

HEALTH CARE PROVIDERS' RELATIONAL APPROACHES WITH PEOPLE
WHO INJECT DRUGS (PWIDs): IMPLICATIONS FOR PWIDs' HEALTH CARE

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By

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ABSTRACT

The objectives of this study were to: (i) understand HCPs' relational approaches to providing care and services to PWIDs to whom they provide care and services to, (ii) examine the factors that influence HCPs relational approaches with PWIDs, (iii) understand the implications of HCPs' relational approaches on PWIDs, and (iv) generate knowledge on how HCPs' relational approaches affect the health care experiences/access of specific vulnerable populations such as: women, Indigenous women, and Indigenous peoples as a whole. The methodological approach of interpretive description was employed. Qualitative data was collected using semi structured interviews and field notes from 11 HCPs who worked with predominantly PWID clients both in the community and in a hospital setting at a health region within the Saskatchewan Health Authority. Inductive thematic analysis was conducted. The interdisciplinary generalist and integrationist approaches enabled the author to draw from knowledge across disciplines (nursing, psychology, public health, and sociology) and integrate theories and frameworks such as: theory of stigma, behavioral model of utilization, and the harm reduction philosophy for substance misuse. Findings of the study revealed that HCP participants had positive relational approaches toward clients who inject drugs, including those with multiple vulnerabilities such as: Indigenous peoples and women. Participants claimed that negative behaviors from HCPs toward IUDs/PWIDs were likely to occur more among HCPs who worked in chaotic work environments, under pressure, and with limited staff. The relational approaches of HCPs toward PWIDs are influenced by workload, family history, and educational background of HCPs. An integrated framework for facilitating a HCP-PWID relational approach for holistic care and health access for PWIDs emerged in the study. The need for deliberateness in system change, and incentives for HCPs, such as: additional job-specific and cultural competence trainings will

be invaluable for HCPs. A degree of attitudinal, cultural, and institutional shift is recommended. Policy and practice integration will help to affirm the need to understand the multiple dimensions of access to health care. This study highlights the need for future research on the relational approach of HCPs with PWIDs among HCPs who provide services to other diverse client groups often in high-pressure, chaotic work situations.

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DEDICATION

To the memory of my father, Chief Davidson Mokolade Gbolagunte, a “go getter”, who believed anything was possible, irrespective of age. My father set the example of hard work and determination by becoming a lawyer and the first speaker of Oyo State House of Assembly after retiring from 35 years of teaching.

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ACRONYMS

AIVL - Australian Injecting and Illicit Drug Users League

CCSA - Canadian Centre on Substance Use and Addiction

CHRC - Canadian Human Rights Commission

CIHR - Canadian Institutes of Health Research

HRI - Harm Reduction International

HCP- Health Care Provider (Range from volunteers to professionals in paid positions)

HCPs' Approach – Comprised of HCPs' practices, attitudes, perceptions & beliefs)

ID - Interpretive Description

IDU - Injection Drug Use

IUD - Individuals Who Use Drugs

NAHO - National Aboriginal Health Organization

NEPs - Needle Exchange Programs

PHAC - Public Health Agency of Canada

PWIDs - People Who Inject Drugs

SHA - Saskatchewan Health Authority

SIS - Safe Injection Sites

WHO - World Health Organization

DEFINITIONS

Health Care Provider (HCP) Relational Approach

In the context of this study, “relational approach” refers to the professional relatedness of HCPs to PWIDs as manifested in the HCPs’ strategy employed in providing care to PWIDs. A positive relatedness would reveal the provision of care in a safe, competent, and humane manner. A negative relatedness would reveal inappropriate provision of care, stigmatizing and being judgemental of PWIDs.

Injection Drug Use (IDU)

Injection drug use is the act of using illicit or recreational drugs using the method of introducing the drug into the body with a syringe and a hollow needle which is pierced through the skin into the body usually intravenous, but also intramuscularly or subcutaneously (Public Health Agency of Canada [PHAC], 2007b).

People Who Inject Drugs (PWIDs)

People who inject drugs (sometimes referred to as injection drug users) are those who use illicit drug by introducing drugs into their body with needle and syringe intravenously and sometimes subcutaneously or intramuscularly (PHAC, 2007b).

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Chapter 1 Introduction

The use of illicit drugs and substance use disorders constitute growing public health problems that contribute to a global burden of disease (Rehm, Taylor & Room, 2006; Wenthur et al., 2013). A higher incidence of health problems exists among people who inject drugs (PWIDs) than other individuals who use drugs (IUDs) because PWIDs experience more marginalization, have increased risk of fatal and non-fatal drug overdose, and have high rates of infectious diseases such as: human immunodeficiency virus (HIV), hepatitis C, and tuberculosis (Mathers et al., 2013; Slev-Ran, Adler, Nitzan, & Fennig, 2013; Whiteford et al., 2013; World Health Organization [WHO], 2012). In Canada, in addition to the health impact of injection drug use (IDU) on PWIDs, the social impacts of injection drug use are extensive, complex, and devastating (Health Canada, 2007). Despite the high morbidity and mortality identified among PWIDs, research studies have shown that many PWIDs do not access health services that are in place for them because of the negative attitudes, stigma, and discrimination that PWIDs experience from health care providers/professionals [HCPs] (Butler & Sheridan, 2010; Lang et al., 2011; Public Health Agency of Canada [PHAC], 2007a). Furthermore, empirical studies have shown that PWIDs do not access care because they believe HCPs lack the knowledge and experience to care for them (Drumm et al., 2003; Lang et al., 2011). In order to limit disease transmission and improve health and social outcomes for PWIDs and their families, it is imperative for health care services to provide appropriate, compassionate and equitable care (Lang et al., 2011).

Indigenous PWIDs have increased health risk indicators associated with injection drug use. The increased health risks are due to cultural status, significant life experiences, generational trauma, and socio-economic status among other social determinants of health (Craib et al., 2003;

PHAC, 2015; Wood et al., 2008). Residential school history and sex abuse were additionally found to be among Indigenous-specific determinants of health for young Indigenous women with the experience of pregnancy and substance abuse (Shahram et al., 2017). In a major city in Saskatchewan, Canada, Lemstra, Rogers, Thompson, Moraros, and Buckingham (2012) compared PWIDs of Indigenous ancestry with those of non-Indigenous PWIDs; the findings showed that Indigenous PWIDs were more likely to be women, younger, less likely to receive paid income, more likely to have attended residential school, or had a parent or grand parent who did. Furthermore, Lemstra et al. (2012) noted that PWIDs of Indigenous ancestry were more likely to use sex trade as a source of income, witness death, or experience permanent separation from a parent as a youth.

This present study focuses on a health region in Saskatchewan. The health problems, particularly the epidemic situation of HIV/AIDS identified among PWIDs stress the importance of equitable access to health care by PWIDs. When PWIDs decide to access services, negative attitudes from HCPs may prevent them from disclosing their drug use status to HCPs, which may ultimately endanger their lives (Ross, Timpson, Williams, Amos, & Bowen, 2007). The health problems, socio economic, and ethnic distribution of HIV/AIDS, and the rapid progression of the disease through IDU, makes the problem of IDU and refusal to access health care/services by some PWIDs worrisome in Saskatchewan and beyond. The findings from previous studies of Lang et al. (2011, 2013) indicate that stigma/discrimination is among the major barriers to access to health care and services by PWIDs in a major city in Saskatchewan, prompted further exploration by this present study. Additionally, the appalling high rates of infectious diseases among PWIDs, particularly among Indigenous PWIDs and Indigenous women who inject drugs in Saskatchewan, makes the issue of access to care a necessity and invariably an important topic

of study in Saskatchewan. There is no known study that has focused on understanding the relational approaches of HCPs with PWIDs and the implications on PWIDs decisions to access health care in Saskatchewan. This present study will help to fill some gaps in the literature in the health sciences field. In the context of this study, relational approaches refer to the professional relatedness of HCPs to PWIDs, as manifested in the HCPs' strategy employed in providing care to PWIDs. In contrast, the term relational inquiry used by Doane and Varcoe (2015) in their textbook *'How to Nurse'* refers to the day to day practice of nursing, with the nurse being an inquirer.

To provide a foundation for this study, this introductory chapter describes the prevalence and incidence rates of IDU/demographics of PWIDs globally, nationally (Canada), and locally (Saskatchewan). In addition, the demographics of Indigenous peoples, Indigenous PWIDs, and Indigenous women are described. The statement of the problem, objectives of the study, research questions and significance are stated thereafter. The chapter ends by outlining the organization of the dissertation.

1.1 Prevalence and Incidence rates of IDU / Demographics of PWIDs

The epidemiology and factors predicting the mortality and morbidity of individuals who use drugs (IUDs), particularly those of PWIDs is provided. The prevalence and incidence of HIV, hepatitis C virus (HCV) and their associated risks among PWIDs globally, nationally and locally are additionally discussed. Furthermore, a discussion on PWIDs/IUDs of Indigenous ancestry is included. The demographics of IUDs and PWIDs in Saskatchewan reveal a predominance of Indigenous peoples among the population of PWIDs and IUDs. To understand the magnitude of the problem of IDU, it is important to know the epidemiology and prevalence

rates globally, nationally and locally. This section briefly highlights such epidemiological and prevalence rates.

1.1.1 Global. Approximately 16 million people worldwide inject drugs (World Health Organization [WHO], 2015). Globally, PWIDs from China, Vietnam, Malaysia, Russia, and Ukraine account for 47% of PWIDs (Harm Reduction International [HRI], 2012). There are 4.5 million PWIDs in South, East and South-East Asia, Russia, and Eastern Europe (HRI, 2012). In Central Asia, there are 3.7 million PWIDs, in North America there are 2.3 million, and 2 million in Latin America (HRI, 2012). In Sub-Saharan Africa, there are 1.8 million PWIDs, in Western Europe there are 1 million, and in the Middle East and North Africa there are 300,000 - 1 million PWIDs (HRI, 2012). Additionally, in the Caribbean and Oceania there are 186,000 and 170,000 PWIDs respectively (HRI, 2012) [See Table 1].

Worldwide, about 3 million PWIDs are estimated to be HIV positive while IDU accounts for some of the HIV cases globally (WHO, 2015). Injection drug use accounts for 30% of the HIV infections outside sub-Saharan Africa (HRI, 2012). In addition, in some parts of Eastern Europe and the central part of Asia, 80% of HIV infections are drug use related (WHO, 2015). Men account for 50% of people who have HIV worldwide and those between the ages of 15 to 24 have been found to be most vulnerable (United Nations Program on HIV/AIDS, 2012).

1.1.2 National. In Canada, between 75,000 and 125,000 people inject drugs, approximately 0.2% -0.4% of the population; a third are women (Canadian Center on Substance Abuse and Addiction [CCSA], 2011). By the end of 2014 there was an increase of 9.7% in the number of people who inject drugs in Canada (PHAC, 2015). Injection drug use (IDU) accounts for high rate of deaths, hospitalizations and new cases of HIV (CCSA, 2011; PHAC, 2007b; PHAC, 2015) and other blood borne disease such as HCV. Approximately 68% of PWIDs were

infected with HCV in Canada by the end of 2011 (Tarsuk, Ogunnaike-Cooke, Archibald, & the I-Track Site Principle Investigators, 2013). During the same period coming up to the end of 2011, up to 14,200 people were living with HIV, which may have been transmitted through IDU (Tarsuk et al., 2013). In 2012, IDU accounted for 14% of positive HIV test reports among which 24.5% were for women, while 10.9% were for men (PHAC, 2013). Among the HIV cases reported, 65.9% individuals indicated being male and 60.3% indicated being of Indigenous ancestry (PHAC, 2012). Two other HIV exposure categories that ranked higher among IDUs in 2011 were the categories of men having sex with men [MSM] who accounted for 50.3% of the MSM population; and the heterosexual relationships group who constituted 30.6% of the population (PHAC, 2013). Additionally, there is an increase in the number of new HIV cases among young women in Canada (Canadian Institute of Health Research [CIHR], 2013; Government of Saskatchewan, 2013).

1.1.3 Local. The province of focus in this present study is Saskatchewan, Canada, where the incidence of HIV/AIDs (a major health issue for PWIDs) is reportedly considered to be alarming and injection drug use is the leading precipitating factor (Canada Broadcasting Corporation [CBC] News Saskatchewan, 2017a; Government of Saskatchewan, 2015; Health Canada, 2012, 2014; Saskatoon Health Region [SHR], 2014). Next to the ranking of IDU as the highest risk factor for HIV is heterosexual activity and then MSM (Government of Saskatchewan, 2013, 2015). In 2015, the total number of newly identified cases of HIV in Saskatchewan was 160 and 61% of the cases were associated with IDU (Government of Saskatchewan, 2015). The epidemiology of HIV in Saskatchewan is different from the rest of Canada. In the year 2006, Saskatchewan had the highest prevalence rates for HIV in Canada at twice the national average at 20.8 versus 9.3/100,000 (PHAC, 2006). Saskatchewan had 2.5

times the national average per capita for HIV in 2011 (Government of Saskatchewan, 2013) and this has further increased (changed for the worse) in 2016 (CBC News Saskatchewan, 2016). Saskatchewan now has the highest HIV rate (14.6 in 100,000 compared to 5.8 in 100,000) and up by 800% in the whole of Canada (CBC News Saskatoon, 2015; CBC News Saskatchewan, 2017a; Government of Saskatchewan, 2015).

In 2016, First Nations peoples accounted for 10.7% of the Saskatchewan population while Métis accounted for 9.9% of the same (Statistics Canada, 2017). Within the total population of Canada, First Nations were 2.8% and Métis 1.7% of the population (Statistics Canada, 2017). Among all (prevalence rates) HIV cases reported in Saskatchewan in 2012, 82% (58 of 71 cases) were of Indigenous ancestry (Government of Saskatchewan, 2013). Among the newly identified cases (incident rates) of HIV in 2012, 74% of them self reported to be of Indigenous ancestry (Government of Saskatchewan, 2013).

The age range of PWIDs, who reported IDU as their main risk factor to contracting HIV in 2012 was between 14 and 58 years (Government of Saskatchewan, 2013) and by 2015, the mean age was 37.9% (Government of Saskatchewan, 2015). Further, in Saskatchewan in 2012, approximately 45% of the men who reported IDU as the HIV risk factor ranged between the ages of 14 and 58 years, while 59% of the women's age ranged between 20 and 44 years (Government of Saskatchewan, 2013). Additionally, up to 80% of the clients of street/sexual health clinic, SHR, self-identified as First Nations or Métis (Plamondon et al., 2007).

Indigenous peoples are overrepresented among the group with HIV/AIDS, and the soaring rates of the infection on some reserves in Saskatchewan [up to 3.5% of the population] are comparable to those of some countries in the developing world [Central African Republic-3.82%, Guinea Bissau-3.74%, Nigeria-3.17%, Rwanda-2.85%] (CBC News Saskatchewan,

2015; Health Canada, 2012, 2014; Public Health Agency of Canada [PHAC], 2012). Injection drug use continues to be the main risk factor to contracting HIV in the province. This situation in Saskatchewan is regarded as an epidemic and a real Canadian crisis (CBC News Saskatchewan, 2015).

1.1.4 Demographics of Indigenous IUDs/PWIDs. Aboriginal (Indigenous) peoples is the collective name given to the original descendants of North America (Aboriginal Affairs & Northern Development Canada [AANDC], 2012). In Canada, Indigenous peoples comprise of First Nations, Métis and the Inuits and are recognized as such by section 35 of the Canadian Constitutional Act of 1982 (Waldram, Herring, & Young, 2006). In 2016, approximately 1,673,785 people self-identified as Indigenous persons in Canada, representing 4.9% of the total population of Canada (Statistics Canada, 2017). Indigenous peoples of Canada are disproportionately represented among individuals with substance use problems (Centre for Addiction Research of British Columbia [CARBC], 2009; Health Canada, 2012, 2013). Indigenous youth were found to be more likely to smoke, use inhalants and use cannabis more regularly than non-Indigenous youth, while substance use among Indigenous men was found to be a contributory factor for violence in Indigenous families (Alberta Health Services [AHS], 2009).

Over one quarter of Indigenous peoples in Canada have substance use disorders (AHS, 2009). In 2011, human immuno-deficiency syndrome (HIV) infection rate was 3.4 times higher among Indigenous peoples than non-Indigenous peoples (PHAC, 2011). In general, the age of onset for drug use was lower for Indigenous peoples and they experience numerous barriers to participating in harm reduction programs sometimes due to travel distance and/or lack of culturally appropriate programs (PHAC, 2007a). Diseases like HIV and HCV rose to an alarming

level among Indigenous peoples including Indigenous women who use drugs. The Cedar Project Partnership and colleagues (2008), in a gender difference HIV and HCV vulnerability study confirmed increasing rates of HIV and HCV diseases among Indigenous women. By the end of 2011, 6,380 (8.9%) of all HIV infections were Indigenous peoples with an estimated prevalence rate of 544 per 100,000 population (Health Canada, 2013). Women living with HIV were estimated to have been 16, 600 in number, which accounted for 23.3% of the total population of people living with HIV in Canada (Health Canada, 2013; PHAC, 2011). For HCV, IDU accounts for 68–80% of all cases (Canadian Medical Association, 2011; PHAC, 2014).

Table 1.1. Prevalence Rates of People Who Inject Drugs Table

Location	No of PWIDS in Thousands/Millions
Global	16
South, South –East Asia, Russia, Eastern Europe	4.5
Caribbean	186,000
Central Asia	3.7
Latin America	2.0
North America	2.3
Oceania	170,000
Sub-Saharan Africa	1.8
Western Europe	1.0
Middle East and North Africa	300.000 – 1.0
National (Canada)	75,000-125,000
Saskatchewan	5,000

Table compiled from Canadian Centre on Substance Use and Addiction [CCSA] (2011); Harm Reduction International [HRI] (2012); Saskatchewan Ministry of Health (2008).

1.1.4.1 Indigenous women. Indigenous women represent 4% of the total Canadian female

population (Statistics Canada, 2010, 2016). In addition, young Indigenous women below the age of 30 account for a disproportionate number of all new HIV-positive cases in Saskatchewan (Saskatchewan Ministry of Health, 2010). In SHR, the HIV rate among women in 2009 was 31.3/100,000 (de Bruin, Gibson & Trischuk, 2010).

A magnitude of substance use/abuse and injection drug use (IDU) problems exist globally, in Canada, and in Saskatchewan. Some empirical and grey literature reveals that prevalence and incidence rates differ tremendously for some populations such as Indigenous peoples. The increasing and ever-changing epidemiology, prevalence, and incidence rates of mortality and morbidity among IUDs /PWIDs buttress the importance for the need for an abundance of relevant research studies, such as this, on every aspect of the problems of PWIDs. Why the researcher chose to study this topic is discussed in the theoretical scaffolding section under subsection 2.3.1 – Location of the researcher.

1.2 Statement of the Problem

Despite the high rate/spread of HIV and other blood borne diseases associated with IDU among PWIDs in Saskatchewan, the literature reveals that the negative relational approaches of HCPs toward PWIDs is a barrier to accessing health care/services by PWIDs. There is no known study of the relational approaches of HCPs with PWIDs in Saskatchewan. There is a need to understand the relational approaches of HCPs toward PWIDs and the implications of the relational approaches on the access of health care/services access for PWIDs.

1.3 Objectives of the Study

The objectives of the study are: to (i) understand HCPs' relational approaches to providing care and services to PWIDs to whom they provide care and services to, (ii) examine the factors that influence HCPs relational approaches with PWIDs, (iii) understand the

implications of HCPs' relational approaches on PWIDs, and (iv) generate knowledge on how HCPs' relational approaches affect the health care experiences/access of specific vulnerable populations such as: women, Indigenous women, and Indigenous peoples as a whole.

1.4 Research Questions

The research questions are:

- 1) What are HCPs' relational approaches to providing care and services to PWIDs whom they come in contact with in their professional work?
- 2) What factors influence HCPs relational approaches with PWIDs?
- 3) What are the implications of HCPs' relational approaches (with PWIDs) on PWIDs' experiences with and the patterns of accessing health care services?
- 4) How do HCPs' relational approaches affect the health care experiences/access of specific vulnerable populations such as: women, Indigenous women, and Indigenous peoples?

1.5 Relevance and Significance of the Study

The results of this study would help to bridge the gap in the literature by generating knowledge and research evidence that could inform health care practice and enhance positive health outcomes for PWIDs in the health region of study. The study will lay a foundation for creating effective practice and policy frameworks for access to health care by PWIDs that go beyond reactionary approaches (down stream approach of reacting after damage may have occurred, rather than a preventative upstream approach). Additionally, this study would contribute to the use of interpretive description (ID) methodological design in the fields of the health sciences and substance abuse.

1.6 Organization of the Dissertation

In the present chapter, the research topic is introduced and the prevalence and incidence

rates of IDU/demographics of PWIDs are presented. The statement of problem, objectives of the study, the research questions, and relevance of the study are subsequently stated. Chapter 2, presents the theoretical scaffolding of the study. The theoretical scaffolding consists of a comprehensive literature review and the theoretical fore-structure of the study. The fore-structure includes the researcher's location as researcher and her personal and/or theoretical positions that influenced the shaping of the study. Additionally, discussed in chapter 2 are: Goffman's (1963) theory of stigma, cultural competence (Campinha-Bacote, 2002), and Tervalon and Murray-Garcia (1998)'s self-reflection and lifelong learner model which were the conceptual frameworks that served as the interpretive lenses of the findings in this study. Additionally, the behaviour model of health utilization (Andersen, 1995; Phillips, Morrison, Andersen, & Aday, 1998) was employed. In chapter 3 the approach to inquiry – interpretive description (ID), the methodological design and procedure, which includes the sampling strategy, data collection method, and data analysis are stated. In the results section – chapter 4, the findings of the study are presented. In chapter 5, the findings of the study are discussed along with the limitations. The concluding summary is presented in Chapter 6.

Chapter 2 Theoretical Scaffolding

In the interpretive description (ID) approach to inquiry, the design used in this research, the theoretical scaffolding of the study is emphasized. The two components to theoretical scaffolding are: the literature review and the theoretical fore-structure. Theoretical scaffolding serves to “*prepare the ground*” (Thorne, 2008, p. 53) as it positions the study within the existing knowledge and the identification of theoretical and conceptual ideas brought to the study to influence how the study is shaped (Thorne, 2008, 2016). Theoretical fore-structure includes the researcher’s location as researcher (her worldview) and other disciplinary and personal and/or theoretical positions that influence the shaping of the study (Thorne, 2008, 2016).

2.1 Literature Review

This literature review provides a synthesis of the findings from research studies related to HCPs approaches with IUDs and PWIDs. The state of existing literature on the topic of HCPs relational approaches toward PWIDS will be examined. Additionally, the literature on the implications of HCPs approaches/attitudes toward PWIDs, implications of IDU for Indigenous peoples, and the interdisciplinary approach of this study are addressed.

2.1.1 Goals of the literature review. The goals of this literature review were to find, summarize, and assess the state of existing literature on the topic of HCPs relational approaches toward PWIDS. In addition, the literature review helped the researcher to further understand the research topic and identify gaps in literature that may raise questions for further research. The focus of the literature review was to determine any paucity in evidence-based research in this research area of study.

2.1.2 Literature review methods. This section will describe the literature review methods. Details of the following topics will be described below: Search strategy, data search

limitations, and sources of information. The search was conducted between April 2013 and December 2015.

2.1.2.1 Search strategy. This literature review provided a synthesis of the findings from research studies related to HCPs approaches with individuals who use drugs (IUDs) or PWIDs. The researcher conducted electronic searches to gather relevant articles and documents. Three databases were used, namely Cumulative Index to Nursing and Allied Health (CINAHL), Medline Ovid, and Scopus. Additionally, Google searches were conducted. International documents and articles from the United Nations and WHO were searched. Searches for relevant government documents, articles and reports were also conducted among national and provincial government agencies' and organizations' websites in Canada. The Canadian agencies and organizations searched specifically were: the CCSA, the CIHR, Health Canada, the PHAC, and Statistics Canada. Saskatchewan agencies searched were: The Government of Saskatchewan, the Saskatchewan Ministry of Health, and the SHR.

In CINAHL, the Medical Subject Headings (MeSH) terms relevant to the research topic were identified with a librarian. The MeSH terms were then used in various combinations by the researcher to retrieve articles and documents. The terms “substance abusers” or “intravenous drugs” was combined with “mental services need and demands”. This search combination yielded 57,043 articles and documents, consisting of 47 academic journals and five magazines. The search was further refined to the combination of “substance abusers” or “intravenous drug users” and “professional-patient relations” and “health personnel, minority” and with a limit to articles/documents dated between 1990 and 2015. The results from this search yielded 52 articles/documents. The researcher went through the abstracts of each journal and picked eight academic articles. The journal articles were from Australia (2), Brazil (1), Canada (1), the United

States (2), and the United Kingdom (2). The criteria used in picking these journals were that all articles and documents had to be written in English language, must be dated between the year 1990 and 2015, and the journal articles had to be peer reviewed. Articles with qualitative, quantitative, and mixed methods methodologies were all included. All articles that discussed the psychosocial aspects of drug use in relation to attitude/stigma of health care providers toward drug use, IUDs and PWIDs were included, while articles that focused only on the pharmacological aspects of drugs were excluded.

A similar search was conducted in Medline Ovid database. The terms “health personnel or allied health personnel or caregivers or health educators or health facility administrators or infection control practitioners or medical staff or nurses or nursing staff or pharmacists or physicians” were combined with the Mesh terms "attitude of health personnel" and “substance abuse, intravenous”. This search yielded 42 articles/documents. The same criteria as mentioned above were used to refine and select seven relevant articles.

In Scopus, the key words searched were “health care provider” or “doctor” or “nurse” or “pharmacist” and “attitude or stigma or bias” and "injection drug use". This search resulted in 56 documents. These results consisted of articles (45), reviews (10) and conference paper (1). The articles chosen from this database and that suited the criteria were 11 in number. The total number of articles selected from the three databases were 26 using the criteria mentioned above (See Appendix K for Literature Review Summary Table). A secondary search was initialized by hand searching the reference lists of the selected articles/studies and other documents found on various websites. A bibliography comprising of 171 references was compiled from the electronic databases, the international, national (Canada) and provincial (Saskatchewan) articles, and documents. The literature originated from around the world with the majority from Canada. In

addition, four articles or documents from international organizations were chosen and 15 were chosen from government agencies/other agencies in Canada. The literature was reviewed using the themes of epidemiology, health care providers' approaches/attitudes toward PWIDs, HCP and PWIDs rapport, and negative attitudes in form of stigma/discrimination.

2.1.3 Data search limitations. The MeSH terms used for words are varied in the databases. A thorough search on the identification of the appropriate MeSH terms was carried out in this literature review. However, some Mesh terms and key words relevant to the future research may not have been well captured. This may have resulted in missing out some key studies that could be highly invaluable to the study. In this literature review, it was observed that there were a limited number of studies focusing on HCPs relational approaches toward PWIDs in countries where statistics have revealed more addiction problems (such as in Asia and Africa). Building on the findings of discrepancies such as this, the researcher hopes to conduct an extensive systematic review in a future program of research on this topic.

2.1.4 Sources of information. The journal articles reviewed in this study were retrieved from the three electronic databases mentioned above: CINAHL, Medline Ovid and Scopus. Grey literature included in the review were also retrieved electronically from agency/organization websites and by conducting Google search. The grey literature consisted of government reports like the Romanow (2002) report and major reports and publications from the Canadian Government websites like PHAC, CCSA, and Health Canada. In addition, information was sourced for by retrieving documents/articles from websites of international organizations such as the World Health Organization (WHO) and the United Nations (UN). Provincial reports and government documents were retrieved from the Government of Saskatchewan and Saskatchewan health websites. Some local reports from Saskatchewan were retrieved from reports from the

health region of study, the Saskatchewan Addictions research chair website, and local media releases.

2.2 Focus Areas of the Literature Review

This literature review focused on the following areas: HCP approaches toward PWIDs; implications of HCPs approaches on IUDs/PWIDs; and terms relevant to the study. Additional areas of focus were: implications of IDU on specific populations (like Indigenous peoples and women); the interdisciplinary approach; stigma and discrimination within the multidisciplinary addiction literature; and government reports on stigma and discrimination.

2.2.1 Health care providers (HCPs). A diverse group of HCPs regularly or occasionally come in contact with PWIDs. Some health departments that see PWID clients/patients include the emergency departments, mental health and addictions units, public health services, obstetrics and gynecology units, addiction agencies, and more. The HCPs involved in addressing PWIDs issues usually include, but are not limited to primary health care staff, nurses, addiction workers, sociologists, psychologists, public health professionals, mental health staff, physicians, medical students, pharmacists and Indigenous social workers, among others. Various studies have been conducted among HCPs in diverse work settings globally. Monks, Topping, and Newell (2013) in the United Kingdom studied the views of nurses (and patients) in medical wards. Monks et al. (2013) found that a combination of factors including lack of educational preparation of nurses and their prejudgment/distrust of patients result in negative nurse-patient relationships. Kelleher and Cotter (2009) in Ireland conducted a descriptive study in an emergency department on doctors and nurses' attitudes concerning substance use and substance users. Kelleher and Cotter (2009) in their findings identified knowledge deficits in relation to intervention strategies, which suggested that substance-using patients were managed inadequately. Additionally, James and

Omoaregba (2013) studied the opinions of medical students on individuals who use and abuse drugs in a teaching hospital environment in Nigeria. In their study, they found that medical students had positive attitudes toward individuals who misuse psychoactive substances; however, they preferred treatment to be offered to them by trained specialists. Furthermore, medical students with a history of psychoactive substance use in James and Omoaregba's (2013) study expressed more positive attitudes towards their patients.

McLaughlin, McKenna, Leslie, Moore, and Robinson (2006) conducted a study among health and social care professionals' who worked in community settings in Northern Ireland. The findings of the study revealed that many participants had little or no training for working with illicit drug users, and would reject the offer of education in this area to avoid contact with illicit drug users. Additionally, the participants displayed negative views of the client group. Primary health care practitioners including general practitioners, community pharmacists, and key drug experts (with specialist knowledge in drug treatment and law enforcement) in the community constituted the health care provider study sample by Butler and Sheridan (2010) from New Zealand. The findings of Butler and Sheridan's (2010) study revealed that practitioners were more sympathetic with "over-users" of prescription drugs than "abusers". Nevertheless, these sympathetic practitioners observed that there is a lack of appropriate services and support network for the patients.

A major theme found in the empirical studies reviewed in this section is lack of specialized training/education of HCPs for working with individuals who use drugs. This invariably affects the attitude of HCPs toward IUDs and PWIDs. Additionally, distrust and detachment from HCPs toward IUD/PWID patients was another major theme that emerged. Resources and services for HCPs are limited.

Health care providers in different professions constantly provide care and services to PWIDs in diverse capacities and work settings. Education and/or focused specialization in working with those who use/abuse drugs and PWIDs have been found to play a vital role in influencing attitude and practice of HCPs. Studies mentioned above show that research have been conducted among HCP in diverse work settings, however Slev-Ran et al. (2013) in Israel hypothesized and confirmed that practitioners who specialize in fields with more focused education about substance use and addictions are less judgmental towards addictions or IUDs. Very limited research studies have been conducted on this finding of Slev-Ran et al. (2013). The paucity in research in this area, particularly in Canada and the SHR, authenticated the need for this study.

2.2.2 Relational Approaches of HCPs in their practice with PWIDs. In the context of this study, “relational approach” refers to the professional relatedness and attitude of HCPs to PWIDs as manifested in the HCPs’ strategy employed in providing care to PWIDs. A positive relatedness would reveal the provision of care in a safe, competent, and humane manner. A negative relatedness would reveal inappropriate provision of care, stigmatizing, and being judgemental of PWIDs. Attitude has been defined as “a mental and neural state of readiness organized through experience, exerting a dynamic influence upon the individual response to all objects or to situations with which it is related” (Allport, 1961, as cited in Breckler & Wiggins, 1989, p. 407). Another definition describes attitude in relation to beliefs, knowledge and behaviour as “a predisposition, toward any person, ideas or objects, it contains cognitive, affective and behavioural components” (Zimbardo & Ebbesen, 1969, as cited in Ewhrudjakpor, 2009, p. 19). In addition, Ross and Darke (1992) in Australia developed a tool to measure attitudes to IDUs. What HCPs know and believe about PWIDs may influence their clinical

practice with and attitude toward them.

In 2011, the Australian Injecting and Illicit Drug Users League (AIVL, 2011) conducted a study among HCPs who provided clinical services to PWIDs in Australia. The AIVL (2011) reported that younger professionals that include nurses, pharmacists, physicians, and emergency department staff mostly treated PWIDs with disdain. These young professionals had limited work experience with PWIDs and they generally relied on societal stereotypes or norms in their clinical practice with PWIDs. The young professionals described PWIDs as having “the junkie look with rotten teeth” (AIVL, 2011, p. 42). Health care providers went as far as saying to their patients who inject drugs “we haven’t got time for you; there are sicker people than you” (AIVL, 2011, p. 68).

Pharmacists are concerned about PWIDs’ shoplifting habits and the effects of having them around on pharmacists’ “normal” clientele (Gfk Blue Moon, 2010 as cited in AIVL, 2011). In addition, HCPs have pre-conceived notions about what their interaction with PWIDs would be like based on PWIDs appearance. Health care providers looked for signs of problematic behaviour in PWIDs, which already colours their future interaction with them (AIVL, 2011).

Physicians, who work with PWIDs, often believed that PWIDs complain of pain so they can be prescribed opiates (AIVL, 2011; de Bruin et al., 2010). Physicians accused PWIDs of wanting to get “stoned” and of “drug-seeking behaviour” (NSW Users and AIDS Association, 1995, as cited in AIVL, 2011, p. 69). In Saskatoon, SK, Canada and Australia respectively, de Bruin et al. (2010) and AIVL (2011) posited that physicians denied PWIDs pain relief medication. HIV- positive PWIDs who have chronic pain are also denied adequate pain relief medications by physicians. According to AIVL (2011), physicians would not give anything stronger than Tylenol for excruciating pain because they are PWIDs.

The Australian Injecting and Illicit Drug Users League (AIVL, 2011) illustrate in their study that HCPs assume that all IUDs who have hepatitis C virus (HCV) are definitely PWIDs and do not deserve treatment at all. Furthermore, an IUD described that when he owned up to having HCV (because it was the proper thing to do) to his dentist, the dentist accidentally “cut his finger, flew into a panic, and didn’t finish the job” (AIVL, 2011, p. 62). Additionally, emergency staff discharge very ill PWIDs because they believe they are pretentious and drug seeking which leads to irreversible negative consequences for PWIDs most of the time (AIVL, 2011).

Results from other empirical literature reviewed in this study are consistent with that of AIVL (2011) that reveals stigma and discrimination among HCPs toward PWIDs. Lang et al. (2013) indicated in their study that service providers (whose professions were not specified) identified stigma and discrimination as part of the major barriers to accessing care by PWIDs in Saskatoon, SK, Canada. Other barriers of access to care as identified in the small urban city of Saskatoon (260,000) are: insufficient utilization of resources, inadequate continuing education of service providers, and the unique and demanding nature of PWIDs (Lang et al., 2013). The studies of Lang et al. (2011) in Saskatoon, Sleeper and Boschain (2013) in the United States, and Simmonds and Coomber (2009) in the United Kingdom conducted among PWIDs/substance abuse clients, additionally confirmed stigma and discrimination from HCPs toward PWIDs.

Wenthur and colleagues (2013) in the United States examined the issue of stigma from the perspective of pharmacists and pharmacy students, while Chang, Simon, and Dong (2012) had nurses as their study participants in Taiwan. Irrespective of the sample population (be it HCPs or PWIDs/IUDs), stigma and discrimination toward IUDs and PWIDs were confirmed in all the studies reviewed in this section. The focus of the two related studies of Lang et al. (2011)

and Lang et al. (2013) conducted in Saskatoon, were not to study HCPs approaches toward PWIDs but mainly to examine barriers to PWIDs' access to healthcare services. However, the result that stigma and discrimination from HCPs toward PWIDs are part of the barriers to access to services is common to the two studies. Lang et al. (2011) first conducted a qualitative study that examined the views of twenty-five PWIDs through group discussions and interviews. Two years later, Lang et al. (2013) conducted an exploratory investigation with focus groups among twenty-seven service providers. Numerous studies have been conducted on the attitudes of HCPs toward PWIDs/IUDs around the world including the studies reviewed that were conducted in the United Kingdom, the United States, Taiwan and Canada. There is no study in Saskatchewan that has focused on the relational approaches of HCPs towards PWIDs and the implications this may have on PWIDs health outcome and access of PWIDs.

2.2.3 Stigma and discrimination from HCPs towards PWIDs. In a systematic review on stigma among HCPs toward patients with substance use disorders and its consequences for healthcare delivery, van Boekel, Brouwers, van Weeghel, and Garretsen (2013) in Tilburg, Netherlands, found that HCPs generally have a negative attitude towards patients who have substance use disorders. In Connecticut, in the United States, Sleeper and Boschain (2013) studied the real-life experiences of stigma, as perceived by adult substance abuse patients currently enrolled (or enrolled in the last six months preceding the study) in a residential substance abuse treatment program. The results of the study revealed that substance abuse patients experienced stigmatizing behaviors from nurses, counselors, therapists, doctors, and other ancillary staff within the residential substance abuse program.

The reasons for stigma and discrimination from HCPs probably originate from societal views. The general public are “happy to discriminate against” PWIDs thinking this would deter

PWIDs from injecting drugs (AIVL, 2011, p. 42). Health care providers in AIVL (2011) study, particularly the younger professionals, discriminated against PWIDs based on public opinion. The AIVL (2011) further reported that discrimination against PWIDs is overwhelming and the grounds of discrimination are generally related to stereotypes (dangerous), myths (junkie head, always one) and misconceptions (failure) about PWIDs.

People who inject drugs (PWIDs) that have multiple layers of vulnerability and marginalization such as those who have Indigenous ancestry and at the same time are women are not provided with culturally safe practice and treatment environment by HCPs (Durey, 2010). Some HCPs do not have enough knowledge in or understanding of the Indigenous culture, enough to be able to provide holistic services to their Indigenous patients, and neither are they patient enough to listen to their clients (patients) to understand their needs. Health care providers were generally found to lack adequate education, training, and support structures in their work with this population (Lang et al., 2013; van Boekel et al., 2013).

Chu and Galang (2013) in Toronto, ON, Canada, found results that were contrary to the existing literature as the nurses in their study had neutral attitudes towards patients with a history of illicit drug use; they found that the nurses had low motivation and role support in caring for illicit drug use patients. Chu and Galang (2013) suggested increased use of specific organizational tools, such as: increased role support to address nurses' clinical concerns and to support the therapeutic nurse/patient relationship, which would ultimately enhance care delivery. In the studies reviewed in this section, only the study of Chu and Galang (2013) revealed a varied view of neutral attitude of HCPs approach toward IUDs and not of HCPs discrimination and stigma. Chu and Galang (2013) however noted that the reason for this could have been the low motivation and role support of the nurses in their study toward their IUD patients.

2.2.4 Theoretical basis for stigma and discrimination. There are many multidisciplinary and varied definitions of stigma. The definition of stigma, which originated from the social sciences by Goffman (1963), will be considered for the purpose of this study. In the literature “Stigma... is the situation of the individual who is disqualified from full social acceptance” (Goffman, 1963, preface). The stigmatized individual is “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). Stigma can be when persons are dehumanized based on their social identity or participation in a negative or an undesirable social category (Goffman, 1963). Additionally, Goffman (1963) used the concept of stigma to refer to individuals who are considered to be different, particularly, in a different way based on characteristics that differentiates them from the rest of the society. Some of these characteristics may be some form of disability or mental illness that cannot be changed. Those stigmatized do not fully feel socially accepted and are constantly struggling to adjust their social identities. Such people, in addition to those physically deformed and mental ill as already mentioned, include drug people with addiction, and those involved in prostitution (Goffman, 1963). Stigma is a Greek word that originally referred to bodily signs like tattoos that exposed the moral status of criminals, slaves, or traitors (Goffman, 1963). The purpose of these signs was to advertise that the bearer is ritually polluted and should be avoided, particularly in public places (Goffman, 1963). In present times, the term “stigma” is still used like the original use in literal sense but now applies more to the disgrace than the bodily mark (Goffman, 1963).

A great variability and a need for a definition that encompasses all types of stigma led Link and Phelan (2001, p. 363) to apply the term “stigma” when there is “the co-occurrence of its components labeling, stereotyping, separation, status loss, and discrimination and further indicate that for stigmatization to occur, power must be exercised”. Recent researchers in the

United States have identified several types of stigma, which include public, perceived, enacted, and self-stigma (Kulesza, Larimer, & Rao Kulesza, 2013). In public stigma, the public endorses prejudice against a specific stigmatized group, which results in discrimination towards members of the group (Corrigan & Watson, 2002). Perceived stigma refers to the process where stigmatized individuals or groups think that other people believe negative stereotypes about other individuals in the same stigmatized group as them (Livingston & Boyd, 2010). Enacted stigma refers to the direct experience of discrimination and rejection from members of the larger society (Luoma et al., 2007). Self-stigma refers to when the stigmatized individual has negative thoughts, feelings, and diminished self-image as a result of identifying with the stigmatized group and anticipates rejection from the larger society (Corrigan, Watson, & Barr, 2006).

Another form of stigma is structural stigma. This type of stigma refers mainly to the social rules, norms, legislations, policies, and practices in social institutions that lead to obstacles for, and restrict the rights, and opportunities of individuals [such as individuals with mental illness] or groups (Corrigan et al., 2005; Livingston, 2013). Inequities and injustices that have become norms cause people to have unequal access to socio-economic and political resources, and power (Livingston, 2013). Paterson, Hirsch, and Andres (2013), in their study in Nova Scotia, NS, Canada, identified the need to see stigma from beyond an individualistic approach, but also from an institutional perspective. Patterson et al. (2013) studied stigmatization of individuals who use drugs, and who have hepatitis C, in emergency departments. The Patterson et al. (2013) report conceptualized stigma from a multifaceted view point, that stigma occurs and is nurtured by both internal (such as HCPs attitudes and the hospital environment) and external structures (such as physician shortages and the mandates of emergency departments to reduce wait times).

