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ASSISTED DYING LAW AMENDMENTS

Niagara District Council of Women

Whereas #1 the Federal Government legalized medical assistance in dying in June 2016; and

Whereas #2 Bill C-14, the federal “Assisted Dying Law in Canada” contains flawed restrictions that violate end of life rights; therefore be it

Resolved #1 that the National Council of Women of Canada (NCWC) adopt as policy that:
   a) people in the Assessed and Approved category be given the option to waive the late-stage consent requirement
   b) people with dementia or another capacity-eroding condition be able to make advance requests
   c) all rules surrounding end-of-life choices respect the Constitution, including the Canadian Charter of Rights and Freedoms; and be it further

Resolved #2 that NCWC urge the Government of Canada to:
   a) give people in the Assessed and Approved category the option to waive the late-stage consent requirement
   b) allow people with dementia or another capacity-eroding condition to make advance requests
   c) ensure that all rules surrounding end-of-life choices respect the Constitution, including the Canadian Charter of Rights and Freedoms.

Background

1. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). Assented to: June 17, 2016, Bill C-14.


“Grievous and irremediable medical condition
(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
(a) they have a serious and incurable illness, disease or disability;
(b) they are in an advanced state of irreversible decline in capability;
(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.”
“Mature minors, advance requests and mental illness

9.1 (1) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition.”

2. Medical assistance in dying, Government of Canada, Health, April 25, 2019

https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

You must be able to give informed consent both:

- at the time of your request
- immediately before medical assistance in dying is provided


https://www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada

“The ban on advance requests has had serious implications for individuals who have been approved for MAID and plan to die in the next days or weeks. In some cases, patients choose to reduce or even refuse pain medication out of fear that they will be too impaired to provide final consent for MAID. For some, the pain associated with their medical condition is too great, and they must effectively abandon their request for MAID in order for their pain to be kept under control.

The ban on advance requests also affects the rights of people who want to create a written declaration for MAID that could be honoured months or years in the future — for example, a person with early-stage dementia who wants to make a request for MAID that could be carried out after they have lost capacity. For a person in this position, the ban on advance requests could effectively deny them the option of assisted death, or it may lead them to access MAID earlier than they would have wanted.”

“Critics of the law, including a number of legal scholars, argued that some of the restrictions in Bill C-14 may be unconstitutional and would inevitably be challenged in court. They were right. Nearly two weeks after the law received royal assent, Julia Lamb, a 25-year-old B.C. woman, along with the British Columbia Civil Liberties Association, launched a Charter challenge against aspects of the federal assisted dying law. One year later, two Montrealers suffering from debilitating chronic illnesses launched a similar challenge in the province of Quebec.”
Eliminating the Commodification of Women and Girls

Council of Women of Saskatchewan
Saskatoon Council of Women
Prince Albert Council of Women

Whereas 1: commodifying women and girls and the LBGTQ+2 community reduces them to a status defined by quality and for them to be seen generally as disposable and,

Whereas 2: because laws promoting gender equality and banning harmful practices are often not implemented or followed, women still face significant challenges and endure severe injustices, and

Whereas 3: women and girls are often commodified for economic gains and purposes, and

Whereas 4: the commodification of women and girls often occurs as a way of gaining a livelihood, and

Whereas 5: the eradication of poverty will lead to the eradication of exploitation and commodification of the people, therefore be it

Resolved 1: The National Council of Women of Canada (NCWC) adopt as policy that women and girls are not commodities and deserve to be treated as human beings with rights and privileges, therefore be it further

Resolved 2: The National Council of Women of Canada (NCWC) urge the Government of Canada ensure all women are treated as human beings with rights and privileges under the protection of the law, and be it further

Resolved 3: The National Council of Women of Canada (NCWC) urge the Government of Canada to ensure all Canadians have a basic income level where they can thrive and prosper.

Background

1. Definition of Commodification: https://www.youtube.com/watch?v=OjjoTWk6Oks
   - Commodification is the transformation of goods, services, ideas, and people into commodities, or objects of trade. A commodity, at its most basic, according to Arjun Appadurai, is "any thing intended for exchange," or any object of economic value.

• Nancy Jo Sales’ book, *American Girls: Social Media and the Secret Lives of Teenagers*, has been heralded by many reviewers as a “harrowing” window into the teenage mind. However, Sales’ Book is actually an early look at thingification – one of feminism’s greatest obstacles in the digital age. Sales spent two and a half years interviewing over 200 teenage girls across 10 states about their online experiences. By thingification, she meant the making of ourselves into ‘things’ - commodities for others’ consumption. By turning our lives into a series of images and attempting to be desired or ‘liked’ by everyone, we end up in a state of alienation – both from others and from ourselves. As Sales states in her conclusion, this state of being is at odds with the goals of feminism which is, at its core, defined by ‘self-respect and respect for others’.

