

**Intersections Between Violence and Health Promotion Among
Indigenous Women Living in Canada**

Julie Williams

A thesis submitted in partial fulfillment of the requirements for the
Master's degree in Nursing

School of Nursing
Faculty of Health Sciences
University of Ottawa

© Julie Williams, Ottawa, Canada, 2019

Abstract

Violence against Indigenous women is a major public health concern worldwide and Canada is no exception. Multiple forms of violence inform the broader context of violence against Indigenous women. Nurses are likely to encounter Indigenous women in a variety of settings, but evidence suggests that nurses may lack understandings of violence. This thesis explored the following question: How does extant qualitative research conducted in Canada, contribute to understanding the health and wellbeing of First Nations, Métis and Inuit (Indigenous) women who have experienced violence? During the development of this thesis, significant gaps were highlighted including underrepresentation of Inuit women in the literature, limited focus on health promotion, and lack of methodological approaches to systematic reviews that were participatory and inclusive of the community. Therefore, a secondary aim of this thesis was to privilege perspectives of Inuit women and their communities, by developing a study protocol for a collaborative and community centered approach to reviewing and assessing the extant literature. A configurative and inductive approach based on thematic synthesis was used to systematically search, retrieve, analyze and synthesize extant literature. Post-colonial feminist theory and intersectionality were used as theoretical lenses to emphasize intersections between multiple forms of violence and locate the problem within the broader context of colonization and oppression. Sixteen studies were included in this review, fifteen qualitative and one mixed methods study. Four themes with subthemes emerged based on analysis and synthesis of findings in the included studies: 1) ruptured connections between family and home, 2) that emptiness... my spirit being removed, 3) seeking help and feeling unheard, and 4) a core no one can touch. These themes represent interconnected pathways that influenced health among Indigenous women, and have implications for healthy public policy, clinical practice, and nursing education.

Acknowledgments

I would like to thank my thesis supervisor Dr. J. Craig Phillips for his unwavering support and motivation when he knew I needed it most. The mentorship and guidance that he provided throughout the course of my studies were invaluable. Our lively discussions furthered my understanding of my research topic, nursing theory, research methods, social justice and Indigenous issues. I would also like to thank my thesis advisory committee members Dr. Brandy Vanderspank-Wright and Dr. Wendy Gifford who both provided valuable feedback and helped me tremendously with concept and methodological development. In addition, I am grateful for my community mentors Martha Flaherty and Beverly Illauq for taking the time to teach me about Inuktitut language, culture, and history. They are patient and kind teachers, powerful community advocates, and amazing women. *Qujannamiik!* I would also like to thank my family for believing in me and for their understanding of my absence during the seemingly endless hours of reading, thinking and writing. Lastly, the body of knowledge upon which my systematic review is based would not exist without the people who participated in the original research studies. Therefore, I am indebted to all of the First Nations, Inuit, and Metis women who demonstrated remarkable courage, sharing their stories with qualitative researchers in hopes of improving the lives of others. It is my intention to re-highlight their experiences because they are more than poignant stories, they are a powerful call for action on violence and health inequities.

List of Abbreviations

TVIC – Trauma and violence informed care

VAW – Violence against women

IPV – Intimate partner violence

PAR – Participatory action research

SEP – Socio-economic position

RCAP – Report of the Royal Commission on Aboriginal Peoples

TRC – Truth and Reconciliation Commission

MMIWG – Missing and Murdered Indigenous Women and Girls

WHO – World Health Organization

STI – Sexually transmitted infection

SDH – Social determinants of health

OCAP® – Ownership, Control, Assess, Possession

HIV – Human immunodeficiency virus

PTSD – Post-traumatic stress disorder

ITK – Inuit Tapirit Kanatami

NRI – Nunavut Research Institute

NT – Northwest Territories

NAHO – National Aboriginal Health Organization

Table of Contents

Abstract.....	ii
Acknowledgments.....	iii
List of Abbreviations.....	iv
Table of Contents	v
List of Tables, Illustrations, Figures, and Graphs.....	ix
Chapter One: Introduction.....	1
Research Problem.....	1
Relevance to Nursing	3
Health promotion with marginalized populations.	4
Trauma and violence informed care.	6
Marginalization and a closer exploration of violence.	6
Understanding trauma	9
Research Aims and Objectives.....	11
Participation of Indigenous Rights-holders	12
Epistemological Stance.....	14
Theoretical Lens.....	16
Relevance of Epistemic and Theoretical Lens to Thesis	17
A Configurative Approach.....	19
Thesis Layout	22
Chapter 2: Systematic Review Manuscript.....	23
Abstract.....	24
Theoretical Lens.....	28

Methodology	28
Defining limits of the review	29
Search strategy and study selection.....	30
Quality appraisal	33
Data extraction and analysis	33
Systematic Review Findings.....	35
Study characteristics	35
Theme 1: Ruptured connections between family and home	38
Theme 2: That whole emptiness... your spirit being removed	43
Theme 3: Seeking help and being unheard.....	48
Theme 4: A core no one can touch	54
Discussion	58
Implications for nursing practice	59
Implications for future research	60
Conclusion.....	62
References.....	64
Appendix A: Search Strategies.....	72
Appendix B: Review Findings (Tables)	78
Appendix C: Statement of Contributions Form.....	89
Chapter 3: Study Protocol Manuscript.....	90
Abstract.....	91
Research Question and Objectives	93
Background and Significance.....	94
Theoretical Lens and Methodological Rigour	98
Post-colonial feminist theory.....	99

A Cultural humility approach.....	99
Positionality of the principal investigator (JW)	100
A Collaborative Methodology	101
Systematic Review	104
Defining the limits of the review	104
Literature search and retrieval	105
Mapping the extant literature	106
Data extraction and analysis	107
Knowledge Sharing	108
Engaging the community	108
Conducting knowledge sharing sessions	111
Developing the knowledge sharing guide	112
Critical appraisal of systemic review findings	113
Creating the mixed knowledge synthesis	114
Maintaining an audit trail.....	115
Ethical Considerations	116
Ethical approval	116
Potential benefits	117
Mitigating potential risks	117
Informed consent.....	118
Data management and storage	119
Expected Outcomes.....	119
Disseminating Knowledge	120
References	121
Appendix A: Search Strategy.....	127
Appendix B: Knowledge Sharing Sessions.....	129

Appendix C: Statement of Contributions Form.....	131
Chapter Four: Integrated Discussion and Conclusion	132
Summary of Systematic Review Findings	132
Implications for Nursing Practice	134
Disrupting the normalization of violence.....	135
Cultural humility as a way forward.....	136
Promoting structural competency.....	137
Intersectionality and health equality.....	137
Responding to structural violence.....	139
Harm reduction and sexual health promotion.....	140
Interventions that build on strengths and capacity.....	141
Implications for Nursing Education	142
Research on Indigenous Health – A National Priority	143
Research setting.....	144
Diversity among Indigenous Peoples.....	145
Life history and exposure to violence.....	147
A Focus on substance use and HIV.....	148
(Re)Considering How Violence is Explored	149
Capacity building and research partnerships.....	150
Future research - contribution of the study protocol.....	151
Reflections on Research and Cultural Bias.....	152
Conclusion.....	156
References	158

List of Tables, Illustrations, Figures, and Graphs

Figure 1. Search Results (Systematic Review)

Figure 2. Interconnected Themes with Subthemes (Systematic Review)

Figure 3. Components of Configurative Mixed Knowledge Synthesis (Study Protocol)

Table 1. Eligibility Criteria for Studies (Systematic Review).

Table 2. Characteristics of Studies Included in the Systematic Review

Table 3. Sample Characteristics of Participants of Studies Included in the Systematic Review

Table 4. Summary of Proposed Research Process (Study Protocol)

Table 5. Eligibility Criteria for Studies (Study Protocol)

Table 6. Potential Community Research Partners (Study Protocol)

Intersections Between Violence and Health Promotion Among Indigenous Women Living in Canada

Chapter One: Introduction

Research Problem

Violence against women (VAW) is a global health problem with an associated burden of disease estimated to be greater than either smoking or obesity (World Health Organization [WHO] 2010). Violence rarely occurs in isolation; women may be exposed to various forms of violence across the lifespan, and exposure to violence earlier in life, is a risk factor for later exposure (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Importantly, violence by a current or former partner is cited as one of the most frequently occurring forms of violence that women experience (WHO 2010). Intimate partner violence (IPV), also known as spousal abuse or domestic violence, impacts health, wellness, and the ability to participate and enjoy activities of daily living and further, it disproportionately affects women (WHO 2010). Notably, there is a strong correlation between violence and women's health. Health related consequences of violence include: unwanted pregnancy, pregnancy related complications, sexually transmitted infections (STI) (including HIV), physical injuries, chronic pain, as well as multitude of mental health disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), suicidal behaviours (i.e. ideation, attempt), and suicide (García-Moreno et al., 2005). Additionally, unhealthy behaviours associated with violence such as increased rates of smoking, alcohol and drug use may lead to increased morbidity and mortality (García-Moreno et al., 2005). Health inequities resulting from violence are unjust and cause significant social suffering. Nurses have a professional and moral imperative to orient care toward reducing these inequities and to promote social justice (Canadian Nurses Association, 2010).

Despite Canada's universal healthcare, and early leadership and commitment to action on the social determinants of health (SDH), significant health inequities persist within this country (Hankivsky & Christoffersen, 2008), especially among Indigenous people – Inuit, Métis

and First Nations Peoples. Indigenous women experience higher rates of violence compared to both Indigenous men and the general population of Canadian women and this violence can be linked to poor health status among them (Andersson & Nahwegahbow, 2010). The disparity in rates of IPV between regions and populations within Canada is a major national concern (Brennan, 2011; Charron, Penney, & Senécal, 2010; Paletta, 2008; Perreault, 2011, 2015; Sinha, 2013). According to Sinha (2013), Indigenous women living in the Canadian territories (Yukon, Northwest Territories and Nunavut) experienced both increased incidence and severity of IPV compared to the rest of Canada. The prevalence of IPV in these three territories is considerably higher than in the provinces (Sinha, 2013). Sinha (2013) also remarked that rates of IPV in Nunavut are double that of the North West Territories (Sinha, 2013). Women in the territories were more likely to experience injuries and an increased prevalence of more severe forms of IPV such as being beaten, choked, threatened with a weapon, or sexually assaulted (Sinha, 2013). In Nunavut, the sexual assault rate is 10 times the Canadian national average (Charron et al., 2010; Sinha, 2013) and females are more than twice as likely to be victims than males; the proportion of sexual assaults committed within the context of IPV is unknown (Galloway & Saudny, 2012). Compared to the rest of Canada, Nunavut has higher rates of unwanted pregnancy, pregnancy related complications, STIs, mental health concerns, physical injuries, and increased rates of smoking (Galloway & Saudny, 2012). These health problems have been documented to be associated with IPV (García-Moreno et al., 2005).

The rationale for a focus on Indigenous women is not that violence, and the sequela of health and social problems associated with violence, are of concern only to Indigenous women; violence against *all* women is a global health problem (García-Moreno et al., 2005). Rather, health and social problems are influenced by contexts that must be understood (Browne, McDonald, & Elliott, 2009; Moffitt & Fikowski, 2017; Varcoe & Dick, 2008). Within a Canadian context, the problem of violence disproportionately affects Indigenous people and in particular Indigenous women (Brennan, 2011; Charron et al., 2010; Perreault, 2011, 2015; Sinha, 2013). It

is important to also note that Indigenous culture does not cause or condone violence against women, and studies have shown that the elevated risk of IPV observed among Indigenous women in Canada cannot be fully explained by controlling for socio-economic and other factors (Brownridge, 2008; Daoud, Smylie, Urquia, Allan, & O'Campo, 2013; Pedersen, Malcoe, & Pulkingham, 2013). These findings support theories that poor health outcomes and social problems are linked with colonization and intergenerational trauma (Brownridge et al., 2017; Daoud et al., 2013; Pedersen et al., 2013), and emphasize the importance of contextualized understandings of violence.

Relevance to Nursing

Unfortunately, there is conflicting evidence and knowledge gaps on how to support women exposed to violence (Wathen, MacGregor, & MacMillan, 2016). For example, most research focuses on experiences of living with violence or the crisis of leaving a violent relationship. Few studies have examined health promotion and healing after leaving (Ford-Gilboe, Wuest, & Merritt-Gray, 2005; McDonald & Dickerson, 2013). Among nurses and other frontline healthcare providers, early interventions for violence focused on universal screening practices, encouraging women to leave abusive homes, and providing referrals to shelters and other resources (Wathen et al., 2016). These interventions may at times be the only option; however, they can also lead to displacement from family and home (Daoud et al., 2016; Schmidt, Hrenchuk, Bopp, & Poole, 2015). Furthermore, these interventions are also based on an assumption that leaving one violent relationship will result in a life free from violence and oppression. However, given that early exposure to violence is a risk factor for later exposure, this assumption is not necessarily true (Davies et al., 2015). The risk of unresolved trauma and the structural barriers that women experience both during and after leaving abusive relationships, limits their ability to engage in health promotion and may cause further health deterioration (Cook, Dinnen, & O'Donnell, 2011; Davies et al., 2015; Schmidt et al., 2015; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003). These persistent health inequities suggest

that the current standard of care does not meet the needs of women experiencing violence (Wathen et al., 2016).

Because, violence results in short and long term health problems, nurses are likely to encounter these women in a wide variety of health care settings (e.g., emergency departments, primary care clinics, home visits, community and inpatient mental health). Nurses are, therefore, well positioned to engage in primary prevention efforts at the community and population levels, as well as to provide important interventions and support to women and families experiencing violence (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011; Jack, Ford-Gilboe, Davidov, & MacMillan, 2017). Health promotion is recommended as a means to prevent further exposure to violence and poor health outcomes (WHO, 2010), and nurses should, therefore, engage in health promotion with women experiencing violence. Yet, health promotion may have certain limitations as a nursing intervention with marginalized populations such as Indigenous women, because these interventions commonly focus on decontextualized strategies such as health teaching and encouraging healthy behaviours. As a result, for nursing interventions to be both effective and meaningful, they ought to stem from in-depth and contextually bound understanding of the impact of cumulative trauma and structural barriers in the lives of Indigenous women experiencing violence (Brownridge et al., 2017; Varcoe et al., 2017).

Health promotion with marginalized populations. Health promotion was first conceptualized more than 30 years ago as part of a call to action on global health inequities and the social determinants of health (SDH) in international declarations made at Alma Ata (WHO, 1978), Ottawa (WHO, 1986), and Astana (WHO, 2018). The Ottawa Charter for Health Promotion (hereafter referred to as 'The Charter') defined health promotion as "the process of enabling people to increase control over and to improve their health ... [To achieve health] and wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs and to change and cope with the environment" (WHO, 1986, p. para 3). The Charter also identified five fundamental strategies for action: build healthy public policy, create supportive

environments, strengthen community action, reorient health services and develop personal skills (WHO, 1986). Unfortunately, in the decades since The Charter was signed, health promotion has often focused on decontextualized strategies of developing personal skills for individuals (Solar & Irwin, 2010).

Because violence among Indigenous populations is complex and health promotion has been conceptualized in a variety of ways, the link between these two concepts may not be clearly evident. The SDH influence experiences of violence and health promoting behaviours which are both temporally and contextually bound (Hankivsky & Christoffersen, 2008; WHO, 2010). Erroneously, the SDH are often conceptualized as a simple list of factors that influence health status rather than a complex context that weaves all aspects together from micro to macro levels (Hankivsky & Christoffersen, 2008; Solar & Irwin, 2010). This simplistic view of SDH may also contribute to nurses focusing on developing personal skills and healthy behaviours when engaging clients in health promotion. A focus on decontextualized strategies is especially problematic for marginalized populations, such as Indigenous women, where healthy choices are often constrained by the convergence of multiple forms of violence (Browne & Smye, 2002). For example, many communities in northern Canada are geographically isolated and largely populated by Indigenous people who are effectively on the margins (both geographically and socially) of Canadian society. Most of these communities experience disproportionate rates of poverty and unemployment, lack of educational opportunities, and a contextual reality that includes food insecurity and overcrowded housing that is often in serious need of repair (Inuit Tapiriit Kanatami, [ITK], 2014; 2018). These problems all contribute to high rates of violence, substance use, and suicide (Paletta, 2008; Royal Commission on Aboriginal Peoples [RCAP], 1996). The resulting health inequities are compounded by a lack of access to safe and adequate health and social services (Levan, 2003; Moffitt & Fikowski, 2017). Moreover, from a nursing perspective, the ways in which violence intersects with nursing care may be overlooked (Alshammari, McGarry, & Higginbottom, 2018; Beccaria et al., 2013). The

problem of violence goes beyond the immediate physical injuries or a medical diagnosis of post-traumatic stress disorder; violence is responsible for significant short and long term health problems among women (García-Moreno et al., 2005). The health effects of violence are not always obvious (Alshammari et al., 2018). Unfortunately, survivors of violence often do not receive responses they want and/or need from nurses (Feder, Hutson, Ramsay, & Taket, 2006).

Trauma and violence informed care. Health promotion remains a cornerstone of primary health care and nursing practices, but nurses in general should be more attentive to the ways in which violence restricts health-promoting behaviours (Ford-Gilboe et al., 2005; Varcoe, Browne, & Cender, 2014). More recently, trauma and violence informed care (TVIC) is recommended as a means to orient healthcare toward equity, create supportive environments in healthcare and reduce health disparities (Browne et al., 2016; Ponc, Varcoe, & Smutylo, 2016; Varcoe, Wathen, Ford-Gilboe, Smye, & Browne, 2016). Varcoe et al. (2016) identify four key principles of TVIC: 1) understand trauma, violence and its impacts on people's lives and behavior; 2) create emotionally and physically safe environments for all clients and providers; 3) foster opportunities for choice, collaboration and connection; and 4) use strengths-based and capacity-building approaches to support clients. TVIC is distinct from trauma specific treatment; furthermore, trauma and *violence* informed care is not equivalent to trauma-informed care. Trauma-informed care recognizes the links between psychological trauma, behavior and health, and seeks to create safe spaces for clients. TVIC "expands [this] concept to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life...so that problems are not seen as residing only in [the person's] psychological state, but also in social circumstances" (Varcoe et al., 2016, p. 1). TVIC provides clear links to health promotion, SDH, and intersectional frameworks aimed at reducing health inequities (Browne et al., 2016).

Marginalization and a closer exploration of violence. The following sections explore the concept of violence and intersections between violence and trauma among Indigenous

women living within a diverse Canadian context. Multiple definitions of IPV and related concepts such as spousal abuse exist. The WHO provided a commonly cited IPV definition as any “behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours” and includes violence by both current and former partners (WHO, 2010, p. 11). Though the WHO definition of IPV appears comprehensive, this definition may not accurately conceptualize the problem of IPV occurring among Indigenous populations in Canada. IPV is not simply an undesirable behaviour occurring within an intimate dyad. Within the Indigenous context, it is a problem of entire communities and families that can be traced back to interventions of the state designed to disrupt Indigenous families and instill patriarchal, settler colonial, and Christian values (Goulet, Lorenzetti, Walsh, Wells, & Claussen, 2016). For example, Canadian policies forced the removal of young Indigenous children from their homes to attend State and church administered residential schools that were often located far from the children’s families. These displaced Indigenous children were not allowed to speak their language, and a multitude of abuses (e.g. physical, sexual and psychological) occurred frequently within these schools. IPV is, therefore, described as a social syndrome “maintained through a constellation of social problems that operate together. Historical, social and economic conditions are intertwined” (Goulet et al., 2016, p. 13). Furthermore, in contemporary contexts, racism in mainstream society continues to promulgate demeaning stereotypes of Indigenous women that diminish their value as human beings (Culhane, 2003; Goulet et al., 2016).

It is the convergence of multiple forms of violence occurring over generations that forms the broader context surrounding violence against Indigenous women (Goulet et al., 2016). This broader context also influences behaviors that link violence to poor health (Andersson & Nahwegahbow, 2010). More specifically structural violence, systemic discrimination (racism and sexism), and lateral violence all place Indigenous women at greater risk of experiencing interpersonal violence committed by intimate partners and others. Structural violence is “social

arrangements that put individuals and populations in harm's way... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people" (Farmer, Nizeye, Stulac, & Keshavjee, 2006, para 5). Lateral violence is described as displaced violence where rather than directing violence towards one's oppressors; it is instead enacted against one's peers, friends, and family. In an Indigenous context, lateral violence is related to colonization and oppression and is more likely to occur when anger, shame, and blame are internalized and suppressed (Native Women's Association of Canada, n.d.). Lateral violence, including a strong tendency to 'shame and blame' victims, may contribute to a lack of services in rural and remote communities (Levan, 2003). Some community leaders fail to acknowledge the severity of the issue and refuse to support the creation of shelters and treatment programs. Further, those who open their homes to victims may be accused of breaking up families and become a target of violence themselves (Levan, 2003; Moffitt & Fikowski, 2017). Women leaving a violent relationship must often leave their community to access services in urban centers, isolating them from potential sources of support, and disconnecting them from family and friends (Moffitt & Fikowski, 2017).

Indigenous women are, therefore, further marginalized by these multiple and intersecting forms of violence and oppression. Marginalization is "the peripheralization of individuals and groups from a dominant, central majority. [It is] a sociopolitical process, producing both vulnerabilities (risks) and strengths (resilience)" (Hall, 1999, p. 89). Among Indigenous Peoples in Canada, this 'sociopolitical process' is indelibly bound to colonization and includes discriminatory government policies and programs, such as the reserve system and Indian Residential Schools, which resulted in loss of land *and* culture, removal of children from families and homes, as well as attempts at forced assimilation (RCAP, 1996; Truth and Reconciliation Commission [TRC], 2015). Yet, some Indigenous communities have remained culturally strong and healthy and other communities are beginning to recover their health and wellbeing (Andersson, Shea, Amaratunga, McGuire, & Sioui, 2010; Haskell & Randall, 2009). Among

marginalized populations resilience may stem from overcoming adversity and living an invisible yet highly examined life (Culhane, 2003; Hall, 1999). It is particularly important for nurses to understand the complex context of Indigenous women's lives so they can focus on the strengths of these women, and reduce vulnerabilities that contribute to social suffering and poor health (Browne & Fiske, 2001; Varcoe et al., 2017). Importantly, better understandings of individual and community strengths, rather than, a focus on risk and deficits, may lead to greater health equity (Andersson et al., 2010; Browne, Varcoe, & Fridkin, 2011).

Understanding trauma. A fundamental understanding of trauma is important to understanding problems of violence and the (un)healthy behaviours that ensue after exposure to violence (Herman, 2015). Varcoe et al. (2016) provide the following definition of trauma:

Trauma is both the experience of, and a response to, an overwhelmingly negative event or series of events... Events become traumatic due to complex interactions between the person's neurobiology (affecting, for example, their ability to self-regulate), their previous experiences of trauma and violence, including the role of others in supporting (or not) self-regulation and recovery, and the interaction of broader community and social structures. (Varcoe et al., 2016, p. 3)

Trauma, which results from a single event is sometimes called simple or acute trauma; whereas, trauma which occurs repeatedly over time may be referred to as complex trauma (Herman, 2015). Influential books such as Herman's *Trauma and Recovery* have been dedicated to understanding symptoms of psychological trauma and its impacts on behaviors of individuals exposed to domestic violence. Herman (2015) recognized a need for an expanded spectrum of trauma diagnoses that includes complex PTSD. She argued that complex trauma is distinct from unresolved trauma that occurs from a single incident and more accurately reflects the behaviors and (mal)adaptations associated with repetitive and prolonged trauma such as living with domestic violence (Herman, 2015). It should be noted that despite the advocacy efforts of researchers and clinicians, neither complex trauma nor complex-PTSD (CPTSD) were

officially recognized diagnoses in the DSM IV or V (Bellamy & Hardy, 2015; Herman, 2015). Yet, denoting some progress, CPTSD is proposed to be included in the WHO's eleventh edition of the International Classification of Diseases (ICD-11) (Hyland, Shevlin, Fyvie, & Karatzias, 2018; Karatzias et al., 2017; Powers et al., 2017). Of note, experiences of trauma do not automatically imply that problems will ensue or that a person will develop a subsequent mental disorder and many Indigenous Peoples and communities have demonstrated considerable resilience despite traumatic circumstances (Bellamy & Hardy, 2015).

A complex trauma framework is useful in understanding the continuously traumatic effects of colonization and violence experienced by Indigenous people in Canada (Haskell & Randall, 2009). Indigenous groups, as well as researchers and clinicians have begun to explore the concept of historical trauma and the intergenerational transmission of trauma, especially in relation to the Indian Residential School experience (Bellamy & Hardy, 2015; Bombay, Matheson, & Anisman, 2014). Historical trauma is the accumulation of collective traumas and stressors occurring in the past, which continue to affect the health and wellbeing of individuals and communities (Bombay et al., 2014). TVIC brings explicit attention to the cumulative effects of all forms of violence including historical and ongoing, structural, systemic, institutional and interpersonal violence (Varcoe et al., 2016). This aspect of TVIC is critical because of the ongoing and historical violence that has traumatized many individuals and entire communities of Indigenous Peoples across Canada (RCAP, 1996; TRC, 2015).

The problems outlined above indicate that nurses require sufficient, culturally relevant, and contextually bound knowledge to guide their nursing care practices in a variety of settings. Nurses must understand violence in context before existing nursing practices with Indigenous women can move forward in meaningful ways. Furthermore, research is required to create, implement, and evaluate nursing interventions that are tailored to context, strengths-based, and community centered. Importantly, nursing research and interventions must collaborate with individuals, families and communities to build capacity and promote health and wellbeing

(Andersson & Nahwegahbow, 2010; Varcoe et al., 2014; Wathen et al., 2016). Health disparities that occur as a result of violence are significant to nursing practice and highlight a need for contextualized understandings (Browne et al., 2011). Although, violence against women causes immense suffering and health inequity globally, in Canada, the convergence of gender, geography and colonization, influence both risk of violence and health outcomes (Paletta, 2008; Perreault, 2015; Varcoe & Dick, 2008). Nurses, as primary care providers, need to support Indigenous women in their efforts to promote their own health and insure that families survive violence and thrive. Currently, there are few nursing studies about Indigenous women's experiences of violence in the Canadian context, and, to date, no systematic reviews of existing qualitative health literature in this substantive area were found.

Research Aims and Objectives

This thesis seeks to answer the following question: How does extant qualitative research conducted in Canada, contribute to understanding the health and wellbeing of Indigenous women who have experienced violence? The primary aim of this thesis was to explore the perspectives of First Nations, Métis and Inuit (Indigenous) women living in Canada about how violence influences their health and wellbeing. To accomplish this aim, a systematic review of qualitative research was undertaken (Chapter 2). Objectives that guided this review were to:

- 1) Describe experiences of violence in the lives of Indigenous women living in Canada;
- 2) Understand ways in which Indigenous women relate these experiences of violence to their health and wellbeing; and
- 3) Explore how Indigenous women promote healing and wellbeing after exposure to violence.

A secondary aim of this thesis was to develop a study protocol for another systematic review using a collaborative and community centered approach that would privilege perspectives of Inuit women and their communities (Chapter 3). This protocol seeks to address limitations that I identified while conducting the first systematic review. These limitations relate to both the extant

literature upon which the review was based and challenges inherent in current systematic review methods. For example, research reports, included in the review, are authors' interpretations of Indigenous women's perspectives elicited through interviews. The specific perspectives of First Nations, Métis and Inuit were not typically delineated in these reports; more often, these perspectives were grouped together under the broader term Aboriginal. Inuit perspectives in particular were absent in the majority of reports that were located and included in the systematic review. The perspectives of Inuit women are essential and have not routinely been sought when previous research has been conducted (Healey & Meadows, 2007). Furthermore, systematic review methods that take a collaborative and community centered approach are rare (Jamal et al., 2015) and the process of involving stakeholders and community partners are not clearly articulated in descriptions of review methods (Gough, Thomas, & Oliver, 2012; Pollock et al., 2018). To address these limitations, I developed a study protocol using a modified approach to configurative mixed knowledge synthesis. A configurative mixed knowledge synthesis is a systematic review of qualitative research that includes a second source of data (e.g. focus groups; Gough et al., 2012). These methods were modified to be more collaborative and inclusive of community research partners at all stages of the research process. Knowledge shared during the course of the proposed configurative mixed knowledge synthesis will expand on findings from previously published research and contribute to methodological development of participatory approaches to systematic review, as well as, determine how those methods align with Inuit ways of knowing.

Participation of Indigenous Rights-holders

Participatory approaches (including decolonizing methodologies important in Indigenous research) "share a core philosophy of inclusivity and of recognizing the value of engaging in the research process (rather than including only as subjects of research) those who are intended to be the beneficiaries, users, and stakeholders of the research" (Cargo & Mercer, 2008 p. 326). However, a participatory approach to systematic review is rare (Jamal et al., 2015). Pollock et

al. (2018) conducted a scoping review of stakeholder involvement in systematic reviews. They note it is becoming more common to report stakeholder involvement, but that unfortunately the authors of reviews do not describe the process of how they involved stakeholders (Pollock et al., 2018). Involving Indigenous stakeholders or more accurately, Rights-holders, is fundamental to ethical conduct of research with Indigenous People. First Nations established four key principles of ownership, control, access, and possession for the ethical conduct of research. These principles, known as OCAP®, affirm that “First Nations have control over data collection processes in their communities, and that they own and control how this information can be used” (First Nations Information Governance Centre, 2018, para. 2). OCAP® are explicitly First Nations principles and do not specifically apply to Inuit research. The Inuit Tapiriit Kanatami (ITK) which means “Inuit are united in Canada” is the national voice representing Inuit. Their work focuses on the rights, health and wellbeing of Inuit. The ITK (2018) have outlined a national Inuit research strategy. This document describes research priorities including health equity, violence against Inuit women and children, and the ethical conduct of research. This ethical conduct includes capacity building for the purpose of Inuit self-determination in research. The ITK also emphasize the need for greater ownership and control over research, and access to data. Perhaps most relevant to systematic reviewing they highlight that,

Inuit seek access to existing research but do not always have access because our institutions cannot afford the expensive search engines and platforms that universities and governments enjoy. There is a continued need to improve methods for sharing data with Inuit in ways we would like to receive it. (ITK, 2018, p. 20)

Therefore, the development of the study protocol (Chapter 3) is an important step in negotiating a mutually beneficial relationship between academic researchers and Inuit partners that seeks to increase access to research that could be used to inform policy and practice in healthcare.

Epistemological Stance

The purpose of this section is to reflect on my ways of knowing in relation to my nursing praxis and how that influences my understanding and ways of being as a researcher. Clarifying theoretical perspectives is an essential element of the research process in an effort to build on disciplinary (nursing) knowledge and ensure that the findings are relevant to clinical practice (Thorne, 2008). In the previous sections, I provided evidence that the problem of violence against women is a worldwide public health problem of great concern to nurses. My perspectives on the convergence between violence and the SDH are also informed by living and providing nursing services in different places across Canada. For instance, I lived and worked as a registered nurse in Yellowknife, Northwest territories. Yellowknife was the primary medical travel destination for all of the rural and remote communities of the Northwest Territories and Kitikmeot region of western Nunavut, where individuals traveled to receive healthcare that was unavailable in their home communities. I provided inpatient and outpatient nursing care to the diverse and predominantly Indigenous population living across these regions. Notably, many women I cared for were experiencing adverse effects of violence and this illustrated first hand for me the complex intersections between violence, health, gender, and culture. The challenges women faced in their communities were increased by the remote location, lack of services, and high staff turnover among health and social service workers (Levan, 2003; Moffitt & Fikowski, 2017), which made discharge planning a complex process. Yet, these women demonstrated considerable strength and resiliency and have inspired me to reflect on my own values including the ways in which these values inform my nursing practices. Living in a community that was primarily comprised of Indigenous people (Dene and Inuit), I developed a much greater appreciation of cultural strengths and understanding of their concerns about colonization and oppression. I respect the accumulation of Indigenous knowledge and recognize that Indigenous knowledge is shared, not collected, and knowing is relational and inter-connected to land and history (Cajete, 2015; Healey & Tagak Sr, 2014).

My epistemological stance which guides this thesis, is consistent with the critical paradigm and is further informed by intersectionality and post-colonial feminist theory. Nursing research can be used to inform policy, service provision, clinical practices, and determine future research directions. However, research is often conducted by teams of academics working in isolation from the communities they purport to serve; which I find problematic. The colonizing potential of research, misappropriation of knowledge and further marginalization are additional risks of this research project. Ongoing reflection and dialogue, key aspects of critical research (Mill, Allen, & Morrow, 2001), may insure that future research is ethical, useful and culturally meaningful to the communities it claims to serve. I believe that research is inherently value laden, influenced by government and other powerful institutions, and biased towards dominant culture and that these biases are not always acknowledged in mainstream research. According to Guba and Lincoln (1994) the ontology of critical theory is one of *historical realism*; knowledge is value dependant, socially constructed and historically situated. These multiple realities are “as limiting and confining as if they were real” (p. 111). The ontology and epistemology are therefore linked and the values of the researcher, participants and others influence the research findings (Guba & Lincoln, 1994).

Furthermore, research, no matter how well intended, may expose marginalized populations to risk (Kincheloe, McLaren, & Steinberg, 2011) and perpetuate health inequities. Research about “risk factors” and Indigenous women can be harmfully framed as lifestyle and individual choices when it is removed from the socio-cultural-political context that perpetuates powerlessness and incapacitates choice and when this research is used to inform policy and practice it can lead to health inequities (Browne & Smye, 2002). For example, public health campaigns that focus on a discourse of risk of substance use or HIV among Indigenous women can increase stigma, and lead to further vulnerability, to trauma and shame (Browne & Smye, 2002). Research conducted with Indigenous people requires careful framing of findings so that data are not misinterpreted and stereotypes are not perpetuated. Critical theory research is

conducted with the explicit intent of emancipation, empowerment and change; therefore, careful consideration is given when framing findings to avoid inadvertently contributing to further marginalization (Kincheloe et al., 2011). This illustrates 'the transactional nature of inquiry' in the epistemology; and this transaction requires that dialogue and praxis be included in the methodology of critical theory (Guba & Lincoln, 1994).

Theoretical Lens

Post-colonial feminist scholarship falls under the umbrella of critical theory; it seeks to uncover power inequalities and discrimination resulting from the intersection of gender, culture and social class in a post-colonial context (Anderson & McCann, 2002). This is an ideal lens because the research problem described above is both gender-based and rooted in colonization. The term post-colonial does not refer to a distinct location in time or place, but a fluctuating process characterized by historic and ongoing colonization and decolonization (Browne, Smye, & Varcoe, 2005, 2007). *Post-colonial theory* is relevant to Indigenous health research because of the effects of colonialism on all facets of health and wellbeing; these well documented effects of colonialism (e.g. poverty, despair, and political isolation) are the root cause of suicide, depression, substance use and family violence (National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG], 2018; RCAP, 1996; TRC, 2015). Post-colonial does not suggest the period of colonization is over; rather, it is an ongoing process that continues to affect Indigenous people through structural violence and racism occurring in multiple settings, including healthcare (Anderson & McCann, 2002). Post-colonial is described, as a time for back and forth reflection, that must occur if we are to move beyond the domination and discrimination of colonialism (Browne & Smye, 2002).

Feminist theory contributes an intersectional analysis to explore how gender-based violence intersects with other forms of violence and oppression (Browne et al., 2011). Intersectionality is a term first coined by Crenshaw (1991), building on the work of Black feminist scholars such as 'bell hooks' (a pen name used by Gloria Jean Watkins). Crenshaw utilized

intersectionality to explore violence against minority women. Intersectionality and “the intersectional paradigm provides a normative framework that captures the complexity of lived experiences and concomitant, interacting factors of social inequity, which, in turn, are key to understanding health inequities” (Hankivsky & Christoffersen, 2008, p. 272). This framework emphasizes that poor health is not simply the result of individual behaviors or (lack of) coping skills; health inequities result from intersecting oppressions such as poverty, gender-based violence and cultural discrimination (Browne et al., 2011). Synthesizing qualitative research using an intersectional approach may capture the complexity of SDH such as gender, culture, socio-economic position (SEP) and the ways in which they influence Indigenous women’s experiences of violence.

Furthermore, “feminism moves beyond initial critical theory in the belief that the individual experience can be oppressive, and that it is equally valuable to liberate the individual woman from her oppression as to liberate a group of people” (Bent, 1993, p. 296). This belief supports the use of qualitative methodologies to explore experiences of women and may give voice to their individual experiences and life histories. Nurses have adopted a variety of intersectional frameworks for research and practice, more specifically, emancipatory and reflective approaches to practice. Intersectionality and post-colonial feminist theory inform my perception of the effect violence and displacement may have on health among Indigenous women, and these theories influenced this study’s research design. For example, an intersectional approach to defining and linking violence and health promotion was used as a conceptual framework in this thesis to create a more nuanced and contextualized understanding of these concepts than any one definition alone could provide.

Relevance of Epistemic and Theoretical Lens to Thesis

Although violence against Indigenous women is a global problem, this problem cannot be separated from the context in which it occurs. Even within Canada, Indigenous Peoples are not a homogenous group and experiences may differ within and between communities and from

region to region. Colonization, gender, culture, geography and violence are all important determinants of health among Indigenous women. These determinants intersect in a myriad of ways which are only beginning to be understood by researchers and nurses. Nursing studies have used post-colonial feminist methodologies to uncover power inequalities in healthcare and have contributed to nursing's knowledge of cultural safety and TVIC (Browne et al., 2011). Their work demonstrated that this theoretical perspective is both appropriate for nursing research more generally and to the study of violence in particular.

All forms of violence and structural inequities limit choices available to people and may lead to further violence and social isolation. Unfortunately, "with few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease" (Farmer et al., 2006, p. 1686). An intersectional analysis of determinants of health provides a greater understanding of underlying pathways that determine health inequity rather than offering a simple list of factors that influence health status (Hankivsky & Christoffersen, 2008). For example, the WHO suggested distinctions be made between determinants of health inequity that are structural factors and the determinants of health that have a more direct influence on health status (Solar & Irwin, 2010). Determinants of health inequity (e.g., socioeconomic position, gender, ethnicity, education, and occupation) operate collectively via power, control and access to resources to determine the unequal distribution of the SDH between populations (Solar & Irwin, 2010).

