purpose of this section is to situate myself in relation to this research. To preface, this is a community-based participatory project involving several First Nations communities as well as Family Health Teams in Northeastern Ontario; therefore, it is important that I state that I am a researcher and aspire to be an ally to Indigenous Peoples. I do not share many of the experiences of those who I have interacted with during this project, namely, the primary care providers working in health care system on Manitoulin Island, Indigenous or non-Indigenous alike. Through a brief introduction into who I am, I hope to shed some light on how my upbringing, experiences and values may have shaped this research and propose strategies on how to minimize my subjectivity. Furthermore, my objective is to demonstrate the importance of reflexivity in a study such as this.

Reflexivity is a process defined by thoughtful self-awareness wherein the researcher periodically reflects on how their interests or positions influences the research and its participants (Hyett, Marjerrison, & Gabel, 2018; Jootun, McGhee, & Marland, 2009). Given an inherent subjective component in qualitative research, reflexivity is seen as a useful tool that contributes to the trustworthiness of the research as well as making meaning of the findings presented (Hyett et al., 2018; Patnaik, 2013). By virtue of reflexivity, I am obligated to remain transparent throughout all steps of this project and confront how my own experiences, attitudes, values and biases may have influenced the process at hand. In a sense, reflexivity ensures that I am accountable to the findings. Finally, Patnaik (2013) asserts that the purpose of reflexive writing is to elicit a much richer understanding of the data and ensures the data presented accurately represents the research and its participants.

I was born and raised in Thornhill, Ontario, by parents who immigrated to Canada from Egypt. Similar to many other immigrant families, Canada offered them a chance at a better life. Slowly but surely, my parents became acculturated to the dominant Western culture, while simultaneously upholding their middle eastern culture. I experienced both Canadian and Egyptian culture growing up. While our family originated from humble beginnings and our story is a testament to how hard work and tenacity pays off, we recognize the privileges Canada has to offer and the positions of privilege we have here.

I was enrolled in French immersion starting from grade one all the way through high school. I had an affinity towards the sciences and writing, preferring biology or English class over art class. I immersed myself in books, often sitting on the floor in the library for hours to read and journal my thoughts. I have always empathized with those who are pushed to the side, outcasts, or who cannot advocate for themselves, so my volunteerism revolved around working with underserved children, disabled children or the elderly. These volunteer experiences sparked my interests in law - to fight for the innocent and seek justice for them. When it came time to choose an undergraduate degree, I was conflicted between pursuing a biomedical degree and a law degree, so I thought, "why not both?".

I moved to Sudbury to attend Laurentian University for an undergraduate degree in Forensic Science. Forensics was very rigorous, lab oriented, and guided heavily by scientific method. The analysis of data was almost exclusively quantitative in nature, and I became adept in this type of work. Although I would not learn the concepts of epistemology and ontology until my graduate degree, the nature of reality and means of obtaining knowledge were realist and positivistic, respectively. As scientists, we were trained to search for one objective truth that could be measured quantitatively and analyzed for validity and significance. The ways in which I

analyzed anything in life, whether in my academics or personal life, were guided by the same scientific and objective principles. There was no such thing as “perspective”- something was either “correct” or “incorrect”. I realize that this may influence the way in which I approach my research today, as there is conflict between my former ways of thinking and Indigenous ontologies and epistemologies as well as the constructivist Grounded Theory methodology I used for this study. Remaining mindful of this tendency and being able to adapt to other processes of thinking is crucial in making room for Indigenous ways of knowledge and maintaining the integrity of this research.

I learned about Indigenous history for the very first time during my graduate studies. My hometown had a predominantly Jewish demographic so some of my elementary curriculum was focused on Jewish history. I do not recall learning much about Canadian history other than the how colonization was seemingly patriotic and innocuous. I can clearly remember learning about the Holocaust, in which over six million Jewish people were killed due to anti-Semitism. To this day, I remain horrified at the idea of such dehumanization of a group that led to genocide. Fast-forward to my graduate studies, I can draw parallels between what I learned about the Holocaust to the horrors of colonialism on Indigenous soil (National Inquiry into Missing and Murdered Women and Girls, 2019). For most Indigenous Peoples and many scholars, colonization is not merely one isolated period of time, rather, it is an ongoing problem in Canada (Churchill, 2012). One current example of this is the recent National Inquiry into the Missing and Murdered Indigenous Women and Girls, which implores the Canadian government to recognize the ongoing genocide of Indigenous women and girls (National Inquiry, 2019). It is concerning to see the health disparities within Indigenous communities due to colonialism and the reluctance of Canada to call genocide towards Indigenous Peoples, genocide. Nonetheless, I am also inspired

by the resilience Indigenous Peoples continue to show despite being marginalized. My motivation behind pursuing this research project was to impact the lives of First Nations Peoples in a way that is useful and meaningful to specific communities in Northern Ontario. Being a non-Indigenous researcher, a recurring question I would ask myself is “can I help someone or contribute in a positive way”?

I am often discovering what it means for my Western perspective to conflict with Indigenous perspectives and I strive to conduct my research in the most respectful and culturally appropriate way possible. Historically, research by non-Indigenous researchers was done *on* Indigenous communities instead of *with* Indigenous communities. There was little collaboration with Indigenous co-researchers and the Indigenous communities or lives were rarely impacted positively (Snow, 2018). Colonial approaches in research are compared to putting Indigenous People under a microscope (Smith, 1999) and have led to research atrocities, like the harmful nutritional experiments that were conducted on Indigenous children in residential school without consent (Mosby, 2013). Due to the history of unethical research conducted on Indigenous Peoples, there are feelings of distrust and skepticism among Indigenous communities towards research (Hyett et al., 2018; Porsanger, 2004). Even the word “research” suffices to evoke negative feelings, as Smith (1999) put it: “‘Research’” is probably one of the dirtiest words in the indigenous world’s vocabulary” (pg. 1). As I learned about this pattern of research, I became much more cognisant of my responsibility in making sure I did not repeat it. Choosing an appropriate method and approach to research became integral to the research itself. As will be discussed in detail in other sections, community based participatory research (CBPR) is an approach that can facilitate Indigenous driven research (Creswell, 2009).

When I reflect on what it means to be engaging in research intended to benefit the lives of First Nations Peoples, I cannot help but question my legitimacy as a novice researcher, as put by Snow (2018). Defining what it means for me to be an ally to Indigenous Peoples was helpful in guiding this research project. To tie this back to reflexivity, being an ally can be thought of as a reflexive process. This meant reflecting on my own beliefs, assumptions, motives, and being critical of how these impacted this research (Hyett et al., 2018). Along my research journey, I was driven by practical steps I could take to fit characteristics of a settler ally. The first step was guided by the *Truth and Reconciliation Commission of Canada* (TRC), whereby being an ally involves recognizing my responsibility for Canada's colonial involvement of Indigenous Peoples, to strive to make amends (TRC, 2015), and to use methods that are equitable, humanizing, cooperative, unifying and strive for cultural synthesis (Freire, 2000). Another step was to work to eliminate barriers to Indigenous scholars, which meant validating and supporting Indigenous narratives and avoiding deficit narratives and misrepresentation. Working collaboratively with First Nations communities during this research project has helped me greatly in this area. Ultimately, recognizing my position as an aspiring ally has helped me to realize that I cannot speak on behalf of Indigenous Peoples. I must therefore relinquish control and put it in the hands of the experts, relying on Indigenous Peoples perspectives to direct my research. Finally, as "allyship" is a title designated by the communities I wish to be allied with, it would not be my place to prescribe myself as an ally to Indigenous Peoples; rather, I am an *aspiring* ally to Indigenous Peoples. Adhering to these practical steps has helped me grow as a researcher and ensured I was conducting research characterized by decolonization and reconciliation (TRC, 2015). These guidelines would later help me as I contributed to a CBPR

study on Manitoulin Island with a research focus on the increased rates of Intimate Partner Violence amongst Indigenous women and men.

1.2 Background

Intimate Partner Violence (IPV) is a public health issue receiving increased global awareness. IPV is defined as physical, psychological, emotional, financial, sexual, or spiritual violence experienced in any intimate relationship (Bair-Merritt, 2010; Dehan & Levi, 2009; World Health Organization (WHO), 2012). It has been argued that women predominantly bear the burden of violence within intimate relationships and studies investigating the prevalence and severity of IPV experienced by women have been studied in great amounts. For instance, according to a global United Nations study based on national crime statistics (2018), women are 82% likely to be murdered by an intimate partner, compared to 12% among men.

Many research studies indicate that Indigenous¹ women living in Canada are disproportionately affected by IPV (Andersson & Nahwegahbow, 2010; Romans et al., 2007). For example, Brownridge (2008) presents estimated rates of IPV in Canada at 12.6% for Indigenous women compared to 3.5% of non-Indigenous women. Although risk markers for violence for Indigenous and non-Indigenous women are similar, research lends support to structural, historical and political factors such as ongoing colonization and racism to explain elevated rates of IPV towards Indigenous women by men (Andersson & Nahwegahbow, 2010; Brownridge, 2003; Burnette, 2013; Varcoe et al., 2017). Moreover, about half of the Indigenous population in Canada live in rural, remote and Northern regions either on or off reserve

¹ Unless stated as “First Nation”, the term “Indigenous” is an all-encompassing term which can refer to Peoples who identify as First Nation (status or non-status), Métis or Inuit (Bartlett et al., 2007)

(Statistics Canada, 1998) and it is suggested that Indigenous women experience a higher rate of violence in rural areas compared to urban areas. Further, most statistics collected related to intimate partner violence and Indigenous populations are off reserve (North East LHIN, 2011) which begs further research for on-reserve Indigenous populations.

The severity of violence against Indigenous women gave rise to “the National Inquiry into Missing and Murdered Indigenous Women and Girls,” with a mandate covering all forms of violence against Indigenous women and girls (National Inquiry, 2019), and research and interventions directed towards Indigenous women as survivors of violence have become more common. In line with the *United Nations (UN) Declaration on The Rights of Indigenous Peoples*, the Canadian Government has started to take steps to address intimate partner violence against Indigenous women and increase safety of Indigenous women by funding a network of shelters that provide services for women and children living on reserve (Government of Canada, 2018). Although steps have been taken to address violence against Indigenous women, the research on intimate partner violence among Indigenous Peoples in rural, remote and Northern Canadian regions remain scarce and needs further inquiry (Brownridge, 2003).

One particular Northern Canadian region of interest is Manitoulin Island, Ontario. Formative research completed in collaboration with health staff at Mnaamodzawin Health Services Inc. and researchers at the Northern Ontario School of Medicine (NOSM) sought to identify women’s health research priorities on Manitoulin Island. During this consultation, IPV was identified as a significant health and social issue and prioritized as an issue for CBPR by three First Nations in the Manitoulin District (Bennett et al. 2019).

Manitoulin is the world’s largest freshwater island and is in North Eastern Ontario. Manitoulin District is home to approximately 13 000 people; from this approximately 60 percent

are of non- Indigenous background and 40 percent are Indigenous. To break it down even further, approximately half of the Indigenous population are women (Statistics Canada, 2017). The importance of this research project emerges from the detrimental effects IPV has on individuals , families, and communities of First Nation women on Manitoulin Island (Bennett et al., 2019; Maar & Shawande, 2010). Currently, there is little to no research available that addresses IPV against First Nations Peoples in a clinical setting on Manitoulin Island (Brownridge, 2003; Bennett et al., 2019).

1.3 Relevance of Study

IPV is a pressing health and social issue that requires combined efforts of First Nation communities, researchers, health service providers, and policy makers (Brownridge, 2003; First Nations Information Governance Centre, 2012). Research shows that primary care providers may play important roles in addressing the effects of IPV experienced by Indigenous women (McMurray & Param, 2008). However, providers face some challenges within their practice, especially in rural, remote and Northern settings, that must be addressed in order to more effectively support their patients who are experiencing violence, such as screening, training and referral processes (García-Moreno, 2002). Given a paucity of this type of research, especially on reserve, the lack of local, long term and sustainable community-based strategies to address IPV is perhaps not surprising (Andersson & Nahwegahbow, 2010; Bennett et al., 2019).

Exposing some of the current barriers to the provision of care for IPV in a clinical setting while building on current strengths in the local health care system will be a basis for establishing direction in tackling the pervasive phenomenon. It is anticipated that this project will not only help various service providers to better address clients experiencing IPV in a culturally relevant way, but it will contribute to improved health outcomes of First Nation women as well.

1.4 Operational Definitions

1.4.1 Intimate Partner Violence

The definition of Intimate Partner Violence (IPV)² varies depending on type of literature. Some studies focus on the physical aspect of IPV, while others may choose to focus on sexual, or emotional/psychological violence. What makes defining IPV even more complicated is how certain groups, by no fault of their own, have normalized violent behavior (Jewkes, 2002; Pan et al., 2006). For the purposes of this thesis, a broader definition of IPV pulled from various mainstream and Indigenous organizations and studies will be employed.

It would be beneficial to deconstruct the term “intimate partner violence”. To start, “intimate partner” is a person with whom someone has a close personal relationship with and is characterized by some or all the following dimensions: emotional connectedness, familiarity with each other’s lives, identification as a couple, regular physical and/or sexual behavior. (Centre of Disease Control, 2018). Examples of intimate partners include current or former spouses, boyfriends, girlfriends, dating partners or sexual partners. IPV is inclusive of heterosexual or same-sex partners and does not necessarily include sexual intimacy (CDC, 2018).

The next term to be discussed is “violence”. The WHO defines violence as any behavior causing physical, sexual or psychological harm (WHO, 2012). The National Institute of Justice

² The definition of IPV is much more nuanced and all-encompassing than historical terms such as domestic violence or familial violence. Today, IPV is the more appropriate term to use as it encompasses violence between partners who may not necessarily be confined to domestic or familial settings. Among these types of violence include child abuse, elder abuse and violence amongst co-habiting partners. (Holmes & Hunt, 2017; Wahab & Olson, 2004)(WHO, 2012) (NIJ, 2017)(Canadian Mental Health Association, 2015; Najafizada, Bourgeault, Labonte, Packer, & Torres, 2015)

(NIJ) and Centre of Disease Control and Prevention (CDC) outline four main types of IPV: physical violence, sexual violence, psychological violence and stalking. (NIJ, 2017; CDC, 2018). Physical violence includes a range in behaviors including the use of physical force or a weapon intended to cause bodily injury or death, such as shoving, choking, suffocating, shaking, pulling hair, slapping, punching or burning. Sexual violence is characterized by rape, sexual coercion (non-physical pressured sex), unwanted sexual contact (e.g. groping) and verbal harassment of sexual nature. Psychological/emotional violence is characterized by the use of control to traumatize the survivor. These can be done through coercion, acts or threats of acts, such as humiliation, verbal abuse, withholding information or finances, isolation from family, and threatening to take away children. Stalking includes a trend of threatening or harassing behavior that is unwanted and induces fear or safety concerns in the recipient. IPV can vary in frequency and severity, ranging from one episode to ongoing episodes (NIJ, 2017; CDC, 2018).

1.4.2 Primary Care & Primary Care Provider

Primary care is defined as “first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system.” (Ontario Primary Care Council, 2016, pg.4). Donaldson and colleagues (1996) incorporated patient, family, community and integration in their definition of primary care, which is “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” (Donaldson et al. 1996).

Historically, the term “primary care provider” has been reserved for physicians, while others have included nurse practitioners as well as physician assistants (Care et al. 1996). Due to a shortage of family physicians in recent years, the Ontario provincial government decided to

implement Family Health Teams and community health centre sites, which collectively, provide primary health care for millions of Ontarians (Canadian Mental Health Association, 2015). Primary health care therefore has increasingly diverse access points such as through nurse practitioner led clinics, solo physician practices, community programs such as home care and long-term facilities, and provincially funded Aboriginal Health Access Centres as well as federally funded First Nations health centres (Maar, 2004). Family Health Teams and community health centres have expanded the primary health care model to be multidisciplinary, inclusive of providers such as physicians, registered nurses, nurse practitioners, social workers, and dietitians and community health workers (Canadian Mental Health Association, 2015; Najafizada, Bourgeault, Labonte, Packer, & Torres, 2015).

An expanded definition of a primary care provider will be employed to include various disciplines who provide care in Family Health Teams as well as First Nations community clinics. Examples of primary care providers on Manitoulin Island may therefore include physicians, registered nurses, nurse practitioners, mental health workers, social workers, and community health workers.

