A Gendered Analysis of Implementation and Impacts of Prescribed Safer Supply in BC: A Qualitative Exploration during Dual Public Health Emergencies.

by

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We acknowledge and respect the lək^{w}əŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

Women and gender diverse persons often remain underserved by harm reduction programs and initiatives (e.g., needle distribution, supervised consumption services, prescribed safer supply programs). A lack of attention to gender and other intersecting factors in the design of harm reduction programs means that the needs of women and gender diverse persons may be overlooked or unmet. This research provides a gendered analysis of the design, implementation, and impacts of prescribed safer supply during the dual public health emergencies (overdose emergency and the COVID-19 pandemic) in British Columbia (BC), Canada. A qualitative methodology informed by critical, feminist, and implementation theory guided this dissertation. The research questions were: (1) Do the existing clinical guidance and policy direction on prescribed safer supply address the unique needs of women and gender diverse persons in BC? (2) Using prescribed safer supply as a case study, how could health equity be integrated into the Consolidated Framework for Implementation Research (CFIR)? (3) What were women's and gender diverse person's experiences accessing or attempting to access prescribed safer supply in BC during the dual public health emergencies (overdose emergency and COVID-19 pandemic)? The dissertation is organized into three papers, one for each research question.

In **paper one**, I examine how BC's prescribed safer supply initiatives (as represented in the Risk Mitigation Guidance [RMG] and prescribed safer supply policy direction) respond to the unique intersecting needs of women and gender diverse persons who use drugs. This study drew on intersectionality-based policy analysis (IBPA) developed by Hankivsky et al. (2012). Findings revealed that the documents were primarily gender silent. When gender was mentioned, it was in

the context of reproduction. None of the documents mentioned specific considerations for women or gender diverse persons seeking or receiving prescribed safer supply.

In **paper two**, based on my experience using the CFIR to organize a study evaluating prescribed safer supply in BC, I conducted a critical analysis of the framework with specific attention to equity and gender. Findings from the critical analysis were used to generate recommendations on how to further integrate health equity and gender considerations into the CFIR and implementation science (IS), more generally. Based on my experience, I see community-based participatory research as a potential approach that can help to operationalize equity considerations in the CFIR

In **paper three** interpretive description (ID) was used to analyze 21 in-depth interviews with women and gender diverse persons who accessed prescription opioids or stimulants under the RMG during the dual crisis of drug overdose during the COVID-19 pandemic. Interviews were conducted as part of a larger evaluation of the RMG in BC in 2020-21. Findings highlight that women and gender diverse persons experienced a lack of gender-responsive supports when accessing or attempting to access prescribed safer supply.

Together, this research offers novel evidence that can be used to improve women's and gender diverse persons' access to harm reduction services, specifically prescribed safer supply programs. The findings from this research extend our understanding of current overdose responses and inform ongoing public health and harm reduction efforts in BC, Canada, and beyond. Findings from this research highlight that current policy documents and emerging models of prescribed safer supply are predominately gender silent and do not address the unique and specific barriers faced by women and gender diverse persons who use drugs. Further research is needed to

specifically examine how gender intersects with race, class, and sexuality to influence people's access to safe supply. Implications for nursing policy, practice, research, and education include specialized training and education around harm reduction for nurses and student nurses, expanding registered nurse prescribing to include medications for safer supply, and future research examining nurse's role (including nurse practitioners) in safer supply responses.

Table of Contents

List of Abbreviations

BC: British Columbia

CFIR: Consolidated Framework for Implementation Research

CIHR: Canadian Institute for Health Research

COVID-19: Corona Virus Disease of 2019

GBA+: Gender-based Analysis Plus

HIV: Human Immunodeficiency Virus

HCV: Hepatitis C Virus

IBPA: Intersectionality-Based Policy Analysis

ID: Interpretive Description

IPV: Intimate Partner Violence

PWUD: People Who Use Drugs

Reader's Guide

The following body of work represents the culmination of five years of asking questions, devising plans, and gathering knowledge which ultimately formed my doctoral dissertation. In Chapter One, I begin this dissertation by identifying the research problem, offering my personal connections to the topic, and discussing how I developed and answered my research questions. As this is a paper-based dissertation, the following chapters (two, three, and four) consist of three papers; each paper outlines an individual research project with a specific purpose and scope. Yet, all studies are connected by the shared focus on the gendered contexts of substance use and the impacts that gender and other intersecting factors have on access to health and harm reduction care for women and gender diverse persons. In Chapter Five, I discuss the ways in which I envision the culmination of this research to impact the discipline of nursing.

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Dedication

For Kasper.

Perhaps it may seem strange that I dedicate this academic work to you. Yet, it is not the topic rather the spirit in which this work was generated that I devote to you.

Remember to fight for justice, be heard, be you.

Chapter One: Introduction

In British Columbia (BC), Canada, the unprecedented drug overdose emergency, which was made worse by the global Coronavirus of 2019 (COVID-19) (Government of Canada, 2022), became known as dual public health emergencies. Since the COVID-19 pandemic, overdose deaths skyrocketed along with additional substance-related harms (British Columbia Coroner Service, 2022). In 2021, overdose deaths in the province increased by 130%, a record high, compared to 2019 (British Columbia Coroner Service, 2022). Data from 2022 reported that more than 2,272 people died due to overdose (British Columbia Coroner Service, 2023). The increase in drug-related mortality and morbidity since the emergence of COVID-19 has been partially attributed to pandemic restrictions (Canadian Centre on Substance Use and Addiction, 2020; Nguyen & Buxton, 2021; Palis et al., 2022).

Restrictions included the closures of international borders, which influenced the illicit drug supply in Canada and the province of BC (Canadian Centre on Substance Use and Addiction, 2020). Additionally, overdose deaths and overdose-related morbidity increased as public health attention and resources were devoted to COVID-19 responses, such as vaccination and testing, while less attention was paid to harm reduction and overdose prevention (Goldenbery, 2020; Linas et al., 2020; McNeil et al., 2022; Vasylyeva et al., 2020). Closures and reduction in the capacity of harm reduction services, opioid agonist therapy, and withdrawal management and treatment services placed people who used drugs at increased risk of overdose and other harms (Russell et al., 2021). In response to the dual public health emergencies, federal and provincial governments implemented policies and emergency harm reduction responses to counteract the potentially

detrimental effects of the COVID-19 pandemic for people who use substances (British Columbia Centre on Substance Use, 2020).

Prior to the dual public health emergencies, people who use drugs have, for decades, advocated for a safe supply—where people have access to a regulated or known supply of drugs. In other words, having access to options to disconnect from the illegal toxic drug supply (Canadian Association of People who Use Drugs [CAPUD], 2019). In March 2020, as part of the government response to anticipated escalations in overdose deaths, BC issued province-wide clinical guidance to support the prescription of pharmaceutical alternatives to the unregulated toxic drug supply. This Risk Mitigation Guidance (RMG) was issued as an emergency harm reduction response for people who use drugs to support physical distancing while reducing the risks of withdrawal and overdose (British Columbia Centre on Substance Use, 2020). RMG provided clinical guidance for the prescription, in-person or by telehealth, of opioids (tablet hydromorphone and sustained-release oral morphine), stimulants (dextroamphetamine and methylphenidate), and benzodiazepines (clonazepam and diazepam) to support people at high risk of overdose and COVID-19 infection. The guidance outlined that those prescriptions for pharmaceutical alternatives were not meant to serve as substance use treatment. The RMG prescriptions, understood within the community to represent a form of prescribed safer supply, represented the first instance of an attempt to implement a population-based prescribed safer supply initiative internationally, and comprehensive evaluation is underway (Nosyk et al., 2021).

Gender, intersecting with race, class and other identities, is critical in these dual public health emergencies (Brabete et al., 2021; MacMillan et al., 2021). Women particularly felt the related and interconnected harms and effects of dual public health emergencies (Brabete et al.,

2021). Although the rates of overdose and COVID-19 mortality are higher among men, due to intersecting marginalizing forces (e.g., gendered violence, racialization, and poverty), women clearly remained vulnerable and potentially underserved by health and harm reduction initiatives (Boyd et al., 2020; Brabete, 2021). Aspects of social isolation, lockdowns, financial uncertainty, and attitudes about gender roles exacerbated interpersonal and structural violence and substance use in the context of COVID-19 (Brabete et al., 2021). Women were three times more likely than men to face underemployment during the COVID-19 pandemic (Gavrilovic et al., 2022). For women who used illicit substances, this meant a lack of resources to secure substances. Women who relied on the informal economy, especially sex work, lost their income when the pandemic hit or were forced to work in dangerous conditions (Benoit & Unsworth, 2022; Gavrilovic, 2022.).

The lack of data and understanding of how the dual emergencies impacted gender diverse persons is particularly problematic because marked differences exist between them, men, and women regarding their drug use and their experience of the laws, policies, and health services that affect them (Canadian HIV/AIDS Legal Network 2020). Harm reduction services need to extend beyond the current gender binary to address the multiplicity of needs of people who use drugs. In this dissertation, "gender diverse persons" is used as an umbrella term that encompasses genders other than those defined by the binary (women and men), including transgender, non-binary, genderqueer, Two-Spirit, agender, and other terms with which people personally identify (Thorne et al., 2019). My dissertation research is focused on the gendered aspects of prescribed safer supply during the dual public health emergencies. Given that the social-structural drivers of gender discrimination impact all people who use drugs whose identities fall outside the dominant group of cisgender men, I chose to include women and gender diverse persons as the target

population for this dissertation. Understanding the nuanced ways that the dual emergencies may differentially impact women and gender diverse persons is needed to inform potential public health interventions, specifically, safer supply.

Conceptual Issues and Definition of Terms

To enhance clarity, I provide an overview of key terms and concepts used in this dissertation.

Sex refers to a set of biological and physiological attributes whereby a person is defined as being female, male, or intersex according to physical and physiological features, including chromosomes, gene expression, hormone levels and function, and reproductive anatomy (Canadian Institutes of Health Research [CIHR], 2020). Sex is typically categorized as female or male, but there is variation in the biological attributes and how those attributes are expressed (CIHR, 2020). When used in this work, the terms female and male apply to those who were assigned as female or male at birth.

Gender refers to the socially constructed roles, behaviours, expressions, activities, and identities of girls, women, boys, men, and gender diverse persons. Gender, as a concept, influences how individuals perceive themselves and one another, how they interact intra- and interpersonally, and the distribution of power and resources in society (CIHR, 2020). Gender identity is not confined to a binary, nor is it static; gender exists along a continuum and can change over time. There is considerable diversity in how people and groups understand, experience, and express gender through their roles, expectations, relations with others, and the complex ways that gender is institutionalized and enacted in society. For this project, I conceptualized gender as a dynamic social process that is concerned with the "complex ways in which social differences between the sexes acquire meaning and become structural factors in the organization of social

life" (Braidotti, 2003, p. 3). Gender is relational and extends beyond the person or interpersonal relations to include the broader system relations of power of which all peoples are a part (Bungay, 2008; Harding, 1987; Smith, 1999). Gender affects substance use and also has implications for potential interventions. I will report the same terms used in the original sources when reviewing the literature. The terms **woman** or **women** include those who identify with this gender. Similarly, the terms **man** or **men** include those who identify with this gender. The term **gender diverse** (defined below) includes anyone who identifies with this gender, for example, trans, genderqueer, non-binary.

Gender identity is defined as "one's innermost concept of self as male, female, a blend of both or neither" (Human Rights Campaign, n.d., para 2). Gender identity is often the focus of how an individual perceives themselves—gender identity can be the same or different from their assigned sex at birth (Human Rights Campaign, n.d.).

Gender expression is often associated with an individual's external appearance of gender identity. Gender can be expressed through behaviour, appearance, clothing, et cetera. Gender expression may or may not conform to dominant socially constructed definitions and characteristics commonly associated with being feminine or masculine (Human Rights Campaign, n.d.).

Gender diverse is sometimes used as an umbrella term that encompasses genders other than those defined by the binary (women and men), including transgender, non-binary, genderqueer, Two-Spirit, agender, and other terms with which people personally identify (Thorne et al., 2019) but does not imply any specific gender expression or sexual orientation. The scope of this study is limited to women and gender diverse persons. Woman defines anyone who identifies

with this gender, and gender diverse, as defined above, includes anyone who as transgender, non-binary, or gender-fluid.

Intersex is a general term used sometimes to describe a variety of situations in which a person is born without a binary definition of female or male. For example, a person may be born with genitals that seem to be in-between the usual male or female types. Often intersex is not a term people self-declare as most intersex people may never be aware of the differences and some find the label derogatory when used in the context of possessing a 'condition' (Human Rights Campaign, n.d.).

Harm reduction "refers to policies, programs, and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies, and drug laws" (Harm Reduction International, n.d., para 1).

Low-threshold service models often refer to services that require minimal demands on the person(s) accessing the services; for instance, by reducing or removing barriers to access. According to a publication by the BC government, low-threshold services are flexible, person-centred, remove real or perceived barriers, and improve people's engagement and follow-up in the program/service (Government of BC, n.d.).

Marginalization is a concept that refers to the root causes of inequitable access to basic human rights and social disconnection. Marginalized populations or groups are communities of people that experience exclusion and discrimination (social, political, and/or economic) because of unequal power relations across political, social, economic, and/or cultural dimensions (National Collaborating Centre for Determinants of Health, 2022).