3. **The Female Body as a Commodity** Soon Wei Yee, Otterbein University
https://digitalcommons.otterbein.edu/cgi/viewcontent.cgi?article=1067&context=stu_dis

• Does gender equality alleviate injustices? In this thesis, Soon Wei Yee argues that gender equality is a contentious concept and equality only applies to a population of people who meets certain social criteria i.e. class, wealth, fair/white race, and education level. “Gender equality contributes to the commodification of the female body in both the public and private spheres for different purposes. A capitalist society commodifies the female body for her exchange-value to satisfy the insatiable needs of a capitalistic patriarchy.”

4. **Let’s Talk About Gender and Commodification of the Female Body:** School of Women and Gender Studies Nalumansi Angel Elizabeth, Makerere University

• “…there is an increase in the number of cases related to commodification of female bodies. In this highly sexualized economy, women and their male counterparts have actively commodified the female bodies, directly or indirectly. Unlike older generations, this digital era has openly taken on this act that is completely gender insensitive. I say this with all bitterness, “Women’s bodies are not goods or commodities, so regardless of what the sole purpose for their commodification, it is uncalled for.”
The norm against commodifying human beings can be traced back to the elimination of slavery. Slavery—and other institutions under which the whole human body has been historically degraded into an instrument for the arbitrary use by the “owners” of this “property”—has long been banned by international and national laws. Unlike slavery, however, the commercialization of certain parts or elements of the human body has never been universally prohibited throughout the world. The law applies the notion of commodification to separate between things and persons and argues that the person cannot be commodified or treated as a proper object for sale and purchase. Carole Pateman noted already in 2002: “Where lines are to be drawn about property and commodification, what should be alienable and inalienable, and where the balance should be between the two are some of the most pressing issues of the new century.” The objectification, commodification and commercialization of the body, which once used to be the experience of women only, have now become a more general practice in biotechnology and even in healthcare.

In Karl Marx’s manifesto, under ‘The Fetishism of the Commodity and the Secret Thereof’, he uses the example of a piece of wood altered into a table, stating that, “as soon as it steps forth as a commodity, it is changed into something transcendent”. So, the moment the wooden table is tagged with a price, with monetary value placed on for purchasing purposes, “it becomes a property that can be exchanged/traded. This property, otherwise known as a commodity, has…properties …capable of satisfying human wants.” (Marx, 1867)

The concept of a commodity and the word itself changes meaning when dealt with in various capital industries which engage in trade. For the purpose of exploration, the meaning of commodity shall be narrowed down to “an economic good, that is subject to ready exchange or exploitation within a market “.

This article explores the commodification of the female body and how it is exploited in the beauty “market".
Stop Commodifying Feminism (and All Activism) Sophia Brill
https://www.theagleonline.com/article/2019/01/opinion-stop-commodifying-feminism-and-all-activism

- Commodification is the process by which something or someone is treated as a commodity — an economic good or service. In other words, commodification is when a product assumes loosely (if at all) related attributes to increase its value. This ridiculousness becomes dangerous when such commodities are social movements, and their distributors are companies whose only tie to activism is the potential for profit.
Eliminating Systemic Racism in the Health Care System

Council of Women of Saskatchewan
Saskatoon Council of Women
Prince Albert Council of Women

“It takes courage to say the word “racism”; but if we stand together & say it out loud, that is the first step in partnership to change the health care landscape in Canada.”

– Dr. Nel Wieman

Whereas 1: Racism, discrimination, and stigma have contributed to the lack of culturally safe health care and support services, and have created significant inequities in health services and outcomes between Indigenous and non-Indigenous Canadians, and

Whereas 2: It is essential to create an environment where Indigenous Peoples are respected and health services are provided in an equitable and safe manner without discrimination, and

Whereas 3: Meaningful engagement with First Nations, Inuit, and Métis must reflect the unique interests, priorities and circumstances of each People, and ensure that it reflects the perspective of Indigenous Peoples and communities in Canada, and

Whereas 4: The Chief Public Health Officer Health Professional Forum (the Forum) set up an Indigenous Health Sub-Group of the Forum to share and build upon the work of member organizations to advance Indigenous cultural competence, awareness, safety and humility among health professionals, and

Whereas 5: The College of Family Physicians of Canada, the Society of Rural Physicians of Canada, and the Indigenous Physicians Association of Canada have formally requested the federal leadership to address adverse health effects on Indigenous people in Canada, and

Whereas 6 “Reclaiming Power and Place: The National Inquiry’s Final Report reveals that persistent and deliberate human and Indigenous rights violations and abuses are the root cause behind Canada’s staggering rates of violence against Indigenous women, girls and 2SLGBTQQIA people.” therefore, be it