1.5 Overview of IPV

Around the globe, intimate partner violence is one of the most common forms of gender-based violence (World Health Organization, 2012; Wuerch et al., 2019). IPV occurs among all socio-economic, religious, ethnic, and cultural groups, and is most frequently experienced by women (Brownridge, 2008; Burnette, 2013; Garcia-Moreno et al., 2006; Weaver, 2009). The consequences of IPV are vast, with death being the most extreme form of physical violence. Key findings from a United Nations (2018) study revealed that more than half of the 87,000 women killed around the world each year (58 % or 50,000) are killed intentionally by an intimate partner

or family member, making the home the most dangerous place for women. What raises more concern on this issue is that there has been minimal action taken to prevent these homicides and there is little evidence that these numbers are decreasing (UN, 2018). Statistics Canada (2013) reports that IPV accounts for 12 % of all police reported violent crimes and at a rate of 341 per 100,000 population (Statistics Canada, 2013). In addition to the harmful health outcomes IPV has on women, IPV also has a considerable economic impact. Billions of dollars have been expended to address the health-related costs of violence towards women in Canada, including medical and mental care costs, lost productivity, income assistance, and transition housing. (Day, 1995; Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004; Varcoe et al., 2011).

1.6 IPV in Indigenous Communities: Theoretical Perspectives

The reported estimates of IPV experienced by Indigenous women are quite significant, ranging anywhere between 25% and 90-100% in some populations (Bopp, Bopp, & Lane, 2000; D. A. Brownridge, 2003). Given that estimates are confounded by various factors such as the underreporting of IPV, methodology employed by a study, location of study (e.g.: rural vs. urban area), how researchers decided to define IPV, and different interpretations of household surveys and personal interviews, it makes it extremely difficult to ascertain IPV prevalence and study

IPV

comprehensively using statistical data. (Andersson & Nahwegahbow 2010; Brownridge, 2003). Despite the variability of statistics, some authors agree unanimously that Indigenous women in Canada face elevated rates of IPV victimization *relative* to non-Indigenous women (UNODC, 2018; A. Brownridge, 2008; Wahab & Olson, 2004). The United Nations (2018) report that Indigenous girls and women in Canada were much more likely to experience violence than non-Indigenous women, both in terms of victimization and lethality (UNODC, 2018). Brownridge

(2008) conducted a study with two national samples 1999 and 2004, it was found that Indigenous women were four times more likely to experience IPV compared to non-Indigenous women. To add, the Indian and Northern Affairs Canada (1996) reported that Indigenous women were likely to die from violence at a rate five times more than the general woman population. Finally, the Ontario Native Women's Association reports staggering rates of IPV: Indigenous women are eight times more likely to experience abuse compared to non-Indigenous women (Andersson & Nahwegahbow, 2010). Of those women, 87 % had been physically injured and 57 % had been sexually abused (Health Canada, 1997). Moreover, Indigenous women are also more likely to experience emotional abuse (Statistics Canada, 2004), ongoing violence subsequent to separation from an intimate partner (Pedersen, Malcoe, & Pulkingham, 2013), and are exposed to more severe forms of violence (e.g.: use of weapons, rape) (Mihorean, 2005).

Theoretical Perspectives

It is important to discuss the root causes of the elevated rates of IPV in First Nations communities. This is to prevent further stigmatization and the attribution of IPV to First Nations culture rather than to social, political, economic and historical marginalization (Hyett et al., 2018). To comprehend the high rates of IPV towards women in Indigenous contexts, it is helpful to discuss the underlying colonial context (Weaver, 2009). Although women all over the world face oppression based on their race and sex, the oppression faced by Indigenous women is unique due to the effects of colonization (Weaver, 2009).

Prior to colonization -the shifting and undermining of a group's values, beliefs and ways of life only to feel pressured to conform to the colonizer's values, beliefs, and ways of life -

Indigenous women were highly revered, and held sacred in their societies (Weaver, 2009). Many First Nation societies were traditionally matrilineal and matrilocal, (Weaver, 2009) where women carried a valued role of sustaining the well-being of their communities. From then on, a striking contrast had emerged; what had used to be an egalitarian society shifted to a male dominated society, fueled by the tainted application of Christian doctrine (Anderson, 1991). The idea that a woman's subjugation to a man was God's plan for humanity permeated many Indigenous societies (Anderson, 1991). Aside from the pressure to assimilate to Eurocentric culture, Indigenous Peoples have endured devastating events as a result of colonization which includes: colonial governments seizing Indigenous land achieved by the decimation or forced removal of Indigenous Peoples; removing children from their families and forcing them to attend residential schools, in which innumerable cases of physical and sexual abuse are documented; forced sterilization; and the banning of traditional cultural and religious practices (Evans-Campbell, 2008; Söchting, Corrado, Cohen, Ley, & Brasfield, 2007). The trauma arising from colonial structures, such as the *Indian Act* in 1876, the Sixties Scoop and residential schools, has promoted and propagated the use of violence against the Indigenous Peoples and remains deeply entrenched intergenerationally (Burnette, 2013; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). High rates of IPV experienced by Indigenous women is closely linked with historical trauma.

1.6.1 Historical Trauma Theory

Historical trauma is defined as a cumulative, devastative and chronic intergenerational experiences that occurs to a group through a life course. (Brave Heart, Chase, Elkins, & Altschul, 2011; Burnette, 2013). Historical trauma theory is complementary to critical theory in that it builds on the concept of internalized oppression. Historical trauma theory strives to explain that

when a group undergoes genocide (both physically and culturally), this oppression is internalized, which subsequently results in members targeting one another (Burnette, 2013). This internalized oppression ultimately leads to social harms, such as IPV. This may explain why many of the dehumanizing tactics used to subjugate Indigenous Peoples through colonization are the same ones used towards women in IPV (Brownridge, 2003; Burnette, 2013). As a result of subjugation and the failure of the oppressors openly accepting responsibility for their infliction, those who have been oppressed have mourned in a manner that is incomplete and this has been referred to as historical unresolved grief (Doka, 1989). Many of the same effects from historical unresolved grief were passed down to further generations in Indigenous Peoples (Wesley-Esquiaux & Smolewski, 2010). Historical trauma response is a term to describe the negative affect and behavior associated with multi-generational trauma, such as depression, self-destructive behavior, low self-esteem, suicidal ideation and acts, and restricted emotional expression (Burnette, 2013). Evans-Campbell (2008) built on this response into an elaborate framework including familial and community constituents. Inter-generational family level responses to historical trauma include damaged family communication and parenting stress, while community level responses include the disintegration of traditional culture, internalized racism, widespread alcoholism, and other physical ailments. She asserted that the historical trauma theory is applicable to all colonized Indigenous Peoples (Evans-Campbell, 2008). Many perpetrators of IPV have themselves been abused, resulting in a vicious and persistent self-perpetuating cycle (Andersson & Nahwegahbow, 2010). Despite historical trauma, Indigenous Peoples have shown resilience and demonstrate the capacity to recover from such inflicted traumas through resilience theory.

1.6.2 Resilience Theory

Ungar (2008) described resilience in a way that is much more than merely overcoming adversity. In the context of psychological or environmental stressors, or both, Ungar defined resilience as “both the capacity of individuals to navigate their way to health sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual’s family, community and culture to provide these health resources and experiences in culturally meaningful ways” (Ungar, 2008, pg. 225). Resilience theory aims to explain how individuals, families and communities are functioning and healing despite oppression, discrimination and subjugation. In addition, resilience theory attempts to explain how dehumanization can lead to transcendence in those who are oppressed, but who yearn for emancipation. Freire (2000) asserted that praxis, deep reflection, critical dialogue, and the desire to create social change for structural inequality is required in order to overcome this oppression in ways that are not sub-oppressive. Patterson (2002) described resilience as the interaction between risk factors and protective factors, whereby risk factors increase negative life outcomes and protective factors buffer against negative life outcomes. These factors are correlated with resilience because they either increase or decrease the chance that an individual will recover after hardships. Greene (2008) expands on this by saying that risk and protective factors may have a cumulative effect on the trajectory of life outcomes. In simpler terms, more risk factors act synergistically to create a greater negative effect on life outcome than a single risk factor while protective factors have a positive effect.

The mainstream literature discusses risk and protective factors in the lives of women. From a review of the 1999 Canadian General Social Survey data focused on violence and victimization, the sociodemographic risk factors associated with IPV include being of younger

age, being separated/divorced or single, having children in the household, and having poor physical health (Romans et al., 2007). Similarly, Brownridge and his colleagues (2008) conducted a study that explored IPV amongst non-Indigenous women from a nested ecological framework, which suggested risk factors for IPV such as female independence, the presence of children, and younger age (Brownridge, 2008). Moreover, pregnancy (D. Brownridge et al., 2011), stress induced by poverty, heavy alcohol consumption, normalized violence, and conflict-ridden relationships (especially from jealousy, finances or a women gender role “transgressions”) were found to be a risk factors for IPV (Jewkes, 2002). Regarding what could protect a non-Indigenous woman from IPV, Davis (2002) conducted a study with 17 non-Indigenous women who had been abused. It was found that women were able to protect themselves and learn to be resilient by factors such as securing financial resources, seeking out social support, practicing spirituality, using humor, attaining skills, self-reflection, and self-nurturing through journaling or poetry (Davis, 2002). Another protective factor from violence include high levels of female empowerment. Women may feel empowered from different sources, such as education, income, and community roles, but all of these do not necessarily provide the same levels of protectiveness (Jewkes, 2002).

There is a need to distinguish risk and protective factors between Indigenous and non-Indigenous women. This ties into Greene’s (2008) assertion that resilience depends on the context in which a person is situated, wherein Indigenous survivors of violence may be affected by culturally unique moderators. Upon reviewing the literature about Indigenous Peoples, the factors that may contribute to family violence include low socioeconomic status, alcohol/substance abuse, and the impact of colonialism on Indigenous Peoples (Shea, Nahwegahbow, & Andersson, 2010; Wahab & Olson, 2004). Moreover, Oetzel and Duran

(2004) conducted a comprehensive study that investigated risk factors for IPV at multiple levels, including individual, interpersonal and organizational levels. They found that at an individual level, risk factors included being female, being between the age of 16-24, having a lower socioeconomic status, substance abuse, and a fragile cultural identity. Interpersonally or at the family level, risk factors included patriarchal dominance, severance of family bonds, and the belief that women should endure IPV for the sake of the children. At an organizational level, risk factors included lack of routine screening, a deficient health care infrastructure for addressing IPV, and a lack of punitive action against abusers. One key community or societal risk factor that is unique to Indigenous women is historical trauma from colonization, which is argued to contribute to the other aforementioned risk factors (Burnette, 2013).

There are some studies that report the protective factors for IPV both for Indigenous Peoples in general and for Indigenous women. For example, Grandbois and Sanders (2009) sought to include information on community resilience from their work with elders. The elders emphasized obtaining strength from strong unity amongst community members, a strong tribal identity, and maintenance of traditional practices. A case study by Waller et al. (1998) explored what protected Indigenous women from IPV. Through qualitative interviews the protective factors included self-protection, perseverance despite abusive situations, and the maintenance of traditional Indigenous practices. Moreover, in an ethnography with Indigenous women, Burnette (2013) outlines protective factors for Indigenous women across multiple levels. At an individual level, protective factors include survivance, faith, using their talents and abilities, pursuing education, autonomy and bicultural competence. At a familial level, protective factors included strong family ties, non-violent values and enculturation (Burnette, 2013)

Resilience theory relies on a strengths-based framework as opposed to a deficit-based framework. In addition, resilience theory challenges the conventional theories that paint Indigenous women who have experienced (or who are experiencing) IPV as being passive and helpless recipients of violence (Freire, 2000).

1.7 IPV in a Clinical Setting

A growing body of evidence suggests that IPV has a profound negative impact on the individual experiencing it and, on their children, (Zink & Putnam, 2005). Primary care providers often witness the negative physical, emotional and social health outcomes of IPV in their patients, some of which may include chronic injury, unwanted pregnancy, higher risk of sexually transmitted diseases, substance abuse, mood disorders, high dropout rate, and child apprehension (Andersson & Nahwegahbow, 2010; Black, 2011). These providers are the first point of contact and are often the preferred person for disclosure, giving them a unique frontline role in identifying and supporting those who have been survivors³ of IPV, mitigating violence, and contributing to better health outcomes for the woman and her children (Kalra, Di Tanna, & García-Moreno, 2017). Providers also play a role in collecting and documenting probative evidence for legal action against the perpetrator of abuse, offering continuity of care, as well as referring survivors to other services that address their needs and those of the family (e.g.: social welfare, community resources) (Kalra et al., 2017).

In mainstream literature, there is widespread consensus that providers play a role in addressing IPV experienced by their patients (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Davidson et al., 2001; McMurray & Param, 2008; Usta & Taleb, 2014). However, providers often overlook IPV by treating patients' presenting complaints, without getting to the

³ The term "survivor" is used in place of "victim", as "victim" may imply that the woman is a passive recipient of violence and is not involved in defending themselves against violence (Usta & Taleb, 2014)

root of the issue (Usta & Taleb, 2014). Unfortunately, providers face many barriers that hinder the identification of IPV and provision of care for their patients who experience IPV (Black, 2011). A primary barrier to the provision of quality care related to IPV by a provider is the avoidance of addressing IPV with patients due to being unprepared or inadequately equipped to handle the situation (Beynon et al., 2012; Davidson et al., 2001; Djikanovic, Celik, Simic, Matejic, & Cucic, 2010). When patients did disclose IPV, providers felt they lacked the training regarding how to proceed with addressing the issue, unsure as to what their role might be, or knowing which health professional or services to whom a patient should be referred. Other barriers to intervening or delivering adequate care included time constraints, resulting in the failure to address IPV within the allotted time frame of the office appointment; and a lack of resources in rural settings (Beynon et al., 2012). Additional barriers discussed in the literature included provider tolerance for violence, whether the provider has been a perpetrator, survivor or witness of IPV, placing the blame on the survivor, or religious beliefs that allow men to abuse their wives (Beynon et al., 2012; Djikanovic et al., 2010; Usta & Taleb, 2014; Wood, Maforah, & Jewkes, 1998; Zakar, Zakar, & Kraemer, 2011). Other barriers for providers included believing that addressing IPV is not within their role, thinking that IPV is irrelevant to healthcare, or women being hesitant to disclose IPV to a male provider (Usta & Taleb, 2014). Facilitators for providing sensitive care to women experiencing IPV included training, community resources, professional tools/protocols and policies (Beynon et al., 2012), interdisciplinary collaboration (Zink & Putnam, 2005) and education of healthcare staff in IPV (Evans-Campbell, 2008).

Ferris (1994) conducted a national survey to evaluate provider knowledges, attitudes and the detection of IPV⁴ experienced by Indigenous patients. The results demonstrated that physicians with a high number of Indigenous patients suspected they were missing cases of abuse, to which they attributed cultural barriers, infrequency of patient visits, patient unresponsiveness and no perceived need to disclose the abuse to the provider. McMurray and Param (2008) described cultural and communication barriers to equitable and optimal healthcare access for Indigenous women. From the provider's side, there is a tendency to dismiss First Nations health outcomes as being attributed to culture, when they ought to be framed under structural, historical, and political mechanisms. The reluctance that providers experienced to addressing IPV is further compounded by additional cross-cultural complexities, for example, a lack of understanding about the phenomenon or for feeling inappropriate to challenge a culture's gender relations and perceived behavioral norms (McMurray & Param, 2008). From the patient's perspective, there is often hesitation in sharing IPV experiences with a provider due to power differentials and the perception that the provider is not familiar with or appreciates the value to traditional medicine, a key component to Indigenous healing (Manitowabi & Shawande, 2013; McMurray & Param, 2008). Other barriers that prevent a woman's disclosure of IPV to a provider include the mistrust of institutions and authority figures due to effects of residential schools, the fear that social services will apprehend her children, and the lack of services or support in rural or remote communities (Allard, 2013). The authors argued that the role of the provider is to provide care that is accessible, equitable, and empowering for Indigenous women. The authors also asserted that there ought to be the collaboration between sectors in health in order to maintain a continuity of health.