Illegal toxic drug supply. In Canada, illegal drugs refer to those substances in which a person is prohibited to possess or use due to the laws determined by the federal government. The illegal drug supply is the market dedicated to the producing, distributing, and selling of prohibited substances. In Canada, toxicology data confirms that the illegal drug supply consists of increasingly adulterated drugs with unknown contents (often fentanyl and other analogues) in unknown doses (Government of Canada, 2023).

Safe(r) Consumption Services (SCS) refer to harm reduction programs that offer a variety of low-threshold services for people who use substances (Government of Canada, 2021), although language varies slightly across programs. The characteristic that often defines an SCS is that it is a site where people can use pre-obtained drugs with the support and safety of skilled personnel. Most SCSs are unique and offer different health and social service options. For example, some SCS do not limit the type of consumption allowed at the site, e.g., allowing for injection, oral, or intranasal forms of consumption. Some sites are restricted to injection and are often referred to as supervised injection sites. In Canada, SCS is often referred to as *sanctioned* if the SCS has applied for and received an exemption to the Controlled Drugs and Substances Act, which allows the site to operate freely without any repercussion from law enforcement. In contrast, an unsanctioned SCS is a site or organization has not been granted the exemption.

Overdose Prevention Sites (OPS) in the Canadian context are similar to SCS as the purpose is to provide a safer space for people who use drugs to use pre-obtained substances. The difference between OPS and an SCS is often the lack of permanency of an OPS (PIVOT, n.d.). OPS are often set up rapidly in communities to address an urgent need, e.g., a high overdose rate due to a contaminated supply of illicit drugs. Both a SCS and an OPS can apply for an

exemption to the Controlled Drugs and Substances Act; however, for an OPS this process meant to be less onerous and quicker, but this exemption lasts for a shorter duration, usually about three to six months (PIVOT, n.d.). When drug-related overdoses were declared a public health emergency in 2016, BC rapidly established OPS; these lifesaving interventions continue to serve as an example of a "novel and nimble" approach to reducing harm during a public health emergency (Wallace, et al., 2019 p. 64).

People who use drugs (PWUD) often refers to those who self-identify as someone who uses(d) illicit substances.

Peers, in the context of substance use, refer to individuals with current and/or former experience with substance use and the stigmatization and criminalization that often accompanies substance use—specifically illicit substance use (SOLID, n.d.).

Substance Use and **Drug Use** are terms I have chosen to use interchangeably rather than problematic substance use, substance abuse, or substance misuse to avoid focus on the actions of individuals who use substances rather than the context of their use. For this research, substance use refers to both continued use of and dependency on substances (illicit and licit). Illicit substances refer to those currently considered illegal or prohibited by current federal drug policy. Licit use of substances refers to the use of regulated, legalized drugs, or use of prescription drugs as directed (Government of Canada, 2022).

Structural Inequities refer to how policies and practices in health, social services, justice, and other systems operate to produce an inequitable distribution of health determinants (Farmer et al., 2006; Varcoe et al., 2014). Inequities are structural because they are embedded in the political and economic organization of our social world with differential effects based on several

dimensions, including gender, age, class, race, ability, size, sexual orientation, geographic location, and other dimensions.

Structural Violence is a concept that is linked to the concept of structural inequity and the multiple intersecting "social machinery of oppression" (Farmer et al., 2006, p. e449). Structural violence refers to the social arrangements that place certain people and populations in harm's way. For instance, structural violence is expressed in unequal access to employment, resources, political power, education, and health care.

Additional definitions and concept clarification will be provided as they arise throughout this dissertation.

Review of Relevant Research Literature

Given the context of the ongoing overdose emergency, I specifically focused on research published primarily between 2010 and 2023. I chose Canadian studies because the overdose emergency and corresponding policy and practices have been implemented differently in different geographical regions. Studies that involved both men and women within the context of illicit substance use were included as the study approaches, topics, and findings of this work were relevant to my overall research objectives. A paucity of research attends to substance use among gender diverse persons. Wherever possible, I draw attention to studies that have looked beyond the gender binary. In reviewing the relevant literature, I explored current knowledge about women, gender diverse persons, and access to harm reduction in the Canadian context. Because my research was embedded in the dual public health emergencies (i.e., COVID-19 and overdose), I critically examined and summarized the literature related to both public health responses and novel harm reduction interventions.

The Situation—An Unprecedented Unintentional Overdose Crisis

At the time of writing, North America was witnessing an unprecedented overdose emergency taking people's lives at alarming rates. In Canada, 20 people died daily from overdose-related deaths (Government of Canada, 2023). These deaths were primarily due to the increase of highly potent synthetic opioids, fentanyl, and its analogues, in the illicit drug supply (Canadian Centre on Substance Use and Addiction, 2020). Beginning in 2010, Canada's illicit drug market witnessed a significant shift, where heroin began to be replaced with illicitly manufactured fentanyl (Ciccarone, 2021). Since then, the adulteration of drugs in the illicit market has been widespread, with fentanyl, benzodiazepines, and other contaminants found in the circulating illicit drug supply (Canadian Centre on Substance Use and Addiction, 2021). The overdose crisis deepened during the COVID-19 pandemic. Across the country, overdose deaths and overdose-related morbidity increased as public health attention, and resources were devoted to COVID-19 responses, such as vaccination and testing, while less attention was paid to harm reduction and overdose prevention responses (Goldenberg, 2020; Linas et al., 2020; McNeil et al., 2022; Vasylyeva et al., 2020). International border closures affecting drug supply chains and the potential for increased isolation while using substances were also identified as significant factors that exacerbated the overdose deaths and opioid-related morbidity during the pandemic (Nguyen & Buxton et al., 2021; United Nations, 2020; Vasylyeva et al., 2020).

The province of BC was one of the most impacted places in the world by illicit drug overdoses. Beginning in 2011, overdose deaths began to climb substantially in the province, and in April 2016, the government declared a public health emergency (Government of British Columbia, 2016). By 2017, life expectancy in BC decreased by 0.3 years for men and by 0.1 years

for women, and unintentional overdose became the leading cause of death for people between the ages of 19 to 39 in the province (Government of British Columbia, 2022; Ye et al., 2018). The provincial government promised to invest $332 million to implement a comprehensive public health strategy supporting a compassionate approach to prevention, treatment, harm reduction, and enhancing surveillance and research. A key component of the strategy was to expand harm reduction services in the province (Government of British Columbia, n.d.). Governments and communities worked to create and implement harm reduction measures, defined as policies, strategies and practices to reduce the harmful effects of drug use on individuals and communities, including stigma, without expectation of reduction of drug use (Harm Reduction International, n.d.).

Strategies included increasing access to naloxone, implementing drug-checking services, distributing harm reduction equipment, and increasing proactive follow-up support for people at high risk of drug toxicity (Government of British Columbia, n.d.). While progress was made, people continued to die at unacceptable rates, which demonstrated that the declaration and response were insufficient to address the crisis (Irvine et al., 2019). Following the onset of COVID-19 in 2020, the number of overdose deaths in the province more than doubled compared to 2019 (Palis et al., 2022). Governments and communities continued to struggle to respond to the dual emergencies. In addition to scaling up existing harm reduction measures, the province and communities developed additional novel policies and practices such as prescribed safer supply—described in depth below.

While the dual public health emergencies were significant drivers of morbidity and mortality among people who use substances, the impacts were exacerbated by the broader social,

environmental, and structural inequities in which people's lives were embedded (Goldenberg, 2020; Vasylyeva et al., 2020). Punitive drug policies, socioeconomic marginalization, colonialism, stigma, and discrimination were critical in shaping the substance- and health-related outcomes among PWUD (Boyd et al., 2020; Collins, 2020). These social-structural inequities were further shaped and exacerbated by gender discrimination, transphobia, and homophobia among women and gender diverse persons, creating unique contexts and impacts on health and health equity.

Women, Gender Diverse Persons, Drug Use, and the Overdose Crisis

The overdose crisis in BC has taken the lives of over 10,000 people, with the majority of deaths being males aged 30 to 59 (British Columbia Coroners Service, 2023). Deaths among women are increasing overtime. In April 2022, 506 females died due to overdose, compared to 334 deaths in 2020 (British Columbia Coroners Service, 2023). Currently, it is not possible to identify gender diverse people in the BC Coroners data. As men constitute the majority of those impacted by the crisis, the impacts of overdose on women and gender diverse persons have often been overlooked (Collins et al., 2019). Although marked differences between men, women, and gender diverse persons exist with respect to their substance use and corresponding access to health and harm reduction services, the statistical data and crude mortality estimates often obscure the gendered dimensions of the crisis (Canadian HIV Legal Network, 2020; Collins et al., 2019). This is especially the case concerning gender diverse persons who use drugs, as the existing population-based data sources which reveal sex and gender differences in overdoses are limited to the binary definitions, which obscures and excludes gender diverse persons.

Research demonstrates that women and gender diverse persons, especially those with intersecting marginalized identities related to race and class, are differentially impacted by

substance-related risks and harms compared to cisgender men (Boyd et al., 2020; Collins et al., 2019; El-Bassel & Strathdee, 2015; Thumath et al., 2021). In Canada, HIV and HCV disproportionately affect women who use drugs. In 2019, the proportion of reported HIV cases among females attributable to injection drug use was 38.4% compared to 14.6% for men (Canadian HIV Legal Network, 2020). Research conducted internationally and nationally has revealed that women who inject drugs are more likely than men to share injection equipment, more likely to require assistance injecting, and more likely to be injected by a sexual partner. (Azim et al., 2015; Canadian HIV Legal Network, 2020). For women who sell sex, the risk is even higher; sex workers who inject drugs are more likely to reuse, borrow, or rent injecting equipment (Canadian HIV Legal Network, 2020).

In Canada, gender-based violence is a critical determinant of health for women and gender diverse persons who use illicit drugs, particularly for those who sell sex or who are Indigenous and/or trans (Canadian HIV Legal Network, 2020). Women who use illicit drugs are more likely than their male counterparts to experience sexual violence, intimate partner violence, and State[1] violence. In BC, due to the rapid and severe intoxication associated with the highly potent and adulterated supply of illicit drugs, women have been victims of theft and/or sexual assaults (Boyd et al., 2018). Additionally, in a study investigating policies and practices around allowing for *splitting and sharing* of substances among people who use OPS/SCS, women and gender diverse persons stated concerns that they could be coerced or even forced to share with others, which limited their safety and agency (Xavier et al. 2021).

[1] The State in this research is defined as the institutions that govern, order, and organize society and define what activities and behaviours are appropriate within the society (Barnsley, 1985).

Women who use illicit substances face societal stigma in every area of life, including personal relationships and relationships with coworkers and people in their communities (Bungay, 2008; Riveria et al., 2015; Wathen et al., 2019). The stigma is often due to societal expectations and stereotypes of women's behaviour. Historically, women who use substances (especially illegal substances) have been positioned within the health and social discourse as women who have abandoned their nurturing and mothering role within society and are viewed as individually weak and of low moral character (Boyd, 2004; Bungay, 2008). Substance use is viewed as a *betrayal* of their responsibility to their families and society (Stone, 2015). This dominant gender stereotype has increased the regulation of women by the State, including the criminal justice and child welfare systems (Boyd, 2004; Boyd et al., 2018; Stone, 2015).

Pregnant women who use substances often face ongoing attempts to criminalize substance use during pregnancy, putting them at risk of detection, arrest, and punishment (Stone, 2015). The fetal endangerment laws present in several states in the U.S. have led to women facing criminal charges for giving birth to infants who test positive for drugs upon delivery. An extreme example is a woman in South Carolina who was convicted of homicide when her pregnancy ended in a stillbirth attributed to the women's use of crack cocaine (Whitner v. State, 1997). According to existing Canadian legislation, drug use during pregnancy is not grounds for intervention, yet coercive practices are used by social and health care providers, such as forced drug dependence treatment (including but not limited to family drug treatment courts) and birth alerts (Cidro et al., 2018; Doenmex et al., 2022).

Canadian women and gender diverse persons who use drugs while parenting experience a disproportionate burden of apprehensions by child welfare authorities (Trocmé et al., 2004) due to

prohibitionist drug policies, which dictate that abstinence is considered to be proper parenting and drug use is considered to be harmful or abusive (Boyd, 2004; Thumath et al., 2021). Women who use drugs who are parenting and marginalized by poverty, mental illness, and racism face a disproportionate burden of apprehensions by child welfare authorities (Trocme et al., 2004). The result is reflected in the high rate of children of women who use/used drugs currently in the care of Canadian child welfare authorities (Boyd, 2004; Thumath et al., 2021).

The stigma related to illicit substance use has a different outcome for women compared to cisgender men while further intersecting with other social locations. First Nations[2] women in BC face disproportionate overdose rates, with an overdose rate of First Nations women over 11 times the rate for non-First Nations women in 2022 (First Nations Health Authority [FNHA], 2022). Ongoing colonization, racism, and the criminalization of illicit substance use have increased Indigenous women's vulnerability to substance use harms and limited their access to health and social services (Benoit et al., 2010; Boyd et al., 2018; Bungay et al., 2010). Thumath and colleagues (2021) looked at the intersections of child custody loss and the risk of an unintentional drug overdose in a group (n=1000) of marginalized cisgender women in Canada. After controlling for known confounders, women who have a child removed through apprehension experienced higher odds of overdose (AOR 1.75; 95% CI 0.92–3.33), and the odds were highest among Indigenous women (AOR 2.09; 95% CI 1.15–3.79).

Women and gender diverse persons who use drugs and sell sex were at increased risk of experiencing substance-related health and social harms (Canadian HIV Legal Network, 2020).