The strengths of an intersectional analysis are that it links contextual factors to individual health, exposes pathways and processes that influence health behaviors, and focuses on resilience as well as risk. Intersectional analysis may be useful to expand our understanding of the SDH and engage in more meaningful health promotion with marginalized populations (Hankivsky & Christoffersen, 2008). The need for an expanded and more nuanced understanding of SDH supported using intersectionality and post-colonial feminist theory as a

lens in this thesis. As a result, an intersectional approach formed the basis of linking and defining key concepts and was used to explore the problem of violence against Indigenous women in the systematic review in Chapter Two and to develop the study protocol for the configurative mixed knowledge synthesis with Inuit women described in Chapter Three. Qualitative methodologies, which may deepen our understanding of lived experiences and social processes, are congruent with an intersectional approach. Qualitative research exploring the perspectives of Indigenous women may provide a valuable source of knowledge. This research has the potential to inform and/or contribute to nurses' understandings of health promotion and TVIC. The review of qualitative research, presented in manuscript format in Chapter Two, focused on Indigenous women's experiences of violence in a Canadian context. Synthesizing qualitative research is a contentious issue. Furthermore, systematic reviews are generally conducted from a positivist or post-positivistic paradigm. Therefore, systematic review methodologies may be viewed as incommensurable with a critical paradigm. Another challenge of this review was how OCAP principles and other ethical considerations related to the rights of Indigenous people to self-determination in research, could or should influence methods. There is less emphasis on ethical considerations when research is in the public domain and data is not being collected from participants and this was one of the key aspects of the study protocol presented in Chapter Three. Both the systematic review presented in Chapter Two and the study protocol presented in Chapter Three utilize a configurative approach to synthesizing qualitative research and this is the focus of the following section.

A Configurative Approach

There is a diverse array of systematic review methods. Barnett-Page and Thomas (2009), for example, identified at least 12 types of qualitative synthesis in addition to quantitative reviews, mixed method reviews, integrative reviews, and scoping studies. There is considerable overlap between the various types of reviews and although no agreed upon typology exists, a number of authors have compared and contrasted various review methods (e.g. Barnett-Page &

Thomas, 2009; Gough et al., 2012; Grant & Booth, 2009; Sandelowski, Voils, Leeman, & Crandell, 2012). Many of these methods are still relatively new and although all aim for a systematic and rigorous process, some methods are not well described and others have been applied inconsistently. Therefore, a key challenge when conducting a qualitative systematic review is how to choose and apply systematic review methods.

A configurative and inductive approach informed by methods of thematic synthesis (Thomas & Harden, 2008) guided the exploratory systematic review of qualitative evidence presented in Chapter Two. Gough et al. (2012) describe two broad approaches to systematic reviews – configurative and aggregative – these reviews differ on various dimensions. Gough et al. (2012) reasoned that configurative reviews can be exploratory where a basic methodology is predetermined but may evolve iteratively throughout the research process. Sampling and study selection may be purposive or theoretical, and studies may or may not be excluded based on quality, but rather on relevance. While the overall aim of “aggregative research tends to be about seeking evidence to inform decisions, [configurative research, seeks] concepts to provide enlightenment through new ways of understanding” (Gough et al., 2012, p. 3). I chose a configurative approach because the goal of ‘new ways of understanding’ is consistent with the specific aims of the proposed research project – namely, to explore how existing literature contributes to understandings of the health and wellbeing of Indigenous women living in Canada who have experienced violence. Methods for this systematic review were chosen based not only on the specific aims and review question, but also on the availability of existing literature with which to answer the review question (Sandelowski et al., 2012). Preliminary literature searches found extant literature in the target area that is diverse and lacks the homogeneity necessary to complete an aggregative review (the logics of aggregation require more homogeneity of studies from which to pool findings) (Gough et al., 2012).

Sandelowski et al. (2012) suggest the main distinction between review types is the degree to which the logics of aggregation or configuration are used in data analysis and

synthesis of findings. Further, they suggest that aggregation and configuration may be used in the same review with aggregation preceding configuration but not vice versa (Sandelowski et al. 2012). Thematic analysis and content analysis are the predominate methods of qualitative data analysis and they reflect logics of configuration and aggregation respectively. Thematic synthesis, the method chosen for this review, uses thematic analysis to guide data analysis and produce a configurative style synthesis (Thomas & Harden, 2008) The process of aggregation involves merging and averaging similar findings resulting in a pooled summary of findings, while configuration “links and meshes” to arrange diverse findings into a “coherent theoretical rendering of them” that is further removed from the original studies, but “better captures the ideas of pattern... [yielding a] more-than-the-sum-of-the-parts and novel-whole view” (Sandelowski et al., 2012, p. 326). It was determined by consensus that it would not be possible to use logics of aggregation in data analysis and synthesis in this review because of limitations inherent in existing literature.

Even though considerable variation exists in review methods, all systematic reviews and scoping studies encompass a systematic and rigorous process which generally includes: 1) identifying research aims and question(s), defining the limits of the review and developing a search strategy; 2) searching and retrieving the research reports; 3) determining which studies to include, appraisal of study relevancy and/or quality, detailing the studies and data extraction; 4) mapping the extant literature; 5) data analysis; and 6) synthesizing the findings (Gough et al., 2012; Whitemore & Knafl, 2005). Some reviews may progress through these phases in a linear way as they adhere to a strict protocol, others may progress more iteratively out of necessity or by design (Gough et al., 2012). While Gough et al. (2012) reason that configurative reviews can have a more iterative design; Sandelowski et al. (2012) argue that all review methodologies involve a degree of iteration because “in research synthesis studies, methods must always be accommodated to the actual reports of research under review and to the nature of the findings presented in them” (p. 320). For example, Thomas and Harden (2008) described using thematic

analysis in a review of children's views about healthy eating; they noted because so few studies address their topic directly, they risked having a review with no findings to report. However, by using a more iterative approach with respect to searching and inclusion criteria, as well as an inductive and interpretive (configurative) approach to data analysis, they were able to 'go beyond' the original research findings to generate new interpretations and explanations. Based on initial appraisal the existing body of research for this review appeared to be heterogeneous and sparse. This suggested a concern similar to that identified by Thomas and Harden (2008) of having 'no findings' to review if rigid a priori criteria were imposed. Consequently, inductive and configurative approach was deemed appropriate for this review.

Thesis Layout

To begin this exploration, this chapter described the problems of violence against Indigenous women living in Canada that formed the impetus for this thesis. The description of this problem was followed by the conceptual and contextual background that situates this research problem as an issue among nurses working with Indigenous women living in Canada. The research question, aims and objectives were then presented. The next section provided an examination of the researcher's epistemological stance and theoretical lens that guided the research process. This chapter concluded with a presentation of the overall configurative approach to synthesizing qualitative research that was used in the systematic review and proposed configurative mixed knowledge synthesis.

Chapter Two presents a systematic review of qualitative research conducted with Indigenous women living in Canada. Chapter Three describes a study protocol for a configurative mixed knowledge synthesis based on extant literature and discussions with Inuit community members and Inuit associations located in Ottawa. Finally, Chapter Four provides an integrated discussion and conclusion to this thesis that situates it within the current literature and suggests recommendations for future nursing research, practice and education.

Chapter 2: Systematic Review Manuscript

**Intersections Between Violence and Health Promotion Among
Indigenous Women: A Qualitative Systematic Review**

This chapter is prepared for submission to the Journal of Trauma, Violence and Abuse

Julie Williams, BScN, RN

University of Ottawa, School of Nursing

Wendy Gifford, PhD, RN

University of Ottawa, School of Nursing

Brandi Vanderspank-Wright, PhD, RN, CNCC(C)

University of Ottawa, School of Nursing

J. Craig Phillips, LLM, PhD, RN, APRN, ACRN, FAAN

University of Ottawa, School of Nursing

Abstract

In Canada, like other postcolonial countries (e.g., Australia and the United States), Indigenous women experience a disproportionate burden of intimate partner violence (IPV). Intersections between IPV and other forms of violence such as racism, gender-based discrimination and structural violence, create a dangerous milieu where 'help seeking' may be deterred. Poor health outcomes occur as a result. Nurses have a professional role to promote social justice, as well as engage in culturally safe and trauma and violence informed care to promote health and healing. The aim of this review was to explore the perspectives of First Nations, Métis and Inuit (Indigenous) women living in Canada about how violence influenced their health and wellbeing. This systematic review of qualitative research was based on methods of thematic synthesis (Thomas & Harden, 2008). A comprehensive search of electronic databases (Medline, Proquest Nursing and Allied Health, Proquest Thesis and Dissertations, CINAHL, Scopus, Web of Science, and PsychInfo) was undertaken. Two independent reviewers screened studies for relevance and congruence with eligibility criteria. Thematic analysis was used to analyze the extracted findings, develop descriptive and analytic themes and create a configurative style synthesis. Sixteen studies were included in the review, 15 qualitative and one mixed-methods study. Four themes with subthemes were identified including: 1) ruptured connections between family and home, 2) that emptiness... my spirit being removed, 3) seeking help and feeling unheard, and 4) a core no one can touch. Together these themes form complex pathways that influenced health among women exposed to violence; representative quotes and supporting citations are used to illustrate the synthesized findings.

Keywords: Indigenous women, intimate partner violence (IPV), domestic violence, structural violence, nursing, qualitative research, systematic review, colonization, Canada, cultural humility, trauma and violence informed care.

Violence and Health Promotion Among Indigenous Women: A Systematic Review of Qualitative Research

Violence against women is a global public health concern that causes significant health disparities and social suffering (World Health Organization [WHO], 2010). Violence against women results in both short and long term health problems, such as injuries, mental health problems, sexually transmitted infections (including HIV), and perinatal complications (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Nurses are likely to encounter these women who have experienced violence in a wide variety of health care settings (e.g., emergency departments, mental health settings, primary care clinics, home visits, Feder, Hutson, Ramsay, & Taket, 2006; Trevillion et al., 2014). Nurses are, therefore, well positioned to engage in primary prevention efforts at community and population levels, as well as to provide interventions and support for individual women and families experiencing violence (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011; Jack, Ford-Gilboe, Davidov, & MacMillan, 2017). Yet, evidence suggests nurses do not always have the knowledge, resources, and skill to engage in meaningful and efficacious ways with women who have experienced violence (Alshammari, McGarry, & Higginbottom, 2018; Feder et al., 2006; Hollingsworth & Ford-Gilboe, 2006; Trevillion et al., 2014).

The majority of violence against women is committed by male intimate partners and occurs within the context of family and home. This type of violence, known as intimate partner violence (IPV), is “any behaviour within an intimate relationship that causes physical, sexual or psychological harm” (WHO, 2010, p. 11). Notably, violence disproportionately effects Indigenous women, and they often face greater structural barriers to leaving violent relationships and accessing health and social services that may support healing (Browne, 2007; Browne & Fiske, 2001; Daoud, Smylie, Urquia, Allan, & O'Campo, 2013; Moffitt & Fikowski, 2017; Pedersen, Malcoe, & Pulkingham, 2013). First Nations, Métis and Inuit (Indigenous) women living in Canada experienced increased rates of more severe forms of IPV, including being beaten,

threatened with a weapon and sexual assault, compared to both Indigenous men and the general population of Canadian women (Perreault, 2015; Sinha, 2013). Reported rates of IPV among Indigenous women are estimated to be 2-4 times higher than the general population of women in Canada (Brownridge et al., 2017; Daoud et al., 2013). These elevated rates of violence are consistent with other post-colonial countries such as Australia (Chmielowska & Fuhr, 2017; Willis, 2011). Internationally, increased prevalence and severity of all forms of violence among Indigenous populations are inextricably linked to colonization and oppression – Indigenous culture does not cause violence against women (Chmielowska & Fuhr, 2017; Goulet, Lorenzetti, Walsh, Wells, & Claussen, 2016). Moreover, violence must be situated and understood within the broader problem of colonization that marginalizes Indigenous women through systemic discrimination and structural violence (i.e. violence imbedded in social policy and structural systems that causes avoidable suffering and harm, limits individual and collective agency of people, and constrains access to social determinants of health such as housing, education and income (Farmer, Nizeye, Stulac, & Keshavjee, 2006)).

In Canada, IPV, like other forms of family violence, resides within entire Indigenous communities and can be linked to historical and present day government interventions, such as Indian Residential Schools and the Indian Act (Goulet et al., 2016; Royal Commission on Aboriginal Peoples [RCAP], 1996). Many of these policies were designed to disrupt lifeways, displace Indigenous peoples from their homelands and assimilate them into settler colonial society. Canadian policies forced the removal of young Indigenous children from their homes to attend State and church-run schools, which were often located far from the children's families, they were not allowed to speak their language, and many experienced various forms of abuse (Truth and Reconciliation Commission [TRC], 2015). While colonization is detrimental to all people, gender based discrimination and patriarchal values inherent in Canada's mainstream society intersect with colonization and further marginalize Indigenous women (National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG], 2018).

Violence against Indigenous women is a health issue that influences nursing care and is amenable to nursing interventions (Browne et al., 2016; Varcoe et al., 2017). Unfortunately, some nurses may be unaware (or have misconceptions) of the broader context of Indigenous women's lives and the problem of violence (Browne, 2007; Browne & Fiske, 2001). Advancing nurses' understandings of health disparities related to violence against Indigenous women is imperative and requires exploring the problem in context. Although, IPV has devastating effects on the health and wellbeing of Indigenous women and their communities, nursing research that explores this problem, as well as interventions designed to prevent violence and support Indigenous women and their families, are limited (Andersson & Nahwegahbow, 2010; Browne, McDonald, & Elliott, 2009). Understanding violence from an Indigenous women's perspective is a requisite to properly informing nursing care and health promotion strategies with Indigenous women. Alleviating social suffering and health inequities associated with violence, coupled with perceived lack of understanding among nurses and other service providers, created the impetus for this systematic review. Compared to quantitative research, qualitative research may provide more nuanced and contextualized understandings of Indigenous women's experiences of violence, and the ways in which violence influences their health and wellbeing. Therefore, this review focused on the following broad exploratory question: How does extant qualitative research, conducted in Canada, contribute to understanding the health and wellbeing of First Nations, Métis and Inuit (Indigenous) women who have experienced violence?

Objectives that guided this study were to:

- 1) Describe experiences of violence in the lives of Indigenous women living in Canada;
- 2) Understand ways in which Indigenous women relate experiences of violence to their health and wellbeing;
- 3) Explore how Indigenous women, promote healing and wellbeing after exposure to violence.

This review begins with a brief description of the theoretical lens that influenced the study's overall research design. Post-colonial feminist theory provided a theoretical lens through which intersections between violence and health promotion among Indigenous women were explored. Review methods are based on thematic synthesis, a configurative and inductive approach to qualitative evidence synthesis as articulated by Thomas and Harden (2008). After a brief introduction to thematic synthesis, the search strategy and methods of study selection, data extraction and analysis are described. Finally, the results of the systematic review are presented and followed by a discussion of implications for clinical practices, research, and education in nursing.

Theoretical Lens

Post-colonial feminist theory provided an intersectional lens through which to view the problem of violence experienced by Indigenous women. Post-colonialism is neither historically nor temporally bound and importantly *does not* imply that the process of colonization is over (Anderson & McCann, 2002). When combined with feminism, this lens seeks to expose power inequalities and discrimination resulting from the intersections of gender, race [culture], and social class in a post-colonial context (Anderson & McCann, 2002; Browne, Smye, & Varcoe, 2007). Contextual factors, also known as social determinants of health (SDH), influence the risk of violence and ability to engage in health promoting behaviours (WHO, 2010). Colonization, gender, and socioeconomic position are all important SDH among Indigenous women. Viewed through an intersectional lens, the SDH are not discrete categories, nor are they transferable from one context to another (Hankivsky & Christoffersen, 2008). The SDH are interwoven and indelibly bound to geographical, temporal and cultural contexts. In essence, the SDH are fluid social locations people navigate on a daily basis throughout their lives.

Methodology

A configurative approach informed by methods of thematic synthesis (Thomas & Harden, 2008) guided this exploratory systematic review of qualitative evidence. This process

included defining the limits of the review, developing a search strategy and study selection, detailing the studies, data extraction, and data analysis and synthesis. In the next section we describe the approach and provide rationale for why it was the best fit for this review. Following this, we detail research methods guided by the process outlined by Thomas and Harden (2008) for thematic synthesis – a method based on configurative and thematic analysis. While Thomas and Harden (2008) describe a configurative approach, it is brief and we therefore further drew on Gough, Thomas, and Oliver (2012), Sandelowski and Barroso (2007), and Thorne (2008) for methodological guidance.

Gough et al. (2012) describe two broad approaches to systematic reviews – configurative and aggregative – that differ on various dimensions. Gough et al. (2012) reasoned that configurative reviews can be exploratory where a basic methodology is predetermined but may evolve iteratively throughout the research process. Sampling and study selection may be purposive or theoretical, and studies may or may not be excluded based on quality, but rather on relevance. Thematic synthesis, the method chosen for this review, uses thematic analysis to guide data analysis and produce a configurative style synthesis. Aggregative reviews that seek to pool findings require a more homogenous body of literature than what is currently available in the substantive area; moreover, aggregating findings may decontextualize findings. The use of a configurative approach ensured that review findings remained firmly grounded within the broader problem of colonization in the Canadian context.

Defining limits of the review. Population, concept, and context were used to define inclusion criteria, (see Table 1). The population was Indigenous women, the concept was experiences linked to IPV and health promotion, and the context was Canada. Because, the aim of the review was to focus on perspectives of Indigenous women, studies must have included qualitative interviews or focus groups with Indigenous women to meet inclusion criteria. One of the key decisions was whether to include studies with samples that were not exclusively Indigenous women, these studies were examined on a case-by-case basis to determine

whether it was possible to differentiate and extract findings specific to Indigenous women.

Excluded from the review were survey style studies, quantitative studies and qualitative studies in which Indigenous women's voices were not discernable or with no human subjects, for example, discourse or media analysis.

According to Sandelowski and Barroso (2007), another key decision when setting parameters is whether to include only those studies with research questions that specifically address the concept, in this case, violence and health. Alternatively, the inclusion criteria may be expanded to studies with other research purposes that are likely to contain findings concerning the topic of interest. For example, studies of homelessness, substance use and HIV were likely to contain findings related to violence and were included for title and abstract screening and retained for further review as appropriate. Therefore, the data-set for this review included all qualitative studies conducted with First Nations, Métis or Inuit women living in Canada with findings related to IPV and health.

Table 1. Eligibility Criteria for Studies to be Included in the Review.

Criteria	Inclusion	Exclusion
Study Design	Any research design utilizing qualitative interviews with Indigenous women including mixed methods	Survey style interviews, Quantitative, discourse and media analysis, reviews of all kinds, grey literature, abstracts
Population	Indigenous women	Non Indigenous women
Concept	Intimate partner violence and Health promotion	Violence and trauma more generally such as Indian Residential School experiences.
Context	Canada	Not Canada
Language	English	Any other language
Date Range	No limit	No limit

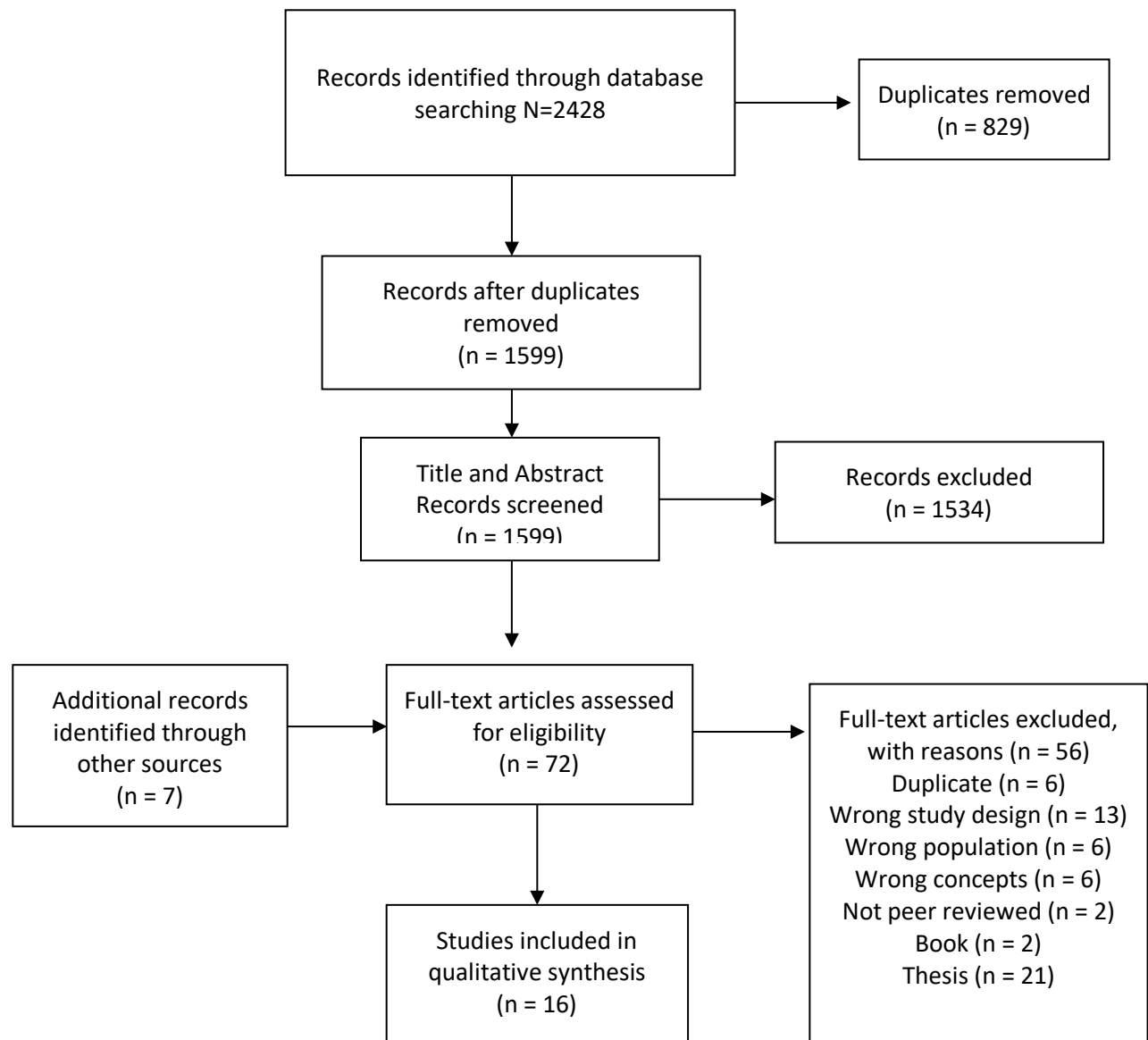
Search strategy and study selection. A search strategy for electronic databases using a combination of keywords and Medical Subject Headings (MeSH) was developed in consultation with a health sciences librarian. Search filters for Indigenous Peoples in Canada were based on those developed by Campbell, Dorgan, and Tjosvold (2016a, 2016b). The search strategy was initially developed for Medline and then adapted for Proquest Nursing and

Allied Health, Proquest Thesis and Dissertations, CINAHL, Scopus, Web of Science, and PsychInfo. These databases were chosen because they were most likely to contain relevant literature. Relevant journals determined to not be well indexed in electronic databases (e.g. Circumpolar Journal of Health, Pimatsawin, Journal of Aboriginal Health) were searched by hand. Citation searches were undertaken through relevant articles and systematic reviews or scoping studies on related topics to identify additional studies. Both academic, peer-reviewed research reports and grey literature such as dissertations, theses, book chapters, and government reports were searched and retrieved. Grey literature were excluded at the full-text screening level, because they did not meet all inclusion criteria as outlined above. The search strategy was purposefully broad to capture all extant literature and ensure an exhaustive search because few studies were located during initial searches. There were no date or language limits imposed on the electronic database searches (searches returned citations in English and French, but only the subset of studies available in English were included in this review). See appendix A for keywords and MeSH headings used for each database, the search dates, and number of citations returned.

Citations and available abstracts from electronic database searching were imported into Covidence, a systematic review software program used to manage the screening process and maintain an audit trail of decisions made during the screening and study selection process. After database searches were imported and duplicates removed, title and abstract screening for relevance was completed by two independent reviewers (JW and JCP). Full text files of relevant studies were then retrieved and imported into Covidence. All potentially relevant research reports from hand searching were also imported in order to be included at the full text screening level of the review. Two independent reviewers (JW and JCP) conducted full-text screening for eligibility and relevance based on the limits of the review. Conflicts at both the title and abstract and full text screening levels were resolved through discussions between the first and second reviewer; the use of a third reviewer to resolve conflicts was not required. The search strategy

located 2437 studies that were imported into Covidence for screening. After duplicates were removed, 1599 studies were considered for title and abstract screening. Seventy-two (72) studies were selected for full text screening and 16 studies were included in the review, 15 qualitative and 1 mixed methods study (See Figure 1).

Figure 1. Search Results



Quality appraisal. Consistent with a configurative approach studies were evaluated on the basis of relevance and contribution to overall synthesis (Gough et al., 2012). This is different from an aggregative approach where studies are excluded on the basis of a pre-determined quality appraisal guide to minimize bias, because the strength of evidence is determined based on a pooled summary of findings (Gough et al., 2012). Evaluating the quality of qualitative research is controversial (Crowe & Sheppard, 2011; Denzin, 2009; Sandelowski & Barroso, 2007; Thomas & Harden, 2008) and research reports that comprised the sample for this review were not formally evaluated or scored for quality for the following reasons. First, the reporting of qualitative research differs considerably based on the journal where it is published. Therefore, the research process and descriptions of findings are not always fully reflected in published reports, which could result in incomplete or biased evaluations (Crowe & Sheppard, 2011). Second, the validity of instruments for evaluating the quality of qualitative research reports are questionable (Crowe & Sheppard, 2011). Further, a checklist and scoring system was unlikely to capture the complexity of research with Indigenous peoples, may privilege western worldviews and could contribute to the colonizing potential of research (Denzin, 2009; Macaulay et al., 2011). Third, issues of quality were more likely to be related to the research topic itself and challenges of conducting research with a population vulnerable by virtue of their social circumstances (Shahram, 2016; Yeager & Bauer-Wu, 2013). Finally, quality appraisal efforts rarely result in qualitative studies being excluded based on quality. Although some reviews suggest using sensitivity analysis (Thomas & Harden, 2008), this process is poorly understood in relation to qualitative research (Crowe & Sheppard, 2011).

Data extraction and analysis. Data analysis and synthesis consisted of two separate parts 1) characterizing the included studies also known as mapping the research field (Gough et al., 2012), and 2) in-depth analysis and synthesis of findings. Data describing the characteristics of studies were extracted and entered into an Excel spreadsheet. Extracted information included: author(s), study date, sample characteristics, topical research area, location of

research, research purpose, methods, ethical considerations and themes as reported by researchers. These data were analyzed using descriptive statistics and numerical summaries to provide a broad look or map of the overall state of knowledge. This map was analyzed using a series of questions for reflection and team discussions (JW and JCP). These questions focused on relevance, ethics, and overall strengths and limitations of the sample of research reports: How does the study contribute to understanding violence from an Indigenous women's perspective? How relevant was this research to the community (e.g., community articulated a need for research, local Indigenous knowledge/values were taken into consideration)? How does the researcher position themselves in relation to the research (e.g., use of reflexivity and cultural humility, Yeager & Bauer-Wu, 2013)? How did researchers apply ethical considerations for research with Indigenous people (e.g. principles of ownership, control, access and possession applied, stakeholder involvement, capacity building, reciprocity)? This reflection and discussion provided a better understanding of how research was conducted and the findings it produced.

During in-depth analysis and synthesis of findings, all of the text in the results and discussion sections of research reports were analyzed; therefore, a predetermined data extraction form for research findings was not required. Specifically, an iterative and inductive process was used. First, the main themes and findings of each report were identified using a process of memoing and coding. The three research objectives (presented earlier) were also used as a lens during initial memoing and coding (i.e. does the text describe an experience of violence, does it link violence and health, and/or relate to healing from the trauma of violence). Studies that were thematically similar were clustered to explore commonalities and consider why similarities and differences were occurring. Initial codes were entered onto an Excel spreadsheet and discussed with the research team (JCP, WG, and BVW). This phase of analysis provided an in-depth understanding of each research report and located patterns related to violence within and across studies. These findings were set aside to allow for new

themes to emerge in the next phase of analysis. In the second phase, a three step process generated new themes that illuminated the perspectives of study participants (Levinsson & Prøitz, 2017; L. Nixon, Gregson, Spedding, & Mearns, 2008). First, all of the participant quotes were located and clustered around the central idea or experience. The second step examined authors' interpretations and descriptions to locate text that expanded on the emerging themes. The third step was to develop a statement that captured the essence of the theme. This phase highlighted women's voices and perspectives. The final phase of analysis was to return to the notes and spreadsheet developed in phase one and compare the new themes to the original findings in the research reports. This was done to further explicate the meaning and potential relationships between themes. Themes were then configured into four main themes with subthemes. This three phase configurative approach ensured findings remained firmly grounded within the context of the original studies. A configurative approach to synthesis requires substantial immersion into the data (i.e. research reports) (Noyes & Lewin, 2011). Thematic synthesis in this review akin to thematic analysis in primary qualitative research (e.g. Thorne, 2008) involved repeated and prolonged periods of reading, rearranging, and searching for patterns and themes, followed by time for reflection. Post-colonial feminist theory provided a lens through which to explore the data. Using this theory located women's individual experiences within the broader Indigenous context of colonization and cultural trauma.

Systematic Review Findings

Study characteristics. This review included 16 studies, 15 qualitative and 1 mixed methods study (see Appendix B for Table 2: Study Characteristics and Table 3: Sample Characteristics). Studies were published between 1995 and 2017 and the majority of studies ($n = 10$) have been published since 2008. The research questions identified in each study were diverse. Notably, the majority ($n = 9$) did not include violence as part of the research question; however, violence was a significant finding in all of the included studies. Seven studies had research questions focused on various types of violence including: childhood sexual abuse ($n =$

2), IPV ($n = 1$) and 'domestic violence' or violence against women more generally ($n = 4$).

Research questions focused on four topical areas and/or the intersections between them and violence, namely, sexual health and/or HIV; substance-use, addictions and mental health; homelessness; and experiences of mothering.

The location (setting) of research/recruitment of research participants took place in (not mutually exclusive): British Columbia ($n = 3$), Alberta ($n = 3$), Saskatchewan ($n = 1$), Manitoba ($n = 3$), an unspecified western Canadian province ($n = 3$), Ontario ($n = 1$), Quebec ($n = 2$), Yukon, NWT, Nunavut ($n = 1$). Studies were equally divided between northern/rural/remote locations ($n = 5$) and urban ($n = 5$) or both ($n = 3$); two studies did not report the specific location of research/recruitment. The total sample of research participants ($N = 372$) included service providers, Indigenous men and Indigenous women. Reported ages for studies' participants ranged from 14-65 years and the reported mean ages ranged from 30-37.8 years. Indigenous women made up approximately 67% of the total sample. Other notable characteristics of the sample were that a large proportion of Indigenous women were mothers, HIV-positive, and/or substance users. This was consistent with research questions and topics being studied. For example, HIV-positive women were part of the inclusion criteria in three studies and there were a total of 52 HIV-positive women (14.6%) in the included studies. This number is likely an under representation because participant quotes in other studies reported HIV-positive status, and one study used convenience sampling of participants already enrolled in the Cedar Project, which is a longitudinal study exploring HIV and Hepatitis C-related vulnerabilities among Indigenous peoples (Shahram et al., 2017).

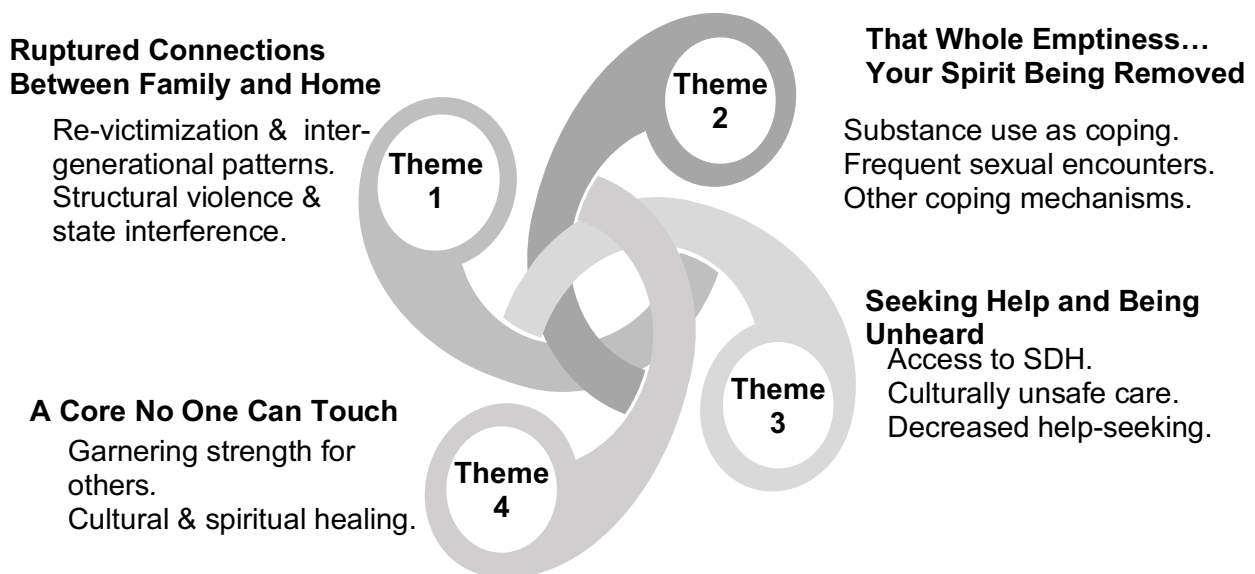
Researchers reported using a variety of qualitative methodologies including: a 'generic qualitative' approach ($n = 5$), ethnography ($n = 3$), phenomenology ($n = 2$), interpretive description ($n = 1$), narrative inquiry ($n = 1$), feminist or intersectional methods ($n = 2$), grounded theory informed by an Indigenous (Cree) methodology ($n = 1$) and mixed methods ($n = 1$). Seven studies ($n = 7$) reported using a postcolonial, feminist or intersectional approaches either

as a stand-alone method or to inform other approaches. Data was collected through individual interviews ($n = 12$), or focus groups ($n = 1$), or a combination of individual and focus group interviews ($n = 3$). Most researchers reported analyzing data through some form of content or thematic analysis, coding process, and group discussions. For the most part, Indigenous women who participated in the interviews, did not participate in group discussions for the purpose of data analysis. McCall, Browne, and Reimer-Kirkham (2009) described that because of women's precarious living situations and changes in health status, it was only possible to reconnect with two participants to discuss findings; however, findings were discussed with additional Indigenous women from outside the study. Some studies engaged Indigenous research assistants in data analysis (Brassard, Montminy, Bergeron, & Sosa-Sanchez, 2015) (Gesink, Whiskeyjack, Suntjens, Mihic, & McGilvery, 2016), consulted with an Indigenous mentor (Shahram et al., 2017) or used member checking (Hagen, Kalishuk, Currie, Solowoniuk, & Nixon, 2013; Herbert & McCannell, 1997; McEvoy & Daniluk, 1995; McKeown, Reid, & Orr, 2004). Varcoe and Dick (2008) described one of the more comprehensive and inclusive approaches to data analysis using a combination of group interviews with women participants and community focus groups to explore emerging themes and develop analytic themes.

Prominent in all of the included studies were vivid descriptions of family violence which illustrated the physical and emotional suffering Indigenous women endured throughout their lives. Past experiences of child abuse and neglect were frequent findings and researchers in all of the included studies noted many of the participants had recently experienced violence in their relationships with intimate partners. Family dysfunction, including alcohol and substance use occurred in the context of poverty, discrimination, colonization, and historical trauma. Violence and poverty were severe and had continuously traumatic impacts among women and their families. Despite the challenges women persevered and actively took steps to resist violence, find safety, and heal from violence, these steps interrupted pathways that led to poor health and demonstrated strength and resiliency among Indigenous women. Four interconnected themes

with subthemes were identified based on findings extracted from the research reports included in this review: 1) ruptured connections between family and home, 2) that emptiness... your spirit being removed, 3) seeking help and being unheard, and 4) a core no one can touch. Together these themes (illustrated in figure 2) form complex pathways that influenced health among women exposed to violence. Themes are described in detail in the following sections; representative quotes and supporting citations are used to illustrate the synthesized findings.

Figure 2. Interconnected themes with subthemes.



Theme 1: Ruptured connections between family and home. Multiple disconnections and experiences of displacement were key findings reported by Indigenous women in eleven of the included studies and these experiences could be linked to colonization and violence (Berman et al., 2009; Brassard et al., 2015; Denison, Varcoe, & Browne, 2014; Gesink et al., 2016; Hagen et al., 2013; McCall et al., 2009; McKeown et al., 2004; Mill, 1997; K. Nixon, Tutty, Downe, Gorkoff, & Ursel, 2002; Schmidt, Hrenchuk, Bopp, & Poole, 2015; Shahram et al., 2017; Varcoe & Dick, 2008). These studies suggest that over time, violence in women's lives caused a rupturing of connections between family and home in a multitude of ways. Women frequently traversed between urban settings and rural communities and this movement was influenced by a number of factors including: seeking shelter and safety from violence, threat of child

apprehension, substance use, accessing health and social services, and connections with family and friends. Patterns of displacement, such as homelessness and State child apprehension, resulted in multiple disconnections from family, community, and culture; emotional trauma; and tenuous sources of social support. Therefore, displacement led to violence and vice versa, in these ways patterns were cyclical in nature.

Re-victimization and intergenerational patterns. Frequent moves, unstable housing and homelessness were patterns of displacement among women that originated in childhood and continued into adulthood. For example, women described experiences of child abuse and neglect perpetrated by both male and female family members and witnessing the abuse of their own mothers; consequently, these women moved numerous times during childhood (Berman et al., 2009; McCall et al., 2009; McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). Some women described moving with their families (typically with their mothers), while other women described being apprehended by the State and placed into foster homes, “I bounced around from group home to foster home my whole life. I was in 20 different foster places and like I think it was like 15 different group homes (Shahram et al., 2017, p. 254). Another woman recalled “mom being taken away in the ambulance... and the [social worker] saying ‘Okay, go pack your suitcase’. And me packing my suitcase. No little toddler should have to do that alone” (Varcoe & Dick, 2008, p. 46). In the study by McKeown et al. (2004), 19 of the 20 participants were placed in foster care as children. Women also described running away from home or foster care during their youth and teenage years because of child abuse and neglect (McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Shahram, 2016; Shahram et al., 2017). A participant in the McKeown et al. (2004) study reflected, “...My mom met a guy... and he was using drugs so she wanted to try it and she got hooked on it... I knew how to shoot them up with needles, like their veins. That’s how the circle starts. I started running away from home” (McKeown et al., 2004, p. 401).