⁴ For the purposes of this thesis, IPV is being used in lieu of "wife abuse" as described in Ferris' (1994) study

There are few studies investigating the intersection between healthcare and IPV in rural, remote or northern communities. Within the limited research, women living in northern Canadian communities have been found to experience higher rates and more severe cases of IPV than those living in urban communities (Wuerch et al., 2019). Women living in these more remote areas often face barriers such as a lack of public transportation or geographical barriers such as far distances to access a health care centre. Due to these barriers, response times to calls are often increased for police and first responders. In addition, women may not have the funds to access a vehicle, lack social or economic support to leave and sustain life after leaving an abusive partner, or do not confide in health or judicial systems because of anonymity and confidentiality concerns (Wuerch et al., 2019). When children are involved, women are hesitant to disclose they are being abused because of the fear that child welfare services will become involved. Indigenous women in these regions are in an especially vulnerable position and often decide not to seek help because of the lack of culturally appropriate services (Wuerch et al., 2019). Most recently, Wuerch and colleagues (2019) conducted an exploratory study with social service and justice providers in a northern region of Saskatchewan, Canada. The researchers investigated the barriers faced by providers with regards to delivering care to Indigenous and non-Indigenous women who have experienced IPV. The results revealed similar barriers and challenges that were found in the existing literature pertaining to rural, remote and northern communities. Participants expressed that building strong and trusting relationships with patients were hindered by high employee turnover rates and by the stigma a patient feels about seeking support from health services. Providers also expressed that survivors of IPV may be deterred from reporting abuse because perpetrators of IPV in northern communities are often not held accountable to the same degree as they might be in urban communities. Despite these challenges,

a number of solutions were proposed by the health care providers who participated in the study: providing a safe and non-judgemental space for IPV survivors that facilitated empowerment; increasing confidentiality by services such as home visits or safe houses; interdisciplinary collaboration; increasing education within the community on IPV and mental health; promoting continuity and consistency of care; and training or retraining employees to understand the nuances of the unique region they work in.

1.8 Research Questions

Primary care providers have often expressed that many of the consequences of IPV are left unaddressed due to a lack of a coordinated approaches to this complex phenomenon (Allard, 2013; Bennett et al., 2019; Black, 2011). We therefore sought the perspectives of providers working on Manitoulin Island on the topic of IPV. The purpose of this study is to address this gap by identifying barriers, facilitators, and recommendations within current health practices from the providers themselves. The research questions are: (1) “From the perspective of a primary care provider, what are the barriers and facilitators within current practices to addressing Intimate Partner Violence experienced by rural First Nations?” and (2) “What are the recommended strategies in a community and clinical setting?” By answering these questions, we hoped to collaboratively identify changes to improve the response in the primary care setting to IPV experienced by rural First Nations patients.

1.9 Theoretical Framework of This Project

A research paradigm is made up of four primary philosophical assumptions: ontology, the beliefs in the nature of knowledge; epistemology, the relationship between the researcher and knowledge; methodology, the researcher’s approach to knowledge; and axiology, the intrinsic value of the knowledge (Crotty, 1998) This research is within a First Nations context and is

situated within an advocacy/ participatory paradigm (Creswell, 2009).⁵ The ontological assumptions of the participatory paradigm are subjective-objective. As Heron put it: “It is subjective because it is only known through the form the mind gives it; and it is objective because the mind interpenetrates the given cosmos which it shapes” (Heron & Reason, 1997, pg 279). The epistemological assumptions of the participatory paradigm explain how the researcher interacts with knowledge in four ways: experiential, presentational, propositional, and practical. Experiential knowing refers to the researcher’s direct empathic encounter with a person, place or thing; presentational knowing refers to creative and symbolic representation we make from our experiential knowing, through “graphic, plastic, musical, vocal, and verbal art forms” (Heron & Reason, 1997, pg 281); propositional knowing arises from the researcher’s conceptualisation of a particular person, place, or thing; and practical knowledge is being skilled or competent at something. The methodology of the participatory paradigm is based on the cooperative relations between researcher and participants. The axiology values the practical knowledge in the assistance of human flourishing (Heron & Reason, 1997).

The participatory paradigm was chosen because it allows the researcher to strive for advocacy on behalf of disenfranchised groups and partners with that group to reach a common goal (Creswell, 2009). Other paradigms of post positivism and constructionism did not prove as useful for this research project. Those would not have allowed the direct incorporation of issues that First Nations communities face, such as the issue of IPV in the context of colonialism, into the worldview (Creswell, 2009). One of the main principles of the participatory paradigm is that there ought to be an action agenda for reform that changes the lives of marginalized participants, social structures in which they live or work or even the researcher’s lives (Creswell, 2009).

⁵ The term “advocacy/participatory” will hereafter be referred to as “participatory”

Researchers who engage in research involving Indigenous and communities are in consensus that consequences of poor health are extremely complex, multi-faceted, and inextricably linked to social contexts (Martin, 2012). First Nations must inevitably navigate two worlds, which are their Indigenous communities and settler communities. First Nations Peoples assert that their pathways to wellness lie within their culture; however, First Nations culture, practices, and Traditional Knowledge utilization is thwarted by colonization (Marshall, Marshall, & Bartlett, 2015). Marshall et al. (2015) emphasize that for community members and communities to recover from poor health, First Nations perspectives must co-exist amongst mainstream perspectives. This synergism in knowledge, as opposed to competition, will work for a better and healthier world (Marshall, Marshall, & Bartlett, 2015) In order to cultivate a culturally safe environment, this research project draws on a concept called *two-eyed seeing*, coined by Albert Marshall, a Mi'kmaw Elder. In healthcare, two-eyed seeing refers to a holistic and guiding principle for many Indigenous Peoples and refers to the bridging together two paradigms -traditional and mainstream paradigms- for better health outcomes for everyone (Marshall, Marshall, & Bartlett, 2015). Using the strengths of traditional knowledge and ways of knowing through one eye, and the strengths of Western knowledges and ways of knowing through the other eye and seeing both perspectives simultaneously. This does not necessarily mean that vision is now made “whole”; rather, one eye is never subsumed by the other, there is an appreciation of two alternative ways of knowing, and it causes reflection on the partiality of one's perspective (Martin, 2012). Indigenous and non-Indigenous perspectives must co-exist in the healthcare field in order to deliver optimal patient-centered care.

1.10 Methodology

1.10.1 Setting

This study takes place on Manitoulin Island, in Northeast Ontario. Manitoulin District is home to seven First Nation communities: Wiikwemikoong Unceded Indian Reserve, M'Chigeeng First Nation, Aundek Omni Kaning, Sheshegwaning First Nation, Sheguiandah First Nation, Whitefish River First Nation, and Zhiibaahaasing First Nation. These seven Anishinabe communities receive health service provision from federally funded health centers on reserve, and from one provincially funded Aboriginal Health Access Centers (i.e.: Noojmowin Teg) as well as from physicians in private practice and Family Health Teams off reserve (Maar, 2004).

1.10.2 Study Design

This research employed a qualitative and CBPR approach to answer the research questions. Data was collected using a combination of semi-structured interviews and focus groups with various Manitoulin Island providers who work on and off reserve. A qualitative and CBPR approach was chosen because it suits the exploration of various participant perspectives, as well as aligns with a participatory paradigm (Creswell, 2009; Tarasuk & Eakin, 1995). Data was analyzed using Grounded Theory which is an inductive and iterative approach to research, whereby theory is developed based on emerging themes rather than being driven by theories available in extant literature (Charmaz, 2014). Grounded Theory is the approach chosen for analysis as it is suitable to answer research questions of any kind, but particularly those where little is known about the topic (Glaser & Strauss, 2000) and provides openness and flexibility in terms of shaping the data analysis to what the community finds relevant (Charmaz, 2014, 2017).

1.10.3 Community Based Participatory Action Research (CBPR)

CBPR⁶ is an integrated approach in which community members work closely alongside the researchers throughout each stage of the research process (Bennett, 2004; Chilisa, 2012). Maguire (1987) describes CBPR as “an alternative style of research, which uses a three-part process of social investigation, education and action to share in the creation of social knowledge with oppressed people” (Maguire, 1987, pg. 3). A participatory action approach can be justified within this study because it has been successfully used in Indigenous health research. In particular, it shifts the research project towards outcomes that are beneficial and meaningful to a particular Indigenous community and is helpful in “restoring power and control, and indigenizing the research process (Hyett et al., 2018, p. 19). In addition, it aligns with a relationship-based participatory paradigm and is useful in creating change tailored to the needs of the community. The primary characteristics of CBPR are as follows: (1) the community defines a local problem, and actively participates through the stages of the research process (in this case, community members on Manitoulin offer their input and expertise); and (2) the research should contain an action agenda for social advocacy and reform that changes the lives of all members involved (Creswell, 2009). To date, the communities on Manitoulin has been involved in the research process by identification that IPV is a local issue (Maar & Shawande, 2010) and playing an active role in determining data collection. Member checking had begun at the stage of the writing of the thesis and will continue during knowledge translation.

1.11 Organization of Thesis

The second chapter of this thesis is a paper entitled “Improving the response of primary health care providers to Rural First Nations Women who experience Intimate Partner Violence”. This

⁶ Although community based participatory action research is sometimes referred to as CP-PAR (inclusive of the word “action”), CBPR will be the acronym used for the purposes of this paper. As the action component is anticipated but not yet executed as part of this study, the “action” component was explained briefly as an expected outcome of this study but excluded as part of this paper.

paper was submitted to a peer-reviewed journal for the purposes of publication. The intent of publication is not merely for academic authorship but as a way to disseminate the results gathered directly back to the participants for which the project was designed. We hope that the results of this research will be useful for the health care practitioners on Manitoulin Island who share similar struggles within the health care system. In addition, we hope that the recommendations offered may be of assistance for providers seeking guidance regarding how to better assist their First Nations patients who experience IPV. Knowledge translation will continue beyond thesis defence with the collaboration of the thesis committee, who are well situated to support this initiative: all members are involved in shaping primary care curricula; one of the academic advisors provides primary care services in one of the participating organizations; one member is an Indigenous health researcher from a participating First Nations; and finally another member leads a multi-year IPV research project in partnership with participating organizations and communities.

The third chapter of this thesis is entitled “Intimate Partner Violence Against Indigenous Men: A Significant yet Overlooked Health Issue”. The topic of this paper was initially unexpected because the original focus was on Indigenous women, however; due to the frequency with which it was brought up by providers, it was important to include it as part of our research. This paper was also submitted for publication to a peer-reviewed journal. We hope to spread awareness on intimate partner violence experienced by First Nation men on Manitoulin Island and highlight the suggestions the providers have given in light of this observation.

The subsequent chapters discuss the overall results of this study as well as discuss the implications of this study for knowledge translation of the results on Manitoulin Island. Then,

chapter four discusses the overall results of this study, the implications of this study for knowledge translation on Manitoulin Island, and the limitations of the study. Finally, chapter 5 provides the conclusions based on this thesis research.

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Chapter 2: Improving the Response of Primary Care Providers to Rural First Nation Women who Experience Intimate Partner Violence

2.1 Abstract

One legacy of colonialism is that Indigenous women living in Canada experience higher rates of intimate partner violence (IPV) and that violence is more severe relative to non-Indigenous women. This results in avoidable physical, psychological, emotional, financial, sexual and spiritual harm in the lives of Indigenous women, families, and communities. Trusted primary care providers are well positioned to provide brief interventions and referrals to treatment and services, but little is known about the providers' preparedness to provide this support to Indigenous women. Information on how well providers respond to Indigenous patients who experience IPV is needed in order to ensure this potential lifeline for support is realized.

The purpose of this community-based participatory study was to elucidate the barriers and facilitators to care for rural Indigenous women who experience IPV from the perspectives of primary care providers and to recommend strategies for clinical and community settings. Using a Grounded Theory approach, we conducted qualitative research with 31 PCPs to discuss their experiences with patients affected by IPV.

The results showed providers often feel a degree of unpreparedness to deal with IPV in a clinical setting.

Underlying the feelings of unpreparedness were:

- Recognition of patients' under disclosure of IPV due to stigma, shame and fear
- Lack of formal provider training on appropriate approaches to IPV
- Lack of referral network due to fragmented, scarce services for IPV
- Lack of understanding of jurisdictional complexity of First Nations and non-First Nations specific services for IPV
- Uncertainty how to negotiate cultural safety around IPV

- Multiple-role relationship & confidentiality dilemmas characteristic of small communities
- Risk of jeopardizing patient-provider relationship

We provide recommendations to improve the provider preparedness to address IPV in the clinical and community setting, based on our research and current evidence. We suggest that increasing providers' comfort to respond to IPV for rural and Indigenous women, which will ultimately lead to improved safety and health outcomes.

2.2 Preamble

The rationale for this paper was based on formative community based participatory research (CBPR) with First Nations communities and health care organizations on Manitoulin Island in 2016. IPV was stated to be an extremely pervasive, yet under-addressed issue and therefore prioritized for research. The individuals from the organizations in the formative research felt a perceived lack of coordinated strategy for IPV and unsure of their preparedness to address IPV in a clinical setting. This paper discusses the results of research conducted with providers on Manitoulin Island and their experience with addressing IPV in a clinical and community setting.

2.3 Background

“Identifying a problem that you can't do anything about is not necessarily a wonderful thing.”

{ Community 2, Participant 1 }

Around the globe, intimate partner violence (IPV) is one of the most common forms of gender-based violence. IPV is defined as physical, psychological, emotional, financial, sexual, or spiritual violence experienced in any intimate relationship and is a grave social issue associated with many adverse health outcomes (Bair-Merritt, 2010; Romans, Forte, Cohen, Du Mont, &

Hyman, 2007; Varcoe et al., 2011). Although seen among all socio-economic, religious, ethnic, and cultural groups (Brownridge, 2008; Burnette, 2013; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; Weaver, 2009), Indigenous⁷ women in Canada experience elevated rates of IPV, which is best explained within the context of multi-generational trauma experienced by Indigenous communities as a consequence of colonization and forced assimilation (Government of Canada, 2015; Klingspohn, 2018).

Estimates of the prevalence of IPV experienced by Indigenous women in the existing literature vary and depend on factors such as levels of underreporting of IPV, methodology employed by a study, location of study (e.g.: rural vs. urban area), how researchers defined IPV, and different interpretations of household surveys and personal interviews (Andersson & Nahwegahbow, 2010; Brownridge, 2003). Thus, reported estimates of IPV experienced by Indigenous women are variable and difficult to ascertain, with studies reporting rates between 25% and 90-100% in some populations (Brownridge, 2003).⁸ Despite this range in estimates, authors agree unanimously that Indigenous women in Canada face elevated rates of IPV victimization *relative* to non-Indigenous women (A. Brownridge, 2008; Wahab & Olson, 2004; UNODC, 2018). For example, Brownridge (2008) conducted a study with two nationally representative populations in 1999 and 2004 and found that Indigenous women were four times as likely to experience IPV compared to non-Indigenous women. In addition, the Ontario Native Women's Association reports shocking rates of IPV: Indigenous women are eight times more likely to experience abuse compared to non-Indigenous women (Andersson & Nahwegahbow,

⁷ Unless stated as "First Nation", the term "Indigenous" is an all-encompassing term which can refer to Peoples who identify as First Nation (status and non-status), Métis or Inuit (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007)

⁸The statistics reported, unless otherwise stated, do not represent First Nation communities living **on reserve**. Most databases from National surveys report data with "self-identified Aboriginal People" and almost always **exclude** First Nation communities on reserve (North East LHIN, 2011)

2010). Furthermore, Indigenous women living in rural and northern Canadian communities were found to experience higher rates and more severe cases of IPV than those living in urban communities (Brownridge, 2003).

In a clinical setting, primary care providers⁹ interact with patients who are experiencing IPV, either suspected or direct disclosure of violence (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). One study suggested that women are not likely to disclose violence unless directly asked (Ramsden & Bonner, 2002), but even when patients present with symptoms indicative of IPV, providers were often reluctant to ask about abuse and grapple with a variety of barriers that prevent them from addressing the abuse (Beynon et al., 2012). Among the studies reviewed, health care providers identified the following barriers: time restraints during the clinical encounter; discomfort in asking; fear of offending; lack of training in how to ask and intervene; cultural or language barriers; attitudes and behaviors from the one experiencing IPV; partner presence; lack of resources/referrals; and a lack of disclosure/denial of abuse (Beynon et al., 2012; Black, 2011a; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Sugg & Inui, 1992; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Conversely, there are also factors that could enable providers to ask about abuse and help patients who are experiencing IPV more effectively, such as being an older and more experienced provider, attending training to respond to abuse, as well as having a history with abuse themselves (Dickson & Tutty, 1998).