Despite the fact that there is no universal definition for stigma, there are some unitary clear indicators for social origins of stigmatization and the factors that perpetuate it. Stigma mainly originated from the perception that there is a difference (Smith, 2002). There is the predisposition to notice that differences are inborn in humans (and human groups) as they depend on behaviors of other members of the group for safety and to function (Smith, 2002). While it is easy for individuals or groups to notice those, who are different or respond negatively to those considered a threat, some differences such as age, gender and skin color are to a large extent considered to be a “natural” or an objective difference (Smith, 2002). For stigmatization to occur differences must be linked to a negative trait (Smith, 2002). For PWIDs, such negative traits may be linked to criminality and to endangering the health of the public through the spread of blood borne diseases HIV or HCV. Stigmatized groups generally have decreased social status and they lack power (Smith, 2002).

The origins of stigma differ in different cultures. An example can be seen in the shift in stigma attitudes in the developed world (the west) about disorders such as depression that are now significantly less stigmatized than it was 10–20 years ago (Smith, 2002). A collection of components of evolution and social behavior in the origin of stigma suggest the existence of psychological mechanisms that have evolved to solve adaptive problems in the society (Kurzban & Leary, 2001).

Discrimination can be defined as the act of treating an individual or group differently, in a negative manner, for reasons such as race, gender or disability (Canadian Human Rights Commission [CHRC], 2013). The reasons the act of discrimination is based upon are termed as “grounds of discrimination” (CHRC, 2013). In Canada, the *Canadian Human Rights Act* identified 11 grounds of discrimination, which are namely race, age, gender, disability, gender

preference and religion. Additional grounds of discrimination are: marital status, family status, nationality or ethnic origin, colour, and a pardoned or record suspended conviction (CHRC, 2013). Discrimination, unlike “stigma”, focuses attention on those who perform the discriminatory act rather than on the recipients (Sayce, 1998). The term used, stigma or discrimination, helps in the understanding of where the responsibility for the problem lies, and how to take differential action (Sayce, 1998).

The origin of discrimination against IUDs and PWIDs according to AIVL (2011) started during the industrial revolution era, the end of the 18th century to the beginning of 19th century. Due to the changes in political, economic and social structure during this era, individuals turned to opium to help cope with the rapid changes they were experiencing (AIVL, 2011). Women who were forced to work to make ends meet left their babies with those who used medication that contained high doses of opium to calm the babies (AIVL, 2011). Countries like China banned the use of opium and were only used for medicinal purposes but sold opium to other countries like the United States and Australia leading to the opium wars (AIVL, 2011). An opium war basically wanted to destroy users of opium in other countries but their own. Numerous events with regard to drugs in the last two centuries gradually led to the discrimination and stigmatization of IUDs, particularly, PWIDs.

2.2.5. Implications of stigmatization and discrimination on PWIDs. Simmonds and Coomber (2009) in Plymouth, United Kingdom posited, “the attribution of and internalization of stigma can reduce the effectiveness of prevention and harm reduction activities” (p. 1). How clients are treated is affected by the stigmatization of client populations. Furthermore, access or full utilization of services offered to clients (or potential clients) is prevented by the internalization of stigma by the clients (AIVL, 2011; Lang et al., 2011; Simmonds & Coomber,

2009). In Canada, the experience of stigmatization has prevented many PWIDs from accessing or fully utilizing health services they may need (Lang et al., 2011) and if they do access services, stigmatization may prevent them from disclosing their drug use status to their HCPs and this may endanger their lives, according to the study of Ross et al. (2007) in Texas, in the United States. Additionally, in the study carried out by Miller, Sheppard, Colenda, and Magen (2001) in Michigan, the United States found that PWIDs receive substandard care when they do access services, and that access to health care is important for PWIDs. In addition, two other studies conducted in the United States by Ahern, Stuber, and Galea (2007) and Young, Stuber, Ahern, and Galea (2005) found that the effects of stigma and discrimination may additionally be negative on IUDs' and PWIDs' mental and psychological health due to exposure to chronic stress and stigmatization.

Some PWIDs experience multiple stigmatizations due to poverty and their race (Kulesza et al., 2013), however, empirical studies have shown that discrimination due to substance use/abuse have the greatest effect on their lives (van Boekel et al., 2013; Young et al., 2005). Negative attitudes from HCPs towards patients result in violence, manipulation, and poor motivation for PWIDs (Young et al., 2005). People who inject drugs (PWIDs) also experience decreased feeling of empowerment and subsequently have poor treatment outcomes (van Boekel et al., 2013). Stigmatizing behaviors and actions in residential substance abuse treatment programs “decrease patient comfort, and increase patient anger and frustration” (Sleeper & Boschain, 2013, p. 92). Alternatively, PWIDs feel they are misunderstood, wrongly judged and not well represented (AIVL, 2011).

In the 2006 SHR report on HIV prevention strategy, the section on community voice on current practice highlighted that “stigma and discrimination are very real in SHR” (de Bruin et

al., 2010, p. 64). Clients reportedly fear to access certain health care services because of stigma and discrimination, their ethnicity and HIV status (SHR, 2006). The PWIDs have avoided some particular health care services such as one tagged “death-valley” due to stigma and discrimination (de Bruin et al., 2010, p. 64). Clients of SHR have indicated that caregivers are lacking in compassion and understanding leading to clients’ avoidance of certain doctors and nurses (de Bruin et al., 2010). In accessing care for pain management, PWIDs also complained that HCPs make assumptions and do not conduct any clinical assessment. Additionally, clients prefer to go to the streets for drugs rather than face negative reaction from HCPs (de Bruin et al., 2010). According to Lang et al. (2011) in Saskatoon, SK, Canada, “to limit disease transmission, and improve health and social outcomes for PWIDs and their families, it is important for health care services, to provide appropriate, equitable and compassionate care” (p. 6). Despite the need for HCPs to provide appropriate and quality care to their clients, studies among mental health service providers have revealed that service providers’ practice with their clients are susceptible to be influenced by the stigmatizing beliefs of the society (Kopera et al., 2015; Overton & Medina, 2008). Additionally, individuals who utilize mental health services are concerned about the influence of HCPs’ societally imbibed perceptions on practice with mental health service users (Charles, 2013). Imbibed societal stigma by HCPs who provide services to PWIDs in Saskatchewan and other places, may be a concern for health institutions (research is needed to gain understanding of the influence of imbibed stigma on the approaches of HCPs with PWIDs).

The studies reviewed showed that the implications of HCPs negative approaches toward PWIDs include: substandard care from HCPs, lack of access or poor utilization of health services by PWIDs, and violence, manipulations, and poor motivation for change among PWIDs. Decreased feeling of empowerment, poor mental and psychological health, and poor treatment

outcomes are additional implications (Bourguignon, Seron, Yzerbyt, & Herman, 2006; Major, Kaiser, O'Brien, & McCoy, 2007). Stigma and discrimination from HCP contribute to increased morbidity and mortality rates among PWIDs. Recognizing these implications will help HCPs, researchers, communities and health policy makers to know how to address the problem of stigmatization and discrimination towards PWIDs.

In Lang and colleagues (2013) study, PWIDs identified four barriers to care which were: stigma and discrimination, inadequate education, poor utilization of resources, and PWIDs unique and demanding nature. Although, Lang et al. (2013) investigated the barriers of accessing care by PWIDs in Saskatoon from the perspectives of service providers, studies focused on investigating the relational approach of HCPs with PWIDs in Saskatchewan are lacking. This study may contribute to filling some gap in that area. Additionally, it was highly invaluable to conduct a study of this nature, which further explored the relational approaches of HCPs and the implications of the approaches for access to care. Exploring HCPs relational approaches may, in addition, help to see if stigma and/or discrimination exist(s) in HCPs practice with PWIDs. The need for this was identified in the study of Lang et al. (2013).

2.2.6 Barriers to care among Indigenous peoples. Despite the significant health needs of Indigenous peoples who inject drugs, particularly women, PWIDs do not frequently access medical and addiction services because of personal shame, and feared stigma and discrimination from HCPs and fear of having their children taken away by social services (Native Women's Association of Canada, 1996; PHAC, 2007b). In addition, in a study by Birch, Ruttan, Muth, and Baydala (2009) in Edmonton, AB, Canada, Indigenous women participants claimed that the care they received when they access services was not culturally appropriate for them. There is therefore a deep concern from Indigenous leadership as well as public health and primary HCPs

about these experiences of Indigenous women. Miller et al. (2011) in Canada recommend culture specific prevention programs for PWIDs. In general, the age of onset for drug use is lower for Indigenous peoples than mainstream Canadians, and Indigenous peoples experience numerous barriers to participating in harm reduction programs sometimes due to travel distance and/or lack of culturally appropriate programs (PHAC, 2007a). Observations from empirical studies as mentioned in this section confirm and stress the issue of multiple risks for Indigenous women who inject drugs.

The impact of colonization cannot be underestimated as a key barrier to access to care for Indigenous peoples (Anderson, Crengle, & Kamaka, 2006) and the effects of past discriminatory practices and policies on Indigenous peoples have been documented comprehensively in Canada (Government of Canada, 1996, 2016; Romanow, 2002). Residential school experiences have affected the health of Indigenous peoples and constituted a major risk factor for injection drug use (Anderson et al., 2006; Lemstra et al., 2012). Barriers of access to care do not only exist among Indigenous peoples, but also exist among provider– Indigenous patient interactions. The inequities in access to care among Indigenous peoples, including Indigenous PWIDs, further contributes to inequalities in health status between Indigenous and non-Indigenous peoples.

2.2.7 Cultural competence, cultural safety, and cultural humility. There has been an increase in diversity in Canada in recent years (Health Canada, 2013). In addition, one in every five Canadian was born outside of Canada according to the 2016 census released by Statistics Canada (Global News, 2017). This increase in diversity makes it pertinent to understand what cultural competence, cultural safety, and cultural humility mean, particularly to HCPs who frequently come in contact with PWIDs who are from diverse cultures and backgrounds particularly the Indigenous culture. This study is focused on a city in a province that has a high

number of the Indigenous population in Canada. In addition, PWIDs who are of Indigenous ancestry are overrepresented among the population of PWIDs in Saskatoon (Plamondon et al., 2007). Negative behaviours toward Indigenous PWIDs by HCPs, as discussed in empirical literature, is compounded if there is a lack of culturally safe health care environment available to Indigenous PWIDs, if and when they access health services. The effect of colonization, assimilation and residential schooling have had negative effects on the self esteem and cultural identity of Indigenous peoples (Waldrum et al., 2006). Health care providers must take Indigenous peoples historical past and traditional wellness beliefs into consideration in addressing their injection drug use issues. The terms cultural competence, cultural safety, and cultural humility are defined below.

2.2.7.1 Cultural competence. Cultural competence can be defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (United States Department of Health and Human Services, 2007, p. 10). Alexander (2008) in the United States defines cultural competence as the possession of specific cognitive and affective skills that are necessary for building culturally relevant relationships between HCPs and patients. Cultural competence is also described by an Australian author as “the ability of systems, organizations, professions, and individuals to work effectively in culturally diverse environments and situations” (Durey, 2010, p. 87). Skill development, continuous self-evaluation and knowledge of the diverse group are necessary to become culturally competent according to Kersey-Matusiak (2012) in Philadelphia in the United States. Cultural competent practice can be used in lessening health care disparities among patients/clients if, when, and how to go about the approach is known and followed as a continuous process (Kersey-Matusiak, 2012).

Many frameworks have been used to develop cultural competency in nursing care. Some of these frameworks include Leininger's transcultural model, Giger and Davidhizar transcultural assessment model, Campinha-Bacote model of cultural competence and Narayanasamy access model (Canadian Nurses Association [CNA], 2009). The Campinha-Bacote model closely relates to what is to be examined in this study. In the Campinha-Bacote model called "*the process of cultural competence in the delivery of healthcare services*", nurses/HCPs are directed to ask themselves a few questions based on awareness, skill, knowledge, encounters, and desire to determine their own cultural competencies (Campinha-Bacote, 2002). Nurses/HCPs need to be aware of their personal cultural biases, prejudices, cultural knowledge, assessment, and communication skills (Campinha-Bacote, 2002). The Campinha-Bacote model builds upon the belief of cultural competence as a continuous process of cultural self-awareness of nurses/HCPs at the individual and organizational levels (Campinha-Bacote, 2002).

2.2.7.2 Cultural safety. In the 1980's, the Maori people of New Zealand were dissatisfied with the quality of the nursing care they received (National Aboriginal Health Organization [NAHO], 2008). To address the need of this colonized Indigenous people, the term cultural safety was developed. Cultural safety originated as a theoretical and methodological approach, which upholds the political ideologies of self-determination and decolonization of the Maori people (NAHO, 2008). Cultural safety was based on a framework of dual cultures (NAHO, 2008). This concept and approach of cultural safety has been applied across the health care spectrum. Additionally, cultural safety helps to analyze power imbalances, institutional discrimination and colonialism in relation to health care (NAHO, 2008; Ramsden, 2002). Cultural safety strives to understand the power differentials in the delivery of health service and addresses inequities through educational processes (CNA, 2009; Ramsden, 2002).

In the work of Ramsden (2002) in New Zealand, Ramsden described her personal experience from the perspective of a Maori nursing student and new graduate in a hospital and environment where Maori people were few and no Maori HCP but herself (for a long time). Ramsden (2002) had unwritten expected roles (from the Maori people) to envisage tension and stress, protect, interpret, and mediate. In addition, Ramsden was expected to provide a safety zone and an environment of trust (Ramsden, 2002). Addressing inequities through the lens of cultural safety improves health access for clients, individuals and populations (CNA, 2009). Additionally, the social, political, and historical aspects of healthcare are exposed, and there is the acknowledgement that we all have a culture. Cultural safety helps to provide care that is regardful of differences among individuals, and sees the patient as a person who can share information on differences, if trust is established (Ramsden, 2002). Cultural competence operates on an equal partnership model where culture is applied in a broad sense and “interactions are bicultural” (Ramsden, 2002, p. 94). Culturally safe practice helps practitioners to consider concepts like racism, discrimination and prejudice in their practice (CNA, 2009).

2.2.7.3 Cultural humility. The concept of cultural humility originated from Tervalon and Murray-Garcia (1998) in the United States, in an attempt to introduce an effective multicultural approach into health care practice and physician training in particular. Tervalon and Murray-Garcia (1998) believed that the model of cultural competence was not adequately meeting the needs of the medical professions. Cultural humility can be defined as a lifelong self-reflective and self-critique process that requires humility to develop and maintain mutually respectful individual relationships and dynamic partnerships with communities (Tervalon & Murray-Garcia, 1998). The main components of cultural humility are: self-reflection and self-critique, learning from patients, maintaining mutual and respectful partnerships with patients and

stakeholders, and a life-long learning process (Chang et al., 2012). In addition is the assumption that cultural humility is a continuous process, that education is lifelong, and that the HCP cannot learn or reach a full understanding of a culture to which they are not members (Tervalon & Murray-Garcia, 1998). Health care providers that practice cultural humility see their patients as being capable as they work to understand their worldviews and any oppressions or discriminations they may be experiencing or have experienced. In a more recent literature scan, Foronda, Baptiste, Reinholdt, and Ousman (2016) in the United States, buttressed the existing definitions of cultural humility and pointed out that a good understanding of the term ‘cultural humility’ will enable individuals and communities to better understand and accomplish an environment that is inclusive, with mutual benefit, and optimal care.

2.2.8 Significance of culturally relevant practice for HCPs. The practice of cultural competence, cultural safety and cultural humility are significant for HCPs working with Indigenous populations in many ways. Gaye Hanson, an experienced nurse and administrator of Cree ancestry shared her practical and multicultural experiences in an interview with Kent-Wilkinson (2006) in Saskatchewan, Canada. In the interview Hanson mentioned that it is important for the HCP working with Indigenous populations to be reflexive and reflective (Kent-Wilkinson, 2006). Health care providers’ awareness of their own cultures helps them to understand and be aware of how their cultures and beliefs can affect their practice. Subsequently, HCPs identification of their personal biases and assumptions decreases the likelihood of imposing their biases and assumptions on their clients/patients (Durey, Thompson, & Wood, 2012; Kent-Wilkinson, 2006).

According to a study in Australia by Durey et al. (2008), to work effectively with Indigenous populations, HCPs need to have effective communication skills to be able to relate

and interact in diverse ways and respond appropriately to different approaches to illness among patients. Good communication helps to establish good rapport and minimize anxiety for patients/clients, particularly to Indigenous patients whose first language may differ from the official language of communication (Durey et al., 2012). Coming to a tertiary hospital from a rural environment may additionally be a source of anxiety for the patient. Clear communication between HCPs and PWIDs prevents HCPs from labeling or recording a patient as being “non-compliant or refusing to attend follow up (Durey et al., 2012).

Durey et al. (2012) suggested training or orientation of physicians on Indigenous culture as a way of understanding the culture of Indigenous patients. Suggestions were further put forward that physicians or HCPs should engage with the Indigenous community, establish contact with Indigenous elders to involve them in planning for programs or solving problem. Additionally, Durey et al. (2012) suggested that physicians in health care settings should actively support Indigenous health workers. Durey (2010) illustrated that collaboration between policy makers, inter-disciplinary HCPs, academics, and Indigenous stakeholders is key in achieving cultural competence and safety.

Indigenous populations can additionally be empowered by HCPs and researchers. In the addictions’ field, there is a practical example of a team of HCPs, researchers and community members in Canada who created a half-day workshop from their research to help women in treatment to draw strength from their cultural heritage and overcome stigma. The workshop is based on the research findings from the project titled “From stilettos to moccasins”, which recognized the need for First Nations, Métis and Inuit women to re-claim, and for some to claim for the first time, a healthy self-identity as Indigenous women (CIHR, 2013; Dell, 2012). The workshop is designed for facilitation by and for community members. All training materials are

included in a kit (which is given out at no cost) including a 30-minute training video (CIHR, 2013; Dell, 2012). “From stilettos to moccasins” training tools such as: half day workshops and educational videos for service providers, have advanced the development of culturally competent, safe, and humility practice among Indigenous peoples.

When HCPs provide culturally appropriate care to Indigenous peoples, clients/patients respond better to care, in essence, the health outcome is deemed to be positive (Durey, 2010; NAHO, 2009). Learning and applying respect and showing understanding of the culture are needed to provide culturally competent care to Indigenous peoples can increase the confidence of the HCP on the job (NAHO, 2009). The HCP is able to address the needs of diverse groups in the society. The culturally competent HCP working with PWIDs will be able to meet the needs of diverse client groups effectively, especially Indigenous women who inject drugs and who have peculiar needs that differ greatly from those of the rest of the population. In addition, HCPs will have increased job satisfaction which will ultimately lead to increased job retention rate in remote and rural Indigenous communities (NAHO, 2009). HCPs will also be involved in lifelong learning and continuing competence as they provide culturally appropriate services to the Indigenous clients/patients (NAHO, 2009).

All studies reviewed in this section affirm the importance of culturally competent, safe, and humility practice by HCPs. Specifically, culturally competent, humble, and safe practice in the health field has been reported to be very important for positive health outcome among patients. However, limited numbers of studies have focused on practice of cultural competence, safety and humility toward IUDs/PWIDs of Indigenous ancestry and of other cultures in Saskatchewan, despite the constantly increasing diversity in the province.

2.2.8.1 Women who use/inject drugs. A third of PWIDs in Canada are women (CCSA, 2011). Ahmad, Poole and Dell (2007) reported in their study in Canada that women have generally and specifically lower problematic rate of drug and alcohol use, however, in the 15 years preceding their study there had been an increase in the use of substances among women. Women are suppressed through shame and discrimination that is usually layered for being women, drug users, have HIV status, and worse still if they belong to a racial minority group or have Indigenous ancestry.

Physiologically, women who inject drugs have higher vulnerability for blood borne diseases like HIV and HCV through needle sharing. Women account for 50% of people who have HIV worldwide and those between the ages of 15 to 24 have been found to be most vulnerable (United Nations Program on HIV/AIDS, 2012). Additionally, women who are commercial sex workers have high risk of blood-borne viruses (PHAC, 2006; Unger et al., 2006). Women who have sex with women (WSW) also have higher prevalence risk of HIV than those who do not (WHO, 2012). The reason for this may be because HCPs and policy makers do not focus on addressing the issues of this group of women as much as they do with women who have heterosexual relationships (WHO, 2012).

Women who inject drugs also have the high tendency to have co-morbidity of illnesses. Marsden, Gossop, and Stewart's (2000) study in London, United Kingdom, highlighted that in addition to women injectors being vulnerable to psychiatric co-morbidity, they exhibit low self-esteem, cutting behaviours, suicide attempts, eating disorders and post-traumatic stress from sexual or domestic violence (Fiorentine, Anglin, Gil-Rivas, & Taylor, 1997; Marsh, D'Aunno, & Smith, 2000). Many women use substance abuse as a way of coping with trauma such as abuse suffered as a child and intimate partner violence (Niccols, Dell, & Clarke, 2010). Niccols and

colleagues (2010) further reported that women accessing health services are more likely than their male counterparts to have more social problems such as relationship problems, social isolation and less number of friends.

Women who inject drugs fear stigma from HCPs in accessing health care and this can be seen as multiple jeopardy for them as they already fear forced treatment or criminal prosecution and having their children taken away from them because of neglect (Niccols et al., 2010). If and when women summon the courage to access services despite the layered stigma they experience, the services do not quite meet their physical, social and psychological needs. Women's life styles such as need for childcare or emotional support are not taken into consideration. In addition, many women usually feel unsafe in co-educational treatment programs because of their experiences with intimate partner violence (Niccols et al., 2010). There is the need for more women friendly services that are less geared towards men.

The WHO (2012) indicated that women who use/abuse drugs have problems of affordable housing, homelessness and lack good nurturing environments for their children. Additionally, women who inject drugs usually engage in commercial sex work to provide for their partners and/or family. For some of these women, the relationship with their spouses is tied to their basic needs of food, shelter, drugs and protection (WHO, 2012). This kind of relationship puts the women in particularly vulnerable positions because of their dependence on and their subordinate position to men. This vulnerability makes these women less able to enforce safe sex and injection habits (WHO, 2012). Addressing the right and targeted issues peculiar to women can make a great difference for the health of women who inject drugs and ultimately the future generation.

2.2.8.2 Summary. The HCPs who mainly provide services to IUDs/PWIDs in the literature include: addiction workers, nurses, and pharmacists. Other HCPs are: physicians, psychologists, social workers, and sociologists. The studies reviewed in this research were conducted among HCPs in diverse settings such as: emergency departments (e.g., Kelleher & Cotter, 2009), medical wards (e.g., Carrol, 1994; Monks et al., 2013), community setting (e.g., Lang et al., 2011; Lang et al., 2013; McLaughlin et al., 2006), and primary health care unit (e.g., Butler & Sheridan, 2010). Evident in the literature review is that HCPs' relational approaches with PWIDs play an impactful role on access to health care, utilization of services, and ultimately the health outcome of PWIDs. Stigma and discrimination from HCPs (negative relational approaches) exist and they constitute major barriers to accessing care by IUDs/PWIDs (Carrol, 1995; Gronholm et al., 2017; Gunn & Guarino, 2016; Lang et al., 2011; Lang et al., 2013; Simmonds & Coomber, 2009; Sleeper & Boschain, 2013).

The relational approach of HCPs toward PWIDs is influenced by many factors. When there is a negative HCP/patient relationship there is the likelihood of lack of educational preparation of the provider, pre-judgement, distrust of patient, and knowledge deficit in relation to intervention strategies (Kelleher & Cotter, 2009; McLaughlin et al., 2006; Monk et al., 2013). Some HCPs would reject the offer of educational training in the area of substance abuse to reduce contact with IUDs (McLaughlin et al., 2006). Nevertheless, HCPs who specialize in fields that have more focused education about substance use and addictions are less judgmental and more positive toward IUDs/PWIDs (Slev-Ran et al., 2013). Work experience of HCPs additionally contribute to their attitude toward PWIDs. Younger professionals sometimes rely on societal stereotypes or norms in their practice (AIVL, 2011), however when young professionals or professionals who are still in training are positive toward their clients/patients, sometimes the

clients/patients do not trust them and prefer to be seen by more experienced professionals (James & Omaoregba, 2013). Emergency staff sometimes discharge really ill patients because they feel they are drug seeking (AIVL, 2013).

Studies in SHA have focused on barriers to PWIDs access to services among PWIDs (Lang et al., 2011) and among HCPs (Lang et al., 2013). In addition, there are risk indicators associated with high rates of IDU among Indigenous populations compared to other cultural groups in Canada (Lemstra et al., 2012) and there are multiple layers of vulnerability and marginalization among PWIDs (e.g., women and indigenous populations). Despite the importance of relational approaches of HCPs with PWIDs, there is no known study in Saskatchewan that has focused on the relational approach of HCPs and PWIDs (specifically among those who work predominantly with PWIDs) and the implications this may have on their PWIDs health outcome.

2.2.9 Government reports on stigma and discrimination. A government report that addresses stigma and discrimination among vulnerable populations (such as individuals with mental health and addictions issues and Indigenous peoples) is *Changing Directions Changing Lives – the Mental Health Strategy for Canada* developed by the Mental Health Commission of Canada (MHCC, 2012). This strategy was developed in consultation with individuals living with mental health issues and illnesses, their families, stakeholders, government and various experts. The mental health strategy has an overall vision that all people living in Canada “have the opportunity to achieve the best possible mental health and wellbeing” (MHCC, 2012, p. 3). Each year, one out of five people living in Canada experience a mental health problem or illness which costs the economy well over \$50 billion dollars (MHCC, 2012). Additionally, only one out of three individuals who experience a mental health and illness report having sought help utilized

services or received treatment (Statistics Canada, 2003). This lack of access is again due to stigma and the fear of being labelled when they do so (MHCC, 2012).

One of the strategic directions (strategic direction 5) recommended in the mental health strategy is that of working with Indigenous peoples to address their distinct mental health needs and acknowledge their unique circumstances, rights, and cultures (MHCC, 2012). The MHCC (2012) strategy put emphasis on First Nations, Inuit and Métis families' and communities' healing from the inter-generational impact of residential schools, child welfare policies and other aspects of colonization that have affected their mental wellness. Mental illness and suicide is to be addressed together for this population (MHCC, 2012). Additionally, for the Métis peoples, there is the need to improve access to mental health and addiction services engagement processes and research that are equitable (MHCC, 2012). The strategy recommends that irrespective of where First Nations, Inuit or Métis peoples reside, they should have access to a full continuum of culturally safe mental health and substance use services, treatment and supports for and by their respective peoples (MHCC, 2012). These recommended approaches for Indigenous peoples, need to be holistic by including traditional, cultural, and mainstream approaches (MHCC, 2012). Another strategic direction (strategic direction 4) recommended by MHCC (2012) is that disparities in risk factors and access to mental health services need to be reduced. In addition, the response of the needs of diverse communities and northerners should be strengthened (MHCC, 2012).

Changing Directions, Changing Lives: Mental Health Strategy for Canada (MHCC, 2012) is a clarion call to all people who live in Canada to make a change in the area of mental health and addictions. The MHCC (2012) emphasizes that irrespective of an individual's background, experiences or circumstances, he or she needs to be provided with equitable access

to a full range of high quality services, treatment and support. In addition to the *Mental Health Strategy for Canada is the First Nations Mental Wellness Continuum Framework model*. The aim of the continuum is to support all individuals across the life span. The model emphasizes the interconnectedness between the physical, spiritual, and emotional aspects of the individual leading to optimal wellness (Health Canada, 2015).

2.2.9.1. Nursing, psychological, public health, and sociological interplay. The interdisciplinary approach was employed in conducting this study and answering the research questions. To effectively carry out the study and generate new knowledge, insight was drawn from the disciplines of nursing, psychology, public health, and sociology. The researcher had background knowledge in conducting research in the disciplines of psychology and public health. Additionally, the researcher obtained expertise guidance of conducting research with insights from the fields of nursing and sociology from her supervisor and advisory committee members. The issues surrounding the health and care of PWIDs is a global problem that requires the knowledge and insights from across applied health disciplines to understand and address the issues. Nevertheless, the focus of this study extended beyond a single disciplinary perspective (see Figure1: Interdisciplinary Approach).

Repko and Szostak (2016) noted in his book on Interdisciplinary studies that insights from two or more fields in a study, help to construct a more comprehensive understanding of the phenomena and provide creativity. In interdisciplinary studies no one disciplinary concept, theory, or assumptions is chosen over the other (Repko & Szostak, 2016). Additionally, Pieters and Baumgartner (2002) pointed out that interdisciplinary studies are not biased by just being interested in the theories and methods of disciplines and ignore the insights generated by alternate theories and methods. In addition to drawing insights from across disciplines (as

mentioned earlier), this study further integrated knowledge, literature, and conceptual frameworks from the disciplines of psychology, public health, nursing, and sociology. The conceptual frameworks that were integrated to provide lenses to analyzing the findings of this study were: the harm reduction philosophy from public health, theory of stigma and discrimination mainly from the fields of psychology and sociology, and the behavioural health care utilization model, mostly used in the applied health fields. The ID methodology chosen as the approach to inquiry in this study additionally enabled the researcher to have a good fit for the novel disciplinary perspective from which this study was conducted, as the underpinnings for the use of ID do not restrict the use of ID to any particular discipline like some other methods. This present study followed the recommendations of Repko and Szostak (2016) that interdisciplinary studies need to go beyond merely drawing from disciplinary perspectives to integrating their insights and models of thinking to advance the understanding of the topic with the goal of making the findings applicable for HCPs (see Figure 2.2: Interdisciplinary Integrationist Approach).

In the United States, Svoboda-Gouvea, Sawtelle, Geller, and Turpen (2013) in designing a framework for analyzing interdisciplinary tasks in a course, articulated four interdisciplinary objectives. Svoboda-Gouvea et al. (2013), expressed that interdisciplinary learning helps to develop deeper levels of conceptual coherence, supports metacognitive learning objectives, shifts student attitudes and expectations about disciplines, and helps scientists across disciplines to have at their disposal a powerful set of practices for reasoning about the world. This present interdisciplinary study afforded the researcher a unique opportunity that would otherwise have been unavailable in a disciplinary program. In addition, this study truly relates with the advantages of interdisciplinarity as expressed by Svoboda-Gouvea et al. (2013).

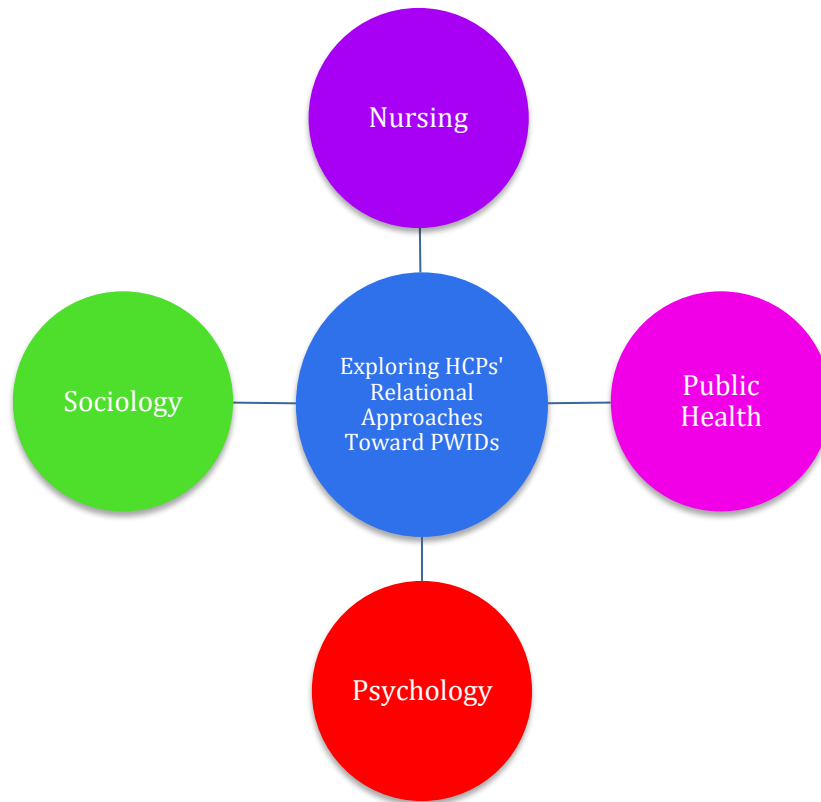


Figure 2.1: The Generalist Interdisciplinary Approach

The Integrated Process of the Interdisciplinary Research Process

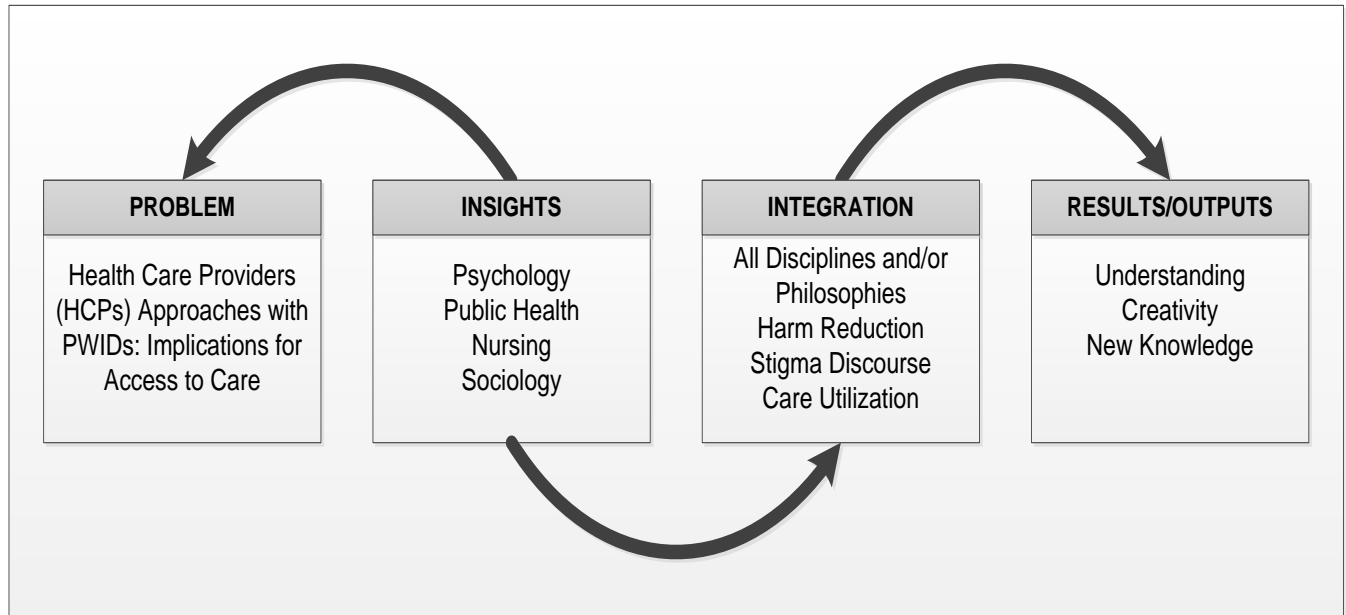


Figure 2.2: The Interdisciplinary Integrationist Research Process

2.2.9.2 Stigma and discrimination within the multidisciplinary addictions literature. In recent years stigma has been discussed in relation to those groups affected with mental health problems (MHCC, 2012), disability (Green, Davis, Karshmer, Marsh & Straight, 2005), past criminal record (Cooke, 2004), PWIDs, and those who have HIV and hepatitis (Plamondon et al., 2007; SHR, 2006; Simmonds & Coomber, 2009). Authors in the addictions area have stated that stigma and discrimination have not been addressed in the multidisciplinary addiction literature as much as they have been addressed in mental health and HIV literature (Kulesza et al, 2013). This may be due to the fact that there is a greater societal acceptance of discriminatory and stigmatizing behavior toward individuals with addiction problems than those who have HIV and mental illness (Adlaf, Hamilton, Wu, & Noh, 2009). Many societies view substance use more from a moral perspective that it is more of a self-inflicted and preventable problem rather than a disease. In addition, the increase in negative attitudes toward drug users in many societies might be due to increased criminalization of the use of drugs (Dell, 2012). This increase in

criminalization may also increase HCPs negative behaviors toward individuals who use drugs, particularly women who sometimes fear their children would be or are actually taken away from them. Empirical literature in the field of stigma and discrimination in the addiction field is gradually increasing as a result of increased awareness of the negative and perpetuating reasons for stigma and discrimination mentioned earlier.

Kulesza et al. (2013) in a literature review conducted in Seattle, Washington in the United States gave a working definition of different types of stigma, provided a synthesized knowledge about stigma among IUDs, and offered ideas and directions for future development in this area of research. In considering stigma and gender, Kulesza et al. (2013) reported that as many as three research studies in their literature review made use of stigma measures from severe mental illness literature. This is the practice in a majority of other addiction literature, which emphasizes the need for the development of measurement for stigma in the area of addictions.

In the mental health field, the MHCC (2012) is making a concerted effort to address stigma. In addition to up to 68 programs of MHCC addressing stigma in the area of mental health, MHCC and the World Psychiatric Association hosted the largest international conference ever on stigma in Canada, in the year 2012 (MHCC, 2012). The conference was titled *“Together Against Stigma, How we see Mental Illness”*. Over the course of MHCC’s work with stigma, they concluded that individuals with lived experiences of stigma must be carried along in the design of delivery of services to address stigma. In addition, MHCC concluded that change in the area of stigma is possible and they encouraged all Canadians to help make a difference (MHCC, 2012). This is a challenge for a more concerted effort on the part of HCPs, policy makers and

researchers in the rapidly growing field of addressing stigma in the addiction field. Stigma and discrimination will be combated!

The empirical studies and grey literature reviewed on the whole revealed, high morbidity and mortality rates found among people who use and/or abuse drugs particularly PWIDs, all confirm the magnitude of substance use/abuse, and injection drug use (IDU) problems globally, in Canada, and in Saskatchewan. Many of the studies identified reasons for the poorer health found among PWIDs. A major reason for poorer health, as alluded to by many of the studies reviewed above, is the lack of PWIDs utilization of health care services available to them due to HCPs perception of, and attitudes toward them. These findings indicate clearly that HCPs approaches with PWIDs require further study. Additionally, HCPs approaches toward PWIDs who are of Indigenous ancestry need to be studied in Saskatchewan and beyond in addition to PWIDs who belong to the main stream culture.

In the exploratory study of Lang et al. (2013), service providers identified four barriers to care which were: stigma and discrimination, inefficient use of resources, inadequate education, and the unique and demanding nature of PWIDs. The present study further explored HCPs' relational approaches. Simmonds and Coomber (2009) study was conducted among pharmacists only; however, this present study was conducted among service providers who come in direct contact daily with PWIDs, and at least weekly contact on the outreach van.

The researcher in this study envisages her study would broaden our understanding of HCPs who work with PWIDs, just as Sleeper and Boschain (2013) study did for nurses who worked with substance abuse (SA) patients in the United States. Additionally, Sleeper and Boschain (2013) carried out their study by revealing real life experiences of stigma as perceived by five adult SA patients from a residential program.

Slev-Ran et al. (2013) in their study in Israel reported the experiences of physicians with individuals with alcohol and drug dependence. Slev-Ran et al. (2013) revealed that physicians reported experiencing lower levels of satisfaction and higher levels of aggression when treating individuals with alcohol and drug dependence, compared to treating other patients. The physicians' attitudes played a big role in the care given to clients who used drugs. This report is consistent with different studies of other professionals such as in the studies on nurses (Carroll, 1994, 1996a, 1996b; Sleeper & Boschain, 2013; von Hippel, Brener & von Hippel, 2008), pharmacists (Simmonds & Coomber, 2009), and medical students (Ding et al., 2005; James & Omoaregba, 2013). Studies among service providers in general to PWIDs include: AIVL (2011), Ding et al. (2005) in Australia, and Lang et al. (2013) in Canada. Additional studies on HCPs included two in Australia by Brener, von Hippel, and Kippax (2007), and by Brener, von Hippel, Kippax, and Preacher (2010); and two in Northern Ireland by McLaughlin and Long (1996), and by McLaughlin et al., (2006). In addition, Ronzani, Higgins-Biddle, and Furtado (2009) focused on primary health care providers in Brazil.

In studying stigma and prejudice, van Boekel et al. (2013) further divided prejudice into implicit and explicit prejudice. This study in Australia assessed whether implicit prejudice can predict independent variance, beyond that predicted by explicit prejudice, in meaningful and unambiguous behaviors or behavioral intentions. van Boekel and colleagues' (2013) findings revealed that implicit prejudice was a significant mediator, beyond explicit prejudice and job satisfaction, of the relation between job stress and intention to change jobs. No study of such focus has been carried out in Canada. Most of the studies in this review were based on self-report not on observations as was this study. Furthermore, Carrol (1993, 1994, 1995) recommended further resources to clarify the implication of status for nursing practice; however, very limited

studies have been conducted in this area. In this study, there were other professionals in addition to nurses, the researcher explored the effects of the number of years HCPs had been working with PWID clients and their practice approach toward them. The study of Ross and Darke (1992) in Australia was consistent with other reviewed studies that PWIDs should be stigmatized, believing that the habit of drug use is within the human control. In the Canadian study of Salvaggio, McKim, Taylor and Wild (2013), rapport of HCPs was confirmed to be an influencing factor for patients' timely presentation at emergency department, compliance, lower level of criminal activity, and satisfaction with care.

2.2.9.3 Harm reduction model. Harm reduction in the area of addictions has been defined as “any program or policy designed to reduce drug-related harm without requiring the cessation of drug use” (Centre for Addiction and Mental Health [CAMH], 2002, p. 1). The types of harm reduction initiatives for IUDs and PWIDs are needle exchange programs (NEPs), safe injection sites, opioid replacement therapy, targeted and low threshold primary health care outlet, heroin maintenance programs, and naloxone distribution among others (Kerr et al., 2010).