Moreover, ruptured connections across the lifespan created additional vulnerabilities to re-victimization (Berman et al., 2009; Denison et al., 2014; Gesink et al., 2016; Hagen et al., 2013; McCall et al., 2009; McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). Cynthia, a participant in the Berman et al. (2009) study was in protective care as a child because of drugs, violence and poverty at home. She reflected on having attended 8 different elementary schools, moving numerous times between the reserve and city as a teen, and had “just moved into a shelter after leaving” her physically abusive common law partner (Berman et al., 2009, p. 423). In the context of family violence, healthy relationships were not role modeled for children. Furthermore, women had witnessed the abuse of their own mothers when they were children supporting the intergenerational nature of IPV. One woman described the trauma of witnessing this violence as a child “I’d be sleeping and my Mom she’d be screaming her head off because Dad would beat her up and I’d walk into the room and there was blood all over the place and she’s bleeding like a stuffed [sic] pig” (Mill, 1997, p. 475). One woman, who was abused by her spouse, shared that parents should teach their children that “they should be honored and that they deserve to be treated with respect and love [by their intimate partners]... But I wasn’t taught that because the example was... my mom took abuse you know? So for me it was normal” (Jacobs & Gill, 2002, p. 26). Another woman shared the first time her partner “attacked” her “my Dad [was abusive], but I never experienced it in a relationship before so I... got my kids up and ran over to my girlfriends upstairs... I didn’t know how to get out of that situation, I kept going back... it went on for 14 years” (Hagen et al., 2013, p. 362). As adults, women left violent relationships, often a number of times. Because, many women did not leave until physical violence was extreme, they fled their homes with few belongings further contributing to already low socioeconomic position. A woman shared her repeated experiences of trying to escape violent situations, “there’s numerous times when I have to grab my baby and run out with just socks, right in the middle of the winter time” (Schmidt et al., 2015, p. 4).

Limited economic resources and unemployment led to challenges in finding and maintaining stable housing, and women described staying in unsuitable living conditions (Denison et al., 2014; McCall et al., 2009; McKeown et al., 2004; Mill, 1997; Schmidt et al., 2015; Varcoe & Dick, 2008). Canada's cold climate is also a notable concern in this context and some women described being unnecessarily exposed to the elements because of unsuitable shelter (e.g., tents) or lack of transportation (Denison et al., 2014; Schmidt et al., 2015). A woman living in the Yukon in winter described "I actually live in the campground... it's hard to sleep... because it's way too cold" (Schmidt et al., 2015, p. 6). Additionally, 'couch surfing' (i.e. moving from house to house, couch to couch) was not an uncommon finding; some women were expected to perform sexual acts in exchange for a place to stay (K. Nixon et al., 2002; Schmidt et al., 2015).

Structural violence and state interference. For many mothers, custody of their children was threatened by unstable housing, food insecurity and substance use (Denison et al., 2014; McCall et al., 2009; McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Schmidt et al., 2015; Shahram et al., 2017). Child apprehension by the state also occurred frequently. One participant recalled: "We're staying in this room, bedroom, and then we had to put a blanket in the closet and [my daughter] slept on the closet floor. And that really hurts" (Schmidt et al., 2015, p. 6). Women in included studies were clearly distressed by ongoing surveillance by the child protection system and losing custody of children was a traumatic event for them (Denison et al., 2014; Shahram et al., 2017). A participant recalled, "They were filling paper work to get him taken away when I was [24 weeks] pregnant... [my social worker] was saying 'IF we don't take him away'... it was so stressful when I was pregnant like all I did was worry..." (Denison et al., 2014, p. 1111). In the study by Shahram et al. (2017), a mother of six described the importance of maintaining connections with children, "When you don't have that bond, that kid's basically someone else's kid... It's that bond that needs to be built in order for a parent to succeed in mothering and parenting their children. [Let us] parent our children and give us that

chance and not just use everything that we have been through and done against us” (Shahram et al., 2017, p. 255). Fear of losing custody of children notably deterred women from accessing formal support, such as healthcare (Brassard et al., 2015; Denison et al., 2014; Schmidt et al., 2015; Shahram et al., 2017), and sometimes pushed women back to remote communities where services were even more limited, and yet, women still accessed healthcare for their children (Denison et al., 2014).

In addition to continued state child apprehensions, residential school experiences also severed connections among families, community and culture; these severed connections disrupted parenting practices. One participant recalled, “My mother was ripped away from her family. She was lonely and isolated. She turned to alcohol... How are we supposed to parent?” (Varcoe & Dick, 2008, p. 45). Women described emotional trauma and physical abuses they had endured as a direct result of attending residential schools. Looking back on her experiences of residential school a woman recalled “I felt like we were in some kind of prison. I cried when I went to the first day of school and never stopped. We couldn’t even go home. Nobody cared. I used to cry myself to sleep at night; I really missed my home and my parents” (Hagen et al., 2013, p. 361). Some women in the studies were separated from their families as children and forced, by the government, to attend residential schools, other women had parents or grandparents who attended (Gesink et al., 2016; Hagen et al., 2013; McKeown et al., 2004; Schmidt et al., 2015; Shahram, 2016; Shahram et al., 2017; Varcoe & Dick, 2008). Yet, some women still did not know their families’ history in relation to residential schools (Mill, 1997; Shahram et al., 2017). Regarding becoming street involved, one woman highlighted, “I’m a third generation . . . my grandma was down here, my mom is down here and I’m down here . . . Well, I kind of figured it out now because of the residential school right . . . there was no way out of being . . . down here” (Shahram et al., 2017, p. 253).

Ongoing patterns of violence and displacement were linked to historical loss of lands and reserve systems that restricted movement of Indigenous peoples. A woman from a Cree

community in Alberta highlighted “I think a lot... of what is happening in our communities stems from that whole colonial process of not just being locked away... [in a residential school], but in our community, communities were locked away in reserve systems where they had to get permission to [leave]” (Gesink et al., 2016, p. 17). Although, women currently do not require government permission to leave home communities, poverty and lack of transportation left women feeling trapped in violent relationships. Furthermore, current lack of infrastructure (e.g. roads, affordable public transportation and housing) to support freedom of movement is a form of structural violence that continues to segregate and isolate Indigenous peoples. The feeling of being unable to leave a violent relationship was described by a number of women: “You feel totally lost in the middle of nowhere... 'cause you're stuck here, you can't do anything... You tough it out” (Brassard et al., 2015, p. 16); “you can't buy a house somewhere else or you can't leave or function on the income that you have there or function elsewhere, off the reserve. It's very difficult” (Varcoe & Dick, 2008, p. 47). Because of housing shortages and overcrowding in many rural and remote communities, women were either forced to remain living with an abusive partner or leave their home and community (Brassard et al., 2015; Schmidt et al., 2015; Varcoe & Dick, 2008). The frustration of this problem was expressed by one woman, “you're the one who has to leave. If the house belongs to him, you can't say, I'm staying get out” (Brassard et al., 2015, p. 17). Leaving a remote community meant women were disconnected from their family and culture – this took an emotional toll (Berman et al., 2009; Schmidt et al., 2015). A woman from Nunavut described the trauma of leaving her home community, “depressed... sad, lonely, all kinds of emotions attached to that because of your culture shock. And you miss the food, you miss the people you left behind” (Schmidt et al., 2015, p. 5).

Theme 2: That whole emptiness... your spirit being removed. In all of the included studies, women's quotes illustrated the severity of physical violence that spanned years (in some cases generations), and clearly indicated they had sustained physical injuries. Yet despite the severity of the physical violence, it was the emotional trauma that emerged as the more

prominent theme across the studies. In the words of one woman, “It’s like someone could come up to me now and smack me on the side of the head and I’d get a bruise and the bruise would go away. Someone could come up and call me a bitch and that would hurt me more than the slap because that doesn’t go away, it stays inside” (Mill, 1997, p. 476). Emotional suffering was palpable; findings in all of the studies included: feelings of shame, self-blame, grief, loss of identity and negative self-worth among women. *Empty, numb, broken spirited, ashamed, powerless, and abandoned* were words women used to describe emotional pain linked to addictions (Gesink et al., 2016; Hagen et al., 2013; Herbert & McCannell, 1997). A woman reflected on the pain caused by the violence and unresolved grief in her life, “it was like I had this big hole and the wind blowing through there and it was just empty. And the feeling was terrible... the pain and everything was just awful... and the addictions almost took it away” (Hagen et al., 2013, p. 362). Another participant added,

There is such a void, when you come out of that place, there is such a void. There is such a cloud of emptiness and you need to fill it and for me I filled it with food and work. It just never was satisfying because it just kept going. For some women it’s booze, it’s drugs, it’s relationships and sex, other things it’s addictions that drive that whole thing. That whole emptiness ... your spirit being removed. (Gesink et al., 2016, p. 19)

Women described how they felt disconnected from their feelings and weren’t living life, “you’re really put into a victim stance, you’re not really living life, you’re walking around like some sort of zombie” (Jacobs & Gill, 2002, p. 25); “because I wasn’t connected to any of my feelings, you kind of just blindly move on from one thing to another. It took recapturing the moment, the pain and hurt of being violated... [the] humiliation and shame... if you are exposed to violence... you get a core belief there, and it’s hard to get out of it, because it keeps going around and around” (Hagen et al., 2013, p. 365). Women expressed a certain inevitability about their life circumstances reflecting the hopelessness and despair caused by intergenerational violence and historical trauma (McEvoy & Daniluk, 1995; Mill, 1997; Schmidt et al., 2015; Shahram et al.,

2017). One woman was afraid, at 11 years old, of “walking the negative path”; she recalled, “thinking I can’t beat it... until that point a part of me was still trying to fight what seemed like an inevitable path... and I thought, I can’t do it. I can’t fight it... I remember giving up and starting to drink” (McEvoy & Daniluk, 1995, p. 228). Another woman explained “when I first started prostituting, I did it because that was what I had to do. I thought that well, if I’m being sexually abused, I might as well get paid for it” (Mill, 1997, p. 478). Yet, women found the strength to survive; unhealthy behaviors that appeared in this context were coping mechanisms and survival strategies.

Substance use as coping. Given the exposure to and availability of drugs and alcohol, many women turned to substance-use as a means of coping with the continuously traumatic consequences of violent social circumstances and intrusive symptoms of emotional trauma and physical pain (Gesink et al., 2016; Hagen et al., 2013; Jacobs & Gill, 2002; McCall et al., 2009; McEvoy & Daniluk, 1995; McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Shahram, 2016; Varcoe & Dick, 2008). For instance, most women in the included studies were exposed early (i.e. at a young age) to drugs and alcohol; children observed family members using these substances; experienced abuse or neglect by intoxicated family members; or were forced to use drugs and alcohol as part of the abuse (Gesink et al., 2016; Mill, 1997; Shahram et al., 2017; Varcoe & Dick, 2008). One woman reflected on her first exposure to drugs and alcohol “My aunties used to get me stoned from weed when they’d be babysitting me and they’d get me drunk too, to laugh at me when I was, like 6, 7, 8” (Shahram et al., 2017, p. 254). Among adolescents and adults, substance use continued to form part of their ongoing abuse in many of the same ways as when they were children; furthermore, gang rapes occurred at parties involving drugs and alcohol (Gesink et al., 2016), and some women were forced into sexual acts either to pay for their own debts related to substance use, or the debts of their partners (K. Nixon et al., 2002; Varcoe & Dick, 2008). Abusive intimate partners and others (drug dealers and pimps) used drugs to force or coerce women into sex work (K. Nixon et al., 2002). One

woman described how her common law partner sold all of her possessions and then brought home a drug dealer to have sex with her to pay for his own drug debts (Varcoe & Dick, 2008). Substance use contributed to increased risk of acquiring STIs, HIV and hepatitis because of inabilities to negotiate safer sexual practices and unsafe practices related to injection drug use such as needle sharing (McCall et al., 2009; McKeown et al., 2004; Mill, 1997).

Substance use, including drugs and alcohol, was the most common coping mechanism that women connected with violence (Gesink et al., 2016; Hagen et al., 2013; Jacobs & Gill, 2002; McCall et al., 2009; McEvoy & Daniluk, 1995; McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Shahram, 2016; Varcoe & Dick, 2008). Substance use was described both as beneficial (e.g., pain relief, helping to forget past experiences, feeling happy, calm, more social, and/or numb), and negatively contributing to feelings of low self-worth, stigma, shame, and social isolation (Gesink et al., 2016; Hagen et al., 2013; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). After her husband's violent behaviours increased, one woman started to use cocaine, "to numb the pain, to numb the guilt, to numb the failure that I had been feeling... So, [using] was burying it" (Varcoe & Dick, 2008, p. 46). Another woman described how she started drinking after being sexually assaulted in high school, "nobody in my family drank or took drugs... I mean, none of it entered my mind until I had left school due to the reason of being sexually assaulted by the teacher and the other students" (Jacobs & Gill, 2002, p. 27). Typically, substance use was initiated or increased among women after traumatic events such as losing custody of their children, sexual assaults, death of a loved one, increasing violence in relationships, the end of a relationship, and/or loss of housing (Jacobs & Gill, 2002; McCall et al., 2009; Mill, 1997; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). Substance use also led to frequent moves, housing instability, losing custody of children, lost income and employment, and economic dependence on abusive partners (Gesink et al., 2016; Hagen et al., 2013; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). Therefore, substance use formed part of the abuse, was increased or initiated after exposure to

violence and traumatic events but also led to violence and trauma; this demonstrated the complexity of substance use in the lives of women experiencing violence.

Frequent sexual encounters. Frequent sexual encounters related to coping with emotional trauma were reported in seven studies; in those studies, women explained that because of sexual abuse they often associated love with sex, and would therefore seek love and attention in unhealthy sexual relationships (Gesink et al., 2016; Hagen et al., 2013; Herbert & McCannell, 1997; Jacobs & Gill, 2002; McEvoy & Daniluk, 1995; Mill, 1997; K. Nixon et al., 2002). Survivors of childhood sexual abuse in two studies described seeking love and attention “being abused... thinking that I was only lovable when I was sexual. There was self-abuse in that sense... promiscuity and letting people do whatever they want with me... things that I didn’t wanna do” (Jacobs & Gill, 2002, p. 26); “I never looked for it [self-esteem] on the inside, because on the inside I was dead... so there I was seeking that kind of [sexual] attention” (Herbert & McCannell, 1997, p. 64). One woman described sex work as a means of regaining power and control lost because of childhood abuse, “I always thought I had control over the men... [that] I had the power. The more money I made, the more wanted and loved I felt because I always associated love with sex” (K. Nixon et al., 2002, p. 1024). Another woman reflected on her behaviors that may have contributed to her acquiring HIV “I wanted to be close to somebody and so I was fairly promiscuous during those years” (Mill, 1997, p. 478)

In the context of violence and displacement, gender and socioeconomic position further marginalized women. For example, because of structural violence (e.g., lack of income, safe transportation, and adequate housing), women were at risk for sexual exploitation and coercion. Negotiating condom use in this context was challenging and women described being exposed to STI’s and HIV. Without family or other support, some women engaged in survival sex or sex work to provide for themselves and/or their children (McCall et al., 2009; McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Schmidt et al., 2015; Varcoe & Dick, 2008). Engaging in sexual acts in exchange for money, food, shelter, drugs, and alcohol was a survival strategy among

some women; other women were coerced or forced into sex work (McKeown et al., 2004; Mill, 1997; K. Nixon et al., 2002; Shahram et al., 2017) One woman who ran away at the age of 12 explained her entry into sex work, “I was broke all the time, I never had any money for food or cigarettes or anything and it came to a point where I would hitchhike to get drugs and somebody would say I’ll give you so much money if you do this for me, and I did it. I walked away crying the first time... when you’re that young... it’s like they have taken advantage of you... [and] you don’t realize what’s going on at the time” (McKeown et al., 2004, p. 402).

Other coping mechanisms. In addition to substance use and frequent sexual encounters, gambling and suicidal behaviors were other coping strategies found in the studies. Suicidal behaviours and thoughts were findings in five studies in relation to ongoing violence as a means of escaping abuse, and coping with emotional pain of untreated mental health issues and unresolved trauma (Gesink et al., 2016; McEvoy & Daniluk, 1995; McKeown et al., 2004; K. Nixon et al., 2002; Schmidt et al., 2015). A woman described that when she was a child “I tried to commit suicide because I knew it wasn’t right what he was doing. I started running away after I got older... [and] sniffing gasoline because that was the only thing I could do because I was so small” (McKeown et al., 2004, p. 402). Gambling was explored by Hagen et al. (2013) and a participant in their study recalled, “part of my gambling was to annihilate myself. Yeah a big part of my gambling was that hate inside me... I just wanted the pain to be over” (p.362). Women described benefits of gambling such as wins making them feel euphoric and like they were “somebody”, social interaction, and allowing them to escape reality; but, eventually losses and mounting debt led to guilt, increased substance use, and more gambling (Hagen et al., 2013).

Theme 3: Seeking help and being unheard. Women described how they frequently remained silent about violence. When women did seek help their concerns were often unheard and their needs remained unmet. Unmet needs were primarily related to accessing social determinants of health (SDH). In general programs and services intended to support women experiencing violence were difficult to navigate. These ineffective services were described as

having narrow mandates, culturally unsafe, and not based on understandings of poverty and abuse.

Access to SDH. Un-met needs among women were primarily related to accessing SDH including: income, employment, education, safe housing, food security, transportation to attend appointments or seek help outside rural communities, social support, and mental health services. Researchers in the majority of studies described that participants wanted more gender specific, strengths-based, and culturally centered programs (e.g., women's sharing circles, programs with Elders, smudging, land-based programs), parenting support, trauma specific treatment and addiction treatment. The lack of programs that are family centered and take into account the unique needs of mothers was expressed by a woman from the Yukon “I was trying to go into a treatment program and I was basically told that my kids would have to go into child care, which is with Child Welfare” (Schmidt et al., 2015, p. 7). One mother suggested she lacked essential resources, knowledge, and support to parent her children effectively, “I lived [in a shelter] for six months but I still... didn’t get the proper help to be a proper parent... I was still unsure of everything in this world. Then [the social worker] wanted me to leave the father and I was like, what? He’s the only guy I know here in town, I don’t have family...” (Denison et al., 2014, p. 1110). Housing was especially critical among mothers, because safe and stable housing was often a prerequisite to maintaining or regaining custody of their children (Denison et al., 2014; Schmidt et al., 2015; Shahram et al., 2017). One woman described the stress of trying to obtain housing, “I would phone all these numbers, every number in the paper, every day, religiously, looking for a place to rent, and I’d shut right down and cry... I was doing everything I needed to do, but it just wasn’t going anywhere” (Schmidt et al., 2015, p. 6).

Culturally unsafe care. In general, programs and services intended to assist women experiencing violence, poverty, and/or mental health challenges, were often difficult to access and navigate. Policies among various agencies impeded women’s access to supports and many of these policies were inconsistently applied thereby adding to women’s confusion and

frustration (Denison et al., 2014; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). In both rural and urban centers, access to formal support was constrained by limited hours, wait times, high staff turnover and vacancies, location and transportation costs, lack of childcare, violence from intimate partners, and negative attitudes among service providers (Denison et al., 2014; Gesink et al., 2016; McCall et al., 2009; Mill, 1997; K. Nixon et al., 2002; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). Ineffective services were described as having narrow mandates, not based on understandings of abuse and poverty, and were culturally unsafe. One woman described her experience being discharged from hospital,

...one of the nurses came in and said that the doctor is discharging you. I said I'm not even better yet and she said, well it's time for you to go now, you need to get your stuff and you need to go, don't let me call security. And sure enough she called security. Security literally came in, grabbed me behind my arms, dragged me down the hallways and threw me out the door, with pneumonia, in wintertime. And I went back in I said can I at least get a bus pass, a bus ticket? And they said this is not a charity this is a hospital. And right now I'm almost in tears... (Denison et al., 2014, p. 1112)

Another woman described her experience after her daughter was born in hospital,

...[the nurses] didn't even care, they just blurted out right in front of everybody else and right away they threw [in] an AIDS case: "Look at what you did to your kid," you know, "How can you live with yourself, what kind of woman are you to have kids in the first place?" you know, "You shouldn't even have sex." (McCall et al., 2009, p. 1773)

These negative attitudes of service providers deterred women from accessing care and given poor health status among many of the women in the included studies this was detrimental to health and wellbeing. A woman commented on ways that services could be improved in the Yukon suggested "when people don't judge you that goes a long way. Understanding, compassion... it makes people who are looking for help feel comfortable enough that they will go back" (Schmidt et al., 2015, p. 4).

Some formal supports were described as helpful including: drug and alcohol counsellors (Denison et al., 2014; Hagen et al., 2013; Schmidt et al., 2015); specialty HIV clinics (McCall et al., 2009); and police were described as both helpful and unhelpful (Gesink et al., 2016; K. Nixon, Bonnycastle, & Ens, 2017; K. Nixon et al., 2002). For example, some women were successful in obtaining restraining and emergency protection orders that limited their contact with abusive partners, “I got a say about my kid now, ‘you can’t just come grab her, ‘cause this time I’ll phone the cops on you.’ So that’s working well” (K. Nixon et al., 2017, p. 69), while other women described negative responses from police or ended up with criminal charges themselves. One women who called the police to her home explained that, “calling the police wasn’t a good idea. I ended up with a lot of [criminal] charges and [my partner] walked away” (K. Nixon et al., 2017, p. 69). In the study by K. Nixon et al. (2002) some women involved in the sex trade had good relationships with the police while others described negative or violent encounters among police that left them fearful. Further it was reported that Indigenous women were more likely to report negative encounters with police than non-indigenous women (K. Nixon et al., 2002). For example, among women who had been physically assaulted, sexually assaulted, or propositioned by police officers, two thirds of these women were Indigenous (K. Nixon et al., 2002).

Support from formal services was often dependent on positive relationships with individual service providers, but these relationships were difficult to rely on in the context of high staff turnover. Not surprisingly, women infrequently accessed formal supportive services (K. Nixon et al., 2002) especially in rural areas (Brassard et al., 2015; Gesink et al., 2016; McCall et al., 2009; K. Nixon et al., 2002; Schmidt et al., 2015; Varcoe & Dick, 2008). Navigating supports were influenced by challenges related to living in rural and remote areas, for example, in small communities, victim shaming and lack of confidentiality deterred women from accessing available services, and lack of services required women to leave their community to access shelters and other supports (Brassard et al., 2015; McCall et al., 2009; Schmidt et al., 2015;

Varcoe & Dick, 2008). Moving disconnected women from social support, interrupted continuity of care and engaging in certain aspects of health promotion such as being close to their family, land and culture (Berman et al., 2009; Brassard et al., 2015; McCall et al., 2009; Schmidt et al., 2015; Varcoe & Dick, 2008).

Decreased help-seeking. Violence was often hidden, and shrouded in silence, which dislocated women from potential sources of support (Brassard et al., 2015; Gesink et al., 2016; Herbert & McCannell, 1997; McEvoy & Daniluk, 1995; McKeown et al., 2004; K. Nixon et al., 2002; Schmidt et al., 2015; Varcoe & Dick, 2008; Wuest et al., 2007). Family members sometimes blamed woman or responded with disbelief, “my own mother would not support me or listen to me... when I was sexually abused by her immediate family, she said I was lying. She abandoned me” (Schmidt et al., 2015, p. 5). Women’s silence surrounding violence was often linked to shame, feeling blamed for the abuse, physical and emotional isolation, lack of supportive services, concerns regarding breaking up of families and losing custody of their children, fear of reprisals from intimate partners and other family or community members, and protecting family reputations (Brassard et al., 2015; Gesink et al., 2016; Herbert & McCannell, 1997; McEvoy & Daniluk, 1995; Varcoe & Dick, 2008).

A woman described the silence around abuse in small, tight-knit communities, “we should’ve let the girl get beaten. We should’ve let him do it... that’s what my mother-in-law said, and she’s an Elder. I think that for many Elders in the community, to keep their family image from being [a] tiny bit tarnished, it has to stay taboo. You can’t talk about it” (Brassard et al., 2015, p. 15). A survivor of sexual abuse explained the rational for her own silence, “the shame has probably been the biggest obstacle for me that keeps me hidden inside myself and never saying anything about it” (McEvoy & Daniluk, 1995, p. 225). Another survivor described the pressure to remain silent, “I was never given the tools to deal with [abuse]... to heal from them... all I was taught in direct and indirect ways was to stuff it and pretend it’s not there, don’t ever talk about it” (Herbert & McCannell, 1997, p. 60). Women described being treated

differently than men and boys in their families and communities, this further emphasized the tacit acceptance of violence against women (Brassard et al., 2015; Gesink et al., 2016; Herbert & McCannell, 1997; McEvoy & Daniluk, 1995; Shahram et al., 2017). A woman reflected on her childhood “My life with [my family was a lot different than my brothers... That’s my grandma’s perspective on things... It’s a woman’s job to cook, clean and kiss your husband’s ass and if you get smacked around it’s your own fault” (Shahram et al., 2017, p. 253).

Feeling ashamed or deserving of abuse could be linked to the broader societal context that devalues Indigenous women on the basis of their gender and cultural identity. The social location and perceptions of Indigenous women were influenced by intersections between gender, culture, poverty and poor health (Brassard et al., 2015; Herbert & McCannell, 1997; McCall et al., 2009; McEvoy & Daniluk, 1995; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008). Women expressed feeling that they were not valued in society, “you feel like a second-class citizen simply because you’re poor... Human worth is not based on how much you make... it’s not a crime to be poor” (Schmidt et al., 2015); “I thought God loved good people and I didn’t fit that category... God loved a white middle-class family of four” (McEvoy & Daniluk, 1995, p. 227). Living with HIV created additional stigma, and one woman described experiences of racism and discrimination, “I get calls, um, people call me a ‘squaw who has AIDS’ and, you know, you probably deserve it because squaws deserved dying, you know, ‘Since we can’t kill you all off, you might as well die off by AIDS” (McCall et al., 2009, p. 1773). Stigma and stereotypes negatively impacted self-identity and self-worth among women. McEvoy & Daniluk highlighted the intersections between cultural and gender-based discrimination:

Mainstream society’s expectation for native people to “walk a negative path” led to the pervasive invalidation of the aboriginal experience: “They [townsfolk] expected you to get drunk and get raped or gangbanged or whatever.” Common negative perceptions and stereotypes of aboriginal women as “dirty drunk Indians... all sluts and bitches who

sleep around with everybody”, left them feeling worthless and undeserving of help.

(McEvoy & Daniluk, 1995, p. 227)

Ineffective services, culturally unsafe care, silence, and the tacit acceptance of violence against Indigenous women decreased help-seeking and may contribute to risk of re-victimization.

Theme 4: A core no one can touch. Capturing the essence of strength and healing amid considerable suffering, one woman described learning to value the power and strength of Indigenous women as an important part of healing. She reflected, “Native women’s experience is very unique... [the things we] have had to endure... Indian women have a core in them no one can touch” (McEvoy & Daniluk, 1995, p. 230). Strength, courage and resilience were interwoven throughout women’s life stories and despite the constraints that violence imposed on their lives. Women described engaging in behaviors that promoted their health and healing. As described above, these behaviours were dependent on previous life experiences and access to resources such as income, safe housing and social support. However, health promotion could best be described, not simply as a set of behaviours or activities women engaged in; but rather, as ways of being and thinking that connected women spiritually, emotionally, and culturally to themselves, their family, community, and the broader Indigenous context within Canada. Most researchers did not examine processes of healing in detail, but aspects of healing were identified across all of the studies including: regaining control over their lives, recognizing strengths, role of mothering, connecting with self and others, the importance of culture and spirituality, developing a sense of self identity and belonging among family and community, engaging in activism, and understanding the broader social context of colonization and violence among Indigenous Peoples.

Garnering strength for others. Physical and emotional pain were apparent in women’s descriptions of violence and their life experiences. Women’s narratives in all of the included studies demonstrated considerable strength in this context. Although control over choices was typically quite constrained by violent oppression and challenging life circumstances, women

maintained a sense of agency and mothers actively took steps to protect their children from violence and abuse (McCall et al., 2009; K. Nixon et al., 2017; K. Nixon et al., 2002; Shahram et al., 2017; Varcoe & Dick, 2008). A mother described how she tried to hide IPV from her children “I didn’t scream, I didn’t cry, I didn’t yell. It didn’t matter how hard he hit me, my children would have never heard me” (K. Nixon et al., 2017, p. 70). The process of regaining control and leaving a violent partner was described by another mother of a young child,

He beat me so bad that my cousins couldn’t pull him off me... I woke up in the morning, my whole left side was black and blue. I couldn’t hardly move my fingers. And I remember just aching and I had to look after my son... I left with my baby [and] just a few clothes. I cleaned up my house [before leaving]. I washed down the walls and I remember looking at the blood splatter and I didn’t want anybody to see it so I washed it all down. (Mill, 1997, p. 480)

Children were a significant motivator for leaving violent relationships, seeking treatment for substance use and an overall desire to create a better life for the future. A mother of grown children expressed “I’m going to get myself healthy. Yeah. And then I might try and find my ... daughter” (Varcoe & Dick, 2008, p. 49). A grandmother described how connections with her family motivated her to stay sober “I’ve got my grandkids to raise and my whole lifestyle’s changed. I don’t drink, anymore. So, that’s it... I’m happy with me for that” (Varcoe & Dick, 2008, p. 49). Children provided hope for the future for one mother,

I want to live like everybody else. I want a life like everybody else. A good life you know. I don’t want to struggle and I don’t want to be put down and I want to be loved and I want a nice home and I want my kids to you know, get the best education possible and I want good for them. I want them to become something...”(Shahram et al., 2017, p. 252)

Even women who did not have custody of their children reported how their children inspired them and gave them strength (McCall et al., 2009; Mill, 1997; Shahram et al., 2017; Varcoe & Dick, 2008).

Throughout their lives women demonstrated courage and engaged in acts of resistance against violence and abuse. This courage may be motivated by connections with others perceived to be more vulnerable than themselves such as younger siblings or their own children. Incidents of child abuse and neglect were common findings in all studies that explored women's life histories; the context of poverty, and parental substance use forced some children to take on a caretaking role and protect younger siblings. A woman reflected on her early childhood experience of abuse, "bottom line was, [for] my parents, their alcohol was more important than their own kids... I remember I even had to go out and steal a can of milk for my baby sister because she didn't have any milk – she was a baby and I was only 5" (Mill, 1997, p. 475). Women often placed the needs and health of others above their own. One woman described the need to protect others began in childhood, "every time we went to my mom's, her boyfriend would touch us... I'd always take my sister's place because I wanted to protect her because she was only three" (Shahram et al., 2017, p. 253). One woman explained how children would help each other to survive, "there was a garbage dump, people were throwing food away and we used to eat from there because they [parents] were always drinking and not buying food... it was always like that" (McKeown et al., 2004, p. 402). Reconnecting and building relationships with estranged family members, especially their parents, was described by some women as an important part of healing. A participant added, "I was [finally] able to talk to my mom, woman to woman, not as her child... and I told her I didn't blame her for what happened in the past" (Mill, 1997).

Cultural and spiritual healing. Women were at various stages in relation to their healing from cultural trauma; these stages ranged from recognizing the importance of culture and spirituality, developing a sense of identity and belonging to engaging in activism. Some women felt conflicted about their culture and this was perceived to be related to internalizing negative stereotypes and their experiences of abuse (Herbert & McCannell, 1997; McEvoy & Daniluk, 1995). A woman who had been gang raped in early adolescence explained, "Indian

men have something that hits raging chords in me. I have a very bad image of Indian men... tied up with my image of offenders" (McEvoy & Daniluk, 1995, p. 228). Another woman added "He [an Indigenous leader] talked about maintenance of the culture and I was thinking why would we want to maintain anything that horrendous?" (McEvoy & Daniluk, 1995, p. 228). The impact of colonization was explored by another woman "I believe in the 'spirit' of our ceremonial practices. They are perceived as male dominated and oppressive toward women... We have a history that reminds us every day of the results of patriarchal influence within our communities" (Herbert & McCannell, 1997, p. 65). Healing groups that included both men and women were triggering among some women who had experienced abuse by male family and community members. Women wanted gender specific healing groups with female Elders and spiritual leaders. Understanding the broader social context of colonization and violence among Indigenous Peoples was also an important aspect of healing. A woman who had survived childhood sexual abuse explained,

I came to understand it wasn't because of me that all these things happened, it was because this had happened to my aunt and uncle and grandfather and great-grandfather... all the way back... it was being collected from the point of European contact and being spilled out on the youngest generation each time. (McEvoy & Daniluk, 1995, p. 229)

Developing a sense of belonging and positive cultural identity within their family and community also contributed to healing. "Describing the role that powwows and her son's traditional dancing had played in her healing, Strong Native Woman said, 'I feel very strong and beautiful. I have a lot of pride now'" (Varcoe & Dick, 2008, p. 49). One woman suggested, "[I] wouldn't have got in touch with what I did had it not been for the other native women. There was no searching, no scrambling. I did not have to seek out to belong" (McEvoy & Daniluk, 1995, p. 230). Another woman added, "I'm proud... I feel I have a vast cultural background... There is so much strength in being a native person and I feel a tremendous spiritual attachment" (McEvoy &

Daniluk, 1995, p. 230). Describing the important role of motherhood in Indigenous culture one woman explained, “I respect myself as the giver of life... this is the highest honor in [our] culture” (Mill, 1997, p. 480). Regarding healing from addictions and trauma one women described spirituality as filling the void and emptiness, “I had to let the creator fill my life with other stuff... It’s filled up with God’s love. So I’ve got this inner peace and it’s almost like serenity” (Hagen et al., 2013, p. 366); another woman described spiritual healing as, “certain connections to your heart, and something much bigger than yourself” (Hagen et al., 2013).

Discussion

This review addresses a gap in the literature by bringing together qualitative research highlighting Indigenous women’s perspectives about the influence of violence on their health and wellbeing. The paucity of studies specifically about IPV necessitated broad inclusion criteria and contributed to the heterogeneous sample of studies. It is notable that despite this seemingly disparate body of research, many commonalities emerged. For example, among Indigenous women included in the studies reviewed, violence in many forms were a pervasive and recurrent problem, caused immense suffering, constrained their choices, influenced their health related behaviours and could be linked to deteriorating health status. The types of violence identified were: child abuse and neglect, IPV, systemic racism, residential school violence, and structural violence such as poverty and social exclusion. Importantly, all forms of violence were enmeshed in the everyday life and history of these women. As a result, it was not possible to tease out specific consequences of any one type of violence. In this regard, an intersectional lens (i.e. post-colonial feminist theory) was an effective approach because it positioned interpersonal violence within the context of structural and systemic violence. This lens highlighted ways in which various forms of violence intersected and amplified challenges women experienced. Moreover, all forms of violence that women experienced could be directly linked to historic and ongoing colonization in Canada. In the included studies, researchers that identified a post-colonial feminist lens made the relationship between colonization and health inequities explicit in

their discussion of findings (e.g. Denison et al., 2014; Varcoe & Dick, 2008). Ideally, a post-colonial feminist lens will increase awareness of problems of colonization and readers may be more likely to attribute unhealthy behaviours to the context that produces them. By using, this lens, we provided a more nuanced and contextualized understanding of complex relationships between violence and health as experienced by Indigenous women.

Implications for nursing practice. Nurses have a significant role to play in supporting Indigenous women who have experienced violence. Important areas for nurses to focus on may include community outreach and system navigation, home visitation and parenting support, mental health and addictions counseling, public health and harm reduction approaches such as safe injection sites, needle exchanges, and sexual health counseling and screening programs. However, none of these supports will be effective if women do not access them. This review found that negative attitudes among health care providers deterred access to care, and these findings are consistent with a number of other studies with Indigenous women (Benoit, Carroll, & Chaudhry, 2003; Browne, 2007; Browne & Fiske, 2001; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008). Nurses must develop a greater understanding of all forms of violence, work to redress power imbalances in healthcare, and engage in reflective practices that promote empathy and compassion. This includes incorporating principles of trauma and violence informed care into existing programs and nursing practices.

The move from trauma informed care, toward trauma and violence informed care is important because it reflects shifting the emphasis to violent social circumstances and resists locating the problem of trauma within the psyches of individuals. Another important shift in nursing is the move from more essentialist understandings of culture towards reflecting on personal biases and oppressive social structures. Tervalon and Murray-Garcia (1998) proposed the concept of cultural humility as an alternative to cultural competency. They suggested 'cultural competency' was problematic because it implies a:

detached mastery of... a finite body of knowledge... [whereas] humility incorporates a lifelong commitment to self-evaluation and ... to redressing power imbalances ...

developing mutually beneficial and non-paternalistic clinical, and advocacy partnerships with communities on behalf of individuals and defined populations. (Tervalon & Murray-Garcia, 1998, p. 117)

Nurses who engage in cultural humility may promote the development of therapeutic and research relationships built on trust and understanding. The empathy and compassion within these relationships may improve help seeking among Indigenous women experiencing violence. Therapeutic alliances built on a foundation of cultural humility hold promise for improving the health and wellbeing of Indigenous women and their communities.

Implications for future research. Limitations of this systematic review include limitations of the extant research upon which the review findings are based. For example, substance use and HIV positive status were inclusion criteria for a number of the studies (Herbert & McCannell, 1997; Jacobs & Gill, 2002; McCall et al., 2009; McKeown et al., 2004; Mill, 1997; Shahram et al., 2017) and this limits the transferability of findings among women whose experiences of violence did not result in or from these health outcomes. Many of the reports did not distinguish between First Nations, Inuit and Métis women and clustered these groups together as one group. However, research locations and reference to home communities as 'reserves' suggest that many of these women were First Nations (Inuit and Métis people do not have reserve systems). Because, historical relocations and current geographical characteristics of Indigenous communities may influence ongoing experiences of violence, displacement, and health this is an important area for future exploration. For example, Inuit women most of whom must leave their home communities via plane, likely have a different experience of leaving a violent relationship and accessing services than First Nations women living near cities in southern Canada. Similarities do exist in experiences of systemic discrimination and colonization among these three groups, but it should not be assumed that the

review findings are in any way transferable to all Indigenous women. Furthermore, First Nations, Inuit, and Métis people have their own unique cultures and lifeways which should guide development of strengths based and culturally meaningful services.