[2] First Nations is a term used to describe Indigenous Peoples in Canada who are distinct from Métis or Inuit (Government of Canada, n.d.).

They incurred high rates of physical, sexual, and structural violence that mediates the impact of harm reduction efforts to reduce or prevent overdose (Canadian HIV Legal Network, 2020). A Vancouver study with women who use drugs and engage in street sex work found that they were subject to heavy policing and high rates of violence and exploitation that likely rendered harm reduction and overdose prevention efforts less effective and exposed them to many health and social harms (Goldenberg, 2019). The literature suggests the urgent need for further strategies to understand and respond to the gendered aspects of substance use, specifically strategies to prevent overdose and substance use harms among women and gender diverse persons.

Brief History of Harm Reduction in Canada

In Canada, harm reduction policies, programs and services have evolved over several decades. The origins of harm reduction in the country can be traced back to the late 1980s when the rates of HIV infections significantly increased among people who injected drugs (Hyska et al., 2017). As a response, Canada began implementing syringe distribution in several key jurisdictions, including Montreal, Toronto, and Vancouver (Hyshka et al.). When the federal funding for the syringe programs ran out, many programs continued with the province's support. Currently, most of Canada's 13 provinces and territories have syringe programs (Government of Canada, 2016; Hyshka et al.).

Federal support for harm reduction continued through the 1990s and 2000s. Support included recognizing harm reduction as a key pillar of federal drug policy and granting two temporary legal exemptions, allowing the establishment of Insite, North America's first legal supervised injection facility, in Vancouver in 2003 (Hyska et al., 2017; Lawrence, 2017).

However, provinces varied in terms of the development of harm reduction policies (Wild et al., 2015).

The 2010s marked a period of challenges for harm reduction efforts in Canada due to a conservative federal government that replaced Canada's drug strategy with a national anti-drug strategy (Government of Canada, 2012; Hyshka et al., 2017). The government also attempted to close Insite by refusing to extend the Controlled Drugs and Substances Act exemption. After a lengthy legal battle, the Supreme Court of Canada unanimously ruled that the federal government's attempts to close Insite went against the country's Charter of Rights and Freedoms by threatening the safety and lives of the people who need to use it. The decision helped to solidify Insite as an effective and ethical healthcare response to injection drug users and created an opportunity for other Canadian jurisdictions to create services based on health, safety, and respect for the personhood of the drug user (Lawrence, 2017). While harm reduction policy and programming is under the purview of individual provinces and territories, the hostility to harm reduction at the national level meant less federal support. Many provincial and municipal decision-makers continued to establish harm reduction programs and services while having to circumvent federal policies grounded in prohibition. However, access to harm reduction services was and remains highly variable across jurisdictions, reflecting inconsistent provincial and territory political support for such programs and services (Hyshka et al.; Wild et al., 2015).

In 2015, a newly elected Liberal Federal government signalled a new willingness to support national and ongoing provincial and territorial harm reduction efforts. The Liberal government returned harm reduction to federal policy by declaring a new Canadian Drugs and

Substances Strategy, with harm reduction again as one of the key pillars in the approach (Government of Canada, 2016; Hyshka et al., 2017).

By 2016, Canada was in the depths of an overdose emergency, with a dramatic increase in opioid-related deaths in several parts of the country. BC, the most western province of the country, has been the most affected. The BC Public Health Officer declared a public health emergency in 2016 due to the high and escalating rates of illicit drug overdoses in the province (Government of British Columbia, 2016). Illicit fentanyl and its analogues in the unregulated drug supply drive the emergency. The emergency continues today. In response, policymakers, healthcare providers, and community organizations in the province worked to increase a range of health sector and community programs and services to prevent, respond to, and mitigate overdose and other drug-related harms (Government of British Columbia, 2017). While harm reduction efforts were scaled up in BC specifically, other federal, provincial, and territorial healthcare decision-makers and drug user groups worked to scale up harm reduction services. Such services included the increase of approved supervised drug consumption programs and overdose prevention sites, national treatment guidelines for opioid use disorder that support harm reduction methods, enhanced community access to naloxone, increase in drug checking services, and the federal Good Samaritan Drug Overdose Act (Government of Canada, 2017; Hyshka et al., 2017). Despite the implementation of these additional harm reduction measures, rates of overdose deaths and harms continued to vary across the country.

In 2020, the onset of the COVID-19 pandemic brought about another public health emergency that increased the risk of overdose and drug-related harm. International border closures led to an increasingly toxic unregulated drug supply (Canadian Centre on Substance Use and

Addiction, 2020). Public health orders to shelter in place and the closure of many harm reduction and social service programs created perilous situations for people who used drugs (Russell et al., 2021). Across the country, rates of opioid-related deaths and harm rose substantially. Given the dual public health, federal and provincial/territorial governments took a renewed focus on scaling up and expanding harm reduction services to support people during this critical period of increasing harm. In addition to scaling up existing harm reduction measures, various provinces and communities developed additional novel policies and practices, such as the Risk Mitigation Guidance (RMG) which permitted the prescribing of medication alternatives to substances including opioids, alcohol, stimulants and benzodiazepines along with the broader policy intervention referred to prescribed safer supply to help respond to the unprecedented emergency.

While the COVID-19 emergency is no longer in effect, the overdose emergency is ongoing. In the Canadian landscape, ongoing support for harm reduction waxes and wanes and varies greatly depending on the jurisdiction. For example, in Alberta, the current conservative government's response to the overdose emergency is to offer only absence-only recovery services while openly opposing harm reduction models. In BC, there appears to be provincial governmental support to continue novel approaches such as offering prescription alternatives for people who use substances or prescribed safer supplies; yet again, support for these approaches varies among individuals, communities, and geographical jurisdictions in the province.

The harm reduction landscape in Canada continues to evolve as new governments take power and community needs shift and evolve. Access to harm reduction services significantly varies across jurisdictions, reflecting political and ideological differences in provincial and territorial commitments. One of the key gaps across all jurisdictions regarding harm reduction

responses and programming is the lack of attention to diversity in this emergency. While men make up the majority of those affected by overdose, women and gender-diverse people face unique and specific barriers regarding the types of harm reduction services and support they need or desire (Collins et al., 2019). Few places in the country offer gender-specific harm reduction spaces and supports.

Harm Reduction and Overdose Prevention

Efforts have been made to provide gender-specific spaces for overdose prevention in Vancouver, BC. These include two women-only (gender fluid and transgender-inclusive) safe consumption services[3] (SCSs). SisterSpace is a women-only community SCS located in the Vancouver neighbourhood of the Downtown Eastside, an area that has been called "the epicentre" of Canada's overdose crisis (Atira, n.d.; Boyd et al., 2020, p. 2). SisterSpace is open to women and femme-appearing gender diverse persons, with 82 percent of the women that use the space identifying as Indigenous (Atira, n.d.). The site has not had a fatal overdose since its inception.

Qualitative research with structurally vulnerable women who accessed SisterSpace found that the space constituted a safe place that offered a "temporary reprieve" from various forms of violence and drug harm, including overdose (Boyd et al., 2020, p. 7). During conversations with the researchers, several women shared that they had forgone co-ed OPSs and other harm reduction services for fear of running into men who have caused them harm (Boyd et al., 2018). Women spoke about their ability to *open up* and speak more openly about their challenges and connect with other women and staff (who were often women with lived and living experience of substance

[3] In Canada, while the language can vary slightly, Safer Consumption Services (SCS) are sites where people can use pre-obtained drugs with the support and safety of skilled personnel (Government of Canada, 2021).

use). In addition to providing a space to use substances safely, women reported that the staff at the OPS helped connect them to other supports, including housing, health and social resources, education, and legal support.

A second women specific SCS is located within a transitional housing and drop-in service in the Greater Vancouver Area. The site is tailored to women who smoke illicit drugs. Research conducted at this site revealed positive experiences similar to findings from women who accessed SisterSpace (Bardwell et al., 2021). When interviewing women who accessed the site, investigators found that having a women's only smoking environment accommodated and generated safety and sociality that recognized gender differences and substance use preference, (i.e., a space that recognized polysubstance use). Similar to Boyd et al. (2018) findings, women at the smoking site reported an ability to engage comfortably in harm reduction services and felt increased safety and decreased risk of overdose while also having a reprieve from other socio-structural harms.

Community-based research in Ontario focused on women's access to and safety at co-ed safe consumption services. Using a community-based research approach, investigators conducted seven focus groups with women and gender diverse clients of OPS and SCS in Ontario (n=33 people with lived and living experience of illicit drug use) (Xavier et al. 2021). One-on-one interviews were also conducted with frontline SCS/OPS staff to determine the barriers and facilitators that shape women's access to SCS. Overall, participants described several gendered barriers to accessing SCS, including privacy concerns, fears of reporting to child protective services, and concerns around safety.

SCS are a key component of BC's overdose and harm reduction responses. While providing a safe place to consume drugs, these spaces offer other critical community, social, and health supports to women who use drugs. Few sites specifically for women and gender diverse persons were available, and the existing services were located in urban contexts. While the women-specific services indicated that women were welcome in the spaces, it is less clear how welcome gender diverse persons were in these SCS spaces.

Overall, the studies with women who use drugs have identified the need for public health interventions, specifically harm reduction and overdose prevention measures, to address how gendered social and structural violence impacts women's health and well-being (Bardwell et al., 2021; Boyd et al., 2020). However, despite the repeated calls for sex and gender to be part of public health and substance use service delivery, many harm reduction services in Canada continued to provide services and care that lack attention to gender or narrowly defined gender in ways that were heteronormative and, as a result, offered care that were not necessarily safe or accessible to women and gender diverse persons who use drugs (Boyd et al., 2020; Collins et al., 2019; Xavier et al. 2021).

Nursing, Substance Use, & Harm Reduction

All nurses, regardless of where they practice, will encounter people who use substances, but substance use nursing is considered a unique specialty practice area (Canadian Nurses Association [CNA], 2017). As a specialty area, *substance use nursing* is defined as an area of practice where nursing care is provided primarily to individuals who use substances and often experience substance use disorders (CNA, 2017). Nurses who specialize in the substance use field practice variously in traditional hospitals, community locations, primary care, harm reduction

services, mental health outreach teams, withdrawal management centres, and private or faith-based organizations. Although substance use nursing has existed for the past five decades, this nursing field often needs to be better understood by the broader healthcare community (Clancy et al., 2007; Rassool & Rawaf, 2008). In recent years, the ongoing overdose emergency has called attention to substance use nursing as a specific and vital area of practice (CNA, 2017). In Canada, there have been efforts by various national and provincial nursing associations to develop policies and practice standards for harm reduction practice. However, seven years into the overdose emergency, these efforts have yet to fully materialize (Gagnon et al., 2020).

Harm Reduction Nursing Practice

Arising as a response to the socially mediated inequities faced by those who use substances, harm reduction is considered both a philosophy and a practice (International Harm Reduction Association [IHRA], 2018; Pauly, 2008). Harm reduction recognizes that nurses have a professional and ethical responsibility to adapt their care to the needs of individuals, groups, and communities to reduce potential substance use harms and promote health, choice, and autonomy (IHRA, 2018). Harm reduction is not limited to a physical space, a health experience, or a specific population (IHRA, 2018). As such, it should be understood (and utilized) as a philosophy of care for all nurses, regardless of their practice setting (IHRA, 2018). At the time of this writing in Canada, no collectively accepted standards of care or specialized training exists for nurses who practice in substance use or harm reduction settings. Instead, we find significant variation in how harm reduction care is practised—which often depends on the individual nurse, the context in which they practice, and the broader healthcare system.

In British Columbia (BC), nurse practitioners (NPs) (nurses who have completed graduate-level education and achieved the advanced nurse practice competencies required for registration as an NP with the provincial regulatory college) can prescribe pharmaceutical alternatives for safer supply (British Columbia College of Nurses and Midwives, n.d.). Additionally, in September 2020, the BC Public Health Officer passed an order for registered nurses and registered psychiatric nurses to prescribe "public health pharmacotherapy" as another measure to prevent and reduce the risk of overdoses in the province (Government of British Columbia, 2020, para. 1). Regrettably the provincial regulatory college of nurses and midwives limited the prescribing to one pharmacological therapy—buprenorphine/naloxone. Typically, this medication is recommended as a first-line therapy for treatment for people diagnosed with opioid use disorder (Bruneau et al., 2018).

COVID-19 and Gender

Crises tend to expose our worst injustices. On March 27, 2020, the United Nations published a statement warning that rates of intimate partner violence (IPV) will dramatically increase owing to the global coronavirus (UN Women, 2020). Forced confinement, financial uncertainty, attitudes about gender roles, and a desire to exert control during a disaster have increased IPV around the globe (Bradley, et al., 2020; Wathen, 2020). In Canada, during the first thirty-six days of the mandated social isolation, eleven women were murdered by a current or previous intimate partner (Battered Women's Support Services, n.d.). Calls to a Vancouver-based domestic violence organization tripled, demonstrating a dramatic increase in the volume of calls and the severity of many of the callers' situations. In Alberta, IPV crisis supports witnessed a 30 to 50% increase in calls in the first three months of the pandemic (Bradley et al., 2020). Advocates in

Toronto and neighbouring regions reported that the number of women seeking emergency services tripled (Amin, 2020).