Harm reduction focuses on reducing harm irrespective of the level of the substance abuse (Fischer, Rehm, Kim & Kirst, 2005). The supposedly failure of abstinence-based treatments to control IDU, the growing risk of HCV and HIV among PWIDs and the public health implications of IDU for the general populace led to an approach that starts at limiting harm initially rather than attempting to totally stop the habit (Saskatchewan Ministry of Health, 2008). Although harm reduction is a different approach to criminalization, it does not aim to legalize illicit drug use (Saskatchewan Ministry of Health, 2008). In Saskatchewan, the approach to harm reduction is rooted in accepting the persons ‘where they are at’, empowering them to make informed choices and to strive to reduce the health and social harms associated with the

behaviour by neither condemning or condoning risk behaviours (de Bruin, Lindberg, & Grauer, 2008). The principles that are key to harm reduction are non-judgement, practical interventions, client-centered approach, and involving PWIDs in decisions that affect them termed “nothing about us without us” (Canadian HIV/AIDS Legal Network, 2006, p. 1). Cheung (2000) illustrated the goal of harm reduction with the link between the conceptual level, programs, policy, and the practical level in his study in Hong Kong. See Figure 2.3 for an illustration of harm reduction model.

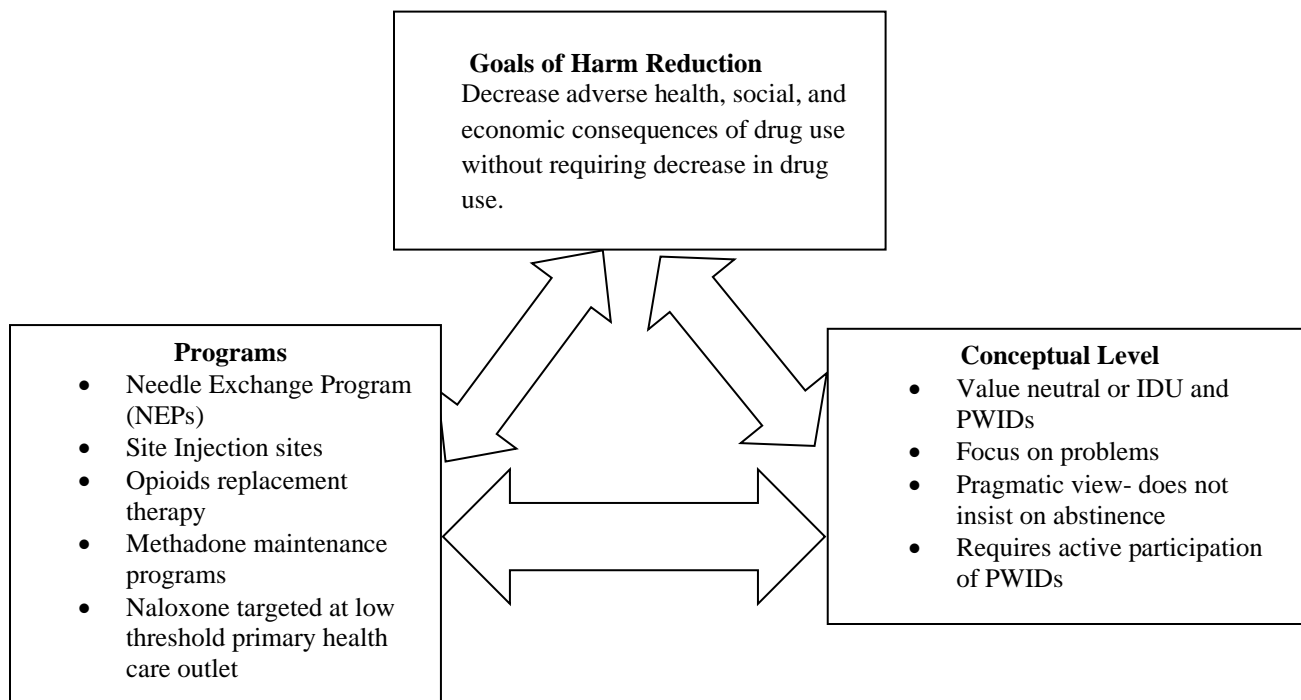


Figure 2.3: Harm Reduction Model- Adapted from Cheung (2000).

Diverse and varied views on harm reduction exist among governments, communities, HCPs and individuals. When a government is in favour of a policy, adequate budgets are made and funding is provided to carry out and support such policies. The opposite is the case when such a policy is not supported or banned by the government. Similarly, when communities accept

policies, there is full support for the success of the program unlike when there is no support, stigmatization and discrimination occur toward the group or individuals affected. Additionally, the views of HCPs about harm reduction correlates with their attitudes and behaviors toward their patients /clients. Views about harm reduction for drug use can be seen as a continuum with those who are in support on one end and those who are not who believe in the traditional abstinence policy on the other end (See Figure 2.3: Harm reduction model).

Needle Exchange Programs (NEPs) and other HR policies for PWIDs are attracted to a quality such as the remarkable reduction on the incidence and prevalence rates of blood borne diseases like HIV and HCV due to reduction in needle sharing. Kerr et al. (2010) and Palmateer et al. (2010) demonstrated in their studies in British Columbia, Canada and Glasgow, Scotland in the United Kingdom respectively, that NEPs reduce syringe sharing and HIV incidence.

Arguments in favor of harm reduction for PWIDs include that harm reduction increases the rate of entry of PWIDs into addiction treatment, the health of the public is protected, and there is a decreased rate of incarceration of PWIDs, which ultimately saves the government millions of dollars (Kerr et al., 2010; Wodak & Cooney, 2005). Additionally, it is argued that harm reduction programs do not increase the use of drugs, crime, and finding carelessly discarded syringes around (Kerr et al., 2010; Saskatchewan Ministry of Health, 2008). The policy of harm reduction has also been found to be very cost effective (Wodak & Cooney, 2005). Furthermore, it is argued in support of harm reduction, that the harm reduction approach is very humane and empowering (Saskatchewan Ministry of Health, 2008).

Those on the other end of the harm reduction continuum, who believe in the abstinence approach, argue that harm reduction enables PWIDs to continue to inject drugs and that the programs are disadvantageous to PWIDs who wish to come clean and who are seeking help

(Kerr et al., 2010; Saskatchewan Ministry of Health, 2008). Critics of harm NEP for PWIDs see HR as an intervention that prolongs the condition and does not empower or encourage PWIDs to attain the level of abstinence.

When not under the influence of drugs, IUDs tend to question their sobriety and those undecided about abstaining remain in their undecidedness when in harm reduction programs (Saskatchewan Ministry of Health, 2008). Additionally, according to van Den Berg's (2013) study in Amsterdam, Holland, those against harm reduction believe it increases the overdose of heroin, levels of carelessly disposed needles, and number of drug arrests among IUDs. Some HCPs believe the focus of harm reduction is in the interest of the government and the public and not so much for the IUDs.

There is the tendency for HCPs whose values and beliefs are more abstinence based, puritanical and religious to view patients/clients in harm reduction programs negatively or provide substandard care to them. Alternatively, HCPs who support harm reduction could treat patients/clients who believe in the abstinence approach differently and negatively also. Nevertheless, despite the varied personal views and opinions, the utmost requirement from every HCP is to give the same level of professional care to every patient/client irrespective of culture, age, gender, disability or gender preference.

2.2.9.4 Behavioural model of health utilization. The behavioral model was originally developed in 1968 and revised in 1995 (Anderson, 1995). The behavioural model of utilization is a frequently used framework that analyzes factors associated with patient utilization of health care services. In addition, the model is used to examine the role of the environment and provider-related factors which are the context in which utilization occur. In this study, the model is used from the lens of environmental and provider-related factors that influence utilization. Access is

defined as “actual use of personal health services and everything that facilitates or impedes their use” (Phillips et al., 1998, p. 3). Additionally, access is not only visiting a medical care provider, but additionally getting to the right service at the right time to promote improved health outcomes (Phillips et al., 1998). Contextualization and measuring access helps with the understanding and planning of health policy by predicting the use of health services, promoting justice, and improving the efficiency of health services delivery (Anderson, 1995; Phillips et al., 1998). In the context of this study, the behavioural health model will provide a lens to interpret the perceptions of HCPs regarding access to care by PWIDs, as impacted by provider-patient relationship. The individual and contextual predisposing characteristics such as: interactions that can facilitate or impede access to services as reported by the participant HCPs will additionally be interpreted from the lens of the behavioural health model.

2.3 Theoretical Fore Structure

The theories of stigma and discrimination will serve as the theoretical forestructure for this study and have been discussed extensively above in sections 2.2.3 and 2.2.5. The location of the researcher in the study, her personal worldview and theoretical influences will additionally be discussed.

2.3.1 Location of researcher. In this section, the researcher’s values and beliefs that influence her choice of study and the interpretive framework chosen for the research will be identified. Reflexivity is important in ID as it helps the researcher to be aware of preconceived biases that may influence the interpretation of the findings (Thorne, Reimer Kirkham & O’Flynn-Magee, 2004).

2.3.2 Personal worldview and theoretical influences. As a qualitative researcher, the researcher embraces the idea of the existence of multiple realities. The research questions will

reflect the quest for the nature of reality and the intention of the researcher in the study will be to report the multiple realities of participants' (HCPs) by presenting their different perspectives about their practice approach with PWIDs. The multiple and different views of participants will be reported in this study.

The worldview of the researcher is social constructivism in nature. With this view, the researcher believes that no objective truth is waiting to be discovered; rather truth or meaning comes to existence in and out of engaging with the realities of our world (Crotty, 1998). "There is no meaning without a mind, "meaning is not discovered but constructed" (Crotty, 1998, p. 9). In social constructivism, "Individuals seek understanding of the world in which they live and work" and "they develop subjective meanings of the experiences – meanings directed toward certain objects or things" (Creswell, 2013, p. 24). Subjective meanings are formed through interaction with others and through historical and cultural norms that operate in individuals' lives (Creswell, 2013).

2.3.3 Personal experiences. The researcher's overarching perspective of life can be summarized as a positive approach to the nature of human understanding. Her life and work experiences discussed in this section reveal her belief in the capacity for human growth and change even in the midst of crisis and difficult life events. The researcher's positive view of life contributed immensely to her choice of the pragmatic approach in understanding HCPs attitude, knowledge, beliefs, and practices with PWIDs in her PhD dissertation.

The researcher's formal disciplinary training in clinical psychology and public health, work experience, and a prior literature search cannot be ignored in the choice of this research topic, questions and methodology design. More importantly the likelihood for her background training, experience and knowledge to affect data analysis of the study was very high if adequate

care was not taken. To avoid this influence, Thorne et al. (2004) recommends that considerable external guidance be given to the researcher to avoid clinging to the assumptions with which they entered the study, which may prevent premature closure to making sense of the emerging findings. This guidance is more important for ID methodology as “bracketing” of experience/preconceptions, according to Ray (1994), is not completely possible. Although considered to be effective in some methodologies.

The researcher worked as a counselor/researcher to IUDs for approximately seven years in Nigeria in the early 1990’s. The stance of the government and society on substance misuse/abuse at that time, in this part of the world, viewed substance misuse as a controllable bad habit rather than a disease. Government efforts were more concerted toward law enforcement and criminalization rather than of prevention, treatment, or harm reduction. Social values were reflected in discrimination and stigma toward this population rather than support and understanding. Additionally, substance misuse/abuse for women considered an abominable behavior. As a result, the researcher may have imbibed (not deliberately, but by default) these social beliefs. These imbibed beliefs, coupled with the researcher’s very structured Christian background may have also compounded the researcher’s belief that substance misuse/abuse is not a disease that should get attention like other chronic diseases such as: diabetes, obesity or hypertension. The researcher may subconsciously believe that such clients deserved lesser attention and care from HCPs like herself. Additionally, in a culture where HCPs yield so much power and influence (more of a top- down approach), it was easier for HCPs practice approach toward the substance misuse/abuse population to have been more negative than positive.

The researcher subsequently practiced as a HCP in Great Britain. The researcher’s client population consisted predominantly of “scripted” (on methadone program) clients who were also

PWIDs. The government and the community's social stance in Great Britain about substance misuse and IUDs were very different from those of the researcher. This work experience was during the period when HCPs worked towards the goals of the national project of "*Tackling drugs to build a better Britain, the government's ten-year strategy for tackling drugs misuse*" (Government of United Kingdom, 1998). With more insight into the prevention and harm reduction approach to substance abuse, the researcher's standpoint gradually shifted more towards that drug abuse is a disease, which invariably influenced her practice approach.

In Canada, as a master of public health practicum student, the researcher further gained knowledge in the area of the 'four pillar drug strategy approach' employed in Canada like in some parts of Europe and Australia, this strategy is a coordinated and comprehensive public safety and public health approaches to public order and public health to create a safer and healthier community (MacPherson, 2001). The four pillars are namely prevention, treatment, harm reduction and enforcement. The researchers' practicum experience of working under the supervision of the University of Saskatchewan's research chair in substance abuse and the deputy medical officer of health, the stakeholders of building relationships around injection drug use for greater engagement (BRIDGE) partnership, and other HCPs of the street/sexual health unit, contributed greatly to the identification of the research problem, questions and choice of the methodological design. The researchers' informal and formal (precarious) experiences, ranging from her family/religious background, formal disciplinary training, to experiences accrued in various cultures and positions as a HCP, greatly contributed to the position and views that she brought to her research (See Figure 2.4: Theoretical Forestructure).

In this chapter, the theoretical scaffolding of the study was presented. The theoretical scaffolding comprised of the literature review and the theoretical fore structure. The literature

review summarized what was known on the present topic of investigation and the theoretical fore structure identified theoretical and conceptual ideas the researcher considered relevant in addition to the background influences she brought to the study. The theoretical scaffolding further helped to see that the research questions as being worthy of asking.

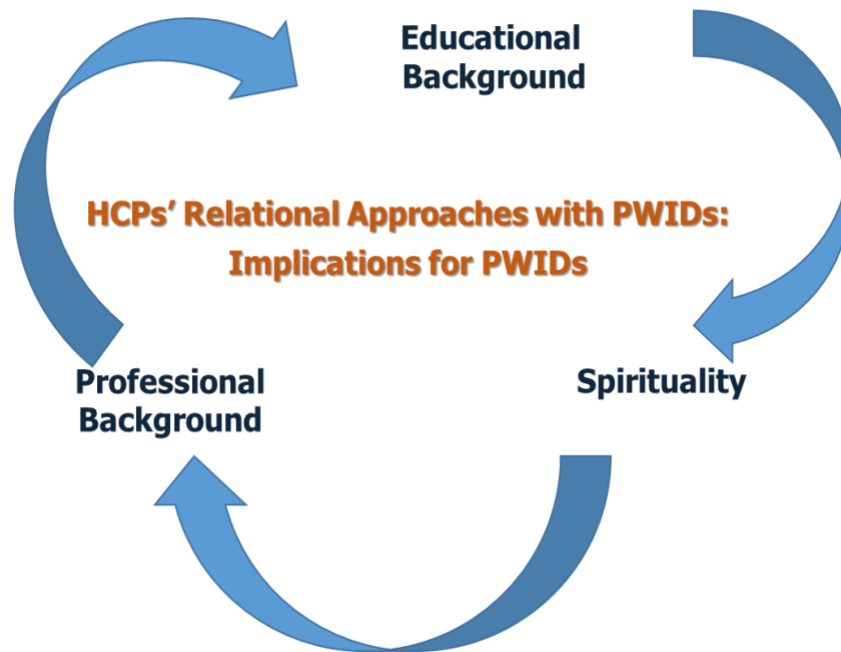


Figure 2.4: Theoretical Forestructure

CHAPTER 3 Approach to Inquiry

In this chapter, the approach to inquiry used in this study (interpretive description) is described. The philosophical underpinnings, strengths and weaknesses of ID are additionally described in this section.

3.1 Interpretive Description

An explorative interpretive descriptive approach known as “Interpretive Description (ID)” (Thorne, Reimer Kirkham, & Mac-Donald-Emes., 1997; Thorne et al., 2004; Thorne, 2008; Thorne, 2016) is used as the basis for conducting this study. Interpretive description (ID) stems from the discipline of nursing and has been used to explicitly address the research problems and questions that originate clinical practice. Interpretive description (ID) was chosen for this study because the author(s) of ID approach created a rationale for linking design options together in a coherent and defensible manner that would suitably meet the needs to generate knowledge in the applied health discipline. Interpretive description (ID) is a disciplinary approach to qualitative research and when ID methodology is employed, there is no need for an unnecessary struggle for a methodological fit with the methods more geared towards other disciplines like anthropology (ethnography), sociology (grounded theory) and education (phenomenology) to adequately answer the research questions (Thorne et al., 1997; Thorne et al., 2004; Thorne, 2008; Thorne, 2016), and there is no need for any unnecessary “methodological acrobatics” just for the sake of disciplinary rules (Thorne et al., 2004). In the present study, employing the ID methodology was highly invaluable; the researcher was enabled to construct the research findings within the design language that fits the need of her interdisciplinary field of study. Interpretive description helps to produce studies that are practical and which have clinical applicability, rather than unnecessarily adhering to disciplinary methodological rules that

produce results of more theoretical value than for practical use (Thorne, 2016). Additionally, ID methodology appealed to the researcher for use in this study because it enables researchers to move their studies beyond the level of what is known to the level of “so what”. The “so what” level further enables the applicability of the study for use.

The use of ID enabled the researcher to interpret the findings to the research questions exploring HCPs relational approaches with PWIDs to a degree that the whole picture of the issue was known. The researcher drew from the perspective of the academic disciplines of nursing, psychology, public health, and sociology, and is more interested in the clinical applicability and practical use of the study. The interpreting approach in ID depends far less on coding, sorting, and organizing than they do on the processes of intellectual inquiry (Thorne et al., 2004). Interpretive description (ID) typically has the key features of the “theoretical scaffolding” as mentioned earlier. The theoretically scaffolding consists of the literature review and the theoretical fore structure sections. The theoretical fore structure aspect describes theoretical assumptions, biases and preconception contributing to the study design. Interpretive description (ID) provides clarity and provides guidance to a study that might otherwise have been a generic qualitative research (Hunt, 2009) as ID focuses on making a study practical and applicable for use.

Regarding sampling, the purposive and theoretical sampling technique can be used in an ID study. For analysis, interpretive description (ID) employs an analytic process that gives a holistic, contextualized account of the data and does not fracture data into small fractured segments (Thorne, 2008). The findings produced by ID move beyond initial descriptive claims that are self-evident, towards more abstracted interpretations. Interpretive description (ID) means an interpretive account of “the associations, relationships, and patterns within the phenomena

that has been described (Thorne, 2008, p. 50). Furthermore, in the analysis of a study that employs ID approach, the theoretical scaffolding is not intended as a framework that rigidly guides the analysis, the new meanings move beyond the theoretical scaffolding and are considered the new meanings developed about the phenomenon (Thorne et al., 2004). In the present study, the researcher paid great attention to inductively generate and develop data so that the ideas such as: frameworks and theories that were brought into the study were carefully noted and regularly examined to ascertain that the ideas were not influencing what were seen and heard in an unintended way. The findings in ID are written up in the form that enlightens the intended clinical audience so that consequently the findings will influence practice (Thorne, 2016).

In summary, ID functions as a coherent methodological framework in which a wide range of options for design can be incorporated and justified (Thorne, 2016). To show the trustworthiness of an ID study, a credibility procedure such as: Lincoln and Guba (1985) (employed in this study) can be used. Thorne (2016) further suggested that choices of credibility procedure chosen might include analytic logic, interpretive authority, moral defensibility, and disciplinary relevance.

3.1.1 The philosophical underpinnings of interpretive description (ID). According to Thorne, 2016, foundational underpinnings of ID include that ID studies be conducted in as naturalistic context as possible and in a way that is respectful of participants' comfort and ethical rights. In addition, ID values subjective and experiential knowledge as a fundamental source of clinical insight. Interpretive description researchers have the worldview similar to the worldview that multiple constructed realities exist and can be studied only holistically (Lincoln & Guba, 1985). Further, ID researchers acknowledge that the researcher and participant interact to influence one another, that is the knower and known are inseparable (Lincoln & Guba, 1985).

In the light of the ID methodology overview discussed earlier, philosophical underpinnings and the researchers' philosophical orientations highlighted above, ID is believed to be best suited to answer the research questions in this study.

3.1.2 Strengths of ID. Interpretive description (ID) has a philosophical alignment with interpretive naturalistic orientations as “it acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities” (Thorne et al., 2004, p. 5). Interpretive description (ID) places utmost emphasis on the interpretive aspect of analysis and goes beyond simply reporting the findings to understanding what the findings mean as a whole (Thorne et al., 2004). The use of ID in this study helped with the interpretation of the findings to the research questions in a way that the whole picture of the issue was known. Interpretive description (ID) has moved beyond some of the more traditional forms of qualitative research such as phenomenology, grounded theory, and ethnography (Thorne et al., 2004) as the strict rules of these more traditional approaches often make it difficult to answer questions related to the applied disciplines (Thorne et al., 2004). By using ID methodology, there is no unnecessary struggle for a methodological fit with the methods more geared towards other disciplines to adequately answer the research questions. The strengths that ID methodology brought to this study have been practically experienced by Hunt (2009) in his use of ID methodology for his doctoral research in Ontario, Canada. Hunt (2009) found ID methodology to be helpful at “providing useful and accessible guidance in elaborating a coherent research design, orients the research process toward clinical context and the generation of practice-relevant findings, and draws attention to disciplinary biases and commitments” (Hunt, 2009, p. 1288). Hunt (2009) mentioned that ID provides clarity and provides guidance to a study that might otherwise have been a generic qualitative research as previously mentioned.

3.1.3 Weaknesses of ID. The researcher envisaged that the major weakness that the use of ID methodology might bring to her study is that ID is a new methodology in which resources and research examples from which knowledge can be drawn are relatively few (but increasing) in number. There is an increased need that ID pay more attention to rigor, research design, and implementation (Hunt, 2009; Thorne et al., 2004).

In addition to the two resources that Hunt (2009) found for methodological guide, there are now two books by Thorne (Thorne, 2008; Thorne, 2016) that are very helpful to guide the ID research process. Since Hunt (2009), there have been many scholarly studies that have used ID. Some ID studies include those of Dmytryshyn, Jack, Ballantyne, Wahoush, and MacMillan (2015), Uren and Galdas (2015), and Paterson, Hirsh, and Andres (2013). However, there is the possibility of not developing sufficient interpretation, which may limit the intended usefulness of the research findings to practical application (Hunt, 2009). In the present study, the researcher painstakingly pursued interpretation to a stage that she believed would yield useful applicable insight to HCPs practice improvements with PWIDs. These weaknesses of ID can be overcome as more scholars are getting to know more about this methodology and scholarly ideas and experiences.

3.2 Setting

Semi structured interviews were conducted at mutually agreed places and times with HCPs (who agreed to participate) at a targeted street/sexual health program and an HIV medical clinic within a health region in the Saskatchewan Health Authority (SHA). The health authority provides a comprehensive range of services and programs such as: hospital and long-term care, public health and home care, mental health and addiction services, prenatal care, palliative care, and more.

The main objective of the street/sexual health program is to prevent the spread of HIV/AIDS, hepatitis B and C, as well as STI's in high risk groups and to encourage healthy lifestyles. The street health program provides services to individuals such as: PWIDs, commercial sex workers, and inmates by providing clean needles in exchange for used ones, safe disposal of used needles, anonymous HIV testing and counselling, immunizations for tetanus, hepatitis A and B, influenza, and pneumonia among other services. Clients access services through the outreach van or at the clinic. The outreach van roams the inner-city streets and makes specific stops in the evenings on every weekday. At the center, services are provided during the day from Monday to Friday with extended hours till 6 p.m two days a week.

The HIV clinic provides outpatient care for residents of Saskatchewan who have tested positive for HIV and/or Hepatitis C. The program helps to prevent transmission, manage symptoms, decrease complications, and enhance quality of life among the clients. In addition, the HIV clinic helps to provide a continuum of care for clients through referrals.

3.3 Sample Size

According to Thorne (2008) sample size in ID can range between five and 30 participants, however, richness of data of information is paramount. In qualitative studies sampling of meaning is of priority rather than frequency (Morse, 2007). Previous studies using ID methodology reached saturation with relatively small samples. Dmytryshyn et al. (2015) reached saturation in ID studies in Canada with relatively small sample size. In this study, richness of data was reached when no new information was received from participants. The driving force for the sample size is the knowledge that is needed to thoroughly understand the research questions (Thorne, 2008). Nevertheless, adequate interpretation of data is key in ID studies and not only the saturation of information at the data collection stage (see section

3.6.1.5).

3.3.1 Sampling procedure. Purposive sampling technique was used to recruit HCPs from the street health program of SHR. This sampling technique is consistent with interpretive description in which participants are chosen based on their ability to provide a useful “angle” (Thorne, 2008, p. 90) on the phenomena of study.

3.3.2 Purposive sampling. Purposive sampling helped to obtain cases that are deemed to be information rich for the study (Morse, 2007; Patton, 1990, 2015). The researcher endeavored to include men and women HCPs, from diverse cultures and professional backgrounds. All healthcare providers (HCPs) were invited from the targeted sexual/street health program and the HIV clinic in SHA and 11 agreed to participate.

3.3.3 Maximum variation. Maximum variation to explore the common and unique target phenomenon across the broad range of varied cases (Sandelowski, 1995) was achieved by endeavoring to interview health care providers with varied backgrounds and work experiences of providing services to diverse populations. The goal of the sampling in this study was for the sample to be highly representative of HCPs of diverse cultures, genders, different professional backgrounds, and different client groups.

3.4 Sampling Strategy

After obtaining ethics approval from the University of Saskatchewan (BEH-15- 237) and operational approval from the health region, the researcher sent out information via e-mails, telephone calls, posters, and word of mouth about the study and the purpose, along with letters of invitation to HCPs. This was done with the approval of the managers of the programs. The researcher went to speak about the project to staff and program managers to invite HCPs to participate in the study. Interested HCP participants were asked to contact the researcher by

email or telephone. After the HCP/participant had contacted the researcher, the researcher gave further information to the participant about the study. When a HCP consented to participate in the study, he or she was included in the list of participants. Mutual time and place were subsequently arranged for the semi-structured interview to take place (all the interviews took place in the respective offices of the participants, except one which took place in a nearby coffee shop). On completing the interview, an honorarium of a \$20 gift card was given to each of the participants at the sexual/street health department, which the participants chose to contribute towards Christmas resources for their clients. At the HIV clinic, the researcher was not allowed by the management to give honoraria to research participants.

3.4.1 Sample selection criteria. The researcher endeavoured to include willing HCP participants who worked at either of the two departments (street/sexual health unit and one of the HIV clinics in the health region) chosen for the study, e.g., as a nurse, social worker, sociologist, etcetera. Participants must have had some relevant work experience on the job or previous related job in paid or volunteer positions for at least one year. Furthermore, it was determined before the interviews that participants had to be over 18yrs of age. All HCPs that agreed to participate in the study met the criteria.

3.5 Data Collection and Procedure

Data collection was conducted with semi-structured interviews and field notes. Each interview was considered as a conversation with purpose. The purpose of the interview was to explore and understand participants' perspectives of their professional relational approach with PWIDs/IUDs and what they perceived the implication of their relational approaches might be for their clients. The interview guide created by the researcher (see appendix C) was used for the semi-structured interviews. An interpretive description approach to inquiry recommends that

data sources must represent “multiple angles of vision” (Thorne, 2008, p. 78). With this in mind, field notes were taken during, and after each interview to enhance the gathering of the data and the notes were analyzed throughout the research process. Field notes serve to help the researcher to provide description of the participant’s environment, processes occurring in their environment, and anything that the researcher found relevant to the study as postulated by Charmaz (2006).

3.5.1 Semi structured interviews. The rationale for conducting semi-structured interviews in the field is to gather data in the naturalistic environment in which HCPs operate on a day-to-day basis. This method emphasized the focus of the research on the practical day-to-day realities (Thorne, 2008). An open-ended semi-structured interview was conducted with each participant to ascertain the HCPs understanding of their practice or relational approach with PWIDs. The focus was on HCPs views and perspectives of PWIDs they came in contact with in their day-to-day work. The researcher started every interview with an icebreaker grand tour question (Spradley, 1979) [e.g., tell me about your role at work] and followed the conversation to a greater understanding as questions gradually became more focused. Probing questions or prompts were used to augment interviews, particularly, during the iterative process. The interview lasted approximately 45-60 minutes. The recorded interviews were subsequently transcribed and immediately thereafter the researcher reviewed the transcripts and tapes for accuracy by reading the transcripts while listening to the tapes. Participants were given the opportunity to review for verification, which they all did.

3.5.2 Field notes. In this study, the field notes included descriptive and reflective information. The descriptive information contained the date, time, and the state of the physical setting. The participant, the participants’ roles, and the role the researcher’s presence may have had on the environment were additionally noted in the descriptive part of the notes. In the

reflective part of the notes, the researcher's reflection about what was noticed, her ideas, questions, and other related thoughts were noted.

3.6 Data Analysis

There is no step-by-step procedure for data analysis in ID. Nevertheless, Thorne et al. (2004) and Thorne (2008; 2016) recommended an alternative approach that data analysis should be a balance between broad prescriptiveness, creativity, and flexibility. The broad prescriptiveness includes employing an inductive analysis approach, an iterative process for data collection and analysis, and constant comparative analysis. Additionally, broad analytic questions are asked, such as: "why is this here?", "Why not something else?", "what does this mean?", and "what is happening here?" At the creative realm, patterns and meanings in the data are depicted. Thorne (2016) cautioned against rigidly adopting existing data analytic techniques in the literature, but suggested that various existing analytic strategies and techniques might be borrowed (from other fields) and critically adapted to suit the purpose of study, make the study truly inductive and applicable. In analyzing the data in the present study, the recommended alternative approach to data analysis by Thorne (2016) [such as: engaging the mind strategically and constructively to make sense of ideas that were core and applicable to the study and pattern recognition and linkages] and a critically adapted version of the procedure of thematic analysis [TA] recommended by Braun and Clarke (2006, 2014) were followed.

3.6.1 Thematic analysis. Phases for thematic analysis adapted from Braun and Clarke (2006) were used to structure and organize the analytic process in this study. The phases are phase 1: familiarization with and summarizing the data; phase 2: generating initial broad-based codes, and phase 3: searching for themes. The other phases are phase 4: corroborating, defining and naming the themes, and phase 5: options for depicting patterns and meanings, and phase 6:

presentation of data. Furthermore, although the phases employed are described in a step-by-step manner, the process of data collection and data analysis were conducted concurrently and in an iterative manner to ensure that the developing themes were grounded in the original data. Additionally, the data analysis was a reflexive process.

3.6.1.1 Phase 1: Familiarization with and summarization of data. Data analysis commenced following the first interview, and continued throughout the interview and research process. Lincoln and Guba (1985) encouraged repeated immersion in data before classifying or creating linkages. The researcher read each transcript over and over again making necessary notes of important points. Raw data of each transcript were summarized keeping the research questions in mind as the process continued. The researcher engaged her mind strategically and constructively in active analysis by endeavoring to make sense of ideas that were core and applicable to the study. The key points made by participants were outlined and individual comments were noted in response to the questions asked in the research. An example of the questions is: “How would you say your relational approach with PWIDs impact your role as a service provider to PWIDs?” The researcher uploaded the transcripts into QSR Nvivo 11 qualitative data management software (QSR International, 2013) as project document.

3.6.1.2 Phase 2: Generating initial broad-based codes. After generating an initial list of ideas from reading the transcripts several times, data entered into Nvivo were organized into meaningful groups leading to the generating of initial broad-based codes. The main purpose of this stage is to temporarily bring together potentially similar ideas in a way that does not invest in formal coding that create subsets of the data (Thorne, 2016). Furthermore, at this stage, the researcher rereads, reflects and hypothesizes the data long in advance before determining exactly what is observed and how they will align with the final analysis (Thorne, 2016). A broad-based

coding ensued using the outlined key points and comments. In an ID study, Thorne (2016) recommends a broad-based coding, which can be described as interpretive thinking rather than merely recording or organizing bits of data. Additionally, general sorting and organizing of data into patterns and the extension of pattern recognition into an understanding of relationship is preferable for use than coding bits with similar properties (Thorne, 2016). The researcher avoided deductive pre-determined analytical strategies such as complex coding systems, content analysis, and overly small unit analysis. Additionally, analytical methods using complex codings for all pieces of raw data that place emphasis on the technical rather than the theoretical or epistemological aspects of the method (Lowenberg, 1993) were avoided by the researcher. Data categories were then initially named with the alphabets such as: category A, category B at this stage. The data in each category informed further analysis.

3.6.1.3 Phase 3: Searching for themes. The researcher subsequently went through the entire data set paying full and equal attention to each data item and identified interesting aspects of data that revealed a repetitive pattern across the data set. The researcher started off by testing out relationships between the data by experimenting with different ways of organizing the material and exploring what new questions and possibilities arose. Electronic files were created with descriptive titles that capture the collection of information copies and pasted into them. No premature meanings were drawn. When interesting quotes were found, they were cut and pasted in a separate file in order to avoid organizing or analyzing data around them. Categories of information were reviewed several times until the researcher believed all cogent points had been identified, categorized and merged. After several changes, the categories became clearer, stronger, and made more sense. An initial thematic map was created and data in the map were reviewed over and over narrowing down by merging similar and related information into broad

categories for the identification of themes. These constituted an initial list of themes. Three more thematic maps were drawn before the final themes were created.

3.6.1.4 Phase 4: Corroborating the themes. The researcher met with her supervisor on three occasions during the process comparing codes and identified themes (to compare ideas as she was more removed from data collection and the data). Both individuals identified many similar themes. The broad initial categories identified were: health care providers' approaches with clients; factors influencing clients' access to services, populations over represented among clients' - their roles and profiles, and theories and policies guiding HCPs practice with PWIDs /IUDs (See the initial thematic maps as they emerged, Appendix L–Emergence of themes). The themes were further clustered and the previous stages were closely scrutinized again to ensure that the clustered themes were representative of the data. The themes identified predominantly answered the research questions (see chapter 4). The researcher's field notes were helpful in providing an alternate angle of vision in the data analysis process.

3.6.1.5 Phase 5: Figuring out options for depicting patterns and relationships. Thorne (2016) described the stage of depicting patterns and meanings as the more creative and interpretive realm. In this study, pattern recognition and linkages began as an iterative reasoning process, which was used to gradually come to an understanding of thinking about and aligning ideas in various ways. The reasoning process helped the researcher to make the best decisions to serve the purpose of exploring the perceptions of HCPs on their relational approaches with PWIDs. As recommended by Thorne (2016), the researcher kept an analytic note during this process. In the analytic portion of the field notes, she posed questions to herself, jotted down the thematic list, and emerging patterns she wished to tackle. The analytic note helped with further expansion and clarification of the emerging findings.

Additionally, the researcher made conscious effort to avoid biases in the ways her mind was making linkages in the pieces and parts of the data by regularly asking herself, “what am I seeing here?” and “why am I seeing that?” This technique helped the researcher to break free of the pre-conceived notion of how the analysis should be done. At this juncture, the researcher began to move from patterns observed to relationships by imaginatively exploring possibilities in her analytic process. In this study, the author endeavoured to avoid premature closure by not stopping to make meaning of the data after the first surprising flash of information. Another helpful way of interpreting data to an appreciable level is to avoid over determining patterns of findings (usually influenced by the researcher’s disciplinary orientation, experience, and knowledge brought into the study). Over determining data can be prevented by accounting for theoretical forestructure (see chapter 2).

3.6.1.6 Phase 6: Producing the report. An account of the themes and sub-themes are presented in the results section. Participant numbers are used to identify the research participants while using their quotes, hence the protection of each participants’ identity. Interpretation of results, which was a rigorous process of intellectual analysis, was also carried out using Thorne’s (2008; 2016) and Thorne et al. (2004) technique of asking questions such as: why is this here, what am I seeing here and why? The analytical description of the results is carried out in the light of existing literature. Factors reported by HCPs as influencing PWIDs behaviours and concepts such as: the environment, social economic status, health, and emotions were considered in interpreting the results from a behavioural health model of utilization view for practicability and the usefulness of the study. For HCPs, their relational approaches(s) influenced by harm reduction philosophy, were considered in interpreting the results. Conclusions were drawn, discussed, and recommendations made (see Figure 5.1: Major Areas of Findings used for the

Synthesis of Interpretations).

3.7 Data Trustworthiness

Dreher's (1994) recommendation, for quality assurance was followed. Firstly, the researcher explicitly accounted for the role that pre-conceived bias might play in the findings as much as possible (see section 2.3 Theoretical fore-structure). Bias may influence the research questions asked, the way they are asked and the methods used to answer the questions. This bias can be the researcher's individual bias or inherent institutional biases. An example of bias that could have been brought to this study by the researcher might be an imbibed belief that PWIDs or IUDs deserve to be punished by the law, rather than seeing the use of drugs as a disease (from the view of the disease model).

Secondly, verification was achieved by conducting a thorough literature search. Thirdly, the researcher kept a reflective journal. The reflective journal helped to guide and document the reactive processes of interpreting and helped to counter bias in the research process (Lamb & Hutlinger, 1989; Lincoln & Guba, 1985). Member check in which the final product is taken back to the participants to check for accuracy (Creswell, 2013; Creswell & Poth, 2018; Sandelowski, 1986) was conducted. Additionally, the researcher shared raw data and analysis with another doctoral candidate for verbal and written critiques. The researcher also shared raw data and analysis with her academic supervisor and met with her on several occasions to discuss the research. Attention was paid to detailed description of method to ensure clarity of process and credibility.

To further enhance the credibility of this study, the researcher employed the credibility criteria for qualitative studies put forward by Thorne (2008; 2016). Thorne's criteria for credibility are: *epistemological integrity*, *representative credibility*, *analytic logic*, and

interpretive authority. Furthermore, Thorne indicated evaluative standards against which research can be judged, particularly in the applied disciplines to include: *moral defensibility*, *pragmatic obligation*, and *disciplinary relevance* that were additionally carried out in this study.

The researcher endeavored to meet *epistemological integrity* in this study by ensuring there is a fit beginning from her assumptions about the nature of knowledge through to the methodological rules that guided the design and process decisions made in the study. For *representative credibility* to be fulfilled, the researcher ensured there were many angles of vision (e.g., sharing data with peers and supervisor) and triangulation of methods (field notes and semi-structured interviews). The researcher met the criteria of *analytic logic* by making her reasoning process in the study transparent from the theoretical scaffolding through to the interpretations of findings and knowledge claims. In demonstrating *interpretive authority*, the researcher endeavoured to show that her interpretations of the findings were trustworthy and were external to her personal biases and experiences. Some direct quotes of participants' perceptions were presented to demonstrate some truths and to show information were not force-fitted into a convenient structure (Janesick, 1994, as cited in Thorne, 2016).

Among the criteria to address some of the subtle criticisms of qualitative research in the applied disciplines is *moral defensibility* (Thorne, 2008; 2016). In applying *moral defensibility* in applied practice disciplines, there is the need to go beyond the ethical claims about protecting participants, into the realm of an awareness revealing how knowledge from the study will be used in the society (Lipson, 1994, as cited in Thorne, 2016). The rationale for the study must be linked to the potential benefits for the findings, after which, the study can be found morally defensible if it places any marginalized group at risk of social censure because of the findings or the manner in which the new knowledge is made accessible to all, including those "whose

purpose may not be consistent with a humanitarian health care agenda” (Thorne, 2016, p. 236). The objectives of the study and its use to generate applicable knowledge to HCPs in their practice in the area of their relational approaches with PWIDs of diverse backgrounds are clearly stated in this study. The implications of HCPs’ relational approaches with PWIDs will hopefully be invaluable for health planning and policy development. As much as possible, the researcher endeavored to present the findings in a culturally sensitive and humble manner.

This study was conducted in a way that reflected that it “might indeed be applied in practice” (Thorne, 2016, p. 237) which contributed to the fulfillment of the credibility criterion of *pragmatic obligation* in this study. An essential credibility standard for an ID research of this nature, *disciplinary relevance* (Thorne, 2008; 2016) was fulfilled in this study. The researcher revealed the relationship between the research and the knowledge she sought to advance in the interdisciplinary field. The use of ID helped to conduct this interdisciplinary research within the tenets of the combined literature and conceptual frameworks from the fields of psychology, public health, nursing, and sociology. Interpretive description helped the researcher to conduct the study within the constraints of the field of interdisciplinary studies without having to borrow methods from areas that would not have been a good fit for the nature of the study.

3.8 Ethical Consideration

Prior to the start of the study, ethics approval was sought through the Behavioural Research Ethics Board (Beh-REB) of the University of Saskatchewan. Additionally, operational approval from the health region of study was sought at the same time. Both were granted through a certificate of approval (#Beh-15-237).

3.8.1 Consent. Written and verbal consents were obtained from participants (HCPs) for both the interview and its digital taping. The consent from all was ongoing during the study.

Consent was voluntary, informed, and preceded the collection of data (CIHR, 2010). There was no deception in the study and research participants were given adequate information about the research including all risks and benefits. Additionally, the researcher let the participants know that they could withdraw from the study at any time if they so wished.

3.8.2 Confidentiality. The researcher assured participants of ultimate confidentiality. Participants were alerted that the researcher had the obligation to report any information revealed that might harm or affect them or others adversely to the appropriate authorities (In accordance with TCPS 2 and Health Information Protection Act [HIPA], Government of Saskatchewan, 2005). The researcher additionally let participants know of who data will be shared with (e.g., peers for review) and let participants know where and how long data will be kept (data kept on the computer of the researcher's supervisor at the University of Saskatchewan with protected password for a period of five years).

3.8.3 Risks. The researcher believed that the benefits of the study outweighed the risks. The participants were assured that their responses to the interview questions would have no negative impact on their jobs.