Other limitations of this review are related to challenges with searching and retrieving research reports. Because not all research that included Indigenous women in their sample were indexed in databases, some studies may not have been retrieved. The same is true for studies with findings related to violence. If violence did not form part of the research question they may have been less likely to be retrieved with the search strategies used in this review. Systematic reviews also have certain limitations inherent in current methodologies. For example, qualitative research is a configuration or interpretation of raw data and narratives; synthesis of these research reports is a re-configuration of findings and as such are further removed from the original data. Systematic review methods do not include a process of member checking, because it would not be possible to contact original participants included in the reviewed studies. Future research should focus on development of review methodologies that include greater participation of the target population in evaluating both the studies included in the review and the synthesis of findings. This is especially important with studies of Indigenous Peoples, so that researchers do not inadvertently contribute to the colonizing potential of research – thereby causing more harm.

The state of knowledge in the area of health among Indigenous women experiencing violence suggests a need for more research. Although, few studies addressed the topic of violence directly, there were numerous descriptions of women's experiences of violence and the negative influence it had on their health and wellbeing. Lacking was a fulsome exploration of health promotion and healing among Indigenous women and this should be an area for future research. A greater understanding of health promotion and healing would be useful to guide the development of strengths based interventions that must be developed in collaboration with Indigenous women and their communities. Community-based research is an important part of

Indigenous methodologies; however, there is a risk when researching violence that women's voices may remain on the margins. Some studies successfully used feminist methodologies to bring Indigenous women's voices front and center while still incorporating a community-based approach that was inclusive of service providers and other community members. Another strength of existing research was the focus on structural and systemic issues which deterred access to care. Many women shared their stories in hopes of influencing policy and practice, and it is the intention of this review to re-highlight their stories and concerns to remind policy makers and practitioners that these issues are still ongoing.

Conclusion

In summary, women in all of the included studies, described multiple experiences of violence. While their quotes were illustrative of pain and suffering, they were also fulsome with strength and courage. Cyclical patterns of displacement and disconnection from family and home could be linked to violence, poverty, and colonization. Leaving violent relationships meant many women had to leave their homes and families, which further disconnected women from potential sources of support. In this context, women were focused on survival through, navigating violent situations, supporting themselves and their children, and coping with physical and emotional pain. When women did seek help, their concerns were often unheard and their needs remained unmet. This highlights the importance of working with women to improve programs and services and change policies that impede their access to more effective outcomes from the social determinants of health. Greater gains in health are likely to be made by action at the structural level (e.g., housing, income, access to safe and affordable childcare); because, action at this level is more likely to prevent violence, support healthy parenting and allow mothers to retain guardianship for their children. Cultural humility is an important strategy for individual service providers to incorporate into their praxis. Nurses who demonstrate compassion and understanding of women's social circumstances will likely help build trusting relationships and improve help seeking among women exposed to violence. The strength and

resiliency of Indigenous women suggest they can and do heal from violence even though their social circumstances may not be conducive to health. Working with Indigenous women and their communities to build effective interventions and promote culturally meaningful care will be important directions for researchers and policy makers into the future.

References

- Alshammari, K., McGarry, J., & Higginbottom, G. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open*, 5, 237-253. doi:10.1002/nop2.133
- Anderson, J., & McCann, E. (2002). Toward a post-colonial feminist methodology in nursing research: exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher*, 9(3), 7-27. doi:10.7748/nr2002.04.9.3.7.c6186
- Andersson, N., & Nahwegahbow, A. (2010). Family violence and the need for prevention research in First Nations, Inuit, and Métis communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(2), 9-33.
- Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's downtown eastside. *Social Science & Medicine*, 56(4), 821-833.
- Berman, H., Mulcahy, G. A., Forchuk, C., Edmunds, K. A., Haldenby, A., & Lopez, R. (2009). Uprooted and displaced: a critical narrative study of homeless, aboriginal, and newcomer girls in Canada. *Issues in Mental Health Nursing*, 30(7), 418-430. doi:10.1080/01612840802624475
- Brassard, R., Montminy, L., Bergeron, A.-S., & Sosa-Sanchez, I. (2015). Application of intersectional analysis to data on domestic violence against Aboriginal women living in remote communities in the province of Quebec. *Aboriginal Policy Studies*, 4(1), 3-23. doi:10.5663/aps.v4i1.20894
- Browne, A. (2007). Clinical encounters between nurses and First Nations women in a western Canadian hospital. *Social Science & Medicine*, 64(10), 2165-2176.
- Browne, A., & Fiske, J.-A. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126-147.
- Browne, A., McDonald, H., & Elliott, D. (2009). *First Nations urban Aboriginal health research discussion paper: a report of the First Nations center, National Aboriginal Health*

- Organization*. Retrieved from National Aboriginal Health Organization, Ottawa, ON:
www.naho.ca/documents/fnc/englishUrbanFirstNationsHealthResearchDiscussionPaper.pdf
- Browne, A., Smye, V., & Varcoe, C. (2007). Postcolonial-feminist theoretical perspectives and women's health. In O. Hankivsky, C. Varcoe, & M. Morrow (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 124-142). Toronto, Canada: University of Toronto Press.
- Browne, A., Varcoe, C., Lavoie, J., Smye, V., Wong, S., Krause, M., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research*, 16(1), 544.
- Brownridge, D., Taillieu, T., Afifi, T., Chan, K., Emery, C., Lavoie, J., & Elgar, F. (2017). Child maltreatment and intimate partner violence among Indigenous and Non-Indigenous Canadians. *Journal of Family Violence*, 32(6), 607-619. doi:10.1007/s10896-016-9880-5
- Campbell, S., Dorgan, M., & Tjosvold, L. (2016a, March 15, 2016). Filter to Retrieve Studies Related to Indigenous People of Canada the EBSCO CINAHL Database. Retrieved from http://guides.library.ualberta.ca/ld.php?content_id=14026803
- Campbell, S., Dorgan, M., & Tjosvold, L. (2016b, March 8, 2016). Filter to Retrieve Studies Related to Indigenous People of Canada the OVID Medline Database. Retrieved from http://guides.library.ualberta.ca/ld.php?content_id=14026803
- Chmielowska, M., & Fuhr, D. C. (2017). Intimate partner violence and mental ill health among global populations of Indigenous women: a systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 52(6), 689-704.
- Crowe, M., & Sheppard, L. (2011). A review of critical appraisal tools show they lack rigor: alternative tool structure is proposed. *Journal of Clinical Epidemiology*, 64(1), 79-89.
- Daoud, N., Smylie, J., Urquia, M., Allan, B., & O'Campo, P. (2013). The contribution of socio-economic position to the excesses of violence and intimate partner violence among

- aboriginal versus non-Aboriginal women in Canada. *Canadian Journal of Public Health*. *Revue Canadienne de Sante Publique*, 104(4), e278-283.
- Denison, J., Varcoe, C., & Browne, A. (2014). Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. *Journal of Advanced Nursing*, 70(5), 1105-1116. doi:10.1111/jan.12271
- Denzin, N. K. (2009). The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative research*, 9(2), 139-160.
- Farmer, P., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PloS Med*, 3(10), e449. doi:10.1371/journal.pmed.0030449
- Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of internal medicine*, 166(1), 22-37.
- Ford-Gilboe, M., Merritt-Gray, M., Varcoe, C., & Wuest, J. (2011). A theory-based primary health care intervention for women who have left abusive partners. *Advances in Nursing Science*, 34(3), 198-214. doi:10.1097/ANS.0b013e3182228cdc
- García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Retrieved from World Health Organization, Geneva, Switzerland
www.who.int/reproductivehealth/publications/violence/24159358X/en/
- Gesink, D., Whiskeyjack, L., Suntjens, T., Mihic, A., & McGilvery, P. (2016). Abuse of power in relationships and sexual health. *Child Abuse & Neglect*, 58, 12-23.
doi:10.1016/j.chiabu.2016.06.005
- Gough, D., Thomas, J., & Oliver, S. (2012). Clarifying differences between review designs and methods. *Systematic reviews*, 1(1), 28.

- Goulet, S., Lorenzetti, L., Walsh, C. A., Wells, L., & Claussen, C. (2016). Understanding the environment: domestic violence and prevention in urban Aboriginal communities. *First Peoples Child & Family Review*, 11(1), 9-23.
- Hagen, B., Kalishuk, R. G., Currie, C., Solowoniuk, J., & Nixon, G. (2013). A big hole with the wind blowing through it: Aboriginal women's experiences of trauma and problem gambling. *International Gambling Studies*, 13(3), 356-370.
doi:10.1080/14459795.2013.819934
- Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, 18(3), 271-283.
- Herbert, E., & McCannell, K. (1997). Talking back: six First Nations women's stories of recovery from childhood sexual abuse and addictions. *Canadian Journal of Community Mental Health*, 16(2), 51-68.
- Hollingsworth, E., & Ford-Gilboe, M. (2006). Registered nurses' self-efficacy for assessing and responding to woman abuse in emergency department settings. *Canadian Journal of Nursing Research*, 38(4), 55-77.
- Jack, S. M., Ford-Gilboe, M., Davidov, D., & MacMillan, H. L. (2017). Identification and assessment of intimate partner violence in nurse home visitation. *Journal of Clinical Nursing*, 26(15), 2215-2228. doi:10.1111/jocn.13392
- Jacobs, K., & Gill, K. (2002). Substance abuse in an urban Aboriginal population: social, legal and psychological consequences. *Journal of Ethnicity in Substance Abuse*, 1(1), 7-25.
- Kurtz, D., Nyberg, J., Van Den Tillaart, S., & Mills, B. (2008). Okanagan Urban Aboriginal Health Research Collective: Silencing of voice: an act of structural violence: urban Aboriginal women speak out about their experiences with health care. *Journal of Aboriginal Health*, 4(1), 53-63.
- Levinsson, M., & Prøitz, T. S. (2017). The (Non-)Use of Configurative Reviews in Education,. *Education Inquiry*, 8(3), 209-231. doi:10.1080/20004508.2017.1297004

- Macaulay, A. C., Jagosh, J., Seller, R., Henderson, J., Cargo, M., Greenhalgh, T., . . . Herbert, C. P. (2011). Assessing the benefits of participatory research: a rationale for a realist review. *Global Health Promotion, 18*(2), 45-48.
- McCall, J., Browne, A., & Reimer-Kirkham, S. (2009). Struggling to survive: the difficult reality of Aboriginal women living with HIV/AIDS. *Qualitative Health Research, 19*(12), 1769-1782.
- McEvoy, M., & Daniluk, J. (1995). Wounds to the soul: the experiences of Aboriginal women survivors of sexual abuse. *Canadian Psychology/Psychologie canadienne, 36*(3), 221-235. doi:10.1037/0708-5591.36.3.221
- McKeown, I., Reid, S., & Orr, P. (2004). Experiences of sexual violence and relocation in the lives of HIV infected Canadian women. *International Journal of Circumpolar Health, 63*(2), 399-404.
- Mill, J. (1997). HIV risk behaviors become survival techniques for Aboriginal women. *Western Journal of Nursing Research, 19*(4), 466-489. doi:10.1177/019394599701900404
- Moffitt, P., & Fikowski, H. (2017). *Northwest Territories Research Project Report for Territorial Stakeholders: Rural and Northern Community Response to Intimate Partner Violence*. Yellowknife, NT.: Aurora Research Institute/ Faculties of Nursing and Social Work, Aurora College.
- National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG]. (2018). *Executive summary from the interim report: Our women and girls are sacred*. Retrieved from www.mmiwg-ffada.ca/wp-content/uploads/2018/05/MMIWG-Executive-Summary-ENG.pdf
- Nixon, K., Bonnycastle, C., & Ens, S. (2017). Challenging the notion of failure to protect: exploring the protective strategies of abused mothers living in urban and remote communities and implications for practice. *Child Abuse Review, 26*(1), 63-74. doi:10.1002/car.2417

- Nixon, K., Tutty, L., Downe, P., Gorkoff, K., & Ursel, J. (2002). The everyday occurrence: violence in the lives of girls exploited through prostitution. *Violence Against Women*, 8(9), 1016-1043.
- Nixon, L., Gregson, M., Spedding, T., & Mearns, A. (2008). *Practitioners' experiences of implementing national education policy at the local level. Technical report*. Retrieved from London: EPPI-Centre:
- Noyes, J., & Lewin, S. (2011). Chapter 5: Extracting qualitative evidence. . In J. Noyes, A. Booth, K. Hannes, A. Harden, J. Harris, S. Lewin, & C. Lockwood (Eds.), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Version 1 (updated August 2011). Cochrane Collaboration Qualitative Methods Group. Retrieved from <http://cqrmg.cochrane.org/supplemental-handbook-guidance>.
- Pedersen, J., Malcoe, L., & Pulkingham, J. (2013). Explaining Aboriginal/non-aboriginal inequalities in postseparation violence against Canadian women: application of a structural violence approach. *Violence Against Women*, 19(8), 1034-1058.
doi:10.1177/1077801213499245
- Perreault, S. (2015). *Criminal victimization in Canada, 2014. Juristat*. (85-002). Statistics Canada Catalogue.
- Royal Commission on Aboriginal Peoples (RCAP). (1996). *Royal Commission on Aboriginal Peoples. Bridging the Cultural Divide: A Report on Aboriginal People and Criminal Justice in Canada*. Ottawa, Canada.
- Sandelowski, M., & Barroso, J. (2007). *Handbook for Synthesizing Qualitative Research*. Retrieved from <https://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=423305>.

- Schmidt, R., Hrenchuk, C., Bopp, J., & Poole, N. (2015). Trajectories of women's homelessness in Canada's 3 northern territories. *International Journal of Circumpolar Health*, 74, 29778. doi:10.3402/ijch.v74.29778
- Shahram, S. (2016). The social determinants of substance use for Aboriginal women: a systematic review. *Women & Health*, 56(2), 157-176. doi:10.1080/03630242.2015.1086466
- Shahram, S., Bottorff, J., Kurtz, D., Oelke, N., Thomas, V., & Spittal, P. (2017). Understanding the life histories of pregnant-involved young Aboriginal women with substance use experiences in three Canadian cities. *Qualitative Health Research*, 27(2), 249-259. doi:10.1177/1049732316657812
- Sinha, M. (2013). *Measuring violence against women: Statistical trends*. (0715-271X). Juristat: Canadian Centre for Justice Statistics.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, 9(2), 117-125.
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, 8(1), 45.
- Thorne, S. (2008). *Interpretive Description*. Walnut Creek, CA: Left Coast Press.
- Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S., & Howard, L. M. (2014). Disclosure of domestic violence in mental health settings: a qualitative meta-synthesis. *International Review of Psychiatry*, 26(4), 430-444.
- Truth and Reconciliation Commission (TRC). (2015). Honouring the Truth, Reconciling for the Future Summary of the Final Report of the Truth and Reconciliation Commission of Canada.
- Varcoe, C., Browne, A., Ford-Gilboe, M., Dion Stout, M., McKenzie, H., Price, R., . . . Day, L. (2017). Reclaiming Our Spirits: development and pilot testing of a health promotion

- intervention for Indigenous women who have experienced intimate partner violence. *Research in Nursing & Health*, 40(3), 237-254.
- Varcoe, C., & Dick, S. (2008). The intersecting risks of violence and HIV for rural Aboriginal women in a neo-colonial Canadian context. *Journal of Aboriginal Health*, 4(1), 42-52.
- Willis, M. (2011). Non-disclosure of violence in Australian Indigenous communities. *Trends and issues in crime and criminal justice*, 405(1).
- World Health Organization (WHO). (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Retrieved from World Health Organization, London School of Hygiene and Tropical Medicine. Geneva, Switzerland: www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf
- Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A. J., & Ford-Gilboe, M. (2007). Patterns of medication use among women survivors of intimate partner violence. *Canadian Journal of Public Health*, 98(6), 460-464.
- Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: essential foundation for clinical researchers. *Applied Nursing Research*, 26(4), 251-256.

Appendix A: Search Strategies

Search Strategy (Proquest Nursing and Allied Health Dec 12th Results 134); Proquest Thesis and Dissertations Dec 12th Results 293)

((ab(Athapaskan OR Saukteaux OR Wakashan OR Cree OR Dene OR Inuit OR Inuk OR Inuvialuit* OR Haida OR Ktunaxa OR Tsimshian OR Gitsxan OR "Nisga'a" OR Haisla OR Heiltsuk OR Oweenkeno OR "Kwakwaka'wakw" OR "Nuu chah nulth" OR "Tsilhqot'in" OR Dakelh OR "Wet'suwet'en" OR Sekani OR "Dunne-za" OR Dene OR Tahltan OR Kaska OR Tagish OR Tutchone OR Nuxalk OR Salish OR "Stl'atlimc" OR "Nlaka'pamux" OR Okanagan OR "Sec wepmc" OR Tlingit OR Anishinaabe OR Blackfoot OR Nakoda OR Tasttine OR "Tsuu T'inia" OR "Gwich'in" OR Han OR Tagish OR Tutchone OR Algonquin OR Nipissing OR Ojibwa OR Potawatomi OR Innu OR Maliseet OR "Mi'kmaq" OR Micmac OR "Mic mac" Passamaquoddy OR Haudenosaunee OR Cayuga OR Mohawk OR Oneida OR Onodaga OR Seneca OR Tuscarora OR Wyandot) OR ti(Athapaskan OR Saukteaux OR Wakashan OR Cree OR Dene OR Inuit OR Inuk OR Inuvialuit* OR Haida OR Ktunaxa OR Tsimshian OR Gitsxan OR "Nisga'a" OR Haisla OR Heiltsuk OR Oweenkeno OR "Kwakwaka'wakw" OR "Nuu chah nulth" OR "Tsilhqot'in" OR Dakelh OR "Wet'suwet'en" OR Sekani OR "Dunne-za" OR Dene OR Tahltan OR Kaska OR Tagish OR Tutchone OR Nuxalk OR Salish OR "Stl'atlimc" OR "Nlaka'pamux" OR Okanagan OR "Sec wepmc" OR Tlingit OR Anishinaabe OR Blackfoot OR Nakoda OR Tasttine OR "Tsuu T'inia" OR "Gwich'in" OR Han OR Tagish OR Tutchone OR Algonquin OR Nipissing OR Ojibwa OR Potawatomi OR Innu OR Maliseet OR "Mi'kmaq" OR Micmac OR "Mic mac" Passamaquoddy OR Haudenosaunee OR Cayuga OR Mohawk OR Oneida OR Onodaga OR Seneca OR Tuscarora OR Wyandot)) OR (ab(Aboriginal* OR Indigenous* OR Metis OR "red road" OR "on reserve" OR "off reserve" OR "First Nation" OR "First Nations" OR Amerindian) OR ti(Aboriginal* OR Indigenous* OR Metis OR "red road" OR "on reserve" OR "off reserve" OR "First Nation" OR "First Nations" OR Amerindian)) OR (ab(Native* OR eskimo*) OR ti(Native* OR eskimo*))) AND (ab((Canad* OR "British Columbia" OR "Columbie Britannique" OR Alberta OR Saskatchewan OR Manitoba OR Ontario OR Quebec OR "Nova Scotia" OR "New Brunswick" OR Newfoundland OR Labrador OR "Prince Edward Island" OR Yukon OR NWT OR "Northwest Territories" OR Nunavut OR Nunavik OR Nunatsiavut OR NunatuKavut)) OR ti((Canad* OR "British Columbia" OR "Columbie Britannique" OR Alberta OR Saskatchewan OR Manitoba OR Ontario OR Quebec OR "Nova Scotia" OR "New Brunswick" OR Newfoundland OR Labrador OR "Prince Edward Island" OR Yukon OR NWT OR "Northwest Territories" OR Nunavut OR Nunavik OR Nunatsiavut OR NunatuKavut))) AND (ab(violence OR abus* OR assault* OR IPV OR DV OR battered women OR spousal homicide OR VAW OR sexual coercion) OR ti(violence OR abus* OR assault* OR IPV OR DV OR battered women OR spousal homicide OR VAW OR sexual coercion))

Search Strategy: Web of Science, Dec 12th Results 272

- # [271](#) #1 AND #2 AND #3
 5 **Refined by:** [excluding] **Databases:** (MEDLINE)
 Timespan=All years
 Search language=Auto
- # [761](#) #1 AND #2 AND #3
 4 Timespan=All years
 Search language=Auto
- # [485,439](#) TS=(violence OR abus* OR assault* OR IPV OR DV OR battered women OR
 3 spousal homicide OR VAW OR sexual coercion OR rape)
 Timespan=All years
 Search language=Auto
- # [586,386](#) TS=(Canad* OR "British Columbia" OR "Columbie Britannique" OR Alberta OR
 2 Saskatchewan OR Manitoba OR Ontario OR Quebec OR "Nova Scotia" OR "New
 Brunswick" OR Newfoundland OR Labrador OR "Prince Edward Island" OR
 Yukon OR NWT OR "Northwest Territories" OR Nunavut OR Nunavik OR
 Nunatsiavut OR NunatuKavut)
 Timespan=All years
 Search language=Auto
- # [595,525](#) TS=(Athapaskan OR Saulteaux OR Wakashan OR Cree OR Dene OR Inuit OR
 1 Inuk OR Inuvialuit* OR Haida OR Ktunaxa OR Tsimshian OR Gitsxan OR
 "Nisga'a" OR Haisla OR Heiltsuk OR Oweenkeno OR "Kwakwaka'wakw" OR "Nuu
 chah nulth" OR "Tsilhqot'in" OR Dakelh OR "Wet'suwet'en" OR Sekani OR
 "Dunne-za" OR Dene OR Tahltan OR Kaska OR Tagish OR Tutchone OR Nuxalk
 OR Salish OR "Stl'atlimc" OR "Nlaka'pamux" OR Okanagan OR "Sec wepmc" OR
 Tlingit OR Anishinaabe OR Blackfoot OR Nakoda OR Tasttine OR "Tsuu T'inia"
 OR "Gwich'in" OR Han OR Tagish OR Tutchone OR Algonquin OR Nipissing OR
 Ojibwa OR Potawatomi OR Innu OR Maliseet OR "Mi'kmaq" OR Micmac OR "Mic
 mac" OR Passamaquoddy OR Haudenosaunee OR Cayuga OR Mohawk OR
 Oneida OR Onodaga OR Seneca OR Tuscarora OR Wyandot OR Aboriginal* OR
 Indigenous* OR Metis OR "red road" OR "on reserve" OR "off reserve" OR "First
 Nation" OR "First Nations" OR Amerindian OR Native* OR eskimo*)

Search Strategy (PsychInfo Dec 12th Results 385)

(violence or violent or abus* or assault* or IPV or DV or battered women or spousal homicide or VAW or sexual coercion).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

AND

(exp Indians, North American/ or exp Inuits/ or exp Health Services, Indigenous/ or exp Ethnopharmacology/ or Athapaskan.mp. or Saulteaux.mp. or Wakashan.mp. or Cree.mp. or Dene.mp. or Inuit.mp. or Inuk.mp. or Inuvialuit*.mp. or Haida.mp. or Ktunaxa.mp. or Tsimshian.mp. or Gitsxan.mp. or Nisga'a.mp. or Haisla.mp. or Heiltsuk.mp. or Oweenkeno.mp. or Kwakwaka'wakw.mp. or Nuuchah-nulth.mp. or Tsilhqot'in.mp. or Dakelh.mp. or Wet'suwet'en.mp. or Sekani.mp. or Dunne-za.mp. or Dene.mp. or Tahltan.mp. or Kaska.mp. or Tagish.mp. or Tutchone.mp. or Nuxalk.mp. or Salish.mp. or Stl'atl'imc.mp. or Nlaka'pamux.mp. or Okanagan.mp. or Secwepmíc.mp. or Tlingit.mp. or Anishinaabe.mp. or Blackfoot.mp. or Nakoda.mp. or Tstine.mp. or Tsuu T'ina.mp. or Gwich'in.mp. or Han.mp. or Tagish.mp. or Tutchone.mp. or Algonquin.mp. or Nipissing.mp. or Ojibwa.mp. or Potawatomi.mp. or Innu.mp. or Maliseet.mp. or Mi'kmaq.mp. or Micmac.mp. or Passamaquoddy.mp. or Haudenosaunee.mp. or Cayuga.mp. or Mohawk.mp. or Oneida.mp. or Onodaga.mp. or Seneca.mp. or Tuscarora.mp. or Wyandot.mp. or Aboriginal*.mp. or Indigenous*.mp. or Metis.mp. or red road.mp. or "on reserve".mp. or off-reserve.mp. or First Nation.mp. or First Nations.mp. or Amerindian.mp. or (urban adj3 (Indian* or Native* or Aboriginal*))).mp. or ethnomedicine.mp. or country food*.mp. or residential school*.mp. or ((exp Medicine, Traditional/ or traditional medicine*.mp.) not Chinese.mp.) or exp Shamanism/ or shaman*.mp. or traditional heal*.mp. or traditional food*.mp. or medicine man.mp. or medicine woman.mp. or autochtone*.mp. or (Native* adj1 (man or men or women or woman or boy* or girl* or adolescent* or youth or youths or person* or adult or people* or Indian* or Nation or tribe* or tribal or band or bands))).mp.) and (exp Canada/ or (Canad* or British Columbia or Colombie Britannique or Alberta or Saskatchewan or Manitoba or Ontario or Quebec or Nova Scotia or New Brunswick or Newfoundland or Labrador or Prince Edward Island or Yukon Territory or NWT or Northwest Territories or Nunavut or Nunavik or Nunatsiavut or NunatuKavut))).mp.

Search Strategy Medline Dec 12th Results 334

1 (exp Indians, North American/ or exp Inuits/ or exp Health Services, Indigenous/ or exp Ethnopharmacology/ or Athapaskan.mp. or Saulteaux.mp. or Wakashan.mp. or Cree.mp. or Dene.mp. or Inuit.mp. or Inuk.mp. or Inuvialuit*.mp. or Haida.mp. or Ktunaxa.mp. or Tsimshian.mp. or Gitsxan.mp. or Nisga'a.mp. or Haisla.mp. or Heiltsuk.mp. or Oweenkeno.mp. or Kwakwaka'wakw.mp. or Nuuchah-nulth.mp. or Tsilhqot'in.mp. or Dakelh.mp. or Wet'suwet'en.mp. or Sekani.mp. or Dunne-za.mp. or Dene.mp. or Tahltan.mp. or Kaska.mp. or Tagish.mp. or Tutchone.mp. or Nuxalk.mp. or Salish.mp. or Stl'atl'imc.mp. or Nlaka'pamux.mp. or Okanagan.mp. or Secwepmíc.mp. or Tlingit.mp. or Anishinaabe.mp. or Blackfoot.mp. or Nakoda.mp. or Tstine.mp. or Tsuu T'ina.mp. or Gwich'in.mp. or Han.mp. or Tagish.mp. or Tutchone.mp. or Algonquin.mp. or Nipissing.mp. or Ojibwa.mp. or Potawatomi.mp. or Innu.mp. or Maliseet.mp. or Mi'kmaq.mp. or Micmac.mp. or Passamaquoddy.mp. or Haudenosaunee.mp. or Cayuga.mp. or Mohawk.mp. or Oneida.mp. or Onodaga.mp. or Seneca.mp. or Tuscarora.mp. or Wyandot.mp. or Aboriginal*.mp. or Indigenous*.mp. or Metis.mp. or red road.mp. or "on reserve".mp. or off-reserve.mp. or First Nation.mp. or First Nations.mp. or Amerindian.mp. or (urban adj3 (Indian* or Native* or Aboriginal*)).mp. or ethnomedicine.mp. or country food*.mp. or residential school*.mp. or ((exp Medicine, Traditional/ or traditional medicine*.mp.) not Chinese.mp.) or exp Shamanism/ or shaman*.mp. or traditional heal*.mp. or traditional food*.mp. or medicine man.mp. or medicine woman.mp. or autochtone*.mp. or (Native* adj1 (man or men or women or woman or boy* or girl* or adolescent* or youth or youths or person* or adult or people* or Indian* or Nation or tribe* or tribal or band or bands)).mp.) and (exp Canada/ or (Canad* or British Columbia or Colombie Britannique or Alberta or Saskatchewan or Manitoba or Ontario or Quebec or Nova Scotia or New Brunswick or Newfoundland or Labrador or Prince Edward Island or Yukon Territory or NWT or Northwest Territories or Nunavut or Nunavik or Nunatsiavut or NunatuKavut)).mp.

2 domestic violence/ or spouse abuse/ or intimate partner violence/ or physical abuse/ or rape/

3 violence/

4 (violence or violent or abuse* or assault* or battered women or VAW or sexual coercion* or spousal homicide* or DV or IPV).ti,ab,kw.

5 2 or 3 or 4

6 1 and 5

Search Strategy CINHAI Dec 12th Results 235

(MM "Intimate Partner Violence") OR (MH "Domestic Violence+") OR (MM "Exposure to Violence") OR (MM "Dating Violence") OR (violent or violence or abus* or assault* or IPV or DV or battered women or spousal homicide or VAW or sexual coercion or rape)

AND

(((MH "Eskimos") OR (MH "Native Americans") OR (MH "Indigenous Peoples+") or (MH "Health Services, Indigenous") or (MH "Indigenous Health") or (MH "Ethnopharmacology") or Athapaskan or Saukteaux or Wakashan or Cree or Dene or Inuit or Inuk or Inuvialuit* or Haida or Ktunaxa or Tsimshian or Gitsxan or "Nisga'a" or Haisla or Heiltsuk or Oweenkeno or "Kwakwaka'wakw" or "Nuu chah nulth" or "Tsilhqot'in" or Dakelh or "Wet'suwet'en" or Sekani or "Dunne-za" or Dene or Tahltan or Kaska or Tagish or Tutchone or Nuxalk or Salish or "Stl'atlimc" or "Nlaka'pamux" or Okanagan or "Sec wepmc" or Tlingit or Anishinaabe or Blackfoot or Nakoda or Tasttine or "Tsuu T'inia" or "Gwich'in" or Han or Tagish or Tutchone or Algonquin or Nipissing or Ojibwa or Potawatomi or Innu or Maliseet or "Mi'kmaq" or Micmac or "Mic mac" Passamaquoddy or Haudenosaunee or Cayuga or Mohawk or Oneida or Onodaga or Seneca or Tuscarora or Wyandot or Aboriginal* or Indigenous* or Metis or "red road" or "on reserve" or "off reserve" or "First Nation" or "First Nations" or Amerindian or (urban N3 (Indian* or Native* or Aboriginal*)) or ethnomedicine or "country food*" or "residential school*" or ((MH "Medicine, Traditional") or traditional medicine*) not Chinese) or (MH"Shamanism") or shaman* or "traditional heal*" or "traditional food*" or "medicine man" or "medicine woman" or autochtone* or (Native* N1 (American* or man or men or women or woman or boy* or girl* or adolescent* or youth or youths or person* or adult or people* or Indian* or Nation or tribe* or tribal or band or bands)))) AND ((MH "Canada+") or (Canad* or "British Columbia" or "Columbie Britannique" or Alberta or Saskatchewan or Manitoba or Ontario or Quebec or "Nova Scotia" or "New Brunswick" or Newfoundland or Labrador or "Prince Edward Island" or "Yukon Territory" or NWT or "Northwest Territories" or Nunavut or Nunavik or Nunatsiavut or NunatuKavut))))

Search Strategy Scopus Dec 12 Results 775

(TITLE-ABS-

KEY (athapaskan OR saulsteaux OR wakashan OR cree OR dene OR inuit OR inuk OR inuvialuit* OR haida OR ktunaxa OR tsimshian OR gitsxan OR "Nisga'a" OR haisla OR heiltsuk OR oweenkeno OR "Kwakwaka'wakw" OR "Nuu chah nulth" OR "Tsilhqot'in" OR dakelh OR "Wet'suwet'en" OR sekani OR "Dunne-za" OR dene OR tahltan OR kaska OR tagish OR tutchone OR nuxalk OR salish OR "Stl'atlimc" OR "Nlaka'pamux" OR okanagan OR "Secwepmc" OR tlingit OR anishinaabe OR blackfoot OR nakoda OR tasttine OR "Tsuu T'inia" OR "Gwich'in" OR han OR tagish OR tutchone OR algonquin OR nipissing OR ojibwa OR potawatomi OR innu OR maliseet OR "Mi'kmaq" OR micmac OR "Micmac" OR passamaquoddy OR haudenosaunee OR cayuga OR mohawk OR oneida OR onodaga OR seneca OR tuscarora OR wyandot OR aboriginal* OR indigenous* OR metis OR "red road" OR "on reserve" OR "off reserve" OR "First Nation" OR "First Nations" OR amerindian OR native* OR eskimo*)) AND

(TITLE-ABS-KEY (canad* OR "British Columbia" OR "Columbie Britannique" OR alberta OR saskatchewan OR manitoba OR ontario OR quebec OR "Nova Scotia" OR "New Brunswick" OR newfoundland OR labrador OR "Prince Edward Island" OR yukon OR nwt OR "Northwest

Territories" OR nunavut OR nunavik OR nunatsiavut OR nunatukavut)) AND

(TITLE-ABS-KEY (violence OR abus* OR assault* OR ipv OR dv OR "battered women" OR "spousal homicide" OR vaw OR "sexual coercion" OR rape))

Appendix B: Review Findings (Tables)**Table 2. Sample Characteristics of Included Studies.**

Author	Topical Area	Purpose	Methodology	Ethics	Reported Themes
Berman et al 2009	Displacement and mental health among girls and young women.	To examine how uprooting and displacement have shaped mental health among three groups: (1) newcomers to Canada (immigrant and refugee girls); (2) homeless girls; and (3) Aboriginal girls.	Narrative inquiry, Critical social theory, Intersectionality theory. Data Collection: Open ended interviews with prompts conducted individually and in small groups. Data Analysis: Narrative and content analysis.	Ethical approval obtained from university's REB. Petitioned REB to waive the requirements of parental consent for participants under 18 years with rational provided. Informed consent described. Described community and academic partnerships with agencies that work closely with the young women. Choice of individual or small group interviews.	1) Experiences of Uprooting. 2) Displacement and disconnection in Dangerous Spaces. 3) Tenuous connections amid spaces of hope. 4) Negotiating spaces of belonging.
Brassard et al. 2015	Domestic violence in remote communities	To gain a better understanding of the underlying causes of overrepresentation of Aboriginal women among victims of domestic violence, as well as the overall complexity of this social phenomenon.	"Feminist Intersectionality approach" Data Collection: Focus groups using a semi-structured interview guide. Data Analysis: "Thematic content analysis"	Two Aboriginal research assistants were hired who spoke the community language fluently. Interview topics chosen in response to concerns of Aboriginal partners on the research team. Specific mention of ethical considerations and OCAP principles. No mention of REB approval.	1) Sociohistorical and political context of domestic violence against aboriginal women: domination systems and differentiation processes. 2) Institutionalization of historically constituted intersecting and interacting social domination systems and differentiation processes. 3) Social production of hierarchical relations of

					othering: process of differentiation and DV against Aboriginal women. 4) Interaction and overlapping of systems of domination, differentiation processes, and their class and geographic dimensions. 5) Interaction of geographic and class dimensions, patriarchy, and gendering process in DV experienced by Aboriginal women
Denison et al. 2013	Accessing care when state apprehension of children is being threatened.	To examine the impact of the threat of child removal on Aboriginal women's experiences accessing of healthcare services.	Ethnography and Postcolonial feminist perspectives. Data Collection: Semi-structured interviews and field notes. Secondary analysis of individual interviews with Indigenous women and HCP and primary interviews with Indigenous women and HCP Data analysis: Thematic analysis and Interpretive description.	Ethical approval obtained from university REB and regional health authority of second research site. Confidentiality, informed consent and safety and well-being of participants mentioned as important considerations. Specific steps not described. No other mention of ethical considerations.	1) Sociopolitical and historical context of women's lives. 2) Ongoing disruption of aboriginal families and communities. 3) Structural inequities and the context of poverty. 4) The bureaucratic structures governing the child protection system. 5) Lack of consistency. 6) Power of the welfare system. 7) Aboriginal women's experiences with the child protection system. 8) Early referral process. 9) Healthcare access in context.
Gesink et al. 2016	STI's	To understand the context, issues, and beliefs around high	Modified grounded theory informed by	Research partnership between university of Toronto and Saddle Lake	1) Abuse of power in relationships.