Gender-based violence, specifically IPV, is a critical determinant of health for women and gender diverse persons who use drugs (Canadian HIV Legal Network, 2020). For women who use illicit drugs, gender-based violence has been linked to elevated rates of syringe sharing, inconsistent condom use, and accidental overdoses (El-Bassel et al., 2019). The intertwined public health emergencies generated another layer of harm for women who use drugs. Women affected by IPV often have difficulty accessing harm reduction services, entering, and completing substance use treatment (if desired), and practising safer drug use (Canadian HIV Legal Network, 2020). Additionally, the criminalization and stigma of illicit drug use can be leveraged by abusive partners to control women, further increasing the risk of substance-related harm and overdose (Steffi, et al., 2021). While both the national and provincial governments identified the need for strategies and responses to support *at-risk* women (women who are unhoused, who engage in sex work, and who use drugs), specific interventions or support with attention to gender never surfaced.

Novel Harm Reduction Interventions: Prescribed Safer Supply

Dual public health emergencies created an urgency necessitating novel strategies (policies and practices) to reduce harm (British Columbia Centre on Substance Use, 2020; Enns et al., 2020). Novel health interventions are *new or original* strategies used to improve health outcomes and mitigate negative consequences (Ivsins et al., 2020; Wallace et al., 2019). In March 2020, due to an anticipated escalation in overdose deaths, BC (the province most affected by the overdose

emergency) issued a province-wide clinical guidance to support the prescription of pharmaceutical alternatives to the circulating toxic drug supply—commonly referred to as prescribed safer supply.

The Risk Mitigation Guidance (RMG) provided direction for the prescribing of opioids (tablet hydromorphone), stimulants (dextroamphetamine and methylphenidate), benzodiazepines (diazepam and clonazepam) and alcohol to persons who are COVID-19 positive or at high risk of COVID-19 transmission or who are at risk for harms related to withdrawal or overdose (British Columbia Centre on Substance Use, 2020). The RMG represented the first occurrence of a population-based prescribed safer supply initiative in the world. A mixed-method investigation of RMG implementation and impacts supports the initiative's promise, but research is ongoing (Noysk et al., 2021), as is the overdose crisis. Building on previous evidence that suggests women and gender diverse persons remain underserved by harm reduction programs and initiatives, research is needed to capture the complexities of accessing prescribed pharmaceutical alternatives to develop future policies and practices that can respond to the unique contexts of women's and gender diverse persons' substance use (Boyd, 2004; Boyd et al., 2018; Boyd et al., 2020; Bungay, 2008; Canadian HIV Legal Network, 2020; Collins et al., 2019; Xavier et al. 2021)

Rationale for the Study

This research aims to provide a gendered analysis of prescribed safer supply policies and practices during dual public health emergencies. This research builds on the existing evidence that women and gender diverse persons often remain underserved by harm reduction programs and initiatives and that current approaches often overlook the specific and unique needs of women and gender diverse persons who use illicit drugs (Boyd, 2004; Boyd et al. 2018., Boyd et al., 2020; Canadian HIV Legal Network, 2020; Collins et al., 2019). To date, no published studies have

offered a gendered analysis of the implementation and impacts of prescribed safer supply. Further, it is unclear how these impacts are experienced across the gender spectrum. Despite the numerous calls for gender-responsive healthcare and harm reduction services, governments and healthcare providers continue to plan, implement, and offer one size fits all or universal services. Without specific attention to understanding the gendered aspects of harm reduction care, people will continue to experience gaps in care or care that is ineffective or unsafe. Overall, this research aims to generate knowledge that will be used to inform future harm reduction and overdose response efforts.

Methodological Considerations

This dissertation consists of three separate but related works, driven by the following research questions:

(1) Do the current clinical guidance and policy direction on prescribed safer supply address the unique needs of women and gender diverse persons in BC?

(2) Using prescribed safer supply as a case study, how could health equity be integrated into the Consolidated Framework for Implementation Research (CFIR)?

(3) What were women's and gender diverse persons' experiences of accessing or attempting to access prescribed safer supply in BC during the dual public health emergencies?

To address these knowledge gaps and my specific research questions, I employed an overall qualitative approach, drawing on three different methods to generate new knowledge on gender-responsive harm reduction and overdose prevention strategies. The following section

describes the theoretical, philosophical, and methodological considerations in answering my research questions.

Situating the Qualitative Research Approach

In the vast landscape of qualitative inquiry, nurses continue to be interested in the strategic use of qualitative methods to meet the needs of the discipline. Often, nurse researchers are interested in methods that generate knowledge that informs the complex health phenomena and the situations they face in their practice. In a global era of health and social inequities, nurses think about the nature and application of knowledge and how knowledge can be generated to intervene in some of the most challenging health issues (Anderson, 2002; Denzin & Lincoln, 2018; Kassam et al., 2020; Reimer-Kirkham & Anderson, 2010; Rodgers, 2005). They recognize that to improve the health of the most marginalized populations, nurse-researchers require approaches that combine a multiplicity of insights and methods that can be adapted to complex health and social contexts. Such work requires what Denzin and Lincoln refer to as Qualitative Researcher-as-Bricoleur.

The *bricoleur* is a French word that describes a "handyman or handywoman who makes use of the tools available to complete a task" (Kincheloe, 2001, p. 680). The concept of *bricolage*, as described by Denzin and Lincoln (2018), is an accessible and helpful metaphor for specifying a particular worldview of qualitative research: "The theoretical *bricoleur* reads widely and is knowledgeable about the many interpretative paradigms (feminism, Marxism, cultural studies, constructivism, queer theory) that can be brought to any particular research problem" (Denzin & Lincoln, 2018, p. 5). A *bricolage* worldview entails pragmatism—where researchers are not committed to any one philosophy (Creswell & Cresswell, 2018). Drawing on the concept of

bricolage, this dissertation research drew on several differing philosophical and theoretical concepts along with multiple qualitative methods that could be used to explore the complex experiences of women and gender diverse persons who use drugs.

Ontological, Epistemological, and Axiological Underpinnings

Drawing on both constructivist and critical paradigms, several assumptions guided the design and implementation of this research. Each dimension impacts how the research questions were formulated, how the three interrelated projects were conceptualized, and how the research was carried out. I used a constructivist ontological position in my research to emphasize that reality is not fixed and is constantly shifting in continual construction and reconstruction (Lincoln & Guba, 2000). Similarly, my epistemology assumed that knowledge is co-constructed between the knower and the known, accounting for the subjective aspects of this interaction.

Additionally, I drew on the unique epistemological assumption associated with interpretive description (ID), which accounts for the disciplinary epistemology (in my case, nursing) that guides and informs the research process (Thorne, 2016). The axiological assumptions embedded in my approach include a commitment and desire to generate knowledge that adds value to the discipline of nursing and knowledge that motivates further action. For example, the collective knowledge generated from this dissertation is meant to advance harm reduction nursing practice, research, and education and to advance gender-responsive drug policy, generally. I applied these assumptions to my data gathering, interpretation, and utilization processes, letting my nursing orientation shape the questions I asked, what sources of data I gathered, how I interpreted the data, and how these interpretations can be applied to harm reduction nursing practice. Finally, I also drew on critical axiological assumptions that assume valuable research is research that provokes

political and social change. In designing this study, I wanted to not only understand the impacts of RMG prescriptions on women's and gender diverse persons' lives but also draw attention to the social and political contexts that shape these experiences in hopes of provoking broader political and policy change.

Theoretical Underpinnings

Gender

Gender is a key guiding concept that informed my dissertation research. I conceptualized gender as a social construction concerned with the "complex ways in which social differences between the sexes acquire meaning and become structural factors in the organization of social life" (Braidotti, 2003, p. 3). Gender is relational and extends beyond personal or interpersonal realms to include the broader systematic power dynamics that all peoples are part of (Bungay, 2008; Harding, 1987; Smith, 1999). Gendered power relations shape all aspects of individual, community, and political life, from intimate relationships to the highest levels of political decision-making. To explore the gendered power relations that shape access to harm reduction among women and gender diverse persons who use drugs, I draw specifically on critical and feminist theory to guide my overall inquiry.

Critical Influences

An interdisciplinary family of critical theories establish a critique of economic, social, and political institutions that structure and control people's lives in oppressive and unjust ways (Bohrer, 2019; West, 2010). Despite wide-ranging interpretations and applications, the *family* of critical theories share a common concern and attention to broad structural and epistemological constraints that govern human experience. The goal of critical research is to generate knowledge

toward the attainment of social justice (Bohrer, 2019). All three projects included in this proposal are underpinned by a critical perspective because the purpose of each project, individually and collectively, is to advance social justice initiatives and improve health equity for women and gender diverse persons who use drugs (Boher, 2019).

The prevailing focus of this dissertation is to study the complex ways in which gender and other intersecting locations impact women's and gender diverse persons' experience with harm reduction interventions, specifically prescribed safer supply. Without attention to the structural and social determinants that influence women's and gender diverse persons' health—including policies, poverty, racism, violence, and criminalization—prescribed safer supply services may exclude women and gender diverse persons if these factors are not accounted for in care delivery. Drawing on a critical lens helps attend to these determinants.

(Intersectional) Feminist Influences

Feminism is a broad-based social, political, and intellectual movement; feminist scholarship in the academy "constitutes a resistant knowledge project dedicated to advancing gender equity and social justice" (Collins, 2019, p. 98). Feminist scholarship is a field of scholars and activists who hold a complex set of identities and social locations, many of whom find their knowledge subjugated outside of what has historically been considered part of the feminist discourse (Ahmed, 2017; Gerbrant, 2019). In a research context, a key feature of conducting feminist research is placing the social construction of gender at the centre of the inquiry (Lather, 1991). While I commit to centring gender in my inquiry, I draw on intersectionality to better attend to the complexity of women's and gender diverse persons' experiences.

In contrast to many conventional feminist theorists who use gender as the fulcrum of their analysis, intersectional theorists (or intersectional feminists) view gender not as a single operating category but as a phenomenon always mediated by race, class, ability, and history (Bohrer, 2019; Collins, 2019). Intersectionality was formed out of a critique by Black feminist scholars who felt that feminist theory was not inclusive and did not accurately attend to the discussion around race (Collins, 2019). By the 1980s, intersectionality gained recognition as a stand-alone theory and an emerging critical perspective for attending to the interaction between and among the social categories (including gender) that shape people's lives (Bohrer, 2019; Collins 2019). Gender in this framework is understood as a fundamental component of social relations based on perceived differences between women, men, and gender diverse persons and a primary way of conveying power and hierarchy (Bohrer, 2019). This position perceives that all social interactions and institutions are gendered in some way, which means that constructions of femininity and masculinity are interconnected in the daily life of political, economic, and legal institutions (Ahmed, 2017; Montesanti & Thurston, 2015). In other words, these constructions play out in everyday experiences. Gender as a social institution organizes *everyday life* in hierarchical positions and categories, which maintains subordinate positions, whether material or ideological, among people (e.g., within the workplace, healthcare system, and family). The term intersectional feminism acknowledges that gender positions (e.g., women) have multiple and layered identities derived from biology, social relations, political location, economic status, and societal power structures (Ahmed, 2017; Collins, 2019). Using an intersectional feminist position helps describe how various socially constructed categories interact on multiple levels and how these intersections contribute to different experiences of marginalization and privilege in society (Lockhart & Danis,

2010). I used intersectional feminism as both a concept and an analytic approach to provide me with direction concerning identifying systems of marginalization to be considered within the realms of women's and gender diverse persons' experience of accessing prescribed safer supply.

Reflexivity

Reflexivity, an integral part of qualitative research, is "a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes" that involves deep introspection and self-reflection (Olmos-Vega et al., p. 242). As a continual practice throughout my doctoral work, I reflected on who I am as a researcher, the locations and privileges in which I entered this work, and how these identities affected the research process and my analysis. Furthermore, qualitative research should involve concrete reflexive practices. Because the data sources for this project included documents and secondary interview transcriptions, I drew on two specific practices that included keeping a private journal and writing a narrative autobiography.

In the private journal I kept throughout the research process I engaged in self-examination to understand how my values, beliefs, preconceptions, and challenges may have impacted the research process. I also created a narrative autobiography to reflect on how my positionality may have influenced all aspects of the research process. The following is excerpted from my autobiography:

> *I identify as a white, middle-class, heterosexual, cis-gender woman in her late 30s, married with one child (22 months) who is medically complex and differently abled. I have rural roots. I grew up as an uninvited settler on a farm in Alberta with my father and brother (the traditional lands of the Blackfoot, Cree and later the Metis people). Our home was*

loving, yet not without challenges. Early exposure to substance use, alterations in mental health, and contact with child and family services shaped my childhood and, eventually, my choice to leave my rural home for a different life. My father was not able to finish high school, and this experience translated into instilling the importance of education in my brother and me. After travelling and studying general sciences, I pursued a nursing degree. After completing my degree—on a whim—I applied for an addiction and mental health services position. To my surprise, I was successful in the interview and began practising in a residential substance use treatment centre. I now believe that my early experiences led me to this area of healthcare. While working in substance use services, I witnessed how often people bumped up against the system and how stigma impeded their ability to receive meaningful care. Particularly troubling to me (as a self-identified feminist) were the challenges women faced. Experiences of systemic and interpersonal violence, child apprehension, and ongoing discrimination were commonplace. These experiences and concerns led me to pursue doctoral work to understand how women could be better supported. My personal identities and locations have undoubtedly influenced the ontological and epistemological roots from which my research stems. Throughout my life, I have always been drawn to issues around inequities and injustices and thus was drawn early on in my doctoral studies to critical and feminist theory. Finally, I acknowledge that my intersecting identities, while some challenging, have granted me a great deal of privilege that also influences the research I do and the opportunities I have been afforded.