Chapter 4 Results

A descriptive account of the findings of the study is presented in this chapter. In so doing, a summary of the participants' sample characteristics is stated. As a preview to the report on the themes, the perspectives of HCPs on the demographics of the clients they provide services to, are stated. Additionally, the professional relationship exhibited by HCPs towards PWIDs, and environmental factors influencing clients' access to services are explored in depth. The findings are reported in a way that answers the research questions. Significant findings are highlighted, while direct quotes representing a majority of views of the participants, such as non-discriminatory attitudes and more are provided to enhance authenticity of the findings. An interpretation of the findings is discussed in the next chapter.

4.1 Health Care Provider (HCP) Participants' Sample Characteristics

The sample for this study consisted of 11 health care providers (HCPs) who work directly with IUDs/PWIDs (see Table 4.1: Participant Characteristics). All of the HCPs who were approached through the manager of one of the units agreed to participate in the study, while a fewer HCPs from the other unit agreed to participate. The participants consisted of more women than men and their ages ranged between 29 and 55 years of age with a mean age of 36.5 years. The number of years the HCPs had been working at the time of the interview ranged between four months and 16 years. All participants had a minimum of a bachelor's degree and one with graduate degree. The HCPs degrees were in nursing/public health (7), sociology/political studies (2) and social work (2) (see Table 4.1). All participants had worked previously in related positions such as working with PWIDs in the community, but not predominantly with IUDs/PWIDs; some had worked in acute settings, the community, and in First Nations

communities. Furthermore, four of the participants worked part time, while the remaining seven were full time staff.

Participants (n = 11)

Age	Mean 36.5 years Range 29-55 years
Gender	Female 10, male 1
Educational Level	At least a Bachelor’s degree 11
Course of Study	
Nursing/Public Health	7
Social Work	2
Sociology/Political Studies	2
No of years on job at time of interview	Mean 3.75 years; Range 4 month - 16 years
Work full time	7
Work part time	4
Indigenous HCPs	2
Caucasians	8
Mixed Race	1

Table 4.1 Participant Characteristics

4.2 Health Care Providers’ (HCPs’) Clients/Patients: Profile of PWIDs

Health care providers (HCPs) in this study expressed that their client population represent men and women, adults and youth, professionals and nonprofessionals (lay people), employed, underemployed, and unemployed. Visible minorities, Caucasians and Indigenous people are also

represented among the PWID population seen by HCPs in this study. The findings from the interviews with HCPs revealed that some populations are disproportionately represented among the clients seen at the two units.

The populations disproportionately represented are: individuals with drug addiction, individuals with chronic pain who are seeking relief with drug use, people with mental health challenges, and individuals generally oppressed. Other overrepresented populations among the clients seen by the HCPs in this study are mainly First Nations peoples who include young Indigenous women; and sufferers from generational trauma/abuse/addictions in general. People in the sex trade, individuals who have been/or are in conflict with the law are additionally included among the client population overrepresented. All clients seen at one of the units have already been diagnosed with HIV and/or Hepatitis C, while most clients at the other unit are encouraged to, or are ready to be tested, or tested for HIV/Hepatitis C, if they have not already been tested.

4.2.1 Individuals seeking relief from chronic pain. Health care providers (HCPs) reported that a significant number of their clients use, or are addicted to drugs because they are seeking relief from chronic physical and/or emotional pain. The PWID claim that many may have been born with a lot of health issues due to poverty, may have been involved in automobile or workplace injuries, and because there does not seem to be good pain management or care and treatment options available to them, they tend to accept a variety of drugs and medication including psycho-active drugs offered to them by friends or family members close to them who in some cases may have addiction problems. Health care providers (HCPs) claim that because there are limited options available in the system (e.g., clinical psychologists, physicians, or psychiatrists who specialize in pain for chronic pain management), those who continue to seek

relief for pain are often seen as drug seekers. Health care providers (HCPs) believe that some clients turn to psychoactive drugs for pain relief as pharmaceutical drugs have not been effective for them. Some of the participants' (HCPs') comments are stated below:

...people with chronic pain...people who've, for example, been in a car accident or been hit by a car or...they have workplace injuries and they're not covered by worker's compensation...or even people who were maybe born with a lot of health issues because they were born in poverty and have chronic physical pain who happen to have a lot of people around them who have addictions and they haven't received adequate pain care and so they're seeking out pain care from their people that are around them and they say, here I have something that'll help you with your pain and that's often how it starts because there just doesn't seem to be a good option in the system right now if you have chronic pain... it's not really dealt with and after a while you're seen as a drug seeker or you have psychogenic pain (P03-3, 112-123).

I have seen a lot of people who have turned to injecting drugs who have had unmanaged pain management. They have found that pharmaceutical approaches haven't been effective and have turned to injecting practices in order to try to manage that pain (P11-3, 65-67).

There was a woman who was in a car accident...all died and she survived. She was obviously prescribed painkillers for acute pain. The physical pain is no longer there, but she still uses, cause that emotional trauma is still there many, many years later (P10-13, 459-462).

4.2.2 Oppressed individuals. People who HCPs considered to be generally oppressed from the onset of life include individuals with mental health issues, people of visible minorities, people in the sex trade, and lesbians. In addition, oppressed individuals include gay, bisexual, and transgendered (LGBT) people. Women are additionally a group of individuals who are oppressed. Comments from three of the participants are reported below:

Just people who are generally oppressed, for example, a visible minority or have mental health struggles like pinpointed right at an early age in school for example, and just labeled as a certain type of person, that made it difficult for them to succeed in the traditional way (P03-4, 133-137).

... people who have had some incarceration. A lot of times there's some conflict with the law in terms of... particularly the women...have experienced or suffered some form of abuse-sexual, physical, emotional abuse (P06-2, 51-53).

We are seeing more people from immigration with hepatitis C... what they're testing, so with more immigration you'll see more people from other cultures... Then we do go to... facilities where people are, you know, still struggling with addictions or marginalization, right (P07-5, 177-179; 181-183).

4.2.2.1 Individuals with mental health challenges. Health care providers (HCPs) claim that many of their clients have mental health challenges that are usually in addition to or a leading factor to substance use, injection drug use, and addiction issues. Two participants specifically mentioned that they see

..a lot of mental health issues” (P01-6, 182)

“some people definitely have mental health issues” (P08-6, 263).

4.2.2.2 Individuals in the sex trade. A good number of those in the sex trade were women introduced to the sex trade at a very young age, sometimes as young as 11. In some cases, according to the HCP participants, the girls were also introduced to drugs and injection drug use by their “street mums” to help numb the pain and the feeling of shame when they are newly introduced into the trade. The participants of this study further mentioned that a good number of their clients are “walking girls”, a slang used for girls in the sex trade. They find the effects of the drug very appealing and they progressively continue to use and inject drugs and often become ultimately addicted. Some of them have already been diagnosed with HIV and Hepatitis. A participants’ response is below:

... Some of those individuals were initiated into injection drug use at a young age and sometimes not necessarily by their choice; they were maybe injected by their street mom or their pimp at that time in order to make it sort of easier to enter the sex trade in a sense because they're in an altered state... With women I'd say a lot of them have been involved in the sex trade and/or go into the sex trade in order to provide to pay for their drugs. (P11-3, 67-73).

4.2.3 Individuals with low income/who live in poverty. Individuals who live in poverty with low income, and many health issues are reported to constitute a significant number of the

clients seen by HCPs in this study. Many HCPs reported the importance of the interconnectedness of determinants of health among their clients. Many of the PWIDs/IUDs are unemployed or underemployed although there are a sporadic few who have good white or blue-collar full-time jobs. The poverty level is very high among clients. Many additionally have housing issues, food security issues, poor education, and problems with being socially included. Some participants' responses are stated below:

They don't have a stable job or education level that allows them to easily gain an income. So, they're people who have more limited access to resources and who are more economically and socially marginalized (P06-2, 32-34).

...or even people who were maybe born with a lot of health issues because they were born in poverty (P03-115-116).

They were born maybe into poverty or they grew up in social services; they were apprehended from their parents (P10-13, 454-455).

4.2.4 Individuals of Indigenous ancestry. Health care providers (HCPs) reported that Indigenous peoples are overrepresented among their clients. Many of them have come from generations of addictions, drug and injection use, generational trauma and abuse, and have experienced discrimination in many forms. Examples in the data below are:

We have a lot of First Nations clients...(P10-13, 444).

...Working with people who have injected drugs, there is diversity within it but what I do see is a disproportionate representation of First Nations individuals who are injecting drugs in our community (P11-3, 62-64).

4.2.4.1 Individuals suffering from generational trauma or abuse. Many of the First Nations clients have also suffered generational trauma, physical/emotional abuse, violence, and sex abuse. Unemployment is rampant and many live in abject poverty and experience poor health due to lack of education, poor housing and/or homelessness. All the interwoven effects of the

social determinants of health that are mainly negative for the clients come to play in their addictions and health issues. Four HCPs responses are quoted below:

Quite a few of our clients are coming...from generations of drug use, their parents injected drugs, their siblings injected drugs, maybe even their grandparents. So, they were really entrenched from the time they were very young. They grew up in a culture of drug use, or their parents...or their older siblings...we do see a lot of generational drug use (P10–13, 444; 450–455).

...Every other woman that we've worked with have experienced or suffered some form of abuse, sexual, physical, emotional abuse (P06–2, 52).

Aboriginal population, whether it's First Nation, Métis, Inuit, it's growing substantially and we've already seen that intergenerational trauma that was caused and that ripple effect is still continuing...(P04–5, 211–213).

... They are also experiencing some type of trauma, whether it be generational from our history of colonization in this country and genocide or it be something very specific to that person, maybe they were sexually abused or physically abused by a family member who was also abused in that sense as a result of generational trauma...(P03–3, 134–137).

4.2.5 Young Indigenous women. The HCP participants in this study revealed that young Indigenous women were disproportionately represented among the population of the clients that they work with. They attributed the reasons for this to include exposure to drug use and sometimes the sex trade at an early age, poverty, lack of education, unemployment, and domestic violence, and abuse. A participant's account is stated here:

...and I'd say again a disproportionate representation of First Nations women as well. Met with lots of people and women included who started using injecting drugs at age eleven (P11–3, 76).

4.2.6 Individuals in conflict with the law. Another group of individuals mentioned by HCPs to be their clients are individuals who are or have been in conflict with the law. Examples stated below are statements from two of the HCPs who participated in the study:

But we know that people are injecting in Corrections and sharing supplies because they don't have new supplies right, and I mean Corrections is an interesting place, there's lots of challenges that would go along with that (P07–11, 490-492).

A lot of times there's some conflict with the law...people who have had some incarceration (P06-2, 51-53).

4.3 The Existing Relational Approaches of HCPs with PWIDs

The perceptions of HCP participants on their relational approaches with their PWID clients are reported in this section. The HCPs further revealed other existing relational approaches (which are mainly negative) that they know of and/or have admitted to have practiced in the past in other health departments. Evident in the results is the mainly positive relational approaches of HCP participants with their PWID clients. Nevertheless, the participants reported their awareness of the existence of negative and neutral (HCP- client relationship) relational approaches.

4.3.1 Positive relational approaches reflected in the practice of HCPs with PWIDs.

Of all 11 HCPs interviewed in this study, most reported exhibiting positive attitudes toward their clients, which included being straightforward and honest with them. Health care providers (HCPs) mentioned that they do not put on any airs around their clients, are non-judgmental of PWIDs, listen to, and are very patient with them. Additionally, the HCPs expressed that they usually never take any accusations from their PWID clients personal, but are very understanding with them. All the eleven HCPs mentioned that their understanding of the issues faced by PWIDs played a major role in the positive attitudes that they exhibit towards their clients. All the participants agreed that there are more negative attitudes and stigma toward PWID/IUD clients in other health services/departments, such as the acute care, than among them where they work directly with PWIDs. Health care providers (HCPs) indicated they are very understanding of their clients' issues, which are most times embedded within the social determinants of health. The HCP participants in this study additionally make clients feel validated and they encourage them to speak up for themselves.

The positive relational approaches of working with PWID clients expressed by participants can be summarized under the main categories of: non-judgmental toward PWIDs; make the safety of PWIDs paramount in their work; and endeavor to establish a trusting relationship with clients (PWIDs). In addition, the category of the positive attitudes reported among HCP participants include that HCPs aim to meet clients where they are at, and that they as HCPs validate and encourage their clients.

4.3.1.1 Safety of clients is paramount. The harm reduction (HR) policy is based on keeping clients safe the best way possible. All the HCPs interviewed in this study were in agreement with this policy, which was obvious in their responses to the interview questions. All HCPs interviewed in this study indicated that clients' safety is paramount in their practice with PWIDs, as can be seen in the participants' statements from the previous page.

In my perspective, if they continue the choices they make, we help them do it safely and looking at public health that they're not infecting others, so that they do it in a safe manner and if they choose to reach out for support, support should be there for helping them getting on the methadone, or whatever medical that they need if it's testing or support or detox (P05-7, 313-317).

I provide services without making them feel unsafe (P04-6, 240-241).

4.3.1.2 Non-judgmental. All the HCPs who participated in this study did not make statements or showed attitudes that suggested their being judgmental toward their clients in any way. The participants, through their answers to the research questions showed deep understanding and in-depth knowledge of their clients' drug issues and circumstances leading to drug use and injecting. Participants in this study affirmed they would not judge anyone as related below:

So, I would never...never judge anyone and I just wanna make sure that they can lead a healthy life that they want (P02-6, 299-300).

But it's really about meeting the client where they're at and being non-judgmental (P11–5, 142).

4.3.1.3 Earn clients trust. Out of the 11 HCP participants in this study, nearly half revealed that they do their best to earn the trust of their clients and that they are honest and straightforward in their dealings with them. They mentioned that it is easier to get to the roots of PWIDs problems when trust is well established. All the participants added that the trust that PWIDs have in them contribute to the reason why many of them keep coming back to access the services they and their department offer them. In addition, all HCPs commented that their clients know that they would not lose any benefits they may be enjoying from the social services even when they are honest with them (HCPs) about their drug use habits, family, social, and/or life circumstances as a whole. A large number of their PWID clients/patients are dependent on social services in one way or the other, which makes the issue of confidentiality extremely important to them (PWIDs).

Furthermore, more than half of the participants (HCPs) acknowledged that the women clients are not afraid of their children being taken away from them here in this clinic. However, the women clients are afraid of the HCPs in the social services department removing their children. According to the health care providers, rather than being fearful of such, these women find it easy to confide in HCP here about everything, including their abusive relationships because they are confident about the support they will receive from them. Additionally, accessing the services of public health department or the positive living program (PLP) program does not affect whatever benefits they may be claiming from social services, rather it enhances their claim, e.g., when trying to get back the custody of their children. The opportunity for PWIDs to access other necessary health care services through a continuum of care are

additionally enhanced when they access public health street/health programs and/or the PLP department. Some HCPs' comments are stated below:

...Reinforce confidentiality so they feel they can trust me to be open about those things because it's easier to actually get to the root of their situation when you have more information...I feel like I need to earn their trust (P03-4, 170-173).

A lot of it is the trust of the person that you develop a trust and a trust of the program. They know that if they access our program they don't get in trouble with social services. They don't get cut off if they on assistance or they do have their custody of their kids if they're trying to get them back. We're not going to hurt that. They know that there's that certain level that they can start at and work with us to access other services or programs (P06-6, 180-185).

4.3.1.4 Meet clients "where they are at". Meeting PWIDs/IUDs "where they are at" is paramount in the practice of all the HCPs in this study. Meeting clients "where they are at" aligns with the mandate of the HR non-judgemental policy that the HCPs practice in their work with clients who access their services. The HCPs meet clients "where they are at" emotionally, psychologically, and physically at their level of need and language. Health care providers further endeavor to meet the basic needs of PWIDs by providing basic supplies (such as: soap, shampoo, and feminine products) and van services. The van service provides needle exchange in the core neighborhoods of the city for easy access for clients. Over half of the HCPs interviewed noted that this approach is beneficial in many ways. All HCPs said that when clients are met exactly at their level need and language, they get more important information that other professionals ordinarily would not be able to obtain from their clients and they are able to establish trust and build their clients up from there. Almost all the HCPs mentioned that this approach of "meeting clients where they are at" further shows the provision of service to client population in a humane manner.

I work within a HR approach for sure. I like to "meet the clients where they're at" (P11-5, 142).

What our mandate is to “meet clients where they’re at” and build trust...we see things that a lot of other HCPs would never see and we hear stories and we learn things that we wouldn’t know if we weren’t meeting people where they’re at with harm reduction...(P03-12, 537–538; 6–249–250; 7–302–307).

I want to meet someone where they’re at but I don’t want to leave them there and I don’t want them to leave there feeling worse than they did when they came in...it’s sort of an iffy balancing act where you have to let them lead and figure out where they want to go with things (P03–16, 693–698).

...Try to work on their terms more and then maybe they will engage and come back if they know they aren’t going to be pushed to do things they’re not ready for...I think most of us, or all of us are very open to trying to work with people and do the best we can to meet them where they’re at (P07–5, 222–223).

4.3.1.5 Validate and encourage. Another finding in this study is that HCPs make conscious effort to make their clients feel validated and supported in their struggles with drug use, and are encouraged to speak out for themselves. According to the participants, the validation of clients hardly happens in other programs that PWIDs access. A couple of the participants said that they try as much as possible to instill in their clients that they have a right to speak out if and whenever they feel things are not going right. This can be seen in the sample comments stated below:

A lot of our clients really often don’t get validation in a lot of places, they have a story just as important as anyone else’s and yet that’s not recognized, so just recognizing the value of first voice and believing what people tell you and making them feel believed (P09–5, 194–196).

... It’s important that people kind of identify and speak up, but that takes a lot of courage sometimes, and I think that’s part of working with people is trying to give them the encouragement...to say it is okay to speak up if you feel that something’s not right here, in a respectful manner...(P02–4, 163–167).

4.3.2 Influential reasons for positive relational approach(es). The guiding philosophy for HCPs’ practice with IUDs and PWIDs in the health region of study is that of harm reduction. The positive relational approaches identified and expressed by HCPs in this study have revealed HCPs’ adherence to the harm reduction policy/philosophy in their practice, such as keeping

clients safe and being non-judgmental of them. The positive relational approaches found among HCPs (which are very consistent with the philosophy of the policy guiding HCPs practice) may be as a result of the need to adhere to the policy guiding their work, and/or an inherent way of thinking and approach that developed out of other reasons. Another probable reason for the positive approaches mentioned by HCPs could be genuine compassion for PWIDs, and/or the HCPs previous knowledge/training.

4.3.2.1 Support of the harm reduction (HR) policy. All of the HCPs in this study affirmed their belief in and support of the HR policy through their comments. The mandate of the HR policy is that it allows clients to be safe and the necessary gap filled. The HR approach additionally helps clients to connect with other agencies, which helps to provide a continuum of care to PWIDs. Some very relevant comments from some of the participants are reported below:

Our program is based on a harm reduction approach and that would be very much kind of how my orientation would be... (P06-3, 73-74).

I believe harm reduction is very necessary because abstinence doesn't work for everybody. And so not everybody is ready to quit or go to treatment, so there has to be something for him or her. I think we know that putting people in jail isn't very effective (P10-8, 261-263).

I work within a harm reduction approach for sure (P11-5, 142).

4.3.3 Negative relational approaches of HCPs with PWIDs. Health care providers (HCPs) in this study indicated that they do not discriminate against, stigmatize, or deal with their clients in a disrespectful way as some other HCPs in other health units/departments might be doing. Participants in the study mentioned that they understand the issues and needs of their clients and always want to see them succeed. Nevertheless, they acknowledged that some HCPs are negative in their approach(es) of working with IUDs/PWIDs. The participants mentioned that there might be some degree of discrimination/stigma from HCPs who work in acute care, which is most

likely to be perceived as unintentional toward individuals who use drugs (IUDs) and people who inject drugs (PWIDs).

The HCP participants in this study explained that the discrimination might sometimes be due to the lack of knowledge and understanding of some HCPs in acute care about the IUD/PWID population and the issues of concern to them. Additionally, according to the participants, HCPs in acute care are sometimes faced with the pressure of prioritizing and needing to attend to patients faced with life threatening issues over IUDs/PWIDs with no life-threatening complaints. Therefore, IUDs/PWIDs may misconstrue this as discrimination/stigma. Participants emphasized that HCPs learn the culture of the unit they work at very rapidly, especially new and inexperienced staff, in an attempt to belong. An example of a HCP's statement is below:

...You learn by example from co-workers mostly rather than any sort of formal anti-oppressive, anti-racist type of training (P03-2, 76-78).

Many of the HCPs in this study who had previously worked in acute care, in hindsight, acknowledged also exhibiting negative relational approaches on the job toward their PWID clients. They expressed that, in hindsight, their negative relational ways were unintentional and at that point they understood very little about the needs and issues of the PWID/IUD population.

A HCP said:

...Going back to when I was a young, new grad...I had a very negative attitude that was just reinforced by the workload and time constraints of my job. As I get older and more experienced, I understand addiction a little bit better and both in my personal life and my professional life (P01-9, 399-403).

In addition, the HCPs expressed that there were times that PWIDs complaints were very valid and needed better services, yet, there were other patients who had more pressing needs, such as those in life and death situations who took precedence of care. Participants expressed that

HCPs in acute care are under a lot more pressure working with patients and may sometimes not have enough patience with PWID/IUD clients. Sometimes the lack of understanding of PWID/IUD patients' issues nature of illness, and needs may additionally make some acute care HCPs feel they are just "drug-seeking". Almost half of the participants in this study had worked in settings/with organizations providing services to predominantly PWID/IUD clients in the past as earlier mentioned. They expressed similarities in HCPs relational approaches toward their clients in those settings/organizations and expressed being in support of the negative notions about PWIDs/IUDs that existed among a section of the community and/or society.

Participants (HCPs) mentioned that some HCPs learn what they live or exhibit the beliefs they inherited from their parents, the society or the system in their approach of working with IUDs and PWIDs. A participant made it known that some HCPs continue to feed off internalized stereotypes, even when they are willing to listen to and understand their clients' issues. Health care providers (HCPs) still end up allowing the negative stereotypes to come to play in their professional relationships with PWIDs. The systemic beliefs inherited by HCPs is expressed when they do think their clients are not worthy of financial benefits or programs because they are IUD/PWIDs and/or women or of Indigenous heritage. Below is one of the HCP's statements on this:

... It is just systemic...I think it's just part of culture, Canadian culture, especially towards Aboriginal peoples...people base what they know on what they know from their parents or society in general and without trying to validate or change their perceptions and learn new things about people. They just go with what they know and, every once-in-a-while you connect with somebody and they're willing to listen and open their eyes a little wider, but I think that's where a lot of it do come from, even just history books in school, it was all the Indians were savages and uncivilized and people just don't understand that history very well and continue to feed off those stereotypes...(P07-4, 145-155).

The perception of participants (HCPs) in this study includes the opinion that in some other departments of health, particularly in acute care settings, HCPs are considered to be

disrespectful toward and discriminate against clients. This perceived behaviour from HCPs toward their clients is considered to be consistent with societal and systemic values in addition to work culture learned over time. These attitudes may have been carried over by some HCPs into their practice with their clients. Health care providers (HCPs) in this study explained that disrespect, stigma, and discrimination could happen more in acute care settings because of the nature of the pressure of work there as mentioned earlier. Many of the HCPs in this study have had the experience of working in acute settings and/or other health care departments before working in their present positions. Some HCPs' comments are as follow:

...I've heard enough stories about some of our clients and when they've had to go to the emergency room and that they're being brushed off...I don't think you can label and say well this hospital or this floor mistreats people, but I think that on any given day you're gonna have somebody in there that's maybe got a less than tolerant attitude towards other people...(P02-4, 172-178).

...We know that IDU clients tend to be very demanding by nature...so when you're in the hospital with those limited resources, and there's only one nurse with so many patients...my tolerance was very low. My patience was very low; my understanding of what was going on was very low (P01-1, 41-46).

... In a community setting, where the majority of the population I dealt with was IDU, you have a different viewpoint. You see the challenges they face every day and you're not competing time wise with, ten other people who, some of which are on death's door and it would be a matter of sometimes in acute care the person using – the person admitted because of an IDU-related illness demanding a piece of toast and they want it right now and the person in the next room who you need to give morphine in versa to because they're dying... there was always that constant struggle, whereas in the community you don't have that. You, just have more patience. You see it very differently, through very different eyes when you're working frontline in the community (P01-1, 46-55).

When I worked in the hospital...I contributed to those feelings of feeling marginalized. I think when I started working in the community; I hope I had the opposite effect. I hope I did a good job of being supportive and being compassionate and relating and de-stigmatizing and – but I think initially as a new nurse and a nurse in an acute care facility, yeah, I would think I contributed negatively, definitely...(P01-4, 162-167).

And I would imagine the nurses working in acute care, somewhat feel the same way still because they're even worse off than I was, in the sense that staffing is a lot less (P01-2, 79-80).

In summary, the HCPs' stated that there were reasons for negative behaviours. These negative behaviours are due to lack of time, lack of resources, and the priority focus of the setting, such as in an emergency situation or in the emergency department.

4.4 Factors that Influence HCPs' Relational Approaches with PWIDs

The perceptions of the participants on the influencing factors on HCPs relational approaches with PWIDs are enumerated in this section. The main factors identified are: beliefs, knowledge, and education of HCPs. Additionally, life experiences, personality, and professional life are contributory factors that influence HCPs relational approaches with PWIDs.

4.4.1 Belief. The beliefs of HCPs influence the relational approaches of HCPs with PWIDs. Beliefs in this context can be divided into two major areas, they are: policy driven beliefs and societal driven beliefs. Policy driven beliefs include HCPs beliefs about the HR policy, its benefits and demerits, while the societal driven beliefs (which are apparent and more negative) of HCPs are mainly based on fear and lack of understanding of the population of PWIDs and their issues. For the policy driven beliefs, the results of this study make it evident that HCPs belief in the HR policy greatly influenced their positive attitudes toward PWIDs (see 4.3.2.1). All the HCPs in this study indicated their support for HR policy. However, the societal driven beliefs about harm reduction and substance abuse, as reported by approximately half of HCP participants in this study are very much tilted towards the negative side. When HCPs inherit or allow their beliefs about injection drug use and/or the HR policy to be influenced by those of the negative side of the society; it may lead to stigma on the part of the HCPs as an individual's beliefs influence his/her actions.

The beliefs of HCPs in this study about their clients were mainly influenced by the harm reduction (HR) policy. The HR policy as earlier mentioned emphasizes and revolves around

keeping clients safe. All the participants in this study expressed support for the HR policy and acknowledged that the safety of their clients is paramount in working and providing services to them.

4.4.1.1 Perceptions of HCPs on the benefits of harm reduction. The benefits of HR emphasized by all HCPs are that HR approach accepts the person “where they are at”, reduce the risk of harm to the individual and the public, is non-judgmental, and empowers PWIDs to make informed choices. When PWIDs know how to prevent infections for themselves, they are additionally in turn helping to prevent passing any infection on to others. Additionally, PWIDs are educated and are given safety skills; they in turn educate others around them about not sharing filter, spoon and other paraphernalia. In addition, PWIDs are helped to identify resources that are available and beneficial to them, which ultimately help to give PWIDs a continuum of care. All participants expressed that HR policy has helped remarkably in the incidence and prevalence rates of blood borne diseases like HIV and hepatitis C due to the needle exchange program. In addition, HCPs believe there is a decreased rate of incarceration of PWIDs due to HR and it is cost effective for the government. Harm reduction is considered by all HCP participants to be an upstream health approach rather than being that of a downstream. With the upstream approach, response and investments are made early and wisely on addressing the issues that have the most impact on the health of PWIDs. Without HR, enormous time and resources are later spent in response to PWIDs poor health.

The benefits of harm reduction in terms of my work, being able to educate people on the ...to reduce diseases, such as HIV... and STIs, so reducing risk for people that are obviously very high rates of catching HIV or hepatitis C or any sexually transmitted diseases (P09–6, 244–248).

In my perspective, if they continue the choices they make, we help them do it safely and looking at public health that they’re not infecting others, so that they do it in a safe manner and if they choose to reach out for support, support should be there for helping

them get on methadone, whatever medical they need, if it's testing or support or detox...(P05-7, 313-318).

... It's a tool. It's not an answer. It's not a treatment. It's not a solution. But it's a tool to help keep people be as safe as possible while they're involved in risky behaviours and if there's a way to change those risks or get them out of it along the way or get them connected. It's not inconsistent with abstinence. It can be part of a continuum of care and approaches to supporting somebody (P06-12, 407-411).

Well, I believe harm reduction is very necessary because abstinence doesn't work for everybody. And so not everybody is ready to quit or go to treatment so there has to be something for him or her. I think we know that putting people in jail isn't very effective (P10-8, 261-263).

...Many of our clients that we've seen over the years do have HIV or many, many of them have Hep C, but our goal is, if we can educate and provide harm reduction and hopefully connect people to care when they're ready to try and go to detox or to treatment, that we really would like to see people not develop those infections. That's the goal, and then that means that our harm reduction is working if they're not getting those infections (P02-2, 76-81).

4.4.1.2 Demerits of harm reduction. Health care providers (HCPs) claim that fear and lack of understanding of professionals and members of the public, who believe in abstinence, lead to assumptions that HR is disadvantageous to all. Critics of harm reduction who believe in abstinence additionally believe it fosters the habit of injecting drugs. According to the HCP participants, those in the community particularly those in the core neighborhoods of the city (who need more understanding), believe HR endangers the lives of the public with the increased number of needles found around, particularly, in the spring season. Furthermore, HCPs say the belief of the society contributes to why people yell at and stone the mobile vans used for needle exchange around the inner city in anger and annoyance.

...For example, we do needle exchange and we give out condoms, but you know that really sets us up for a lot of criticism because if we don't see a decrease in HIV rates, for example, then they say, oh, it's not working, and it's well, first of all, we have nothing to compare it to, had we not had these things we might be in a worse situation (P03-7, 281-288).

...There needs to be other harm reduction practices in place, we can't just do the one thing. So, we're kind of set up to fail in that sense (P03-7, 295-298).

4.4.2 Knowledge of HCPs. The formal training and education of HCPs are very influential in the ways HCPs work with and treat PWIDs. Additionally, HCPs work experience and life experiences contribute to the background knowledge that account for HCPs approach of working with PWIDs. The more knowledge HCPs have about PWIDs, the more their understanding of PWIDs needs.

4.4.3 Education of HCPs. As earlier mentioned, in 4.1, most of the HCPs that participated in this study had at the least a bachelor's degree in their field of study (such as: nursing, sociology, and social work) and they expressed satisfaction in having the kind of jobs they had. Nevertheless, a couple of the participants in this study expressed the absence of specific training in the field of substance abuse in their curriculums of study and that most of the knowledge they had in this field had mainly been learnt on the job. They expressed interest in taking more specific courses and training on the job as they would be very helpful. Almost all of the participants mentioned they had had some education e.g., in cultural competence; however, many more trainings are needed (as identified by HCPs), particularly, for those who have not been opportuned to have had any. Out of the 11 participants in this study, a couple of them mentioned that taking initiatives by HCPs to take relevant trainings have not been too encouraged and sometimes frowned upon by the management.

All health region employees have to go through one training course. And I do believe that they're gonna start kind of keeping it more current like you have to do it every few years (P10-6, 181-182).

4.4.4 Life experiences. All the HCPs interviewed acknowledged that their respective and varied life experiences help them greatly in their work and in understanding the issues and needs of PWIDs. In this study, some HCPs said they had trod the same path of the PWIDs in the past, which probably made it easier for them to understand and identify with PWIDs. Additionally,

some participants expressed having close relatives who had drug problems presently and in the past. An example of how life experiences influence HCPs can be seen in the account of one HCP participant reported below:

I grew up in poverty...I've struggled, I've lived in low-income housing; I struggled with drugs and alcohol in my childhood and youth, as well; I know a lot of people out there from when I was younger. I was never involved in, heavily in the scene, but I did tamper with things when I was younger and I struggled and I think that helps me to understand where people are coming from and be non-judgmental and to know that people can make it through and get out of those things (P07-9, 374-384).

4.4.5 Training on the job and personality. Many of the HCP participants in this study expressed that the training on the job and experiences they accrued on their previous and/or present jobs have helped them greatly in working effectively with PWIDs. In addition, the HCPs believe that supervision on the job, appropriate guidance, and giving of constructive criticisms has helped immensely with working appropriately with PWIDs. In addition to the training on the job, the flair and personality of HCPs was also reported to be a factor for the relational approach employed by HCPs with PWIDs. Some examples of the accounts of some HCPs who participated in this study on the usefulness/influence of work experience in their practice are included below:

I think it's training on the job that has benefitted all...I think it's our personalities that will shine...having some background knowledge and some experience is helpful (P05-6, 353-354).

...As I get older and more experienced, I understand addiction a little bit better and both in my personal life and my professional life (P01-9, 399-403).

...You learn by example from co-workers mostly rather than any sort of formal anti-oppressive, anti-racist type of training (P03-2, 76-78).

4.4.6 Job satisfaction. Most of the HCPs in this study revealed that they enjoy their jobs with PWIDs, although a couple of the participants further mentioned that things could be better

in terms of hierarchical roles and training of staff. All HCPs further mentioned that they hope good things for their clients and are unhappy to see PWIDs fail in their recovery process, totally relapse, or sometimes become homeless. Health care providers (HCPs) feel for their clients when they as HCPs sometimes need to have to break the news of positive HIV, hepatitis c, or other similar ailments to them. Nevertheless, HCPs acknowledged their passion for their jobs, expressed how rewarding it is for them particularly when their clients succeed in their healing journey. Additionally, the HCPs are moved with compassion for their clients for the things they do not have. One of the HCPs was extremely grateful, felt very privileged, and extremely emotional at the thought of what some PWIDs lacked in general:

Well, I enjoy it because it makes me...grateful and humble for all the privileges and all the things that I do have. I think about for my own family being very close and all of the supports. It makes you really appreciate the things that they don't have [crying]. It's hard. It's a lot of gratitude that way in terms of being thankful (P06-7, 217-220).

I enjoy the people...they're kind of just really authentic. They just present as they are; they're not often trying to be fake in some way or be who they think we-want them to be... I mean you see people in crisis and you see people dealing with really hard stuff and it is really rewarding to see people when they do make positive changes in their lives or things are going good for them. It's a rewarding opportunity to...you know when somebody comes and tells you that you were there for them during a difficult time. You know and just, that I enjoy as well just, knowing that we're hopefully making a difference for people (P10-3, 87-97).

4.4.7 Cultural awareness. Cultural awareness in this context encompasses cultural competence, cultural safety, and cultural humility. The HCPs in this study stated that they go about their practice with PWIDs with cultural awareness. All of the participants have had training in cultural awareness since all members of staff in the health region are required to take this course. Nevertheless, out of the eleven participants, a couple mentioned that there is a need for updates of their training on cultural awareness in order to enhance their practice with PWIDs. All HCPs described different but effective ways in which they show understanding and practice cultural awareness with the diverse populations among their clients. Furthermore, the responses

of the HCPs in this study, revealed a growing understanding of cultural humility, cultural safety, and cultural competence. A few examples of HCPs account of how they claim they show cultural awareness in their practice with PWIDs are stated below:

We are also learning about how some cultures, it's less appropriate to talk about sex and to talk about sexual activities and sexual relationships. And that's something that we do in our work. We talk about sex. We talk about how to have safer sex, how to prevent HIV, by using condoms. How to prevent other sexually transmitted infections. And we talk about when somebody is diagnosed with a sexually transmitted infection. We talk about who they've had sex with so that we can offer those people testing and treatment and responsibilities around disclosure and stuff. So just being aware that those conversations might be more difficult for people of different cultures or even different ages. Talking to people that are older, like my parents' age – people in their fifties and sixties – they don't talk about sex [laughs]. So just being aware of those kinds of things as well (P10–5, 168–175).

We offered cultural activities within the clinic, but we never targeted just the First Nations clients that came in. It was open to everybody, not specifically First Nations that came in (P01–5, 194-195)

All...employees have to go through one training course. And I do believe that they're gonna start kind of keeping it more current like you have to do it every few years and especially all the health care workers are gonna come across people from different backgrounds and people from different cultures but. A few years ago, the health region did a survey and found that a lot of the employees didn't score that high in that area so then it was something they implemented as a response to that (P10–6, 181–186).

4.4.8 Van services. The van services provided for the HR services endeavor greatly to meet the needs of PWIDs in the community. The vans have already earmarked regular stops at regular hours in the inner city. These stops are very close and accessible to many of the individuals who inject drugs regularly. People who inject drugs in the community recognize the vans and the license plate number and they access the services provided in a timely manner. On some occasions PWIDs flag down the vans for services. Nevertheless, there have on some occasions been calls from the community of people complaining bitterly about not wanting the “white” vans around their neighborhoods and streets. The complaining individuals sometimes go to the

extent of stoning the vans and those who access the services. Health care providers (HCPs) on the vans have occasionally needed to move the vans to different stops other than the regular ones in order to still provide help to PWIDs. The HCPs are considerate of the community and sometimes need to make other arrangements with clients. Alternatively, some clients are sometimes ashamed to access the services of the vans in their neighborhood so they make arrangements for staff to meet them on other streets. A HCP stated:

We do get calls from community members... not wanting the...van in their community, so there are times, doesn't happen often, that we may have to move a stop where we're going or when the client says come to my house, we actually may park different blocks away and walk to them or we park and then they walk to us, so we are very considerate for the community and we try different ways to meet their needs, for the community members as well as our clients (P05-10, 444-454).

Health care providers (HCPs) in this study stated that they try their best to provide services on the vans in a safe and appropriate manner for their clients and themselves. Health care providers (HCPs) work in twos on the van and there is always a public health nurse on every trip in order to provide HIV, hepatitis c or other STI testings as needed in an opportuned manner.

Additionally, in order to provide service in a continuous manner to PWIDs, all HCPs in the street and sexual health departments meet once a month to discuss the needs and progress of their clients. These meetings are called "street meets". The "street meets" enable HCPs to work in a continuous manner with clients as the HCPs all know what is going on with each client and any HCP is able to pick up from where any other HCP may have stopped the last time. A comment of a HCP is stated below:

But usually through the van one of the benefits is we work as a team and sometimes we'll get a client who will feel like either- the one person that she connects with one of the staff more than the other or that she didn't get good treatment or only gets good treatment from one worker versus the other...it might be just frustration, anger and this enables her to express her anger but still keep the door open by working with one of you. So, one of the benefits of having two of us is one can observe (P06-15, 517-524).

4.5 Implications of HCPs Relational Approaches on PWIDs

Health care providers (HCPs) in this study were of the opinion that their PWID clients were willing to access the health care and services that they provided mainly because of their positive relational approaches with PWIDs. As mentioned earlier, HCPs emphasized that they are non-judgmental toward PWIDs, they meet them where they are at, validate, and encourage their PWID clients. Additionally, HCPs establish trust with their PWID clients and endeavor to keep them safe. All HCPs were of the opinion that clients accessed the services and care they provided fairly adequately and more than they do for other similar programs because of their positive relational approaches toward their PWID clients. Health care provider (HCP) participants buttressed that negative relational approaches of HCPs is a contributory factor for lack of access to care and services by PWIDs, particularly in other units/departments. This finding is consistent with those in the empirical literature (discussed in section 2.1). Health care providers additionally mentioned that when PWIDs experience negative provider-client's relationship while accessing health services, PWIDs tend to have the feeling of inadequacy, distrust their HCP, and have low compliance for medication and appointments.

Other factors that were mentioned by HCPs to influence access of PWIDs to health care and services they provided are: basic needs like food, shelter, and accommodation. Additionally, PWIDs are encouraged to access the vans mentioned above by having regular van stops all the time. Transportation can be an enabler to access if the client does not have a means for it.

Food, snacks, and coffee/tea were reported by HCPs as part of the factors that increase access to the services provided to their PWID clients. At the street and sexual health units, light snacks like granola bars and other snacks are provided to clients if they are keen on having some. Although HCPs expressed that the snacks provided at the street health/sexual health clinics are

not as much as what is provided in other programs to PWIDs/IUDs in the city, the clients still value them as they come in handy and are life savers most of the time, particularly, at such times when food is not served at agencies that do. Health care providers (HCPs) mentioned that coffee/tea is offered in addition to more snacks at other similar agencies. Toiletries such as shampoos, sanitizing gels, and lotions are additionally provided to PWIDs on request. Condoms are also offered to PWIDs in addition to the HR kit they receive for needle exchanged.

Housing is another very huge issue for PWIDs. Health care providers (HCPs) commented that PWIDs cannot deal with their issues if they don't have a stable place to stay. If they don't know where they are going to sleep, it certainly becomes hard for them not to use drugs. Participants in this study further stated that they had witnessed many situations that revealed that when PWIDs' basic needs were met and got really stable accommodation, the PWIDs made really positive changes in their lives. Health care provider participants in this study reported that many clients who may not have suitable accommodations or are homeless take shelter in the offices where services are provided to them particularly during the winter months. Additionally, HCPs reported that bus passes, taxi vouchers, and transportation are provided to their clients if and when need be and this enhances access of clients to their services. Having the flexibility of drop-in services also helps. A HCP comment on access is stated below:

I think that the fact that we run an evening service in our outreach van and we have fixed stops...we try and make it so people don't have to walk far. We're trying to make it accessible in terms of location. Also, we'll go out and do home visits and that's a service that people use a lot as well. I think that enables people 'cause if they have no transportation and they live on the other side of the city, it's pretty tough to come and see us...if you've been identified as a contact to an infection like HIV or Hep C, they're prioritized and they'll see them...our clinics are all drop in. They'll have some appointments booked but most of it is drop in service...they can come and on a day, that works for them without having to schedule an appointment. Having that flexibility is good (P02-9, 378-390).

4.6 Effects of Substance Abuse/Injection Drug Use on PWIDs and the Society

The effects of injection drug use on individuals and ultimately on the society are numerous and have social, economic, and health implications for the individual. In this study, most of the participants mentioned that drug use weighs down the health system in terms of the cost of multiple emergency room visits, increase in the cost of infections, and adverse effects on the economy through unemployment. Additionally, injecting drugs has a ripple effect on homelessness, more children in foster care, more incarcerations and more spread in diseases among others. More women are ending up in the sex trade and/or incarcerated and there is a steady increase in the number of youths involved in injecting drugs.