Research investigating the intersection between the health care system and IPV experienced by rural, remote and Northern Indigenous women is currently uncommon (Wuerch, Zorn, Juschka, & Hampton, 2019). Most recently, Wuerch and colleagues (2019) conducted a qualitative study with community and justice service providers in northern Saskatchewan, Canada, a region whose population is predominantly Indigenous. The aim of this study was to

⁹ Hereafter referred to as provider/s

investigate challenges providers faced in meeting the needs of women who experience IPV. Providers perceived a surrounding stigma from community members around health services. This stigma may stem from factors such as trying to uphold a positive image, low employee retention, and a lack of trust patients may have with their provider, which may in turn hinder strong and trusting patient-provider relationships. Providers also expressed that survivors of IPV may be deterred from reporting abuse because perpetrators of IPV in northern communities are often perceived to not be held accountable to the same degree as they might be in urban communities.

Given the many barriers to accessing support services, provider encounters could represent a lifeline for abused women, especially in low resource environments which are often found in rural Indigenous communities. Practical steps that could be taken to improve the response to IPV in primary care are therefore urgently needed, especially with First Nations women living on reserve.

Study Objective

This research was part of a larger initiative conducted by several First Nations communities in collaboration with researchers at the Northern Ontario School of Medicine. The study identified IPV as a significant health and social issue prioritized for community based participatory research (Bennett et al., 2019). During the planning stage, providers expressed a lack of coordinated approach and an uncertainty in their preparedness to approach this complex phenomenon in the clinical setting (Bennett et al., 2019). The overall aim of this research was to identify the perceived barriers and facilitators in the primary care setting to respond to First Nations who experience IPV and to provide recommendations to improve the response to IPV at a clinical and community level.

2.4 Methods

2.4.1 Approach

We employed a community- based participatory research (CBPR) approach to this study, in which we worked closely alongside community members and organizations throughout each stage of the research process from identification of the research question to knowledge translation (Bennett, 2004; Chilisa, 2012). CBPR was used in such a way that this research would be tailored, beneficial and meaningful to the collaborating First Nations and the Family Health Teams on Manitoulin Island.

2.4.2 Setting

This study took place on Manitoulin Island, in North Eastern Ontario. The Manitoulin District has a population of over 13 000, whereby approximately 5260 are Indigenous. Manitoulin District is comprised of more than 10 villages, seven Anishinabe First Nation communities and many hamlets (Statistics Canada, 2017). The First Nations communities receive health service provision from federally funded health centers on reserve, from one provincially funded Aboriginal Health Access Center as well as from providers working in private practice and Family Health Teams off reserve (Maar, 2004). In this study, providers participated from First Nations Health centres in two communities (Wiikwemikoong Unceded Territory and Whitefish River First Nation) and from two Family Health Teams (whose staff also work in the Emergency Room), located at two hospital sites (Little Current and Mindemoya).

2.4.3 Ethics

This research project adhered to ethical standards and obtained ethics approval from Indigenous and non-Indigenous review boards, the Manitoulin Anishinaabek Research Review Committee (MARRC, 2019) and Laurentian University Research Ethics Board (see Appendix 1) (LUREB,

2019). The two participating communities, Wikwemikong Unceded Reserve and White Fish River First Nation, granted band council resolutions approving this research. Finally, this study also abided by the Tri-Council Policy Statement 2nd Edition – Chapter 9 (Government of Canada, 2016) and respected Ownership, Control, Access and Possession (OCAP) principles (OCAP | FNIGC, 2014).

2.4.4 Participants

For participant selection we contacted health team leads to ask if their team would be interested in contributing to the study. Posters advertising the nature, relevance and expected outcomes for the study were relayed to the health team leads by email. For the purposes of this study, an eligible primary care provider was defined as any professional in the healthcare system who provide direct patient or client services and is accessible through self-referral. In addition, these individuals should have had prior experience with IPV in their practice or find IPV relevant to their practice. Eligible providers included regulated and non-regulated health providers, such as physicians, registered nurses, nurse practitioners, mental health workers, physiotherapists, social workers and community health workers.

2.4.5 Data Collection

The participants were invited to share, over lunch, interactions with individuals in clinic, home care, hospital inpatient and emergency room settings as well as in social situations. Before the start of a focus group or interview, an information page of the study was given for review by participants and consent was given to record the session (see Appendix 2). The lead and senior author collaboratively conducted the facilitation of interviews and focus groups (see Appendix 3). The senior author is a qualitative researcher with more than 20 years of experience in First

Nations and rural health research. Each focus group lasted on average two hours, while semi structured interviews lasted on average one hour.

Consistent with Grounded Theory we applied theoretical sampling to test emergent observations and theories and to better understand nuances and contradictory experiences between the providers. A total of four focus groups and two in-depth semi-structured interviews with healthcare providers were conducted (see Table 1 for details), at which point data saturation was reached.

2.4.6 Data Management & Analysis

The analysis of data followed a Grounded Theory approach, whereby data collection and data analysis were performed concurrently (Charmaz, 2014). The Grounded Theory approach to analysis is inductive, in that themes and categories emerge directly from the data and were not pre-determined (Gulliver, Griffiths, & Christensen, 2012). The data was transcribed verbatim and the initial coding of the data was done by two researchers (KR, MM) using qualitative software, NVivo 12. Data was scanned line by line, and then the researchers moved on to grouping these words, ideas or phrases into larger categories, or themes (Charmaz, 2014). To ensure the validity of emerging themes and categories, coding of the data was performed independently by the co-researchers and then compared, and consensus was reached by involving all researchers in the discussion. Emerging themes were discussed after each data collection session between the primary and senior researcher. A core category that defined the main patterns of concern was established. Member checking was conducted by involving one provider and one community member in the analysis as well as presenting results back to the community for discussion and feedback.

2.5 Results

31 participants (100%) contributed in either a focus group or semi-structured interview. Two of the focus groups as well as the semi-structured interviews were held with members of Family Health Teams in mainstream organizations, while the remaining two focus groups were held at First Nations health organizations. Of the 31 participants, six (19.4 %) self-identified as physicians, five as social workers/personal social workers (16.1 %), two as registered nurses (6.5 %), thirteen as community health workers¹⁰ (41.9 %) , and five as other primary care workers (16.1 %). “Other” primary care workers can be very specific positions to Family Health Teams or First Nation health teams, therefore the grouping is used to protect participants’ identities. Examples of these positions include physiotherapists and administrative workers. The majority of participants were female (90%, n=28) and the rest were male (10%, n=3) and approximately half of the participants were Indigenous. The breakdown of the characteristics of the providers by location, sex, and discipline are shown in Table 1 below.

Table 1: Participant Characteristics

Community	Focus group & Interview Participants		Physicians	Nurses	Community health workers	Social workers, mental health workers	Other primary care
	Men	Women					
Family Health Team Community 1	1	7	2	1		2	3
Family Health Team Community 2	1	6	4		1	2	
First Nation Community 3	1	9			8	1	1
First Nation Community 4	0	6		1	4		1
TOTAL	3	28	6	2	13	5	5

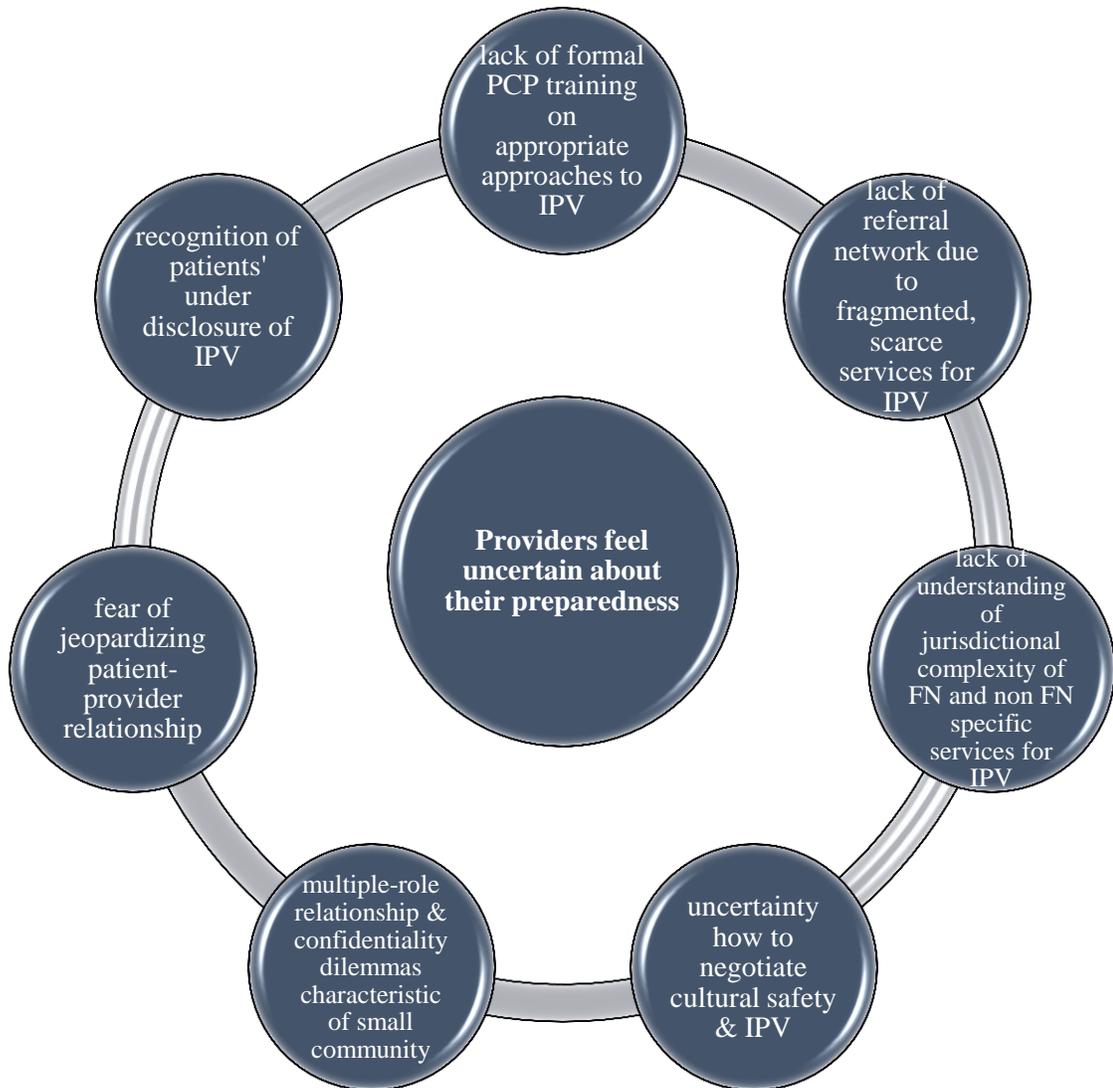
Grounded Theory Results

¹⁰ Community health workers are an under-recognized and unregulated group of individuals who provide health-related services for fellow community members. Examples of titles of community health workers depend on geographic area and populations served, some of which include Community Health Workers, Community Nutrition workers, and Community health representatives (Najafizada et al., 2015)

A core category of concern held by providers when they respond to women who experience IPV was discovered during Grounded Theory analysis. The core concern was the uncertainty of adequate preparedness to respond to women who experience IPV in the primary care setting, compounded by various barriers (see Figure 1). In turn, this concern can lead to a suboptimal approach or lack of response to IPV by providers.

We identified seven main barriers that contribute to the core phenomenon of the unpreparedness to consistently respond to IPV:

1. Recognition of patients' under disclosure of IPV due to stigma and shame
2. Lack of formal provider training on appropriate approaches to IPV
3. Lack of referral network due to fragmented services and limited access to these services for IPV
4. Lack of understanding of jurisdictional complexity of First Nations and non-First Nations specific services for IPV
5. Uncertainty how to negotiate cultural safety & IPV
6. Multiple-role relationship & confidentiality dilemmas characteristic of small communities
7. Fear of jeopardizing patient-provider relationship



***Note: FN=First Nation**

Figure 1: Model of the multiple factors that contribute to providers feeling a lack of preparedness which in turn hinders optimal response to rural and First Nation women who experience IPV

Description of Barriers that contribute to lack of preparedness

1. Recognition of Patients' Under Disclosure of IPV due to Fear, Stigma and Shame

Many providers felt what hindered them from helping both First Nations and non-First Nations patients experiencing IPV was women's reluctance to disclose. Providers saw patient fear, shame or stigma as one element making it harder to identify and respond effectively to IPV.

When you look at intimate partner violence, there's a lot that's not reported in our communities. It's well hidden.

{Community 2, Participant 5}

There's often times reluctance to disclose even if you ask several times.

{Community 1, Participant 1}

*Note: The language patterns in the quotes are slightly modified to help protect the anonymity of the providers on Manitoulin Island.

Sometimes, even when resources are available, patients will not access the services because of fear, stigma or shame. One reason for not disclosing is the shame over staying in the relationship or fear of being pressured into leaving the relationship by providers.

The women's shelter on the island does offer outreach services, it does offer we will come to you, it does home visiting as long as it's safe to do home visiting. Like all of those things are accessible, but still I find people reluctant to be connected to the women's shelter with the perception that they'd have to leave their relationship.

{Community 1, Participant 2}

Another fear that especially affects First Nation mothers is rooted in the historic high rates of child apprehensions coupled with neglect, abuse and even death of Indigenous children in care in Canada (Söchting, Corrado, Cohen, Ley, & Brasfield, 2007). Therefore, disclosing might lead to child apprehensions. This is a real risk to the child as well and the mother may feel that it is a greater risk than being in a home with violence. Awareness of reporting requirements may cause sufficient fear to prevent any disclosure for First Nations mothers.

I think that there's a reluctance to report to us, because there's an understanding out there of what we need to report to [Children's Aid Societies].

{Community 2}

2. Lack of Formal Provider Training on Appropriate Approaches to IPV

Many providers expressed that a lack of training prevented them from addressing the complex issue of IPV in clinical encounters.

You can't open a can of worms because you don't have training for that.

{Community 1, Participant 1 referring to Participant 2}

Moreover, dealing with IPV was described as potentially precarious by many providers.

Well we do want to address violence, especially sexual violence, the topic that has been at our table for a year and a half, two years, maybe longer. And then I think part of the challenge is how we're going to do it, because we know once we open it, that the potential for something to just explode out is high. So we want to be sure we're experienced enough to handle it.

{Community 3, Participant 9}

Coupled with the perception of high risk, there was confusion surrounding protocol or procedures regarding intimate partner violence in a clinical setting and perceived differences between professions. Some expressed concern that there was no explicit response to IPV at all within their discipline:

There's really no standard in our profession on how you deal with [IPV], it's kind of a personal thing, or you call the practice advisor and hope you get somebody who might give you a different answer than someone else.

{Community 1, Participant 2}

A physician noted that although they had learned about IPV in postgraduate education, they were not well prepared to deal with it on a practical level:

It's addressed in residency, but ... at the end, ... you are sort of looking out for it, you know how to identify it, but then again, what do you do with it?

{Community 1}

Non-physician providers discussed not having learned about intimate partner violence in their profession and that presented as a barrier to respond properly. One physiotherapist noted:

They didn't really touch on this kind of stuff [IPV education] in physio school as much.

{Community 1, Participant 2}

Furthermore, IPV within a First Nations context represents a particular gap in health care provider curriculum. A social worker spoke about overall gaps in awareness of First Nations culture, history of colonization or ways of knowing within primary care as a further obstacle:

[There is] not nearly enough [...] But bare minimum, I think anybody that wants to work with First Nations populations should at least take that [First Nations competency course], or take something similar to that. So that they have some context, because if you have absolutely no context and you think it's all pow-wows and jingle dresses...

{Community 1}

The reference to pow-wows underscores the understanding by this provider that a simplistic level of cultural understanding can be observed among providers.

The lack of a coordinated application of a valid screening tool in their practice resulted in many providers being unsure how to broach the topic of IPV with patients:

I'm not sure what the 2018 best practice is: screen, don't screen? Or secondary screening only for suspicious behavior or something?