Resolved 1: That the National Council of Women of Canada adopt as policy that there be no systemic racism in the health care system, and
Resolved 2: That NCWC urge the Government of Canada to review and revise inequitable laws, policies, rules and regulations, as well as access to resources in the health system that give rise to systemic racism and contribute to adverse health effects on Indigenous people in Canada, and

Resolved 3: That NCWC urge the Government of Canada to provide leadership in developing and maintaining respectful processes and relationships in health care environments so they are free of racism and discrimination, allowing all people to feel safe, respected, and valued when seeking care, and

Resolved 4: That NCWC urge the Government of Canada, working in tandem with the College of Family Physicians of Canada, the Indigenous Physicians Association of Canada, the Society of Rural Physicians of Canada, the Canadian Nurses Association, and the Canadian Indigenous Nurses Association to compile a list of resources/tools/learning modules to support cultural awareness/safety among health professionals, and

Resolved 5: That NCWC urge the Government of Canada to engage with First Nations, Inuit, and Métis in the resources/tools/learning modules document to ensure that it reflects the perspective of Indigenous Peoples and communities in Canada, and

be it further

Resolved 6: That as much of the health care delivery in Canada is the responsibility of the Provincial Governments, the National Council of Women of Canada respectfully suggests Provincial and Local Councils ensure their respective governments are aware of this resolution and urge them to take appropriate action.

Definitions:

1. Cultural Safety: Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

2. Indigenous: In this document Indigenous is used as an inclusive term to describe First Peoples, or the people whose ancestors lived for millennia on lands now known as Canada before European colonization. The use of this term allows for individuals and collectives to exercise self-determination in their identity based on their experiences, kin relations, and land ties. This self-determined approach to identity is more likely to accurately include and reflect patients whose lives have been affected by colonization and systemic racism. Aboriginal is a constitutional term created by the Canadian government that collectively refers to three groups: Indians (now commonly referred to as First Nations), Inuit, and Métis (Smylie J. Indigenous Child Well-Being in Canada. In: Michalos AC, ed. Encyclopedia of Quality of Life and Well-Being Research. Vol Dodrecht, Netherlands: Springer Reference; 2014. Pages 3220-3227. http://link.springer.com/referenceworkentry/10.1007%2F978-94-007-0753-5_62.)
Background/Resources:

1. Artem Safarov, Director, Health Policy and Government Relations, College of Family Physicians of Canada

2. Margaret Tromp, President, Society of Rural Physicians of Canada

3. Dr. Nel Wieman, President of the Indigenous Physicians Association of Canada (IPAC), originally from Little Grand Rapids First Nation in Manitoba

4. (Anishnaawbe), and Senior Medical Officer, in the Office of the Chief Medical Officer at First Nations Health Authority (FNHA) in Vancouver, BC.

5. First Nations Health Authority’s Policy Statement on cultural Safety and Humility


7. Northern Health Indigenous Health
   https://www.indigenoushealthnh.ca/initiatives/cultural-safety

8. Uncovering Systemic Barriers to Accessible Cancer Care Among Prince Albert Metis and First Nations: Dr. Chad Nilson/Markus Winterberger
   https://mail.google.com/mail/u/1?ui=2&ik=c7c896b7eb&attid=0.1&permmsgid=msg-f:1648140688698980799&th=16df5f3961c539bf&view=att&disp=inline

9. Sterilization of Indigenous Women in Canada

10. Brian Sinclair: Killed by Racism “Brian Sinclair was a marginalized, indigent, and very vulnerable Aboriginal man. He was cognitively impaired and incapable of advocating for himself. As a double amputee, he was confined to a wheelchair and was also afflicted by chronic illness and by the consequences of a former substance addiction. He had many challenges, but he was a human being. He did not deserve to be ignored to death in a Manitoba, Canada hospital for 34 hours due to medical
professionals making false racist assumptions about him.”
http://ignoredtodeathmanitoba.ca/

11. Keegan Combes “The Fraser Health Authority acknowledged systemic racism in healthcare and promised action to tackle and eradicate racism.”

12. This note was posted by a racist physician: “Attention: native patients please don’t ask for tranquilizers or pain medications”. It was taped to the reception desk at the Miramichi office of Dr. Allister Carter.