4.7 Understanding the Multiple Vulnerability Context for Women and Transgendered

All the HCPs in this study indicated that injecting drugs puts individuals in a vulnerable situation in all areas of life. Such areas include vulnerability in the community, with the health care system, and with the social services. For women who use and/or inject drugs, it is multiple-vulnerability for them. This can be considered to be a situation of “multiple jeopardy”. Health care providers (HCPs) stated that a lot of people struggle with the fact that women inject drugs, particularly, when they are pregnant or are already mothers. Individuals in the society and some HCPs feel they should just quit using drugs even though it is not as easy as it seems.

A HCP in this study further commented that treating women like this creates a lot more harm than good. The HCP said many women had been seen, who inject drugs that have become pregnant and they want to quit using. The women really struggle and this creates for them a spiral of shame because they already feel guilty enough that they cannot quit using drugs even though they genuinely and really want to do the right thing for their babies. One HCP’s opinion was that shame and self-stigma works against these women in their heads and it keeps them

using drugs. Alternatively, the participant commented that she knows of women that have done everything they were asked to do: they have tried to obtain a stable life, for example, getting a place to live, going for detoxification, and starting on methadone treatment. In addition, some women have attended parenting classes, jumped through many hoops, and did everything they needed to do, and yet, their baby was taken away from them. This type of mishap sometimes happens because one of the biggest predictors for a child to be apprehended is simply a history of drug use, not necessarily current drug use. The participant noted that it is really unfortunate because often times even if they were doing well, once their child was taken away, they often went back to using drugs.

Women who inject drugs, particularly young women of Indigenous descent, who mostly have been forced into sex trade, as earlier mentioned, experience multiple jeopardy situations as well. The use of drugs helps the Indigenous young women to dull the shame they experience in the sex trade, it helps them to pay their bills, and most of the time keeps them in their marriages and/or family relationships, which are mostly abusive. Additionally, the HCPs in this study expressed that due to the cycle of circumstantial problems of abuse, violence, poverty, and generational trauma many women who inject drugs found themselves increasingly having conflicts with the law and ultimately incarcerated. A statement from three HCPs in this study that relate to the multiple vulnerability of women are reported below:

...women tend to be concerned about families or their children or childbearing, so they maybe don't want a pregnancy or don't want to become... and so they're having to deal with those issues and sort them out and manage their addiction at the same time. Men, again, might be seen a little bit differently, not usually as concerned about the children and stuff (P02-3, 103-108).

... more often women can be forced into sex work or doing things they don't always want to do so that they can get their drugs that they need. There's a lot of crime involved and just I think they all feel the same way, that they don't want to be there, most of them

don't want to use; many of them fell into it because of pain, emotional or physical and it's a way to escape (P07-6, 242-247).

...when I've worked with women who are pregnant and using substances they are scared! They don't know where to start and they don't want their baby to be addicted. They don't have ill intent for their child so it's about providing support for them and giving them the help that they feel like they need, and that safety is obviously a concern (P11-9, 280).

Health care providers (HCPs) in this study expressed that transgendered individuals who inject drugs experience multiple vulnerability just like anyone else who injects drugs. The transgendered individuals who inject drugs may greatly attract stigma and discrimination from HCPs and the community. A study participant described her client's grief as she narrated to her, her experience at one of the hospitals to her. The HCP participant stated that her client who identifies as a female but who still has her male name on the health card politely requested that the admitting secretary should call her the female version of the name on her health card as she identifies as a woman. The secretary simply reacted to her request by insisting she was going to be called exactly by the name on her card, as she was not going to be the one to call her. When it came to her turn, the name on her card, which was her old (male) name, was announced loudly to call her in. The HCP participant painfully narrated the story, and further reported that her client said the situation made her feel very humiliated as she had dressed like a female and had to walk shamefully in front of everybody. The client had felt judged and discriminated against, she felt the secretary could have simply stuck a note on her health card for whoever would have called her. The client who had had a hard life, who had overcome amazing obstacles, and who had not injected drugs in three years at the point this incident occurred, was still being judged as an injection drug user and also as a transgendered person. See quote below:

...I have a transgendered client on my case load and she is female and identifies as a female and on her health card it's her male name and we were going to...hospital and she'd given her health card and they have to call your name later for when you do the admitting part and she nicely asked for the secretary to call her by the female version of

her name instead of the male version and the lady just said well, you'll get called by the name on the card because I'm not the one that's going to call you. And like, to me that is super rude (P09–12, 504–511).

In considering multiple vulnerability among men, the study participants mentioned that gay males in the sex trade and who inject drugs suffer stigma and discrimination from HCPs and the society the most. However, a study participant stated that the number of their clients in this category has decreased. She was however not sure if this decrease was in relation to the overall population of injection drug users, or that gay males are just not accessing their services.

4.8 Health Care Providers' (HCPs') Relational Approaches with PWIDs of Indigenous Ancestry

The HCPs in this study acknowledged that most of their clients are of Indigenous ancestry and that working with them in a culturally competent manner is paramount in their practice with PWIDs of Indigenous descent. As discussed above (in section 4.4.7), HCPs expressed that their relational approaches with PWIDs reflect their knowledge and continued effort to know and understand PWIDs from a cultural lens, which, is a life-long learning process. The factors that influence HCPs work with PWIDs include: HCPs understanding of the effects of generational trauma and colonization on PWIDs as described in section 4.2.4 above.

Health care provider (HCP) participants further expressed (as described in section 4.3.1.3 Earn clients trust) that a more trusting relationship exists between them and their clients of Indigenous ancestry than between HCPs and PWIDs in similar programs around the city. Health care providers claim that the trusting relationship exists because they are very understanding of what PWIDs have been through, how they feel when treated badly and misunderstood when accessing services. A participant of Indigenous ancestry mentioned that PWIDs express delight when she attends to them, as they believe she truly understands their issues and they can identify

with her, which immediately increases the level of trust and openness in their HCP-client relationship.

In addition, HCPs revealed that cultural activities are offered in one of the units in the study and these activities help clients to be more at ease with the programs/unit as the services and care received became more relevant and meaningful to their Indigenous clients. The epidemic situation of HIV due to IDU in some reserves in Saskatchewan buttress the importance for culturally competent practice among HCPs. The issue of cultural competence and practice are further discussed in the next chapter of this study.

4.9 Identified Ways for Improvement / Identified Needs by HCPs

Health care providers (HCPs) in this study identified areas of needs for improvement in their approaches of working with their clients that can bring tremendous improvement for the care and better health outcomes for PWID/IUD clients. The areas of needs are reported below. Many HCP participants reported the need for more advocacies for clients, better health policies, and the need to address labeling of PWIDs by other HCPs and the community as a whole.

4.9.1 Need for specialized courses and education. Health care providers (HCPs) themselves identified that there is a need for specific courses that would enhance the effectiveness of their work with PWIDs. Such courses need to include those that would help HCPs with working with specific populations such as: Indigenous peoples, immigrants, LGBT population, youth, and women. The HCPs suggested that courses on cultural competence and cultural safety would be highly invaluable for their understanding of different populations and culture.

Among the Indigenous peoples, HCPs mentioned that there is a strong interconnectedness in the family. This interconnectedness, they believe, contributes to helping to break the habit of

drug use/misuse if there are no users around them. People who inject drugs try hard to keep the habit a secret from family members. There is a lot of support for individuals who inject drugs, if there happens to be any in the family. Interconnectedness may strengthen the habit of drug use if PWIDs are always around individuals who inject drugs and whom they have close family ties with. In addition, it is a challenge if there's a lot of injection drug use, if it is intergenerational or cycles of addictions, then it makes it harder to get away from because it is so imbedded into the PWIDs lives and environment. The strong interconnectedness among Indigenous peoples, emphasizes the need to continue to educate HCPs on the interconnectedness of Indigenous families.

Another difference in culture identified by HCPs is that in individuals of other cultures such as those of First Nations and Métis, not having eye contact when having a conversation with someone is normal. Eye contact may be considered as being confrontational and/or intimidating. Nevertheless, it is not so in the culture of HCPs who mostly happen to be of Caucasian origins. Looking at someone in the eye during a conversation is seen as a sign of respect for the other party among Caucasians. Knowing about issues of culture will be helpful to HCPs and more likely to help them achieve great results in the services they provide to PWIDs.

Additionally, it would be helpful for HCPs to understand the cultural values of diverse populations in relation to discussing topics such as: the sexual habits of clients and how to practice safe sex to prevent contracting and/or transmitting sexually transmitted diseases. Discussing the sexual habits of IUDs and PWIDs in a manner that is culturally acceptable to the clients and in an effective way that would bring about positive change is important in HCPs jobs with PWIDs. Sexual health of clients is paramount and prioritized in the harm reduction policy employed by the HCPs. One HCPs comment is stated below:

We are also learning about how some cultures, it's less appropriate to talk about sex and to talk about sexual activities and sexual relationships. And that's something that we do in our work. We talk about sex. We talk about how to have safer sex, how to prevent HIV, by using condoms. How to prevent other sexually transmitted infections. And we talk about when somebody is diagnosed with a sexually transmitted infection. We talk about who they've had sex with so that we can offer those people testing and treatment and responsibilities around disclosure and stuff (P10–5, 168–173).

4.9.2 Need for more Indigenous HCPs. Another need identified by the HCP participants in this study is the need for more Indigenous HCPs. Out of the 11 participants, two HCPs identified themselves as Métis. The two HCPs believe that their clients who were of Indigenous descent identified more with them than they did with other HCPs. The HCPs in this study mentioned that more Indigenous HCPs are needed to further enhance their practice with the overrepresented population of peoples of Indigenous descent among their clients.

Anti-oppressive, anti-racist, and anti-violence training for HCPs were additionally identified to be a need among HCPs. Communication training was another need reported by participant in this study. A HCP stated as reported below that they as HCPs additionally need to be met “where they are at” to be able to meet their clients “where they are at”. A HCP providers’ comment is stated as follows:

If we're going to meet our clients where they're at then we should be met where we're at too, and so there's that and then the training so I think I'd mentioned anti-oppressive, anti-racist, anti-violence type training, maybe something to do with communication (P03–17, 737–740).

4.9.3 Needed societal interventions. Society plays an influential role in the health care and outcome of health of PWIDs/IUDs. Mainly the attitude and reaction of the society has been predominantly those of stigma and discrimination against PWIDs/IUDs. Health care providers (HCPs) in this study indicated that the community, especially that of the inner city make clients feel “lousy” due to societal stereotypes and stigma and as such they need to be educated about issues affecting PWIDs/IUDs and how not to discriminate, stigmatize, or make them feel “lousy”

especially when accessing community services available to them. Additionally, HCPs commented that the community needs more education as they make clients discriminated against. A recommendation for safe injection sites in Saskatchewan was made by a HCP. She said that Saskatchewan has really high rates of injection drug use/overdose and that it seems ridiculous that Saskatchewan would not have an injection site. Another HCP stated:

A supervised injection site would be great; we don't have that here (P07-11, 501).

4.10 Summary of Overall Themes Identified

Four major themes identified in this study were: (1) the non-judgmental and non-discriminatory/non-stigmatizing approaches of HCPs who work with PWIDs on a regular basis in their professional work; (2) the full support of the harm reduction (HR) policy by HCPs (this includes keeping the clients safe and “meeting them where they are at”); (3) and the institutional address of various social determinants of health (particularly gender and poverty) to reduce the vulnerability and predisposition to drug use of individuals who use and/or inject drugs; (4) the final theme identified is the need for education and improvements for HCPs' best practices in their work.

These approaches that the HCP participants mentioned are mainly in line with the HR policy mandate that guides HCPs practice with PWIDs in the health region of study. The participants' approaches were influenced by their beliefs, knowledge/education, and life experiences. Health care providers' cultural awareness and training on the job additionally influence their relational approaches with PWIDs. From the perspectives of the HCP participants in this study, some PWIDs encounter stigma, discrimination, and some judgemental behaviours from some HCPs when they access services, particularly from other departments that do not provide health care and services to predominantly PWID clients. Some HCPs in this study

confessed that they related with their PWID clients in a negative manner while they worked in the hospital setting (particularly in certain units) before they started working in the community setting. The participants further added that the pressure of work, the shortage of staff, and the limited knowledge and experience that they had about the PWID population, influenced their relational approaches with PWIDs at the time. Health care providers (HCPs) in this study further commented that negative relational approaches of HCPs limit the access of care by PWIDs, and gives them the feeling of shame and rejection.

The personal beliefs/life experiences, knowledge, education and cultural awareness of HCPs who work regularly with IUDs/PWIDs play an influential role in their non-judgmental, and positive attitudes towards PWIDs. All participants in this study claim they have non-judgmental, non-discriminatory, and non-stigmatizing attitudes/approaches toward their clients. The HCP participants were well educated and trained in their fields, have experience in the field, and have relevant social experiences that help them in their job roles. In addition, HCPs expressed more confidence and the desire of IUDs/PWIDs to access services that exclusively cater to their need than other services. Furthermore, from the perspectives of HCPs, PWIDs believe these HCPs do not only treat them humanely, but understand their issues and show great confidentiality than HCPs in other services.

The full support of all HCPs of the HR policy was very evident in the responses of the HCP participants in this study. A participant in the study, provided a speculated reason for this. She expressed that all the members of staff in the unit are very passionate about their jobs, they want to be doing the job they are doing, and that is the reason why they chose to apply for their jobs and remain at them. Keeping PWIDs safe, besides being a mandate of the HR, is a major

priority of the HCPs in their approaches with their clients. Additionally, the HCPs are passionate about making a change in this field of substance abuse.

All of the participants expressed that the vulnerability and the predisposition to use/inject drugs can be reduced through the institutional address of the social determinants of health among PWIDs. Gender, social inclusion, culture, food security, and employment are major social determinants of health needed among clients. In addition, gender, housing, healthy child development, and social support network are all important social determinants of health that when addressed among PWIDs would bring a great change in the predisposition to use, the use of, and the ability to stop using among PWIDs. Health care providers (HCPs) recommended that institutional policies (such as the way programs are designed and targeted towards mainstream Canadian) are very important and some of them need to change in order not to set IUDs/PWIDs up to fail, particularly because they consider our society to be a white dominated meritocratic society.

All participants in this study expressed that there is discrimination by some HCPs in acute care settings because of the pressure of work HCPs face, as well as the great needs of PWIDs who wait till they are acutely ill before accessing services. People who inject drugs (PWIDs) do not access services of general practitioners in a timely manner because they fear discrimination and stigma. This delay in accessing services leads to the overload at the emergency unit and increases the wait times. The PWIDs who go to emergency rooms for care, additionally may feel that long waits to be a form of discrimination against them. More HCPs of Indigenous descent are recommended, with appropriate pictures and posters depicting diversity in and around the city to educate the public. The HCPs believe that societal values of negativity toward PWIDs are carried over by HCPs and they affect their approach toward PWIDs greatly

(Figure 5.1: Major Areas of Findings used for the Synthesis of Interpretations).

Additionally, HCPs commented that women, particularly those of Indigenous ancestry who inject drugs, experience a situation of “multiple jeopardy” because of the complexities of their gender role expectations from family, HCPs, and the society. Nevertheless, the participants in this study claimed that they are more compassionate in their relational approaches toward Indigenous women who inject drugs because they are more acquainted with them and the circumstances that affect Indigenous women who inject drugs. According to the participants, negative approaches of HCPs toward Indigenous women who inject drugs, further lead to marginalization of the women. The participants perceived that Indigenous peoples, who are the majority of the PWIDs clients of the HCP participants in this study still experience the effects of generational trauma through colonialism and residential schooling.

The participants of this study emphasized the need to consider the issues of social determinants of health affecting PWIDs, by all relevant sectors of the government and society. Furthermore, HCPs commented on the need for more and continuous culturally competent training for HCPs, inclusion of more substance misuse training in the school curricula of health courses, and the employment of more staff in acute care units in order to reduce the pressure of work on staff due to the nature of work in such units. Additionally, two participants recommended that more HCPs of visible minority should be employed as they would be more able to provide health services to PWIDs of Indigenous ancestry from an experiential and holistic point of view.

The author’s observations of the participants’ attitudes and emotions during the interviews revealed the HCPs’ compassion, openness, empathy, and acceptance of PWIDs. For nine of the research interviews, the HCP sat in the seat their clients sat in (this was unplanned)

when they accessed care, while the researcher sat in the HCP's chair. The research interview process may have felt like a "role reversal" to the participants. The author believed the apparent "role reversal" further helped the participants to express their thoughts and feelings about PWIDs more from the PWIDs' angles of vision. The author noted that the HCPs expressed some frustration with PWIDs, when the participants spoke on topics such as: discussing sex with their women clients, particularly, those of Indigenous ancestry, inability of some PWIDs to grasp the importance of risks associated with IDU, and the topic of relapse. The researcher observed through the emotions and gestures of HCPs, how difficult it was sometimes for HCPs to discuss PWIDs' sexual habits and sexual health with many of their women and Indigenous clients/patients because it is not a topic they talked about culturally or in their upbringing. The author further observed participants' frustration (One HCP was tearful) on how pained they became after a client/patient who had been doing well on his/her healing journey relapsed mostly due to uncontrollable life circumstances such as: death in the family or homelessness. The expression of concern for PWIDs was prominent on the faces of HCPs during the interviews.

Chapter 5 Discussion

This chapter begins with a review of the study intentions (stated below). Thereafter, the interpretation of the major findings of the study are presented using an integrated framework for facilitating a HCP-PWID relational approach for holistic care and health access for PWIDs. The framework was developed in this study by integrating stigma/discrimination discourse, the philosophy of harm reduction, and the behavioural health utilization framework from the lens of the HCPs. The areas of discussion are: HCPs relational approaches with PWIDs, the contextual factors affecting PWIDs' drug use/access to care, and the integrated approach that leads to a holistic HR care recommended in this study.

The validation for the author's interpretations can be found in some of the following key publications such as: the studies of Gronholm, Henderson, Deb, and Thornicroft (2017), Gunn and Guarino (2016), and Lang et al. (2011, 2013). Other studies include: Carlberg–Racich (2016), Reimer Kim (1998), Sleeper and Boschain (2013), and van Boekel et al. (2013). All the studies indicated the implications of stigma on access to health care. Some literature in the analytical fore-structure section of this study are consistent with a few of the conclusions, while new literature was located to highlight new findings. In addition, the implications of these interpretations are discussed along with their implications for health care providers' (HCPs') practice. Recommendations for best practice among HCPs are subsequently enumerated along with the author's definition for HR.

5.1 Review of Rationale for the Study/Research Intentions

In this study, the author set out to explore and understand HCPs' relational approaches with PWIDs in the health region of study, examine issues/factors that influence HCPs' behaviors, and to understand the implications of their approach(es) with PWIDs' in order to,

together with participants, generate knowledge that could be clinically useful for HCPs' practice with PWIDs. Additionally, HCPs relational approaches with PWIDs affect the health care experiences and access of women, Indigenous women, and Indigenous peoples. An additional rationale for the study was to get a baseline of information from HCPs who cared predominantly for IUDs/PWIDs to understand if caring predominantly with PWIDs made a difference in how HCPs related with their clients.

The need for the study arose from the findings in empirical studies that pointed out that despite the health risks that PWIDs and IUDs face in addition to the public health implications of their actions, PWIDs poorly utilize or choose not to access health care services available to them because of their negative experiences, usually of stigma and discrimination from HCPs (AIVL, 2011; Lang et al., 2011, 2013; Simmonds & Coomber, 2009). Two of the studies mentioned above, Lang et al. (2011) and Lang et al. (2013) were conducted in a city in Saskatchewan. Findings from the two Lang et al. (2011, 2013) studies that stigma and discrimination among other factors contributed to barriers to accessing services by PWIDs in the city in Saskatchewan, additionally, contributed to the need for this present study.

This study took a different approach, by exploring relational approaches of HCPs toward PWIDs. Exploring the relational approach (es) of HCPs may be helpful in identifying areas of need and further helpful to generate knowledge for the improvement of HCPs' practice with PWIDs. In addition, HCPs approaches with PWID population that experience increased vulnerability such as women, Indigenous peoples, and Indigenous women were explored to help identify areas of need for improved HCPs' practice with this population and if there are needs.

5.2 Perspectives of Contextual Factors Influencing PWIDs' Drug Use and Utilization of Health Care Services

The perspectives of HCPs on the factors that influence PWIDs' use of drugs and access to health care/services reported in the findings section fall under three categories. The categories are: historical factors, social factors, and gender/sexual preference factors.

The historical factors of generational trauma (particularly the effects of colonialism and residential schooling), social determinants of health, and domestic violence are majorly reported by participants in this study as influencing factors for drug use and pattern of health care utilization among PWIDs of Indigenous ancestry. The effects of the legacy of colonization indeed contribute to the predisposing factors of domestic violence, physical, emotional, and sexual abuse among Indigenous peoples who are overrepresented among IUDs and PWIDs in Saskatchewan. One of the findings in this study was that Indigenous women who inject drugs had themselves, or had at least one parent or grandparent who had suffered from the effect of generational abuse and trauma of residential schooling. Indigenous women who inject drugs are additionally found to be heavily involved in sex trade. The study of Lemstra et al. (2012) conducted in Saskatoon, SK, Canada, validates these findings. The risk indicators that were associated with high rates of injection drug use among Indigenous populations compared to other cultural groups were determined in the Lemstra et al. (2012) study.

The Truth and Reconciliation Commission of Canada (TRC, 2015) made a call to action to the government of Canada at the federal, provincial/territorial, municipal, and local levels to redress the generational effect of residential schooling. In addition, the TRC called for the bridging of the gaps in social, health, and economic areas that exist between the Indigenous and non-Indigenous peoples of Canada (TRC, 2015). The call for a redress and action were mainly in

the areas of child welfare, education, and health for Indigenous peoples. Additional areas for redress were: justice, language, and culture. The healing and reconciliation are happening and a new healing pathway is underway to bring about an inclusive society (TRC, 2015). From the findings in this study, the distinct health needs of Indigenous peoples, particularly, those on the reserves in Saskatchewan are additionally in dire need of redress by all levels of government. The comments from participants in this study buttressed the findings in the literature that the infection rates of HIV are not only thrice as high as that of the Canadian national average (14.6 in 100,000 compared to 5.8 in 100,000), but that HIV rates on some reserves in Saskatchewan are higher (up to 3.5% of the population) than those in some developing countries (CBC News Saskatchewan, 2015; Canadian Press, 2017; Government of Saskatchewan, 2015; Health Canada, 2012, 2014; PHAC, 2012). In addition, Indigenous peoples make up 10% of Saskatchewan population (Statistics Canada, 2016). The above reasons stress the need for health administrators and policies nationally, provincially, and locally to continually prioritize and address all economical, educational, health, and social issues affecting PWIDs in Saskatchewan.

According to the participants in this study, a wrap-around of numerous social factors influence the predisposing factors to IDU, pattern of drug use, access to care/services, and the ultimate health outcome of all (Indigenous and non-Indigenous) PWIDs. Additionally, the participants constantly referred to the social factors as the social determinants of health and the degree to which they are interwoven affect the PWIDs that they provide health services and care for. The social determinants of health constantly referred to by participants include: income/poverty, Indigeneity, gender, age, and the civic status of being in conflict with the law. The findings in this study further revealed that knowledge of the impact of social determinants of health on PWIDs greatly influence HCPs relational approach(es) with PWIDs. Positive relational

approaches of HCPs toward PWIDs occur when HCPs understand the specific social factors that exist in the lives and situation of each PWID client that they provide health services and care to. Addressing social needs such as housing, education, and employment are important in providing health care and services to PWIDs. Additional social determinants of health that are common among PWIDs include: food security, social inclusion, and social network. Gender and sexual preference, which, additionally fall under the social determinants of health as predisposing factor for IDU and an influencing factor for PWIDs' pattern of drug use or health access, is further discussed later on in this chapter.

5.3 Interpretations of HCPs' Approaches with PWIDs

An in-depth interpretation of the findings in the study revealed that the relational approaches of HCPs with PWIDs were mainly influenced by HCPs' beliefs and life experiences; knowledge and education; and cultural awareness. The relational approaches of HCPs toward PWIDs reflected their support for the harm reduction (HR) policy. Health care providers (HCPs) in this study expressed that they strive to meet clients "where they are at", prioritize the safety of their clients, and are non-judgmental toward them. Furthermore, the HCPs stated that they work towards earning the trust of PWIDs through validation and encouragement. The HCPs are particularly interested in seeing their clients succeed. The main foci of the interpretations revolve around the non-judgmental attitude of HCPs' by striving to meet PWIDs "where they are at" and their support of the HR policy as a whole. Additionally, HCPs' personal knowledge (through education and work experience) and knowledge about their clients' and their health issues are areas of focus in this section. Conclusions that have implications for practice are drawn.

5.3.1 Non-judgmental approach. Health care providers (HCPs) in this study expressed that they were non-judgmental toward their clients, unlike the judgmental, discriminatory, and

neutral findings reported in many other studies. Some empirical studies revealed that provider-based stigma occurs among HCPs toward IUDs/PWIDs (AIVL, 2011; Carrol, 1995; Gronholm et al., 2017; Gunn & Guarino, 2016; Lang et al., 2011; Lang et al., 2013; Sleeper & Boschain, 2013; van Boekel et al., 2013). Alternatively, Chu and Galang (2013) in Toronto, ON, Canada, found results that were contrary to the existing literature on discrimination among HCPs. The hospital nurses in Chu and Galang's (2013) study had neutral attitudes towards patients who had a history of illicit drug use in the general internal medicine unit; although they found that the nurses had low motivation and role support in caring for their patients.

Health care providers (HCPs) in this study expressed that discriminatory attitudes occur among some other HCPs due to difficult behaviors that PWIDs exhibit and sometimes because the clients basically have a history of drug misuse or are currently using and/or injecting drugs. Lang et al. (2013) however, found that HCPs discriminate against PWIDs because they are sometimes disappointed at PWIDs' behaviors (e.g., anger, violence, and carelessness with their health) and not necessarily because they inject drugs or have a history of it. Furthermore, PWIDs mentioned that some HCPs discriminate against individuals with blood borne diseases such as hepatitis C, HIV and those with a co-morbidity of drug use and mental illness found among PWIDs. This finding is consistent with those expressed by the service providers in the study of Lang et al. (2013) in Saskatoon, SK, Canada in which HCPs experiences with PWIDs' access to care were explored. Evident from the findings of previous studies and the present one is that, some PWIDs in some health regions in Saskatchewan do not merely perceive stigma and discrimination from HCPs, they truly experience stigma (discrimination and stigma from HCPs toward PWIDs is thereby real in the region of study particularly).

The interpretation for the reality of stigma and discrimination in Saskatchewan is that it is important to address the issue of discrimination and stigma among HCPs, particularly among those who do not work predominantly with PWIDs and those who work in acute care settings. Addressing the issue of stigma/discrimination is necessary in order to increase rate and positively change the pattern of access to care by PWIDs. Many of the HCPs in this study had worked either as nurses, sociologists, or social workers in other settings, organizations and/or departments before their respective present positions. The HCPs in the study had work experience that ranged between four months to over twenty years. Many of the HCPs admitted to discriminating against or stigmatizing their clients in the past, in their various departments or positions. Why they no longer discriminate against or stigmatize their clients is interpreted below. From the findings in this study the reasons extrapolated for the non-judgmental/non-discriminatory approaches of the HCPs were tagged on a number of interwoven factors later discussed.

5.3.1.1 Working predominantly with/increased proximity with PWID clients. From the findings of this study, stigma and discrimination are perceived to occur the most among HCPs who do not care predominantly or do not work in close proximity with PWIDs in the health region of study. Health care providers (HCPs) in the present study had previously worked with either a totally different population, or a combination of populations that included PWIDs/IUDs e.g., the acute care/emergency departments. Working exclusively with a particular population helps to increase proximity, contact, and increases knowledge about the population (Gronholm et al., 2017). Increased proximity has been found to reduce anxiety, fear, and stigma toward individuals with mental illness [including substance abuse problems] (Gronholm et al., 2017). Health care providers (HCPs) in this study have increased proximity and greater exposure to

PWIDs than HCPs in other departments like acute care. Increased exposure and proximity to their clients are believed to have contributed to more positive attitudes that they claimed to have toward PWIDs.

Health care provider (HCP) participants, particularly those in one of the two units where HCPs were interviewed are very conversant with working with many of their patients who have HIV. The HCPs do have positive attitudes toward their patients, which additionally may have been influenced by working in close proximity with the population on a daily basis. Familiarity increased their positive attitudes toward their patients, who represent individuals living with blood borne diseases such as HIV, hepatitis C, and infectious diseases. Findings about familiarity through proximity are consistent with the findings in the study of Carrol (1993) in the United Kingdom in which the attitudes of professionals toward drug users differed because of their differing roles, socialization, and the type and nature of their contact with them. Familiarity with drug users, especially those with HIV infection, is partially associated with positive attitudes among HCPs who work in close proximity with them.

Working exclusively with PWIDs helped the HCP participants in this study to focus more on their clients' problems. The HCPs had the opportunity to work with the same clients for as long as the clients wished and as long as they kept coming. Unlike in acute care settings (as discussed in the previous chapter on findings), participants in this study did not work under pressure with clients/patients with diverse challenges of varied degree of intensity, physical crisis, and physical concerns, rather, they had the opportunity to focus their practice on their clients and their problems in a less chaotic situation, which increased their knowledge of their client population (PWIDs /IUDs).

5.3.1.2 Knowledge/education. From the findings of this study, stigma and discrimination from HCPs toward PWIDs occur less among PWIDs who are very knowledgeable about the health and social issues of PWIDs. The knowledge of the HCPs about PWIDs may have accounted for the non-judgmental attitude from HCPs toward their clients. The knowledge of HCPs in this study was mostly acquired from their background of formal education (all of them had at least a bachelors' degree in their area of specialization), precarious learning, life, and work experiences. Although most participants complained of a lack of enough substance abuse content in their formal education or training, they were still able to gain knowledge about the PWID population through organized workshops (e.g., through existing PWID partnership organizations), work, and life experiences. Similar results were found in the studies of Graham, Julian, and Meadows (2010) and Patterson, Whittington, and Bogg (2007) that revealed that knowledge about mental health patients improves attitudes and stimulates helping behaviors among HCPs.

Additionally, it is important for service providers to be knowledgeable about where to refer their clients. Health care providers (HCPs) in this study sounded very informed about where to refer/send their clients depending on the need of PWIDs. In the study conducted among PWIDs in Saskatoon, Sk, Canada, Lang et al. (2011) revealed that PWIDs reported that their HCPS were not knowledgeable on where to send their clients for services available in the community. The HCPs in this study identified many important points about how to structurally address the best care needed for their clients. The points of the HCPs raised the need to be listened to, supported, and emulated so that care is provided in a culturally competent, safe, and humble manner in other practice sites as well.

5.3.1.3 Job satisfaction. Another interpreted reason for non-judgmental approach of HCPs in this study can be attributed to HCPs' job satisfaction. All participants expressed joy at the job they had. They felt privileged to be in the position to help others. One of the HCPs interviewed was tearful at the thought of how privileged she was to be working with this population and how grateful she was for all the opportunities she had. This further explains why HCPs in this study were very dedicated and showed empathy toward their clients. During the research interviews, it was notable that HCPs genuinely desired to see their clients succeed.

5.3.1.4 Anti-stigma strategies. In the literature, anti-stigma strategies have been categorized into three areas: education (where myths are replaced with accurate knowledge), contact (believing that direct and indirect interaction reduce prejudice), and protests (Corrigan et al., 2001). Education and contacts have been most commonly used (Gronholm et al., 2017). Henderson et al. (2014) reviewed stigma reduction, in relation to specific mental health conditions such as substance misuse. Most of the interventions were educational. Attitudes of HCPs were found to have improved with education. Additionally, some studies revealed improved knowledge, behavioral intentions, and/or clinical competence (Gronholm et al., 2017) with education. Within Canada's *Opening Minds* anti-stigma 10-year program by MHCC initiated in 2009, face-to-face stigma reduction training for HCPs was conducted (Gronholm et al., 2017). The *Opening Minds* training identified the key ingredients associated with attitude change. The two major findings were the multiple forms of contact (which is the case among HCPs in this present study) and an emphasis on recovery (Knaak, Modgil, & Patten, 2014).

In Saskatchewan, an educational approach of reducing stigma may be used among HCPs in all departments, particularly acute care settings (mentioned by all the participants as an area that for which more concern is expressed about discrimination). Some HCPs confessed how they

too had the same behaviors and attitudes toward PWIDs while they practiced in acute care settings as it was more the pressures of the workplaces, than actual stigma or discrimination. Reducing stigma among specific groups can theoretically advance life opportunities for individuals (Corrigan, 2004; Thornicroft, 2006).

5.3.2 Meet clients where they are at. As a reminder, the approach to HR adopted by the SHR is rooted in accepting the person, by “meeting them where they at”, being non-judgmental empowering them to make informed choices and to strive to reduce the health and social harms associated with the behavior by neither condemning or condoning risk behaviors (de Bruin et al., 2008). All HCPs in this study mentioned “meeting clients where they are at” as an approach they employ in working with their PWID/IUD clients. In the study, it became evident that this approach is not only employed by HCPs because it is a policy mandate guiding their practice within the organization/unit, but because HCPs believe in the approach themselves personally and genuinely as they additionally desire to reduce PWIDs’ sufferings. To HCP participants, “meeting clients where they are at” further reflects their desire to see their clients succeed by consciously making the effort to come to their level of needs, trying to “speak their language”, and showing empathy to them irrespective of where they were on the addictions spectrum. The approach of “meeting clients where they are at” ultimately gives PWIDs the confidence to be forth coming with information with their HCPs and establish a good rapport. People who inject drugs (PWIDs) willingly and confidently agree to be tested for blood borne diseases when they are encouraged by their HCP to do so. In addition, this makes contact tracing for blood borne diseases a little easier, as the clients are more forth coming with information.

In making conscious efforts to “meet the clients where they are at”, HCPs show more empathy toward their clients. Health care providers (HCPs) understand their issues more. Most

importantly HCPs reveal their belief in the HR policy; they do not promote abstinence. Health care providers (HCPs) believe in little steps taken at a time and they celebrate every little accomplishment of PWIDs/IUDs in their journey to recovery. Acceptance is key when HCPs strive to “meet clients where they are at”. Health care providers (HCPs) in the study who work directly with PWIDs/IUDs are sincere, open, and encourage them to succeed. Acceptance of PWIDs by HCPs is apparently missing among some other HCPs in other departments/units who may inadvertently discriminate against or stigmatize against PWIDs. For example, when clients need pain medication and HCPs believe they are “drug- seeking”. The beliefs and attitudes of HCPs in this study about HR is expressed in their practice as they exhibit “meeting clients where they are at” and making safety paramount in their practice with PWIDs.

5.3.3 Safety of clients is paramount. Keeping PWIDs safe is part of the mandate of the HR policy that guides the work of HCPs in the region of study. Additionally, in one of the two units that participated in this study, HCPs help patients who are living with HIV or other blood borne diseases to have a positive life style and be safe. Clients are generally encouraged to get tested in order to maintain a safe lifestyle of not sharing needles, not having multiple partners, and to have safe sex.

The positive relational approaches found in this study are discussed from the viewpoints of increased access and good trusting relationship between HCPs and PWIDs. The positive approaches are found predominantly among HCPs who provide services and care for PWIDs and who work predominantly with PWIDs in the community and hospital setting where the work pressure is reduced and the environment is less chaotic. This finding is consistent with the findings in the study of Johnson et al. (2006). Seeing less patients per week was associated with HCPs positive attitude toward PWIDs (Johnson et al., 2006). In addition, Johnson et al. (2006)

revealed in their study on provider interactions among HIV infected patients that when it is ensured that physicians have adequate time to deal with complex issues of their patients, the result might be better attitude and better quality of care.

5.4 Contextual Factors for the Implications of HCPs Positive and Negative Approaches of Providing Services to PWIDs

Participants of this study understood fully that the way they provided services influenced their PWID clients in many positive ways. As reported in the findings section, HCPs who participated in this study emphasized that they provide services to their clients in respectful, empathetic, and non-judgmental ways. Health care providers claimed that they have knowledge about, and understand the major problems faced by PWIDs, which largely accounts for the positive ways they provide services to them. Health care providers (HCPs) believe their clients keep coming back to access services for years because of this. They believe their clients open up sincerely to them and do not fear losing their privileges with social services; privileges such as: money, housing or housing benefits and their children, when they access their services. Some of the HCPs in this study have worked in the unit/department for many years building relationships with the clients, which result in the clients' requesting to see them whenever they come in. The clients feel free with HCPs to ask them for snacks or other supplies (provided by the unit) from HCPs when they need them. People who inject drugs (PWIDs) additionally access the outreach vans faithfully and ask for special arrangements for where to meet in order to avoid being ridiculed by the public or labeled in their neighborhoods.

Blood testing and contact tracing are additionally carried out in a respectful manner as part of the HR program. Clients are encouraged to be tested on the outreach van or at the clinic. Results of the testing are delivered to them privately and respectfully in the consulting rooms or

sometimes in the outreach van. A lot of helpful information are subsequently given in addition to helping their clients to call for needed information or book appointments. The clients are sometimes driven to their appointments if needed. Health care providers (HCPs) further mentioned that some of their Indigenous clients prefer to access services in a particular unit because there is a higher tendency to be seen by relatives or friends at another organization in the city run by an Indigenous organization, and they prefer the anonymity. Some PWIDs thereby view programs besides those run by Indigenous organizations, as a “safe haven”.

Health care providers (HCPs) establish a good and respectable rapport with their clients in order to achieve positive health outcomes. This good rapport can be seen in the way the HCP participants (in a unit) in this study all chose to donate and contribute the honoraria they received from participating in this study to buying gifts and supplies for their clients at Christmas. The caring and respectable rapport keeps PWIDs coming to access services, which helps them to receive appropriate health care in a timely manner that is paramount for positive health outcome. Proximity with clients is associated with positive attitude toward PWIDs (Johnson et al., 2006).

Health care planners need to take into consideration the suggestions of HCPs that included the need to provide services on the weekends. Health care providers (HCPs) participants were concerned with the opening hours of services targeted at PWIDs in the community. They voiced the need to provide services on weekends and to extend hours of services beyond 11p.m during the week (Monday to Friday). Additionally, HCPs would like to see needle exchange programs extended to other parts of the city. Findings in this study revealed that negative HCP-PWID relational approaches lead to less than optimal care for PWIDs. This is consistent with a conclusion drawn in the study of Johnson et al. (2006) that found that positive

provider interactions foster adherence to self-efficacy that is associated with greater adherence to medications.

5.5 Implications of HCP Approaches on PWIDs of Indigenous Ancestry, Indigenous Women, and Women in General

Clearly indicated in the findings of this study is that HCP relational approaches affect individuals and specific populations differently. Interpretations of HCPs relational approaches toward PWIDs toward diverse populations are presented in this section.

5.5.1 Indigenous ancestry. Individuals of Indigenous ancestry experience differential treatment from their service providers when compared with their mainstream Canadian counterparts (Lang et al., 2011, 2013). People who inject drugs (PWIDs) of Indigenous ancestry should utilize health care services provided for them in a timely manner because Indigenous PWIDs are becoming HIV positive at twice the rate of non-Indigenous PWIDs (Government of Saskatchewan, 2013).

Health care providers (HCP) should not hinder PWIDs in any way through their client-patient relationship (CBC News Saskatoon, 2016; Craib et al., 2003). Additionally, there is an alarmingly high incidence (highest in Canada) of HIV/AIDS in Saskatchewan and Indigenous peoples are overrepresented in this group (CBC News Saskatoon, 2016; Government of Saskatchewan, 2015; Plamondon et al., 2007). The rate of HIV infection among the Indigenous peoples has recently gone up to an alarming level and injection drug use is the predominant precipitating factor (CBC News Saskatoon, 2016). The infection rate noted is comparable to countries in the developing world as mentioned earlier (CBC News Saskatoon, 2016).

In order to reduce the stigma of HIV predominantly caused by IDU among Indigenous peoples, a film has been produced in Saskatchewan, titled "*Promising Practices in Indigenous*

Communities in Saskatchewan” (CBC News Saskatchewan, 2016). The film shares the personal stories of individuals living with HIV. Through this film, it is hoped that the fears of individuals living with HIV, the community and Indigenous people will be allayed. The intended audience of this film is for Indigenous PWIDs and for education of the public. This film will encourage people to get tested and assist in erasing the stigma attached to this health condition and will help to inform and educate the public. Hopefully through the film, Indigenous peoples will live healthy lives and be the strength of their communities. Furthermore, it is hoped that community members will stop ostracizing diagnosed individuals from family and community. Human immune deficiency syndrome (HIV) should not be fear based (Carlberg–Racich, 2016). The film shows the stories of how people are addressing HIV through culture and tradition. The stories are positive stories of hope (CBC News Saskatchewan, 2016).

The approach of using a film to correct peoples’ views about HIV and educate the public is highly invaluable. The use of cultural films that show personal case stories can further be used by governments and communities to enlighten the minds of individuals’, including HCPs’, of their myths, fears and stigma about PWIDs, substance misuse, and/or injection drug use especially in Indigenous communities. As previously mentioned in the literature section, the Indigenous peoples, particularly women, are being empowered through videos and workshops to help Indigenous women to reclaim or claim their lives through having a healthy self-identity as Indigenous women (CIHR, 2013; Dell, 2012).

The level of self-esteem, self-identity, education, and awareness of Indigenous PWIDs need to be raised in order to address all social and health issues that may be affecting Indigenous PWIDs. The raise in awareness and education for PWIDs may be done through educational films, training workshop, community research, and the inclusion of culture and tradition in the

programs of the health system thereby providing a holistic approach to health for Indigenous peoples. In summary, from the perspective of the HCP participants in this study and what their clients told them, some Indigenous peoples perceive prejudice from HCPs whose relational approaches are/or seem to be negative. Trust building between HCPs and PWIDs is very important.