{Community 1, Participant 3}

Providers also wondered whether one screening method was more valid than another, and whether more direct or indirect questions would be more effective in opening up a dialogue on IPV, and if opening dialogue was actually helping patients or not.

You don't know how often I ask the wrong question, like ... (what) would be THE best question to elicit the highest or to pick up the biggest number of cases?

{Community 2, Participant 1}

One provider summarized the dilemma for providers due to the lack of good information about IPV:

So there's that whole mystery, it would be nice if people found out what they can do and what options are there if they're hearing or witnessing this. So I don't think that's very well known. People are scared to make that call, or people are scared on how to support. So I think learning more of that would be beneficial.

{Community 3, Participant 6}

One provider reflected how the ambiguity lead to her feeling powerlessness in her role as a primary care provider, especially upon disclosure of intimate partner violence:

[Intimate partner violence] is not even reportable. It's not reportable in a nursing home. It's not part of the process... So, you sort of appreciate them for opening up, encouraging them to maybe take it further or get some sort of counselling. But it's sort of an unsatisfying thing, because how many times would you let an abused woman out of your emerg?

{Community 1, Participant 1}

3. Lack of Referral Network due to Fragmented, Scarce Services for IPV

Some providers mentioned that directing patients who may be experiencing violence in their lives to appropriate agencies in a fragmented rural services landscape is daunting and even overwhelming as described by this participant.

Wow, you feel... overwhelmed, and that they will share that with you, so it's kind of this sign of just, respect on their part, and a burden at the same time because now what do you with some of that information? Some of that is difficult to know, you know, whether you need to involve the law.

{Community 1, Participant 7}

What to do with the information once IPV is disclosed was a major concern for medical staff and for social/mental health providers. Details about referrals and resources were frequently unclear, especially the availability of shelter and support services, long wait times, and if those services were culturally safe and accessible to both First Nations and non-First Nations women. Many providers struggled with connecting First Nations patients with the complicated assortment of federally-funded, often community-specific or regional services as well as mainstream provincial services. Some spoke of making inappropriate referrals to First Nations services to First Nations women who were not eligible for these services due to, for example, place of residency. Those who have worked longer in the area helped when possible to connect patients informally:

I would case manage the linkage into the appropriate community-based agency, because it is a complex system...

{Community 2, Participant 2}

One physician noted that a lack of resources or challenge in accessing existing resources for First Nations as well as non-First Nations women may prevent altogether a provider from helping a patient who was experiencing IPV.

Where the rural challenge is greater is the lack of resources.

{Community 1, Participant 3}

4. Lack of Understanding of Jurisdictional Complexity of First Nations and non-First Nations Specific Services for IPV

A few physicians expressed how the siloed funding imposed on First Nations and the rural health and social services system interfere with the effective delivery of care towards patients who experience IPV,

So she was a Wiikwemkoong patient, but I had referred her to M'Chigeeng [services]. And they all have very long names that I can't pronounce yet, so it is a bit overwhelming for me.

{Community 2, Participant 3}

The comment implies that the patient as a member from one community was ineligible for services provided in another community, however Family Health Team staff often do not understand the First Nations health care system. Regional providers have similar restrictions which fragments care and impedes access.

If we're having as health care professionals difficulty navigating the system and figuring out where people get the help, how much more so for actual patients in the community? [...] I have to admit to not knowing specifically

what resources would be available other than the general mental health services in each of the First Nations communities.

{Community 2, Participant 1}

5. Uncertainty how to Negotiate Cultural Safety and IPV

Another concern that providers voiced about responding to First Nations women who may be experiencing IPV was a fear of being perceived as culturally inappropriate, judgemental or being labeled as an “*outsider, interfering in this relationship.*” {Community 1, Participant 5}. Similarly, First Nations providers also acknowledged cultural safety concerns when it came to connecting with First Nations women who experience IPV with counselling:

Counselling, especially if it's non-Indigenous providers coming in, they're very Westernized in terms of, like some of our young people don't want to sit in the office awkwardly with somebody to try and figure out what's going on with them. They don't talk about ever doing other activities, like taking a walk, doing things that way, or any activity on the land. Because once you get to that point with somebody, it's just a conversation, and an entire counselling session can happen right there, doing that activity and getting to know one another. So that's one of the barriers I saw, is that they don't want to come to the health centre to sit in a room, awkwardly sit there with somebody, trying to explore what's going on with me, you know?

{Community 3, Participant 3}

6. Multiple-role Relationship & Confidentiality Dilemmas Characteristic of Small Community

Multi-role relationships in small rural communities posed a dilemma with respect to confidentiality. One health care worker commented that even when IPV is suspected based on her observations in the community when she was off duty, there was still a perception of a duty to maintain confidentiality. This in turn limits what some providers feel they are able to do.

We had a client who had been sexually assaulted and had physical injuries as a result of that violence, and came in, would talk to the female staff...about her injuries. She'd never say how she'd got them, although we heard that she got them. You're walking on a tightrope of what you could say and what you couldn't say based on what you knew {through observations in the community}. And for her to finally reveal her story and to finally agree, it was over a month in before she agreed to see a health professional [...] But that was a real challenge... to manage her confidentiality, but you wanted to help her and allow her to go through that process, and have her process everything.

{Community 3, Participant 9}

Often providers find it difficult to balance confidentiality and personal relationships in these situations especially when IPV was disclosed to them personally outside of their conventional working hours.

What I've noticed or experienced [in terms of patients' IPV], it's always after hours. Or it's just friend to friend. [...] But where do I draw the line, as a health care professional? I work 8-4. My friendship starts from 4:01 to 7:59 the next day. Am I obligated, because I'm a health care professional, to report this? Or do I do it in confidence as a friend?

{Community 4, Participant 2}

Patients on the other hand can also struggle with their personal relationships with a primary care provider:

And people often times don't want to let anything out because they know that it's gonna be, like, their cousin who works as a nurse in emerg, you know, somebody was passing by because they're here for different reasons and it's gonna be known and it all becomes known. So they wanna hide it. They don't want to disclose it to you, to healthcare professionals.

{ Community 2, Participant 1 }

Another provider spoke about that it can be prohibitive to seek support for IPV if a relative is working in the services system. Privacy was seen as a big concern to access services.

[It's about] recognizing though that a lot of our people are private, and it comes down to confidentiality. That's why we don't see them in the health system too often.

{ Community 2, Participant 5 }

7. Fear of Jeopardizing the Patient-Provider Relationship

Providers also identified their concerns with legal implications for their patients associated with acting on IPV. It is the provider's duty to report to children's protective services in the case of suspected IPV that involves children under the age of 16 in the home. One physician noted:

We always try to tease out whether children are at risk, because children at risk gives you sort of a way to report it, but that might actually ruin your relationship with the patient.

{ Community 1, Participant 1 }

In addition, providers may be targeted with criticism for taking action to helping women. Community or family members, who are not yet ready to deal with the issue of IPV especially where physical acts of violence may involve arrests; one family member for example approached

a provider asking ‘*why would you criminalize my father's behavior?*’” {Community 1, Participant 1 }

Description of Facilitators to care towards Indigenous women who experience violence

After discussing barriers, providers shared what they saw as facilitators for responding to IPV in the PC setting as well as the strengths of their patients in improving their own situation.

Facilitators to respond to IPV in the PC setting

Perhaps one of the strongest facilitators discussed amongst the sample of providers was the concept of working together as a team across health disciplines. One social worker explains this teamwork well, by saying:

We try within our clinic to use the multidisciplinary model and to say ‘okay well, [medical doctors] may not have time to ask more about this, on this day, but would you be willing to talk to this person or this person or this person?’

{Community 2, Participant 7 }

Having a social worker embedded in the family health team opens up new opportunity for more comprehensive services as physician appointments may be too short to address many social issues.

I struggle with how short a doctor’s appointment is. I mean doctors are good people, they would like to ask all the questions, but they’re not in the position to be able to ask all of the questions that would be helpful sometimes. And so I think that pressure to see this many patients... I don’t even think that’s within OUR service delivery kind of training.

{Community 2, Participant 7 }

Sometimes, a team member who has seemingly little impact on helping a patient with IPV may have great insight into the lives of exactly those patients as this physician explained:

But they're the eyes of the community, right? We don't go in the houses, they do! They can come in the house and they sort of - they provide very interesting insights on our rounds because he's the one who actually goes in the house...

{Community 1, Participant 1}

Culturally Safe Care

Several providers mentioned understanding Indigenous culture and values was an enabler to care involving sensitive issues within a clinical setting and that there were some services that are culturally safe.

I think knowing a bit about the culture and knowing how the interconnectedness of the First Nations value system, plays a key role in how far you're going to be able to get. [...] When ...Betty is telling you that Charlie is abusing her, it's not just Betty in the room. Betty brings all of her [family] and ancestors with her as well, and being cognisant of that, being understanding of that, being aware of it, being respectful and mindful of that to allow her to talk about how this is impacting her in this holistic way, in this bigger way.

{Community 1, Participant 8}

On the other hand, Indigenous providers found that culturally sensitive care also entailed giving patients the option to choose cultural options that fit their life path and again this awareness was often present.

We do have people that practice different cultural traditions and religion. Like we have people who still have very strong ties to our church and then we have people who do ceremonies, but we have different types of ceremonies in our communities too, so when you're bringing one culture in too, it might not resonate with everyone in our community.

{ Community 4, Participant 3 }

Some providers offered what has worked for them practically in terms of screening, which includes using progressive screening, a customized script and other means of flagging IPV.

I think everyone that works in the health profession should have a script that they feel comfortable with. And to me, it doesn't matter to me who you are. [...] So it may be a combination of both being direct, and also being gentle. So how does that feel for you? Because for me, being authentic, being present, with you right now, is the primary goal.

{ Community 1, Participant 8 }

Others mentioned that they were actively trying to identify screening that would work in their practice.

2.6 Discussion

Barriers

In general, barriers within care were discussed by providers much more frequently relative to facilitators which is reflective of the uncertainty related to responding to IPV. Some of the barriers to delivery of care experienced on Manitoulin Island were similar to those experienced by providers in other rural, remote or Northern communities in Canada. Common barriers to a similarly structured study with justice workers (Wuerch et al., 2019) are issues such

as limited resources or access to resources in rural areas. However, the health care system on Manitoulin presents with unique barriers given the First Nations services and the organization of health care provision. Challenges regarding confidentiality and reluctance to go to their service provider who may also happen to be a family member were more prominently discussed. In addition, a clear presenting barrier is a lack in coordinated protocols or procedures regarding intimate partner violence across the health care systems on Manitoulin Island. Some providers suggest using universal screening, while others suggest using screening only once a strong trusting relationship between the patient and provider is established. Some primary care providers may experience confusion when faced with the complex health and social services system, especially if not accustomed to the health care system on Manitoulin Island. This confusion may hinder providers from making appropriate referrals to specialized care or support services.

Facilitators

Previous literature has demonstrated that adequate time may help providers identify and support patients who are experiencing IPV (Beynon et al., 2012; Black, 2011). This was validated in our study, in which inadequate time was relevant to physicians more so than other disciplines. Social workers, who are often much less restricted in time, acknowledged that a lack of time was a limiting factor for physicians in potentially helping an abused patient. The social workers in this study recommended interdisciplinary collaboration as a way to address this. This teamwork may help to better identify IPV by providing more opportunities to screen for IPV or for case-finding IPV in patients who may not have regular appointments with a physician. Analysis showed that providers valued knowledge of Indigenous values and the ability to offer safe spaces for traditional practices, in order to provide culturally sensitive care. Providers

should understand that Indigenous Peoples are diverse and have unique needs. In this sense, culturally sensitive care entails a patient-centered approach, wherein the patient chooses what approach is most comfortable with them.

Recommendations:

Our analysis provides the basis for the following recommendations to improve the ability of providers to respond to women who experience IPV in rural and First Nations communities.

1. Continuing to Address Stigma through Community Awareness

Providers felt that empowering the patients directly through ongoing public health campaigns is a helpful strategy. Ongoing funding for these campaigns helps patients to better understand the various dimensions of IPV, what acceptable behaviour in an intimate relationship looks like, to reflect upon their experiences and eventually to be able to seek out and access services they need directly. Information pamphlets, educational videos to play in waiting areas and culturally specific posters, particularly if trying to address Indigenous health, are recommended awareness strategies.

2. Awareness of Local Resources

There is a need to provide information sessions for providers on the available services and to create community specific lists and referral frameworks of resources for accessing information to workshops, counselling and shelter services for rural and First Nations women. There is especially a need to be informed of all women and children related services and agencies in each area and the process for accessing these services or for referring women. This should include understanding of who can access these due to catchment area, First Nations status, geographic location as well as cultural safety. This list of resources should also be accessible by patients, especially in the emergency room.

3. Addressing Cultural Safety

The idea of cultural safety refers ultimately to care that suits a patient's specific needs and is not assumed. While this may include referring a First Nation person to traditional healing such as smudging, sweat lodges and other ceremonies, it may not always be the case. Some providers noted that it is important to not ascribe a certain type of care to a patient just because of their culture. Cultural safety training may be beneficial in delineating how providers should approach these assumptions when interacting with a patient.

4. Support services for perpetrators

Numerous providers mentioned that many perpetrators were struggling with mental wellness, anxiety and control issues and did not have the skills to change their attitude or behaviours towards women. While providers did not deny that there may be need for involving the justice system in some cases, it was felt that *restorative justice* and rehabilitative programs were seen as key to reducing IPV. Some of the providers from counselling professions explained that the perpetrator have themselves abuse histories. Cultural programs for Indigenous men were suggested, for example "I am a Kind Man" offered in some of the local First Nations health organizations (Ontario Federation of Indigenous Friendship Centres, 2013).

5. Engaging Local Community Helpers

Engaging the natural helpers, knowledge holders, grandmothers, grandfathers, and elders within the communities with provider teams and other service organizations to help survivors and abusers was also seen as long-term strategy to address IPV. Several providers mentioned the resilience demonstrated by the First Nations communities on Manitoulin Island, namely around the fact that there are strong ties within small communities. Therefore, implementing concepts into First Nation programming such as individual and community resilience as well as the seven

grandfather teachings were recommended by some First Nation providers. Ungar and Lerner's (2008) international study explains how resilience is inextricably related to context and culture and delineates three protective processes for resilience: how environmental level variables can be more influential than individual level variables; how facilitative environments can positively impact how individuals, families and communities perceive, navigate and access resources; and how a greater exposure to risk can be mitigated when there are resources that target those specific risks.

6. Implications for Provider policies, procedures and education

Finally, while education and training may differ based on the discipline of a provider, this study has implications for policies, procedures and the education of providers. For example, web-based training on how to speak to patients in a clinical setting may be beneficial in creating a safe and non-judgemental environment for a patient to disclose and seek help for intimate partner violence (Queen's Printer for Ontario, 2019).

To continue, there are no clinical guidelines for screening for IPV; some studies have recommended universal screening, while others have recommended selective screening or case finding (O'Doherty et al., 2014). Therefore, perhaps providers should be aware that there is much debate among the literature and existing guidelines. Due to this debate, providers may be reassured in choosing a particular screening tool, assessing the effectiveness of this screening tool and adjusting accordingly.

Moreover, as this study highlighted the importance of cultural sensitivity in delivery of care, this study may lead to reforms to provider undergraduate training or continuing professional development.

Strengths & Limitations of Study

One notable strength of this study was the variety of First Nations community staff and conventional health providers and disciplines involved. However, the participants included in this study are from a single district, therefore the results may not be generalizable to other rural, remote or northern districts of Canada. In addition, 90 % of the providers involved in this study were women and the perspectives of male providers were not explored in as much detail. The perspectives and approaches of men may differ from women. Moreover, as this study included the perspectives of solely providers, further studies may wish to build on this with research with women who have experienced IPV.

2.7 Conclusion

Intimate partner violence is an extremely serious health and social issue that affects Indigenous women at elevated rates (Government of Canada, 2015). This study demonstrated barriers that contribute to the overall feelings of unpreparedness experienced by providers practicing in rural clinical settings, and facilitators that may help identify and respond to IPV. This study can serve as a starting point to more effectively address IPV in rural and First Nations health care systems and inform future programming in the health care system, as well as inform clinical approaches to intimate partner violence.