Research Objective and Overview of Methods

My research was embedded within a broader project entitled: *Risk mitigation for people who use substances during dual public health emergencies* (funded by the Canadian Institutes for Health Research [CIHR]) as reported in Nosyk et al (2021). The subset of qualitative data used in this dissertation was collected within the approved ethical agreements of the broader evaluation.

Description of the Risk Mitigation Guidance Evaluation

Due to an anticipated escalation in overdose deaths in March 2020, BC issued a province-wide clinical guidance to support the prescription of pharmaceutical alternatives to the circulating toxic drug supply. The Risk Mitigation Guidance (RMG) represented the first population-based initiative offering a form of prescribed safer supply. This study, employing a participatory mixed-method design, examined the impact of RMG on people who used substances in BC in 2020–2021 (Nosyk et al., 2021).

A Gendered Analysis of Risk Mitigation Prescriptions for People Who Use Drugs

My dissertation research took place during dual public health emergencies of drug overdose in the context of the COVID-19 pandemic. I was residing at that time in British Columbia (BC), an area in Canada that was considered the epicentre of the overdose emergency. Feeling called to rejoin clinical practice during the pandemic, I took a nursing role on a local harm reduction outreach team. This opportunity to work on the front lines while studying harm reduction responses added a unique layer to my doctoral research by providing a direct lens into the practice of novel harm reduction interventions. While my doctoral research was embedded within the larger RMG evaluation, my specific research aims to provide a gendered analysis of prescribed safer supply during the dual public health emergencies in BC. Specifically, I explored

the barriers and facilitators that influence women's and gender diverse persons' access to and experience of prescribed safer supply during the dual emergencies. In the following section, I provide an overview of the three projects that formed my dissertation and the selected design for each interrelated work.

Summary of Projects and Methods

Study One—Intersectionality-Based Policy Analysis of Prescribed Safer Supply in BC

To answer the research question, *"Do the current clinical guidance and policy directive documents on prescribed safer supply address the unique needs of women and gender diverse persons in BC?* I employed the Intersectionality-Based Policy Analysis (IBPA) method developed by Hankivsky et al. (2012). IBPA is a flexible approach to policy analysis used to capture and respond to "multi-level interaction social locations, forces, factors and power structures that shape and influence human life and health" (Hankivsky et al., 2014, p. 1). In other words, it is a framework that was developed to understand or illuminate how health policy constructs individuals' and groups' relative power according to their social locations (e.g., socioeconomic, political status, gender, age, ability, race, etc.). Rather than completing an analysis of one category of individuals' or groups' identity (e.g., gender), IBPA considers the multiple social locations of individuals and groups within the broader interconnected structures of power.

This project aimed to discover new insights and knowledge about BC's current prescribed safer supply policies with specific attention to gender and other intersecting factors. Rather than focusing on policy issues understood only from a gender lens, I used IBPA to highlight the importance of multiple social locations and structures of power, including but not limited to gender, that influence the availability and delivery of prescribed safer supply in BC. The

framework consists of two core components: a set of guiding principles and a list of 12 overarching questions to shape the policy analysis. The questions are of two types, descriptive and transformative. Descriptive questions generate background information on the policy process; and transformative questions identify alternative policy solutions and responses aimed at promoting equity (Hankivsky et al., 2014).

The data was gleaned from three primary guiding documents (Risk Mitigation in the Context of Dual Public Health Emergencies; Risk Mitigation Guidance Update; and Access to Prescribed Safer Supply in BC: Policy Direction). As the primary investigator, I immersed myself in reading and re-reading the corpus documents. Documents were content analyzed using the two-step IBPA approach. Documents served as data and were transcribed verbatim and entered in NVivo12 qualitative software (NVivo Release 1.0 Mac, March 2020). A coding framework was developed based on the IBPA guiding principles and 12 overarching questions (Hankivsky et al., 2014). Coding proceeded iteratively with the framework being refined as new findings emerged. This strategy focused on both domains of IBPA (Transformative Effects and Structural Innovations) with the specific objective of providing insights and recommendations for future prescribed safer supply policy responses in BC. For a discussion of the findings, please refer to Chapter Two of this dissertation.

Study Two—Critique of the Consolidated Framework for Implementation Research (CFIR)

As a doctoral student collecting and analyzing data for a study focused on evaluating the implementation of a novel harm reduction strategy during dual public health emergencies, I wrestled with the complex issues around the equitable involvement of people who use drugs in implementation research broadly and in our specific implementation research project. Hence, the

second project for this dissertation research aimed to answer the question: (2) *Using prescribed safer supply as a case study, how could health equity be integrated into the Consolidated Framework for Implementation Research (CFIR)?"* Drawing on my experiences of using the CFIR to evaluate prescribed safer supply initiatives during an illicit drug overdose emergency, I critiqued the framework. Publicly accessible documents describing CFIR were retrieved. The selected texts that comprised the data for this project included peer-reviewed and grey literature written by the CFIR developers (n=3). As the principal investigator, I immersed myself in the close reading of the documents and summarized the current strengths and limitations of the CFIR in relation to the concept of health equity. This strategy focused on identifying health equity content in the original and updated versions of the CFIR. Documents were analyzed for content about or related to concepts of health equity (e.g., content on inclusion of services users, attention to gender, race, and other determinants of health, and content around power and inequities). For a discussion of the findings generated from this project, please refer to Chapter Three of this dissertation.

Study Three—A Secondary Analysis of the Experiences of Women and Gender Diverse Persons who Accessed or Attempted to Access Prescribed Safer Supply during the Dual Public Health Emergencies

The third project of this dissertation aimed to answer the research question, *"What were women's and gender diverse persons' experiences of accessing or attempting to access prescribed safer supply in BC during the dual public health emergencies?"* To answer this question, I completed a secondary data analysis of interviews with women and gender diverse persons (n=21) who accessed or attempted to access a prescription for pharmaceutical alternative medications

during the study period (October 2020 to November 2021). Interviews were conducted in person or over the phone.

Interpretive Description (ID) data analysis is an approach rooted in the naturalist and constructivist orientations to knowledge generation (Thorne, 2016). ID was developed by nursing scholars Thorne, Reimer-Kirkham, and MacDonald-Ems (1997) out of the need to generate knowledge that has a clear and direct disciplinary application (Thorne, 2016). ID guided the analysis for this study. The ID approach is unique because there are few prescriptive guidelines regarding the methods investigators may use to gather data; thus, it was an appropriate method for this analysis as the qualitative data had already been collected. ID data analysis relies on inductive reasoning to describe and interpret the meanings gleaned from the data. The analytic approach involves examining pieces, preliminary codes, or patterns that reveal categorical grouping.

The sample of 21 women and gender diverse persons was identified through the demographic information collected in the provincial survey conducted as part of the broader mixed-methods evaluation of RMG in BC. Audio-recorded data were transcribed verbatim, then anonymized and imported into NVivo 12 software (NVivo Release 1.0 Mac).

According to Thorne (2016), data analysis is an immersive process where the researcher must "know the data" well (p.166). As I did not conduct the interviews, I began the analysis by listening and re-listening to the audio-recorded interview transcripts to familiarize myself with the individual cases. The 21 transcripts imported into NVivo were then read several more times to recognize the emerging narrative. I began inductive line-by-line coding of the transcripts. As the coding continued, I began to sort the data, eventually developing categories, which emerged into themes and sub-themes that eventually formed the results. Results from ID studies are meant to

generate knowledge products that can inform the disciplinary context from which the original research question(s) were derived. In this case, the findings from this analysis can be used to strengthen the work harm reduction providers do alongside women and gender diverse persons who use drugs. For a complete discussion of the findings generated from this project, please refer to Chapter Four of this dissertation.

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Chapter Two: Gender and Harm Reduction—An Intersectionality-Based Policy Analysis of Prescribed Safer Supply in British Columbia (BC), Canada

Abstract

Background: North America is facing an unprecedented overdose emergency that was complicated by the COVID-19 pandemic. Despite shifts in drug policy, 21 Canadians died every day due to the toxic drug supply. A prescribed safer supply of pharmaceutical alternatives is a harm reduction strategy that was implemented in British Columbia (BC), Canada, as a policy response to prevent overdose in this context, which was referred to as a dual public health emergency. Existing harm reduction research identified gaps in the accessibility and effectiveness of services for women and gender diverse persons. Using the recent example of prescribed safer supply implemented in BC, we examined the extent to which the existing policy and practice directions address known gendered barriers.

Methods: This study used an intersectionality-based policy analysis approach (IBPA) to analyze the publicly available clinical guidance and policy direction documents (n=3) pertaining to prescribed safer supply for attention to gender and other intersecting factors.

Results: Overall, the documents were gender silent; when gender was mentioned, it was in the context of reproduction and pregnancy. None of the documents mentioned specific considerations to address known gendered barriers for women or gender diverse persons. None attended to the context of continued prohibition of illicit drug use and how this context has differential implications for women and gender diverse persons.

Conclusion: Focus on the gendered experiences of drug use amidst these dual public health emergencies is needed. Steps must be taken to amend or develop safer supply policies and broader

public health policies that attend to intersectional gender dynamics so that women and gender diverse persons who use drugs can access the supports they need or desire.

Keywords: Safer Supply, Gender, Pharmaceutical Alternatives, Intersectionality, Policy Analysis, Canada.

Introduction

North America was facing an unprecedented overdose emergency that was complicated by the COVID-19 pandemic. Despite shifts in drug policy, 21 Canadians died every day due to the toxic drug supply (Government of Canada, 2022). While most deaths were males aged 11 to 65, women and gender diverse persons were also involved. In BC, the province most affected by the overdose emergency, women make up approximately 23% of overdose deaths (British Columbia Coroners Service, 2023). Racism is also a critical factor in the dual emergencies, with a disproportionate number of First Nations women dying due to toxic drugs. In 2022, First Nations women experienced toxic drug-related death rates that were 11 times higher than non-First Nations women (First Nations Health Authority, 2022).

The increasing drug-related mortality has been attributed to the toxic illicit drug supply and the arrival of the COVID-19 pandemic that together led to an unprecedented number of overdoses in the province (Government of British Columbia, 2022; Palis et al., 2022). Since 2016, a public health emergency due to toxic drug overdoses has been in effect in BC. In 2020, another public health emergency due to the COVID-19 pandemic was declared. These two public health emergencies, often called dual emergencies, intersected, and created a uniquely challenging situation for people who use drugs (Government of British Columbia, 2016; Government of British Columbia, 2020). As part of a response to halt overdose deaths, the government of BC, along with researchers, clinicians, and people who use(d) drugs, developed clinical guidance to support the prescribing of pharmaceutical alternatives, specifically opioids, stimulants, and benzodiazepines, for people who were dependant on the toxic illicit drug supply (a form of prescribed safer supply). The clinical guidance or risk mitigation guidance (RMG) released in

March 2020 was considered an important addition to the current drug policy and harm reduction landscape in BC (British Columbia Centre on Substance Use [BCCSU], 2020). In July 2021, a policy directive specific to prescribed safer supply was released. The prescribed safer supply policy builds on the province's experience with RMG but is a separate and distinct policy directive. Most notably, the prescribed safer supply policy was created to decouple the prescribing of pharmaceutical alternatives from the pandemic context, ensuring that the practice of prescribed safer supply would continue beyond the COVID-19 period. As communities across the province work to implement prescribed safer supply, there is a need to examine how this policy response was experienced by different groups of people who use drugs.

Prescribed safer supply for women and gender diverse persons is a critical consideration, given that they experience specific and unique barriers to accessing harm reduction services (Boyd et al., 2018). Many women and gender diverse persons experience gender-based discrimination, aggression, and violence. Pregnant and parenting women who use drugs experience a high degree of State surveillance and are often treated harshly by authorities (inclusive of health providers), and have well-founded fears of child apprehension (Boyd, 2004; Boyd et al., 2018; Canadian HIV Legal Network, 2020; Xavier et al. 2021). These dynamics are more acute for racialized and poor women. Harm reduction services can inadvertently exclude women and gender diverse persons if the intersecting social and structural determinants of health such as racism, gender discrimination and colonization are not accounted for in policy and corresponding service delivery (Boyd, 2004; Boyd et al., 2018). While limited evidence exists that is specific to gender diverse persons, they likely experience disproportionate substance use and substance-related harm due to gender discrimination intersecting with transphobia and homophobia (Bauer & Scheim, 2015). Policies

and clinical guidance must attend to these differences to ensure equitable and acceptable access to prescribed safer supply. The purpose of this study was to provide an analysis of prescribed safer supply in BC, Canada. Specifically, we examined the policy documents that guide the implementation of prescribed safer supply in BC and the implications for women and gender diverse persons who use drugs.

Structural Inequities for Women and Gender Diverse Persons Who Use Drugs

Here we position women's and gender diverse persons' experiences of drug use within the context of structural inequities. Research in critical public health, feminist ethics, and substance use found that structural inequities have profoundly adverse effects on women's health and well-being (Boyd, 2004; Boyd et al., 2018; Varcoe et al., 2014). Structural inequities refer to how policies and practices in health, social services, justice, and other systems operate to produce an inequitable distribution of health determinants. Inequities are structural because they are embedded in the political and economic organizations of our social world, with differential effects based on several dimensions, including gender, age, class, race, ability, sexual orientation, geographic location, and other dimensions. For instance, women who use illicit drugs often experience structural inequities expressed as unequal access to employment, resources, political power, education, and health care.