5.5.2 Indigenous women. Health care provider (HCP) participants in this study understood that being a woman, a person who used drugs, and being a person of Indigenous ancestry is a situation of triple jeopardy. The society and some service providers usually view women of Indigenous ancestry, who use/inject drugs, in a negative way. However, HCPs participants claimed that they are very compassionate toward Indigenous women because they understand their plights and issues. Health care providers (HCPs) see the struggles and desires of PWIDs to be good, particularly, when they desperately want to regain custody of their children (who have been forcefully taken away by social services because of their drug history). In addition, HCP participants encourage Indigenous women to have a voice and speak out for themselves, because they understand the plights and issues of Indigenous women.

Poor treatment of Indigenous women by some HCPs who do not work exclusively with PWIDs, can be attributed to many reasons. Some of the reasons are the lack of understanding of Indigenous women's culture and their cultural norms. Health care providers (HCPs) who do not understand the culture of Indigenous peoples may become frustrated working with some Indigenous women, particularly those who live on the reserve. The reason may be because many Indigenous women may not be comfortable talking about their sexual life, sexual habits, and sexual partners, which, are important information necessary for service providers to know in order to provide appropriate services to Indigenous PWIDs, individuals and their society at large.

One of the participants (P10–5) in this study mentioned that mainstream population of Canadians see eye contact as a sign of honesty, while maximum eye contact for Indigenous peoples is considered to be a sign of disrespect.

Another sign that HCPs in the study understand their PWID client issues is seen in their acceptance of their women clients for who they are. The HCP participants do not deal with them by referring to or judging them for their past behaviors, e.g., their sex life, commercial sex work, or history of incarceration. The genuine concern of the HCPs is particularly seen in gender effect and health care services as reported in the section on findings.

Health care providers (HCPs) need to be aware of their extremely important role in providing services to Indigenous women. The role of the HCP is very important in Indigenous women's healing journey. Health care providers HCPs in this study show that they understand the women's issues, show empathy, acceptance, care for them and have open communication with them. This is consistent with the findings of a Saskatoon community based collaborative research by Dell et al. (2010). Their research findings suggested some skills and traits that service providers should have in order to help Indigenous women in their illicit drug treatment journey, particularly women who have been criminalized. Some of the recommended skills are: empathy, acceptance, and openness. In addition, service providers should have good communication, be inspirational, and support women in their link to spirituality (Dell et al., 2010). The service providers additionally need to assist Indigenous women in acknowledging the past and moving forward for a better future. In SHR, the HCPs working with women on their healing journey of illicit drug use need to possess (non- stigmatizing, empathetic, open, and good communication skills, etc.) revealed in this study by all HCP's, and support women in their link to spirituality. Spirituality may be most important in the healing journey of an Indigenous

woman who is symbolized to be similar to that of mother earth. What Dell and colleagues (2010) found in their study would work the same in Saskatchewan because of the high number of Indigenous women who inject drugs. More Indigenous HCPs, particularly women, need to be employed by the health region of study, to provide services to PWIDs. Indigenous female HCPs would further serve as role models that women on their healing journey from substance abuse would identify with.

5.5.3 Women. Women in general who inject drugs are viewed with compassion (similar to the ways Indigenous women who do the same are viewed) by HCPs who participated in this study. The compassionate view stems from their knowledge about the general situations and conditions that lead women to using drugs, as identified by the HCPs. Health care providers (HCPs) pay extra attention to the safety of the female clients because of their multiple vulnerabilities. The safety of women is paramount because they experience fear of physical harm and are additionally emotionally fearful. The fear of physical harm from their environment, mainly including domestic abuse from partners who force them into using drugs in the first place, and the fear of having more tendency than men to be criminalized. Women who use drugs' emotional fears tend to occur from when they fear to be pregnant (their emotional fears of pregnancy), losing their children to social services, and probable inability to be a good mother. Women of childbearing age have the tendency to suffer more because of their emotional and physical concerns for their children. These women do not want their drug habits to have negative effects such as: health problems on their children. Additionally, they do not want their children to ever use drugs like them. Women whose partners use drugs are at greater risk of contracting HIV infection than women whose husbands do not use drugs (Plamondon et al., 2007).

Health care providers' (HCPs') positive relational approaches are very helpful for the self-image and self-esteem of women who use drugs. Positive attitudes of HCPs aid quick recovery and improve the self-image of the women. In addition, women who use and/or inject drugs have the confidence to seek help unashamedly and not fearfully in a non-judgmental environment. This is a positive thing as it ultimately helps to reduce injection drug use problems and all the associated harm among women. There will be more reported pregnancies. When HCPs gain a more complete understanding of women who use and/or inject drugs, they (HCPs) can more effectively address the needs of pregnant drug-dependent women and their families. Additionally, it is important for HCPs, policy makers, and the society, to address all the safety needs identified in all women, particularly, women of childbearing age. The safety risks can be addressed by offering risk reduction behavior change interventions, which should be offered routinely in primary health care clinics among high-risk clients/patients (Kelly et al., 1994).

5.5.4 Implications of present care and service approaches on practice and PWIDs.

The findings of this study have implications for practice on the different groups in the study. The contextual implications for practice of HCPs and the implications for PWIDs are discussed in this section.

5.5.4.1 Implication on practice. The implication of these findings on practice is to continue with what presently works. Structurally, the environment is conducive for clients to access. Employing the right person for the job has proven effective to a large extent. There is however the need to include substance abuse content in the degree programs relevant for HCPs working with PWIDs'/IUDs' job positions, such as the nursing, psychology, social work, medical, pharmacy, and sociology programs. Further training on stigma, cultural humility, and

more, on the job are considered to be highly invaluable and are additionally considered to be helpful at sustaining change (Graham et al., 2010; Johnson et al., 2006; Patterson et al., 2007).

5.5.4.2 Implication on PWID clients. In describing their clients, HCPs in this study mentioned that a large number of their clients do not have higher education. In addition, unemployment rate is high among them. The impact of experienced and anticipated stigma lead to exclusion from higher education and employment (Lee et al., 2009; Suhrcke & de Paz Nieves, 2011). Assumedly, PWIDs have experienced discrimination through the organizational system, the public, and from some other departments, before they got to access the services of the work units of participants in this study. Although the HCPs do not discriminate against them (PWIDs), the PWIDs/IUDs already feel discrimination by what they have experienced in the past e.g., from the public. The clients already carry with them feelings (from past) and anticipated stigma. This finding is consistent with the findings in the studies of Clement et al. (2015) and Corrigan, Druss, and Perlick (2014) that showed that public, implicit, and structural stigma have adverse effect on seeking care by mental health patients and other clients. The impact of experience or anticipated experience, or a combination of the two, is severe poor access to mental health and physical healthcare (Clement et al., 2015).

Poor access to healthcare services ultimately leads to reduced life expectancy and exclusion from higher education and employment (Lee et al., 2009; Suhrcke & de Paz Nieves, 2011). Stigma constitutes a significant public health concern (Link & Phelan, 2006; Thornicroft, Evans-Lacko, & Henderson, 2014). Even though some HCPs do not discriminate or stigmatize their clients, present in society is the action-oriented view kind of stigma, such as: public stigma and self-stigma [Internalized by merely belonging to a group of internalized people] (Gronholm

et al., 2017). All recommendations for HCPs in the next section of this study are geared toward optimal access to health care for PWIDs.

5.6 Opportunities for an Improved Relational Approach in Engaging PWIDs

Some major recommendations that evolved from the new knowledge gained in this study, about how HCPs relate to PWIDs, are mainly for health care administrators and HCPs. The recommendations put forward are geared at enhancing and improving HCPs practice with PWIDs. Health care administrators are encouraged to provide increased and additional training for staff (HCPs) and reduce negative behaviors (if any) of HCPs toward PWIDs by addressing the issue of stigma and discrimination. Role modelling has power to be the effective at producing change in the work environment. Health care providers are admonished to continue to adhere to HR policy mandate that will continue to place emphasis on the safety of clients and a continuum of care for them. Furthermore, it is recommended that health care administrators and HCPs can together make continued and conscious efforts to address issues of specific populations exclusively.

5.6.1 Training for HCPs. Evident in the findings of this study is that HCPs who work predominantly with PWIDs are not likely to discriminate against or stigmatize their PWID clients. Could one or many departmental trainings in the department have contributed to this non-discriminatory attitude? If the content of the departmental training is closely examined and found helpful, then such departmental trainings should be continued. Participants had mentioned that there had been a few training opportunities for them that they had enjoyed in the past, but not anymore. Many of the current staff have received training in the areas of substance abuse and working with mental health clients. Probably, the culture of the department learned by new staff

that has role modeled good relational approaches and energy. The good departmental culture can be enhanced with improved training for front line staff.

In addition to the present efforts of training to help HCPs in the areas of cultural competence, cultural safety, and cultural humility that exist for staff, HCPs, particularly those who are new members would benefit from training in the areas of culture. Regular and continuous workshops on training on stigma and discrimination should be conducted by the health region. The workshops could be led by trained staff or preferably by contractors from non-government organizations. The training/workshop can additionally be conducted by the HCPs who work directly with PWIDs. These workshops would engage HCPs in recognizing and addressing the problems and implications of stigma and discrimination. Additionally, these professional workshops/trainings should aim to help HCPs at improving and achieving these three areas of desirable qualities recommended by PWIDs in the studies of Lang et al. (2011) and Neale and Kennedy (2002). From past studies, the desirable characteristics of HCPs are: being lenient, friendly and knowledgeable (Lang et al., 2011; Neale & Kennedy, 2002). Training on cultural competence practice would be of great value and can be through knowing the culture, recognizing the role of traditional healers, providing culturally appropriate literature and posters. Interpreters additionally need to be provided if and when needed. Health care administrators and managers in charge should give readily available support to staff and provide assistance in integrating the knowledge HCPs gain into practice. The support of the health care administrators contributes to making HCPs practice a success. Education by HCPs who work with PWIDs on a daily basis would be valuable.

5.6.2 Address stigma and discrimination. More concerted efforts at addressing the issue of stigma and discrimination will be helpful at reducing negative HCP–PWID relationship

the health region of study. These efforts need to be enhanced among staff who do not work predominantly with or on a regular basis with PWIDs, particularly, those in acute care.

Addressing the issue of stigma can increase clients' access to services. Additionally, life opportunities and better health outcomes can be advanced when stigma is eradicated. Provider-based stigma experienced by PWIDs from over the years, are carried over even when PWIDs meet HCPs who show them empathy and little or no discrimination/stigma. Addressing the issue of stigma is carried out in different forms in the health region and has been included as a major part of the Saskatchewan HIV strategy.

By addressing stigma (through training and awareness), there will ultimately be an increased access to testing, early treatment, and addressing of co-morbidities and social determinants of health. Delivery and intervention to reduce discrimination and stigma would work better if led by advocacy groups or mental health charities as found in Schulze (2007) study, rather than by HCPs who are usually seen as a source of stigmatization. Nevertheless, if anti-stigma strategies can be led by HCPs using education and contact, they should preferably be held by HCPs because irrespective of how HCPs feel they treat their clients, they still carry around with them some self-stigma, public stigma, structural stigma and courtesy [acquired by belonging to the group of IUDs] (Knaak et al., 2014). Additionally, educational programs in the applied health/social sciences would benefit immensely from trainings that include role plays and videos of practical scenarios that are encountered in reality on the job and sometimes on a daily basis. Practical educational trainings, such as that on “relational inquiry” (Doane & Varcoe, 2015), would help to bridge the gap between what is learnt theoretically and what obtains in reality.

5.6.3 Informal peer monitoring. A form of informal peer monitoring can be helpful in the health region of study in obtaining and maintaining a positive departmental work culture, which, is apparently lacking and needs to be maintained in most departments. Peer watch could be used as a mechanism to informally measure discrimination of HCPs toward PWIDs. The level of ethical behavior in a department is difficult to legislate at times but it is recommended for an even more improved work environment and approaches of HCPs toward their clients. The departmental culture often influences new staff who usually adopt the culture and norms of the department as part of their attempt to fit in and be accepted by colleagues. Padgett (2013) acknowledged in his study among staff nurses in an urban teaching hospital in the United States, that, safety of patients and professionalism rely on colleagues holding each other accountable for quality care. Additionally, dependence of staff on mutual assistance in the absence of a system of group practice, leads to “mutual deference”, a strategy in which there is reciprocal tolerance and non-interference which enhances discretion on decisions of each nurse about care (Padgett, 2013).

5.6.4 Continuum of care. The continuum of care approach utilized among the partnership organizations who have come together in the health region, has been found to be working well in a region in Saskatchewan. Intensifying the continuum of care would be beneficial to HCPs and PWIDs. In addition, referrals of PWIDs to organizations should be simplified, so much so that PWIDs would not have to fear to access services of other departments. Health Care Providers (HCPs) need to consciously show empathy to their clients in addition to working hard at meeting PWIDs where they are at. Special information sessions or training to familiarize HCPs who do not work with predominantly PWID clients (especially those in acute care) will be invaluable. Such training will help to familiarize HCPs with PWIDs’

needs and issues. Although participants in this study attested to having had such training in the past, if it is no longer offered, this training needs to be revived.

Furthermore, is the importance that HCPs know how to help their PWID clients in addressing any issues that may ultimately determine their overall health. Laying emphasis on addressing the social determinants of health is very important for HCPs and policy makers. Additionally, it is important for all, particularly, policy makers, to understand social determinants not only from the biomedical and behavioural risk factors' perspectives that had prevailed over the years, but additionally from the perspective of societal conditions (Raphael, 2016). The societal conditions of determinants of health are based on the quality and the quantity of economic and social resources that are available and accessible to the members of the society (Raphael, 2016). Some of such economic and social resources include childhood conditions, income, availability and quantity of education, and food. Other such resources are: housing, employment, working conditions, health and social services (Raphael, 2016). The author of this study agrees with Raphael (2016) that the concerted need for government and social policies to focus on improving societal living conditions remains vital for the health of the society. Concerted efforts that shape policy from economic, political, and social perspectives should be made to improve living conditions. There needs to be a shift from targeting the victims of adverse living conditions (such as some PWIDs) for behaviour change, to focusing on improving the primary determinants of health by economic, political, and social policies (Raphael, 2016). In the study of Lang et. al. (2013), PWIDs expressed their desire for their HCPs to be very well informed about what options are available in the community and know exactly in what direction they need to point their clients to help them the best.

The present health care practice with PWIDs and IDUs in the health region where the study was conducted, leans heavily on the traditional medicine approach, nevertheless, cultural competent practice would be invaluable at helping the majority of PWIDS who are of Indigenous ancestry. A majority of participants recommended opening a safe injection site in Saskatoon, which is consistent with what PWIDs suggested in the study of Lang et al. (2011) and was being considered in Saskatchewan (Prince Albert, Saskatoon, and Regina), but has been shut down by public opinion (Cowan, 2017). A simulated safe injection site (SIS) was set up outside the city hall in Regina, Canada for a day to promote awareness about SIS in the Saskatchewan (CBC News Saskatchewan, 2017b; Cowan, 2017). The study participants believe safe injection sites, in addition to reducing drug overdose deaths, will reduce stigma toward PWIDs from the community, HCPs who are not knowledgeable about substance abuse issues, and the health system as a whole. This model intervention is believed to have greatly worked and considered effective in Vancouver, Canada (Cowan, 2017). Since the inception of SIS in Vancouver in 2003, there have been 6,400 overdose interventions, no one has ever died of an overdose and there is a continual prevention of death at the site (Hutchinson, 2017). However, there is a struggle with the rise in Fentanyl at this Canada's first injection site (Hutchinson, 2017). Three SIS are set to take off in Toronto, Canada, in the fall 2018, and the first in the United States, in San Francisco in the summer of 2018 (Rasmus & Fernandez, 2018).

Additionally, HCPs should continue to adhere to the mandate of the HR policy, which is the mandate that governs the practice of HCPs in SHR. Furthermore, it is impressive to know that the HCPs in this study are overwhelmingly supportive of this mandate, which in addition, tend to ironically align with their personal beliefs. Public health officials in Vancouver are focusing on better addiction treatment systems with adequate follow-up, prevention of mental

illness, and increased attention to addiction risk factors such as: trauma from childhood, poverty, and homelessness (Hutchinson, 2017). In Saskatchewan, there is a focus on the naloxone (opiod antidote) program, to address the fentanyl death increase in the province, by increasing access to naloxone and providing training on response to overdose to family and friends of IUDs (Cowan, 2017). Naloxone kits are free for individuals who declare to be opiod users, and to First Nations peoples through the federal First Nations health benefits program (CBC News Saskatoon, 2018). Other people can buy Naloxone kit from the pharmacy for approximately \$50 for the injection, and \$100 for the nasal spray by other people (CBC News Saskatoon, 2018).

5.6.5 Employ more Indigenous staff. When HCPs know their clients and the issues affecting them well, their practice approaches with them will be more appropriate. They will understand that most of their PWID clients initially start using drugs to reduce pain before they became addicted to drug use. Most of the time PWIDs are not drug seeking and it is important for HCPs to know this. Employing more Indigenous HCPs (as recommended by many reports in the past, such as: Royal Commission on Aboriginal Peoples [RCAP], 1996, MHCC, 2012, and Romanow Report, 2002) will enhance HCPs' practice, particularly when working with Indigenous peoples. Indigenous HCPs will have more indebt experience and knowledge of the indigenous culture, which would enable better practice and understanding of the Indigenous clients' culture. Employing indigenous HCPs will additionally enhance culturally appropriate services to PWIDs. Durey et al. (2012), Government of Canada (2016), and Romanow (2002) further impressed in their studies that the voice of Indigenous peoples must be listened to, particularly in health policies, health administration, and care provided for Indigenous peoples.

Additionally, the views of the Indigenous HCPs in this study, emphasizes the importance of the impact that Indigenous HCPs can have on their patients'/clients' feeling of confidence,

safety and trust in the system. One of the participants with Indigenous ancestry recounted her personal experience of how poverty, poor housing, and environment/social network, had affected her poor choices and struggles with drugs and alcohol as a young person. The participant expressed not only knowing many PWIDs in the community, but that she clearly understood what PWIDs were experiencing and could identify with them. The participants with Indigenous ancestry further expressed how their personal experiences have greatly influenced the way they provided care to PWIDs and that their clients felt more trusting and safe with them. The HCP participants with Indigenous ancestry, further expressed that what they knew about PWIDs of Indigenous ancestry was not what they read in history books or societal beliefs, but was from their lived experiences. The intriguing example described by Ramsden (2002) affirms how HCPs of the same culture as the patient or client are, for some reason are more trusted to be able to provide care in a more culturally safe manner. As mentioned in chapter 2, Ramsden experienced the role to envisage tension and stress, protect, interpret, and mediate with Maori people that visited the hospital where she worked. Ultimately, the provision of care in a culturally safe manner can further be enhanced when HCPs of Indigenous ancestry are employed.

5.6.6 Address issues of specific populations exclusively. There is a great need in the city in which the study was conducted for programs, specifically geared at specific populations such as women, Indigenous women, and transgendered individuals. Such programs will be helpful at addressing most issues that these individuals face exclusively. Holistic approach for Indigenous populations have been found to be helpful among Indigenous peoples (NAHO, 2011) and should further be promoted in the health region. Lastly, there is the need for more shared responsibilities between individual health care providers as well as the actual health care system to improve the existing approach of HCPs with PWIDs in this region of study.

The issue of pain identified in this study as a major reason for the drug use and addiction among many PWIDs, needs to be adequately understood by HCPs providing health services to PWIDs. Additionally, Volkow and McLellan (2016) in their study in the United States, found associated risks of opioid diversion, overdose, addiction and pain. People who inject drugs (PWIDs) who are experiencing pain of any kind (most likely for ailments unrelated to their drug use), need to be properly cared for, taken seriously, and not presumed to be ‘drug seeking’ most of the time by HCPs. Many lives will be saved and major health emergencies averted if HCPs are trained to recognize and differentiate real pain from “drug-seeking” pain in PWIDs. More training to identify when PWIDs are genuinely in pain and need medication (not just assuming they are drug seeking) will be greatly beneficial to the clients/patients, reduction of unnecessary use of emergency care, hospital wait times, and the health care system as a whole.

5.7 Integrated Framework for Facilitating a Positive HCP-PWID Relational Approach for a Holistic Care and Health Access for PWIDs

In this interdisciplinary study, a triangulation of lessons learned from three conceptual framework/philosophy served as a guide for the interpretation of the findings, and guided the thoughts behind the development of an integrated framework. The philosophy and policy of HR of substance abuse in the city where the study was conducted; the behaviour model of health utilization (Andersen, 1995; Phillips et al.,1998); and the theory of stigma and discrimination (Goffman, 1963) are the three areas (discussed in chapter 2) that are combined. An integrated framework for facilitating a HCP-PWID relational approach for a holistic care and health access for PWIDs was developed.

The HR approach is one of the pillars of the four-pillar approach used in addressing substance misuse problem in the health region where this study was conducted. The four pillars

are namely: health promotion and primary prevention, HR, law enforcement, and treatment and recovery. As discussed in chapter 2, HR in this city includes intensive education about HR tailored for PWIDs, community and service providers. Additionally, outreach services, needle exchange, and the provision of full range of injection drug equipment are part of the HR program. Insite supervised safe injection sites that are well positioned for outreach and engagement are additionally being considered as part of HR in Saskatchewan (CBC News Saskatchewan, 2017b). According to the participants in this study, the mandate of HR that guides their practice center on keeping PWIDs safe, meeting PWIDs “where they are at”, and not stigmatizing or discriminating against IUDs/PWIDs.

The effectiveness of the harm reduction policy for PWIDs can additionally be enhanced through a health policy that transcends taking only gender, sex, and gender based analysis into consideration. A more effective health policy would be one that is carefully guided by the complex relationships and interactions of the social location of an individual or group, such as: Indigeneity, sexuality, sexual preference, immigration status, age, ability, and religion (Hankivsky et al. 2014). An intersectionality based policy analysis (IBPA) framework [for the policy of harm reduction for PWIDs] will help to advance equity when IBPA is considered in the development, evaluation, and evaluation of policy (Hankivsky et al. 2014). Intersectionality helps to bring about a conceptual shift in the ways researchers, civil service, public health professionals, and policy makers understand the relationships of and interactions of individuals’/groups’ social categories. Furthermore, IBPA promotes that any policy that is made should advance the understanding of the differential effects of health policies in order to bring about an inclusive and socially just health outcome (Hankivsky et al. 2014). In addition, the use of IBPA framework can help to analyze the operation of power and stigmatization in the harm

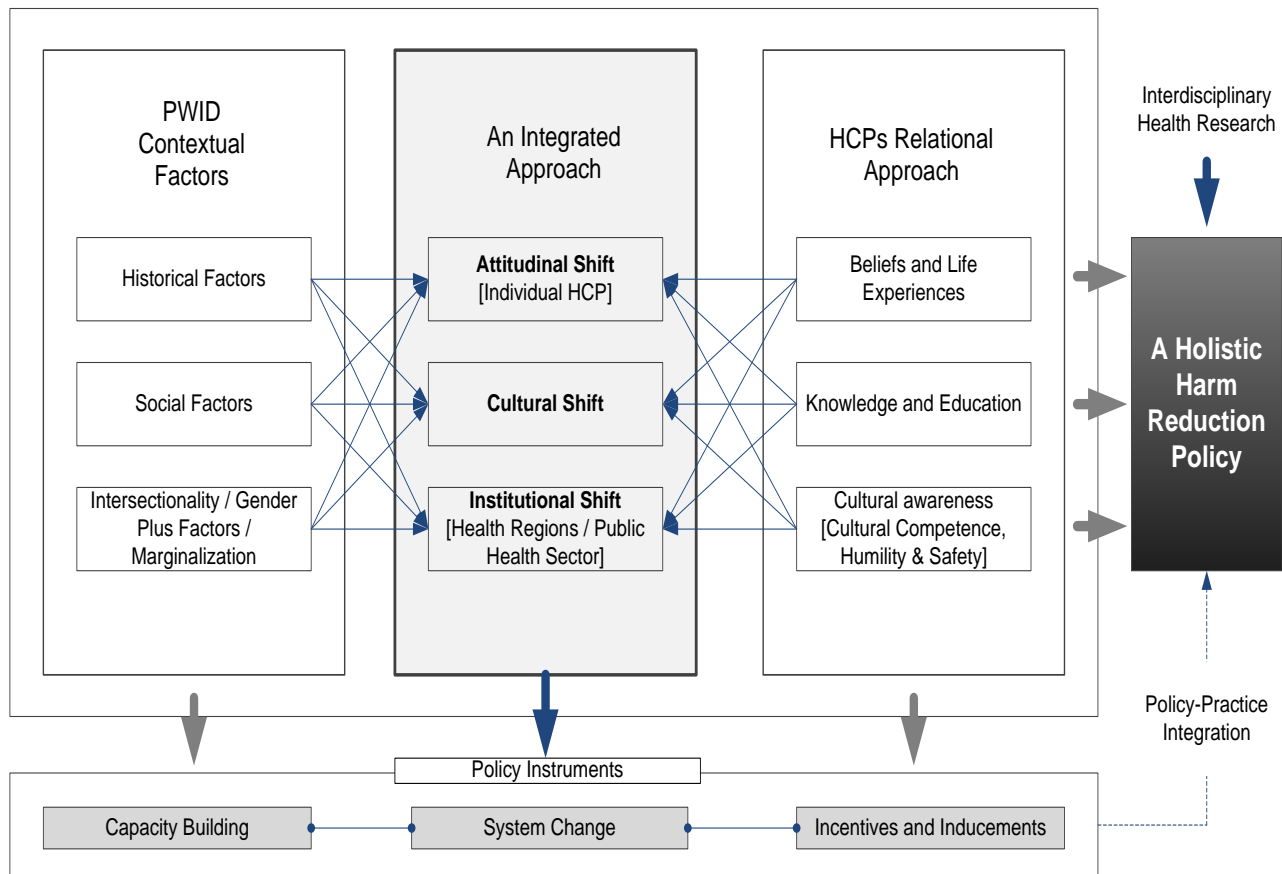
reduction policy for PWIDs, which can bring about the ultimate positive policy shift that may be needed.

Furthermore, social inclusion is important in addressing stigma and discrimination, therefore, Hunting, Grace, and Hankivsky (2015) developed a model of social inclusion for mental health and substance abuse. Hunting et al. (2015) used the intersectionality framework to analyze and understand the circle of belonging model and subsequently proposed an alternative model known as the “intersectionality–informed model of social inclusion and exclusion”. The model of Hunting et al. (2015) helps to improve the understanding of social inclusion, and address the issues of stigma, discrimination, and social exclusion (Hunting et al., 2015). To further understand and address inequality and exclusion, there needs to be a thorough understanding of social inclusion (which is a major problem for many PWIDs). Adequate understanding of social inclusion can guide the design and development of effective policy, programs, and policies (Hunting et al., 2015).

In this study, the behavioral model of utilization (Andersen, 1995; Phillips et al., 1998) is used to explain the context within which PWIDs access services considering the role of the environment (HCP- PWID relational approach). This study focuses on the HCP-PWID relational approach as the major barrier/enabler for access. Andersen (1995) categorizes the factors that influence the utilization of health services into predisposing, enabling, and precipitating factors. Examples of predisposing factors in the context of this study are PWIDs’ health/social status, gender, and Indigeneity. Enabling factors and precipitating factors overlap in this study and they include: HCP-PWID relational approach, environment, and the practice and health policies guiding HCP practice. Stigma is extensively discussed in chapter 2 and is defined as when persons are dehumanized based on their social identity or participation in a negative or an

undesirable social category (Goffman, 1963). By understanding the experience of stigma and discrimination, targets for anti-stigma intervention programs and their evaluation can be created. In the developed framework, the contextual factors for injecting drugs from the perspectives of the HCPs are shown to be historical, social, and gender related. The HCPs relational approaches are viewed from the lens of HCPs' beliefs and life experiences, knowledge and education, and cultural awareness. Additionally, the implications of the interactions between HCPs and PWIDs reveal the need for attitudinal shift (from individual HCP), cultural shift (society/community), and institutional shift (health region /public health sector). The overall interaction of all factors ultimately leads to a holistic HR policy in the region of study.

5.7.1 Holistic harm reduction. A revised approach of harm reduction policy for PWIDs in Saskatchewan will be highly invaluable to all. There needs to be a degree of attitude, cultural, and institutional shift. Additionally, there is the need for a deliberateness in system change, and incentives for HCPs, although many claimed they have job satisfaction. Part of the incentives could be additional job specific and cultural competence trainings. Policy and practice integration will help. In addition, more interdisciplinary applied health research in this area will help to promote awareness and knowledge for practice for PWIDs (see Figure 5.1: Integrated framework for facilitating a positive HCP-PWID relational approach for a holistic care and health access for PWIDs). From the findings of this study, HR can be defined as “a holistic approach that involves programs and policies designed to reduce the negative consequences of drug use without requiring cessation that will ultimately benefit the community and the individual who uses drugs. Holistic approach in the context of this study, additionally, means caring for PWIDs as a whole, not only physically but additionally taking the social determinants of health affecting them into consideration.



An Integrated Framework for Facilitating Access to Care by PWIDs

Figure 5.1: Integrated framework for facilitating a positive HCP-PWID relational approach for a holistic care and health access for PWIDs

5.7.2 Limitations of Study

Due to the researcher’s limited financial resources and time, a purposeful sample of those who worked directly with PWIDs restricted the recruitment of the participants to two departments of the health region in which the study was carried out. Nevertheless, the useful and interesting findings of this study have pointed out the need for future studies. In future studies, HCPs of other departments, particularly those from acute care units should be included and their approaches to practice compared with those of HCPs who work with predominantly PWIDs clients, including other departments would add richness to future studies. Findings from such

HCPs would contribute highly invaluable information for health care practice and provide good comparison of the HCP-PWID relational approach in different settings.

The intention of the researcher was to use maximum variation in her sampling. The researcher invited all HCPs with diverse professional backgrounds to participate in this study; nevertheless, those who agreed to participate consisted mainly of nurses, social workers, sociologists, and individuals with combined sociology and political studies degree. The researcher had hoped other professionals, such as pharmacists, physicians, and psychologists in the units had, additionally, agreed to participate in the study (although they were very few in number). The information obtained from the perspectives of other such professionals would have made the study more representative of diverse professions of HCPs and further enrich the findings. However, there was sufficient variation in experiences and perceptions.

Another limitation of the study was that there was an underrepresentation of Indigenous HCPs. Only two individuals, who self-declared to be of Indigenous ancestry (Métis), participated in the study. The views of more participants of Indigenous ancestry would have contributed to the study, however, it was not clear to the researcher if there were other/more Indigenous peoples among HCPs in the two departments of study. As in qualitative studies, the intent of the study is not for the findings to be generalized to all HCPs who work with PWIDs, or to all departments where HCPs work with PWIDs. However, in a situation where credibility is clearly accounted for, as in this study, the study may be generalizable to a population that shares similar time, place, people, or other social contexts (Tronchim, 2005). This study may be generalizable to the population of HCPs who work exclusively with PWIDs in public health settings or bloodborne disease clinics where HCPs and/or PWID profiles are similar.

Another limitation is that interpretive description [ID] (Thorne, 2008) is a relatively new research method. Nevertheless, resources available for use (such as the text book of Thorne, 2016) on ID methodology are increasing in number now than ever before. The pre-research beliefs and attitudes outlined in the fore-structure/scaffolding section of this study (recommended in ID studies), had the tendency to inform how this study was conducted and analyzed. Nevertheless, the effect of the biases brought to the study were minimized by audio recording the interviews and the review of the data analysis by the research supervisor, and a fellow PhD candidate. The fore structure section reminded the researcher of the pre-interview pre-conceptions and helped her to avoid the influence of her pre-research beliefs on the analysis (even though, it is impossible to completely bracket). Carrying out an interdisciplinary research is particularly challenging because each discipline has specific ways of carrying out research, however, the researcher in this study was able to overcome many of the challenges by employing a research methodology that provided a good fit for interdisciplinary studies. In spite of all the limitations, the primary objective of the study was achieved. The researcher gained insight into the HCPs' relational approaches toward PWIDs, including those of diverse populations of women and Indigenous peoples and further proposed an integrated framework for holistic care and PWIDs' access to health care.

Chapter 6 Conclusion

This chapter concludes the dissertation with a synopsis of the objectives of the study, research questions, and the methodological approach. In addition, the contributions and research significance of the research are presented.

6.1 Synopsis

In this dissertation, the author aimed to understand HCPs' relational approaches to working with PWIDs and the implications of the approaches on access to health care/services by PWIDs. Understanding HCPs relational approaches helped to generate knowledge that could inform health care practice, and invariably enhance positive health outcomes for PWIDs. The perceptions of HCPs who care predominantly for PWIDs in the community and a hospital setting were explored. In this generalist/integrationist interdisciplinary study (as discussed earlier in Chapter 2), the author aimed to (i) understand HCPs' relational approaches to providing care and services to PWIDs to whom they provide care and services to, (ii) examine the factors that influence HCPs relational approaches with PWIDs, (iii) understand the implications of HCPs' relational approaches on PWIDs, and (iv) generate knowledge on how HCPs' relational approaches affect the health care experiences/access of specific vulnerable populations such as: women, Indigenous women, and Indigenous peoples in general.

In chapter 2, the author reviewed literature and concepts on research studies related to HCPs approaches with IUDs and PWIDs. The state of existing literature on the topic of HCPs relational approaches toward PWIDS was examined. Additionally, the literature on the implications of HCPs approaches/attitudes toward PWIDs, implications of IDU for Indigenous peoples, and the interdisciplinary approach of this study were reviewed. In chapter 3, the approach to inquiry used in this study (interpretive description) was described. The philosophical

underpinnings, strengths and weaknesses of ID were additionally described. Furthermore, in chapter 4, a descriptive account of the findings of the study was presented as well as a summary of the participants' sample characteristics. As a preview to the report on the themes, the perspectives of HCPs on the profile of the clients they provide health care and services to, are stated and the professional relationship exhibited by HCPs towards PWIDs and the inherent environmental factors influencing clients' access to services highlighted. The findings were reported in a way that answered the research questions. Significant findings were highlighted, while direct quotes representing a majority of views of the participants were provided. Drawing on the aggregate results, I extrapolated key implications of the results in chapter 5. Additionally, in the same chapter, an integrated conceptual framework that demonstrated a connectivity of conceptual factors and frameworks was proposed. The framework was developed in this study by integrating stigma/discrimination discourse, the philosophy of harm reduction, and the behavioural health utilization framework from the lens of the HCPs. The opportunities for an integrated approach that leads to holistic HR care in the region of study were presented.

6.2 Contributions and Significance

Theoretically, the findings in this study contribute to knowledge related to positively engaging PWIDs, the role of HCPs in facilitating access to quality health care for PWIDs, and a more holistic HR policy. A more holistic HR policy will be highly invaluable to PWIDs, particularly, those with multiple vulnerabilities, who HCP participants claim that they have a myriad of wrap-around issues related to social determinants of health.

The present study affirms that there is the need to understand the multiple dimensions of access to health care as postulated in the conceptual framework of the behavioral model of utilization (Anderson, 1995; Anderson & Davidson, 2007). The interwoven contextual historical,

social, and gender factors influencing PWIDs use of drugs and access to health care, further confirm the importance of understanding the multiple dimensions of access to health care. Participants in this study affirmed that HCP-PWID interactions can facilitate or impede access to health services/care and ultimately determine PWIDs health status. Access does not only mean visiting a health care provider, but additionally getting the right services (including meeting clients “where they are at”) at the right time (Anderson & Davidson, 2007) receiving assessment, social support, treatment, and referrals.

The concept of stigma, according to Goffman (1963) emphasizes that stigma can be when persons are dehumanized based on their social identity or participation in a negative or an undesirable social category. An affirmation of Goffman’s (1963) concept is perceived in this study as participants claimed that indeed PWIDs are dehumanized by some HCPs, including some of the participants, when they lacked enough knowledge about PWIDs, while they worked in other work settings, and/or when they simply wanted to belong (due to the culture of HCPs work environment). The findings from HCP participants in this study, that PWIDs do not access health services that are in place for them because of the negative attitudes, stigma, and discrimination that PWIDs experience from HCPs is consistent with the findings of AIVL (2011), Butler and Sheridan (2010), Lang et al. (2011), and PHAC (2007a). The gender inequality treatment that contributes to multiple vulnerabilities for women and transgendered individuals who inject drugs, reported by HCPs in this study, further affirms Goffman’s concept of stigma. Findings on the multiple vulnerabilities of women, reported in the studies of CIHR (2013), Dell (2012), and Plamondon et al. (2007), additionally validate the findings in this study. Participants claims the influence of Indigeneity and gender on multiple vulnerability due to injecting drugs is consistent with the study of Lemstra et. al. (2012). Indigenous PWIDs were

more likely to be younger women, less likely to receive paid income, more likely to have attended residential school, or had a parent or grand parent attended residential school (Lemstra et al., 2012).

The approach to HR adopted by the health region where the study was conducted is rooted in accepting the person, by “meeting them where they at”, empowering them to make informed choices, and to strive to reduce the health and social harms associated with the behavior by neither condemning or condoning risk behaviors (de Bruin et al., 2008). The findings of this study validate the HR approach employed by the participants, however in light of gaps observed from negative attitudes reported towards PWIDs in this study, a more holistic conceptual approach to HR is recommended. The recommended HR approach for the health region based on the findings of this research is a holistic approach that involves programs and policies designed to reduce the negative consequences of drug use without requiring cessation which, will ultimately benefit the individuals who use drugs and the community. The findings of this study reveal the need to add a physical, social, and mental component (holistic approach) to the definition.

Methodologically, HCPs’ relational approaches with PWIDs and the implications for PWIDs’ health care were explored in this interdisciplinary ID study. The relational approaches of HCPs with PWIDs of Indigenous ancestry, Indigenous women, and women were additionally examined from the perspectives of HCPs. The ID methodology was ideal for this study as the research questions were addressed and new knowledge was generated using a coherent set of strategies for conceptual orientation, sampling, data collection, analysis, and reporting that are relevant to interdisciplinary applied health research. The interdisciplinary approach (generalist/integrationist - Moran, 2010; Repko & Szostak, 2016) enabled the author to draw

from knowledge across disciplines and integrate relevant theories and frameworks such as: the theory of stigma (Goffman, 1963), the behavioral model of utilization (Anderson, 1995; Phillips et al., 1998), and HR philosophy for substance misuse (CAMH, 2002).

From an applied health perspective, creativity of knowledge is the main goal of interdisciplinary studies and as such an integrated framework for facilitating a HCP-PWID relational approach for a holistic care and health access for PWIDs emerged as a part of this study (see Figure 5.1). Health care providers (HCPs) stated their relational approaches with PWIDs, were mainly positive, were non-judgmental toward PWIDs, met them “where they are at”, and prioritized their safety. In addition, HCPs felt they did not stigmatize or discriminate against PWIDs. Apparently, health care providers (HCPs) participants worked fully in line with the HR policy model, which is the model that guides the practice with IUDs/PWIDs in the city, in which the study was conducted. Nevertheless, the negative behaviors of HCPs toward IUDs/PWIDs identified by participants of this study were said to occur mainly among HCPs who work in chaotic situations such as acute care or emergency health care settings. Participants in this study expressed that they themselves in the past were more negative in their behaviors toward PWIDs, when their clients were not predominantly PWIDs. In addition, the negative relational approaches claimed by participants to exist among HCPs in some other departments are influenced by workload, family history, and educational background. A study of HCPs in acute care would be interesting to know their thoughts on this topic. Other reasons are internalized stereotypes (sometimes unknowingly), influence of the system, and information from history books. Less workload or pressure of work and increased knowledge about and/or proximity with PWIDs are associated with positive relational approaches of HCPs toward PWIDs. Positive HCP-PWID relational approaches can be associated with PWIDs’ trust, removal of fear when

services are accessed, willingness to disclose information, and increased access to health care. Ultimately, PWIDs will experience improved health when they can access services in a timely manner and adequately. The participants emphasized that the impact of the negative behaviours of HCPs toward PWIDs are experienced in varied but more intense among Indigenous peoples who use/inject drugs and women, particularly women of childbearing age, Indigenous women, and Indigenous peoples who use/inject drugs. The impact of HCPs negative relational approach with PWIDs is a less than optimal care for PWIDs, particularly among PWIDs who experience multiple vulnerabilities.

The current practice of HCPs who work predominantly with PWIDs in the health region needs to be commended and exemplified. Nevertheless, HCPs who do not work with predominantly PWID clients, particularly those in acute care settings, may benefit from increased substance abuse education (either on the job or in educational curriculum). All HCPs who work with IUDs/PWIDs may benefit from education on issues of determinants of health, which are peculiar to PWIDs. Increased education in the areas of cultural competence, cultural humility, and cultural safety, may be highly invaluable for all HCPs. People who inject drugs (PWIDs) of diverse populations, who are more vulnerable to stigma and discrimination from their HCPs, will benefit from relating with HCPs who are knowledgeable about their culture and who have a lifelong self-reflective experience that shows cultural humility. Bridging power imbalances that may exist between HCPs and PWIDs will promote cultural safety for PWIDs. Additionally, training of HCPs for the recognition of pain and pain-management would be beneficial to PWIDs' safety and health outcomes. Not taking the clients seriously when in pain has led to bad consequences in the past and may be detrimental to the care of PWIDs if or when trully, they are not drug seeking. Health administrators and departmental managers will benefit

from listening to the experiences of, and take suggestions from HCPs who are in direct contact with PWIDs. The suggestions and observations from HCPs in direct contact may help health administrators, managers, and policy makers in making good decisions, plan appropriately, and ultimately implement effective policies. Additionally, implicit stigma from HCPs, perceived by PWIDs, is still a significant concern in the health region where the study was conducted (Lang et al., 2011, 2013).