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Declaration of Conflict of Interest

None declared.

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Chapter 3: Intimate Partner Violence Against Indigenous Men: A Significant yet Overlooked Primary Health Care Issue

3.1 Abstract

Indigenous women and men experience disproportionately high rates of intimate partner violence compared to non- Indigenous women and men. In general, women are often cited as being the recipients of violence, while men are often portrayed as the perpetrators of violence and very seldom as survivors of violence. Most research efforts and interventions are geared towards women, while IPV experienced by Indigenous men is not well investigated, researched or understood. An unanticipated finding in our community based participatory research with Indigenous communities on Manitoulin Island, Ontario, was a degree of awareness by providers of the adverse effects of IPV on Indigenous men. The primary care providers involved in this study cite sufficient cases of male IPV to warrant attention and action in a clinical and community setting, as well as further research. Providers offer recommendations in both of these settings to help address the effects of IPV experienced by Indigenous men.

3.2 Acknowledgements

We would like to thank the 31 participants who were involved in this study and who shared their experience with zeal and compassion. We would also like to thank the participating First Nations communities and affiliate organizations. In addition, we would like to thank the Women's College Hospital's Women's Xchange \$15K Challenge and Canadian Institutes for Health Research for the funding to carry out this project.

3.3 Introduction

You can't address intimate partner violence without looking at both sides of the equation- what's occurring in relationships. {Community 2, Participant 6}

In stark contrast to research on intimate partner violence (IPV) against women, which is any behavior in an intimate relationship causing physical, emotional, sexual, psychological, financial, or spiritual harm (Centre of Disease Control, 2018; World Health Organization, 2012), IPV experienced by men in heterosexual relationships in Canada is generally not well investigated, understood nor is it a focus of services (Government of Canada, 2008; Hines & Malley-Morrison, 2001). Studies suggest that women sustain more severe injuries from violence perpetrated by men than vice versa, but the physical, psychological and financial consequences of women perpetrated violence towards men are not rare nor insignificant (Desmarais, Reeves, Nicholls, P. Telford, & Fiebert, 2012b). In fact, several studies have suggested that men and women experience IPV in similar proportions when severity of injury is not taken into account (Desmarais et al, 2012b; Fiebert, 2014). For example, Desmarais and colleagues (2012a/b) report pooled estimates of intimate partner violence between women and men across 10 years and found that 1 in 4 women (23.1%) have experienced physical violence in an intimate relationship while 1 in 5 men (19.3%) have experienced physical violence in an intimate relationship. Criminal data yielding small numbers of female perpetrated violence may reflect that men may not consider violence against them to be a crime or they are not as fearful or injured when experiencing violence, or there are barriers to addressing IPV through the criminal-justice system (Desmarais et al, 2012b).

Findings from numerous qualitative and quantitative studies on IPV among Indigenous people reveal that Indigenous women in Canada continue to experience significantly higher rates of all types of violence when compared to non-Indigenous women (Brownridge, 2003; Brownridge, 2008; Benoit, Shumka, Phillips, Kennedy, & Belle-Isle, 2015). Indigenous women living in Canada are eight times more likely than other Canadian women to experience abuse by their partners (Andersson & Nahwegahbow, 2010; Ontario Native Women's Association, 1989) and five times more likely to die from violence (Amnesty International, 2004; Indigenous and Northern Affairs Canada, 1996). When it comes Indigenous men and violence, Mt. Pleasant (2016) states that “Indigenous males have largely been studied from the perspective of the perpetrators of violence” (Mt. Pleasant, 2016, pg. 3) but victimization of Indigenous men has been largely ignored. Emerging research shows that Indigenous men experience highly elevated rates of violence, disappearance and murder compared to non-Indigenous men and even Indigenous women (Innes & Anderson, 2015). For example, Statistics Canada (2013) reports that Indigenous men are twice as likely to die from homicide than Indigenous women and are seven times more likely to die from homicide than non-Indigenous men.

Despite the magnitude of violence against Indigenous men, the effects of IPV on Indigenous men is scarcely reported or researched (Brownridge, 2010). Brownridge (2010), using Canada’s General Social Survey (GSS) conducted in 1999, is one of very few studies exploring violence against Indigenous men. This study reports that Indigenous men living off-reserve experience IPV at about 2.5 to 3.5 times the rate of victimization compared with their non-Indigenous counterparts and further that the victimization tends to be more violent. Indigenous men likely experience violence at higher rates for the same reasons (D. A.

Brownridge, 2010) as Indigenous women, which includes intergenerational trauma from the ongoing effects of colonization.

Brownridge's analysis (2010), like that of Hines and Malley-Morrison (2001), contradict the more common narrative of intimate relationship dynamics that casts Indigenous men in the abuser role. The propagation of the narrative that Indigenous men are solely the perpetrators of violence instead of survivors of violence hinders the progression of the prevention strategies, interventions and services targeted towards men that are urgently needed (Innes & Anderson, 2015).

3.4 Objectives of this Study

The aim of this study was to conduct qualitative research on IPV based on the perspective of health care teams based in conventional rural clinics as well as those located in First Nations communities, all of whom provide service to Indigenous people. The objective was to explore how primary care providers¹¹ respond to their patients who are experiencing IPV, with the intent to improve responses in the clinical setting. Our initial focus was on IPV experienced by women; however, during data collection the providers' conversation shifted to stress that Indigenous men are significantly impacted by IPV. The research focus in this paper is therefore on the providers' perceived nature of IPV against Indigenous men and the related implications for primary care services and future research needs.

¹¹ Hereafter referred to as "providers"

3.5 Methods

3.5.1 Study Design

This study employed a qualitative, community-based participatory research (CBPR) approach with participating Indigenous communities on Manitoulin Island, a rural region in North Eastern Ontario. The Manitoulin District has a population of about 13 000 residents. Of this population, approximately 5260 people are Indigenous and there are seven First Nation communities (Statistics Canada, 2017). The data collection and analysis used a grounded theory approach to allow exploration of emerging themes (Charmaz, 2014, 2017).

3.5.2 Participants

To gauge interest in a focus group, the research team reached out to health organizations in two First Nations communities and two rural Family Health Teams (whose team also staffs the Emergency Department) who provide services in the surroundings towns in the district of Manitoulin in Northern Ontario. Following this, posters advertising the nature, relevance and expected outcomes for the study were sent to the primary care managers by email. Eligible providers included (1) individuals who provided direct services to First Nations patients or clients and are accessible through self-referral and (2) found IPV relevant to their practice. Examples of providers as part of this study included regulated and non-regulated health care providers, such as physicians, registered nurses, nurse practitioners, physiotherapists, social workers, mental health workers, and community health workers. Once interest in a focus group was confirmed, a date was picked to optimize attendance at each site. (refer to Table 1). To better understand emerging themes from data collection, nuances and contradictory experiences between the providers, the researchers used theoretical sampling consistent with grounded theory (Charmaz, 2014, 2017). Therefore, two of the providers who were unable to attend due to

unavailability were invited to a semi-structured interview on an alternate date. The lead and senior author, who has more than 20 years of experience with qualitative research in First Nations and rural health, worked collaboratively to facilitate the focus groups and interviews.

3.5.3 Data Collection

31 healthcare providers participated over the course of four focus groups and two semi-structured interviews. Two of the focus groups as well as both interviews were with members of Family Health Teams based on the rural clinics off reserve, while the remaining two focus groups were with First Nations health organizations on reserve. The average duration of a focus group was two hours and the interviews lasted approximately one hour. The participants gave consent to participate (see Appendix 1) and then shared their experiences about IPV as providers through facilitated discussion (see Appendix 2).

3.5.4 Data Management & Analysis

The analysis of data followed a grounded theory approach (Charmaz, 2014). Grounded theory is inductive in that the themes and categories were not pre-set but rather emerged directly from the data. Firstly, the data was transcribed verbatim and then coded by researchers (KR, MM) with the help of a qualitative software, NVivo 12. To ensure the validity of emerging themes and categories, the data coding was independently performed by the co-researchers and then compared and contrasted until consensus was reached by both researchers in the discussion.

3.6 Relationship

In 2016, formative community based participatory research was conducted with Indigenous and non-Indigenous health organizations on Manitoulin Island to prioritize and

subsequently address certain health issues. Intimate partner violence (IPV) arose as one health and social issue that was widespread yet under-addressed on the island. This finding gave rise to several phases of a large project, one being how wellness, from an Indigenous perspective, was obtained through healthy community relationships (Bennett et al., 2019). Another phase, which was the focus of this project, was to better understand how primary care providers are responding to rural Indigenous women who experience violence and how to improve these responses. The results of this study demonstrated an important, albeit unprecedented issue, which was that of violence in relation to Indigenous men.

Although the original direction of this project focused on IPV experienced by First Nation women, providers frequently perceived that rural First Nation men experience IPV and that it is just as a serious and under-addressed issue as it is for many rural Indigenous women. By remaining open to emerging themes discussed by the providers involved in this study, we remained true to the nature of grounded theory. As the discussion began to shift during data collection to men and violence without our prompt, we modified one question for subsequent focus groups/interviews to hone in on this idea (as we did with other emerging themes).

This research project obtained ethics approval from the Manitoulin Anishinaabek Research Review Committee (2019), the Laurentian University Research Ethics Board (REB # 6009722) and by the participating First Nations communities.

3.7 Results

The characteristics of the 31 providers are shown in Table 1 below.

Table 1.

Participant Characteristics

Community	Focus group & Interview Participants		Physicians	Nurses	Community health workers	Social workers, mental health workers	Other primary care
	Men	Women					
Family Health Team Community 1	1	7	2	1		2	3
Family Health Team Community 2	1	6	4		1	2	
First Nation Community 3	1	9			8	1	1
First Nation Community 4	0	6		1	4		1
TOTAL	3	28	6	2	13	5	5

Health providers shared their clinical experiences with men who have been abused by women in intimate relationships under the following themes: *IPV against Indigenous men is a primary health care issue, common disclosures include experiences of severe emotional and physical abuse; men face barriers and potential harms to report IPV, and consequently, there are significant service gaps for Indigenous men who experience IPV.* These providers also had suggestions to address IPV experienced by men on Manitoulin Island.

IPV against Indigenous Men is a Primary Health Care Issue. The providers made it evident that men in the district of Manitoulin experience IPV and that this is increasingly disclosed in a clinical setting.

I have had men say to me that they've been abused. {Community 2, Participant 6}

Anecdotally, couldn't give you numbers, but I would have to say that certainly more men are presenting and talking about being victims themselves."

{Community 1, Participant 8}

Another provider perceived a shift of relationship dynamics between men and women in recent years, particularly with younger patients.

I think relationships that may be at one time primarily more controlling behavior and those non-physical forms of power and control exertion and manipulation and stuff like that has shifted into becoming more hands-on from women to men.

{Community 2, Participant 7}

Common Disclosures Include Experiences of Severe Emotional and Physical Abuse.

Providers shared cases of IPV against their male patients, and the violence endured in the relationship was severe and ranged from physical to emotional/psychological.

I guess his girlfriend took a cast iron frying pan and hit him over the head with it. So he had some challenges there...they give you this backstory about this man, how he'd been abused. So I mean it happens with men, it tends to be a little bit more violent sometimes.

{Community 3, Participant 9}

Emotional abuse in the form of controlling Indigenous men's interactions with others and with the partner was discussed.

I have two [First Nations] men in my practice who have disclosed that they have been, well what I would consider to be in abusive relationships, and in neither of those would I consider physical violence as the issue. It's more of a control issue, more of a "if you don't do what I want, I'm gonna walk out with the kids' issue" And he is very distraught: 'I'm not allowed to have any friends, I'm not allowed to do this, I'm not allowed to do that, because if I do, she'll walk with the kids' ...So I believe that it's quite possible for men to be abused as well. {Community 2, Participant 1}

One provider explained that the emotional abuse can directly impact on the physical health of their male patients and become a major barrier in the management of chronic illnesses.

And I can tell when things are going well, because [the men's] blood work improves, and so those kinds of things, and how they've walked away from the relationship only to go back because that's the only way they're gonna have access to the kids, you know that kind of stuff. {Community 2, Participant 1}

Men Face Barriers and Potential Harms to Report IPV. Although there are more men who are coming forward and disclosing IPV, some providers believe that there is even more significant under-reporting in the clinical setting when compared to reporting of IPV against women. One provider estimated the proportion of men to women who are being abused in the communities on Manitoulin Island.

I think men are less likely to talk about it [...] I just think it's not really reported. Just like [the other provider] said, it's probably half. {Community 3, Participant 6}

The providers in the study were aware that men are being abused and that serious social barriers hinder disclosure. Often, men seem to have a difficult time expressing that they have been victimized possibly as a result of the associated stigma or shame to their masculinity as a result of being abused by a woman. One provider recounted the time an Indigenous man disclosed he was being abused by an intimate partner.

I've seen at least one man in the emergency department who was pushed and shoved by his intimate partner. He was an Indigenous man. He felt ashamed and had difficulty even reporting it because it would tell the people that your woman is shoving you around. It's laughable in most cultures, right? {Community 1, Participant 1}

One provider admitted to hesitation to accept accusations coming from men as there are sometimes conflicting statements given from both sides of the relationship:

It affects men too. I have had men say to me that they've been abused. I think it's often around the legal thing, so when a couple have an argument, they both reach for the phone and they both state that the other one was violent... So you have 'he said, she said' [...] I'm never quite sure when men reveal to me that they've been hit or they've been hurt. {Community 2, Participant 6}

There are Significant Service Gaps for Indigenous Men who Experience IPV. Services such as IPV counselling and shelters tend to be mostly geared towards women. Furthermore, men have a difficult time when police are called to intervene as they are often not believed because stereotypically women are thought of as victims, not perpetrators.

You can send women to [the shelter] ...and they get counselling and support, but with men there's nothing! There's nothing!"

[...]

There's this unfortunate man that has nowhere to go and where do you send this man? And he says "oh yeah there's a couple of houses here for men, they're called prisons".

{Community 1, Participant 1}

3.8 Limitations

This study represents the perspectives of providers in Family Health Teams and in First Nation health centers on Manitoulin Island, both on and off reserve and are not necessarily generalizable to all Indigenous communities in Canada. However, given the emerging research findings of the high rates of violence against Indigenous men and it is likely that IPV against

Indigenous men is a serious issue elsewhere in Canada. A boarder discussion on policy implications of this study is needed.

3.9 Discussion

Providers in this study were most often responding to male patients who disclosed experiencing severe forms of physical and emotional abuse. Observed health consequences went beyond acute injuries, and contributed to anxiety, depression and poor management of chronic illnesses. Thus, this study corroborates the adverse physical and psychological consequences of IPV on Indigenous men noted in research on men in general, including physical injury requiring medical attention, disempowerment, shame, and depression. (Follingstad, Wright, Lloyd, & Sebastian, 1991; Hines & Malley-Morrison, 2001; Statistics Canada, 1999). Our findings also challenge the more common narrative that Indigenous men are solely perpetrators rather than p also frequently survivors of IPV.

While rates of male disclosure seem to be increasing, many providers speculated that men still have great difficulty disclosing IPV. Therefore, it may be that only severe cases were disclosed, whereas financial or spiritual abuse or less explicitly violent forms of physical and mental abuse were perhaps not reported or missed. This study also demonstrated that many providers have observed adverse outcomes of IPV experienced by rural Indigenous men, but some still struggle to accept that men can experience violence perpetrated by their female partners. Underreporting is likely due to (1) Indigenous men experience stigma related to reporting IPV as well as (2) some providers were themselves conflicted about the veracity of these disclosures.

The perception of providers that there is significant exposure of Indigenous men to IPV is congruent with emerging research documenting the high risk of violence experienced by

Indigenous men (D. A. Brownridge, 2010; Innes & Anderson, 2015). Innes & Anderson (2015) argue that there is “little activism or political will to address Indigenous men’s issues, and as a result there are few policies, or social programs designed for Indigenous men” (pg.3). This is true with respect to IPV against Indigenous men and our findings are therefore particularly important because providers can play important roles in an abused individuals’ quality of life, such as using their roles as advocates for social and policy change (Black, 2011; Kalra, Di Tanna, & García-Moreno, 2017).

We therefore believe urgent action is warranted to address violence experienced by Indigenous men and offer recommendations for action.