13. 2020 NCWC Resolution
FIREARM LICENCES AND MENTAL ILLNESS
Proposed by Jeannette Logan, Convenor, Justice

Whereas 1 the National Council of Women of Canada (NCWC) has policy (75.11, 91.4 and 18.1EI) addressing the dangers of firearms including a ban on handguns; and

Whereas 2 NCWC has advocated for measures to address violence against women, including support of the International Convention on the Elimination of all forms of Discrimination against Women (CEDAW); and

Whereas 3 the Government of Canada passed the Firearm’s Act, 1998 and its regulations requiring a person be mentally stable before acquiring a firearm licence (PAL), and for renewal of his/her licence; and

Whereas 4 the Government of Canada delegates the responsibility for carrying out the duties of issuing and revoking licences to provincial and territorial Chief Firearms Officers (CFO); and

Whereas 5 each CFO also has the responsibility to revoke the firearm’s licence of anyone whose health and/or mental state presents a danger to himself/herself, or to other persons; and

Whereas 6 in some provinces and territories it is mandatory for a physician to report such a person to the police to revoke his/her driver’s licence, but it is not mandatory for revoking a firearm’s licence; therefore be it

Resolved 1 that the National Council of Women of Canada (NCWC) adopt policy that a person whose health and/or mental state presents a danger to himself/herself or to others should no longer hold a firearm licence or continue to possess firearms; and further be it

Resolved 2 that NCWC urge the Government of Canada to amend the Firearms Act and its regulations to require the provincial and territorial governments to act so that physicians and other health professionals who have knowledge that a person’s health and/or mental state presents a danger to himself/herself or to another person have a duty to report in order that the person’s firearm licence can be revoked and the firearms seized; and

Resolved 3 that the Government of Canada communicate this new requirement to the provincial and territorial medical licensing bodies, and to the Chief Firearms Officers, and that implementation be evaluated annually in order to reduce violence against women.
Background

https://www.canadianfirearmsinstitute.ca/how-do-i-get-a-firearms-license-in-canada/

Not everyone is eligible for a firearms licence. You must be a responsible Canadian citizen, who does not have a criminal record and is mentally stable.

The first licence is called a Possession Acquisition License (PAL) and is a basic firearms licence which allows you to buy and possess the types of firearms primarily used for hunting purposes, for example, rifles and shotguns.

The second licence is called a Restricted Possession Acquisition Licence (RPAL), this type of licence allows you to buy and possess any type of firearm that is permitted by law for sporting or hunting purposes in Canada. For example, pistols and some semiautomatic rifles require a RPAL. You must take the PAL course before taking the RPAL course.

You don’t have to be licensed to shoot a gun in Canada; however you will be given a safety orientation and be instructed and monitored closely to ensure your safety and the safety of those around you when you try it.

2. Federal Regulations


Firearms Licences Regulations SOR/98-199 FIREARMS ACT

The chief firearms officer of a province may issue licences...only to residents of the province.(There are exceptions.)

3 (1) Subject to subsection 14(2), an application for a licence to possess and acquire firearms that is made by an individual must be accompanied by

• (a) a photograph of the applicant that is sufficient to identify the applicant accurately and that meets the requirements of subsection 14(1);
• (b) a statement signed by a person who has known the applicant for at least one year and is at least 18 years old confirming that the photograph accurately identifies the applicant and that the person has known the applicant for at least one year;
(c) a statement signed by two persons, other than a person referred to in paragraph (d), who have known the applicant for at least three years and are at least 18 years old, with their names printed legibly on it, confirming that they have known the applicant for at least three years and that, to their knowledge,

(i) the information in the application is true, and

(ii) there is no reason why it would be desirable, in the interests of the safety of the applicant or any other person, that the applicant not possess a firearm; and

(d) subject to subsection (2), the name, date of birth, current address and telephone number of every spouse, common-law partner and other person with whom the applicant is in a conjugal relationship at the time of making the application or with whom the applicant has been in a conjugal relationship within the two years before the application is made.

A chief firearms officer who issues a licence to an individual shall attach to it the condition that the individual shall report any changes in the individual’s name or address to a chief firearms officer within 30 days after the change.

Revocation

16 (1) A chief firearms officer who issues a licence to an individual shall consider revoking it if the chief firearms officer becomes aware that the individual has been involved in an act of domestic violence or stalking.

Eligibility to Hold Licences-General Rules—Public safety

5 (1) A person is not eligible to hold a licence if it is desirable, in the interests of the safety of that or any other person, that the person not possess a firearm, a cross-bow, a prohibited weapon, a restricted weapon, a prohibited device, ammunition or prohibited ammunition.

Criteria

(2) In determining whether a person is eligible to hold a licence under subsection (1), a chief firearms officer or, on a reference under section 74, a provincial court judge shall have regard to whether the person, within the previous five years,

(a) has been convicted or discharged under section 730 of the Criminal Code of

(i) an offence in the commission of which violence against another person was used, threatened or attempted,

(ii) an offence under this Act or Part III of the Criminal Code,

(iii) an offence under section 264 of the Criminal Code (criminal harassment),

(iv) an offence under section 264.1 of the Criminal Code (criminal harassment of a dependent in a family relationship),
• (iv) an offence relating to the contravention of subsection 5(1) or (2), 6(1) or (2) or 7(1) of the *Controlled Drugs and Substances Act*, or
• (v) an offence relating to the contravention of subsection 9(1) or (2), 10(1) or (2), 11(1) or (2), 12(1), (4), (5), (6) or (7), 13(1) or 14(1) of the *Cannabis Act*;

(b) has been treated for a mental illness, whether in a hospital, mental institute, psychiatric clinic or otherwise and whether the person was confined to such a hospital, institute or clinic, that was associated with violence or threatened or attempted violence on the part of the person against any person; or

• (c) has a history of behaviour that includes violence or threatened or attempted violence on the part of the person against any person.