		STI rates from a Cree perspective.	Indigenous (Cree) methodology. Data Collection: Narrative approach using unstructured, open ended interviews. Data Analysis: Inductive thematic analysis.	Cree nations described in detail. OCAP principles described. Ethical review by Blue Quills First Nations College and University. Band council approved and research team comprised of Cree community research partners. Cree protocol for knowledge sharing.	2) Physical, mental, emotional, and spiritual wounds. 3) Disruption to the medicine wheel. 4) Seeking medicine through: a) sex, drugs and alcohol or b) Wahkohtowin, ceremony and tradition.
Hagen et al. 2013	Trauma and problem Gambling	To shed light on the lived experiences of a small sample of Canadian Aboriginal women who were struggling with a history of social trauma and current problem gambling.	Hermeneutic phenomenology Data Collection: Narrative based individual interviews Data Analysis: "Phenomenological data analysis"	Approval from REB not mentioned. Process of obtaining informed consent described. Researchers position themselves as non-Aboriginal researchers and discuss methods in relation to risk of colonizing potential of research.	1) The three tigers: describes social trauma and emotional, physical and sexual abuse both past and present. 2) A big hole with the wind blowing through it, describes their reasons for gambling. 3) I'm somebody today, describes the experience and repercussions of gambling. 4) A letter to John, describes the process of healing and recovering from social trauma and problem gambling.
Herbert et al. 1997	Childhood sexual abuse and addictions	To create a discourse about recovery that embodied and reflected the life experience of six First Nations women	Exploratory, emancipatory, feminist methods Data Collection: Individual open-ended interviews	No mention of REB approval. Or OCAP. Researchers discuss positionality. First author is a 'Shuswap scholar concerned with creating First Nations feminist	1) Alcohol abuse and addictions: parental alcoholism and community alcoholism, understanding their own alcoholism and getting treatment.

		who had experienced childhood sexual abuse and addictions.	Data Analysis: Not described	discourse' and was a member of a First Nations recovery movement from which participants were selected. Second author is third generation European ancestry. Researchers sought feedback on transcribed data and a again after themes were summarized. Power dynamics and privilege discussed.	2) Sexual abuse: incident(s) of and experiencing the sexual abuse, responses of families and communities to the sexual abuse, effects of the sexual abuse. 3) Recovery process: recovery as an individual process, spirituality in recovery, racism. 4) Gender issues: internal perceptions of self as woman, family and community's perception of the role of women.
Jacobs et al. 2002	Substance abuse	To explore the relationship between substance abuse and physical/sexual abuse in a sample of Aboriginal peoples living in an urban community.	Mixed Methods Study Data Collection: Open- ended individual interviews. Used "In-depth ethnographic interviews" Data Analysis: Content Analysis	No mention of ethical considerations except individual informed consent. REB approval not mentioned. No themes of reflexivity, reciprocity or community involvement.	1) Family dysfunction characterized by male dominance and anger mismanagement. 2) Experiencing multiple abuses as children and adults including physical, emotional and sexual assault and this was linked with the consumption of alcohol. 3) Loss of personal identity and loss of control in one's life.
McCall et al. 2009	HIV and accessing healthcare and social services	To examine Aboriginal women's experiences of living with HIV/AIDS by looking at how they experience formal support systems	Interpretive Description and Post-colonial feminist perspectives. Data Collection: Semi-structured	No mention of REB approval but author describes research was Master's thesis. Informed consent and honorarium described. Described involvement of Aboriginal community-based	1) Fear of rejection when seeking services. 2) Finding strength in adversity. 3) Struggles with symptoms. 4) HIV as just one of many competing problems.

		including health care services.	individual interviews. Data Analysis: Interpretive description	consultant. Themes reviewed by consultant, two participants and discussion group that included Aboriginal community workers and service providers.	
McEvoy et al. 1995	Childhood sexual abuse	To examine, in-depth, the lived experiences of child sexual abuse for six adult native women.	Phenomenology Data Collection: Unstructured interviews using the "Adlerian technique" Data Analysis: Colaizzi's (1978) seven step method of phenomenological analysis.	Ethical considerations not discussed.	1) Sense of shame and guilt. 2) Sense of acute vulnerability. 3) Sense of internal fragmentation. 4) Sense of invalidation and cultural shame. 5) Need to make sense of the abuse. 6) Experience of reintegration.
McKeown et al. 2003	Sexual violence and dislocation as risk factors for HIV	To describe the experience of violence, economic hardship and relocation/dislocation as they relate to HIV risk.	"Qualitative Research" Data Collection: in-depth, open-ended, individual interviews. Data Analysis: "coded by three authors"	REB approval from University of Manitoba. Community meeting of 17 organizations that provide HIV/AIDS services in Winnipeg voiced need for research on the determinants of HIV infection among women of all ethnicities. Focus group of HIV positive women suggested investigation of violence and relocation. One woman from this group assisted with study. Aboriginal	(Violence in childhood (sexual abuse, physical & emotional abuse); Violence as adults (sexual, physical and emotional abuse); disclosure of childhood sexual abuse; Run-aways; CFS involvement; correctional institutions and being incarcerated as children; relocation/dislocation; injection drug use; social support networks; other coping mechanisms;

				research assistant conducted recruitment which may have led to sample of women majority being Aboriginal.	
Mill 1997	HIV and "risk behaviours"	To understand the cultural factors that influence HIV transmission in Aboriginal women.	"Qualitative research approach" Data Collection: In-depth individual interviews and field notes. Data Analysis: Qualitative software program (Non-numerical unstructured data indexing, searching and theorizing) was used to identify themes and subthemes.	Not discussed.	1) Formative years: a) Family relationships (turbulent childhoods, frequent moves and unstable family units), b) parental substance abuse, c) physical, emotional and sexual abuse. 2) Survival Strategies: a) running away b) substance abuse in time period prior to HIV infection, c) promiscuity and prostitution, d) relationships with boyfriends and husbands e) Children. 3) Looking back: a) knowledge of sexually transmitted diseases, b) self-esteem.

Nixon et al. 2002	Violence among sex workers.	To describe women's experiences of violence, the associated health problems, the protective strategies they used, and their attempts to leave the streets.	"A mainstream qualitative approach", "draws from a variety of qualitative research techniques" Data Collection: Semi-structured interviews both individual and focus group format. Data Analysis: Independent coding by research team for major themes and group discussion of these themes to reach consensus	Not Discussed	1) Childhood victimization. 2) Violence from pimps and intimate partners. 3) Violence from customers. 4) Violence from police and other professionals. 5) Violence from members of the public. 6) Violence directed at themselves and others. 7) Health-related issues. 8) Protective Strategies 9) Attempts to leave the streets.
Nixon et al. 2015	Mothering and Violence in Urban and Remote communities.	To explore the protective experiences and capacities of Aboriginal and non-Aboriginal abused mothers, including mothers living in geographically remote or isolated regions.	"Generic" approach to exploratory, qualitative research. Data Collection: Semi-Structured individual interviews with Indigenous women. Data analysis: Thematic analysis and "grounded theory techniques."	Approval obtained from university REB, No other ethical considerations discussed.	1) Protecting Children from Immediate Physical Harm. 2) Mitigating the potential emotional harms of exposure to violence. 3) Preventing children from continuing the violence in their own future relationships. 4) Accessing informal supports.

Schmidt et al. 2015	Substance-use and/or mental health concerns and homelessness	To learn about the barriers and supports experienced by homeless women in the North when accessing mental healthcare, shelter, housing and other services.	“Variety of Methods” Data Collection: Semi Structured, individual interviews. Data Analysis: Thematic analysis and “collaborative coding process” with research team.	Approval from the University of British Columbia REB. Research licenses obtained from each of Yukon, NWT, Nunavut. Local research assistants conducted Interviews in English and Inuktitut (in Iqaluit only). Honorarium and transportation and childcare costs covered. Informed consent, confidentiality and safety were considerations discussed.	1) Trajectory of women’s mental health and homelessness. 2) Key issues in their lives. 3) Women’s strengths and goals. 4) Services used. 5) Entry point. 6) Barriers for access. 7) Strengths of services. 8) Limitations of services. 9) Cultural aspect of services. 10) Potential service and policy adjustments. Vicious Cycles model was developed with 4 overarching themes: Unresolved trauma, Poverty and social exclusion, Inability to find and maintain housing, Ineffective services.
Shahram et al. 2017	Substance use and pregnancy	To understand the life experiences of pregnant-involved young Aboriginal women with alcohol and drugs.	Ethnographic and life history methods informed by postcolonial and intersectionality approaches. Data Collection: Semi structured individual interviews. Data Analysis: “inductive and non-linear” process of coding data and	Approval obtained from REB at the University of British Columbia and the Cedar Project partnership Ethics Review committee. Informed consent, safety and confidentiality discussed. Honorarium and childcare expenses reimbursed. Non-Aboriginal researcher. Aboriginal mentor was engaged and guidance	1) Intersectional identities. 2) Life history of trauma (abuse, violence, and neglect, intergenerational trauma, separations and connections). 3) The ever-presence of alcohol and drugs. 4) The highs and lows of pregnancy and mothering (strategies for survival, inner strength, and capacities for love, healing and resilience).

			attempting to locate this in social contexts to conduct a “multilevel intersectional analysis.”	from Aboriginal study coordinators at the Cedar Project.	
Varco & Dick 2008	Risk of violence and HIV for rural women	To identify strategies to minimize the interacting risks of violence and HIV infection among women in rural communities; to improve understanding of the relationship between violence against women and their risk of exposure to HIV, as well as the impact of social and economic factors on risk for HIV for women living in rural communities.	Ethnography Data Collection: Individual and group interviews with women who had experienced IPV. A focus group with community members and service providers. Field notes and textual data such as media articles and policy documents. Data Analysis: Using “principles of ethnographic analysis” group analysis with women and community focus group.	Communities in a rural area initiated the research project. Both (non)Aboriginal invited to participate. Partnership between academic and community researchers. Themes of collaboration, reciprocity and capacity building. No mention of REB approval.	1) Aboriginal women’s lives shaped by colonialism; 2) Multiple experiences of violence created risk for exposure to HIV. 3) Substance use related to violence in complex ways. 4) Violence and substance use created multiple disconnections. 5) Risks in context: a) misconceptions about violence and HIV, b) challenges to social service provision in rural areas, c) inadequate and varied community resources and leadership. 6) Despite the challenges, women persevered.

Table 3. Sample Characteristics of Included Studies.

Author	Study Location (Urban or Northern, Rural Remote NNR)	Total Sample Size(N)	Indigenous women (n, %)	Other Sample Characteristics	Age Range and Mean
Berman et al. 2009	Southwestern Ontario (Urban)	19	Aboriginal (6, 32%)	Homeless, Aboriginal and Newcomer girls to Canada.	14-19 years (mean = NR)
Brassard et al. 2015	4 remote Aboriginal communities in Quebec. (NRR)	40	Aboriginal (17, 43%)	Community members (men and women) either directly or indirectly affected by DV and service providers.	NR
Denison et al. 2013	Northern region and urban center in western Canadian province (Urban and NRR)	24	FN (12, 50%) Status FN (7, 29%) Nonstatus FN (1, 4%) Métis (1, 4%)	Indigenous mothers (n=12) who have experienced threat of child apprehension. Service providers (n=12)	23-49 years (mean = 34)
Gesink et al. 2016	Saddle Lake Cree Nation in Alberta (NRR)	25	NR	Community participants including service providers, "Balance of Men and women" who were comfortable talking about STI's.	18-65 years (mean = NR)
Hagen et al. 2013	Western Canada	7	Aboriginal (7, 100%)	Aboriginal women who have experienced social trauma and problem gambling.	NR
Herbert et al. 1997	NR	6	FN (6, 100%)	5 grew up on reserve, all are sexual abuse survivors in treatment for substance use, all reported "continued victimization" as adults.	25-53 years (mean = NR)
Jacobs et al. 2002	Montreal, Quebec (Urban)	30	Inuit (8, 26.7%) FN (15, 50%)	Mothers (23, 77%) Urban Aboriginal social service providers including health, legal and family services and service users.	(range = NR) mean = 34.4
McCall et al. 2009	Large city in a western Canadian province (Urban)	8	Aboriginal (8, 100%)	Mothers (8, 100%), All HIV+ women, 7/8 women came from rural reserves.	31-47 years (mean = NR)
Mcevoy et al. 1995	Vancouver, British Columbia (Urban)	6	Aboriginal (6, 100%)	Aboriginal women survivors of childhood sexual abuse accessing treatment in Vancouver 5 of the women were born and raised on reserves in Ontario or BC.	29-53 years (mean = NR)

McKeown et al. 2003	Winnipeg, Manitoba (Urban)	20	FN (18, 90%)	at least 18 were mothers All women were HIV+, 18 were born in rural areas	22-48 years (mean = 37)
Mill 1997	Northern Alberta (NRR)	8	Aboriginal (8, 100%)	Mothers (7,89%) All women were HIV+	21- 42 years (mean = 30.4)
Nixon et al. 2002	Alberta, Saskatchewan and Manitoba (Urban)	47	Aboriginal (26, 55.3%)	Women involved in prostitution before the age of 18 years.	18-36 years (mean = NR)
Nixon et al. 2015	Winnipeg and Thompson Manitoba (Urban & NRR)	18	Aboriginal (14, 78%)	Mothers (18, 100%) Sample of abused women, various cultural backgrounds.	21-44 years (mean = 37.8)
Schmidt et al. 2015	Nunavut, NWT, Yukon (NRR)	61	FN (22, 36%) Inuit (20, 33%) white (7, 11%) unspecified (12, 20%)	Mothers (45, 74%) Homeless or marginally housed women accessing mental health services.	19-56 years (mean = 32)
Shahram et al. 2017	BC cedar project sites. (Urban and NRR)	23	Aboriginal (23, 100%)	Mothers (23, 100%) Ever pregnant Aboriginal women.	21-40 years mean = 30
Varcoe & Dick 2008	Rural Community in British Columbia (NRR)	30	FN (11, 37%) Caucasian (11, 37%) mixed ethnicity and Aboriginal (8, 27%)	Study examined risk of HIV transmission. None of the women were HIV+ all experienced some form of violence.	16-58 years mean = NR

Abbreviations FN= First Nations

NR= Not reported

NRR= Northern, rural, remote

Appendix C: Statement of Contributions Form

ÉCOLE DES SCIENCES INFIRMIÈRES
Programmes des études supérieures



SCHOOL OF NURSING
Graduate Programs

STATEMENT OF CONTRIBUTIONS FORM

March 17, 2019

(Date)

To Whom It May Concern:

The present is to confirm that
(Student Name)

Julie Williams

contributed as a whole to the manuscript entitled: Violence and Health
Promotion Among Indigenous Women: A Systematic
Review of Qualitative Research

Dr. J. Craig Phillips
(Name of Supervisor)

in his/her role as supervisor,

and Dr. Brandi Vanderspank-Wright
Dr. Wendy Gifford

(Names of co-authors, if appropriate)

Guided the work and made editorial suggestions for the manuscript

Student Signature

Supervisor Signature

Chapter 3: Study Protocol Manuscript

Violence, Displacement, and Health Promotion among Inuit Women: A Configurative Mixed Knowledge Synthesis Protocol

This chapter is prepared for submission to the International Journal of Indigenous Health

Julie Williams, BScN, RN

University of Ottawa, School of Nursing

Brandi Vanderspank-Wright, PhD, RN, CNCC(C)

University of Ottawa, School of Nursing

Wendy Gifford, PhD, RN

University of Ottawa, School of Nursing

J. Craig Phillips, LLM, PhD, RN, APRN, ACRN, FAAN

University of Ottawa, School of Nursing

Abstract

Violence, trauma and displacement create a vicious cycle that is a root cause of health inequity among women worldwide, and particularly among Inuit women in Canada's territorial north. Currently, there is a paucity of evidence about violence in general to inform both primary prevention and harm reduction strategies – especially among women living outside urban areas. These women often must travel or relocate to urban centers to access services such as shelters and healthcare. The objective of developing this systematic review study protocol is to better understand the influence of violence and displacement on health promotion with Inuit women living in an urban center and to explore how existing literature does or does not contribute to these understandings. These understandings may be used to develop strengths-based, culturally safe, and community-centered interventions with Inuit women. A collaborative approach to systematic review was designed by incorporating existing review methods with an Inuit research framework (Piliriqatigiiniq Partnership Model for Community Health Research). The study protocol for the configurative mixed knowledge synthesis was developed to explore transferability of findings, and collaborate with Inuit to create a more meaningful synthesis of research, and share findings. Focus groups are proposed as integral to the study protocol and are designed to address a gap in the existing research by focusing on health promotion. Collaborating with Inuit women to create a synthesis of findings linked to violence from this diverse literature would be valuable to inform more effective and contextually tailored health promotion strategies with Inuit communities. Conducting this research would also contribute to methodological development because research methods that specifically described collaborative and community-centered approaches to systematic reviews were not located.

Keywords: Indigenous health, Inuit women, displacement, intimate partner violence, health promotion, healing, structural violence, participatory research, systematic reviews, qualitative research

**Violence, Displacement, and Health Promotion among Inuit Women:
A Configurative Mixed Knowledge Synthesis Protocol**

Violence, trauma and displacement create a vicious cycle that is a root cause of health inequity among women worldwide (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005), and particularly in Inuit communities within Canada (Paletta, 2008). Currently, there is a paucity of evidence about violence in general to inform both primary prevention and harm reduction strategies – especially among women living outside urban areas (World Health Organization [WHO], 2010). Many Indigenous communities in northern and rural regions of Canada have limited access to health and social services because of remote location, funding and staff shortages (Levan, 2003). Nurses represent the majority of health care providers in the north and they have few resources, limited professional support to ease the burden, as well as high vacancy rates and staff turnover (Moffitt & Fikowski, 2017; Office of the Auditor General of Canada, 2017). Limited access to culturally safe health and social services may negatively impact outcomes among women experiencing violence. For example, women's homelessness in the Yukon, Northwest Territories (NT) and Nunavut is a hidden problem linked to violence, unresolved trauma, and substance use (Schmidt, Hrenchuk, Bopp, & Poole, 2015).

The displacement of Indigenous women and children related to violence is a national concern in Canada (National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG], 2018). In order access shelters, transitional housing and health care, women must often must leave their home communities, family, and social support networks (Moffitt, Fikowski, Mauricio, & Mackenzie, 2013). As a result, some women either do not leave and/or return to abusive situations (Moffitt & Fikowski, 2017; Moffitt, Fikowski, Mauricio, & Mackenzie, 2013), while other women move to urban centers in southern provinces far from their family, culture and land, which contributes to further loss and traumatization (Pauktuutit Inuit Women of Canada, 2017). Although, rates of violence against Inuit women living in urban centers are not reported; Canadian government reports highlight that the problem of violence against women is

particularly acute in Nunavut. For example, the sexual assault rate among women living in Nunavut is approximately 10 times the national average (Paletta, 2008; Sinha, 2013). A variety of factors may contribute to displacement among Inuit women, including: poverty, violence and gaps in health and social services (Levan, 2003; Pauktuutit Inuit Women of Canada, 2017).

Moreover, among Indigenous Peoples, the problems of violence, displacement, and colonization are inextricably linked and contextually bound (Andersson & Nahwegahbow, 2010; Healey, 2016). Research that takes into consideration the influence of context on Inuit women's experiences of healing from violence are sparse (Healey & Meadows, 2007). Initial literature searches identified few health related studies with Inuit women specifically, and studies with Inuit living outside land-claims areas were virtually non-existent. This severely limits nurses' understandings about how to develop and implement interventions that may support health promotion and healing among Inuit women and their families. More knowledge and understanding is needed to inform nursing practice with Inuit women. Therefore, the purpose of developing this study protocol is to better understand the influence of violence and displacement on health promotion with Inuit women living in an urban center. These understandings may be used to develop strengths-based, culturally safe, and community-centered interventions with Inuit women.

Research Question and Objectives

This study is exploratory in nature because of the limited body of knowledge in the substantive area which is violence and health among Indigenous women. It is also exploratory because the chosen method of systematic review – configurative mixed knowledge synthesis, is still in developmental stages. Therefore, this review will result in two outputs, a synthesis of extant literature and methodological development. The review question which is purposefully broad, is consistent with a configurative mixed knowledge synthesis and exploratory research - how does existing qualitative research contribute to understanding health and healing after experiences of violence among Inuit women living in Canadian urban centers? The review

question will be used to define the topical, methodological, and geographical boundaries of this review but will be refined in collaboration with Inuit community research partners as an important part of the research methodology.

The objectives specific to this configurative mixed knowledge synthesis are to: 1) develop a more contextualized understanding of Inuit women's experiences of health and wellness after exposure to violence, 2) seek the perspectives of an urban Inuit community, and 3) explore how existing literature does or does not contribute to these understandings (i.e. what do community research partners perceive to be strengths and limitations of the literature?) To accomplish these objectives, this review proposes a collaborative approach to interpreting and evaluating research findings for relevancy through knowledge sharing and discussion sessions with Inuit community members and service providers.

Background and Significance

First Nations, Métis and Inuit women and children are particularly vulnerable to ongoing displacement and health risks related to violence and abuse (Brownridge, 2008; Paletta, 2008). Inuit women living in the north suffer the highest rates of violence against women in Canada and most of the perpetrators are intimate partners and family members (Charron, Penney, & Senécal, 2010; Sinha, 2013). Intimate partner violence (IPV) is a complex and often hidden problem. IPV includes violence by both current and former partners and is defined as any "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2010, p. 11). Violence against women has serious short and long term consequences to health including unwanted pregnancy, pregnancy related complications, sexually transmitted infections (STIs), mental health disorders (e.g., depression, post-traumatic stress disorder), physical injuries, and increased rates of smoking, alcohol, and drug use (WHO, 2010). According to the Inuit health survey, Inuit women experience many of these health related concerns (Galloway & Saudny, 2012). Compared to the rest of Canada, Nunavut also

has much higher rates of family violence including IPV and sexual violence that result in poor health and wellbeing (Galloway & Saudny, 2012; Paletta, 2008). These associations between violence and negative health outcomes cannot be ignored. Women living in the Yukon, NT, and Nunavut, experienced both increased incidence and severity of IPV compared to the rest of Canada (Sinha, 2013). The prevalence of IPV in Nunavut is double that of the NT (Sinha, 2013). Women in the territories were more likely to experience injuries and increased prevalence of more severe forms of spousal violence such as being beaten, choked, threatened with a weapon, or sexually assaulted (Charron et al., 2010; Sinha, 2013).

Reported statistics likely underestimate the severity and prevalence of violence (García-Moreno et al., 2005). The way that questions are asked (e.g., choice of words, format of data collection, telephone versus paper survey) and risk of stigma or further violence may deter disclosure. Analysis of population based surveys and police crime statistics have identified risk factors and consequences associated with IPV (WHO, 2010). Similar to the general population, risk factors for Inuit women to experience IPV include: young age, experiencing abuse as a child, being pregnant and leaving/threatening to leave the relationship. In contrast, risk factors for Inuit men to be abusive include: being under 24 years of age, unemployed, have low formal education, drink heavily, and to have been exposed to violence against his mother (Kinnon, 2014). While exact causes of increased IPV for Inuit women are not known, contributing factors may include: discrimination; alcohol and substance abuse (Charron et al., 2010; Kinnon, 2014); intergenerational trauma related to residential schools, family relocations and separations (Brownridge et al., 2017; Healey, 2016); rapid social change in response to more recent contact with settler colonial society; and the impact of the Inuit specific determinants of health including: housing shortages, socioeconomic position, and loss of language and culture (Inuit Tapiriit Kanatami [ITK], 2014). This underscores the need for primary prevention strategies to stop the cycle of violence, and harm reduction strategies to increase the safety of women already experiencing IPV. Although, intersections between gender and living in a remote community are

typically understood as negatively influencing violence against women; gender, culture, and community should not be underestimated as significant sources of strength and resiliency from which to build effective interventions (Andersson, Shea, Amaratunga, McGuire, & Sioui, 2010; Healey, 2013). For example, among some women, motherhood, language and culture were sources of strength and important to a sense of self identity (Healey & Meadows, 2007). A strong desire to protect children and give them more opportunities influenced women's decisions to leave abusive relationships, seek treatment for substance use, and move to urban centers (e.g., Denison, Varcoe, & Browne, 2014; Ford-Gilboe, Wuest, & Merritt-Gray, 2005; Shahram et al., 2017).

Moreover, experiences of violence and other negative health outcomes of colonization are influenced by history and geography. Inuit, in Canada, experienced an intense period of colonization occurring for the most part over a single generation, which resulted in adverse health outcomes among Inuit such as tuberculosis epidemics (Public Health Agency of Canada, 2013). Policies of forced assimilation, relocation and family separation are divided into three main structural interventions or events which occurred simultaneously: relocation to the high Arctic to protect Canadian sovereignty, removal of children to residential schools and other child apprehensions, and forced medical evacuations (Healey, 2016). This cultural trauma resulted in disrupted family attachments and unresolved grief that is linked to health inequities and violence in Nunavut today (Healey, 2016). The population of Inuit women living in urban areas across Canada is growing and little is known about their health and healing practices (Arriagada, 2016). There is a paucity of research on health and healing practices among Inuit woman in general and research that explores intersections between violence and migration to urban centers in particular (Healey & Meadows, 2007). The transferability of research that is conducted outside an Inuit context is limited by the socially constructed nature of health inequities for Inuit women related to violence, gender, and colonization, as well as the geography of their homeland.

Ottawa, Ontario, has the largest population of Inuit living outside land-claims areas followed by Edmonton, Yellowknife, Montreal, and Winnipeg (Arriagada, 2016). It should be noted that these cities are all medical travel destinations, where Inuit are transferred for treatment that is not available in their home communities. Furthermore, given that the majority of Inuit communities in Nunavut and NT are not connected via road and air-travel may be cost prohibitive for women leaving violent homes, it is likely that medical travel played a role in migration. Although all five of these cities have an Inuit boarding home for medical travel, Ottawa also hosts other Inuit specific organizations and services, a factor that may influence migration to the city. As noted in a previously conducted needs assessment of parents of Inuit children living in Ottawa, accessing medical care for children, as well as employment and education opportunities, and housing shortages and food insecurity in the north, influenced migration of Inuit families to Ottawa (Ottawa Inuit Children's Center, n.d). Inuit families living in Ottawa appear to have greater access to Inuit specific services that may also result in experiences different from those families living in other urban centers; therefore, restricting research to Ottawa is a potential limitation of the proposed project. However, given the limited resources available for the proposed project conducting research in Ottawa is also a strength, because there is greater access to agencies with mandates to serve Inuit living across Canada. A larger and better-resourced community may provide more opportunities to connect and engage with Inuit women and service providers.

To date, research has not explored strategies and processes Inuit women engage in to promote their health and healing after leaving a violent relationship and migrating to an urban center. No studies were found that describe how nurses or nurse researchers have formally engaged with Inuit women in health research to address the convergence of violence and relocation among these women. Accordingly, the proposed project aims to ensure an inclusive approach to research by engaging with Inuit women, who are underrepresented in the substantive area. Furthermore, researchers have also begun to question the ethics of

requesting vulnerable persons to participate in “more studies to obtain information we already have” (Sandelowski & Barroso, 2003, p. 783), or information we do not necessarily require. Systematic reviews are therefore an important means of ensuring research is not duplicated or redundant and Indigenous communities should be involved in this process. Even while we argue the urgent need for this research and the benefits of undertaking it, an important question remains – How can nurses create a safe space for research with Inuit women and their community? This question guided the overall development of this research protocol. For example, the theoretical framework (discussed in the following section) is informed by a decolonizing approach which seeks to collaborate with Indigenous communities, promote cultural humility among academic researchers, minimize bias and encourage reflexivity and reciprocity. Ethical considerations discussed at the end of this proposal also informed the research design.

Theoretical Lens and Methodological Rigour

Minimizing the colonizing potential of research. The colonizing potential of research, misappropriation of Inuit knowledge and further marginalization are risks that must be addressed at all stages of this proposed research. These are risks inherent in both the systematic review portion of this project and the knowledge sharing sessions (via focus groups and interviews); however, these risks would likely be higher in a typical systematic review whereby academic researchers critically appraise and synthesize research in isolation from the community. The overarching collaborative and strength-based approach to this research project is intentionally chosen to minimize the potential for further marginalization and colonization. Ownership, Control, Access, and Possession (OCAP) are principles that must be met for research with First Nations Peoples in Canada. The ITK identify national priorities for research with Inuit in Canada; they also emphasize ownership, control and access (possession is not mentioned) and further highlight the importance of capacity building, relationship building, collaboration and consultation (ITK, 2018). The Piliriatigiiniq Partnership Model for Community

Health Research (Healey & Tagak Sr, 2014) aligns research in a way that is congruent with Inuit values and ways of knowing and will be used as an overarching framework to guide the proposed study. The proposed project will also maintain an audit trail, utilize member checking, and employ mindfulness and reflective journaling as tools to promote cultural humility, reduce bias and enhance rigor (Yeager & Bauer-Wu, 2013).

Post-colonial feminist theory. Post-colonial feminist theory informs my perception of the effect violence and displacement may have on health among Indigenous women and is an ideal lens because the problem of violence against Inuit women forms at the intersections between gender-based violence and the problem of colonization and cultural oppression. Post-colonial feminist theory seeks to uncover power inequalities and discrimination resulting from the intersection of gender, culture and social class in a post-colonial context (Anderson & McCann, 2002). The term post-colonial does not refer to a distinct location in time or place, but a fluctuating process characterized by historic and ongoing colonization and decolonization (Browne, Smye, & Varcoe, 2005; 2007). Colonization is an ongoing process that continues to effect Indigenous people through structural violence and racism occurring in multiple settings including healthcare (Anderson & McCann, 2002). Feminist theory contributes to this lens by exploring how gender-based violence intersects with other forms of violence and oppression (Browne et al., 2011).

A Cultural humility approach. A cultural humility approach will be used to promote reflexivity, relationality and reciprocity. The cultural humility approach requires the researcher to reflect on and inventory personal and professional values followed by careful consideration of the participants' perspective, this reflective process is described as "an unpeeling of the layers that make up a person" (Yeager & Bauer-Wu, 2013, p. 253). Reflexivity, relationality and reciprocity may ensure rigor, address possible bias, and equalize power relations between researcher and participants (Vandenberg & Hall, 2011). The Piliriqatigiiniq Partnership Model for Community Health Research address these concepts and further note: researchers must be

prepared to answer questions about their intentions and perspectives because reflexivity is key to building positive, respectful relationships that build on individual and community strength (Healey & Tagak Sr, 2014). Researchers must give attention to and have knowledge of historical and current context of Inuit communities; and collaboration “promotes active engagement, the sharing of knowledge, advocacy and action” (Healey & Tagak Sr, 2014, p. 12). This model aligns a cultural humility approach (Yeager & Bauer-Wu, 2013) to research with Inuit communities. In addition to engaging in cultural humility, the proposed study uses a theoretical lens (post-colonial feminist theory) that make certain assumptions explicit and assumes prior knowledge of the negative outcomes of colonization. The latter is an important theoretical consideration for the proposed study because locating violence within the context of colonization is critical, in order to avoid further marginalizing Inuit communities in general and Inuit men in particular. Engaging Inuit communities in research means respecting the accumulation of Indigenous knowledge that may be shared within the context of the study, and recognizing knowledge is shared rather than collected, and that knowing is relational and inter-connected to both land and history (Healey & Tagak Sr, 2014).

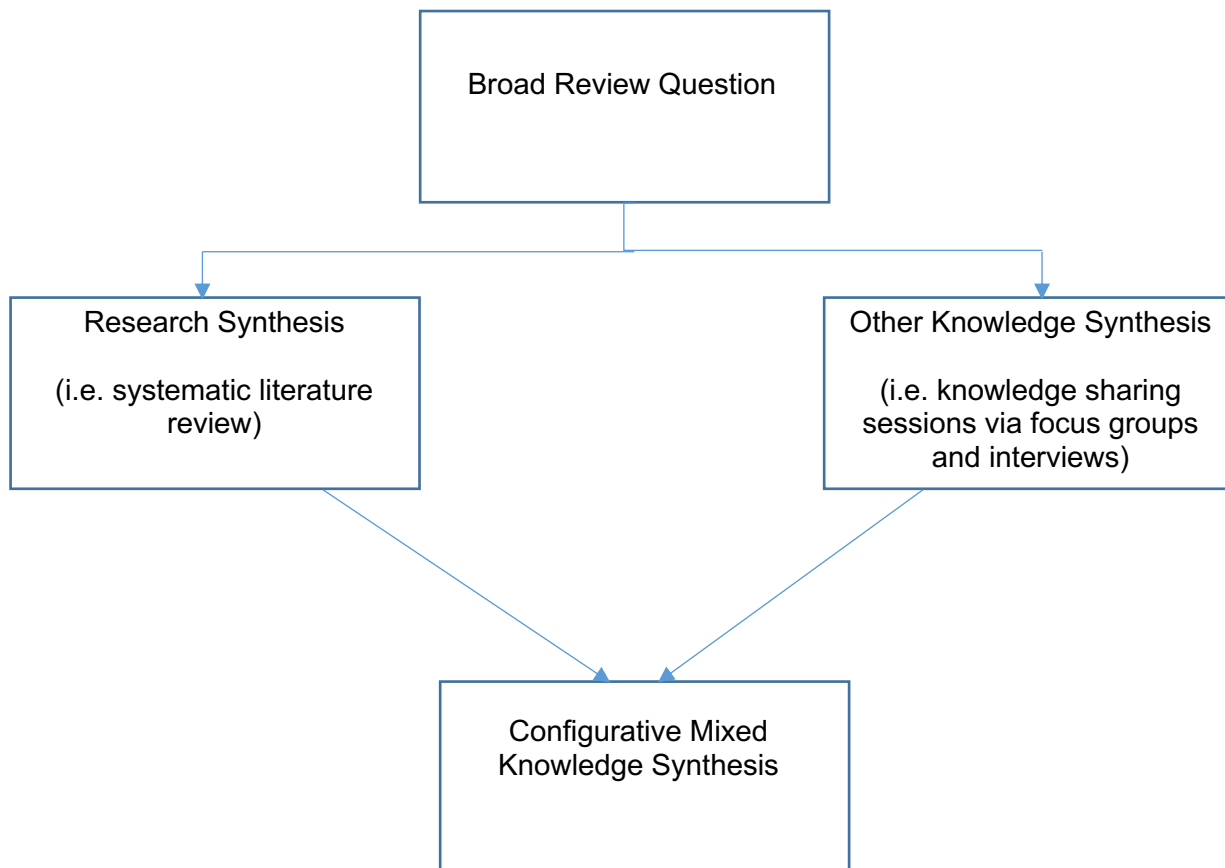
Positionality of the principal investigator (JW). I respect the accumulation of Indigenous knowledge that may be shared within the context of this research and recognize knowledge is shared, not collected, and that knowing is relational and inter-connected to land and history (Healey & Tagak Sr, 2014). The colonizing potential of research, misappropriation of Inuit knowledge and further marginalization are risks I will take every effort to prevent by using a cultural humility approach to research (Yeager & Bauer-Wu, 2013), and following principles of ownership, control, access and possession. As a non-Indigenous person, I humbly acknowledge myself as a learner of Inuit culture, knowledge, life ways, and history. I have taken a workshop on cultural trauma presented by the Tungasuvvingat Inuit located in Ottawa and an 8 week Inuktitut language and culture course offered by 'Inuktitut NG'. This course was taught by a

respected Inuk elder/grandmother, and a 'Qallunat' (non-Inuk) with strong familial ties to the Inuit community in Ottawa and Nunavut.

A Collaborative Methodology

In a configurative mixed knowledge synthesis, like all systematic reviews, the primary source of data is reports of research already conducted and publicly available. The inclusion of a secondary source of data, for example, interview, survey, or focus group data, is what distinguishes a configurative mixed knowledge synthesis from other types of research synthesis (Gough, Thomas, & Oliver, 2012). The process of configurative mixed knowledge synthesis includes defining the limits of the review, searching and retrieving research reports, mapping the extant literature (detailing the studies), refining the review question and determining subset of studies for in-depth synthesis, data extraction and analysis, collection and analysis of a secondary source of data, and creating the final synthesis (Gough et al., 2012). The inclusion of a secondary source of data may be considered a form of theoretical triangulation, and may increase transferability of existing qualitative research. The knowledge and perspectives shared by community partners (via focus groups and interviews) will be considered a secondary source of data; however, the intention is to engage Inuit partners in a collaborative process of data analysis and synthesis. It is important to note that within an Indigenous research paradigm, knowledge and stories are *shared* not collected, and interviews consist of dialog where both the researcher and participant may ask and answer questions and reflect a conversational style. Therefore, to privilege an Inuit worldview, data collection via focus groups and interviews are referred to as knowledge sharing sessions in this protocol. This should not be viewed as simple semantics, but rather reflective of efforts to shift away from traditional western approaches that may inadvertently contribute to the colonizing potential of research.

Figure 3. Components of Configurative Mixed Knowledge Synthesis (Study Protocol)
(Figure is adapted from Gough et al. (2012) p. 6 licensed under CC-BY 2.0).



This configurative mixed knowledge synthesis consists of three main phases or components: 1) systematic review of extant qualitative research; 2) knowledge sharing sessions; and 3) creating the mixed knowledge synthesis (See Figure 2). For the purpose of clarity these components are divided into sections and discussed separately; however, consistent with a configurative approach, these phases will proceed in an iterative fashion (Gough et al. 2012). This process will proceed in an iterative way because a collaborative approach to exploring research with community partners is a somewhat novel approach to research synthesis and will require flexibility in research design. Furthermore, Sandelowski, Voils, Leeman, and Crandell (2012) argue all reviews involve a degree of iteration in method

because “in research synthesis studies, methods must always be accommodated to the actual reports of research under review and to the nature of the findings presented in them” (p. 320). Importantly, although community engagement is discussed in the second section with knowledge sharing, community engagement will be initiated with key stakeholders at the start of the research process and maximized throughout the research process.

As previously noted, configurative style reviews are less common than aggregative reviews and as such, methods are still in a largely developmental stage. Gough et al (2012) describe a configurative mixed knowledge synthesis, yet they do not provide exemplars of this review in practice. As a result, we could not locate any reviews that specifically utilize this method. Although this method is not well developed and tested, we determined that this style of review has value as an approach that would allow for greater participation and knowledge sharing with community research partners. As such we have adapted the methods described by Gough et al. for this purpose. The process we will follow for the proposed configurative mixed knowledge synthesis (including potential roles and responsibilities of the principal investigator and community research partners) are summarized in Table 4.

Table 4. Summary of Proposed Research Process (Study Protocol).

Research Phase	Role of Principal Investigator	Involvement of Community Research Partners
Defining limits of the review	- Develop research question and inclusion and exclusion criteria.	- Consultation with representatives from agencies re: review question, and scope.
Searching and retrieving research reports	- Develop electronic search strategy in consultation with librarian scientist. - Determine data sources (grey literature). - Conduct literature searches using electronic databases and complementary hand searching approaches. - Import search results into citation management software	- Consult regarding awareness of relevant sources of grey literature, reports and research that Indigenous agencies may have produced that may not be published on websites etc. - Opportunities to be the second reviewer for screening studies will be offered to community research partners as part of a capacity building approach.

	(Covidence) and remove duplicates. - Title and abstract screening by JW and second reviewer. - Full text screening by JW and second reviewer.	
Mapping the extant literature (detailing the studies)	- Upload each study that meets inclusion criteria to its own computer file. - Record details of study characteristics into individual computer file and table/matrix format using a priori guide. - Refine review question and determine subset of studies for in-depth synthesis.	- Seek input from advisory panel on refined review question and subset of studies for synthesis.
Data extraction and analysis	- Extract all findings from subset of studies selected for in-depth synthesis. - Analyze research findings using thematic analysis to identify initial descriptive themes.	- Opportunities to be involved in data extraction and analysis will be offered to community research partners.
Knowledge sharing sessions	- Engage participants of knowledge sharing sessions (snowball engagement technique) and purposive sampling to organize potential participants into knowledge sharing sessions. - Develop questions to guide knowledge sharing. - Conduct sessions including presentation an analysis of review findings.	- Assist with engaging community participants for knowledge sharing sessions. - Advisory panel to provide feedback on discussion questions and knowledge sharing session guide. - Provide feedback on grouping of participants for knowledge sharing sessions. - Assist with facilitating knowledge sharing sessions
Creating the final synthesis	- Analysis of knowledge sharing session transcripts and notes. - Writing the research report and synthesis.	- Member checking with individual participants and sharing final report with representative agencies for feedback.