Recommendations:

1. **Health care provider training:** Education is needed about male and female roles in IPV. In order to make the clinical setting a safe space for men and women to disclose violence
2. **Patient education:** Promotion and prevention activities are also important and should include posters in hospitals and clinics acknowledging that the many forms of IPV and that men as well as women experience IPV.
3. **Community awareness and development:** In a community setting, efforts should include providing safe spaces holding prevention activities. In these spaces, individuals can learn about the long-term consequences of experiencing childhood abuse, which might normalize the experience of violence for men and women as adults. Focusing on cultural strengths related to relationships, such as teaching about healthy relationships from an Indigenous cultural perspective is also an important strategy.

4. Addressing Service Gaps: Moreover, health care provider education, exploration of screening approaches, development of culturally-save services for Indigenous men who experience IPV to access, including shelter services, as well as prevention strategies are urgently needed (Desmarais, Reeves, Nicholls, P. Telford, et al., 2012; Desmarais, Reeves, Nicholls, P Telford, et al., 2012). Providers should be encouraged to use their roles as advocates to support these important health, social and policy improvements.

3.10 Conclusion

The results of this study suggest that Primary Care Providers are beginning to recognize the negative effects of IPV on the health and well-being of Indigenous men as a primary care issue with effects that include acute injuries, mental health issues and deterioration of existing health conditions. To ameliorate the impact of IPV against Indigenous men collaborative action is required by researchers, clinicians, educators, health care administrators and policy makers. More comprehensive quantitative and qualitative research is needed in Indigenous communities to explore the types of IPV and the rates at which these are perpetrated against Indigenous men, and their impact on the health and well-being of Indigenous men and to document arsing cultural, health and social service's needs.

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Chapter 4: Discussion

4.1 Summary and Synthesis of Results

Although awareness of the impact of violence experienced by Indigenous peoples is proliferating, especially through various media outlets, many argue that the Canadian society are not doing their part in addressing this issue of violence. Recently, an inquiry that exposes the poor response in addressing violence against Indigenous people is the National Inquiry into Missing and Murdered Women and Girls (MMIWG), that poignantly express:

“Colonial violence, as well as racism, sexism, homophobia, and transphobia against Indigenous women, girls, and 2SLGBTQQIA people, has become embedded in everyday life –

whether this is through interpersonal forms of violence, through institutions like the health care system and the justice system, or in the laws, policies and structures of Canadian society. The result has been that many Indigenous people have grown up normalized to violence, while Canadian society shows an appalling apathy to addressing the issue.” (p.4)

This inquiry, which started in 2016, was mandated by Canada’s federal government along with the 13 provinces and territories of Canada to report on the causes behind elevated rates of violence as well as “institutional policies and practices implemented in response to violence experienced by Indigenous women and girls in Canada, including the identification and examination of practices that have been effective in reducing violence and increasing safety” (MMIWG, 2019, p. 5). Testimonies were given from almost 2500 survivors of violence, family members who have lost loved ones due to violence and expert witnesses, Elders, knowledge keepers, front line workers and officials. The report, which argues that the violence experienced by Indigenous women and girls amounts to genocide, also outlines recommendations through calls for justice. One call for justice of many was for the Canadian government to fully implement the recommendations from the Truth and Reconciliation Commission of Canada (MMIWG, 2019).

The MMIWG inquiry adds further evidence to how violence, including IPV, within Indigenous communities is under-addressed. It demonstrates the need for action by our government and justice system, and by all other systems that come into contact with Indigenous women who may be experiencing violence. This study is important because it is the largest project on Manitoulin Island that addressed violence and strived to improve the responses in the health care system to rural First Nation women and men who are experiencing violence.

To reiterate, the two research questions for this study were “From the perspective of a primary care provider, what are the barriers and facilitators within current practices to addressing Intimate Partner Violence experienced by rural First Nation individuals?” and (2) “What are the recommended strategies in a community and clinical setting?” These questions were posed to providers who offer care to Indigenous people on Manitoulin Island, in health care organizations both on and off reserve. The first of the papers focused on the barriers and facilitators within current practices towards Indigenous women, while the second paper describes the gendered issues experienced by Indigenous men, a topic that emerged in this Grounded Theory based research. Focus groups and individual interviews were transcribed and then analyzed with the help of a qualitative software, NVivo 12.

Chapter 2: “Improving the response of Primary Care Providers to Rural First Nation Women who experience Intimate Partner Violence

The first research question was included to investigate the unique barriers and facilitators within current practices when providers offer care towards First Nation individuals who experience violence. This led to the discovery of ways to address clinical gaps and build on current strengths. This paper began to address this question but focused on the providers’ experience with First Nation women. Overall, the results of this study suggest that primary care providers felt unprepared to address IPV particularly with First Nation women.

Feelings of unpreparedness are a result of numerous barriers such as lack of disclosure of IPV, lack of training, scarce services, a complex cross-jurisdictional issues that affect Indigenous services , issues regarding confidentiality, uncertainty in how to negotiate cultural safety, and the risk of jeopardizing the relationship with a patient. However, these barriers were found to be moderated by facilitators such as interdisciplinary collaboration and being committed to learning

about and offering culturally safe care. Providers shared clinical barriers similar to barriers delineated by social justice workers in other rural areas of Northern Ontario, for example scarce resources and a lack of training (Wuerch, Zorn, Juschka, & Hampton, 2019), but also exhibit unique barriers for a small rural regions with various First Nations communities. For instance, the fragmented cross-jurisdictional health and social system that exists for Indigenous people makes it hard for some providers to understand and discern certain referral streams and make appropriate referrals. Another barrier identified that is common to rural practices is the tension between being a provider and knowing a patient personally, which posed issues with confidentiality.

Several facilitators to feeling prepared to respond to IPV were also identified, the notion of utilizing other members of a health team, either to prevent burnout or to address what one was unable or unprepared to do, was brought up numerous times by the providers. Therefore, creating opportunities for health care providers to work collaboratively across health disciplines should improve the responses to IPV in a clinical setting. Another facilitator identified by providers was the concept of culturally safe care. The term “culturally safe” as coined by Ramsden (2002), a Maori nurse, goes beyond the concept of “cultural competency” and has many dimensions. While cultural competency entails a provider attaining knowledge, skills or attitudes to work more respectfully with people of different cultures (Ward, Branch, & Fridkin, 2016) , someone who practices cultural safety acknowledges one’s position in a social, economic and political context and works to disturb unequal power relations. “Safety” is defined by those who receive the care, not by those who provide it (Ward et al., 2016) and fosters an environment to confront one’s biases and pre-conceived notions about a culture and to work towards improving access to care by those who face health inequities (Bearskin, 2011). In the context of this study, a focus on

culturally safe care with First Nations individuals responding to IPV was seen as particularly complex but important issue. Providers should be cognisant of cultural differences and culturally relevant care available for First Nations and should actively challenge racism and discrimination within the health care system. Supporting the narrative that Indigenous people are “stuck” in the past or should just “get over it” should be confronted in oneself and in others, if present, as this attitude could lead to prejudice and discriminatory care (Ward et al., 2016). Practical ways to do this, as outlined by Ward and colleagues (2016) require going beyond having good intentions. It requires actively speaking up and making change, taking responsibility for one’s own learning, engaging in self-reflection and being committed to life-long learning. In addition, providers should be mindful and make room for the option of traditional cultural approaches for First Nation patients, which is seen as a form of decolonization and uses Indigenous knowledge as a means of resorting wellness (Hill, 2010). Cultural approaches certainly have a role in responding to IPV. The *National Inquiry to Missing and Murdered Women and Girls* identified cultural safety as a means to increase the effectiveness of support services for Indigenous women and girls. Services and processes that are culturally safe and empower Indigenous people include a trauma-informed approach, and the use of Indigenous language, spirituality, religion and self-determination.

The second research question was “what are the recommended strategies in a community and clinical setting?”. This question was included to improve the responses to rural First Nation women who are experiencing IPV in the future. Many of these strategies, as with the facilitators, work to counteract the barriers found in the first research question. The first strategy is to continue efforts to reduce stigma associated with IPV with community and provider awareness, which could be implemented at a clinical level. Awareness of violence can be heightened by

public campaigns, such as information pamphlets, culturally specific posters and educational videos in waiting rooms. Reducing the stigma of talking about violence with other people through community awareness may address under disclosure of IPV due to shame and stigma in the community as noted by providers in Family Health Teams and First Nations health organizations.

The second strategy is for providers to gain a deeper understanding of local resources, the Indigenous health care system in general and the jurisdictional issues that can impede access to services. By providing information sessions for the providers regarding what resources are available, those who do not yet have a strong grasp on the health provision distribution on Manitoulin Island can better understand referral streams based on where they work and the characteristics of a patient.

The third strategy in a clinical and community setting is to incorporate elements of culturally sensitive care. Providers in this study express that components of offering culturally sensitive care may or may not include offering First Nation centred services to a First Nation woman; rather, offering care that suits the needs of the particular individual. Some providers emphasize that offering culturally safe care means to explore the needs and wants of the patient and to guide them appropriately. Having the patient choose what type of care they would prefer, whether Western, traditional or a mixture of both, gives a patient a sense of autonomy and ensures she does not feel a type of care is being forced.

The fourth strategy at a clinical and community level is to offer help for perpetrators. Several providers express that acknowledging both sides of the relationship is necessary in addressing violence in relationships. Making use of restorative justice and other community

programs was seen as a step in helping the perpetrator address deeper issues that may be impacting the way they treat an intimate partner.

The fifth strategy is to engage local community helpers as a community level strategy. This could include having trusted individuals within the community such as elders, traditional knowledge helpers and grandmothers or grandfathers help teach and guide community members on what healthy relationships look like. The teachings of these community leaders, as pointed out by some providers in this study, may be informed by beliefs and values inherent to Indigenous ways of life, such as holistic care, the seven grandfather teachings and community resilience.

Finally, the sixth strategy is to have these strategies inform future programming and education, which will be discussed further in the implications for knowledge translation section below.

As the study progressed, it became clear based on the emergent themes of the Grounded Theory methodology that the scope ought to be expanded to include the IPV experiences of Indigenous men. Time and time again, the providers expressed that Indigenous men are also subject to IPV, that this reality is increasingly exposed in the primary care setting and that there is less awareness of IPV towards men than towards women. Although the priority of this study was primarily to discuss violence experienced by rural Indigenous women, we wished to make room to discuss the nature and extent of First Nation men who experience IPV. The male experience was not excluded from this study in keeping with the Grounded Theory approach and because of the various reports that recommend expanding the inquiry of violence towards Indigenous peoples to women *and* men. (FNIGC, 2012).

Chapter 3: “Intimate Partner Violence Against Indigenous Men: A Significant yet Overlooked Primary Health Care Issue”

The results from this study showed that Indigenous men experience intimate partner violence, sometimes in very physical or emotional forms. Despite experiencing violence, there are limited services available for Indigenous men because most of the scarce services are directed towards women. The recommendations that resulted from this research begin to address the violence experienced by Indigenous men and include: to continue working towards reducing the stigma such that men can be more comfortable coming forward with disclosure of IPV; to be mindful that men are not always the perpetrators of IPV, as the current narrative would suggest; and to make use of rehabilitative structures for those who perpetrate violence. The reasons for elevated rates of violence towards Indigenous men compared to non-Indigenous men should be looked at through a colonial lens, as put by Mt. Pleasant (2016) : “ if we look at the historical roots of why [Indigenous] women become targets of violence today, we realize that Indigenous men were also the targets of this very same historical colonial violence.” (pg. 3).

4.2 Next Steps: Implications for Knowledge Translation

Consistent with the action component of CBPR, this project has an action agenda for improving the response to IPV in the clinical setting on Manitoulin Island. The results from this study may have direct impacts on the health care system and community programming as well as indirect impacts in the lives of First Nation men and women, families and communities who are experiencing violence.

As a starting point, our team can relay a summary of findings in staff and interagency meetings with participating organizations. From there, it would be beneficial to lay out asset mapping that identifies existing supports as well as gaps in services. These findings have implications for reform in provider curriculum, and continuing education. A health and medical sciences planning group could be beneficial in disseminating these results into curriculum and

education. Concepts such as broader forms of protective factors against IPV, including spirituality, interconnectedness with others and knowledge and practice of traditional practices, as well as cultural competency (especially towards Indigenous ways of life) should be included (Bourque Bearskin, 2011; Kirmayer, Sehdev, Whitley, Dandeneau, & Isaac, 2009). Finally, we can work collaboratively with First Nation leaders and natural helpers to help reinforce concepts, at their discretion, into future community programming.

Limitations of Study

From a theoretical perspective, qualitative studies have been shown to be extremely effective at a primary care level and are not entirely non-generalizable (Leung, 2015). The results may not be generalizable to other Indigenous communities in Canada as these communities are not uniform in ways of life and beliefs (Davy, Harfield, McArthur, Munn, & Brown, 2016). However, it is likely that there is some common ground between the results of this study and the results with other rural, remote or Northern Canadian areas. Qualitative research is not free from limitations. For example, the presence of the researchers during data collection could have impacted the responses of the participants, i.e.: social desirability bias (Anderson, 2010; Nederhof, 1985). The research team acknowledges that this study does not capture all of the barriers, facilitators and recommendations by providers on Manitoulin Island. Further, the opinions expressed from the perspective of the providers may not necessarily align perfectly with the opinions expressed by those who actually experience violence.

4.3 Future Research

There is much room for further research regarding intimate partner violence and rural First Nations individuals. For instance, as this study was focused on the perspective of the provider and their perception of the issue, it would be beneficial to conduct further community

based participatory studies. Future studies should include the perspectives of abused survivors including their experiences within the clinical system and their perceptions on how the community addresses violence. In addition, to test generalizability, a similar structured study with a different group of providers in a nearby rural, remote or Northern Ontario community may be executed. Moreover, while these results in this study may be beneficial, further studies testing the effectiveness of the recommendations given are required. Furthermore, more research is needed to understand the extent of IPV experienced by Indigenous men and the steps that can be taken to care for these men in a clinical and community setting. These studies may include quantitative and qualitative studies aiming to estimate the prevalence of IPV towards rural Indigenous men compared to rural Indigenous women and elucidating the barriers and facilitators to accessing care from Indigenous' males' perspectives.

To conclude, this study highlights the experiences of rural primary care providers as it relates to their Indigenous patients who experience IPV. The first portion focuses on reporting barriers and facilitators within current clinical practices as well as recommended strategies moving forward in a clinical and community setting. The second portion was included to demonstrate how providers perceive the effects IPV has on Indigenous men and to work towards expanding the conversation to include Indigenous men. This study was important because it was expressed as a need directly from the communities on Manitoulin Island and is intended to help improve responses to IPV on the Island. It is also important because it might serve as a framework for other rural, remote and Northern regions of Ontario which have an Indigenous demographic.

4.4 References

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Chapter 5: Conclusion

5.1 Final Thoughts

Addressing IPV on Manitoulin Island in First Nations communities is no trivial feat. A solution will not occur overnight and will continue to take the collaborative work of many systems and sectors. There must be knowledge translation of this information back into the

communities of Manitoulin Island as well as subsequent studies on the effectiveness of the recommendations should they be implemented by health care systems, education, policy and community programming on Manitoulin Island. Although there is no panacea for IPV, this study shows that we can develop strategies to reduce the effect of IPV within the health care system and community. On Manitoulin Island, many concerns have been raised by thoughtful and caring primary care providers and there is a general hunger for greater solutions that are coordinated in nature. There is potential for providers to be more confident in their preparedness to respond to First Nation women and men who experience violence and thereby encourage healing.

As I reflect back on this study and all of its components, two ideas vital to healing come to mind: First Nation healing and community resilience.

One Anishinaabe view of good health and wellness is termed *mino-bimaadiziwin*, meaning “the good life” (Manitowabi & Shawande, 2013). *Mino-bimaadiziwin* transcends the Western individualistic and physically focused model of wellbeing. A study by Maar & Shawande (2010) confirmed in their qualitative studies with Anishinaabe people of the Manitoulin Area that the elements fundamental to their wellness include the health of relationships with family, community, and the land. True to their beliefs and values, the Anishinaabe community members view healing as an interconnection between the earth, body, and spirit; and to be well means to live a balanced life (Manitowabi & Shawande, 2013). The conceptualization and significance of *mino-bimaadiziwin* has been seen in the literature over the last decade in relation to historical religious practices of Ojibwe in America, Indigenous women’s health and healing, Cree wellbeing, Indigenous social work and environmental activism, and most recently, clinical integration (Debassige, 2010; Manitowabi & Shawande, 2013). The focus ought to be how *mino-*

bimaadiziwin can be restored in the lives of First Nation individuals, families and communities through various social and political institutions.