3. When to disclose confidential information - Physicians


Physicians often face situations where their duty to keep patients' information confidential conflicts with a statutory duty or a concern for public safety. These issues can be challenging to resolve and can expose physicians to medico-legal risk if not carefully managed.

**Duty of confidentiality**
Physicians' duty to maintain patient confidentiality is fundamental to the therapeutic relationship. It ensures that patients feel free to speak openly with their doctor about their health concerns and medical history, which in turn improves their treatment outcomes.

The duty of confidentiality is not only an ethical obligation, but also a legal one. However, it is not absolute and is subject to exceptions in limited circumstances. The exceptions to a physician's obligations to protect confidential patient information can arise in two distinct contexts:

• when doctors are required by law to disclose the information, or
• when the doctors are permitted by law to disclose the information

In the first case physicians must disclose the medical information (e.g. doctors have a statutory duty to report); in the second, physicians may lawfully disclose the information (e.g. privacy legislation exceptions that permit doctors to disclose personal health information without consent).
Duty to report
Physicians may be obligated by some legislation, policies, or by-laws to report confidential patient information to a third party, such as a government body. This mandatory obligation is generally referred to as a “duty to report.” For example, each province and territory has legislation requiring that physicians report to child welfare authorities a child in need of protection, or report to the medical officer of health patients with certain communicable diseases. In some jurisdictions, motor vehicle legislation requires physicians to report any patient who has a medical condition that may make it dangerous to drive.¹

Is there a “duty to warn”?
Canadian courts have not expressly imposed a mandatory “duty to warn” on physicians to alert third parties of a danger posed by patients. However, the Supreme Court of Canada has held that a physician was permitted to warn police when aware of the serious, imminent danger posed by a patient to an identifiable group against whom the patient had made specific threats.³ In Québec, legislation permits physicians to notify the police if they have “reasonable grounds to believe that a person is behaving in such a way as to compromise the safety of that person or another person by the use of a firearm.”⁴ Physicians generally may only provide the information that is required to facilitate a police intervention, but that can include confidential patient information.

The Canadian Medical Association’s Code of Ethics states that a physician may disclose a patient’s personal health information to a third party without consent where “the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves.”⁵

References
1. In some jurisdictions (e.g. Alberta, Québec, and Nova Scotia), reporting an unfit driver is at the physician’s discretion.
3. Smith v. Jones (1999). The Supreme Court of Canada did not follow American cases, such as Tarasoff v. Regents of University of California (1976), which have imposed a separate “duty to warn” on physicians.
4. An act to protect persons with regard to activities involving firearms, L.R.Q. c. P-38.001.
There is a Chief Firearms Officer for each Province and Territory. The Chief Firearms Officers are responsible for the decision-making and administrative work related to licences, authorizations to transport and authorizations to carry, and transfers of firearms by individuals and businesses.

This involves determining an applicant’s eligibility and either issuing, refusing to issue, renewing or revoking the licence, authorization to transport, carry, transfer or sponsor. It also involves setting conditions on these documents.
HEART DISEASE AND WOMEN
Researched and written by Carla Kozak, proposed by Karen Herzog
on behalf of Ukrainian Women’s Association of Canada

WHEREAS #1 heart disease is the major cause of premature death in women in Canada, killing five times more women than breast cancer each year; and

WHEREAS #2 most of what we understand about heart disease and the tools we use to treat it are based on clinical trials done on and procedures developed for men (women being included in only 30% of these trials); and

WHEREAS #3 women having heart attacks often present with symptoms different from those of men, such as extreme fatigue, shortness of breath and heaviness or pressure on the chest rather than crushing pain, resulting in under diagnosis or missed diagnosis; and

WHEREAS #4 many studies in the past 20 years show that neither women in general -nor medical professionals in particular - recognize the differences in heart attack symptoms between men and women, resulting in women often being misdiagnosed and under-treated; and

WHEREAS #5 even with a definitive diagnosis of heart disease, women are less likely than men to receive potentially beneficial medications, to be referred to rehabilitation programs or to receive guidance in reducing their risk of further heart attacks; and “women are under-researched, under-diagnosed, under-treated, under-supported, under-aware”; THEREFORE BE IT

RESOLVED #1 that NCWC establish as policy that the medical profession be better educated as to the symptoms of heart disease in women; and

RESOLVED #2 that NCWC urge the Federal and Provincial governments of Canada to establish a continuing mandate for the Ministries of Health to promote and finance programs within the Canadian health system to increase knowledge of and improve treatments for heart disease in women; and

BE IT RESOLVED that medical schools in Canada be urged to introduce curriculum about the crucial differences in symptoms of heart disease in men and women and the emerging tools to help diagnose and treat heart disease in women.