The author believes the HR model is apparently working in Saskatchewan, particularly at providing safety and a continuum of care for PWIDs. Positive approaches of HCPs toward PWIDs in all health care settings and in the community will enhance the continuum of care approach and ultimately increase access of PWIDs to available health care services (e.g., the PWIDs will be more willing to access services, when they know they will not be judged or stigmatized by HCPs). Harm reduction goes beyond supplies, HR helps to increase access and deals with stigma and isolation through the HR philosophy of non-judgemental attitude of HCPs. Addressing the mental, physical, and spiritual needs of PWIDs by implementing a more holistic policy will be highly invaluable to the health region. As part of the HR model Saskatchewan is contemplating on opening safe injection sites (SIS) in the major cities of Saskatchewan in the nearest future (CBC News, Saskatchewan, 2017b). The author believes that adding the model of safe injection sites (SIS) to the HR model in Saskatchewan can additionally increase access and reduce overdose among PWIDs. The model of safe injection sites (SIS) may prove to be a helpful model in Saskatchewan as it has been in Vancouver. Some believe that SIS would lead to more problems in the community, however, SIS apparently do not. Safe injection sites make a difference in the society and do not promote the use of drugs (Nato Association of Canada [NAOC], 2017). Additionally, in Saskatchewan, there continues to be an increased rate of drug

overdose caused by Fentanyl (Cowan, 2017) since the completion of this study. It is a possibility that the results of this study might be different if the researcher were to conduct the study now. The results might reveal that the HCPs who are already compassionate, might be even more compassionate toward their clients, while those who downplay PWIDs health conditions (probably because of work pressure), would desist from doing so because of the increased risks of overdose that PWIDs may face if they do not access services or if they do not do so in a timely manner.

In summary, this study lays a foundation for a practical, actionable, and novel integrated interdisciplinary framework for facilitating a positive HCP relational approach for a holistic care/policy that goes beyond reactionary approaches. An additional key contribution of the study is that the study identified key HCP/PWID relational approaches among HCPs who work exclusively with PWIDs. The gap in the literature was additionally bridged by generating knowledge and research evidence that could inform health care practice and enhance positive health outcomes for PWIDs in the city of study. Finally, this study contributes to the use of ID methodological design in the applied health fields and substance abuse.

6.3 Future Research

Health researchers and policy-makers in the province of Saskatchewan, Canada and other jurisdictions with comparative social, economic and policy milieu will benefit from future studies that focus on the relational approaches of HCPs (who do not work with predominantly PWID clients) with their patients/clients. A comparison of the professional relationship of HCPs who work predominantly with PWIDs, and HCPs who do not would be useful. Exploratory research questions such as: “are there any differences between the relational approaches of HCPs in the hospital settings and those who work in the community” would be invaluable. In addition,

examining the relational approaches of HCPs and PWIDs from the perspectives of PWIDs (when they access health services) would contribute immensely to knowledge and help to clarify if PWIDs' experiences with HCPs are real or implicit/perceived.

The models of intersectionality, intersectionality–informed model of social inclusion and exclusion, and the integrated framework for facilitating a positive HCP-PWID relational approach for a holistic care and health access for PWIDs will be valuable for future studies in examining stigma, discrimination, and social exclusion among PWIDs and HCPs who work with them. Ultimately results from such studies will additionally contribute to policy design, development, and implementation for PWIDs.

6.4 Conclusion

At the initial stage of the study, the author had thought her findings from the HCP participants would basically add to the information in the literature that stigma and discrimination exist among HCPs toward PWIDs (AIVL, 2011; Sleeper & Boschain, 2013; van Boekel et al., 2013). However, findings of this study (that HCPs meet clients “where they are at”, are non-judgemental, and keeping client safe) among HCPs who worked predominantly with PWIDs, in the community and hospital settings, surprisingly contradicted the author's initial expectations. The author noted in her interviews of the participants in this study that the HCPs related with their clients like family and showed immense compassion toward them. A HCP participant was tearful during the interview when she talked about the life circumstances and challenges that most PWIDs encountered, and how these challenges had led to many relapses of drug use and injecting among PWIDs. Many of the HCP participants were genuinely passionate about their jobs and really wanted to see their clients/patients succeed in their healing journey. The compassion expressed toward PWIDs from HCPs was additionally noted by the author as

the HCPs (in one of the two units in the study) chose to donate their honoraria from the research to PWIDs. Furthermore, the participants in this study exemplified cultural humility and cultural safety, particularly, toward PWIDs of Indigenous ancestry (who were a majority of the clients) by being aware of their constant need to know more about the culture of their clients/patients and realizing that cultural knowledge and competence is a lifelong process. In addition, the participants expressed the desire for more cultural competence training. The author did not perceive any power imbalance in the perceptions of accounts of the participants in their relational approaches with PWIDs which further revealed cultural safety in the study participants' practice with PWIDs.

In the authors privileged role as researcher, she was able to learn from participants that cultural humility is indeed a lifelong process that adds to effective holistic care for vulnerable populations. The HCPs who work predominantly with PWIDs can be considered to be in the best position to educate other HCPs about the needs of PWIDs because they apparently understand the population more, probably due to proximity (familiarity with issues affecting PWIDs) with PWIDs. The author, a uniquely equipped (combination of her cultural, educational, and experiential background) individual in terms of ability to appreciate relational approach, chose to study the implications of relational approach in PWID populations. She was very open about understanding the importance of cultural competence, cultural humility, and cultural safety in HCPs practice, understanding a health issue from an interdisciplinary perspective, and aimed to conduct a study that would be useful for practice (by employing ID methodology). The theoretical purpose of the study has been served, and hopefully, the practical use of the study will contribute to fulfilling the wider purpose that is the ultimate goal. Positive HCP relational approaches across all community, and hospital units providing services to PWIDs will be highly

invaluable. When appropriate policies are designed and implemented with issues of diverse populations in mind, stigma, discrimination, and structural discrimination are addressed.

“People will forget what you said, people will forget what you did, but people will never forget how you made them feel” (Maya Angelou Quotes, 2017).

References

- Aboriginal Affairs and Northern Development Canada. (2012). *Terminology*. Retrieved from <http://www.aadnc-aandc.gc.ca/eng/1100100014642/1100100014643>
- Adlaf, E. M., Hamilton, H. A., Wu, F., & Noh, S. (2009). Adolescent stigma towards drug addiction: Effects of age and drug use behavior. *Addiction Behaviour, 34*, 360–364. <https://dx.doi.org/10.1016/j.addbeh.2008.11.012>
- Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination, and the health of illicit drug users. *Drug Alcohol Depend, 88*, 188–196. <https://dx.doi.org/10.1016/j.drugalcdep.2006.10.014>
- Ahmad, N., Poole, N., & Dell, C. (2007). Women's substance use in Canada. Findings from the 2004 Canadian addiction survey. In N. Poole & L. Greaves (Eds.), *Highs & lows, Canadian perspectives on women and substance use* (pp. 5–9), Toronto, ON: Centre for Addiction and Mental Health.
- Alberta Health Services. (2009). *Aboriginal mental health and substance use*. Retrieved from <http://www.heretohelp.bc.ca/sites/default/files/images/Aboriginal.pdf>
- Alexander, G. R. (2008). Cultural competence models in nursing. *Critical Care Nursing Clinicians North America, 20*(4), 415–421. <https://dx.doi.org/10.1016/j.ccell.2008.08.012>
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1–10. <https://dx.doi.org/10.2307/2137284>
- Anderson, I., Crengle, S., & Kamaka, M. L. (2006). Indigenous health in Australia, New Zealand, and the Pacific. *Lancet, 367*, 1775–1785. [https://dx.doi.org/10.1016/S0140-6736\(06\)68773-4](https://dx.doi.org/10.1016/S0140-6736(06)68773-4)

- Andersen, R. M., & Davidson, P. L. (2007). Improving access to care in America: Individual and contextual indicators. In R. Andersen, T. Rice, & G. Kominski (Eds.), *Changing the U.S. health care system: Key issues in health services policy and management* (pp. 3–31), (3rd ed.). San Francisco: Jossey-Bass.
- Australian Injecting and Illicit Drug Users League. (2011). “*Why wouldn’t I discriminate against all of them?*”: *A report on stigma and discrimination towards the injecting drug user community*. Canberra, Australia. Retrieved from <http://canadianharmreduction.com/sites/default/files/AIVL%20IDU%20Stigma%20%26%20Discrimination%20Report%20Nov%202011.pdf>
- Birch, J., Ruttan, L., Muth, T., & Baydala, L. (2009). A case for culturally competent care for Aboriginal women giving birth in a hospital setting. *Journal of Aboriginal Health*, 4(2), 24–34. <https://dx.doi.org/10.18357/ijih42200912323>
- Bourguignon, D., Seron, E., Yzerbyt, V., & Herman, G. (2006). Perceived group and personal discrimination: Differential effects on personal self-esteem. *European Journal of Social Psychology*, 36(5), 773–789. <https://dx.doi.org/10.1002/ejsp.326>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://dx.doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2014). What can “thematic analysis” offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*, 9, 1–2. <https://dx.doi.org/10.1191/1478088706qp063oa>
- Breckler, S. J., & Wiggins, E. C. (1989). On defining attitude and attitude theory: Once more with feeling. In Pratkanis, A. R., Breckler, S. J., & Greenwald, A. G. (Ed.), *The third*

Ohio State University Volume on attitudes and persuasion. *Attitude structure and function* (pp. 407–427). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Brener, L., von Hippel, W., & Kippax, S. (2007). Prejudice among health care workers toward injecting drug users with hepatitis C: Does greater contact lead to less prejudice? *International Journal of Drug Policy*, *18*(5), 381–387.
<https://dx.doi.org/10.1016/j.drugpo.2007.01.006>

Brener, L., von Hippel, W., Kippax, S., & Preacher, K. J. (2010). The role of physician and nurse attitudes in the health care of injecting drug users. *Substance Use & Misuse*, *45*(7–8), 1007–1018. <http://dx.doi.org/10.3109/10826081003659543>

Butler, R., & Sheridan, J. (2010). Innocent parties or devious drug users: The views of primary healthcare practitioners with respect to those who misuse prescription drugs. *Harm Reduction Journal*, *7*, 21. <https://dx.doi.org/10.1186/1477-7517-7-21>
Retrieved from <http://www.harmreductionjournal.com/content/7/1/21>

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, *13*, 181–184.
<https://dx.doi.org/10.1177/10459602013003003>

Canadian Broadcasting Corporation News Saskatchewan. (2015, June 3). HIV epidemic sweeping Saskatchewan reserves. *CBC News Saskatchewan*. Retrieved from <http://www.cbc.ca/news/canada/saskatchewan/hiv-epidemic-sweeping-saskatchewan-reserves-1.3097212>

Canadian Broadcasting Corporation News Saskatchewan. (2016, July 12). Film on HIV in Saskatchewan aims to break stigma. *CBC News Saskatchewan*. Retrieved from

<http://www.cbc.ca/news/canada/saskatchewan/film-on-hiv-in-saskatchewan-hoping-to-break-stigma-1.3676172>

Canadian Broadcasting Corporation News Saskatchewan. (2017a, October 12). Saskatchewan's HIV rate highest in Canada, up 800% in 1 region. *CBC News Saskatchewan*. Retrieved from <http://www.cbc.ca/news/canada/saskatchewan/saskatchewan-hiv-rate-highest-canada-1.4351057>

Canadian Broadcasting Corporation News Saskatchewan. (2017b, October 4). Simulated safe injection site in Regina aimed at creating awareness. *CBC News Saskatchewan*. Retrieved from <http://www.cbc.ca/news/canada/saskatchewan/unsanctioned-supervised-injection-site-regina-1.4328212>

Canadian Broadcasting Corporation News Saskatoon. (2016, December 1). Saskatoon Health Region sees 55% hike in HIV cases. *CBC News Saskatoon*. Retrieved from <http://www.cbc.ca/news/canada/saskatoon/saskatoon-health-region-hiv-1.3876252>

Canadian Broadcasting Corporation News Saskatoon. (2018, April 4). How to access life-saving take-home naloxone kits in Saskatchewan. *CBC News Saskatoon*. Retrieved from <http://www.cbc.ca/news/canada/saskatoon/naloxone-kits-saskatchewan-1.4605725>

Canadian Centre on Substance Use and Addiction. (2011). *Injection drug users' overview*. Retrieved from <http://www.ccsa.ca/Eng/Topics/Populations/IDU/Pages/InjectionDrugUsersOverview.asp>

Canadian HIV/AIDS Legal Network. (2006). *"Nothing about us without us"*. Retrieved from <http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf>

Canadian Human Rights Commission. (2013). *What is discrimination?* Retrieved from

- <http://www.chrc-ccdp.ca/eng/content/what-discrimination>
- Canadian Institute of Health Research. (2010). *Ethical conduct for research involving humans*. Tri-Council policy statement (2nd ed.). Retrieved from http://pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf
- Canadian Institute of Health Research. (2013). *From stilettos to moccasins: A healing journey*. Retrieved from <http://www.cihr-irsc.gc.ca/e/46772.html>
- Canadian Medical Association. (2011). *High rates of injection drug use in urban Aboriginal youth signal need for prevention programs*. Retrieved from <http://www.cmaj.ca/cgi/doi/10.1503/cmaj.101257>
- Canadian Nurses Association. (2009). *Cultural competence and cultural safety in nursing education*. Retrieved from http://www2.cna-iic.ca/cna/documents/pdf/publications/First_Nations_Framework_e.pdf
- Canadian Press. (2017, October 13). Saskatchewan has highest HIV rate in country: Health department. *The Canadian Press*. Retrieved from <https://globalnews.ca/news/3802519/saskatchewan-hiv-rates-sunrise-health-region/>
- Carlberg–Racich, S. (2016). Harm reduction interventions in HIV care: A qualitative exploration of patient and provider perspectives. *Peer Journal*, 4(e), 1932. <https://dx.doi.org/10.7717/peerj.1932>
- Carroll, J. (1993). Attitudes of professionals to drug abusers. *British Journal of Nursing*, 2(14), 705–711.
- Carroll, J. (1994). Do nurses' views affect care of i.v. drug users? *Nursing Times*, 90(38), 11–12.
- Carroll, J. (1995). The negative attitudes of some general nurses towards drug misusers. *Nursing Standard*, 9(34), 36–38.

- Carroll, J. (1996a). Attitudes to drug users according to age of staff. *Professional Nurse*, 11(6), 401.
- Carroll, J. (1996b). Attitudes to drug users according to staff grade. *Professional Nurse*, 11(11), 718–720.
- Cedar Project Partnership, Mehrabadi, A., Paterson, K., Pearce, M., Patel, S., Craib, K. J., ... & Spittal, P. M. (2008). Gender differences in HIV and hepatitis C related vulnerabilities among Aboriginal young people who use street drugs in two Canadian cities. *Women & Health*, 48(3), 235–260. <https://dx.doi.org/10.1080/03630240802463186>
- Centre for Addiction and Mental Health. (2002). *CAMH and harm reduction: A background paper on its meaning and application for substance use issues*. Retrieved from http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/public_policy_submissions/harm_reduction/Pages/harmreductionbackground.aspx
- Centre for Addictions Research of British Columbia. (2009). *Aboriginal mental health and substance use*. Retrieved from <http://www.heretohelp.bc.ca/sites/default/files/images/Aboriginal.pdf>
- Chang, E., Simon, M., & Dong, X. (2012). Integrating cultural humility into health care professional education and training. *Advances in Health Sciences Education*, 17(2), 269–278. <https://dx.doi.org/10.1007/s10459-010-9264-1>
- Charles, J. L. K. (2013). Mental health provider-based stigma: Understanding the experience of clients and families. *Social Work Mental Health*, 11(4), 360–375. <https://dx.doi.org/10.1080/15332985.2013.775998>
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: Sage Publications.

- Cheung, Y. W. (2000). Substance abuse and developments in harm reduction. *Canadian Medical Association Journal*, 162(12), 1697–1700.
- Chu, C., & Galang, A. (2013). Hospital nurses' attitudes toward patients with a history of illicit drug use. *Canadian Nurse*, 109(6), 29–34.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ...Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine* 45, 11–27. <http://doi.org/10.1017/S0033291714000129>
- Cooke, C. L. (2004). Joblessness and homelessness as precursors of health problems in formerly incarcerated African American men. *Journal of Nursing Scholarship*, 36(2), 155–160.
- Corrigan, P. W. (2004). Target-specific stigma change: A strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal*, 28, 113–121.
<http://dx.doi.org/10.2975/28.2004.113.121>
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15(2), 37–30. <http://dx.doi.org/10.1177/1529100614531398>
- Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., ...Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27(2), 187–195. <https://dx.doi-org.cyber.usask.ca/10.1093/oxfordjournals.schbul.a006865>
- Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology Science and Practice*, 9(1), 35–53. <https://dx.doi.org/10.1093/clipsy.9.1.35>
- Corrigan, P. W., Watson, A. C., & Barr, E. (2006). The self-stigma of mental illness:

- Implications for self-esteem and self-efficacy. *Journal of Social Clinical Psychology*, 25, 875–884. <https://dx.doi.org/10.1521/jscp.2006.25.8.875>
- Corrigan, P., Watson, A., Heyrman, M., Warpinski, A., Gracia, G., Slopen, N.,... Hall, L. (2005). Structural stigma in state legislation. *Psychiatric Services*, 56(5), 557–563. <https://dx.doi-org.cyber.usask.ca/10.1093/oxfordjournals.schbul.a006865>
- Cowan, P. (2017, October 5). Safe injection sites not in the works for Saskatchewan. *Regina Leader- Post*. Retrieved from <http://leaderpost.com/news/local-news/safe-injection-sites-not-in-the-works-for-saskatchewan>
- Craib, K. J. P., Spittal, P. M., Wood, E., Laliberte, N., Hogg, R. S., Li, K., ... Schechter, M. T. (2003). Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver. *Canadian Medical Association Journal*, 168(1), 19–24.
- Creswell, J. A. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles, CA: Sage Publications.
- Creswell, J. A., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Los Angeles, CA: Sage Publications.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London, England: Sage Publications.
- de Bruin, P., Gibson, S., & Trischuk, H. (2010). *Saskatoon Health Region HIV prevention, treatment & support strategy*. Saskatoon, SK: Saskatoon Health Region. Retrieved from http://www.saskatoonhealthregion.ca/your_health/documents/SHRHIVPreventionTreatmentandSupportStrategyFINALSept302010.pdf
- de Bruin, P., Lindberg, B., & Grauer, K. (2008). *Street health program highlights report* (April 1st, 2007 - March 31st, 2008). Saskatoon, SK: Saskatoon Health Region.

- Dell, C. A. (2012). *From stilettos to moccasins: Aboriginal women drug users in conflict with law*. Retrieved from <http://www.addictionresearchchair.ca/creating-knowledge/national/Aboriginal-women-drug-users-in-conflict-with-the-law/>
- Dell, C., Kilty, J., Fillmore, C., Grantham, S., Lyons, T., Clarke, S., & Hopkins, C. (2010). Turtle finding fact sheet: The role of the treatment provider in Aboriginal women's healing from illicit drug abuse. *CES4Health.info*. <http://www.ces4health.info/find-products/view-product.aspx?code=Z3KNXKHD>.
- Ding, L., Landon, B. E., Wilson, I. B., Wong, M. D., Shapiro, M. F., & Cleary, P. D. (2005). Predictors and consequences of negative physician attitudes toward HIV-infected injection drug users. *Archives of Internal Medicine*, *165*(6), 618–623.
<https://dx.doi.org/10.1001/archinte.165.6.618>
- Dmytryshyn, A. L., Jack, S. M., Ballantyne, M., Wahoush, O., & MacMillan, H. L. (2015). Long-term home visiting with vulnerable young mothers: An interpretive description of the impact on public health nurses. *BMC Nursing*, *14*(1), 12.
<https://dx.doi.org/10.1186/s12912-015-0061-2>
- Doane, H. G., & Varcoe, C. (2015). *How to nurse: Relational inquiry with individuals and families in changing health and health care contexts*. Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins. Retrieved from <https://copac.jisc.ac.uk/id/35734959?style=html>
- Dreher, M. (1994). Qualitative research methods from the reviewer's perspective. In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 281–297). Thousand Oaks, CA: Sage Publications.

- Drumm, R. D., McBride, D. C., Metsch, L., Page, J. B., Dickerson, K., & Jones, B. (2003). The rock always comes first: Drug users' accounts about using formal health care. *Journal of Psychoactive Drugs*, 35(4), 461–469.
<https://dx.doi.org/10.1080/02791072.2003.10400493>
- Durey, A. (2010). Reducing racism in Aboriginal health care in Australia: Where does cultural education fit? *Australian and New Zealand Journal of Public Health*, 34, 87–92.
<https://doi.org/10.1111/j.1753-6405.2010.00560.x>
- Durey, A., Hill, P., Arkles, A., Gilles, M., Peterson, K., Wearne, S., ... Pulver, J. (2008). Overseas-trained doctors in Aboriginal rural health services: Negotiating professional relationships across cultural domains. *Australian and New Zealand Journal of Public Health*, 32(6), 512–518. <https://dx.doi.org/10.1111/j.1753-6405.2008.00301.x>
- Durey, A., Thompson, S., & Wood, M. (2012). Time to bring down the twin towers in poor Aboriginal hospital care: Addressing institutional racism and misunderstandings in communication. *Internal Medicine Journal*, 42(1), 17–22.
<https://dx.doi.org/10.1111/j.1445-5994.2011.02628.x>
- Ewhrudjakpor, C. (2009). Knowledge, beliefs and attitudes of health care providers towards the mentally ill in Delta State, Nigeria. *Ethnobiology and Ethnomedicine*, 3(1), 19–25.
<https://dx.doi.org/10.1080/09735070.2009.11886332>
- Fiorentine, R., Anglin, M., Gil-Rivas, V., & Taylor, E. (1997). Drug treatment: Explaining the gender paradox. *Substance Use and Misuse*, 32, 653–678.
<https://dx.doi.org/10.3109/10826089709039369>

- Fischer, B., Rehm, J., Kim, G., & Kirst, M. (2005). Eyes wide shut? A conceptual and empirical critique of methadone maintenance treatment. *European Addiction Research, 11*(1), 1–12. <https://dx.doi.org/10.1159/000081410>
- Foronda, C., LynBaptiste, D., Reinholdt, M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210–217. <https://dx.doi.org/10.1177/1043659615592677>
- Global News. (2017, October 25). Census 2016: More than one fifth of Canadians are foreign-born, proportion from Asia growing (By Leslie Young). *Global News*. Retrieved from <https://globalnews.ca/news/3823778/canadians-immigrant-foreign-born-asian-census-2016/>
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.
- Government of Canada. (1996). Gathering strength. *Report of the Royal Commission of Aboriginal Peoples*. Retrieved from www.aincinac.gc.ca/ch/rcap/sg/si1_e.html#Volume%203
- Government of Canada. (2016). *Report of the Royal Commission on Aboriginal Peoples*. Retrieved from <https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx>
- Government of Saskatchewan. (2005). *Health Information Protection Act [HIPA]*. Retrieved from <https://www.saskatchewan.ca/search#q=HIPA&sort=relevancy>
- Government of Saskatchewan. (2013, November 30). *Annual Report on HIV and AIDS in Saskatchewan, 2012: The profile of people living with HIV in Saskatchewan*. Retrieved from www.health.gov.sk.ca: <http://www.health.gov.sk.ca/hiv-aids-annual-report-2012>

- Government of Saskatchewan. (2015). *HIV and AIDS in Saskatchewan*. Retrieved from https://www.saskatchewan.ca/~media/files/health/ministry_overview/annual_reports/archive/hiv-aids/hiv-aids-annual-report-2010.pdf
- Government of United Kingdom. (1998). *Tackling drugs to build a better Britain: The government's ten-year strategy for tackling drugs misuse*. Department of Health. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006530
- Graham, A. L., Julian, J., & Meadows, G. (2010). Improving responses to depression and related disorders: Evaluation of an innovative, general, mental health care workers training program. *International Journal of Mental Health Systems*, 4, 25. <http://dx.doi.org/10.1186/1752-4458-4-25>
- Green, S., Davis, C., Karshmer, E., Marsh, P. S., & Straight, B. (2005). Living stigma: The impact of labeling, stereotyping, separation, status loss, and discrimination in the lives of individuals with disabilities and their families. *Sociological Inquiry*, 75(2), 197–215. <https://dx.doi.org/10.1111/j.1475-682X.2005.00119.x>
- Gronholm, P. C., Henderson, C., Deb, T., & Thornicroft, G. (2017). Interventions to reduce discrimination and stigma: The state of the art. *Social Psychiatry Psychiatric Epidemiology*, 52, 249–258. <http://dx.doi.org/10.1007/s00127-017-1341-9>
- Gunn, A., & Guarino, H. (2016). “Not human, dead already”: Perceptions and experiences of drug-related stigma among opioid-using young adults from the former Soviet Union living in the U.S. *International Journal of Drug Policy*, 38, 63–72. <https://dx.doi.org/10.1016/j.drugpo.2016.10.012>

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., ... Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, 13(1), 119–149. <https://dx.doi.org/10.1186/s12939-014-0119-x>

Harm Reduction International. (2012). *The global state of harm reduction: Towards an integrated response*. Retrieved from http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf

Health Canada. (2007). *Reducing the harm associated with injection drug use in Canada*. Retrieved from <http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/injection/references-eng.php#a24>

Health Canada. (2012). *First Nations and Inuit health. HIV and AIDS*. Retrieved from <http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/aids-sida/index-eng.php>

Health Canada. (2013). *Canadian alcohol and drug use monitoring survey: Summary of results for 2012*. Ottawa, ON: Author. Retrieved from <https://www.canada.ca/en/health-canada/services/health-concerns/drug-prevention-treatment/drug-alcohol-use-statistics/canadian-alcohol-drug-use-monitoring-survey-summary-results-2012.html>

Health Canada. (2014). *First Nations mental wellness continuum framework: Summary report*. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_mental/2014-sum-rpt-continuum/index-eng.php#f1

Health Canada. (2015). *First Nations mental wellness continuum framework*. Retrieved from http://www.thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf

- Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., ... Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *Lancet I*, 467–482. [http://dx.doi.org/10.1016/S2215-0366\(14\)00023-6](http://dx.doi.org/10.1016/S2215-0366(14)00023-6)
- Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research*, 19(9), 1284–1292. <https://dx.doi.org/10.1177/1049732309344612>
- Hunting, G., Grace, D., & Hankivsky, O. (2015). Taking action on stigma and discrimination: An intersectionality-informed model of social inclusion and exclusion. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, 4(2), 101–125.
- Hutchinson, B. (2017, September 1). Canada's first safe injection site struggles with the rise of fentanyl. *Macleans*. Retrieved from <http://www.macleans.ca/news/canada/canadas-first-safe-injection-site-struggles-with-the-rise-of-fentanyl/>
- James, B. O., & Omoaregba, J. O. (2013). Nigerian medical students' opinions about individuals who use and abuse psychoactive substances. *Substance Abuse Research and Treatment*, 7, 109–116. <https://dx.doi.org/10.4137/SART.S12129>
- Johnson, M. O., Chesney, M. A., Goldstein, R. B., Remien, R. H., Catz, S., Gore-Felton, C., ... NIMH Healthy Living Project Team. (2006). Positive provider interactions, adherence self-efficacy, and adherence to antiretroviral medications among HIV-infected adults: A mediation model. *AIDS Patient Care & STDs*, 20(4), 258–268. <https://dx.doi.org/10.1089/apc.2006.20.258>

- Kelleher, S., & Cotter, P. (2009). A descriptive study on emergency department doctors' and nurses' knowledge and attitudes concerning substance use and substance users. *International Emergency Nursing, 17*(1), 3–14.
<http://dx.doi.org/10.1016/j.ienj.2008.08.003>
- Kelly, J. A., Murphy, D. A., Washington, C. D., Wilson, T. S., Koob, J. J., Davis, D. R., ... Davantes, B. (1994). The effects of HIV/AIDS intervention groups for high-risk women in urban clinics. *American Journal of Public Health, 84*(12), 1918–1922.
<https://dx.doi.org/10.2105/AJPH.84.12.1918>
- Kent-Wilkinson, A. (2006). Interview with Gaye Hanson. *N814.3 Aboriginal Health Issues*. College of Nursing, University of Saskatchewan. Saskatoon, SK: Author.
- Kerr, T., Small, W., Buchner, C., Zhang, R., Li, K., Montaner, J., & Wood, E. (2010). Syringe sharing and HIV incidence among injection drug users and increases access to sterile needles. *American Journal of Public Health, 100*(8), 1449–1453.
<http://dx.doi.org/10.2105/AJPH.2009.178467>
- Kersey-Matusiak, G. (2012). Culturally competent care: Are we there yet? *Nursing Management, 43*(4), 34–39. <https://dx.doi.org/10.1097/01.NURSE.0000410308.49036.73>
- Knaak, S., Modgill, G., & Patten, S. B. (2014). Key ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. *Canadian Journal of Psychiatry, 59*, S19–S26. <https://dx.doi.org/10.1177/070674371405901S06>
- Kopera, M., Suszek, H., Bonar, E., Myszkka, M., Gmaj, B., Ilgen, M., ...Wojnar, M. (2015). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students. *Community Mental Health Journal, 51*(5), 628–634.
<https://dx.doi.org/10.1007/s10597-014-9796-6>

- Kulesza, M., Larimer, M., & Rao, D. (2013). Stigma among individuals with substance use disorder: A systematic review of the literature. *Journal of Addictive Behaviors, Therapy and Rehabilitation*, 2(2). <http://dx.doi.org/10.4172/2324-9005.1000106>
- Kurzban, R., & Leary, M. (2001). Evolutionary origins of stigmatization: The functions of social exclusion, *Psychological Bulletin*, 127(2), 187–208. <http://dx.doi.org/10.1037/0033-2909.127.2.187>
- Lamb, G., & Huttlinger, K. (1989). Reflexivity in nursing research. *Western Journal of Nursing Research*, 11, 765–772. <https://dx.doi.org/10.1177/019394598901100612>
- Lang, K., El-Aneed, A., Berenbaum, S., Dell, C., Wright, J., & McKay, Z. (2011). Qualitative assessment of crisis services among persons using injection drugs in the city of Saskatoon. *Journal of Substance Use*, 1–9. Retrieved from <http://www.addictionresearchchair.ca/translating-knowledge/publications/substance-use-problematic-use-and-abuse/>
- Lang, K., Neil, J., Wright, J., Dell, C. A., Berenbaum, S., & El-Aneed, A. (2013). Qualitative investigation of barriers to accessing care by people who inject drugs in Saskatoon, Canada: Perspectives of service providers. *Substance Abuse Treatment, Prevention, and Policy*, 8(1), 35. <https://dx.doi.org/10.1186/1747-597X-8-35>
- Lee, S., Tsang, A., Breslau, J., Aguilar-Gaxiola, S., Angemeyer, M., Borges, G., ...Kessler, R. C. (2009). Mental disorders and termination of education in high-income and low and middle-income countries: Epidemiological study. *British Journal of Psychiatry*, 194, 411–417. <http://dx.doi.org/10.1192/bjp.bp.108.054841>

- Lemstra, M., Rogers, M., Thompson, A., Moraros, J., & Buckingham, R. (2012). Risk indicators associated with injection drug use in the Aboriginal population. *Aids Care*, *24*(11), 1416–1424. <https://dx.doi.org/10.1080/09540121.2011.650678>
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. London, England: Sage Publications.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385. <https://dx.doi.org/10.1146/annurev.soc.27.1.363>
- Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *Lancet*, *367*, 528–529. [http://dx.doi.org/10.1016/S0140-6736\(06\)68184-1](http://dx.doi.org/10.1016/S0140-6736(06)68184-1)
- Livingston, J. D. (2013). Mental illness-related structural stigma: The downward spiral of systemic exclusion. *Mental Health Commission of Canada*. Retrieved from www.mentalhealthcommission.ca
- Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*, 2150–2161 <https://dx.doi.org/10.1016/j.socscimed.2010.09.030>
- Lowenberg, J. S. (1993). Interpretive research methodology: Broadening the dialogue. *Advances in Nursing Science*, *16*(2), 57–69. <https://dx.doi.org/10.1097/00012272-199312000-00006>
- Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addiction Behaviour*, *32*(7), 1331–1446. <https://dx.doi.org/10.1016/j.addbeh.2006.09.008>
- MacPherson, D. (2001). *A framework for action: A four-pillar approach to drug problems in Vancouver*. Retrieved from <http://donaldmacpherson.ca/wp->

content/uploads/2010/04/FrameMavundiawork-for-Action-A-Four-Pillars-Approach-to-Drug-Problems-in-Vancouver1.pdf

- Major, B., Kaiser, C. R., O'Brien, L. T., & McCoy, S. K. (2007). Perceived discrimination as worldview threat or worldview confirmation: Implications for self-esteem. *Journal of Personality and Social Psychology, 92*(6), 1068–1072. <http://dx.doi.org/10.1037/0022-3514.92.6.1068>
- Marsden, J., Gossop, M., & Stewart, D. (2000). Psychiatric symptoms among clients seeking treatment for drug dependence: Intake data from the national treatment outcome research study. *British Journal of Psychiatry, 176*(3), 285–289. <https://dx.doi.org/10.1192/bjp.176.3.285>
- Marsh, J., D'Aunno, B., & Smith, D. (2000). Increasing access and providing social services for women with children. *Addiction, 95*(8), 1237–1248. <https://dx.doi.org/10.1046/j.1360-0443.2000.958123710.x>
- Mathers, B. M., Degenhardt, L., Bucello, C., Lemon, J., Wiessing, L., & Hickman, M. (2013). Mortality among people who inject drugs: A systematic review and meta-analysis. *Bulletin of the World Health Organization, 91*(2), 102–123. <https://dx.doi.org/10.2471/BLT.12.108282>
- Maya Angelou Quotes. (2017). *Top 10 Maya Angelou quotes*. Retrieved from https://www.brainyquote.com/lists/authors/top_10_maya_angelou_quotes
- McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283–288. <https://dx.doi.org/10.1111/j.1365-2850.1996.tb00127.x>

- McLaughlin, D., McKenna, H., Leslie, J., Moore, K., & Robinson, J. (2006). Illicit drug users in Northern Ireland: Perceptions and experiences of health and social care professionals. *Journal of Psychiatric and Mental Health Nursing*, 13(6), 682–686.
<https://dx.doi.org/10.1111/j.1365-2850.2006.01015.x>
- Mental Health Commission of Canada. (2012, April). *Changing directions, changing lives: The mental health strategy for Canada unveiled*. Retrieved from
<http://www.mentalhealthcommission.ca/english/pages/default.aspx>
- Miller, C., Pearce, M., Moniruzzaman, C., Christian, C., Schechter, M., & Spittal, P. (2011). The Cedar Project: Risk factors for transition to injection drug use among young, urban Aboriginal people. *Canadian Medical Association Journal*, 183(10), 1147–1154.
<https://dx.doi.org/10.1503/cmaj.101257>
- Miller, N. S., Sheppard, L. M., Colenda, C., & Magen, J. (2001). Why physicians are unprepared to treat patients who have alcohol and drug-related disorders. *Academic Medicine*, 76, 410–418.
- Monks, R., Topping, A., & Newell, R. (2013). The dissonant care management of illicit drug users in medical wards, the views of nurses and patients: A grounded theory study. *Journal of Advanced Nursing*, 69(4), 935–946. <https://dx.doi.org/10.1111/j.1365-2648.2012.06088.x>
- Moran, J. (2010). *Interdisciplinarity* (2nd ed.). New York, NY: Routledge.
- Morse, J. M. (2007). Strategies of intraproject sampling. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (4th ed., pp. 529–539). Boston, MA: Jones & Bartlett Publishers.

- National Aboriginal Health Organization. (2008). *Cultural competency and safety: A guide for health administrators, providers, and educators*. Ottawa, ON: Author. Retrieved from <http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf>
- National Aboriginal Health Organization. (2009, April). *Cultural competency and safety in First Nations, Inuit and Métis health care* [Fact sheet]. Ottawa, ON: Author. Retrieved from <http://www.naho.ca/documents/naho/english/factSheets/culturalCompetency.pdf>
- National Aboriginal Health Organization. (2011). Holistic health and traditional knowledge. Ottawa, ON: Author. Retrieved from <http://www.naho.ca/blog/2011/07/25/holistic-health-and-traditional-knowledge/>
- Native Women's' Association of Canada. (1996). *Aboriginal women and substance abuse: Needs consultation*. Retrieved from <http://www.nwac.ca/sites/default/files/reports/AboriginalWomen&SubstanceAbuse.pdf>
- Nato Association of Canada. (2017). *Canada, fentanyl, and safe injection sites: A closer look at harm reduction*. Retrieved from <http://natoassociation.ca/canada-fentanyl-and-safe-injection-sites-a-closer-look-at-harm-reduction/>
- Neale, J., & Kennedy, C. (2002). Good practice towards homeless drug users: Research evidence from Scotland. *Health & Social Care in the Community*, 10(3), 196–205. <https://dx.doi.org/10.1046/j.1365-2524.2002.00357.x>
- Niccols, A., Dell, C. A., & Clarke, S. (2010). Treatment issues for Aboriginal mothers with substance use problems and their children. *International Journal of Mental Health & Addiction*, 8(2), 320–335. <http://dx.doi.org/10.1007/s11469-009-9255-8>
- Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counselling & Development*, 86(2), 143–151. <https://dx.doi.org/10.1002/j.1556-6678.2008.tb00491.x>

- Padgett, S. M. (2013). Professional collegiality and peer monitoring among nursing staff: An ethnographic study. *International Journal of Nursing Studies*, 50(10), 1407–1415.
<http://dx.doi.org/10.1016/j.ijnurstu.2012.12.022>
- Palmateer, N., Kimber, J., Hickman, M., Hutchinson, S., Rhodes, T., & Goldberg, D. (2010). Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: A review of reviews. *Addiction*, 105(5), 844–859. <http://dx.doi/10.1111/j.1360-0443.2009.02888.x>. PMID 20219055.
- Paterson, B., Hirsch, G., & Andres, K. (2013). Structural factors that promote stigmatization of drug users with hepatitis C in hospital emergency departments. *International Journal of Drug Policy*, 24, 471–478. <https://dx.doi.org/10.1016/j.drugpo.2013.01.008>
- Patterson, P., Whittington, R., & Bogg, J. (2007). Measuring nurse attitudes towards deliberate self-harm: The self-harm antipathy scale (SHAS). *Journal of Psychiatric Mental Health Nursing*, 14, 438–445. <http://dx.doi.org/10.1111/j.1365-2850.2007.01102.x>
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.
- Patton, M. Q. (2015). *Qualitative evaluation and research methods*. Thousand Oaks, CA: Sage Publications.
- Phillips, K., Morrison, K., Andersen, R., & Aday, L. (1998). Understanding the context of healthcare utilization: Assessing environmental and provider-related variables in the behavioral model of utilization. *Health Services Research*, 33(3), 571–596.
- Pieters, R., & Baumgartner, H. (2002). Who talks to whom? Intra-and interdisciplinary communication of economics journals. *Journal of Economic Literature*, 40(2), 483–509.

<http://dx.doi.org/10.1080/09595230600944453>

Plamondon, K., Opondo, J., Ross, T., Grauer, K., Lindberg, B., & de Bruin, P. (2007). *Building partnerships for health: A strategic planning framework for injection drug use in Saskatoon*. Saskatoon; SK: Saskatoon Health Region, Public Health Services.