Systematic Review

Defining the limits of the review. In research synthesis studies, the researchers typically begin by defining the substantive, methodological, temporal and geographical limits for

the proposed project (Sandelowski & Barroso, 2007). Eligibility criteria is summarized in Table 5. The substantive area has already been defined to encompass the influence of violence on the health of Inuit women. Because initial literature searches identified few studies with Inuit women, studies conducted with First Nations and Métis women will also be included. Studies that include non-indigenous women and other community members, such as service providers, will be examined on a case-by-case basis to determine if it is possible to differentiate findings specific to Indigenous women.

Table 5. Eligibility Criteria (Study Protocol)

Criteria	Inclusion	Exclusion
Study Design	Any research design utilizing qualitative interviews with Indigenous women including mixed methods	Survey style interviews, Quantitative, discourse and media analysis, reviews of all kinds, conference abstracts
Population	Inuit, First Nations and Métis women	Non-indigenous women only
Concept	Intimate partner violence and Health promotion	Violence and trauma more generally such as Indian Residential School experiences
Context	Canada and/or the Circumpolar region for example Greenland and Alaska	Not Canada and outside the circumpolar region
Language	No limit	No limit
Date Range	No limit	No limit

Literature search and retrieval. Based on preliminary searches, it is anticipated that approximately 15-20 studies will make up the bibliographic sample. I will locate these studies with commonly used strategies to ensure an exhaustive search. These strategies include: 1) online database searching using keywords and medical subject (MeSH) headings; 2) hand searching of relevant journals and anthologies (book chapters); 3) area scanning of adjacent bookshelves and electronically in library catalogs; database searches of authors known to publish on the topic; 4) ancestry approach of reference lists until citation redundancy occurs; 5) descendancy approach using online tools such as Google Scholar; and 6) informal approaches such as contacting researchers or agencies known to work in the target area (Sandelowski & Barroso, 2003, 2007). Further, a search strategy for online databases was developed in consultation with a health sciences librarian (See Appendix A), there will be no date or language

limits imposed on the electronic database search. Both academic, peer-reviewed research reports and grey literature will be retrieved and screened. The use of all of these search strategies will increase the likelihood of capturing studies that might otherwise escape retrieval.

Citations and available abstracts from electronic database searching will be automatically imported into a citation management software (Covidence) and duplicates will be removed. The principal investigator (JW) and a second reviewer will screen titles and abstracts for inclusion in full-text screening. Citation searching will occur during full-text screening to identify additional studies; any potentially relevant citations will be imported by hand into the citation management software. Discrepancies will be resolved through discussion with the team and/or use of a third reviewer if necessary. Given that findings related to violence may not be clearly indicated in the title or abstract of studies with aims not explicitly linked to violence, more time and resources will likely be required for full text screening. A similar problem may emerge in identifying studies that include Indigenous women in the sample if this was not part of the sampling strategy or research aims, again suggesting the need for more reports to be full-text screened. The principal investigator (JW) is Anglophone, therefore, she will only screen the subset of research reports available in English. During title and abstract screening, if any relevant research reports written in languages other than English are found they will be retained until the end of this stage of the review. At this point, a determination will be made as to whether the number of reports written in languages other than English warrants recruiting additional team members capable of reviewing in other languages (example French or Inuktitut) or seeking translation services. Any relevant research report excluded based on language would be a limitation of the proposed project. However, even if these reports are ultimately excluded from the final synthesis due to lack of resources, highlighting their existence would be valuable towards mapping the research field.

Mapping the extant literature. As soon as a study is retrieved and deemed to meet initial inclusion criteria, it will be scanned or downloaded into its own computer file. Details of

each of the studies will be recorded using an a priori guide (e.g., Sandelowski & Barroso, 2007) that will be further refined as the project progresses to ensure the inclusion of all salient features from each study. These details will be recorded both in individual files for each study and in a table or matrix such as Excel that allows the format and visual display to be mapped or presented in a variety of different ways as part of data analysis. As studies are retrieved and details of study characteristics are recorded in tables a map of the topical area or research field will be created. Maps may be used to “inform the process of synthesis... an analysis of the map may lead to a decision to synthesize only a subset of studies, or to conduct several syntheses” (Gough et al., 2012, p. 5). It is at this stage that refinement of the review question and inclusion criteria may occur (Sandelowski & Barroso, 2007) and the final subset of studies for in-depth analysis and synthesis will be determined. These maps will be used for data analysis and to explore initial findings in focus groups because large amounts of data can be displayed more easily and emerging themes may be visualized by the principal investigator and community research partners.

Data extraction and analysis. Findings will be extracted in detail and imported into computer files for retrieval and thematic analysis. After findings are extracted from individual research reports, data will be analyzed using principles of thematic analysis (Thorne, 2008). Initial coding will be conducted independently by the principal investigator after reading and rereading each research report and comparing this to the data organized and displayed in the matrixes and maps created during the detailing and data extraction phase. Although theoretical perspectives may assist in organizing emerging themes, a primarily inductive process will be used in initial coding consistent with thematic analysis. These initial codes will be discussed with the research team and considered in light of the research questions. The initial descriptive themes will form the basis for knowledge sharing sessions with community research partners. If possible, opportunities to be involved in data analysis/synthesis (e.g., thematic coding of research reports) will be offered to Inuit community members to participate. This approach is

consistent with negotiating a collaborative research relationship that seeks to maximize community involvement and control.

Knowledge Sharing

Engaging the community. Piliriqatigiiniq Partnership Model for Community Health Research, an Inuit specific research model (Healey & Tagak Sr, 2014), will guide community engagement and collaboration. I respectfully acknowledge the resources required to build culturally respectful and trusting relationships among researchers and participants. The ITK and Nunavut Research Institute (NRI) (2006) describe a continuum of community involvement that may occur at each of the three stages of research (project design, data collection, and analysis), from basic consultation to community initiated and directed research. Therefore, a range of options may be presented as part of negotiating a research relationship and building trust with community groups. A key consideration for research with marginalized populations, and the agencies who serve them, is the time and resources available to them (Cargo & Mercer, 2008). Creating a safe space for research means full consultation and collaboration while being respectful of limited resources; agencies may be underfunded or short staffed, and women may be focused on day-to-day living (Cargo & Mercer, 2008). Tensions between feasibility and full-participation may become evident as time and resources would be required of those participating in knowledge sharing sessions and/or data analysis. The desired level of participation will be assessed throughout the research process.

Levac, Colquhoun, and O'Brien (2010) suggest that all scoping studies should have a consultation phase with stakeholders, an argument that extends to other types of reviews such as the proposed configurative mixed knowledge synthesis (Potential stakeholders are presented in Table 6). Initial consultation will occur early in the review process to determine interest and desired level of participation in the proposed project. Ideally, an advisory panel will be formed from representatives from Inuit organizations, service providers, and an Inuit Elder. The purpose of the advisory panel would be to review documents and consult on aspects of research such as

review questions, interview guides and assist in facilitating knowledge sharing sessions with community participants. It would not be feasible to host formal knowledge sharing sessions (via focus groups and interviews) for all aspects of the review, therefore the combination of an advisory panel and knowledge sharing sessions with community members would maximize community collaboration and participation. The primary purpose of the knowledge sharing sessions would be to engage in a group process of data analysis and critical appraisal of extant research and review findings.

Table 6. Potential Community Research Partners (Key Stakeholders).

Inuit Organization	Description	Address
Pauktuutit Inuit Women of Canada	Association representing Inuit women across Canada, head office located in Ottawa.	1 Nicholas Street, Suite 520 Ottawa, ON, K1N 7B7 T: (613) 238-3977
Akausivik Family Health Team	Inuit specific family health clinic located in Ottawa.	24 Selkirk St, Suite 300 Vanier, ON, K1L 0A4 T: (613) 740-0999
Tungasuvvingat Inuit	Agency that provides services to Inuit living outside land claims areas and operates an Inuit specific healing center.	1071 Richmond Road, Ottawa, ON K2B 6R2 T: (613) 565-5885
Ottawa Inuit Children's Center	Supports Inuit children and their families living in Ottawa, offers head start programs, daycare and other family support programs.	224 McArthur Ave, Ottawa, ON, K1L 6P5 T: (613)744-3133

Community research partners (i.e. participants) may consist of representatives and service providers from Inuit organizations (see Table 6) and other community members. Organizational/governmental permission is not required to conduct research with individual community members; however, it will be required to conduct research with employees of Inuit agencies. I will request a meeting with the participating agencies, as part of negotiating a research relationship. Permission will be obtained from the participating agencies, and written letters of permission/support will be requested and obtained prior to commencing any research activities with employees or agency representatives. If it is agreeable to the agencies, a poster

will be placed at the agencies, and an e-mail will be distributed to agencies' employees to inform potential participants of the study. It would be beneficial to seek multiple perspectives from Inuit living across Canada, however, given the location, resources and experience of the principal investigator the Inuit community living in Ottawa will be engaged first. Depending on outcomes of initial focus groups in Ottawa, additional knowledge sharing sessions may be planned in another urban location (e.g. Edmonton or Winnipeg), alternatively individual interviews may be conducted via phone or internet. Locating and engaging with research partners and participants in other cities would require assistance from Inuit agencies. Strengths and limitations of restricting research to Ottawa were described in the background section.

Healey and Tagak Sr (2014) advocate against a sampling approach that is exclusionary because Inuit relational epistemology is holistic, inclusive and relationships between people are a foundation for knowing. After consultation with Inuit representatives and service providers, a "snowball engagement" technique (Healey & Tagak Sr, 2014) will be used to identify additional participants such as Inuit women, Elders, and other interested community members. This method "focuses on the establishment of trusting relationships... the project is supported by community members, who then encourage others to engage in the study"; furthermore, "from a relational perspective, participants are *engaged*, not recruited to participate in a project" (Healey & Tagak Sr, 2014, p. 6). Any interested community members will be asked to contact the principal investigator (JW) directly and a letter of information will be sent via e-mail. Each participant will be offered \$20 cash as compensation for attending the knowledge sharing session. This compensation is offered as a token of appreciation, and it is offered in cash in an effort to alleviate any economic inconveniences such as transportation or childcare costs. All participants who attend the knowledge sharing session will receive the \$20 compensation regardless of how long they stay (note, any participant who chooses to withdraw after the study has begun will still receive the \$20 compensation).

Conducting knowledge sharing sessions. Knowledge sharing sessions may consist of a combination of one-on-one dialogue, and group discussions. Group discussions may have certain advantages such as capitalizing on a variety of perspectives and the group process “to generate certain kinds of social knowledge, such as the beliefs and attitudes that underlie behavior” (Thorne, 2008, p. 131). The primary purpose of the knowledge sharing sessions is to analyze the data extracted from the research reports. Discussions will focus on exploring the initial descriptive themes identified in the research reports, perceived gaps, strengths, limitations and relevance of this literature within an Inuit context, and developing higher level analytic themes. If any participant is uncomfortable expressing their perspectives in a group setting, opportunities for one-on-one discussions will be provided.

Initial discussion groups will consist of service providers and representatives from Inuit specific organizations, and other interested members of the Inuit community living in the Ottawa area including, but not limited to Inuit women who have experienced violence. Because, groups work best if they are not large (e.g., 6-8 as an upper limit) (Thorne, 2008, p. 133), I have chosen a lower limit of 5 and an upper limit of 10 participants per group as a reasonable number that would accommodate possible absences or attrition. If more than 10 persons wish to participate this will be accommodated via multiple groups, if required. Configurations of discussion groups (example separate groups for men and women or service providers and community members) will be determined in consultation with the advisory panel. Depending on availability of participants, group sessions may be repeated until data saturation is reached (estimated to be 3-5 group sessions). Therefore, estimated sample size is 5-50 participants and I will make the selection of participants on a first come/first served basis. Potential participants will be informed of this on the information sheet. Knowledge sharing sessions will take place in a location that is agreeable to research participants, ideally a conference room located at one of the participating agencies. Knowledge sharing group sessions will occur outside working hours on a day and time that is most convenient for all participants/research partners. Knowledge sharing sessions

will be audio-recorded. If any individual is uncomfortable with participating in an audio-recorded session, an opportunity will be provided for a one-on-one session, where detailed notes may be taken in place of audio recording.

Developing the knowledge sharing guide. Prior to participating in the knowledge sharing sessions, participants will be provided with a copy of the guide and asked to reflect on the questions based on their own experiences and/or the experiences of women they have known who have left their home communities as a result of violence (they will not be required to make or bring notes). Reflecting on questions in advance will provide participants with the background information to contribute to discussions in the knowledge sharing sessions. The knowledge sharing sessions will consist of two parts: 1) discussion questions designed to ground participants' perspectives in their own experiences; and 2) a critical appraisal of the research findings (See Appendix B for sample knowledge sharing guide that was developed based on preliminary reviews of the literature).

During the first portion of the session, each participant will have an opportunity to share their own perspectives on health promotion and healing after violence. This portion of the session will be guided by broad open-ended questions such as: what does health promotion mean to you? or How do Inuit women heal after experiencing violence? Specific questions will be developed based on findings of the systematic review and refined in collaboration with the advisory panel. These questions may also be developed to expand on themes that are emerging from the systematic review but which lack sufficient depth based on existing review findings. The two parts of the knowledge sharing session may be conducted contiguously or broken into two separate sessions depending on the needs of participants. For example, following the first portion of the session, the principal investigator (JW) or another member of the research team, will check in with participants individually by circulating around the room and asking if everyone is prepared to proceed. Anyone who feels traumatized or triggered by the discussions will be provided with a quiet space and support from a member of the research

team or designated community support person. If the majority of participants are ready, the second part of the session will proceed as planned.

Critical appraisal of systemic review findings. In the second part of the knowledge sharing sessions, findings from the systematic review will be presented by the principal investigator (JW). A handout will also be provided that summarizes the initial findings and emerging themes. The participants will be asked to share their perspectives on these findings. Critical appraisal of the overall findings of the systematic review will be guided by the following questions:

1. What do you think are strengths and limitations of this research?
2. How meaningful are these findings to you?
3. How do you envision future health promotion research with Inuit women who have experienced violence?

These questions were developed based on preliminary research, but will be refined based on the findings of this review and consultation with members of the advisory panel.

Evaluating the quality of qualitative research is contentious (Crowe & Sheppard, 2011; Denzin, 2009; Sandelowski & Barroso, 2007; Thomas & Harden, 2008). The research process and descriptions of findings are not always fully reflected in published reports, which could result in incomplete or biased evaluations (Crowe & Sheppard, 2011), and the validity of instruments for evaluating the quality of qualitative research reports are questionable (Crowe & Sheppard, 2011). A checklist and scoring system is unlikely to capture the complexity of research with Indigenous peoples, may privilege western worldviews and could contribute to the colonizing potential of research (Denzin, 2009; Macaulay et al., 2011). Quality appraisal will be discussed with community research partners to determine if and how individual reports of research included in the review should be appraised for quality. A series of reflective questions that focus on relevance, ethics, and overall strengths and limitations of the sample of research reports may be used as a basis for a general appraisal of extant research. For example, How does the study contribute to understanding violence from an Indigenous women's perspective? How relevant

was this research to the community (e.g., community articulated a need for research, local Indigenous knowledge/values were taken into consideration)? How does the researcher position themselves in relation to the research (e.g., use of reflexivity and cultural humility, Yeager & Bauer-Wu, 2013)? How were ethical considerations for research with Indigenous people incorporated into the research design (e.g. principles of ownership, control, access and possession were applied, stakeholder involvement, capacity building approach, themes of reciprocity)?

Creating the mixed knowledge synthesis. The collaborative approach to analyzing findings proposed for this project is modeled on Varcoe and Dick (2008) study on intersecting risks of violence and HIV among women living in a rural community. In their study, researchers completed initial analysis of data which included individual interviews with women; this analysis formed the basis for discussion in community focus groups and the additional data was used to expand the final analysis (Varcoe & Dick, 2008). Therefore, data analysis will proceed in two iterative phases, the first based on extant literature will begin as soon as research reports are retrieved, and the second after these emerging themes and findings are discussed in knowledge sharing sessions with Inuit research partners. This additional data from knowledge sharing sessions will be used to expand the final analysis. All data will be analyzed using principles of thematic analysis and interpretive description (Sandelowski & Barroso, 2007; Thorne, 2008).

All group knowledge sharing sessions will be audio recorded and transcribed word for word. After knowledge sharing sessions are transcribed, numerical codes will be assigned to participants to remove identifiers. Only the principal investigator (JW) will have access to these codes. This information will only be retained for the purpose of providing participants an opportunity to review their own quotes. Transcripts from the focus groups will then be read and reread in a process of line-by-line coding. Data analysis will include returning often to both parts of the data and the sum of the parts in an iterative process of thematic coding; the aim is illuminating insight and making findings accessible through thematic summary and

conceptualizing findings (Thorne, 2008). Community research partners will be consulted and a process of member checking will occur throughout data analysis and synthesis. The review and dissemination process will be collaborative and inclusive of participants. Transcripts of group discussions will not be provided to maintain privacy of all participants, and quotes will be anonymous and selected to not include identifying information. However, all participants will have an opportunity to review their own quotes, in the context that it will be used in the document, prior to dissemination of those quotes. If during this process any participant raises concerns that a particular quote inadvertently contains identifying information or does not accurately reflect their intended meaning; the quote will be altered or removed altogether to the satisfaction of participants. Members of the advisory panel will be sent a copy of the research report and offered an opportunity to review and provide written feedback prior to research dissemination/publication.

Maintaining an audit trail. Maintaining an audit trail is recommended to keep track of the decision process and increase rigour (Thorne, 2008). This is especially important where decisions will be influenced by the needs and wants of the community, and may help inform future nursing research with Inuit. Furthermore, the preliminary literature review in the target area suggested that not all studies conducted with Indigenous women that had findings related to violence are indexed in databases as such, and moreover much of this literature was found within grey literature. An additional challenge and perhaps contentious issue, will be to synthesize a seemingly disparate body of qualitative evidence. To overcome these challenges, I propose a more iterative approach to the research design; an exhaustive search and mapping of the available literature followed by refinement of objectives, review questions, and inclusion criteria in collaboration with community research partners, prior to undertaking analysis and synthesis of qualitative research. In this way an audit trail, which will be meticulously documented, will be more accessible to end-users, and the rigor, feasibility, and quality of the study will be increased.

Ethical Considerations

Ethical considerations are central to a research project with Indigenous people, especially for Inuit women who may be further marginalized by violence within their families and communities. There are many layers of complexity and potential risks that must be addressed. Key concerns considered in developing the protocol include the rights of Indigenous people to participate in research to determine what they want to know and how they want to know it, and minimizing risks related to researching violence against women. These concerns and how they were addressed will be evaluated in the reviewed research reports and may be a discussion point in focus groups as well. Ethical approval would not typically be required for a qualitative research synthesis, because the primary source of data is reports of research already conducted and publicly available. Therefore, systematic reviews would not normally be subject to the same ethical considerations as studies involving human subjects. However, by engaging with Inuit partners in the systematic review process, this project seeks to increase community control of and access to research that has the potential to inform healthcare. This community collaboration may allow for important insight into which knowledge gaps most urgently need to be addressed in future studies.

Ethical approval. Ethical approval will be obtained from the University of Ottawa Health Sciences and Science Research Ethics Board, prior to recruiting participants for the knowledge sharing sessions in the proposed study. Ethics approval is not required from Nunavut Research Institute, because all research will be conducted in Ottawa, only Nunavut and NT have research licensing requirements (ITK & NRI, 2006, p. 27). However, the websites of the Nunavut Research Institute and Qaujigiartiit Health Research Centre were reviewed for additional ethical guidance. The researcher has completed the Tri-Council training for conducting research with human subjects, and all guidelines set out by Tri-Council research policy will be met. Informed consent will be obtained prior to participating in research activities (See Appendix C for English consent forms and information sheets).

Potential benefits. Potential benefits to research participants may include: feeling relief and/or personal growth because of the opportunity for reflection and sharing in a positive, non-judgmental space about their life experiences and perspectives on health promotion in the context of violence. The participants will be invited to actively take part in sessions that are designed to be culturally safe and stimulating. Consistent with a collaborative and strength-based approach, the participants may feel a sense of accomplishment or pride for contributing to a research process that may further nursing knowledge and quality of care in the future. The participants will specifically be invited to provide their feedback for improvements to the research process. This systematic review project will make academic research accessible to community research partners and participants who may be working with survivors of violence in the community. Participants will have access to existing research that would otherwise be time consuming to search for, and possibly expensive to retrieve.

Mitigating potential risks. Among individual participants, potential risks of participating in knowledge sharing sessions include: psychological or emotional discomfort (e.g., anxiety, stress, loss of confidence, regret for disclosing personal information) related to sharing their perspectives in a focus group setting; psychological or emotional harm from recalling trauma related to their past or current life experiences; and social repercussions (e.g., negatively judged by peers or employer due to confidentiality limits of focus group discussions). Given the sensitive nature of the topic, participants will have the choice of participating in a knowledge sharing via focus group or an individual interview. Anonymity cannot be guaranteed during knowledge sharing (focus group) sessions. All potential participants will be informed during the scheduling of sessions that the sessions are group based and that attending the group session includes risk of co-participants recognizing the participant at the start of the session or later in the community. Participants will be informed on consent forms and study information sheets, that their identity cannot be protected because of the nature of the research being conducted. Participants will not be named in reporting or data analysis and names and contact information

will only appear on the consent forms. Prior to the commencement of sessions, participants will have an opportunity to read, ask questions about, and sign the informed consent for research participation form, they will also be provided with a list of available community resources.

During the knowledge sharing sessions, safe space guidelines (e.g. University of North Florida LGBT Resource Center, n.d.; University of Victoria, 2017) will be used to minimize emotional discomfort during the sessions and to ensure that participants do not face judgment/stigmatization from co-participants. At the start of group discussions, participants will be reminded of the importance of creating safe spaces for all participants to share knowledge and perspectives. Participants may use their given name or a pseudonym during group discussions. Participants will be made aware that if any participant is uncomfortable sharing their perspectives in a group setting, opportunities will be provided after the session where they can share their perspectives privately. Knowledge sharing sessions will be held at a location with a space separate from the room where group discussions will take place. This will allow participants to retreat to a private space in the event group discussion triggers distress. Members of the research team/support persons will be available to offer on-the-spot support during and/or immediately after the group sessions. Additionally, these persons are trained to assess for risk of harm and/or severe emotional distress and will assess participants' safety including risk of harm to self or others and ensure immediate follow-up as required. A safety protocol (e.g., Langford, 2000) will be used to address confidentiality, and safety of women who may be at risk of ongoing violence, or emotional distress. If any individual is uncomfortable attending the group sessions and still wishes to participate, the principal investigator (JW) will provide an opportunity for a one-on-one knowledge sharing session.

Informed consent. The language of the study is English; however, the participant population is comprised of Anglophones and Inuit. Informed consent forms will be translated into Inuktitut and back-translated by a qualified Inuktitut translator. If any interested participant does not read or write English or Inuktitut an opportunity will be negotiated to provide verbal recorded

consent and every effort to obtain a qualified translator will be made to insure the participant has the opportunity to participate in the research (Healey & Tagak Sr, 2014). Healey and Tagak Sr (2014) recommend that informed consent include an audiotaped explanation of the project in English and Inuktitut. Written consent, consistent with University of Ottawa, will be obtained from all agencies and individuals participating in the proposed study.

Data management and storage. Consent and assent forms, written records and audio recordings will be stored in a locked cabinet at the University of Ottawa in the office of the project supervisor Dr. J Craig Phillips. Additional digital copies will be stored by the principal investigator (JW) and the project supervisor (JCP) for the full five-year term using Sync.com a cloud storage solution featuring 2048 bit RSA, 256 bit AES, SSL and TLS encryption. Sync.com storage solution meets security guidelines of PIPEDA, PIPA, FIPPA, ATIPPA, and PHIPA. Consent forms will be stored for the full five-year conservation period. Data will be stored for five years following completion of data collection, analysis and dissemination. All members of the research team including community research partners will be consulted before the data conservation period is deemed ended.

Expected Outcomes

Expected outcomes of the proposed project include: 1) a conceptual map of extant health research conducted with Indigenous women who have experienced violence, with an emphasis on a contextualized understanding of their health experiences; 2) a synthesis of findings highlighting community perspectives on the influence of violence and migration on health promoting pathways among Inuit women; and 3) methodological development of configurative mixed knowledge synthesis and community-centered systematic review. This configurative mixed knowledge synthesis will enhance understanding of Inuit women's health, thus increasing nurses' ability to tailor trauma and violence informed care (TVIC) to an urban Inuit context, and may provide evidence to inform future directions for clinical practice innovations and raise important questions for future research. TVIC is a strength-based

approach to improving healthcare and reducing health inequities; this approach centers on understanding the impact of violence on people's lives and behavior and brings explicit attention to all forms of violence that may lead to health inequities (Varcoe, Wathen, Ford-Gilboe, Smye, & Browne, 2016). TVIC and postcolonial feminist theory are theoretical lenses used in this study to shift from a narrow focus on individual behaviors and coping skills to a more contextualized understanding of health promotion after exposure to violence. Knowledge developed during the course of the proposed project will contribute to the growing field of TVIC.

Disseminating Knowledge

Postcolonial feminist theory informs the proposed research design and stresses the importance of transferring knowledge into action. From this perspective research must: carefully frame findings, link everyday realities to historical context, give voice to participants, pay close attention to intersectional analysis of risk and resilience/strengths, align research to praxis, and develop a dissemination plan to support action (Anderson & McCann, 2002; Browne, Varcoe, & Fridkin, 2011). Therefore, an explicit goal of this research is to work with participants to determine who needs to know about the findings, and how they should best learn about it. The target audiences for this research are service providers and policy makers/advocates in a position to make adjustments in their praxis. My long-term goals are to develop a program of research that advances TVIC with Inuit women exposed to violence. By partnering with Inuit women and their communities, there is hope for the development of interventions to improve the health and wellbeing of these women and their communities that expands cultural humility among health care providers who work with these communities.

References

- Anderson, J., & McCann, E. (2002). Toward a post-colonial feminist methodology in nursing research: exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher*, 9(3), 7-27. doi:10.7748/nr2002.04.9.3.7.c6186
- Andersson, N., & Nahwegahbow, A. (2010). Family violence and the need for prevention research in First Nations, Inuit, and Métis communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(2), 9-33.
- Andersson, N., Shea, B., Amaratunga, C., McGuire, P., & Sioui, G. (2010). Rebuilding from resilience: research framework for a randomized controlled trial of community-led interventions to prevent domestic violence in Aboriginal communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(2), 61-88.
- Arriagada, P. (2016). *Women in Canada: A gender based statistical report, First Nations, Métis and Inuit women*. (Statistics Canada Catalogue no. 89-503-X ISSN 1719-4407). Retrieved from www.statcan.gc.ca/pub/89-503-x/2015001/article/14313-eng.htm
- Browne, A., Varcoe, C., & Fridkin, A. (2011). Addressing trauma, violence, and pain: research on health services for women at the intersections of history and economics. In O. Hankivsky, J. de Leeuw, B. Lee, & N. Vissandjée (Eds.), *Health Inequities in Canada: Intersectional Frameworks and Practices* (pp. 295-311). Vancouver, BC: University of British Columbia Press.
- Brownridge, D. (2008). Understanding the elevated risk of partner violence against aboriginal women: a comparison of two nationally representative surveys of Canada. *Journal of Family Violence*, 23(5), 353-367.
- Brownridge, D., Taillieu, T., Afifi, T., Chan, K., Emery, C., Lavoie, J., & Elgar, F. (2017). Child maltreatment and intimate partner violence among Indigenous and Non-Indigenous Canadians. *Journal of Family Violence*, 32(6), 607-619. doi:10.1007/s10896-016-9880-5

- Cargo, M., & Mercer, S. (2008). The value and challenges of participatory research: strengthening its practice. *Annu. Rev. Public Health*, 29, 325-350.
- Charron, M., Penney, C., & Senécal, S. (2010). *Police-reported crime in Inuit Nunangat*. (110015647X). Statistics Canada.
- Crowe, M., & Sheppard, L. (2011). A review of critical appraisal tools show they lack rigor: alternative tool structure is proposed. *Journal of Clinical Epidemiology*, 64(1), 79-89.
- Denison, J., Varcoe, C., & Browne, A. (2014). Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. *Journal of Advanced Nursing*, 70(5), 1105-1116. doi:10.1111/jan.12271
- Denzin, N. K. (2009). The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative research*, 9(2), 139-160.
- Ford-Gilboe, M., Wuest, J., & Merritt-Gray, M. (2005). Strengthening capacity to limit intrusion: theorizing family health promotion in the aftermath of woman abuse. *Qualitative Health Research*, 15(4), 477-501.
- Galloway, T., & Saudny, H. (2012). Inuit Health Survey (2007–2008): Nunavut community and personal wellness. *Montreal, QC: Centre for Indigenous Nutrition and the Environment McGill University*.
- García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Retrieved from World Health Organization, Geneva, Switzerland
www.who.int/reproductivehealth/publications/violence/24159358X/en/
- Gough, D., Thomas, J., & Oliver, S. (2012). Clarifying differences between review designs and methods. *Systematic reviews*, 1(1), 28.
- Healey, G. (2013). Tradition and culture: an important determinant of Inuit women's health. *International Journal of Indigenous Health*, 4(1), 25-33.

- Healey, G. (2016). (Re)settlement, displacement, and family separation: contributors to health inequality in Nunavut. *Northern Review*, 1(42), 47-68.
- Healey, G., & Meadows, L. (2007). Inuit women's health in Nunavut, Canada: a review of the literature. *International Journal of Circumpolar Health*, 66(3), 199-214.
- Healey, G., & Tagak Sr, A. (2014). Piliriqatigiinniq 'working in a collaborative way for the common good': a perspective on the space where health research methodology and Inuit epistemology come together. *International Journal of Critical Indigenous Studies*, 7(1), 14.
- Inuit Tapiriit Kanatami. (2018). *National Inuit Strategy on Research* Retrieved from <https://www.itk.ca/wp-content/uploads/2018/03/National-Inuit-Strategy-on-Research.pdf>
- Inuit Tapiriit Kanatami [ITK]. (2014). *Social Determinants of Inuit Health in Canada*. Retrieved from www.itk.ca/wpcontent/uploads/2016/07/ITK_Social_Determinants_Report.pdf
- Inuit Tapiriit Kanatami [ITK], & Nunavut Research Institute [NRI]. (2006). *Negotiating research relationships with Inuit communities: a guide for researchers*. Retrieved from Ottawa and Iqaluit: <http://www.nri.nu.ca/sites/default/files/public/files/06-068%20ITK%20NRR%20booklet.pdf>
- Kinnon, D. (2014). *Engaging Inuit men and boys in ending violence against women and girls: a gender-based analysis*. Retrieved from Pauktuutit Inuit Women of Canada: http://pauktuutit.ca/wp-content/blogs.dir/1/assets/EMB_GBA_Report.pdf
- Langford, D. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research*, 10(1), 133-142.
- Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science*, 5(1), 69.
- Levan, M. B. (2003). *Creating a framework for the wisdom of the community: Review of victim services in Nunavut, Northwest and Yukon Territories*: Department of Justice Canada.

- Macaulay, A. C., Jagosh, J., Seller, R., Henderson, J., Cargo, M., Greenhalgh, T., . . . Herbert, C. P. (2011). Assessing the benefits of participatory research: a rationale for a realist review. *Global Health Promotion, 18*(2), 45-48.
- Moffitt, P., & Fikowski, H. (2017). *Northwest Territories Research Project Report for Territorial Stakeholders: Rural and Northern Community Response to Intimate Partner Violence*. Yellowknife, NT.: Aurora Research Institute/ Faculties of Nursing and Social Work, Aurora College.
- Moffitt, P., Fikowski, H., Mauricio, M., & Mackenzie, A. (2013). Intimate partner violence in the Canadian territorial north: perspectives from a literature review and a media watch. *International Journal of Circumpolar Health, 72*. doi:10.3402/ijch.v72i0.21209
- National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG]. (2018). *Executive summary from the interim report: Our women and girls are sacred*. Retrieved from www.mmiwg-ffada.ca/wp-content/uploads/2018/05/MMIWG-Executive-Summary-ENG.pdf
- Office of the Auditor General of Canada. (2017). *Report of the Auditor General of Canada, Health Care Services- Nunavut*. Retrieved from www.oagbvg.gc.ca/internet/English/nun_201703_e_41998.html.
- Ottawa Inuit Children's Center. (n.d). *Nipivut – Our Voice: A community needs assessment for Inuit families in Ottawa, final report*. Retrieved from www.ottawainuitchildrens.com/wp-content/uploads/2012/06/nipivut_eng.pdf
- Paletta, A. (2008). *Understanding Family Violence and Sexual Assault in the Territories, First Nations, Inuit and Métis Peoples*. Department of Justice Canada.
- Pauktuutit Inuit Women of Canada. (2017). *Understanding the Needs of Urban Inuit Women: Final Report*. Retrieved from www.pauktuutit.ca/project/understanding-the-needs-of-urban-inuit-women-final-report/

Public Health Agency of Canada. (2013). *The Chief Public Health Officer's Report on the State of Public Health in Canada: Infectious Disease—The Never-ending Threat:*

Tuberculosis—Past and Present. Retrieved from www.phac-aspc.gc.ca/cphorsphcrespcacsp/2013/tuber-eng.php.

Sandelowski, M., & Barroso, J. (2003). Writing the proposal for a qualitative research methodology project. *Qualitative Health Research*, 13(6), 781-820.

Sandelowski, M., & Barroso, J. (2007). *Handbook for Synthesizing Qualitative Research*.

Retrieved from

<https://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=423305>.

Sandelowski, M., Voils, C. I., Leeman, J., & Crandell, J. L. (2012). Mapping the mixed methods—mixed research synthesis terrain. *Journal of mixed methods research*, 6(4), 317-331.

Schmidt, R., Hrenchuk, C., Bopp, J., & Poole, N. (2015). Trajectories of women's homelessness in Canada's 3 northern territories. *International Journal of Circumpolar Health*, 74, 29778. doi:10.3402/ijch.v74.29778

Shahram, S., Bottorff, J., Kurtz, D., Oelke, N., Thomas, V., & Spittal, P. (2017). Understanding the life histories of pregnant-involved young Aboriginal women with substance use experiences in three Canadian cities. *Qualitative Health Research*, 27(2), 249-259. doi:10.1177/1049732316657812

Sinha, M. (2013). *Measuring violence against women: Statistical trends*. (0715-271X). Juristat: Canadian Centre for Justice Statistics.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, 8(1), 45.

Thorne, S. (2008). *Interpretive Description*. Walnut Creek, CA: Left Coast Press.

University of North Florida LGBT Resource Center. (n.d.). Brave Space/Safe Space Guidelines For Critical Dialogue through Conscious Questioning & Active Listening. Retrieved from https://www.unf.edu/lgbtrc/Safe_Space_Guidelines.aspx

- University of Victoria. (2017). Guidelines for Creating Safer Spaces. Retrieved from <https://onlineacademiccommunity.uvic.ca/psn/guidelines-for-creating-safer-spaces/>
- Vandenberg, H., & Hall, W. (2011). Critical ethnography: extending attention to bias and reinforcement of dominant power relations. *Nurse Researcher*, 18(3).
- Varcoe, C., & Dick, S. (2008). The intersecting risks of violence and HIV for rural Aboriginal women in a neo-colonial Canadian context. *Journal of Aboriginal Health*, 4(1), 42-52.
- Varcoe, C., Wathen, N., Ford-Gilboe, M., Smye, V., & Browne, A. (2016). VEGA briefing note on trauma-and violence-informed care. *VEGA Project and PreVAiL Research Network*.
- World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Retrieved from World Health Organization, London School of Hygiene and Tropical Medicine. Geneva, Switzerland: www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf
- Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: essential foundation for clinical researchers. *Applied Nursing Research*, 26(4), 251-256.

Appendix A: Search Strategy

In preparation for the proposed project, I completed a preliminary search and appraisal of the literature on health and healing among Indigenous women experiencing violence. The purpose of this preliminary work was to 1) search for existing systematic/literature reviews with similar research aims as the proposed study; 2) estimate the size and composition of the bibliographic sample for the proposed project; 3) determine which review methods may be most appropriate; 4) explore what may be some of the more salient features and findings in the research reports to extract, analyze and synthesize in the proposed project; and 5) based on this exploration develop an initial guide for data extraction and appraisal of the literature in the proposed project.

A focused search of CINAHL and MEDLINE used Inuit, women, and violence as keywords and mapped subject headings; this search found no relevant studies, therefore the search terms were expanded, and other search strategies used. The most fruitful strategy used an ancestry/descendancy approach with Google Scholar, and the resulting process was iterative rather than linear. A grey literature search reviewed websites of Inuit organizations, and federal and territorial governments to search for relevant studies and reports. This preliminary search found five studies exploring the health of Inuit women, with some findings related to violence and/or migration (e.g. Healey, 2014a, 2014b, 2016; Levan, 2003; Schmidt et al., 2015). These studies did not specifically include Inuit women living outside land-claims areas, nor explicitly address the effect of violence and migration to urban centers on health. Researchers from the western provinces conducted the majority of peer-reviewed qualitative research with Canadian Indigenous women exposed to violence and focused mostly on First Nations women living with HIV (e.g. McCall et al., 2009; Varcoe & Dick, 2008; Mckeown, Reid, Turner, & Orr, 2002). No systematic reviews were located that addressed the proposed research aims; however, two literature reviews were found on related topics (Healey, 2007; Moffitt, Fikowski, Mauricio, & Mackenzie, 2013) and their reference lists were valuable resources for identifying

additional relevant studies. Based on this initial search the bibliographic sample for the proposed project is estimated to be 10-15 reports of qualitative studies.

A search strategy for electronic databases using a combination of keywords and mesh headings was developed in consultation with a health sciences librarian. Search filters for Indigenous Peoples in Canada were based on those developed by Campbell, Dorgan and Tjosvold (2016a,b). The search strategy was initially developed for Medline and then adapted for Proquest Nursing and Allied Health, Proquest Thesis and Dissertations, CINAHL, Scopus, Web of Science, and PsychInfo. These databases were chosen because they were most likely to contain relevant literature. The search strategy was purposefully broad to capture all extant literature because few studies were located during initial searches. There were no date or language limits imposed on the electronic database search.