REFERENCES

http://doi.org/10.1111/jocn.14589
Landini P. Heart disease is the number one killer of women – so why is no one talking about it? Globe and Mail, 5 April 2019

2. Heart and Stroke Foundation: News release: Women’s heart health is another glass ceiling we need to smash: Women’s hearts are victims of a system ill-equipped to diagnose, treat and support them: https://www.heartandstroke.ca/what-we-do/media-centre/heart-report

3. Heart and Stroke:

4. Smith R, etc:

Harvard:


5. Heart and Stroke:

Heart and Stroke:

6. ALL references stated this.

7. Harvard Heart Letter:

8. Heart and Stroke: Heart Report 2018
Update on Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA Persons

Provincial Council of Women of Saskatchewan
Council of Women of Saskatoon
Council of Women of Prince Albert

Whereas 1: In 2012, the National Council of Women of Canada (NCWC) urged the Government of Canada to investigate and resolve unsolved cases of murdered and missing Indigenous women and girls, bring perpetrators to justice, and address the systemic violence that affects Indigenous communities, and

Whereas 2: The Government of Canada initiated a national inquiry into missing and murdered Indigenous women and girls that began in September, 2016, that was tasked with identifying the root causes of all forms of violence against Indigenous women, girls, and persons who identify as 2SLGBTQQIA and to make recommendations for change, and

Whereas 3: Persistent and deliberate human and Indigenous rights violations and abuses continue to be the root cause behind Canada’s staggering rates of violence against Indigenous women, girls, and persons who identify as 2SLGBTQQIA, and

Whereas 4: Indigenous family members and survivors of violence are often victims of multigenerational and intergenerational trauma and marginalization in the form of poverty, insecure housing or homelessness and barriers to education, employment, health care and cultural support, and

Whereas 5: Specific colonial and patriarchal policies displaced Indigenous women from their traditional roles in communities and governance and diminished their status in society, leaving them vulnerable to violence, and

Whereas 6: Racism, sexism, femicide, and misogyny against Indigenous women, girls, and persons who identify as 2SLGBTQQIA have become so embedded in everyday life that this violence has been normalized, therefore be it

Resolved 1: that the National Council of Women of Canada (NCWC) adopt as policy the 231 recommendations of the Missing and Murdered Indigenous Women and Girls inquiry, and be it further

Resolved 2: that the National Council of Women of Canada (NCWC) urge the Government of Canada to immediately address the 231 recommendations of the National Inquiry into Missing and Murdered Indigenous Women and Girls, and be it further

Resolved 3: that the National Council of Women of Canada (NCWC) urge the Government of Canada to ensure all cases of missing and murdered Indigenous women, girls,
and persons who identify as 2SLGBTQQIA be investigated effectively and immediately, and be it further

Resolved 4: That the systemic violence against Indigenous women, girls, and persons who identify as 2SLGBTQQIA be eliminated, and be if further

Resolved 5: that the National Council of Women of Canada (NCWC) urge the Government of Canada to collaborate with the provinces, territories, and Indigenous governments to:

- Enhance efforts on unresolved cases
- Increase public awareness
- Develop programs that address racism
- Strengthen and improve data collection, including DNA of unidentified bodies
- Include gender-based analysis of all legislation and programs related to missing and murdered Indigenous women, girls, and persons who identify as 2SLGBTQQIA
- Focus on prevention efforts that include the
  - Provision of safe, secure, affordable housing
  - Elimination of poverty
  - Increased access to services for Indigenous women, girls, and persons who identify as 2SLGBTQQIA
  - Funding support groups for Indigenous women and persons who identify as 2SLGBTQQIA
  - Provision of quality education within Indigenous communities
  - Support for community capacity building
  - Development and delivery of antiviolence programs.

Background

   - “The National Inquiry’s Final Report reveals that persistent and deliberate human and Indigenous rights violations and abuses are the root cause behind Canada’s staggering rates of violence against Indigenous women, girls and 2SLGBTQQIA people. The two volume report calls for transformative legal and social changes to resolve the crisis that has devastated Indigenous communities across the country. The Final Report is comprised of the truths of more than 2,380 family members, survivors of violence, experts and Knowledge Keepers shared over two years of cross-country public hearings and evidence gathering. It delivers 231 individual Calls for Justice directed at governments, institutions, social service providers, industries and all Canadians.”