Drug policy analysis concerning women's substance use had focused on individual or proximate determinants of substance use (e.g., genetics, individual trauma). The role of larger structural systems that create, shape, and maintain harms associated with drug use were often ignored, and failed to recognize how such harms connect to broader structural conditions. In Canada, colonization and entrenched structural racism towards Indigenous Peoples (including

First Nations, Métis, and Inuit) have led to significant inequities in overdose. Indigenous women have described how historical and ongoing colonial policies and programs, such as the impact of residential schools and the mass removal of Indigenous children from their families into the child welfare system cause injury and perpetuate the trauma that leads to and sustains drug use (Canadian HIV Legal Network, 2020).

The emergence of COVID-19 further complicated how women and gender diverse persons who use drugs were exposed to multiple and intersecting harms (United Nations, 2020). Social isolation, lockdowns, financial uncertainty, and attitudes about gender roles exacerbated interpersonal and structural violence and drug use in this context (Brabete et al., 2021). Women were three times more likely than men to face underemployment during the COVID-19 pandemic (Gavrilovic et al., 2022), which resulted in a lack of resources to secure substances for women who use drugs. Women who relied on the informal economy, especially sex work, lost income when the pandemic hit or were forced to work in dangerous conditions as well as losing access to outreach and other support services (Benoit & Unsworth, 2022; Gavrilovic et al., 2022). The COVID-19 pandemic impacted women's overall health, overdose risk, and access to harm reduction and healthcare support (Brabete et al., 2021).

Given the intersecting social and structural factors that shape women's and gender diverse persons' access to and experience of harm reduction services, we used an intersectionality-based policy analysis (IBPA) approach to analyze prescribed safer supply policy in BC to understand gender and other relevant structural and individual factors that increase inequities and overdose risks. Before describing the IBPA methodology, we provide an overview of the BC drug policy

context and how women and gender diverse persons have been located in this drug policy landscape.

British Columbia Drug Policy Context and the Role of Intersectional Locations

In Canada, national drug policy frames the context for government actors and healthcare leaders to implement harm reduction services. Drug laws are a federal jurisdiction, but the development and implementation of policies and programs around substance use is the responsibility of provincial and territorial governments. While harm reduction is considered part of the federal approach to substance use, prohibition prevails (Canadian Drug Policy Coalition, n.d). Many provincial and municipal decisions makers created and implemented novel harm reduction approaches while having to circumvent federal policies grounded in prohibition. Risk Mitigation Guidance (RMG), for example, offers support in the prescription of pharmaceutical alternatives to the toxic drug supply. With the arrival of COVID-19 further complicating the overdose emergency, the province of BC, under the auspices of a public health emergency, implemented a policy-level intervention that was introduced into a healthcare system to provide a workaround to federal prohibition policy by prescribing pharmaceutical alternatives to the illicit toxic drug market.

The introduction of RMG and the corresponding prescribed safer supply policy direction suggested steps in the right direction in terms of supportive drug policy; however, identifying how to ensure equitable access to these interventions, specifically for underrepresented groups such as women and gender diverse persons, was critical. Even though drug use is gendered, (i.e., women and gender diverse persons who use drugs incur unique risks and harms compared to cisgender men who use drugs) the needs of this population have not figured prominently in harm reduction

policy or programming. Beginning with a disregard for women drug users and followed by a period of repressive policies and practices, women in Canada have been underserved by harm reduction policies and responses (Boyd, 2004). The overdose response in Canada was found to be "gender-neutral," erasing the gendered experiences and needs in the content of the emergency (Collins et al., 2019, p. 43). Gender diverse persons have also been largely unrecognized in drug use policy and dialogue, and specific data and understanding were lacking. Without explicit attention to the needs and experiences of women and gender diverse persons, drug policy will continue to contribute to the marginalization of this population, even if unintentionally.

Context in British Columbia and Prescribed Safer Supply

Following the declaration in March 2020 of the COVID-19 pandemic, BC released interim clinical guidance—termed risk mitigation (RMG)—that provided clinical direction for the prescription of tablet opioids (tablet hydromorphone and sustained-release oral morphine), stimulants (methylphenidate and dextroamphetamine), and benzodiazepines (clonazepam and diazepam) to people dependent on the illicit drug supply (BCCSU, 2020). The RMG recommendations were not intended to treat substance use disorders, but to reduce risks of withdrawal, overdose, and COVID-19 infection. The prescribing practices outlined in the RMG sat outside of the clinical standards of practice for prescribers and was thus at the discretion of community prescribers to offer RMG prescriptions or not. The subsequent guidance, referred to as RMG2, focused on reviewing the clinical guidance included in the original RMG document rather than the broader policy concept of prescribing pharmaceutical alternatives to the illicit drug supply. Significant changes addressed principles for care planning, guidance on initial medications trials, limitations of urine drug tests, informed consent, advice on missed doses of opioids and

stimulants, managing benzodiazepine withdrawal, cannabis withdrawal, the role of peer navigators and peers in care, rural and remote considerations, guidance on billing, and updated clinical example scenarios (BCCSU, 2022).

In 2021, the BC government released a policy directive specific to prescribed safer supply, which was an "enabling document that supports the provision of pharmaceutical grade alternatives to illicit drugs for people who are at risk of drug toxicity and other harms" (Government of British Columbia, 2021, p. 3). The prescribed safer supply policy was created to move beyond RMG by requiring health authorities to implement and expand the practice in their jurisdictions, provide a broader range of pharmaceutical alternatives (e.g., fentanyl), and extend prescribed safer supply beyond the context of COVID-19. The policy document details eligibility criteria for medication coverage and lays out timelines and expectations to regional health authorities for implementing prescribed safer supply. Also included in the directive was a requirement that all pragmatic or clinical settings take part in the provincial prescribed safer supply evaluation and monitoring process.

Purpose

As the health and safety of women and gender diverse persons who use drugs became increasingly vulnerable in the overdose emergency, intersectional gender policies and corresponding approaches were needed more than ever to facilitate equitable access to prescribed safer supply. The introduction of Risk Mitigation Guidance (RMG) and prescribed safer supply provincial documents guiding the response to the overdose emergency suggests positive advances in harm reduction policy and programming. This research aimed to determine how these documents represented the needs of women and gender diverse persons in BC, Canada. Our

research question asked: *"Do the current clinical guidance and policy directive documents on prescribed safer supply address the unique needs of women and gender diverse persons in BC?* Through an Intersectionality-Based Policy Analysis (IBPA) of prescribed safer supply guiding documents, we offered structured recommendations for policy actors in BC, Canada, and elsewhere.

Methodology

Intersectionality-Based Policy Analysis (IBPA)

This study draws on intersectionality to address how gender and other factors were represented in prescribed safer supply policies in BC, Canada. Intersectionality as a concept was formed out of a critique of feminist theory by Black women and women of colour who felt that feminist theory was not inclusive and did not accurately attend to discussions around race (Guittar & Guittar, 2015). Intersectionality scholarship is typically considered to have begun with Kimberlé Williams Crenshaw (1989), who are credited for coining the term, "intersectionality"; however, many Black women before had written about the exclusivity and lack of representation of women of colour in feminist discourse (Hancock, 2016). Intersectionality has since evolved from the primary examination of race and gender to a broader inquiry of intersecting social categories that affect all aspects of a person's life (Guittar & Guittar, 2015). According to Collins (2015), intersectionality provides insight into how "race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape social inequalities" (p. 2).

In scholarship, intersectionality is a method, analytic approach, and concept. Our study uses intersectionality as both a concept and as an analytical approach to understand the differential impacts of prescribed safer supply policies and practices on women and gender diverse persons in BC. The IBPA framework was developed to operationalize intersectional theory, specifically regarding understanding and analyzing health policy. Although many policy analysis frameworks exist, IBPA is unique in that the framework uses intersectional theory to capture the intersecting dimensions of policy contexts, including history, living/lived experiences, diverse pieces of knowledge and intersecting social locations (Hankivsky et al., 2014). Examples of the IBPA framework used in drug policy are limited. Hunting used the IBPA framework to examine the national Fetal Alcohol Syndrome Disorder (FASD) policy in Canada, finding that an IBPA lens helped to shift the frame from blaming individuals (mothers) to understanding substance use by attending to structural inequities and social contexts (Hunting as cited in Hankivsky et al, 2014). Despite limited examples, there is merit to employing IBPA in drug policy studies to capture the nuanced social and structural locations of people who use drugs. Such an analysis can help identify specific inequities for women and gender diverse persons regarding drug use and support, and thus provide specific policy recommendations.

IBPA provides a flexible policy analysis approach to capture and respond to "multi-level interacting social locations, forces, factors and power structures that shape and influence human life and health" (Hankivsky et al., 2014, p. 1). In other words, this framework was developed to understand or illuminate how health policy constructs individuals' and groups' relative power according to their social locations (e.g., socioeconomic, political status, gender, age, ability, race). Rather than completing an analysis of one category of identity (e.g., gender), IBPA considers the

multiple social locations of individuals and groups within the broader interconnected structural determinants of health. The framework consists of two core components: a set of guiding principles and a list of 12 overarching questions to shape the policy analysis. The questions are of two types: descriptive, to generate background information on the policy process, and transformative, to identify alternative policy solutions and responses to promote equity (Hankivsky et al., 2012). Refer to Appendix A for a complete list of IBPA-associated questions. An IBPA framework to analyze policy and practices surrounding prescribed safer supply draws attention to differences and inequities among diverse groups, including women and gender diverse persons. Rather than focusing on policy issues understood only from a gender lens, the IBPA approach conceptualizes gender as one discourse and structure among the multiple social locations and structural factors influencing the availability and delivery of prescribed safer supply in BC.

Data

Apart from having a specific policy, initiative, intervention, or program to analyze, there are no specific data sources associated with the IBPA method; instead, researchers had flexibility to choose data that they considered to be most appropriate to answer the research question (Hankivsky et al., 2012). The primary data source used for this project were documents (n=3). Document analysis is a valuable qualitative research method to analyze various books, newspaper articles, academic journals, policy documents, clinical guidelines, and institutional reports (Morgan, 2022). Any document with text can be a source for qualitative analysis. Our data for analysis was sourced from three guiding documents: 1) Risk Mitigation in the Context of Dual Public Health Emergencies (BCCSU, 2020), 2) Risk Mitigation Guidance Update (BCCSU,

2022), and 3) Access to Prescribed safer supply in British Columbia: Policy Direction (Government of British Columbia, 2021).

Data Analysis

The analytic steps involved in the IBPA followed a three-step concurrent and iterative course.

Phase One: Reading and Re-reading the Data.

All documents uploaded to NVivo software (Version 12) were publicly accessible; thus, no research ethics board approval was required. Initially, two close readings of the three corpus documents were done. The first reading allowed the first author (GS) to become familiar with the documents' content, language, and layout to understand the purpose and objectives. Using an intersectional perspective, the eight guiding principles of the IBPA framed and directed GS's approach to the second close reading—in other words, the IBPA principles and associated questions sensitized GS to concepts of intersectionality while taking a close read of the data (corpus documents).

Phase Two: Creating a Coding Framework using the IBPA.

The first author (GS) developed a coding framework to guide data analysis using NVivo software (Version 12). Refer to Appendix B for coding framework details. The framework contained key concepts and language in the IBPA guiding concepts and in both the descriptive and transformative questions. Hankivsky et al. (2012) suggest that the IBPA framework be used flexibly and that users of the framework apply the questions as they pertain to the specific needs of their analysis. In this case, the questions were adapted to address the specific research question

pertaining to the needs and representation of women and gender diverse persons in the prescribed safer supply documents.

Phase Three: Extracting and Summarizing the Data.

The data were then coded thematically using the IBPA framework. Documents were coded by the first author (GS) and discussed with the additional research team members. Emergent themes were analyzed with attention to intersectionality and relevant social, political, and structural determinants. The RMG1 and RMG2 were developed and released as clinical documents to provide guidance on clinical practice for prescribers in the context of the dual public health emergencies, specifically during the COVID-19 pandemic. The prescribed safer supply policy directive was developed and released to guide regional health planning bodies to expand prescribed safer supply services in their health jurisdictions. Analysis and critique were based on the IBPA framework and principles, keeping in mind the original intent of the documents being analyzed.

Findings

Three themes emerged: (1) Gender Silent or Gender as Reproduction, (2) Broad Target Groups, and (3) Gender-Neutral Context.

Gender Silent or Gender as Reproduction

Gender was mainly silent in all three of the corpus documents. Only the prescribed safer supply policy direction explicitly mentioned “women” (four times in the document) and “gender” (four times in the document). Gender or related terms were not included in the RMG1 or RMG2 clinical guidance documents except for discussing the gendered experience of pregnancy. When discussing pregnancy, the original RMG1 document states that:

> extreme caution should be used and (added) care should be provided in collaboration with the patient's obstetrician if available, a perinatal addiction specialist should be consulted. A thorough discussion of alternatives, risks, and benefits should be had with the patient, including potential risks to the fetus. (British Columbia Centre of Substance Use, 2020, p. 25)

While the original RMG1 expressed "extreme caution" around RMG and pregnancy, the updated RMG2 version focused only on the eligibility of pregnant women, stating: "For youth and pregnant individuals, in collaboration with the patient, referral to health and social services and connection to appropriate resources should be offered" (British Columbia Centre of Substance Use, 2022, p. 6). The RMG2 document included even less around gender than the original document, with only one mention of pregnancy. Given that both the RMG1 and RMG2 are clinical guidance documents, we would expect content on gender integration, including specific strategies or gender-orientated programming that could be applied during the planning, implementation, and assessment of RMG.