Search Terms for Indigenous and Canada (Campbell, Dorgan & Tjosvold, 2016a,b)

Athapaskan or Saulteaux or Wakashan or Cree or Dene or Inuit or Inuk or Inuvialuit* or Haida or Ktunaxa or Tsimshian or Gitsxan or "Nisga'a" or Haisla or Heiltsuk or Oweenkeno or "Kwakwaka'wakw" or "Nuu chah nulth" or "Tsilhqot'in" or Dakelh or "Wet'suwet'en" or Sekani or "Dunne-za" or Dene or Tahltan or Kaska or Tagish or Tutchone or Nuxalk or Salish or "Stl'atlimc" or "Nlaka'pamux" or Okanagan or "Sec wepmc" or Tlingit or Anishinaabe or Blackfoot or Nakoda or Tasttine or "Tsuu T'inia" or "Gwich'in" or Han or Tagish or Tutchone or Algonquin or Nipissing or Ojibwa or Potawatomi or Innu or Maliseet or "Mi'kmaq" or Micmac or "Mic mac" Passamaquoddy or Haudenosaunee or Cayuga or Mohawk or Oneida or Onodaga or Seneca or Tuscarora or Wyandot or Aboriginal* or Indigenous* or Metis or "red road" or "on reserve" or "off reserve" or "First Nation" or "First Nations" or Amerindian or (urban N3 (Indian* or Native* or Aboriginal*)) or ethnomedicine or "country food*" or "residential school*" or ((MH "Medicine, Traditional") or traditional medicine*) not Chinese) or (MH"Shamanism") or shaman* or "traditional heal*" or "traditional food*" or "medicine man" or "medicine woman" or autochtone* or (Native* N1 (American* or man or men or women or woman or boy* or girl* or adolescent* or youth or youths or person* or adult or people* or Indian* or Nation or tribe* or tribal or band or bands) AND Canad* or "British Columbia" or "Columbie Britannique" or Alberta or Saskatchewan or Manitoba or Ontario or Quebec or "Nova Scotia" or "New Brunswick" or Newfoundland or Labrador or "Prince Edward Island" or "Yukon Territory" or NWT or "Northwest Territories" or Nunavut or Nunavik or Nunatsiavut or NunatuKavut AND

Search Terms for IPV

violent or violence or abus* or assault* or IPV or DV or battered women or spousal homicide or VAW or sexual coercion or rape

Appendix B: Knowledge Sharing Sessions

Prior to participating in the knowledge sharing sessions [focus groups], we ask that you take a few moments to reflect on: your own challenges and successes in navigating towards and negotiating for resources that promote wellbeing, and the healing pathways of women you have known who left their home communities as a result of violence. This will provide you with the background information to contribute to discussions in the knowledge sharing sessions. The knowledge sharing sessions will consist of two parts, a reflection activity designed to ground your perspectives in your experiences, and a critical appraisal of the literature review findings. These two parts may be conducted as one session or broken into two separate sessions depending on the needs of participants. During the reflection activity, each participant will have an opportunity to share their perspectives on health promotion based on their own reflections. Following the reflection activity, the principal investigator or another member of the research team, will check in with participants to ensure everyone is prepared to proceed.

Knowledge Sharing Session (Focus Group Interview) Guide

Part A: Reflection Activity.

This portion of the knowledge sharing session will be guided by the following two questions and sub-questions:

Thinking about Inuit women who have experienced violence:

1. What does health promotion and healing mean to you?
2. How does movement between rural and urban spaces influence health promotion?
 - a. What kinds of resources/supports promote safety and wellbeing?
 - b. What are some common challenges and successes women experience when promoting their own safety and wellbeing?

Participants will receive the above questions when they receive the information letter and consent form prior to the Knowledge Sharing Session, so they can consider their responses ahead of time.

Additional clarifying questions will be used as needed during the sharing session and may include the following questions:

1. What did that mean for you?
2. How did that make you feel?
3. Please tell me more about that.

Part B: Critical Appraisal of Systematic Review Findings.

In the second part of the knowledge sharing sessions, findings from the systematic review will be presented by the principal investigator (JW). A hand-out will also be provided summarizing the findings. The participants will be asked to share their perspectives on these findings. This portion of the knowledge sharing session will be guided by the following questions:

4. What do you think are strengths and limitations of this research?
5. How meaningful are these findings to you?
6. How do you envision future health promotion research with Inuit women who have experienced violence?

Appendix C: Statement of Contributions Form

ÉCOLE DES SCIENCES INFIRMIÈRES
Programmes des études supérieures



SCHOOL OF NURSING
Graduate Programs

STATEMENT OF CONTRIBUTIONS FORM

March 17, 2019

(Date)

To Whom It May Concern:

The present is to confirm that
(Student Name)

Julie Williams

contributed as a whole to the manuscript entitled: Violence, Displacement,
and Health Promotion Among Inuit Women: A Configurative
Mixed Knowledge Synthesis Protocol

Dr. J. Craig Phillips

(Name of Supervisor)

in his/her role as supervisor,

and Dr. Brandi Vanderspank-Wright

Dr. Wendy Gifford

(Names of co-authors, if appropriate)

Guided the work and made editorial suggestions for the manuscript

Student Signature

Supervisor Signature

Chapter Four: Integrated Discussion and Conclusion

This thesis was guided by the following broad exploratory question: How does extant qualitative research conducted in Canada, contribute to understanding the health and wellbeing of First Nations, Métis, and Inuit women who have experienced violence? I conducted a systematic review of qualitative research that explored the perspectives of Indigenous women about how violence influences their health and wellbeing. The process of completing this review involved scrutinizing existing systematic review methods and reflecting on myself as a researcher to determine how the research process could be improved to better answer the review question. An examination of systematic review methods identified a lack of clearly articulated methodological approaches that were participatory and inclusive of community research partners. As a white, settler colonial woman, I questioned how my experiences and biases might influence the research findings? How could methods be improved to be more inclusive of community research partners – especially with regard to evaluating findings? These questions were the impetus for the study protocol. This thesis resulted in two scholarly outputs, a systematic review of qualitative research and a study protocol for a configurative mixed knowledge synthesis.

The following chapter is an integrated discussion of thesis findings and nursing implications. I first summarize the findings of the systematic review. Following this, I explore recommendations for nursing practice, interventions, and education based on integrations of review findings and theoretical understandings. Next, I discuss implications and opportunities for future nursing research based on strengths and limitations of the literature included in the review. Lastly, I reflect on potential cultural biases, my experiences conducting research, and provide concluding remarks.

Summary of Systematic Review Findings

The purpose of the systematic review of qualitative research was to explore the perspectives of Indigenous women about how violence influences their health and wellbeing.

Initial literature searches identified a dearth of literature that included perspectives of Indigenous women; therefore, search strategies and inclusion criteria were intentionally broad to capture all extant research. Sixteen studies were included in this review fifteen qualitative and one mixed methods study. The majority of studies were conducted in the western provinces of British Columbia, Alberta, Saskatchewan and Manitoba. Two studies were located from Quebec, one from the northern territories and no studies were located from the maritime provinces. Despite the large population of Ontario, only one study was conducted in that province. The sample included a near balance of urban and rural settings. Ages of participants ranged from 14-65 years and reported mean ages ranged from 30-37.8 years. Only one study specifically explored the perspectives of young women (under the age of 20 years) and none of the studies explored the perspectives of women over the age of 65 years.

A number of the studies identified their theoretical perspectives as feminist, post-colonial feminist or based on Intersectionality. The professional discipline of researchers may also influence their theoretical lens. The majority of researchers came from the discipline of nursing and social work. Other disciplines of the researchers included medicine, psychology and public health. This review found a dearth of studies that addressed violence as part of the research question and/or objectives, but findings of violence were common in studies on the topic of HIV and substance use. Four themes with subthemes emerged based on analysis of findings in the included studies: 1) ruptured connections between family and home, 2) that emptiness... my spirit being removed, 3) seeking help and feeling unheard, 4) a core no one can touch. These themes represent interconnected pathways that influenced health among research participants. The main findings related to the review objectives were as follows:

Objective 1) To describe experiences of violence in the lives of Indigenous women living in Canada. All of the included studies either had substantial findings related to violence or less commonly research questions that specifically focus on violence more generally or a specific type of violence such as childhood sexual abuse. This review found numerous quotations from

women describing violence that they had experienced throughout their lives. These descriptions identified relationships between family violence (e.g. intimate partner violence (IPV) and child abuse) and structural violence such as poverty and discrimination. Immense harms from residential schools and colonization were evident. Women's descriptions inextricably tied violence to displacement (e.g. homelessness, frequent moves and child apprehension).

Objective 2) To understand ways in which Indigenous women relate these experiences of violence to their health and wellbeing. The main findings were that women described their emotional pain from the cumulative effects of violence, unresolved grief from family separations and loss, and behaviours that emerged as a result of coping with trauma and violent social circumstances. Negative reactions from healthcare providers deterred access to care and contributed to poor health. Complex relationships between violence, substance use and HIV were specifically explored by researchers and participants.

Objective 3) To explore how Indigenous women promote healing and wellbeing after exposure to violence. Patterns of healing noted across the studies included ways of being and thinking that connected women spiritually, emotionally, and culturally to themselves, their family, community, and the broader Indigenous context within Canada. Children also figured prominently as a motivator to leave violent relationships and regain control over health and wellbeing. This review found most studies did not specifically explore healing from violence. Researchers described aspects of healing such as engaging in cultural practices, but did not typically provide thick descriptions with direct quotations from participants. Two studies, both written over twenty years ago, provided the most in-depth exploration of healing (Herbert & McCannell, 1997; McEvoy & Daniluk, 1995).

Implications for Nursing Practice

The findings of my systematic review that suggest Indigenous women may be deterred from accessing care because of the negative attitudes and judgments of nurses is particularly concerning. Simply understanding associations between violence and poor health may not

guarantee empathy and understanding of the everyday lived reality of women exposed to violence. Data indicate that women suffering from violence, and poor mental or sexual health often have negative experiences when they access healthcare and delay seeking preventive and needed care as a result (Denison, Varcoe, & Browne, 2014; Feder, Hutson, Ramsay, & Taket, 2006; McCall, Browne, & Reimer-Kirkham, 2009; Reisenhofer & Seibold, 2013). Women felt nurses commonly responded to them with a task-oriented approach that was perceived as hurried and focused on physical aspects of care, or worse yet, indifference, pity, judgment, and blame (Denison et al., 2014; Feder et al., 2006; McCall et al., 2009; Reisenhofer & Seibold, 2013). Further, women suggested they just wanted to be treated like another human being – deserving of empathy. In studies included in the review, experiences of racism and discrimination when accessing healthcare further decreased Indigenous women's help seeking behaviours and access to care. These findings are consistent with findings reported in other health related studies with Indigenous women (Benoit, Carroll, & Chaudhry, 2003; Browne, 2007; Browne & Fiske, 2001; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008).

Disrupting the normalization of violence. Indigenous service providers and community members described how violence had become 'normalized' in their communities because of residential schools and intergenerational violence and trauma (Brassard, Montminy, Bergeron, & Sosa-Sanchez, 2015; Gesink, Whiskeyjack, Suntjens, Mihic, & McGilvery, 2016; Jacobs & Gill, 2002; McEvoy & Daniluk, 1995). Multiple experiences of violence were normalized and/or trivialized in both urban and rural settings. One sex worker in an urban center stated, "I have seen girls thrown into fences, [receive] licks from their boyfriends... I have grown to think that it's common. We see that down here all the time" (Nixon, Tutty, Downe, Gorkoff, & Ursel, 2002, p. 1024). Despite this tacit acceptance, not all women described their experiences as 'normal'. One survivor of childhood sexual abuse asked her classmates, "what life was like at home because I didn't know if it was normal or not... I came to the conclusion it wasn't normal" (McEvoy & Daniluk, 1995, p. 228). Violence is not normal for anyone and should not be an

expected part of life for Indigenous women and children. Disrupting the normalization of violence and discouraging language among service providers that conceptualizes violence as common, normal or accepted is critical, because the tacit acceptance of violence against Indigenous women and children may decrease help seeking among them (Levan, 2003; Moffitt & Fikowski, 2017). Furthermore, this tacit acceptance may perpetuate violence and contribute to the dearth of programs and services to support women experiencing violence in rural and remote communities, especially when persons in positions of power do not acknowledge that violence is a problem (Levan, 2003; Moffitt & Fikowski, 2017).

Cultural humility as a way forward. Engaging in critical reflection on personal biases and other practices that promote structural competency (Metzl & Hansen, 2014), cultural safety (Brascoupé & Waters, 2009), and cultural humility (Yeager & Bauer-Wu, 2013) are key to creating safe spaces for clients. Tervalon and Murray-Garcia (1998) proposed the concept of cultural humility as an alternative to cultural competency. They suggested ‘cultural competency’ was problematic because it implies a “detached mastery of... a finite body of knowledge... [whereas] humility incorporates a lifelong commitment to self-evaluation and ... to redressing power imbalances ... developing mutually beneficial and non-paternalistic clinical, and advocacy partnerships with communities on behalf of individuals and defined populations” (Tervalon & Murray-Garcia, 1998, p. 117). Cultural safety is widely cited in the literature on healthcare in Canada and is another way to conceptualize the responsibility of care providers to remedy power imbalances within healthcare; however, it is often defined by what it is not. Culturally unsafe care is “any actions that diminish, demean or disempower the cultural identity and wellbeing of an individual” (Brascoupé & Waters, 2009, p. 7). Therefore, cultural humility may offer greater clarity about actions healthcare providers should take to create safe spaces for clients. Furthermore, the nature of trauma and people’s reactions to it are barriers to connecting with others, and safe spaces are a prerequisite to establishing connections between people (Herman, 2015). In this way, trauma and violence informed care (TVIC) brings the overlapping

concepts of trauma-informed care, cultural safety and health equity together into one integrated approach to providing healthcare (Varcoe, Wathen, Ford-Gilboe, Smye, & Browne, 2016).

Promoting structural competency. Structures are systems “that produces and reproduces the social world, and that is thus deeply linked to culture because it provides the system of values affixed to bodies and diseases” (Metzl & Hansen, 2014 p. 128).

Institutionalized forms of racism and gender discrimination is far more subtle, yet just as destructive as overt forms of discrimination. Structural competency refers to developing a skill set that seeks to understand how structural forces shape health and influence interactions between clinicians and clients (Metzl & Hansen, 2014). This approach calls for reframing cultural presentations in structural terms, for example, recognizing that impoverished neighbourhoods with a large immigrant population may not have access to a drug store or insurance plan, rather than assuming a particular cultural group is resistant to taking medications. Furthermore, as demonstrated in the systematic review, all forms of violence and structural inequities limit choices available to Indigenous women and may lead to further violence and social isolation. Healthcare providers including nurses may not be adequately prepared to understand or address the problem of structural violence. Farmer et al. note that healthcare providers lack knowledge about social determinants of health (SDH). They highlight the importance of understanding structural violence and suggest that

unfortunately, with few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease. (Farmer, Nizeye, Stulac, & Keshavjee, 2006, p. 1686)

Intersectionality and health equality. Viewing SDH through an intersectional lens may improve understandings of how structural violence causes health inequities and may help build structural competency among nurses. An intersectional analysis exposes underlying pathways that determine health inequity rather than offering a simple list of factors that influence health

status (Hankivsky & Christoffersen, 2008). The World Health Organization (WHO) suggests making a distinction between the *determinants of health inequities* (e.g. socioeconomic position, gender, ethnicity, education, and occupation) and the *determinants of health* (e.g. material circumstances, behaviors, and psychosocial factors) which have a more direct influence on health status (Solar & Irwin, 2010). This distinction helps to illustrate underlying pathways that lead to poor health. Determinants of health inequities, are structural factors that collectively influence power, control and access to resources. This collective influence contributes to the unequal distribution of the determinants of health in society (Solar & Irwin, 2010) and helps to explain why certain health problems are prevalent in some populations more than others. In the following paragraph, findings from the systematic review are used to illustrate an intersectional approach to exploring SDH.

Nursing studies included in the systematic review used an intersectional lens to uncover power inequalities in healthcare (e.g., McCall et al., 2009; Varcoe & Dick, 2008). Their findings contribute to nursing knowledge of cultural safety and TVIC. Furthermore, these findings support existing evidence that poor health is not simply the result of individual behaviors or coping skills – health inequities result from intersecting oppressions such as poverty, violence and discrimination (Browne, Varcoe, & Fridkin, 2011). In Canada, substantial inequities in sexual health exist between Indigenous women and the general population of Canadian women, for example higher rates of HIV are reported among Indigenous women (Bourgeois et al., 2017). Participants in many of the reviewed studies described behaviors including unprotected sex, frequent sexual encounters, and substance use that increased risks of acquiring sexually transmitted infections (STIs) (including HIV) and unplanned pregnancy. However, an intersectional approach shifts the focus from these behaviors onto structural factors.

Gender, ethnicity and socio-economic position may define an at risk population. But, these determinants of health inequity more accurately represent intersecting systems of oppression – Indigenous women experiencing violence have little power, control, or access to

resources. As described by Ford-Gilboe, Wuest, and Merritt-Gray (2005), Wenzel, Leake, and Gelberg (2001), and supported by the systematic review findings, women experiencing homelessness or financial hardship after leaving an abusive relationship are typically focused on survival, safety, and security, leaving them with little power or control over their everyday decisions. In this context survivors of IPV are vulnerable to violence not only from their former partners (Pedersen, Malcoe, & Pulkingham, 2013), but also family, friends and strangers (Levan, 2003; Schmidt, Hrenchuk, Bopp, & Poole, 2015). As was revealed in the systematic review, their reproductive and sexual health choices may be violated through sexual coercion and/or sexual assault (Gesink et al., 2016) or they may be forced to engage in sexual activity in exchange for food, shelter, and to support children (Schmidt et al., 2015). The above analysis suggest interventions aimed at behaviour modification and health education at the individual level may be ineffective and highlights the importance of interventions at the structural level (Solar & Irwin, 2010).

Responding to structural violence. Interventions aimed at structural factors are likely to increase available choices and improve peoples' capacity to engage in health promoting choices (Andersson, Shea, Amaratunga, McGuire, & Sioui, 2010; Ford-Gilboe et al., 2005; Solar & Irwin, 2010; Wathen, MacGregor, & MacMillan, 2016). Creating safe spaces and promoting meaningful collaboration with Indigenous women and their communities are likely to improve connections with other community members, increase social support and reduce social isolation (Andersson et al., 2010). Furthermore, from a structural violence perspective, poor coping skills and unhealthy behaviours may be reframed as adaptations (Varcoe, Browne, & Cender, 2014; Varcoe et al., 2016), because as findings from the systematic review indicate, these behaviours are a means of surviving with limited resources. When healthcare providers respond to these behaviors in a negative way it may lead to feelings of loss of power and control for women that are already marginalized by violence (McCall et al., 2009; Schmidt et al., 2015). Therefore, as described by Denison et al. (2014) woman experienced further harm and trauma when

interacting with the healthcare system and were deterred from accessing care. Studies in the systematic review demonstrated that building a trusting relationship and collaborating with women to identify strengths is an important aspect of health promotion and essential to the formation of an effective therapeutic alliance (Denison et al., 2014; McCall et al., 2009; Schmidt et al., 2015; Shahram et al., 2017; Varcoe & Dick, 2008).

Harm reduction and sexual health promotion. Poor sexual and reproductive health are known outcomes of violence (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). But, service providers and community members in two of the studies in the systematic review highlighted that the dynamics of sexual coercion were poorly understood in relation to sexual health promotion (Gesink et al., 2016; Varcoe & Dick, 2008). For example, some young women perceived casual sexual relationships to be safer than “committed monogamous relationships” because of the risk of physical and emotional abuse, sexual coercion, forced unprotected sex, inability to negotiate condom use, infidelity among partners, abandonment, and economic dependence in long-term relationships (Gesink et al., 2016). Therefore, choosing casual sexual relationships over a long-term partner may reduce risk of violence for some women, but increases the risk of STI transmission because of multiple sexual partners. Some of the women’s partners forced unprotected sex on the women, used injection drugs and many of the women’s partners had multiple sexual partners, which increased their vulnerability to STIs (Varcoe & Dick, 2008). Women reported greater capacity negotiating condom use during one time sexual encounters (including sex work) than with boyfriends, spouses and common law partners (Gesink et al., 2016; Mill, 1997). McKeown, Reid, and Orr (2004) reported that despite having the power and ability to insist on condoms during sex work, few women did. However, Mill (1997) found, among women engaged in sex work, most women used condoms regularly to protect themselves from infection. Among sex workers, unprotected sex was more likely to occur if women were under the influence of substances, or if customers offered more money to have sex without a condom and women were desperate for drug money (Mill, 1997).

Given the challenges some women have negotiating condom use with partners, routine screening for STI's, HIV, and cervical cancer should be encouraged because early detection may improve outcomes and prevent further transmission of infection if treatment can be started promptly. From a reproductive justice perspective women should be engaged in contraceptive counseling based on needs and values, not coercion and financial cost (Stote, 2017). Women should be provided with information about all means of preventing pregnancy if they so wish. Furthermore, cost of all forms of contraception should not deter women from accessing them. Engaging with men and boys to encourage healthy sexual relationships that includes better understandings of consent is an important strategy to prevent sexual violence (Kinnon, 2014).

Interventions that build on strengths and capacity. Researchers and policy-makers call for the healthcare sector to be more responsive to violence and trauma, and aim to improve the health and wellbeing of families experiencing violence (Wathen et al., 2016). Family health promotion may help break cycles of violence and poverty; preventing violence across the lifespan (WHO, 2010). As demonstrated in this systematic review and consistent with Varcoe & Dick, (2008), Indigenous women face challenges to meet their needs related to intersections of violence, poverty, displacement, and discrimination (Varcoe & Dick, 2008). Displacement that occurs as a result of violence forces women to cope with a new environment, but may also represent new opportunities to satisfy needs and realize aspirations (Ford-Gilboe et al., 2005). Women draw on internal and external resources as they engage in health promotion and adapt to their environment (Ford-Gilboe et al., 2005). Service providers and policy makers must address known and modifiable risks, and remove barriers to women's efforts toward health promotion after leaving a violent environment (Ford-Gilboe et al., 2005).

Although individualized models of empowerment may be engaged, a community-based approach to building on strengths and increasing capacity is suggested to be the most effective (Solar & Irwin, 2010). For example, Haskell and Randall (2009) found an individualized focus on trauma was problematic in their work with Indigenous communities and called for a more

contextualized complex trauma framework. Chandler and Lalonde (1998) also problematized an individualized focus; they found youth suicide rates among First Nations in British Columbia to be highly variable by community and that community level factors were most predictive of risk and resilience. The focus of their study was suicide and not violence, but it is possible that community cultural continuity factors such as measures of self-government, control over health and education, and elected band councils composed of more than 50% women (Chandler & Lalonde, 1998, 2008) may also be protective against violence.

Ginwright (2018) described one community centered and strengths based approach to trauma called healing centered engagement. This holistic approach involves “culture, spirituality, civic action and collective healing... [It] views trauma not simply as an individual isolated experience, but rather highlights the ways in which trauma and healing are experienced collectively” (Ginwright, 2018, para 10). Findings of the systematic review support this approach to healing, for example, connecting with others, engaging in cultural and spiritual practices and understanding the problem of colonization all influenced the health and healing of women in the reviewed studies. Indigenous groups suggest promotion of Indigenous cultural values is an important strategy to address family violence because their values emphasize mutual respect, and traditional gender roles were more egalitarian than those of the dominant colonial culture in Canada (Andersson & Nahwegahbow, 2010; Kinnon, 2014). Furthermore, surviving in the face of adversity and discrimination should be a testimony to the strength and resiliency of all Indigenous cultures in Canada (Andersson et al., 2010; Chandler & Lalonde, 1998, 2008).

Implications for Nursing Education

The transformative shift towards equity in healthcare suggests nurses must actively engage in change starting from within themselves, and advocate for systemic and policy changes within healthcare and government more generally (Varcoe et al., 2014). The concepts of cultural humility and TVIC weave together in many ways, and hinge on critical awareness of self, context, and reflexivity. Therefore, nurses must reflect on and change attitudes and

assumptions (Varcoe et al., 2014), but nurses must develop a set of skills too, which depends on an ability to use an intersectional lens to see connections and pathways from the macro to micro level, and piece together a complex puzzle. For instance, knowledge of the correlation between violence and HIV may not provide nurses with an understanding of pathways that lead to unhealthy behaviors, and HIV transmission, nor ensure empathy for the everyday reality of Indigenous women (McCall et al., 2009). Similarly, nurses who are informed of the historical context of Indigenous communities, may not translate into nurses who understand current patterns of unhealthy relationships and behaviors among Indigenous women experiencing violence.

Nursing curriculum must be developed that address these problems and incorporate practices that promote structural competency and cultural humility such as reflection exercises (Browne, 2007; Browne et al., 2016; Varcoe et al., 2014). These interventions should be evaluated for efficacy including behavioral and attitudinal changes among nursing students and practicing nurses. Knowledge of violence should be incorporated into theory and practice courses, for example teaching nurses signs and symptoms of trauma and how to respond to disclosures of violence. Furthermore, an intersectional approach, which emphasizes structural violence, should be taught to promote more nuanced understandings of the social determinants of health, health promotion and principles of primary health care (Browne et al., 2011).

Research on Indigenous Health – A National Priority

The systematic review presented in this thesis echoes the findings of Wathen et al. (2016) highlighting many gaps and conflicting evidence on how best to support all women exposed to violence. For example, most health research among women around the globe focused on experiences of living with violence or the crisis of leaving, few studies examined health and healing in the years after leaving (Ford-Gilboe et al., 2005; McDonald & Dickerson, 2013). In 2009, a report prepared for the now defunct National Aboriginal Health Organization (NAHO) cited health promotion and healing in urban settings as a research priority, and noted

that in spite of the intersecting risks of violence and displacement from family and home on the health of women, few studies explored this topic (Browne, McDonald, & Elliott, 2009). As revealed in this systematic review, research that has been produced since 2009 has, in many ways, described the essence of the problem of violence and displacement. Yet, this research also indicated displacement remains an insidious problem. Findings from my systematic review suggest that culture and connecting with others to develop a sense of identity and belonging was an important part of collective healing among Indigenous women; although, evidence to support in-depth understandings of healing and health promotion were lacking and were not sufficiently studied. Overall, this review found a dearth of qualitative literature that explored Indigenous women's health and healing after exposure to violence. This represents an important gap in the area of Indigenous women's health.

Research setting. This review also highlighted the importance of understanding contextual factors. Notably geography influenced access to healthcare and other resources. Studies suggested that experiences differed in rural and urban settings (Brassard et al., 2015; McCall et al., 2009; Nixon, Bonnycastle, & Ens, 2017; Schmidt et al., 2015; Varcoe & Dick, 2008). Although, some researchers identify a lack of research in rural settings, other researchers suggest Indigenous health experiences in urban settings should be a priority. For instance, NAHO urged researchers to give more consideration to "the factors [and processes] that promote health and healing in urban settings" (Browne et al., 2009, p. 37). This review found that the available literature was scarce but balanced on both accounts. Perhaps what was more evident on closer inspection was not the dichotomy between urban versus rural, but rather the fluidity of movement between these two spaces and the ongoing displacement of women as a result of violence and structural inequities. Regardless of urban or rural context, service providers including nurses may display discriminatory attitudes that compounds the problem of access to culturally meaningful health and social services (Denison et al., 2014; McCall et al., 2009; Nixon et al., 2002; Schmidt et al., 2015; Shahram et al., 2017). Women may further be

deterred from accessing care because many health concerns associated with violence such as mental health disorders, substance use and sexually transmitted infections (including HIV) are stigmatized (García-Moreno et al., 2005; McCall et al., 2009; Mill, 1997). Delayed access to care often leads to poor health outcomes.

Diversity among Indigenous Peoples. Culture and context such as rural or urban setting may influence research findings and should inform nursing interventions. Therefore, research that clusters these three distinct groups may not be appropriate and the transferability of research from one context to another is questionable. This review found that most studies referred to participants as *Aboriginal* and did not specifically distinguish cultural groups. However, the description of research settings and reference to reserves suggested samples consisted mostly of First Nations women. Future research should delineate specific perspectives if all three groups are included (Inuit Tapiriit Kanatami [ITK], 2018); furthermore, Inuit and Métis perspectives should specifically be included in future research in the area of violence and women's health. Indigenous peoples and communities are not a homogenous group. Inuit, Métis and First Nations Peoples are three distinct groups of Indigenous peoples living in Canada and considerable variations exist within and between groups related to geographical homelands, languages, and cultures (Royal Commission on Aboriginal Peoples [RCAP], 1996). While similarities do exist in overall experiences of colonization and implementation of national level government policies and interventions, lived experiences of colonization are unique to each community, family, and individual (RCAP, 1996). In a more contemporary context, increasing urbanization of Indigenous peoples adds to this diversity (Arriagada, 2016).

Understanding displacement. Experiences of uprooting, homelessness and state apprehension of children were particularly salient themes in the systematic review, which included research that spanned over the last 23 years. Indigenous women “seek refuge from poverty and violence on reserves only to meet the same in urban centers... Even relatively

privileged Native women speak of the on-going search for safety and home” (McConney, 1999, p. 214). Almost 20 years after this quote was articulated, the situation for Indigenous women remains virtually unchanged as evidenced by the disproportionate incidence of murder and violent crime experienced by Indigenous women and girls necessitating the ongoing national Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) (MMIWG, 2018).

Cyclical patterns of displacement and loss of healthy familial relationships found in this review also indicate parenting was undermined by systemic and structural violence, for example, the mass State apprehension of Indigenous children to residential schools. The last residential school closed in 1996, but, the current overrepresentation of Indigenous children in the child welfare system suggests this problem is far from over (Gerlach, Browne, Sinha, & Elliott, 2017). There is a growing body of evidence in Canada to suggest that present day violence and health inequity is caused by historic and ongoing colonization, discrimination, and displacement of Indigenous Peoples (Andersson & Nahwegahbow, 2010; Healey, 2016; MMIWG, 2018; RCAP, 1996; Truth and Reconciliation Commission [TRC], 2015).

A 2009 report prepared for NAHO, noted that in spite of the intersecting risks of violence and displacement from family and home on the health of Indigenous women, few studies explored this topic directly (Browne et al., 2009). Although displacement was clearly identified as a problem and descriptions provided in the studies reviewed, less clear was how migration patterns may influence health promotion and healing especially among Inuit women. For example, urban centers typically have greater access to health and social services compared to rural and remote communities (Schmidt et al., 2015; Varcoe & Dick, 2008), but mainstream services in urban centers may not be meeting the needs of Indigenous women who have experienced violence (Denison et al., 2014; McCall et al., 2009; Nixon et al., 2002; Shahram et al., 2017). Leaving a small community may contribute to cultural trauma and loss of social support networks (Schmidt et al., 2015), but also provide greater access to education and employment opportunities (Berman et al., 2009). Additional, qualitative research is needed to

explore how movement between rural and urban centers influences health promotion and healing.

The problem of displacement in relation to violence may benefit from quantitative exploration. For example, a recent quantitative study by Brownridge et al. (2017) found, in addition to socioeconomic factors, that childhood victimization explained a significant proportion of the disparity in rates of IPV between Indigenous women and the general population of Canadian women. This study did not explore the role of displacement as it relates to childhood victimization. Furthermore, the child protection system may have both mediating and moderating effects, because child apprehension may reduce immediate harms and prevent the escalation of violence that could result in injury or even death. But, child apprehension also causes frequent moves, dislocates children from family support, and disrupts culture and lifeways (Blackstock, Trocme, & Bennett, 2004; Gerlach et al., 2017). Multivariate statistical models may help correlate displacement with poorer health outcomes, as well as provide additional evidence that involvement with the child protection system may be correlated with future risk of IPV (Brownridge et al., 2017). This research could be used as a political tool among Indigenous groups to advocate for systemic and policy changes because quantitative evidence speaks in a language that policy makers understand and may carry more weight among policy makers and politicians because it is more generalizable (Fallon et al., 2013).

Life history and exposure to violence. Findings from this systematic review suggests a life history approach may be an important strategy for future research to explore healing from violence. This approach revealed how early childhood exposure to violence, and multiple disconnections and displacement created vulnerabilities to violence and poor health later in life (e.g., McKeown et al., 2004; Mill, 1997; Shahram et al., 2017). Although the intention of these studies was to explore HIV (McKeown et al., 2004; Mill, 1997) or substance use (Shahram et al., 2017) women recounted multiple experiences of violence in their life history and violence was a major finding. This approach also generated findings that described relationships between

cumulative exposure to violence and the emergence of unhealthy behaviours. Specifically, over time, emotional trauma, lack of social support, and poverty constrained choices and influenced women's behaviours (McKeown et al., 2004; Mill, 1997; Shahram et al., 2017). In addition to physical injuries and emotional trauma that occurred as a direct result of violence, unhealthy behaviors, such as substance use and unsafe sexual practices among women linked violence and poor health.

Women explored complex connections between their experiences of violence and their physical, emotional, and sexual health, especially with regards to alcohol and substance use. Unhealthy patterns of behavior, such as substance use and multiple sexual partners, were coping mechanisms and survival strategies. These behaviours created additional health challenges among women and increased the risk of acquiring HIV and other sexually transmitted infections (Gesink et al., 2016; McKeown et al., 2004; Mill, 1997; Varcoe & Dick, 2008). Given women's ongoing challenges and the social context of their lives, healthy coping strategies, such as attending trauma counseling, engaging in recreational activities, or connecting with friends and family, may be unavailable to many women (Hagen, Kalishuk, Currie, Solowoniuk, & Nixon, 2013; Schmidt et al., 2015). Understanding the life histories of Indigenous women who have recovered from trauma may provide important insights into health promotion and healing.

A Focus on substance use and HIV. Studies included in the review were mostly with Indigenous women living in the western provinces and focused on substance use and HIV (e.g., McCall et al., 2009; McKeown et al., 2004; Varcoe & Dick, 2008). These studies connected Indigenous women's ongoing displacement, poverty, social exclusion, and violence, to an erosion of coping skills and unhealthy behaviors, which led to substance use and HIV. This made a significant contribution to existing quantitative data (e.g. high reported rates of HIV) by revealing the complex pathways that link historical context to the health inequities found today. However, this focus on HIV and substance-use limits transferability of findings, and excludes a

large portion of indigenous women for whom violence did not result in these outcomes. It is unclear how or if findings from this systematic review are transferable to Indigenous women not experiencing HIV, poverty, or substance use.

It is assumed that many women have experienced different outcomes after exposure to violence and that these outcomes would be informed by their unique social location (García-Moreno et al., 2005). For instance, it is likely that the stigma of HIV and substance use also influenced women's help seeking behaviours, such as attending health clinics and counseling, seeking help from family and friends and using shelters and social assistance programs (McCall et al., 2009; Mill, 1997). This systematic review found these multiple stigmas (e.g., violence, HIV, substance use, gender and cultural identity) may intersect with and amplify negative experiences, including judgment from nurses and other service providers. Importantly, future research should also explore the perspectives of women whose life experiences include violence but not HIV and/or substance use. These explorations may reveal important considerations for HIV prevention and better understandings of health promotion and healing more generally.

(Re)Considering How Violence is Explored

This review found that while few studies with Indigenous women had research questions that focused on violence; violence was a common theme in studies of sexual health, substance use and homelessness (e.g., McCall et al., 2009; Schmidt et al., 2015). This suggests the importance of addressing violence directly as an important strategy to reduce homelessness, substance use, and transmission of sexually transmitted and blood born infections, and improve overall health and wellbeing (García-Moreno et al., 2005). Furthermore, some studies that focused on violence had samples that included a large proportion of Indigenous women, even though this was not an inclusion criterion (McKeown et al., 2004; Nixon et al., 2017; Nixon et al., 2002; Schmidt et al., 2015; Varcoe & Dick, 2008), which supported statistics regarding the

disproportionate amount of violence experienced by Indigenous women (Brennan, 2011; Paletta, 2008). T

he inclusion of participants other than Indigenous women at times made it difficult to distinguish the voices of Indigenous women from other cultural groups or other community members. Furthermore, the voices of women from distinct cultural groups were aggregated and homogenized as “Aboriginal” and this does not reflect the diversity of Indigenous people and their voices across Canada. Aspects of health promotion and healing may be unique among different Indigenous groups and influenced by geographical locations. Therefore, collaborating with Inuit, Métis and First Nations communities to synthesize findings linked to violence from this diverse literature would be valuable. For example, findings that academic researchers deem as important to explore in future research may not be congruent with community priorities (Inuit Tapiriit Kanatami, 2018).

Capacity building and research partnerships. Collaborative approaches to exploring health promotion should be a research priority (Browne et al., 2009; Inuit Tapiriit Kanatami, 2018). A research partnership between academic researchers and communities may build community research capacity and move toward Indigenous self-determination in research. Ideally, community led qualitative research will form the basis of interventions to address violence and promote collective healing, because strategies to address violence are unlikely to be effective if communities do not have input into their development, implementation, and evaluation (Andersson et al., 2010; Gesink et al., 2016; Varcoe & Dick, 2008). Many communities may have a wealth of knowledge about health and healing, but communicating that knowledge to service providers and policy makers may be challenging (Andersson et al., 2010). Knowledge sharing among communities and researchers is required to inform more effective and contextually tailored and trauma-and-violence-informed health promotion strategies with Indigenous women. For example, (Varcoe et al., 2017) described the development and pilot

testing of a health promotion intervention for Indigenous women who have experienced IPV, however this was the only nursing intervention found during the course of this review.

A capacity building approach may include collaborating with community research partners to write grant proposals, secure funding and help guide research processes and dissemination of results in ways that policy makers and practitioners understand (Andersson et al., 2010; Inuit Tapiriit Kanatami, 2018). Decolonizing methodologies are important to guide research and include practices (e.g., cultural humility) that redress power imbalances between academic researchers and community research partners (Chilisa, 2012; Healey & Tagak Sr, 2014; Yeager & Bauer-Wu, 2013). Furthermore, compensation for community research partners would allow them to become more fully engaged in the research process, rather than risk the token participation that may occur when community research partners are expected to volunteer their time (ITK, 2018). Non-Indigenous people must assume a role in reconciliation through critically examining and dismantling oppressive systems to create space for Indigenous people to do the important work of Indigenizing (Browne et al., 2016; Jimmy, Allen, & Anderson, 2015).

Future research - contribution of the study protocol. The problem of violence against Indigenous women and the knowledge gaps identified above suggests a need for further research, and raises questions regarding the existence of sufficient research to warrant another systematized review project. Yet, TVIC is a burgeoning area and research continues to be conducted in the area of violence and health among Indigenous people. Furthermore, as noted by Sandelowski and Barroso (2003), “calls for more research in a target domain do not necessarily entail the collection of yet more data, but, rather might require the insightful mining of data already collected” (p. 783). For instance, literature searches found that while few studies with Indigenous women had research questions that focused on violence; violence was a common theme in studies of sexual health and substance use (e.g., McCall et al., 2009; Schmidt et al., 2015). However, the transferability of existing research to women who are not HIV positive or did not experience substance use is questionable, as is the transferability of

research between First Nations, Métis and Inuit. Therefore, collaborating with Inuit women to explore their insights into extant literature would be valuable and make a unique contribution to both understandings of violence and methodological development.