2. Definition 2SLGBTQQIA: Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual.
3. **The Final Report lists 231 steps, or ‘Calls for Justice’**.
   - The report reads, "It must be understood that these recommendations, which we frame as 'Calls for Justice,' are legal imperatives – they are not optional."
   - "These Calls for Justice represent important ways to end the genocide and to transform systemic and societal values that have worked to maintain colonial violence. They’re directed at federal, provincial and Indigenous governments to address areas of human and Indigenous rights, culture, health and wellness, security and justice.
   - Other recommendations are directed at industries, institutions, services such as media, health-care providers, educators, police, Correctional Service Canada and those who work in child welfare.
   - Finally, the report calls on all Canadians to be part of the change. "Each person has a role to play in order to combat violence against Indigenous women, girls and 2SLGBTQQIA [two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual] people. Beyond those calls aimed at governments or at specific industries or service providers, we encourage every Canadian to consider how they can give life to these Calls for Justice."

4. **The report also identifies these important issues**:
   - Testimony from family members and survivors of violence spoke about a surrounding context marked by multigenerational and intergenerational trauma and marginalization in the form of poverty, insecure housing or homelessness and barriers to education, employment, health care and cultural support.
   - Experts and Knowledge Keepers spoke to specific colonial and patriarchal policies that displaced women from their traditional roles in communities and governance and diminished their status in society, leaving them vulnerable to violence.
   - Language barriers, health, and social services provided by religious congregations and interaction with Indigenous and provincial police forces have exacerbated violence against Indigenous women and girls.
   - Colonial structures, evidenced by the Indian Act, the Sixties Scoop, residential schools, and breaches of Inuit, Metis, and First Nations rights, led directly to the current increased rates of violence, death, and suicide of Indigenous women and girls.
   - The exact number of murdered and missing Indigenous women and girls has been unrecorded for many decades.

5. **Status of Women, Canada: About Gender Based Violence; Statistics**
   - Some populations are more likely to experience violence and may face unique barriers and challenges that put them at particular risk. For example:
     - women are at a 20% higher risk of violent victimization than men when all other risk factors are taken into account;
     - of all sexual assault incidents, nearly half (47%) were committed against women aged 15 to 24;
• Indigenous women (10%) were more than three times as likely to report being a victim of spousal violence as non-Indigenous women (3%). Indigenous identity is a key risk factor for victimization among women, even when controlling for the presence of other risk factors;
• women with a disability were nearly twice as likely as women without a disability to have been sexually assaulted in the past 12 months;
• lesbian and bisexual women are 3.5 times more likely than heterosexual women to report spousal violence;
• six in ten (58%) senior victims of family violence were female, with a rate 19% higher than that of male seniors; and
• women living in the territories are victimized at a rate eight times higher than those living in the provinces. Women living in the territories have a risk of violent victimization about 45% higher than men’s (when controlling for other risk factors). Remote and isolated communities face particular challenges related to access and availability of support.

6. Marginalization of Aboriginal Women
   https://indigenousfoundations.arts.ubc.ca/marginalization_of_aboriginal_women/
• Despite the vast socio-cultural diversity amongst Canada’s hundreds of First Nations, historians and experts largely agree that a balance between women and men’s roles typically existed in pre-contact Aboriginal societies, where women and men had different, but complementary roles. Many First Nations were matrilineal, meaning that descent – wealth, power, and inheritance — were passed down through the mother.
• “Women were respected for their spiritual and mental strength and men were respected for their spiritual and physical strength. Women were given the responsibility in bearing children and were given the strength and power to carry that responsibility through. Men had always respected that spiritual and mental strength and women respected the men’s physical strength. There was always a balance between men and women as each had their own responsibilities as a man and as a woman.”

   Beverley Jacobs,

   Former NWAC president and Mohawk activist,

   “International Law/The Great Law of Peace,” 35

• As non-Aboriginal settlers first arrived in what is now Canada, they brought with them their patriarchal social codes and beliefs and tried to make sense of Aboriginal society through a patriarchal lens. As the colonies consolidated to form the Dominion of Canada, Crown policies were created throughout the country with the goal of assimilating and “civilizing” First Nations peoples based on a European model. These policies had profound effects on Aboriginal women across the country.

7. How Colonialism Affects Women
• “Colonial power and the capitalist economic system that came with it have had a huge impact on Indigenous women’s lives. In pre-colonial times, Indigenous men and women often had different, but valuable roles in their societies. In European culture, men were seen as superior to women. This was not the case in the Indigenous world. Colonial policies and practices tried to end Indigenous beliefs, customs, language and culture. These attempts had dramatic and mostly negative effects on Indigenous women’s role in society.”