The prescribed safer supply policy direction, again a document created to inform health policy, includes a section on "gender-based analysis+ lens (GBA+)":

> intersecting biological, social, economic, and cultural factors shape people's experiences of substance use (e.g., sex, gender, age, race, ethnicity, Indigeneity, ability, rurality, socioeconomic status, values, attitudes, perceptions, behaviours). These factors can also shape how services respond to people's needs in terms of access and barriers. (Government of British Columbia, 2021, p. 15)

The GBA+ lens section of the prescribed safer supply policy direction stated that "sex and gender" should be considered at all planning levels for prescribed safer supply initiatives (Government of British Columbia, 2021, p. 15). While the policy direction says that structural conditions shape people's experience of substance use, it fails to mention these considerations in the development of safe services. Nor are there any specifics as to how future policy and programming could incorporate gender considerations in safe services. Additionally, it would be helpful if the policy direction document was clear on the gender balance and gender representation of the policy actors and others (including those with lived/living experience) who created it. Absent are financial resources or specific budget or personnel allocations for gender-based activities—something we could expect to see in a policy directive that meaningfully includes a gender perspective in drug policy and drug policy planning.

None of the corpus documents specifically mention gender diverse persons or the considerations that could be offered in delivering the policy responses (RMG or prescribed safer supply). Again, the RMG and prescribed safer supply responses were addressed through mainstream homogenous (largely cisgender men) considerations. Both versions of the RMG (RMG1 and RMG2) documents provided "clinical scenarios" that "are intended to provide examples of how this interim clinical guidance can be utilized" (British Columbia Centre of Substance Use, 2020, p.19), including a reference to a trans individual wanting to access RMG. No specific attention was given to any possible unique needs or considerations for the individual and thus reflects a perfunctory effort to be inclusive to gender diverse persons rather than a meaningful consideration.

Broad Target Groups

While the policy problem represented a predominantly homogenous group of people, all three documents attempted to identify specific *target groups*. One such group was Indigenous Peoples because they are a prominent feature in the prescribed safer supply policy direction. The policy direction document acknowledges provincial government support for a "commitment to reconciliation" (Government of British Columbia, 2021, p. 6) and identifies that high rates of overdose and harm affecting Indigenous and First Nations communities result from long-standing structural inequities (Government of British Columbia, 2021). The prescribed safer supply policy document provides statistics for First Nations women who were disproportionately affected by the overdose crisis but includes no details regarding any specific gender (or other) considerations or how Indigenous women would or could benefit from the policy response and no discussion of activities designed to meet women's potentially different or diverse intersecting needs when accessing prescribed safer supply.

The RMG1 document omits explicit guidance for working with Indigenous Peoples (women, youth, or gender diverse persons). The RMG2 document offered guidance in the form of principles of care: "Overarching principles of care that should guide care planning and provision include: Indigenous cultural safety and humility, harm reduction, and trauma- and violence-informed care" (British Columbia Centre on Substance Use, 2022, p. 19) with no specific examples of how to offer culturally informed care. Details on the review and consultation process, including the gender balance of those who participated, were absent. Given that the RMG1 and RMG2 were clinical guidance documents and knowing the burden of unintentional overdoses and harms faced by Indigenous Peoples and the overrepresentation of Indigenous women affected by overdose in the province, we would expect to see specific considerations to support Indigenous

Peoples and communities (particularly women and gender diverse persons) who try to access RMG prescriptions.

A focus on the relationship between access to prescriptions where a person is geographically located was noticed. A target group of these policy documents was those living in rural and remote communities. Although the highest absolute number of deaths occurred in the province's most populated areas (Vancouver, Surrey, and Victoria), rural and remote regions continued to experience disproportionately high mortality rates. Across regional health authorities, the mortality rate in the northern region of the provinces (a large, primarily rural area with an over-representation of Indigenous Peoples) was the highest—53 per 100,000—compared to the provincial mortality rate—42 per 100,000 (British Columbia Coroners Service, 2022a). All three documents acknowledge that many people living in rural and remote areas of the province likely face barriers to access support and prescriptions. One section of the RMG1 document pertains to "rural and remote considerations," in that "rural and remote communities may have limited health services (e.g., clinics or pharmacies), which requires that patients travel to neighbouring communities to access substance use care" (British Columbia Centre on Substance Use, 2020, p. 14). Although the document includes strategies to mitigate barriers and increase access to prescriptions for people living in rural or remote areas, including telemedicine, there is no mention of how rurality and gender may intersect. A new section of the RMG2 was allocated to "rural and remote" considerations (British Columbia Centre on Substance Use, 2022, p. 48), gender was only mentioned in relation to pregnancy. None of the three corpus documents recognized the intersections of geography and gender or provided any specific considerations.

The prescribed safer supply policy document noted the intersection of Indigeneity and geography, that a large proportion of First Nations and other Indigenous Peoples in BC live in rural and remote areas:

> For effective rural and remote service delivery, it will be important to work closely with available community organizations and substance use outreach teams, including local First Nations health services, that can assist with engaging and retaining clients, supporting seamless transitions between services, and providing wraparound care. (Government of British Columbia, 2021, p. 22)

No mention was found regarding the potential challenges for Indigenous women, who comprise a large part of the rural and remote population in the province (Bleakney & Melvin, 2022).

Gender Neutral Context

Hankivsky et al. (2012) claimed that the contexts of time and space were fundamental in analyzing policy. All three documents were firmly grounded in the context of COVID-19, overdose, and drug toxicity in BC, Canada. The policy problem was represented as a problem facing a homogenous group of people. It was understood in those documents that drug policy responses at that time ought to be driven by actions to address the majority population (cisgender men) with the ambitions of universal policies with little accounting for the lived/living experiences of women and gender diverse persons. The author/reviewer list of the clinical guidance documents included those with lived/living experiences and the policy direction acknowledged existing research on safer supply initiatives, as well as consultations with key stakeholders, experts, Indigenous partners, and organizations, and “people with lived and living experience, addiction medicine physicians and other clinicians, and regulatory colleges and professional associations”

(Government of British Columbia, 2021, p. 12). No details about the representation and breadth of the group of people with lived/living experiences were included in the consultation. The process of who, how, and in what ways people with lived/living experiences were included in the discussion, and the production of the documents was missed.

None of the corpus documents attended to the intersections of the current context of criminalization, women, and prohibition. The documents did suggest a possible shift in the drug policy landscape in BC, but all three documents and corresponding responses notably occurred within the context of continued criminalization and prohibition. Producing, selling, and distributing illicit drugs is still illegal in Canada and the persistent context of criminalization results in increased violence and harm for people who use illicit drugs, especially women, women of colour, and gender diverse persons (Boyd et al., 2022). The RMG documents mentioned "criminalization" by assessing if a person engaged in "criminal behaviour" or had experience with the criminal justice system. They also hypothesized that one of the benefits associated with prescriptions would include the "reduction or cessation of illicit substance use, reduced risk of overdose, and reduced need to engage in high-risk and criminalized activities" (British Columbia Centre on Substance Use, 2020, p. 53). Absent again was how criminalization may intersect with other factors, including gender.

Discussion and Recommendations

The purpose of this research was to analyze clinical and government documents that shape approaches to prescribed safer supply in BC, with attention to intersectional gender dynamics. The analysis focused on three documents, the Risk Mitigation Guidance and the Risk Mitigation Guidance Update (RMG1 and RMG2), both clinical guidance documents, and Access to

Prescribed Safer Supply, a policy direction document. All three corpus documents were analyzed with the IBPA framework. Overall, the documents were gender silent; when gender was mentioned, it was within a biomedical context that focused on reproduction and pregnancy. No specific considerations for women or gender diverse persons were found but would be helpful for their care providers. All three documents identify target groups, specifically Indigenous Peoples and those living in rural and remote areas, but the one-size-fits-all approach to these groups obfuscated where inequities lie. Finally, none of the three corpus documents attended to the context of continued prohibition of illicit drug use and how this context has differential implications for women and gender diverse persons.

Intersectional gender dynamics should be considered essential to the development of effective policies and practices pertaining to substance use. In the context of dual public health emergencies of substance and COVID-19, public health responses must be informed by intersectional gender dynamics to ensure that women and gender diverse persons who use drugs can access the services and supports they require. It is unreasonable to expect health planning bodies to decide what these gendered dynamics and considerations should be without explicit guidance.

All documents were found to be primarily gender-silent, yet research has long demonstrated that there are often specific and unique needs of women and gender diverse persons in terms of substance use, health services, and harm reduction supports (e.g., income support, trauma and violence, safety, autonomy) (Boyd et al., 2018; Canadian HIV Legal Network, 2020). Failure to include these considerations to date in policy direction and clinical guidance for prescribed safer supply is an important finding—one that needs to be remedied in future planning

processes. As a matter of public health and equity, prescribed safer supply services and programs should address the intersecting and underlying structural inequities that limit women's and gender diverse persons' access to harm reduction and life-saving services. Prescribed safer supply programs should be tailored to the intersecting needs of women and gender diverse persons who use illicit substances and include multifaceted, low-threshold interventions to address gender-based violence, transphobia, homophobia, trauma, child welfare concerns, and other structural determinants of health (Boyd et al., 2022; Canadian HIV Legal Network, 2020).

Canada makes efforts to integrate gender into policymaking—both the national health authority and the national research funding institute have policies that integrate gender into health services and research (Canadian Institutes of Health Research, 2020), but these efforts have not progressed in harm reduction drug policy. Only one corpus document—the prescribed safer supply policy direction—named gender-based analysis+ (GBA+) as a guiding principle for developing and implementing prescribed safer supply, and guidance on supporting gender diverse persons included one perfunctory example without due attention to context. Specific recommendations for gender-inclusive training in policy and programming is needed to support healthcare prescribers and others in their understanding of how factors associated with gender insect with other health and social determinants. Training can facilitate safe dialogues about bias and privilege. Gender-inclusive training will also help prescribers develop gender-inclusive vocabulary and the confidence to have gender-affirming conversations in their practice.

Similar to past and current drug policy-level interventions in Canada and BC, gender is the focus for risks and regulation. The emphasis on reproduction and pregnancy recreates gender stereotypes, where the main *concerns* for women who use drugs are centred around pregnancy and

motherhood (Boyd, 2004). While reproduction and pregnancy are important experiences, pregnant people should not be reduced to a single identity; in other words, they should *only* be treated as pregnant. Health and policy actors must recognize that women have a multiplicity of health and social needs related to physical, mental, and sexual health and well-being that are separate from reproduction. Further, prescribed safer supply services and programs should be accessible to pregnant people and people caring for children. Such programs should include low-threshold interventions to support mental health, sexual and reproductive health, prenatal care, and other parenting, housing and income supports. Given current child welfare practices with this population, support for child welfare system navigation and advocacy are also required.

All three corpus documents focus on target populations, specifically those living in rural and remote areas and those identifying as Indigenous Peoples or First Nations. Creating target groups can be problematic as people included in target groups often have a multiplicity of needs and concerns. For example, women living in rural/remote areas of Canada and BC have lower employment rates and are overrepresented in low-income situations, and most of these women identify as First Nation or Indigenous Peoples (Statistics Canada, 2022). Applying an intersectional lens uncovers the underlying factors that influence access to and experiences of prescribed safer supply for women and gender diverse persons living in rural and remote areas and illuminate current gaps in policy and services.

None of the corpus documents acknowledged the ongoing political context of prohibition in BC and Canada. Repressive laws, policies, and practices continue to stigmatize and marginalize people who use drugs, especially women and gender diverse persons, that alienates them from social, health, and harm-reduction services (Canadian Drug Policy Coalition, 2021). The failure of

Canadian prohibition has tremendous implications for women and gender diverse persons and their children (Boyd et al., 2022; Canadian HIV Legal Network, 2020). Women who use drugs, especially racialized and poor women, face intense stigma and regulation, often resulting in women's detention and child apprehension. Boyd et al. (2022) interviewed 40 mothers and birthing parents who used women-only supervised consumption sites in Vancouver and found that stigma and violence made it difficult for them to feel safe and comfortable accessing life-saving harm reduction services. Cisgender, transgender, non-binary, and Two-Spirit people who use drugs often hesitate or do not access harm-reduction services for fear that their children will be apprehended or fear of other forms of personal and structural violence. Their research recommends that:

> non-punitive policies, including access to safe, nontoxic drug supplies, are critical first steps to decreasing women's overdose risk alongside gender-specific and culturally informed harm-reduction responses, including community-based, peer-led initiatives to maintain parent-child relationships. (Boyd et al., 2022, p. S191)

The meaningful participation of women and gender diverse persons who use drugs would uniquely position BC's policymakers and healthcare actors to amend or develop safe supply policies and practices that are non-punitive, gender-attentive, safe, and child-friendly. The prescribed safer supply policy and practice guidance should be driven by lived/living expertise. For this to occur, women and gender diverse persons who use drugs must be meaningfully engaged in reviewing and updating current safer supply guiding documents with specific attention to gender. Policy actors are responsible for developing an action plan outlining the specific steps

and process of who and how people with lived/living expertise are involved in the review process. The action plan should be made publicly available, and results reported.

Applying an intersectional analysis helps to understand the multiplicity of experiences of drug use and recognize the ongoing and intersecting effects of structural factors (gender discrimination, racism, colonization) that permeate Canada and BC's health and social care systems. With a more nuanced, intersectional understanding, access to safer nontoxic drugs will be achievable for women and gender diverse persons in the province of BC and elsewhere.