Public Health Agency of Canada. (2006, August). *I-track. enhanced surveillance of risk behaviours among injecting drug users in Canada: Phase 1 report*. Retrieved from <http://www.catie.ca/en/resources/i-track-enhanced-surveillance-risk-behaviours-among-injecting-drug-users-canada-phase-1-re>

Public Health Agency of Canada. (2007a). *A population health approach to understanding injection drug use*. Retrieved from http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Scan_injection/1-eng.php

Public Health Agency of Canada. (2007b). *Appendix one: Definition of terms and concepts*. Retrieved from http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Scan_injection/app_1-eng.php

Public Health Agency of Canada. (2011). *Summary: Estimates of HIV prevalence and incidence in Canada, 2011*. Retrieved from www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimat2011-eng.php

Public Health Agency of Canada. (2012). *Fact sheet: People who inject drugs*. Retrieved from <http://www.phac-aspc.gc.ca/aids-sida/pr/sec3-eng.php>

Public Health Agency of Canada. (2013). *At a glance - HIV and AIDS in Canada: Surveillance report to December 31st, 2012*. Retrieved from <http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2012/dec/index-eng.php>

Public Health Agency of Canada. (2014). *Summary of key findings from I-Track Phase 3 (2010–*

- 2012). Retrieved from <http://www.phac-aspc.gc.ca/aids-sida/publication/reports/i-track-phase-3/assets/pdf/i-track-phase-3-eng.pdf>
- Public Health Agency of Canada. (2015). *HIV and AIDS in Canada: Surveillance report to December 31, 2014* Surveillance and Epidemiology Division, Centre for Communicable Diseases and Infection Control. Retrieved from http://publications.gc.ca/collections/collection_2016/aspc-phac/HP2-25-2015-eng.pdf
- QSR International. (2013). *Nvivo 10*. Retrieved from http://www.qsrinternational.com/products_nvivo.aspx
- Ramsden, I. M. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* (Unpublished doctoral dissertation). Victoria University of Wellington, New Zealand.
- Raphael, D. (Ed.). (2016). *Social determinants of health: Canadian perspectives* (3rd ed.). Toronto, ON: Canadian Scholars's Press.
- Rasmus, A., & Fernandez, L. (2018, February 7). Safe drug injection sites in San Francisco expected to open in July, be first in nation. *KTVU.com*. Retrieved from <http://www.ktvu.com/news/safe-drug-injection-sites-in-san-francisco-expected-to-open-in-july-be-first-in-nation-reports>
- Ray, M. A. (1994). The richness of phenomenology: Philosophic, theoretic, and methodological concerns. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 117–133). Thousand Oaks, CA: Sage Publications.
- Rehm, J., Taylor, B., & Room, R. (2006). Global burden of disease from alcohol, illicit drugs, and tobacco. *Drugs and Alcohol Review*, 25, 503–513.
<https://dx.doi.org/10.1080/09595230600944453>

- Reimer Kim, S. R. (1998). Nurses' descriptions of caring for culturally diverse clients. *Clinical Nursing Research*, 7(2), 125–146. <https://dx.doi.org/10.1177/105477389800700204>
- Repko, A. F., & Szostak, R. (2016). *Interdisciplinary research: Process and theory* (3rd ed.). Los Angeles, CA: Sage Publications.
- Romanow, R. (2002). Chapter 10: A new approach to Aboriginal health. *Romanow Report: Final report of the commission on the future of health care in Canada*. Retrieved from http://webhome.idirect.com/~janet313/janetsjo/romanow/chapt_10.html
- Ronzani, T. M., Higgins-Biddle, J., & Furtado, E. F. (2009). Stigmatization of alcohol and other drug users by primary care providers in southeast Brazil. *Social Science & Medicine*, 69(7), 1080–1084. <https://dx.doi.org/10.1016/j.socscimed.2009.07.026>
- Ross, M. W., & Darke, S. (1992). Mad, bad and dangerous to know: Dimensions and measurement of attitudes toward injecting drug users. *Drug & Alcohol Dependence*, 30(1), 71–74. [https://dx.doi.org/10.1016/0376-8716\(92\)90038-E](https://dx.doi.org/10.1016/0376-8716(92)90038-E)
- Ross, M. W., Timpson, S. C., Williams, M. L., Amos, C., & Bowen, A. (2007). Stigma consciousness concerns related to drug use and sexuality in a sample of street-based male sex workers. *International Journal of Sex Health* 19(2), 5765. https://dx.doi.org/10.1300/J514v19n02_05
- Royal Commission on Aboriginal Peoples. (1996). *Report of the Royal Commission on Aboriginal Peoples*. Retrieved from <https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx>
- Salvaggio, G., McKim, R., Taylor, M., & Wild, C. (2013). *Patient-provider rapport in the health care of people who inject drugs*. Retrieved from

<http://sgo.sagepub.com/content/3/4/2158244013509252>

<https://dx.doi.org/10.1177/2158244013509252>

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27–37. <http://dx.doi.org/10.1097/00012272-198604000-00005>

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18, 179–183. <https://doi.org/10.1002/nur.4770180211>

Saskatoon Health Region. (2006, April). *Report of the medical health officer - Investigation of an HIV cluster among injection drug users (IDUs) in Saskatoon, Saskatchewan.*

Retrieved from

http://www.saskatoonhealthregion.ca/your_health/documents/HIVHCVClusterOutbreak2006.pdf

Saskatoon Health Region. (2014). *HIV strategy report 2012–2013*. Retrieved from

https://www.saskatoonhealthregion.ca/locations_services/Services/Positive-Living/Documents/SHR%20HIV%20Strategy%20Report%202012-13%20Final%202014-04-04.pdf

Saskatchewan Ministry of Health. (2008, December 31). *A review of the needle exchange program in Saskatchewan: Executive summary*. Prepared for the Population Health

Branch Saskatchewan Ministry of Health. Prepared by Laurence Thompson Strategic Consulting [LTSC]. Saskatoon, SK: LTSC. Retrieved from

<http://www.health.gov.sk.ca/needle-exchange-exec-summary>

Saskatchewan Ministry of Health. (2010). *Saskatchewan's HIV strategy 2010–2014*. Retrieved from <http://www.health.gov.sk.ca/hiv-strategy-2010-2014>

- Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health*, 7, 331–343. <https://dx.doi.org/10.1080/09638239817932>
- Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, 19(2), 137–155. <https://dx.doi.org/10.1080/09540260701278929>
- Shahram, S. Z., Bottorff, J. L., Oelke, N. D., Dahlgren, L., Thomas, V., & Spittal, P. M. (2017). The Cedar Project: Using Indigenous-specific determinants of health to predict substance use among young pregnant-involved Indigenous women in Canada. *BioMed Central Women's Health*, 17(1), 84–96. <https://dx.doi.org/10.1186/s12905-017-0437-4>
- Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy*, 20(2), 121–130. Retrieved from [http://www.ijdp.org/article/S0955-3959\(07\)00207-1/abstract](http://www.ijdp.org/article/S0955-3959(07)00207-1/abstract) <https://dx.doi.org/10.1016/j.drugpo.2007.09.002>
- Sleeper, J. A., & Boschain, S. S. (2013). Stigmatization by nurses as perceived by substance abuse patients: A phenomenological study. *Journal of Nursing Education and Practice*, 3(7), 92–98. Retrieved from <http://www.sciedu.ca/journal/index.php/jnep/article/view/1490> <http://dx.doi.org/10.5430/jnep.v3n7p92>
- Slev-Ran, S., Adler, L., Nitzan, U., & Fennig, S. (2013). Attitudes towards nicotine, alcohol and drug dependence among physicians in Israel. *Journal of Substance Abuse Treatment*, 44(1), 88–89. <http://dx.doi.org/10.1016/j.jsat.2012.04.001>
- Smith, M. (2002). Evolutionary origins of stigmatization: The functions of social exclusion. *Advances in Psychiatric Treatment*, 8, 317–323. <https://dx.doi.org/10.1234/12345678>

- Spradley, J. (1979). *The ethnographic interview*. New York, NY: Holt Rinehart & Winston Publishing.
- Statistics Canada. (2003). *Canadian community health survey: Mental health and well-being*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/030903/dq030903a-eng.htm>.
- Statistics Canada. (2010). *Population counts*. Retrieved from <http://www80.statcan.gc.ca/wes-esw/page1-eng.htm>
- Statistics Canada. (2016, February 23). *First Nations, Métis, and Inuit women*. Women in Canada: A gender based statistical report. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/160223/dq160223a-eng.htm>
- Statistics Canada. (2017, October 25). *Aboriginal peoples in Canada: Key results from the 2016 Census*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/171025/dq171025a-eng.pdf>
- Suhrcke, M., & de Paz Nieves, C. (2011). *The impact of health and health behaviors on educational outcomes in high-income countries: A review of the evidence*. World Health Organization Regional Office for Europe, Copenhagen, Denmark.
- Svoboda- Gouvea, J., Sawtelle, V., Geller, B. D., & Turpen, C. (2013). A framework for analyzing interdisciplinary tasks: Implications for student learning and curricular design. *CBE Life Science Education*, 12, 187–205. <https://dx.doi.org/10.1187/cbe.12-08-0135>
- Tarsuk, J., Ogunnaike-Cooke, S., Archibald, C. P., & the I-Track Site Principle Investigators. (2013). Descriptive findings from a national enhanced HIV surveillance system, i-track phase 3, 2010–2012: Sex-based analysis of injecting, sexual and testing behaviours among people who inject drugs. *Canadian Journal of Infectious Diseases & Medical Microbiology*, 24(Supplement A), 81A.

- 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.
<https://dx.doi.org/10.1353/hpu.2010.0233>
- Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.
- Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). New York, NY: Routledge.
- Thorne, S., Reimer Kirkham, S., & Mac-Donald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health, 20*, 169–177. [https://dx.doi.org/10.1002/\(SICI\)1098-240X\(199704\)20:2<169::AID-NUR9>3.0.CO;2-I](https://dx.doi.org/10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I)
- Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methodology, 3*(1), 1–11.
<https://dx.doi.org/10.1177/160940690400300101>
- Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. Oxford, United Kingdom: Oxford University Press.
- Thornicroft, G., Evans-Lacko, S., & Henderson, C. (2014). Stigma and discrimination. In S. C. Davies (Ed.). Annual report of the chief medical officer 2013, *Public mental health priorities: Investing in the evidence*. Department of Health, London, UK.
- Trochim, W. M. (2005). *Research methods: The concise knowledge base*. Cincinnati, OH: Atomic Dog Publishing.
- Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to action*. Retrieved from

http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

Unger, J., Michele, D., De Rosa, C., Hyde, J., Ritt-Olson, A., & Montgomery, S. (2006). Needle-sharing among young IV drug users and their social network members: The influence of the injection partner's characteristics on HIV risk behavior. *Addictive Behaviours, 31*, 1607–1618. <https://dx.doi.org/10.1016/j.addbeh.2005.12.007>

United Nations Program on HIV/AIDS. (2012). *Fact sheet: Women, girls, gender equality and HIV*. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120217_FS_WomenGirls_en.pdf

United States Department of Health and Human Services. (2007). *Other definitions of cultural competence*. Bureau of Health Professionals. Retrieved from <http://bhpr.hrsa.gov/diversity/cultcomp.htm>.

Uren, A., & Galdas, P. (2015). The experiences of male sudden cardiac arrest survivors and their partners: A gender analysis. *Journal of Advanced Nursing, 71*(2), 349–358. <https://dx.doi.org/10.1111/jan.12499>

van Boekel, L. C., Brouwers, E., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug Alcohol Dependence, 131*(1–2), 23–35. <https://dx.doi.org/10.1016/j.drugalcdep.2013.02.018>

van Den Berg, L. (2013). Syringe machine push for addicts in hot spots. *The Australian*. Retrieved from <http://www.heraldsun.com.au/news/law-order/syringe-machine-push-for-addicts-in-melbournes-heroin-hot-spots/story-fni0fee2-1226646482548>

- Volkow, N. D., & McLellan, A. T. (2016). Opioid abuse in chronic pain: Misconceptions and mitigation strategies. *New England Journal of Medicine*, 374(13), 1253–1263.
<http://dx.doi.org/10.1056/NEJMra1507771>
- von Hippel, W., Brener, L., & von Hippel, C. (2008). Implicit prejudice toward injecting drug users predicts intentions to change jobs among drug and alcohol nurses. *Psychological Science*, 19(1), 7–11. <https://dx.doi.org/10.1111/j.1467-9280.2008.02037.x>
- Waldram, J. B., Herring, D. A., & Young, T. K. (2006). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives* (2nd ed.). Toronto, ON: University of Toronto Press.
- Wenthur, C. J., Cross, B. S., Vernon, V. P., Shelly, J. L., Harth, B. N., Lienhoop, A. D., . . . Murawski, M. M. (2013). Opinions and experiences of Indiana pharmacists and student pharmacists: The need for addiction and substance abuse education in the United States. *Research in Social & Administrative Pharmacy*, 9(1), 90–100.
<https://dx.doi.org/10.1016/j.sapharm.2012.03.003>
- Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., ... Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the global burden of disease study 2010. *The Lancet*, 382(9904), 1575–1586. [https://dx.doi.org/10.1016/S0140-6736\(13\)61611-6](https://dx.doi.org/10.1016/S0140-6736(13)61611-6)
- Wodak, A., & Cooney, A. (2005). Effectiveness of sterile needle and syringe programmes. *International Journal of Drug Policy*, 16(8), 31–44.
<https://dx.doi.org/10.1016/j.drugpo.2005.02.004>
- Wood, E., Montaner, J. S., Li, K., Zhang, R., Barney, L., Strathdee, S. A., & Kerr, T. (2008). Burden of HIV infection among Aboriginal injection drug users in Vancouver, British

Columbia. *American Journal of Public Health*, 98, 515–519. <https://dx.doi.org/10.2105/AJPH.2007.114595>

World Health Organization. (2012). *Treatment of injection drug users with HIV/AIDS: Promoting access and optimizing service delivery*. Retrieved from http://www.who.int/substance_abuse/publications/treatment_idus_hiv_aids.pdf


World Health Organization. (2015). *HIV/AIDS: Injection drug use*. Retrieved from <http://www.who.int/hiv/topics/idu/about/en/>

Young, M., Stuber, J., Ahern, J., & Galea, S. (2005). Interpersonal discrimination and the health of illicit drug users. *American Journal of Drug Alcohol and Abuse*, 31(3), 371–391. <https://dx.doi.org/10.1081/ADA-200056772>

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Interdisciplinary Department of the University of Saskatchewan



***PARTICIPANTS NEEDED FOR
RESEARCH IN EXPLORING HEALTH CARE PROVIDERS'
APPROACHES WITH PEOPLE WHO INJECT DRUGS (PWIDS)***

We are looking for volunteers to take part in a study exploring health care providers' relational approaches with people who inject drugs.

As a participant in this study, you must be working with PWIDs at the Street Health or HIV clinic. You would be asked to participate in a semi-structured interview.

Your participation would involve one session,
which is approximately 45-60 minutes.

In appreciation for your time, you will receive
a gift card honorarium.

For more information about this study, or to volunteer for this study,
please contact:

Adelugba, Busola

Graduate Interdisciplinary Program

at

306-966-7849 or

Email: ola891@mail.usask.ca

**This study has been reviewed by, and received approval
through, the Research Ethics Office, University of Saskatchewan.**

Appendix B



Email Contact

Invitation to Participate in Exploring Health Care Providers' (HCPs) Approaches with People who Inject Drugs (PWIDs): Implications for PWIDs' Health Care

Dear

My name is Adelugba, Olubusola. I am a PhD candidate in the Graduate Interdisciplinary program at the University of Saskatchewan. My background is in psychology and public health. I am emailing you to kindly ask for permission to invite members of staff of the street/sexual health program to participate in my research study on Exploring Health Care Providers' Approaches with People Who Inject Drugs (PWIDs): An Interpretive Description. I am interested in exploring the relational approaches of HCPs with PWIDs in this department, being major health care providers (HCPs) to people who inject drugs (PWIDs) in Saskatoon. This study will be from a pragmatic based approach, which allows individuals, including HCPs to use positive language to describe PWIDs' challenges and struggles. Additionally, the positive pragmatic approach will help HCPs to see hope, opportunities and solutions instead of mainly hopelessness and problems in PWIDs situations. Existing problems, realities, and difficulties among PWIDs will not be ignored, however, positive basis of resources and the strengths that will contribute to the foundation to address the challenges resulting from the problems will hopefully be identified.

One session of semi structured interview with HCPs that will last approximately 45-60 minutes will be conducted at a mutually agreed time and place. I have obtained an ethics approval from the Research Ethics Board of the University of Saskatchewan and an operational approval from the Health Region to conduct this study (please see the attached file). For more information about the study please see the attached documents (Research ethics approvals, recruitment poster, consent form, and the transcript release form). Please contact me via email for any questions that you may have about this study. I look forward to hearing from you.

Thank you.

Adelugba, Olubusola.

Invitation Letter:

Exploring Health Care Providers' (HCPs) Approaches with People who Inject Drugs (PWIDs):
Implications for PWIDs' Health Care

Dear _____,

My name is Busola Adelugba. I am a doctoral candidate in the Interdisciplinary graduate program at the University of Saskatchewan. My background is in psychology and public health. I am conducting a research study as part of the requirements of my degree on *Exploring Health Care Providers' (HCPs) Approaches with People who Inject Drugs (PWIDs)*. I would like to invite you/members of staff of the street health unit and the members of staff in the department to participate.

I am studying HCPs' unique approaches (beliefs, attitudes, and knowledge) in their practice with PWIDs. This study aims to examine issues/factors that influence HCPs behaviors from a pragmatic approach, and to understand the implications of their approach(es) for PWIDs in order to generate knowledge that could be clinically useful for HCPs practice and enhance positive treatment outcomes for PWIDs.

If staff members decide to participate, they will be asked to meet with me for a semi-structured interview. In particular, they will be asked questions about their practice approaches (knowledge, attitude, and beliefs) towards PWIDs. The meeting will take place at a mutually agreed upon place and time, and should last about 45-60 minutes. The interview will be audio taped and transcribed verbatim so that I can accurately reflect on what is discussed. Participation is confidential. Participants would receive an honorarium in form of a gift card in appreciation of your participation. You may contact me at ola891@mail.usask.ca if you would like to participate. Thank you for your consideration.

With kind regards,

Adelugba, Olubusola.

Appendix D

Participant Consent Form

Project Title: Health Care Providers' Relational Approaches with People who Inject Drugs (PWIDs): Implications for PWIDs Health Care

Researcher(s): Adelugba, Olubusola Adepeju, B.Sc, M.Sc, MPH, PhD(c)
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Purpose(s) and Objective(s) of the Research:

- The objectives of this study are: to (i) understand HCPs' relational approaches to providing care and services to PWIDs to whom they provide care and services to, (ii) examine the factors that influence HCPs relational approaches with PWIDs, (iii) understand the implications of HCPs' relational approaches on PWIDs, and (iv) generate knowledge on how HCPs' relational approaches affect the health care experiences/access of specific vulnerable populations such as: women, Indigenous women, and Indigenous peoples as a whole.

Procedures:

- An open-ended semi-structured interview will be conducted with each participant to help the researcher to gain an understanding around health care providers' (HCPs) practice approach toward PWIDs. The interview will be conducted at a mutually agreed place and time.
- On completing the interview, an honorarium of a \$20 gift card will be given to you for participating in the study.
- The interview will take approximately 45-60 minutes, will be digitally recorded with your permission, and transcribed verbatim. The recording may be stopped at any time if you so wish.
- After the researcher has reviewed the interview transcripts and tapes for accuracy, you will have the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you deem fit.
- Please feel free to ask any questions regarding the procedures and goals of the study or your role.

Funded by: Not Applicable.

Potential Risks:

- There are no known or anticipated risks to you by participating in this research. However, if there are any issues, you may contact the Employee and Family Assistance Program (EFAP) for counselling at 800-663-1142
- It is believed that the benefits of the proposed study will outweigh the risks if any.
- There will be ultimate confidentiality in this study.

Potential Benefits:

- The study may provide valuable understanding, information and evidence on best practice approaches toward PWIDs to inform policy in Saskatoon.
- The study results may help to: provide information and evidence on HCPs approaches with PWIDs in their clinical practice.
- The study may contribute to the use of ID design in the substance abuse field.

Compensation:

- You will be given an honorarium of \$20 in appreciation of your participation.
- If you decide to withdraw from the study after the honorarium has been received, you do not have to return it.

Confidentiality:

- There will be ultimate confidentiality in the study.
- Every attempt will be made to report only aggregate findings so as not to reveal your individual identity.
- Names will not be used, and all identifying information that may be linked to you will be removed.
- Identifying information will be stored separately from the data and will be destroyed when data collection is complete and it is no longer required.
- Data will be shared with researchers' supervisor and will be kept locked up in her PhD supervisor's office at the University of Saskatchewan for a period of five years when it is no longer needed.
- As with all studies with humans, the researcher has the obligation to report to the appropriate authorities any information revealed that might harm or affect you or others adversely.

Right to Withdraw:

- Your participation is voluntary and you may choose to answer only those questions that you are comfortable with.
- You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.
- Your decision to participate in the study or not will have no effect on your position, employment, or how you will be treated.
- Should you wish to withdraw, your contribution will not be included in the study.
- You can withdraw from the study at any time up until the researcher has begun the analysis.

Follow up:

- To obtain results from the study, please refer to the University of Saskatchewan website to view a copy of the dissertation. You may also email the researcher at ola891@mail.usask.ca

Questions or Concerns:

- You may contact the researcher(s) using the information at the top of page 1
- This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics. Office @usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Continued or On-going Consent:

- You will have the opportunity to read your transcripts from the typed interview after which you will be able to change your wordings or interpretations to adequately comply with your intent.
- After you have reviewed your transcripts, verbal consent of your intent to remain in the study will be sought and obtained.

Your signature below indicates that you have read and understood the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
<i>Researcher's Signature</i>	<i>Date</i>	

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix E
Demographic Form

Unique ID: _____ Date: _____

Age: _____ (yrs.) Gender: Male _____ Female _____ Other _____

Cultural background

I self-declare as a(an):

Member of a visible minority _____

Indigenous person _____

None of the above _____

I choose not to respond _____

Discipline _____

Highest level of education completed: Diploma / Bachelor / Masters / PhD

Other Please specify: _____

Job title: _____ Number of years in this position: _____

Specialty area: _____

Full time: _____ Part time _____ Casual _____

Previous Work History _____

Main PWID population you work with (gender, culture & age) _____

In this study, the overarching research questions which will be reflected in the questions that I you will be asked are:

- 1) What are HCPs' relational approaches to providing care and services to PWIDs whom they come in contact with in their professional work?
- 2) What factors influence HCPs relational approaches with PWIDs?
- 3) What are the implications of HCPs' relational approaches (with PWIDs) on PWIDs' experiences with and the patterns of accessing health care services?
- 4) How do HCPs' relational approaches affect the health care experiences/access of specific vulnerable populations such as: women, Indigenous women, and Indigenous peoples?

Interview Questions

1. Please tell me about your role in your job.

Prompt: What do you enjoy about working with PWIDs?

Prompt: What do you not like or the challenges you face in working with PWIDs, if any?

Prompt: Do you sometimes feel like never having to work with PWIDs but rather with another client group? Why or why not?

Prompt: How would you describe how you relate with your PWID clients?

2. Kindly describe your observed profile of the diverse populations of PWIDs you provide services to (such as: main stream Canadians, other minority ethnic groups, women/girls, Indigenous peoples, and Indigenous women/girls).

Prompt: What would you consider the implications and effects of injecting drugs on the

different populations you described?

Prompt: What are the similarities and differences of the effects and implications of injecting drugs on the groups of people you described, if any?

Prompt: How do the diverse social/economic profile and the implications of injecting drugs on these diverse populations influence your role in your practice approach with them?

3. Some individual beliefs and government debates and policies reveal that it is a waste of time to try to help PWIDs, and that PWIDs should rather be put in jail with health care resources and HCPs' energy directed at "sicker" people. What are your thoughts about this?

Prompt: In your personal opinion, what would you consider as the benefits and/or demerits of harm reduction services for PWIDs?

4. Your long-term client/patient whom you had been encouraging to live a healthy lifestyle through harm reduction suddenly shows up with a positive HIV diagnosis after disappearing for a few months. He has come on a day when you have a very busy schedule providing services to some pregnant PWID clients with young children. What would you do?
5. In your opinion, do PWIDs access available services and care offered to them, willingly, easily and adequately? If they do, how and how adequately. If they do not, why not?

Prompt: What do you consider as the enablers and barriers for your clients/patients to accessing the street health clinic and/or van services provided to them?

6. How would you say your relational approach with PWIDs impact your role as a service provider to PWIDs?

Prompts: How do you feel the way you treat (your rapport with) PWIDs impact their health choices, overall health, and ultimate health outcomes?

7. What resources (e.g., structural enablers, HCPs' training, provincial or national policies etc.) do you consider helpful to providing services to PWIDs?
8. Joy, a 21-year-old woman of Indigenous ancestry is a client of the street health unit. In the last couple of months, she had regularly accessed the van services of the unit exchanging dirty needles for clean ones, and frequently discussing minor health issues with staff. Occasionally, her partner came along with her also to collect clean needles for his use. Joy had mentioned to one of the street health nurses before that she was not happy in her relationship with her partner but feared to leave him because of economic reasons and his constant threat to her. Joy has a three-year-old daughter and is expecting another baby. One morning Joy came to the clinic, not looking too well, and with scars on her face. After waiting impatiently for 15 minutes at the clinic, Joy began to curse and use swear words at HCPs on duty. She further accused the HCPs of looking at her with disdain and talking to her rudely. She said she felt humiliated every time she came in and was treated differently from other female clients who were not of Indigenous ancestry and who dressed better. Additionally, Joy said that would be her last time accessing any service of such.
 - (a) What do you think are Joy's main issues and complaints?
 - (b) Why do you think Joy felt the way she did?
 - (c) What role would you play as Joy's HCP?

Appendix G



Transcript Release Form

Exploring Health Care Providers' Approaches with People Who Inject Drugs (PWIDS): An Interpretive Description

I _____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Olubusola Adelugba.

I hereby acknowledge the release of this transcript to Olubusola Adelugba to be used in the manner described in the consent form. I have received a copy of this transcript release form for my own records.

(Name of Respondent).

(Date)

(Signature of Respondent).

(Signature of Researcher)

Appendix H

Table of Reviewed Literature (26)

Study authors	Country of Origin	Study Purpose	Population sample	Study Design	Instrument	Results
Australian Injecting and Illicit Drug Users League (AIVL, 2011).	Australia	To learn more about the perceptions of the general community and some subsections of it, such as the medical professionals towards PWIDs.	HCPs (General practitioner, pharmacists, nurses, substance abuse workers) PWIDs Members of the general public	Market research	Focus groups	Stigma and discrimination associated with PWIDs are both institutionalised and pervasive. Members of the general public saw stigma and discrimination as good behaviour toward PWIDs. Participants believed stigmatising and discriminatory attitudes and actions would discourage people from taking up the habit of injecting drug use.
Brener, L., von Hippel, W., & Kippax, S. (2007).	Australia	To examine the relationship between contact and health care workers' attitudes towards their HCV positive IDU clients.	60 health care workers (doctors and nurses). 120 clients with HCV acquired from injecting drug use.	Quantitative design.	IDU SCIAT (An attitude to IDU scale). Interviews	Increased contact with clients with HCV is associated with more favourable explicit attitudes and more negative implicit attitudes among HCPs toward

						<p>PWIDs.</p> <p>HCWs that had greater contact with HCV positive clients also had HCV positive clients who held more favourable explicit attitudes toward them.</p>
<p>Brener, L., Von Hippel, W., Kippax, S., & Preacher, K. J. (2010)</p>	<p>Australia</p>	<p>To examine if the perception of controllability of drug use is associated with more negative attitudes toward PWIDs.</p> <p>To know if there is an association between conservatism and more negative attitude and if this relationship will be mediated by perceptions of the controllability of drug use</p>	<p>60 health care workers (doctors and nurses) who treat PWID patients.</p>	<p>Exploratory study and path analysis</p>	<p>Five item controllability scale</p> <p>Revised Wilson Conservatism scale</p> <p>Worry scale</p>	<p>Conservative health care workers have more negative attitudes toward their PWID clients but only to the extent of additionally seeing drug use as under the individuals' control. Health care workers, who perceived IDU as being under the clients' control, attributed more of their clients' ailments to their injection drug use. More conservative health care workers might be different from their liberal counterparts in the type of the</p>

						<p>diagnoses they make regarding their PWID clients.</p> <p>Negative attitudes towards PWIDs are associated with increased concern of health care workers about the behaviour of their clients who inject drugs and also have greater endorsement of the belief that PWIDs should disclose their HCV status.</p>
Carroll, J. (1993).	United Kingdom	<p>To describe the context in which health and social service professionals perform their roles in caring for PWIDs.</p> <p>To assess the implications for staff of different organizational structures and the extent of interagency collaboration.</p> <p>To examine the experiences of caring professionals</p>	248 health and social care providers working with PWIDs.	Exploratory study	Interviews and likert-type attitude scale.	<p>The attitudes of professionals to drug users differ because of their differing roles, socialization, and the type and nature of their contact with clients.</p> <p>Familiarity with drug users, especially those with HIV infection, is partially associated with positive attitudes among HCPs</p>

		and to document their responses to the demands encountered in working with PWIDs.				
Carroll, J. (1994).	United Kingdom	To determine the roles attitude and clinical staff grade play in providing services to intravenous drug users.	121 general and mental health nurses who treat intravenous drug users at least weekly in 4 health boards of West Scotland. Their grades ranged from C to I (majority of participants indicated they provided health counselling to patients).	Interview Study	Attitude Scale (Ross and Linn, 1973, as cited in Carrol, 1994). One way ANOVA	The higher the staff grade, the more positive the nurses were to intravenous drug users
Carrol, J. (1995).	United Kingdom	To know if nurses' attitudes could affect their emotional responses and the subsequent care they gave to patients.	82 HCPs	Interview Study	Interviews	Staff have judgmental and punitive attitudes toward drug misusers.

Carroll, J. (1996a).	United Kingdom	To describe the context in which professionals perform their caring role in the treatment of i.v drug users and, in particular, to identify differences in attitude to service delivery between staff from different age groups.	121 HCPs - Staff Nurses (general, mental health, and prison nurses), qualified social workers, and addiction counsellors.	Interview Study	Personal Interviews Updated version of a United States attitude scale.	Younger HCPs tend to be more positive in their attitudes towards PWIDs Older HCPs tend to be less concerned about the risks from HIV infection than younger ones. More research is needed into the effects of age group on attitudes.
Carroll, J. (1996b).	United Kingdom	To describe the context in which nurses treat intravenous drug users and especially the degree to which status affects attitudes and service delivery.	121 general and mental health nurses. Sub sample of 248 professionals working with PWIDs in west and central Scotland.	Interview study	Personal Interviews with qualified nurses SPSS (ANOVA) Attitude scale (Ross & Linn, as cited in Carroll, 1996b).	There is a tendency for senior professionals to be more positive in their attitudes toward PWIDs.
Chu, C., & Galang, A. (2013).	Canada	To examine registered nurses' attitudes toward patients with illicit drug use admitted	73 (out of 102) full-time and part-time RNs respondents, employed in the	Prospective, cross-sectional survey	Drug and Drug Problems Perception Questionnaire (DDPPQ)	Nurses had a neutral attitude toward working with patients with a history of illicit drug use, however they had low

		to the general internal medicine unit of an urban hospital. To identify nurse-specific and environmental factors influencing these attitudes.	general internal medicine unit at St. Michael's Hospital, in Toronto			motivation and role support (i.e., perception of receiving support to fulfil one's professional role) related to caring for individuals who use drugs.
Ding, L., Landon, B. E., Wilson, I. B., Wong, M. D., Shapiro, M. F., & Cleary, P. D. (2005).	United States	To evaluate physicians' training, experience, and practice characteristics. To examine associations between their attitudes toward HIV-infected persons who are PWIDs and quality of care.	2864 HIV infected patients 551 Clinicians	Cross-sectional surveys	Interviews and Surveys	Physicians who have negative attitudes toward IDUs are more likely to believe that PWIDs are less adherent to treatment regimens and to withhold antiretroviral treatment. Although many physicians have negative attitudes toward HIV-infected PWIDs, those attitudes did not affect the care they provide to HIV patients overall and PWIDs.
Durey, A., Thompson S., & Wood, M. (2012).	Australia	To identify how cross-cultural misunderstandings affect the quality of	Informal conversations and observation of Community	Eclectic Approach	Observations and informal discussions	Physicians and HCPs need to do more than just deliver evidence-based interventions.

		<p>care to Aboriginal patients in hospital.</p> <p>To offer suggestions for improvement to practice.</p> <p>Also explores the concept of institutional racism and challenges doctors to reflect on their role in perpetuating power imbalances.</p>	<p>HCPs.</p> <p>Drew on Literature.</p>			<p>HCPs need to critically reflect on their own attitudes to and practices with Aboriginal Australians and work collectively to effect systemic change which creates a more inclusive and safe environment for all people accessing healthcare.</p>
James, B. O., & Omoargba, J. O. (2013).	Nigeria	To determine attitudes of medical trainees toward substance use.	200 fifth-year medical students of the Igbinedion University Okada who had completed their 10-week clerkship in psychiatry at the Federal Neuropsychiatric Hospital, Benin City	Survey	Modified form of the Substance Abuse Attitude Scale (SAAS).	Medical students had positive attitudes toward individuals who misuse psychoactive substances; however, they preferred treatment to be offered by trained specialists and held restrictive views regarding cannabis and alcohol use. Participants who were male or had a lifetime

						history of psychoactive substance use expressed more positive attitudes.
Kelleher, S., & Cotter, P. (2009).	Ireland	To determine emergency department doctors' and nurses' knowledge and attitudes regarding problematic substance use and substance users.	145 emergency department doctors and nurses working in three university teaching hospitals in Ireland	Survey	Adapted Substance Abuse Attitude Survey (SAAS).	Knowledge deficit in relation to intervention strategies, and other substances was identified. The majority of participants have never received any specific training regarding substance use and which suggested that substance-using patients are managed inadequately.
Lang, K., Neil, J., Wright, J., Dell, C. A., Berenbaum, S., & El-Aneed, A. (2013).	Canada	To explore what service providers perceive to be the greatest barriers for PWIDs to receive optimal care.	27 service providers	Exploratory Investigation	Focus groups	Service providers identified four barriers to care which were: stigma and discrimination, inefficient use of resources, inadequate education, and the unique and demanding nature of PWIDs. Additionally, many successful services were

						identified.
McLaughlin, D., & Long, A. (1996).	Northern Ireland	To examine research on health professionals' opinions and perceptions of the issues surrounding illicit drugs and their use.	5 common themes across literature were examined perceptions of clients who use illicit drugs; perceptions of the different illicit drugs; thoughts on legalization of illicit drugs; giving care to illicit drug-using clients, thoughts on the service best-able to care for the clients who use illicit drugs, generalist or specialist.	Literature review	Literature review (method not specified)	HCPs project heavily on to the client all their own negative perceptions of illicit drug use, in the care setting leading to very unsatisfactory and unsafe care, resulting in both client and carer being dissatisfied with the whole aspect of care. Additionally, specialist teams are swamped by HCPs who are referring almost every illicit drug-user to these services.
McLaughlin, D., McKenna, H., Leslie, J., Moore, K., & Robinson, J. (2006).	Northern Ireland	To explore the perceptions of a sample of health and social care professionals towards illicit drug users in Northern Ireland.	35 health and social professional	Survey	Focus Groups Face to face Interviews	Many participants reported little or no training for working with illicit drug users, and would reject offer of education in this area to avoid contact with illicit drug users.

						Many professionals displayed negative views of the client group. The social and health providers were unprepared and unwilling to face the challenges of working with individuals who use drugs.
Monks, R., Topping, A., & Newell, R. (2013).	United Kingdom	To explore how registered nurses, manage and deliver care to patients admitted to medical wards and medical assessment units with complications of drug use and to elicit the experiences and views of those receiving that care.	29 registered nurses 12 medical ward patients admitted for complications of drug problems	Qualitative (grounded theory)	Semi-structured interviews	Dissonant care emerged in two categories of lack of knowledge of care and distrust and detachment. Negative attitudes and experience of conflict contributed to the negative nurse-patient relationship.
Ronzani, T. M., Higgins-Biddle, J., & Furtado, E. F. (2009).	Brazil	To examine the views of primary health care providers (PHC) providers in Southeast Brazil on the	609 PHCs providers.	Non – controlled exploratory study.	Questionnaires Judgement scale regarding alcoholism (Babor et al. 1986,	PHC providers stigmatize the use of alcohol and other drugs.

		use of alcohol and other drugs which reflect stigma moralization, or judgement.			as cited in Ronzani et al., 2009) Personal difficulty evaluation	
Ross, M. W., & Darke, S. (1992).	Australia	To determine the dimensional structure of attitudes toward IDUs and to develop an instrument, with good psychometric properties, which could be used to measure attitudes to injecting drug users.	143 workers at a drug and alcohol research unit and an AIDS treatment facility	Quantitative study. (Factor analysis)	Questionnaires AIDUS scale	Workers viewed IDU as a disease and not a personal choice, as criminals that should be removed from the society and as people one should not want to have any contact with. These dimensions provide a useful psychometric index for their measurement.
Salvaggio, G., McKim, M., Taylor, M., & Wild, C. (2013).	Canada	To describe determinants and consequences of patient-provider rapport among PWIDs.	89 PWIDs from the community, Additional 8 PWIDs from the community, 7 HCPs based in the Community and hospital setting.	Mixed methods.	Focus groups and survey interviews.	Drug-related behaviours, addiction severity, provider expertise, patient-centred care, and perceived discrimination, influence HCPs rapport with PWIDs rapport in turn, influences patient compliance and timing of care.

<p>Simmon L., & Coomber, R. (2009).</p>	<p>United Kingdom</p>	<p>To consider the way social stigma impacts PWIDs and operates within them and the consequences of these for prevention and harm reduction among PWIDs.</p>	<p>12 pharmacists providing needles (one pharmacist owned two outlets) in 13 pharmacy outlets in the far south west of England 4 key personnel 91 PWIDs</p>	<p>Qualitative (Case study)</p>	<p>Interviews</p>	<p>Much can be done to reduce stigma related to IDU and drug use in general. IDUs stigmatize lesser IDUs.</p>
<p>Sleeper, J. A., & Boschain, S.S. (2013).</p>	<p>United States</p>	<p>To broaden the understanding of nurses who care for substance abuse (SA) patients by revealing real life experiences of stigma as perceived by SA patients.</p>	<p>5 adults previously (in the last 6 months) or currently enrolled in a residential SA treatment program.</p>	<p>Phenomenology</p>	<p>Interviews</p>	<p>A theme identified experiences of stigma from nurses, counsellors, therapists, doctors and ancillary staff within residential SA programs. Additionally, patients got feelings that staff their own needs above those of the clients. In another theme participants indicated their experience of feeling that the treatment setting limited or eliminated their personal</p>

						freedom.
Slev-Ran, S., Adler, L., Nitzan, U., & Fennig, S. (2013).	Israel	To examine physicians' attitudes in Israel towards nicotine, alcohol and drug use, and dependence.	208 Physicians	Questionnaire (50 items)	Survey	Physicians reported experiencing lower levels of satisfaction and higher levels of aggression when treating individuals with alcohol and drug dependence than with other patients. Their attitude played a big role in the care given to clients who used drugs.
Van Boekel, L. C., Brouwers, E., van Weeghel, J., & Garretsen, H. (2013).	Netherlands	To assess health professionals' attitudes towards patients with substance use disorders and examine the consequences of these attitudes on health care delivery for these patients in Western countries.	28 Studies	Systematic review of published articles in western countries	Databases search using Pubmed, PsycINFO and Embase	HCPs express negative attitudes towards patients with substance use disorders. More education for health care providers may help improve their attitude. Violence, manipulations and poor motivation were perceived as factors in the health care delivery for substance abuse disorder patients. There was lack of adequate education,

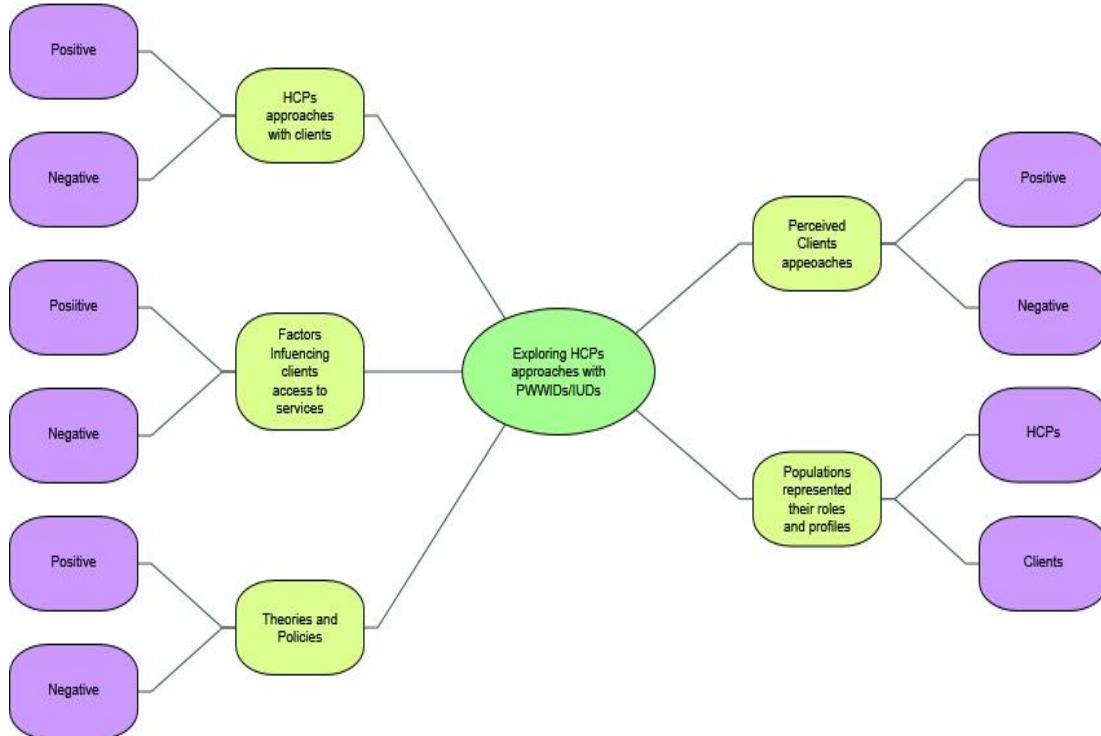
						<p>training among HCPs.</p> <p>Additionally, HCPs lacked support structures for working with this patient group.</p> <p>Patients' feelings of empowerment and treatment outcomes were diminished with negative attitudes of HCPs.</p> <p>HCPs had less personal engagement and diminished empathy with a more task oriented approach toward in their delivery of healthcare toward patients with substance use disorders.</p>
<p>von Hippel, W., Brener, L., & von Hippel, C. (2008).</p>	<p>Australia</p>	<p>To assess whether implicit prejudice can predict independent variance, beyond that predicted by explicit prejudice, in meaningful</p>	<p>Participants were 44 drug and alcohol (D&A) nurses in the Sydney metropolitan area.</p> <p>Nurses were recruited from D&A</p>	<p>Quantitative study</p>	<p>Self-reported questionnaire on a laptop computer and</p> <p>The Single Category Implicit Association</p>	<p>Implicit prejudice was a significant mediator, beyond explicit prejudice and job satisfaction, of the relation between job stress and intention to change jobs.</p>

		and unambiguous behaviors or behavioral intentions.	treatment facilities, needle and syringe exchange programs, and primary-care facilities that cater to IDUs.		Test (SC-IAT; Karpinski & Steinman, 2007, as cited in von Hippel et al., 2008), which measured implicit attitudes toward IDUs.	
Wenthur, C. J., Cross, B. S., Vernon, V. P., Shelly, J. L., Harth, B. N., Lienhoop, A., & Murawski, M. (2013).	United States	To assess the relatively perceived importance of substance abuse topics in pharmacy among student Pharmacists and pharmacy practitioners in the state of Indiana.	A class of students at Purdue University College of Pharmacy and Licenced Indiana Pharmacists .	Survey	Questionnaire	Three hundred and fifty students and six hundred and twenty-five pharmacists' responses suggest of pharmacy students in further education in the area of SA and perceived need for increased educational exposure during the student pharmacy training.

Appendix I

Thematic Maps of Emergence of Themes

Thematic Map 1



Thematic Map 2