Indigenous communities show tremendous resilience despite the effects brought upon by historical and ongoing colonization. Indigenous resilience is unique in that it is not isolated to one sudden and impersonal event, such as a natural disaster or catastrophe, but rather, is in part how Indigenous Peoples have dealt with long-term structural violence. Therefore, any interventions must “take a long-term approach to rebuild, repair and revitalize community strengths and institutions”. (Kirmayer et al., 2009). Providers in this study expressed how First Nations Peoples lean on strong family/friend ties, the connection with their cultural identity, and self-determination for support. Community resilience aligns with Indigenous values of relation to others and creation, and similar to mino-bimaadiziwin, should be a focal point of healing on Manitoulin Island.

To conclude, the long-term healing for First Nations Peoples on Manitoulin Island is inextricably related to elements fundamental to Indigenous values, beliefs and ways of life. The purpose of this study was not to propose a “solution” to violence (that would be much too facile), but rather, to begin to scratch the surface of an extremely complex issue and to provide insight into support in one specific aspect: the primary care setting. Our hope long term is that the continuation of this conversation and continued efforts on Manitoulin Island will contribute to healing for First Nations Peoples.

5.2 References

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Glossary of Terms

Colonization: Process in which a foreign settler population comes to new land to create a new majority society, and seizes or suppresses Indigenous land, lives or identities (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007)

Community Health Centres (CHC): Health care organizations with community health care workers. Community health workers are an under-recognized and unregulated group of

individuals who provide health-related services for fellow community members. Examples of titles of community health workers depend on geographic area and populations served, some of which include Aboriginal Health Workers, Community Nutrition workers, and Community health representatives (Najafizada et al., 2015). CHCs have a model of care that strives to improve access to care for populations who experience barriers to care (Glazier, Hutchison & Kopp, 2015)

First Nation: All Indigenous people in Canada who are not Métis or Inuit (Bartlett et al., 2007)

Family Health Teams: Health care organizations who offer primary care and include a “team of family physicians, nurse practitioners, registered nurses, dietitians, social workers and other professionals, whose programs and services are geared to local health and community needs” (Glazier, Hutchison, Kopp, 2015, pg. 1)

Indigenous: Descendants of the original inhabitants of North America. According to the Canadian Constitution Act of 1982, there are three groups of Indigenous people- First Nations, Métis, and Inuit (Bartlett et al., 2007)

Intimate Partner Violence (IPV): any behavior causing physical, sexual or psychological harm in an intimate relationship (Garcia-Moreno et al., 2006)

Northern Ontario: “comprised of 10 territorial districts (145 municipalities): Kenora, Rainy River , Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin, and Parry Sound.” (Registered Nurses’ Association of Ontario, 2015, pg. 12)

Primary Care Provider: A broadened definition to include any licensed professional who provides, coordinates or helps a patient access a variety of health care services. Examples of primary care providers include physicians, registered nurses, nurse practitioners,

physiotherapists, social workers, mental health workers, and community health workers (Health Care, 2018)

Praxis: “Reflection and action upon the world in order to transform it” (Freire, 1970, p. 36)

Reflexivity: An author’s process of ongoing critical self-awareness in the context of research (Mills, Durepos, & Wiebe, 2010).

Remote: mostly Indigenous regions where there is reliance on third party transportation to access transportation to larger centre (Registered Nurses’ Association of Ontario, 2015)

Rural: regions in Ontario with a population of less than 30,000 that are more than 30 minutes away from regions that have a population of more than 30,000 (Registered Nurses’ Association of Ontario, 2015)

Settler Ally: An individual engaged in reconciliation in historical and current wrongdoings and the rectification of unjust colonial systems (Smith, Puckett, Simon, 2015)

Sub-oppression: Harmful behavior by those who are oppressed towards fellow group members (Freire, 2008).

Appendices

APPENDIX 1: Laurentian University Research Ethics Approval (Original and Amended)



APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS
Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New / Modifications to project / Time extension X	
Name of Principal Investigator and school/department	Marion Maar, Sheldon Tobe, Maurianne Reade, Frances Kilbertus, NOSM, Darrel Manitowabi, Anthro, Beaudin Bennett, MIR candidate, Pamela Williamson, Noojmowin Teg Health Centre, Mariette Sutherland, SDHU, Lisa Boesch (NOSM RA)
Title of Project	Perspectives on Intimate Partner Violence on Manitoulin Island First Nations Communities (Phase 2)
REB file number	6009722 (formerly 2016-05-02)
Date of original approval of project	July 20, 2016
Date of approval of project modifications or extension (if applicable)	July 07, 2017
Final/Interim report due on: (You may request an extension)	July 20, 2018
Conditions placed on project	Any interim adverse incidents must be reported to REB

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

REB Form - Annual Report and Request for Changes to a Project

Project Info

File No: 6009722

PI: Maar Marion(Faculty of Medicine)

Project Title: Perspectives on Intimate Partner Violence on Manitoulin Island and First Nations Communities

Submitted: 2017/06/07 09:22 AM

Submitted by: N/A

Event Info

Event No: 6009722-35276

Notes:

Common Questions

1. Preamble

#	Question	Answer
1.1	I have read and understand the following statement: Research is subject to continuing research ethics review throughout the life of the project. If there are unanticipated substantive issues requiring changes to the original project as approved, researchers must submit a Request for Changes to Project with sufficient details to enable the REB to make an informed judgment about the continue ethical acceptability of the research.	Yes

2. Project Progress

#	Question	Answer
2.1	Date of the original ethics approval	2016/07/20
2.2	Is the research completed? ("Completed" means having concluded all the contact with potential or actual participants for the purposes of the project, except for final feedback of the project's results).	No
2.3	If not, please indicate the tentative date of completion.	
2.4	Is this a multi-year project? (Please note that annual reporting is required)	No

3. Project Development

#	Question	Answer
3.1	How many participants participated in the project?	21
3.2	Were some participants removed from the study? How many, and for what principal reason?	No
3.3	Did some participants leave the study after they agreed to participate? How many, and for what principal reason?	No
3.4	Specific issues or problems that arose (e.g., difficulty in recruiting, unexpected or serious events, ambiguities, etc) and how you handled them.	N/A
3.5	How are you ensuring security of data, identifying information, or	The data is stored in locked filing cabinets and password protected computer(s) and external hard

	biological materials during storage?	drives (for data backup) in NOSM dry lab space where there is key card entry. Identifying information has been removed from the data.
3.6	My project deals with secondary data only. (researcher must still answer the previous question)	No

4. Changes to Project

#	Question	Answer
4.1	Recruitment methods or types of participants	<p>We intend to expand upon Phase 2 (Photovoice) by including additional groups to attend Photovoice sessions that will focus on Indigenous wellness and healthy relationships. Based on our previous Photovoice sessions, community partners have chosen to focus on healthy relationships (i.e. strengths) instead of violence prevention (deficits) and are interested in learning the perspectives of men, Indigenous knowledge holders (those with knowledge of land-based traditions), Elders and families who access traditional medicine services. Therefore we intend to conduct further Photovoice sessions to learn about how Indigenous wellness (mino-bimaadiziwin) is influenced by personal, family, community and land-based relationships. We plan on conducting these sessions with the following groups:</p> <ol style="list-style-type: none"> 1. First Nation men (age 16 +) who are involved in traditional land-based activities; 2. Families involved with traditional healing services; 3. Elders <p>Recruitment methods will remain the same.</p>
4.2	Procedures	<p>The number of Photovoice sessions conducted will be determined by each individual group. The main focus of the sessions will be based on the original research question: How is mino-bimaadiziwin (Indigenous wellness) influenced by personal, family, community and land-based relationships? However participants will be invited to select specific questions related to the topic of healthy relationships every week. These sessions will be recorded by Debajehmujig Theatre group for the purpose of developing educational videos based on the Indigenous knowledge shared. Participants will contribute to Photovoice sessions as follows: 1. Researchers will accompany First Nations men who engage in traditional land-based activities as identified by the host community. These may include sports, hunting, fishing, boating, etc. We will only accompany participants who are already planning the activities. We will not ask them to engage in any new or previously unscheduled activity. Photovoice discussions will be conducted during these activities. 2. Photovoice sessions will be conducted during family visits with families involved with traditional healing services. 3. Photovoice</p>

		sessions will be conducted during regular meetings at the local health centre with female Elders.
4.3	Forms: letters, consent etc. **Please attach any revisions with changes highlighted	Letter of information and consent form (attached)
4.4	Other changes not listed above	<p>The following students will be involved in the project: Kristin Rizkalla - Laurentian University Breanne Frid - Laurentian University Breton Burke - Queen's University Yaeji Han - Northern Ontario School of Medicine Charlotte Roy - Northern Ontario School of Medicine Miles Sutherland - Community RA in Whitefish River First Nation Annie Kingston Miller is no longer involved with this project.</p> <p>The following researchers will be involved in the project: Darrel Manitowabi - Co-Principal Investigator, Laurentian Mariette Sutherland - Sudbury and District Health Unit Pamela Williamson - Noojmowin Teg Health Centre Maurianne Reade - Northern Ontario School of Medicine Frances Kilbertus - Northern Ontario School of Medicine Sheldon Tobe - Northern Ontario School of Medicine Lisa Boesch (Research Assistant) - NOSM</p>
4.5	I have obtained funding for my study since the original application	Yes
4.6	If yes, please specify the funder	Public Agency (SSHRC, NSERCC, etc.)
4.7	If Other, please specify	
4.8	Due date of next report	2017/09/30

Attachments

Doc / Agreement	Version Date	File Name	Description
Consent Form	2017/04/24	2017 04 24 Letter of Information and Consent - Photovoice.docx	Letter of Information and Consent

APPENDIX 2: Letter of Information/Consent Form



Letter of Information

(Service Provider Interviews)

Project Title: Perspectives on Intimate Partner Violence on Manitoulin Island First Nations Communities

Principal Investigators:

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Research Sponsor: Women's College Hospital Fund, Women Xchange

Purpose of the Study:

The purpose of this research is to identify intimate partner violence (IPV) behaviors between Aboriginal men and women on Manitoulin Island. The term intimate partner violence is used in place of domestic violence in the context of this research project. The term acknowledges that abuse, whether physical, financial, emotional or sexual, takes place in intimate relationships, regardless of whether the individuals involved share a domestic partnership. The term intimate partner violence best fits with the nuanced analysis of abuse which this project has set out to undertake. We hope to gain a better understanding of the mental, emotional and physical impacts of IPV in communities, to learn about community strengths that may foster resilience and promote healthy family relationships, and to determine the types of health and social services supports needed in the communities, to assist those affected by IPV.

Procedures involved in the Research:

You are being asked to participate in an interview to discuss your thoughts and perceptions of IPV based on your work in the community, and to identify key strengths that may improve IPV issues. If you agree, we will audio record these sessions.

Potential Harms, Risks or Discomforts:

By participating in this session, there is the potential that you may feel uncomfortable, embarrassed or upset in talking about your thoughts or experiences. You do not need to discuss or answer any questions that makes you uncomfortable or that you do not want to answer.

If you become visibly upset or uncomfortable during the session due to the topic of intimate partner violence or for other reasons, a list of local mental health care providers will be made available to you.

If needed, an Elder will be available to provide culturally appropriate assistance.

Other support services available include:
Manitoulin Health Centre - Mindemoya - (705) 377-5311

Noojmowin Teg Health Centre - (705) 368-2182

Mnaamodzawin Health Services Inc. - (705) 368-2182

Haven House (VAW Shelter) - (705) 377-5160

Rainbow Lodge (Addictions and Healing Centre) - (705) 285-4335

Nadmadwin Health Services (Wiki) - (705) 859-3164

Crisis Line – 1-866-996-0991

Government of Ontario Mental Health Helpline - 1-866-531-2600

Potential Benefits:

As a participant you will be given the opportunity to share your thoughts and perspectives related to intimate partner violence in your community. This project will also act as an opportunity for Aboriginal women to regain influence and power that has been eroded due to intergenerational trauma and Indian Residential Schools, and to create a discussion on the hidden harmful behaviors that have been silently accepted as unchangeable. We anticipate that this research will help organizations, social services and primary care to better address intimate partner violence. We also anticipate that raising awareness on intimate partner violence will enhance empowerment of communities and individuals to address this issue.

Payment or Reimbursement:

There will be no payment for your participation.

Confidentiality:

Anything that you say or do will not be attributed to you personally. Anything that we find out about you that could identify you will not be published or told to anyone else, unless we get your permission. Your privacy will be respected. Your name will not be stored with the interview transcript.

The information (raw data) will be kept on password protected computers, locked filing cabinets, and external hard drives. These storage devices will be kept in a secured research office at the Northern Ontario School of Medicine in Sudbury, ON. All researchers will be required to sign an Oath of Confidentiality. Only researchers will have access to the data.

Legally Required Disclosure:

Information obtained will be kept confidential to the full extent of the law and we will treat all information provided to us as subject to researcher-participant privilege.

Participation:

Your participation in this study is voluntary. It is your choice whether to participate or not. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still participate in this project in the future.

Information About the Study Results and Ethics:

Presentations of research findings will be made available to all interested Aboriginal health centres and band councils on Manitoulin Island. Media sources, such as Wiky TV 5, the *Manitoulin Expositor* or “100.7 The Island FM” may provide venues to share the findings of this study if deemed appropriate. You may obtain information about the study and the results by contacting Marion Maar at 1-800-461-8777.

This study has been reviewed and approved by the Manitoulin Anishinaabek Research Review Committee (MARRC) and the Laurentian University Research Ethics Board (REB # 2016-05-02). If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

Research Ethics Officer
Laurentian University Research Office
Telephone: 705-675-1151 ext 3681 or toll free at 1-800-461-4030
Email: ethics@laurentian.ca

CONSENT FORM

I have read the information presented in the information letter about a study being conducted by Marion Maar, Northern Ontario School of Medicine, and Kristin Rizkalla, Laurentian University, in collaboration with First Nations community organizations.

I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so. I have been given a copy of this form.

I consent to the audio taping of this session.

Date: _____

Name of Participant _____

Signature of Participant _____

Participants who provide verbal consent:

(Name of participant): _____ has been informed of the study's purpose, potential risks and benefits of participating, and has voluntarily agreed to participate in this study.

Name of researcher: _____

Date: _____

Location: _____

APPENDIX 3: Focus Group/Semi-Structured Interview Questions

1. Can you tell me, based on your work with your patients/clients, your thoughts on intimate partner violence and how it impacts primary care? How does IPV affect patients/clients (trauma, ability to take care of their health, chronic illnesses, other SDOH, other?) Does it affect First Nations women differently than non-FN?
2. How does IPV come up in interactions with patients? (Probes: Do patients feel safe to disclose? Are they trying to hide it? Does IPV come up often? Do you suspect it often? Do you bring it up with your patients/clients and how? What is the response? Indignation, shame, denial?)
3. What resources are available to help patients who are struggling with IPV? Which ones do you regularly refer clients to? Are there differences in services for FN vs non-FN? Do you provide any counselling yourself? (what referrals would you make, what are some key ways to improve IPV related issues in the community?)
4. How prepared do you feel in helping patients experiencing IPV? How about specifically to FN women? Did your training prepare you to support patients with IPV? (Undergraduate and CME).
5. What resources or training are necessary to more effectively deal with IPV? How about specifically to FN women? What would you like to see in terms of training? Is there training specific to FN people that you would need?
6. What would you like to see in order to improve responses to IPV from the primary care perspective?
7. Imagine we spoke again about this topic in 5 years. At that time you are happy to describe to me that there have been some very positive changes related to how IPV is addressed in the health and social services system. What positive changes would you hope to report?
8. Will any of the information discussed today CHANGE your future practice?

Probes

1. What do you mean by that?
2. Has anyone else had the same experience?
3. Do you think other primary care providers have had similar experiences?
4. Has anyone else had a different experience?
5. Are you able to provide some examples?
6. I would like to hear more
7. Please expand on that thought