• “We’ve gone from sacred, to scared, to scarred. Before contact, women were respected as sacred beings. Contact with settlers introduced a new way of life where people were scared by the changes imposed on them and that they had to adapt to. Today we are scarred by the legacy of colonialism, the residential schools, the Sixties Scoop. Those scars will always be there but they don’t define us. It’s a scar, it’s not an open wound. We’re in transition. Now we want to learn and relearn, accept the traditions and ceremonies, feel the beauty of the culture again. And be ready to welcome people back, be ready to help them connect back with being sacred again.”
  – Nina Cordell, Thompson, Manitoba
UPDATE: SUPPORT FOR THE FAMILY CAREGIVER
Niagara and District Council of Women

Whereas #1 in 1997 NCWC urged the Government of Canada to develop and institute a system which ensures a minimum standard of financial security for the family caregiver, the system to include:

a) extending eligibility for the seven year exemption under CPP regulations, at present applicable to child rearing, to include persons performing unpaid care for elderly or disabled family members; and
b) providing refundable tax credits for caregivers; and

Whereas #2 existing tax relief programs do little to support low-income caregivers, but a caregiver allowance will enable caregivers to continue to provide care and save money for health and social services; and

Whereas #3 eligibility criteria for tax credits excludes caregivers not related through blood or marriage and those who do not live in the same residence as the care recipient; therefore be it:

Resolved #1 that the National Council of Women of Canada (NCWC) adopt as policy that:

a) low-income caregivers be given an allowance,
b) unrelated caregivers be eligible for tax credits; and be it further

Resolved #2 that NCWC urge the Government of Canada to:

a) provide a caregiving allowance for low-income caregivers
b) allow tax credits to caregivers not related through blood or marriage and those who do not live in the same residence as the care recipient.

Background


http://www.ontariocaregivercoalition.ca/caregiver-allowance.html

“There are two main reasons why a caregiver benefit is needed in addition to current tax credits:

1. The value of existing tax credits is so low that they do not adequately respond to the often intense, costly, and time-consuming demands of caregiving. In addition, non-refundable tax credits tend to provide greater benefit to higher income earners. If a caregiver does not make enough income these tax credits are meaningless. Moreover, the relationships of dependency recognized under the eligibility criteria for the tax credits are narrow and includes only biological and marital/common-law relationships. This excludes caregivers not related through blood or marriage and those who do not live in the same residence as the care recipient. A broader definition of qualifying relationships would increase equal treatment of
diverse family structures and relationships.

2. Providing financial support through a caregiver allowance will enable caregivers to continue to provide care in the community, saving the health and social system $50,000/person/year. According to preliminary evaluation of the Caregiver Benefit Program in Nova Scotia, the caregiver benefit reduced the probability that individuals would be admitted to long-term care, resulting in savings to the government in long-term care costs.”


“Caregiving can have a significant financial impact on caregivers. Caregivers incur out-of-pocket expenses such as transportation costs, purchasing care aids, and hiring professional help to assist with care.”

“Governments provide limited financial support for caregivers and minimal funding for home care and social support programs. Often, caregivers must take on the full burden and costs when providing care.”

3. We should care more about caregivers by Nathan Stall, CMAJ March 04, 2019.

“Unpaid or informal caregivers provide up to 75% of care services, which equates to about $24–$31 billion in unpaid work annually.”

“The most common form of financial support for Canadian caregivers is tax relief, yet only a small minority receive tax credits. Many caregivers are unaware of available financial assistance, and government portals for tax information are often difficult to navigate. Eligibility for federal and provincial tax credits is generally restricted to caregiving relatives; Manitoba is notable for supporting anyone who assumes unpaid caregiving responsibilities. Most caregiver tax credits are also nonrefundable (provincial credits in Quebec and Manitoba are exceptions), meaning that caregivers must be earning sufficient income to claim the credit as a deduction. In general, existing tax relief programs do little to support low-income caregivers; Nova Scotia stands out for providing low-income caregivers with a monthly benefit.”

“In 2015, the federal government extended the compassionate care benefit to 6 months to provide Employment Insurance for caregivers looking after critically ill or dying family members. While welcome, this benefit supports caregiving only for those at imminent risk of death, neglecting recurrent exacerbations of chronic illness, which is more typical of age-related caregiving needs. Worthy alternatives exist in European countries such as Sweden, where some municipalities provide informal caregivers with direct allowances or reimbursements for caregiving activities.”


https://www.canada.ca/en/services/benefits/ei/caregiving.html
Through Employment Insurance, you could receive financial assistance of up to 55% of your earnings, to a maximum of $562 a week. These benefits will help you take time away from work to provide care or support to a critically ill or injured person or someone needing end-of-life care.

As a caregiver, you don’t have to be related to or live with the person you care for or support, but they must consider you to be like family.