The study protocol for the configurative mixed knowledge synthesis was developed to increase research rigour, explore transferability of findings, and address ethical considerations such as ownership and control, reciprocity, decolonization, and community capacity building when conducting systematic reviews. Moreover, the knowledge sharing sessions (via focus groups and interviews) proposed as an integral part of the study protocol are designed to address a gap in the existing research by focusing on health promotion and healing from violence. Therefore, collaborating with Inuit women to create a synthesis of findings linked to violence from this diverse literature would be valuable to inform more contextually tailored health promotion strategies with Inuit communities. Conducting this research would also contribute to methodological development because research methods that specifically described collaborative and community centered approaches to systematic reviews were not located.

Reflections on Research and Cultural Bias

The first, and perhaps most important consideration, is that this review was conducted by a non-Indigenous person and all members of the thesis committee were also non-Indigenous. Despite engaging in reflection and other strategies to promote cultural humility the analysis of findings is likely influenced by my social locations (e.g. middle class, white, settler colonial, nurse) and my own life experiences. Therefore, it is important to explore and reflect on my experiences and how they may have influenced this research. The cultural humility approach requires the researcher to reflect on and inventory personal and professional values followed by careful consideration of the participants' perspective, this reflective process is described as "an unpeeling of the layers that make up a person" (Yeager & Bauer-Wu, 2013, p. 253). Hence, I will begin this exploration with a brief discussion of my life thus far and how my understanding of colonization has evolved.

I was born and raised in a small town, located equidistance between Calgary and Red Deer, Alberta. It was by no means remote, but it was certainly rural and surrounded by ranchers and farmers of western European descent. My town was also affected by natural resource extraction – a key aspect and driver of colonization. Rapid social changes occurred related to the boom-bust economy and influx of transient workers. Reflecting back, I understand that resource extraction has benefits such as employment, but also how colonization may negatively influence all people. Yet, my first understanding of colonization consisted of Eurocentric studies about explorers. My grade-school experiences pre-date RCAP findings and TRC recommendations. School assemblies opened with singing god save the queen, not an acknowledgment that the land we are gathered on is traditional and unceded territory of Indigenous Peoples. To be honest, my understanding of Indigenous Peoples was informed by misconceptions and stereotypes. Canales (2000) suggested *exclusionary othering* results from a failure to take the role of those perceived as different or inaccurate role-taking based on stereotypes.

After high school, I moved to Calgary to attend university and then on to Yellowknife to work as a registered nurse. Working as a nurse on a medicine unit illustrated for me first hand health inequities related to poverty, colonization, and violence. I cared for many women experiencing violence and addictions; initially, it was difficult to see strength amid the pain and suffering. The north is also deeply affected by natural resource extraction, abandoned gold mines leave scars on the land and many of the lakes around Yellowknife are polluted with toxic arsenic. Signage that water is unsafe for swimming dot otherwise pristine northern landscapes. Indigenous references to the interconnectedness of land and health resonate first-hand in this context. Living in Yellowknife was a turning point in my understanding of colonization and Indigenous peoples. Surrounded by Indigenous people, I was no longer in the majority. Mainstream issues in the north are Indigenous issues and I became increasingly aware of political struggles and Indigenous rights to self-determination and land.

Canales (2000) suggests the longer we spend in a community of others the less likely we are to rely on a single story perpetuated by stereotypes. Exclusionary othering is essentially the opposite of empathy – seeing the world as others see it in an attempt to understand another’s feelings without judgment, and must be communicated to be felt by another (Wiseman, 1996). Canales (2000) depicts empathy as a process of *inclusionary othering* by taking the role of the other and attempting to view their world through which an understanding develops; this understanding is necessary for connection and empowerment to occur. A lack of critical consciousness may result in pathologizing and isolating ourselves and others (Brown 2006). By the time I left the north, a new critical consciousness had emerged. I had developed a profound respect for the strength and resilience of Indigenous Peoples and women in particular. I began to see in the cold, dark winters, a tapestry of strength and resilience of people, interwoven with adversity and pain. I further recognized the importance of Indigenous culture to empower communities. When I began graduate studies, I had a strong desire to conduct research that would benefit Indigenous women and promote health equity and social justice.

From a research perspective, my life experiences are strengths because they increased my knowledge of a broader Canadian context, including a Northern Indigenous context, than what I might otherwise possess if I had lived in one place my entire life. Although, these experiences also reflect potential cultural biases that may have influenced my research process and findings. Conversely, how has this work influenced me? Importantly, one cannot study oppression without becoming acutely aware of privilege. I am privileged and accompanying that growing recognition of how my privilege stems from colonization was a sense of guilt and shame. Guilt which we ascribe to flawed behavior rather than a flawed self, while still painful, can be highly adaptive and lead to change (Brown, 2006). Therefore, feeling guilty about exploitation and harmful treatment of Indigenous people that has occurred during research past and present may lead to positive change in the future. At times during this thesis, while I was reading about the colonizing potential of research and privileging of western worldviews, I

wondered if a non-Indigenous person could or should conduct this research. With every word I wrote, I wondered how it would be perceived by Indigenous readers, would they perceive it the way I intended? Similarly how would non-Indigenous colleagues evaluate my work which deviates from many typical approaches? When I met with Inuit organizations to begin negotiating a research relationship I felt uncomfortable that I would receive a graduate degree, a benefit that may confer substantial privilege. I was asking for their mentorship and time, yet given the constraints of a masters project, I could realistically offer few benefits in return.

Conducting the systematic review allowed me much greater insights into the lives of Indigenous women. However, the violence women experienced was often difficult to read about; therefore, immersing myself in data analysis was not an easy process. There is a risk of experiencing vicarious trauma defined as “the emotional residue of exposure that [practitioners] have from... hearing trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured... it is a state of tension and preoccupation” with the trauma stories described by others (American Counseling Association, n.d., p. para 3). These risks were minimized by taking time for reflection and discussing with others my emotions related to the content I was reading. The challenge of vicarious trauma and the need for prevention will likely be much greater in research projects that I may undertake in the future. For example engaging in knowledge sharing with community research partners and interviewing women whom have experienced violence and trauma directly.

During this thesis project, I have experienced considerable growth and understanding about myself as a nurse, researcher, and individual. My understanding of the problem of violence and colonization has increased immensely. I am grateful for all the relationships I have formed with people along the way, and the knowledge that they shared with me. I am especially thankful for the guidance of my community mentors that I met early on in the program and the opportunity to take an Inuktitut language and culture course. Although, the most memorable part of the course was driving an amazing Inuk elder back and forth from Ottawa to Kemptville and

the knowledge and laughs we shared. My life's experiences have afforded me opportunities to gain a broader perspective of the challenges and lifeways of other people who live within the geographic boundaries of what is known as Canada.

Conclusion

In conclusion, this thesis contributes to our understandings of the intersections between violence and health among Indigenous women. To my knowledge this thesis was the first systematic exploration of qualitative research in this substantive area. As such, it illuminates the unique experiences of First Nations, Metis, and Inuit women and maps extant research in a way that may inform future research and policy directions. This thesis highlighted many gaps in our understandings and suggests the need for additional research which supported the development of the review protocol described in Chapter 3. The development of methodological approaches to systematic reviews that privilege Indigenous worldviews, engage with ethical principles for research with Indigenous people in a meaningful way, and facilitate knowledge translation and community action, should all be part of a comprehensive research priority. My experience conducting this research suggests these types of reviews will require substantial time and resources. For example, time must be spent learning about the culture and building trusting relationships with community research partners.

Health disparities between Indigenous women and other Canadian women remain prominent and nurses have a moral imperative to orient care toward reducing these inequities and to promote social justice (Canadian Nurses Association, 2010). Georges (2004) reasoned nurses perpetuate suffering when they fail to break the silence about the politics producing it. Therefore, illuminating the concerns of Indigenous women in Canada is critical to raise awareness in nursing and develop collaborative approaches for more meaningful and safe care. Nurses must speak up against discrimination that occurs in health care and encourage their colleagues to become more informed about the social injustices and historical traumas that Indigenous People have collectively endured. Furthermore, ongoing violence against

Indigenous women suggests a multifaceted approach is required including: violence prevention, support for health promotion and healing with women already exposed to violence, and ensure existing harm reduction strategies (e.g., reducing transmission of STI's and HIV) are informed by the complex dynamics of trauma and violence. The suffering of Indigenous women must be felt to promote empathy and cultural humility among nurses; however, visual representations and research findings should be framed around strengths, not deficits, and positioned within the context of colonization. Indigenous women must be *seen*, *heard* and *understood*, if we are to move toward reconciliation within healthcare and the broader Canadian society

References

- Alshammari, K., McGarry, J., & Higginbottom, G. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open*, 5, 237-253. doi:10.1002/nop2.133
- American Counseling Association. (n.d.). Vicarious Trauma: Fact Sheet #9
Retrieved from <https://www.counseling.org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf>
- Anderson, J., & McCann, E. (2002). Toward a post-colonial feminist methodology in nursing research: exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher*, 9(3), 7-27. doi:10.7748/nr2002.04.9.3.7.c6186
- Andersson, N., & Nahwegahbow, A. (2010). Family violence and the need for prevention research in First Nations, Inuit, and Métis communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(2), 9-33.
- Andersson, N., Shea, B., Amaratunga, C., McGuire, P., & Sioui, G. (2010). Rebuilding from resilience: research framework for a randomized controlled trial of community-led interventions to prevent domestic violence in Aboriginal communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(2), 61-88.
- Arriagada, P. (2016). *Women in Canada: A gender based statistical report, First Nations, Métis and Inuit women*. (Statistics Canada Catalogue no. 89-503-X ISSN 1719-4407).
Retrieved from www.statcan.gc.ca/pub/89-503-x/2015001/article/14313-eng.htm
- Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC medical research methodology*, 9(1), 59. doi:10.1186/1471-2288-9-59

- Beccaria, G., Beccaria, L., Dawson, R., Gorman, D., Harris, J., & Hossain, D. (2013). Nursing student's perceptions and understanding of intimate partner violence. *Nurse education today*, 33(8), 907-911.
- Bellamy, S., & Hardy, C. (2015). Post-traumatic stress disorder in Aboriginal People in Canada: review of risk factors, the current state of knowledge and directions for further research. *National Collaborating Centre for Aboriginal Health*, 1-28.
- Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's downtown eastside. *Social Science & Medicine*, 56(4), 821-833.
- Bent, K. (1993). Perspectives on critical and feminist theory in developing nursing praxis. *Journal of Professional Nursing*, 9(5), 296-303.
- Berman, H., Mulcahy, G. A., Forchuk, C., Edmunds, K. A., Haldenby, A., & Lopez, R. (2009). Uprooted and displaced: a critical narrative study of homeless, aboriginal, and newcomer girls in Canada. *Issues in Mental Health Nursing*, 30(7), 418-430.
doi:10.1080/01612840802624475
- Blackstock, C., Trocme, N., & Bennett, M. (2004). Child Maltreatment Investigations Among Aboriginal and Non-Aboriginal Families in Canada. *Violence Against Women*, 10(8), 901-916. doi:<http://dx.doi.org/10.1177/1077801204266312>
- Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 51(3), 320-338. doi:10.1177/1363461513503380
- Bourgeois, C., Edmunds, M., A, A., Jonah, L., Varsaneux, O., & Siu, W. (2017). *HIV in Canada: Surveillance Report, 2016. Canada Communicable Disease Report*. Retrieved from <https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2017-43/ccdr-volume-43-12-december-7-2017/hiv-canada-2016.html>.

- Brascoupé, S., & Waters, C. (2009). Cultural safety: exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *National Aboriginal Health Organization: Journal of Aboriginal Health*, 5(2), 6-41.
- Brassard, R., Montminy, L., Bergeron, A.-S., & Sosa-Sanchez, I. (2015). Application of intersectional analysis to data on domestic violence against Aboriginal women living in remote communities in the province of Quebec. *Aboriginal Policy Studies*, 4(1), 3-23.
doi:10.5663/aps.v4i1.20894
- Brennan, S. (2011). Violent victimization of Aboriginal women in the Canadian provinces, 2009. *Juristat: Canadian Centre for Justice Statistics*.
- Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in society: The journal of contemporary social services*, 87(1), 43-52.
- Browne, A. (2007). Clinical encounters between nurses and First Nations women in a western Canadian hospital. *Social Science & Medicine*, 64(10), 2165-2176.
- Browne, A., & Fiske, J.-A. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126-147.
- Browne, A., McDonald, H., & Elliott, D. (2009). *First Nations urban Aboriginal health research discussion paper: a report of the First Nations center, National Aboriginal Health Organization*. Retrieved from National Aboriginal Health Organization, Ottawa, ON: www.naho.ca/documents/fnc/englishUrbanFirstNationsHealthResearchDiscussionPaper.pdf
- Browne, A., & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing Aboriginal women. *Nurse Researcher*, 9(3), 28.
- Browne, A., Smye, V., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *Canadian Journal of Nursing Research*, 37(4), 16-37.

- Browne, A., Smye, V., & Varcoe, C. (2007). Postcolonial-feminist theoretical perspectives and women's health. In O. Hankivsky, C. Varcoe, & M. Morrow (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 124-142). Toronto, Canada: University of Toronto Press.
- Browne, A., Varcoe, C., & Fridkin, A. (2011). Addressing trauma, violence, and pain: research on health services for women at the intersections of history and economics. In O. Hankivsky, J. de Leeuw, B. Lee, & N. Vissandjée (Eds.), *Health Inequities in Canada: Intersectional Frameworks and Practices* (pp. 295-311). Vancouver, BC: University of British Columbia Press.
- Browne, A., Varcoe, C., Lavoie, J., Smye, V., Wong, S., Krause, M., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research*, 16(1), 544.
- Brownridge, D. (2008). Understanding the elevated risk of partner violence against aboriginal women: a comparison of two nationally representative surveys of Canada. *Journal of Family Violence*, 23(5), 353-367.
- Brownridge, D., Taillieu, T., Afifi, T., Chan, K., Emery, C., Lavoie, J., & Elgar, F. (2017). Child maltreatment and intimate partner violence among Indigenous and Non-Indigenous Canadians. *Journal of Family Violence*, 32(6), 607-619. doi:10.1007/s10896-016-9880-5
- Cajete, G. (2015). *Indigenous Community: Rekindling the Teachings of the Seventh Fire*. St. Paul, Minnesota: Living Justice Press.
- Campbell, S., Dorgan, M., & Tjosvold, L. (2016a, March 15, 2016). Filter to Retrieve Studies Related to Indigenous People of Canada the EBSCO CINAHL Database. Retrieved from http://guides.library.ualberta.ca/ld.php?content_id=14026803
- Campbell, S., Dorgan, M., & Tjosvold, L. (2016b, March 8, 2016). Filter to Retrieve Studies Related to Indigenous People of Canada the OVID Medline Database. Retrieved from http://guides.library.ualberta.ca/ld.php?content_id=14026803

Canadian Nurses Association. (2010). *Social Justice.... a means to an end, an end in itself*.

Retrieved from Canadian Nurses Association, Ottawa, ON: www.cna-aiic.ca/~media/cna/page-content/pdf-en/social_justice_2010_e.pdf

Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science*, 22(4), 16-31.

Cargo, M., & Mercer, S. (2008). The value and challenges of participatory research: strengthening its practice. *Annu. Rev. Public Health*, 29, 325-350.

Chandler, M., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35(2), 191-219.

Chandler, M., & Lalonde, C. (2008). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In L. Kirmayer & G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 221-248): University of British Columbia Press.

Charron, M., Penney, C., & Senécal, S. (2010). *Police-reported crime in Inuit Nunangat*. (110015647X). Statistics Canada.

Chilisa, B. (2012). Postcolonial indigenous research paradigms. *Indigenous research methodologies*. Thousand Oaks, CA: Sage, 98-127.

Chmielowska, M., & Fuhr, D. C. (2017). Intimate partner violence and mental ill health among global populations of Indigenous women: a systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 52(6), 689-704.

Cook, J. M., Dinnen, S., & O'Donnell, C. (2011). Older women survivors of physical and sexual violence: a systematic review of the quantitative literature. *Journal of Women's Health*, 20(7), 1075-1081.

Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against Women of Color. *Stanford Law Review*, 43(6), 1241-1299. doi:10.2307/1229039

- Crowe, M., & Sheppard, L. (2011). A review of critical appraisal tools show they lack rigor: alternative tool structure is proposed. *Journal of Clinical Epidemiology*, 64(1), 79-89.
- Culhane, D. (2003). Their spirits live within us: Aboriginal women in Downtown Eastside Vancouver emerging into visibility. *American Indian Quarterly*, 27(3/4), 593-606.
- Daoud, N., Matheson, F., Pedersen, C., Hamilton-Wright, S., Minh, A., Zhang, J., & O'Campo, P. (2016). Pathways and trajectories linking housing instability and poor health among low-income women experiencing intimate partner violence (IPV): toward a conceptual framework. *Women & Health*, 56(2), 208-225.
- Daoud, N., Smylie, J., Urquia, M., Allan, B., & O'Campo, P. (2013). The contribution of socio-economic position to the excesses of violence and intimate partner violence among aboriginal versus non-Aboriginal women in Canada. *Canadian Journal of Public Health. Revue Canadienne de Sante Publique*, 104(4), e278-283.
- Davies, L., Ford-Gilboe, M., Willson, A., Varcoe, C., Wuest, J., Campbell, J., & Scott-Storey, K. (2015). Patterns of cumulative abuse among female survivors of intimate partner violence: links to women's health and socioeconomic status. *Violence Against Women*, 21(1), 30-48. doi:10.1177/1077801214564076
- Denison, J., Varcoe, C., & Browne, A. (2014). Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. *Journal of Advanced Nursing*, 70(5), 1105-1116. doi:10.1111/jan.12271
- Denzin, N. K. (2009). The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative research*, 9(2), 139-160.
- Fallon, B., Chabot, M., Fluke, J., Blackstock, C., MacLaurin, B., & Tonmyr, L. (2013). Placement decisions and disparities among Aboriginal children: further analysis of the Canadian incidence study of reported child abuse and neglect part A: comparisons of the 1998 and 2003 surveys. *Child Abuse & Neglect*, 37(1), 47-60.
- doi:<https://dx.doi.org/10.1016/j.chiabu.2012.10.001>

- Farmer, P., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PloS Med*, 3(10), e449. doi:10.1371/journal.pmed.0030449
- Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of internal medicine*, 166(1), 22-37.
- First Nations Information Governance Centre. (2018). The First Nations Principles of OCAP® (OCAP® is a registered trademark of the First Nations Information Governance Centre). Retrieved from <https://fnigc.ca/ocapr.html>
- Ford-Gilboe, M., Merritt-Gray, M., Varcoe, C., & Wuest, J. (2011). A theory-based primary health care intervention for women who have left abusive partners. *Advances in Nursing Science*, 34(3), 198-214. doi:10.1097/ANS.0b013e3182228cdc
- Ford-Gilboe, M., Wuest, J., & Merritt-Gray, M. (2005). Strengthening capacity to limit intrusion: theorizing family health promotion in the aftermath of woman abuse. *Qualitative Health Research*, 15(4), 477-501.
- Galloway, T., & Saudny, H. (2012). Inuit Health Survey (2007–2008): Nunavut community and personal wellness. *Montreal, QC: Centre for Indigenous Nutrition and the Environment McGill University*.
- García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Retrieved from World Health Organization, Geneva, Switzerland
www.who.int/reproductivehealth/publications/violence/24159358X/en/
- Georges, J. (2004). The politics of suffering: implications for nursing science. *Advances in Nursing Science*, 27(4), 250-256.

- Gerlach, A., Browne, A., Sinha, V., & Elliott, D. (2017). Navigating Structural Violence with Indigenous Families: The Contested Terrain of Early Childhood Intervention and the Child Welfare System in Canada. *International Indigenous Policy Journal*, 8(3).
doi:10.18584/iipj.2017.8.3.6
- Gesink, D., Whiskeyjack, L., Suntjens, T., Mihic, A., & McGilvery, P. (2016). Abuse of power in relationships and sexual health. *Child Abuse & Neglect*, 58, 12-23.
doi:10.1016/j.chiabu.2016.06.005
- Ginwright, S. (2018). Is This the Future of Healing Trauma? Retrieved from
<https://upliftconnect.com/the-future-of-healing-trauma/>
- Gough, D., Thomas, J., & Oliver, S. (2012). Clarifying differences between review designs and methods. *Systematic reviews*, 1(1), 28.
- Goulet, S., Lorenzetti, L., Walsh, C. A., Wells, L., & Claussen, C. (2016). Understanding the environment: domestic violence and prevention in urban Aboriginal communities. *First Peoples Child & Family Review*, 11(1), 9-23.
- Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, 26(2), 91-108.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 2, pp. 163-194). Thousand Oaks, CA: Sage Publications, Inc.
- Hagen, B., Kalishuk, R. G., Currie, C., Solowoniuk, J., & Nixon, G. (2013). A big hole with the wind blowing through it: Aboriginal women's experiences of trauma and problem gambling. *International Gambling Studies*, 13(3), 356-370.
doi:10.1080/14459795.2013.819934
- Hall, J. M. (1999). Marginalization revisited: critical, postmodern, and liberation perspectives. *Advances in Nursing Science*, 22(2), 88-102.

- Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, 18(3), 271-283.
- Haskell, L., & Randall, M. (2009). Disrupted attachments: a social context complex trauma framework and the lives of Aboriginal peoples in Canada. *Journal of Aboriginal Health*, 5(3), 48-99.
- Healey, G. (2013). Tradition and culture: an important determinant of Inuit women's health. *International Journal of Indigenous Health*, 4(1), 25-33.
- Healey, G. (2016). (Re)settlement, displacement, and family separation: contributors to health inequality in Nunavut. *Northern Review*, 1(42), 47-68.
- Healey, G., & Meadows, L. (2007). Inuit women's health in Nunavut, Canada: a review of the literature. *International Journal of Circumpolar Health*, 66(3), 199-214.
- Healey, G., & Tagak Sr, A. (2014). Piliriqatigiinniq 'working in a collaborative way for the common good': a perspective on the space where health research methodology and Inuit epistemology come together. *International Journal of Critical Indigenous Studies*, 7(1), 14.
- Herbert, E., & McCannell, K. (1997). Talking back: six First Nations women's stories of recovery from childhood sexual abuse and addictions. *Canadian Journal of Community Mental Health*, 16(2), 51-68.
- Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror*. New York: Basic Books, NY.
- Hollingsworth, E., & Ford-Gilboe, M. (2006). Registered nurses' self-efficacy for assessing and responding to woman abuse in emergency department settings. *Canadian Journal of Nursing Research*, 38(4), 55-77.
- Hyland, P., Shevlin, M., Fyvie, C., & Karatzias, T. (2018). Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder in DSM-5 and ICD-11: Clinical and Behavioral Correlates. *Journal of Traumatic Stress*, 31(2), 174-180.

- Inuit Tapiriit Kanatami. (2018). *National Inuit Strategy on Research* Retrieved from <https://www.itk.ca/wp-content/uploads/2018/03/National-Inuit-Strategy-on-Research.pdf>
- Inuit Tapiriit Kanatami [ITK]. (2014). *Social Determinants of Inuit Health in Canada*. Retrieved from www.itk.ca/wpcontent/uploads/2016/07/ITK_Social_Determinants_Report.pdf
- Inuit Tapiriit Kanatami [ITK], & Nunavut Research Institute [NRI]. (2006). *Negotiating research relationships with Inuit communities: a guide for researchers*. Retrieved from Ottawa and Iqaluit: <http://www.nri.nu.ca/sites/default/files/public/files/06-068%20ITK%20NRR%20booklet.pdf>
- Jack, S. M., Ford-Gilboe, M., Davidov, D., & MacMillan, H. L. (2017). Identification and assessment of intimate partner violence in nurse home visitation. *Journal of Clinical Nursing*, 26(15), 2215-2228. doi:10.1111/jocn.13392
- Jacobs, K., & Gill, K. (2002). Substance abuse in an urban Aboriginal population: social, legal and psychological consequences. *Journal of Ethnicity in Substance Abuse*, 1(1), 7-25.
- Jamal, F., Langford, R., Daniels, P., Thomas, J., Harden, A., & Bonell, C. (2015). Consulting with young people to inform systematic reviews: an example from a review on the effects of schools on health. *Health expectations*, 18(6), 3225-3235.
- Jimmy, R., Allen, W., & Anderson, V. (2015). Kindred practice: Experiences of a research group working towards decolonization and Indigenization in the everyday. *Education Matters: The Journal of Teaching and Learning*, 3(1).
- Karatzias, T., Cloitre, M., Maercker, A., Kazlauskas, E., Shevlin, M., Hyland, P., . . . Brewin, C. R. (2017). PTSD and Complex PTSD: ICD-11 updates on concept and measurement in the UK, USA, Germany and Lithuania. *European Journal of Psychotraumatology*, 8(sup7), 1-7. doi:10.1080/20008198.2017.148103
- Kincheloe, J., McLaren, P., & Steinberg, S. (2011). Critical pedagogy and qualitative research: moving to the bricolage. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4th ed., pp. 163-177). Thousand Oaks, CA: SAGE.

- Kinnon, D. (2014). *Engaging Inuit men and boys in ending violence against women and girls: a gender-based analysis*. Retrieved from Pauktuutit Inuit Women of Canada:
http://pauktuutit.ca/wp-content/blogs.dir/1/assets/EMB_GBA_Report.pdf
- Kurtz, D., Nyberg, J., Van Den Tillaart, S., & Mills, B. (2008). Okanagan Urban Aboriginal Health Research Collective: Silencing of voice: an act of structural violence: urban Aboriginal women speak out about their experiences with health care. *Journal of Aboriginal Health*, 4(1), 53-63.
- Langford, D. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research*, 10(1), 133-142.
- Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science*, 5(1), 69.
- Levan, M. B. (2003). *Creating a framework for the wisdom of the community: Review of victim services in Nunavut, Northwest and Yukon Territories*: Department of Justice Canada.
- Levinsson, M., & Prøitz, T. S. (2017). The (Non-)Use of Configurative Reviews in Education,. *Education Inquiry*, 8(3), 209-231. doi:10.1080/20004508.2017.1297004
- Macaulay, A. C., Jagosh, J., Seller, R., Henderson, J., Cargo, M., Greenhalgh, T., . . . Herbert, C. P. (2011). Assessing the benefits of participatory research: a rationale for a realist review. *Global Health Promotion*, 18(2), 45-48.
- McCall, J., Browne, A., & Reimer-Kirkham, S. (2009). Struggling to survive: the difficult reality of Aboriginal women living with HIV/AIDS. *Qualitative Health Research*, 19(12), 1769-1782.
- McConney, D. (1999). Differences for our daughters: racialized sexism in art, mass media, and law. *Canadian Woman Studies*, 19(1-2).
- McDonald, P., & Dickerson, S. (2013). Engendering independence while living with purpose: women's lives after leaving abusive intimate partners. *Journal of Nursing Scholarship*, 45(4), 388-396.

- McEvoy, M., & Daniluk, J. (1995). Wounds to the soul: the experiences of Aboriginal women survivors of sexual abuse. *Canadian Psychology/Psychologie canadienne*, 36(3), 221-235. doi:10.1037/0708-5591.36.3.221
- McKeown, I., Reid, S., & Orr, P. (2004). Experiences of sexual violence and relocation in the lives of HIV infected Canadian women. *International Journal of Circumpolar Health*, 63(2), 399-404.
- Metzl, J. M., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, 103, 126-133. doi:10.1016/j.socscimed2013.06.032
- Mill, J. (1997). HIV risk behaviors become survival techniques for Aboriginal women. *Western Journal of Nursing Research*, 19(4), 466-489. doi:10.1177/019394599701900404
- Mill, J., Allen, M., & Morrow, R. (2001). Critical theory: critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research*, 33(2), 109-127.
- Moffitt, P., & Fikowski, H. (2017). *Northwest Territories Research Project Report for Territorial Stakeholders: Rural and Northern Community Response to Intimate Partner Violence*. Yellowknife, NT.: Aurora Research Institute/ Faculties of Nursing and Social Work, Aurora College.
- Moffitt, P., Fikowski, H., Mauricio, M., & Mackenzie, A. (2013). Intimate partner violence in the Canadian territorial north: perspectives from a literature review and a media watch. *International Journal of Circumpolar Health*, 72. doi:10.3402/ijch.v72i0.21209
- National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG]. (2018). *Executive summary from the interim report: Our women and girls are sacred*. Retrieved from www.mmiwg-ffada.ca/wp-content/uploads/2018/05/MMIWG-Executive-Summary-ENG.pdf

Native Women's Association of Canada. (n.d.). Aboriginal Lateral Violence: What is it?

Retrieved from www.nwac.ca/wp-content/uploads/2015/05/2011-Aboriginal-Lateral-Violence.pdf

Nixon, K., Bonnycastle, C., & Ens, S. (2017). Challenging the notion of failure to protect: exploring the protective strategies of abused mothers living in urban and remote communities and implications for practice. *Child Abuse Review*, 26(1), 63-74.
doi:10.1002/car.2417

Nixon, K., Tutty, L., Downe, P., Gorkoff, K., & Ursel, J. (2002). The everyday occurrence: violence in the lives of girls exploited through prostitution. *Violence Against Women*, 8(9), 1016-1043.

Nixon, L., Gregson, M., Spedding, T., & Mearns, A. (2008). *Practitioners' experiences of implementing national education policy at the local level. Technical report*. Retrieved from London: EPPI-Centre:

Noyes, J., & Lewin, S. (2011). Chapter 5: Extracting qualitative evidence. . In J. Noyes, A. Booth, K. Hannes, A. Harden, J. Harris, S. Lewin, & C. Lockwood (Eds.), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Version 1 (updated August 2011). Cochrane Collaboration Qualitative Methods Group. Retrieved from <http://cqrmg.cochrane.org/supplemental-handbook-guidance>.

Office of the Auditor General of Canada. (2017). *Report of the Auditor General of Canada, Health Care Services- Nunavut*. Retrieved from www.oagbvg.gc.ca/internet/English/nun_201703_e_41998.html.

Ottawa Inuit Children's Center. (n.d). *Nipivut – Our Voice: A community needs assessment for Inuit families in Ottawa, final report*. Retrieved from www.ottawainuitchildrens.com/wp-content/uploads/2012/06/nipivut_eng.pdf

- Paletta, A. (2008). *Understanding Family Violence and Sexual Assault in the Territories, First Nations, Inuit and Métis Peoples*. Department of Justice Canada.
- Pauktuutit Inuit Women of Canada. (2017). *Understanding the Needs of Urban Inuit Women: Final Report*. Retrieved from www.pauktuutit.ca/project/understanding-the-needs-of-urban-inuit-women-final-report/
- Pedersen, J., Malcoe, L., & Pulkingham, J. (2013). Explaining Aboriginal/non-aboriginal inequalities in postseparation violence against Canadian women: application of a structural violence approach. *Violence Against Women*, 19(8), 1034-1058.
doi:10.1177/1077801213499245
- Perreault, S. (2011). *Violent victimization of Aboriginal people in the Canadian provinces, 2009*. (0715-271X). Juristat: Canadian Centre for Justice Statistics.
- Perreault, S. (2015). *Criminal victimization in Canada, 2014*. *Juristat*. (85-002). Statistics Canada Catalogue.
- Pollock, A., Campbell, P., Struthers, C., Synnot, A., Nunn, J., Hill, S., . . . Morley, R. (2018). Stakeholder involvement in systematic reviews: a scoping review. *Systematic reviews*, 7(1), 208.
- Ponic, P., Varcoe, C., & Smutylo, T. (2016). Trauma-(and violence-) informed approaches to supporting victims of violence: policy and practice considerations. *Victims of Crime Research Digest*, 9.
- Powers, A., Fani, N., Carter, S., Cross, D., Cloitre, M., & Bradley, B. (2017). Differential predictors of DSM-5 PTSD and ICD-11 complex PTSD among African American women. *European Journal of Psychotraumatology*, 8(1), 1338914.
- Public Health Agency of Canada. (2013). *The Chief Public Health Officer's Report on the State of Public Health in Canada: Infectious Disease—The Never-ending Threat: Tuberculosis—Past and Present*. Retrieved from www.phac-aspc.gc.ca/cphorsphcrespcacsp/2013/tuber-eng.php.

- Reisenhofer, S., & Seibold, C. (2013). Emergency healthcare experiences of women living with intimate partner violence. *Journal of Clinical Nursing*. doi:10.1111/j.1365-2702.2012.04311.x
- Royal Commission on Aboriginal Peoples. (1996). *Royal Commission on Aboriginal Peoples. Bridging the Cultural Divide: A Report on Aboriginal People and Criminal Justice in Canada*. Ottawa, Canada.
- Sandelowski, M., & Barroso, J. (2003). Writing the proposal for a qualitative research methodology project. *Qualitative Health Research*, 13(6), 781-820.
- Sandelowski, M., & Barroso, J. (2007). *Handbook for Synthesizing Qualitative Research*. Retrieved from <https://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=423305>.
- Sandelowski, M., Voils, C. I., Leeman, J., & Crandell, J. L. (2012). Mapping the mixed methods—mixed research synthesis terrain. *Journal of mixed methods research*, 6(4), 317-331.
- Schmidt, R., Hrenchuk, C., Bopp, J., & Poole, N. (2015). Trajectories of women's homelessness in Canada's 3 northern territories. *International Journal of Circumpolar Health*, 74, 29778. doi:10.3402/ijch.v74.29778
- Shahram, S. (2016). The social determinants of substance use for Aboriginal women: a systematic review. *Women & Health*, 56(2), 157-176. doi:10.1080/03630242.2015.1086466
- Shahram, S., Bottorff, J., Kurtz, D., Oelke, N., Thomas, V., & Spittal, P. (2017). Understanding the life histories of pregnant-involved young Aboriginal women with substance use experiences in three Canadian cities. *Qualitative Health Research*, 27(2), 249-259. doi:10.1177/1049732316657812
- Sinha, M. (2013). *Measuring violence against women: Statistical trends*. (0715-271X). Juristat: Canadian Centre for Justice Statistics.

- Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health*. Retrieved from www.who.int/social_determinants/publications/9789241500852/en/
- Stote, K. (2017). Decolonizing Feminism: From Reproductive Abuse to Reproductive Justice. *Atlantis-Critical Studies in Gender Culture & Social Justice*, 38(1), 110-124.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, 9(2), 117-125.
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, 8(1), 45.
- Thorne, S. (2008). *Interpretive Description*. Walnut Creek, CA: Left Coast Press.
- Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S., & Howard, L. M. (2014). Disclosure of domestic violence in mental health settings: a qualitative meta-synthesis. *International Review of Psychiatry*, 26(4), 430-444.
- Truth and Reconciliation Commission. (2015). Honouring the Truth, Reconciling for the Future Summary of the Final Report of the Truth and Reconciliation Commission of Canada.
- University of North Florida LGBT Resource Center. (n.d.). Brave Space/Safe Space Guidelines For Critical Dialogue through Conscious Questioning & Active Listening. Retrieved from https://www.unf.edu/lgbtrc/Safe_Space_Guidelines.aspx
- University of Victoria. (2017). Guidelines for Creating Safer Spaces. Retrieved from <https://onlineacademiccommunity.uvic.ca/psn/guidelines-for-creating-safer-spaces/>
- Vandenberg, H., & Hall, W. (2011). Critical ethnography: extending attention to bias and reinforcement of dominant power relations. *Nurse Researcher*, 18(3).
- Varcoe, C., Browne, A., & Cender, L. (2014). Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In P. N. Kagan, M. C.

- Smith, & P. L. Chinn (Eds.), *Philosophies and practices of emancipatory nursing: Social justice as praxis* (pp. 266-284). New York, NY: Routledge.
- Varcoe, C., Browne, A., Ford-Gilboe, M., Dion Stout, M., McKenzie, H., Price, R., . . . Day, L. (2017). Reclaiming Our Spirits: development and pilot testing of a health promotion intervention for Indigenous women who have experienced intimate partner violence. *Research in Nursing & Health*, 40(3), 237-254.
- Varcoe, C., & Dick, S. (2008). The intersecting risks of violence and HIV for rural Aboriginal women in a neo-colonial Canadian context. *Journal of Aboriginal Health*, 4(1), 42-52.
- Varcoe, C., Wathen, N., Ford-Gilboe, M., Smye, V., & Browne, A. (2016). VEGA briefing note on trauma-and violence-informed care. *VEGA Project and PreVAiL Research Network*.
- Wathen, C., MacGregor, J., & MacMillan, H. (2016). Research Brief: Identifying and Responding to Intimate Partner Violence Against Women. *PreVAiL Research Network. London, ON*.
- Wenzel, S. L., Leake, B. D., & Gelberg, L. (2001). Risk factors for major violence among homeless women. *Journal of Interpersonal Violence*, 16(8), 739-752.
- Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing*, 52(5), 546-553.
- Willis, M. (2011). Non-disclosure of violence in Australian Indigenous communities. *Trends and issues in crime and criminal justice*, 405(1).
- Wiseman, T. (1996). A concept analysis of empathy. *Journal of Advanced Nursing*, 23(6), 1162-1167.
- World Health Organization. (1978). *The Declaration of Alma Ata*. Paper presented at the International Conference on Primary Health Care, Alma Ata.
- World Health Organization. (1986). *Ottawa Charter for Health Promotion: An International Conference on Health Promotion: the Move Towards a New Public Health, November 17-21, 1986, Ottawa, Ontario, Canada: WHO*.

- World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Retrieved from World Health Organization, London School of Hygiene and Tropical Medicine. Geneva, Switzerland: www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf
- World Health Organization. (2018). *Declaration of Astana*. Paper presented at the Global Conference on Primary Health Care From Alma-Ata Towards Universal Health Coverage and the Sustainable Development Goals, Astana, Kazakhstan.
- Wuest, J., Ford-Gilboe, M., Merritt-Gray, M., & Berman, H. (2003). Intrusion: the central problem for family health promotion among children and single mothers after leaving an abusive partner. *Qualitative Health Research*, 13(5), 597-622.
- Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A. J., & Ford-Gilboe, M. (2007). Patterns of medication use among women survivors of intimate partner violence. *Canadian Journal of Public Health*, 98(6), 460-464.
- Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: essential foundation for clinical researchers. *Applied Nursing Research*, 26(4), 251-256.