Limitations

This analysis was intended to assist policymakers to understand the potential needs of women and gender diverse persons in harm reduction policy and programming, specifically prescribed safer supply; however, these results have some limitations. First, this analysis was conducted from documents produced in a unique and specific context (dual public health emergencies of overdose and COVID-19 in BC, Canada); thus, recommendations from the analysis may not apply to other contexts or regions. Second, this study was conducted by white cisgender women. GS is a nurse with clinical practice experience in harm reduction and a family member with lived experience of substance use. BP is a community-based nurse researcher who works with a wide range of people who use drugs. KU is a social epidemiologist with expertise in substance use services research. LM is a nurse researcher who works with providers and programs that support pregnant and newly parenting people who use substances. Further work led by people who identify as gender diverse, Indigenous, and Black, among other identities, is required.

Conclusion

Harm reduction policies and approaches have been part of the Canadian drug strategy for several years. The emphasis has been on policies and practices that reduce the harms of both legal and illegal drugs and provide health and social services based on compassion, dignity, and human rights (Canadian Drug Policy Coalition, n.d.). As Canada currently grapples with the ongoing overdose crisis, people who use drugs and their families, as well as activists, researchers, and care providers, seek ways to keep people alive and well. Having reviewed policy and services in BC using the IBPA Framework, with its ability to address diversity, we identified that the current prescribed safer supply policy and services are based on a one-size-fits-all approach with no specific attention to gender. The absence of gender considerations has implications for the health and well-being of people who face intersecting marginalization, specifically women and gender diverse persons who use drugs. Based on our analysis, we identified several recommendations that policy actors can use to integrate gender awareness into future guiding documents as a critical leverage point to reduce health inequities and respect human rights, particularly the right to dignity for women and gender diverse persons. Amongst dual public health emergencies, steps need to be taken to amend or develop safer supply policies and broader public health policies that attend to intersectional gender dynamics so that women and gender diverse persons who use drugs can access the supports they need or desire. Without such action, women and gender diverse persons who use drugs will continue to be underserved by lifesaving interventions in BC, Canada, and elsewhere.

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Chapter Three: Toward Health Equity in Implementation Science—Lessons from Harm Reduction Research using the Consolidated Framework for Implementation Science (CFIR)

Abstract

Ongoing health system improvement requires that evidence-based interventions are taken up and applied to routine practice. The field of implementation science (IS) aims to accelerate the integration of these policies and practices. The Consolidated Framework for Implementation Research (CFIR) is an IS framework that can be used in diverse contexts to identify facilitators and barriers to successful use of novel interventions. An update to the original framework, CFIR 2.0, was released in 2022. In our commentary, we review and critique the updated framework and share experiences from our research using the CFIR to evaluate novel harm reduction interventions during an illicit drug overdose crisis in North America. Based on our experience, we see community-based participatory research as an potential approach that can help to operationalize equity considerations in the CFIR. Also, to enhance attention to equity in implementation, we recommend using explicit equity language and expanding the focus of CFIR to include a broader range of structural and systemic determinants in all framework domains. These recommendations can assist IS researchers and practitioners studying substance use policies and practices to capture issues, including potential disparities surrounding implementation.

Keywords: Substance Use Research, Implementation Science, Consolidated Framework for Implementation Research (CFIR), Health Equity, Safer Supply, Harm Reduction

Introduction

The illicit drug overdose crisis continues across North America. Since the declaration of the COVID-19 pandemic in 2020, overdose deaths have increased such that more than 24,000 Canadians have died unexpectedly due to opioid toxicity since 2016 (Government of Canada, 2022). The distribution of overdose harms and deaths differs by class, ethnicity/race, and geography, with burdens disproportionately borne by people who live in poverty and/or are racialized (British Columbia Coroner Service, 2023; Government of Canada, 2022; U.S. Centre for Disease Control and Prevention, 2022). A greater number of overdose deaths in Black Americans compared to non-Black people suggests a disproportionate impact of overdose on Black Americans (U.S. Centres for Disease Control and Prevention, 2022). Indigenous Peoples account for 10% of overdose deaths in Canada, despite representing only 2.6% of the total population (Government of Canada, 2022; Lavalley et al., 2018). First Nations women are disproportionately impacted by toxic overdose. In 2022, First Nations women experienced toxic drug-related death rates that were 11 times higher than non-First Nations women (First Nations Health Authority, 2022). While this data highlights increasing recognition of the role of structural determinants of health, gaps remain in understanding and offering equitable lifesaving responses to the people, groups, and populations most affected.

In Canada, the illicit drug supply is contaminated with fentanyl and its analogues with more than 21 people dying each day of an unregulated drug supply (Government of Canada, 2023). While death rates vary across the country, British Columbia (BC), the province on the west coast of Canada, has been the most affected. The provincial Public Health Officer declared a public health emergency in 2016 due to the high and escalating rates of illicit drug overdoses

(Government of British Columbia, 2016). This emergency continues today. In response, policymakers, healthcare providers, and community organizations have increased a range of health sector and community programs and services to prevent, respond to, and mitigate overdose and other drug-related harms (BC Government, 2017).

Overdose responses have varied across jurisdictions in BC, but examples include availability of more supervised consumption sites, overdose prevention services, take-home naloxone, and drug checking services, as well as continued support for implementation of the Good Samaritan Drug Overdose Act[4] and wrap-around harm reduction services, such as prescribed safer supply (British Columbia Centre on Substance Use, 2020; BC Government, 2017; Hatt, 2022; Wallace et al., 2019). Evidence suggests that while progress towards implementing these increased harm reduction measures has been made, a gap remains in curbing the harms, especially for the most marginalized populations including women, gender diverse and Indigenous people (Boyd, 2018; First Nations Health Authority, 2022; Greer et al., 2021, Lavalley et al., 2018; Selfridge et al., 2020, Special Advisory Committee on the Epidemic of Opioid Overdoses, 2021).

The onset of COVID-19 in 2020 made an already devastating situation worse. In Canada, the rates of deaths due to apparent opioid overdose increased by 91% during the first two years of the COVID-19 pandemic (Government of Canada, 2022). In BC, more than 3,000 people died from overdose deaths from 2020 to 2022, making it the leading cause of accidental death and the

[4] The Good Samaritan Overdose Act encourages people to report or intervene in overdose situations by exempting them from criminal charges.

second leading cause of death in the province, only after cancers (British Columbia Centre for Disease Control, 2021; British Columbia Coroners Service, 2022b). The increased mortality was due to the increasingly toxic drug supply and pandemic-related closures that affected access to care and lifesaving services, forcing many people who use drugs to use alone (Canadian Centre on Substance Use and Addiction, 2020; Grebley et al., 2020).

In March 2020, as part of the government's response to the anticipated escalation in overdose deaths and new COVID-19 infections, interim clinical guidance was issued that enabled physicians and nurse practitioners to prescribe pharmaceutical alternative medications for people who use drugs (British Columbia Centre of Substance Use, 2020). The risk mitigation guidance or RMG provided clinical direction for the prescription (in-person or via telehealth) of opioids (tablet hydromorphone and sustained-release oral morphine), stimulants (dextroamphetamine and methylphenidate), and benzodiazepines (clonazepam and diazepam) to support people at high risk of overdose and COVID-19 infection. The implementation of RMG in BC during the pandemic represents the first population-based initiative offering a form of prescription-based *safer supply*.

As the overdose response continues to roll out, researchers have a critical role in evaluating these emergency measures. Parallel to clinical research investigating the effectiveness of pharmaceutical alternative medications for people who use illicit drugs, there is a need to evaluate the implementation of novel emergency overdose responses. We were part of a larger research team that used the Consolidated Framework for Implementation Research (CFIR) to study the implementation and impacts of prescribed safer supply during the dual public health crises in BC (Nosyk et al., 2021). Thus, we have firsthand experience operationalizing the framework in a collaborative and community-based participatory research (CBPR) project studying the

implementation and outcomes of prescribed safer supply in response to a crisis with distinct equity considerations. For a complete description of the study protocol, please see Nosyk et al, 2021. Drawing on our experience using the CFIR to study prescribed safer supply in BC, our commentary aims to share insights gained related to equity in IS. While many of our insights pertain to the CFIR specifically as this was the framework used in our study, findings are nonetheless relevant to IS and equity more broadly. We begin by providing an overview of implementation science.

Implementation Science

Implementation science (IS) is "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006, p.1). Implementation science attempts to address the gap between research evidence and its translation into health practice and/or policy by examining the determinants of the uptake of health interventions. Many conceptual models and frameworks have been developed to analyze what facilitates or hinders the uptake of a policy or practice (Damschroder, 2020; Woodward et al., 2021). One of the most widely used is the Consolidated Framework for Implementation Research (CFIR), a comprehensive metatheoretical approach to systematically evaluate the implementation of an intervention (Damschroder et al., 2009). Integrating components from implementation theories ranging from over 13 different disciplines, the CFIR was developed to assist in the identification of factors that influence implementation (Allen et al., 2021; Cannon et al., 2019; Hudson et al., 2020; Mc Sween-Cadieux et al., 2019).

Consolidated Framework for Implementation Research (CFIR)

The CFIR, which guides the systematic assessment of multiple implementation contexts to identify factors influencing implementation, consists of 39 theoretical constructs organized into five interrelated domains based on context: Intervention Characteristics, Outer Setting, Inner Setting, Characteristics of the Individuals, and Process of Implementation (Damschroder et al., 2009). These five domains integrate constructs and subconstructs to identify potential factors (i.e., barriers or facilitators) most likely to influence implementation. The CFIR can be utilized in various health research designs, and many resources and guides have been developed to support researchers using the framework (VA Centre for Clinical Management Research [CCMR], n.d.). Depending on the nature of the intervention and how it is studied, only certain factors (constructs) may be relevant and different strategies will be devised to address the relevant construct. In other words, the CFIR can be adapted to the objectives of the study. Additionally, instead of the CFIR specifying a research approach to be used in an implementation evaluation, "how the CFIR is used will depend on the type of evaluation you are conducting" (CFIR, n.d.).

Members of our team have applied CFIR, first published in 2009, to research in different settings, including public health, primary care, and substance use (Pauly et al., 2020; Pauly et al., 2021; Wallace et al., 2019; Wallace et al., 2020). In our research to evaluate the implementation and impacts of prescribed safer supply in BC, our team used the CFIR to organize the study and design the data collection tools. For example, we incorporated questions in the qualitative interview guides that focused on the five CFIR dimensions.

The CFIR is among the most used IS frameworks (Damschroder et al., 2022). Several users have critiqued various aspects (Kirk et al., 2015). For example, the provider-centric focus contradicts the current trend for health research to place patients (patient centred research), or

those with experience of the health issues or health system, at the centre of research process (Pauly et al., 2022). Others have highlighted that the framework has yet to systematically assess and address unique factors contributing to healthcare inequities, including institutional and structural issues, notably racism (Allen et al., 2021). An updated version, CFIR 2.0, was released in an attempt to address such concerns based on user feedback gathered via literature review and surveys (Damschroder et al., 2022).

CFIR Changes and Harm Reduction Implementation Research

Many harm reduction interventions have an established evidence base for their effectiveness (Hunt et al., 2003; Kennedy et al., 2017; Poiter et al., 2014; Ritter & Cameron, 2006). How these policies and practices are implemented and the context in which they are introduced vary greatly (Rhodes et al., 2016; Wallace et al., 2020). While harm reduction interventions strive to mitigate inequities, challenges to implementation for marginalized populations remain (Collins et al., 2019). The CFIR can be used to assess and understand the interactions and multiple contexts in which harm reduction or prescribed safer supply initiatives are introduced. As noted earlier, we demonstrated that the CFIR is relevant and valuable in understanding what is needed to successfully implement harm reduction policies and practices (Pauly et al., 2021; Wallace et al., 2020), but the framework must better incorporate equity considerations to ensure equitable implementation. For example, several researchers who used the CFIR in their studies observed that the framework could benefit from adaptations to identify common implementation inequities which ultimately contribute to population health disparities (Allen et al., 2021; Sebastian et al., 2021). This is true for many areas of health research but critical in emergency substance use responses where well-known disparities exist in access,

receipt, use, quality, and care outcomes for many people, especially those affected by structural disadvantages (Rhodes, 2009).

CFIR 2.0 and Equity Considerations

Of the several changes in the updated CFIR 2.0, we focused on the changes relevant to integrating equity. One critique of the original CFIR was that *Patients* were given a minimal voice. Like other forms of health research, implementation research is often conducted with limited involvement of the people most affected by the health concerns being investigated. Such research fails to address equity issues and, at worst, contributes to further inequities by not understanding or addressing key issues relevant to the people most impacted (Shelton et al.,2021; Wallerstein & Duran, 2010).

In response to the call for "Nothing About Us Without Us" by people who use drugs (Canadian Association of People who Use Drugs, n.d. para 1), principles and frameworks for substance use research promoting the equitable involvement of people with lived or living experiences of drug use in all stages of the research process have been developed (Neufeld et al., 2019; Pauly et al., 2022; Souleymanov, 2016). Strategies that centre the experiential knowledge of health service users in the research process renders the research outcomes more likely to improve health policy, practice, and systems.

The original CFIR provided limited opportunities to centre people who use drugs or promote equitable partnerships with *People who Use/d Drugs* in IS. One of the most significant changes to CFIR 2.0 is to "centre Innovation Recipients (formerly patients)" in the framework (Damschroder et al., 2022, p. 14). Previously, only *patient's* perceptions in the original CFIR were only included in the *Inner Domain.* CFIR 2.0 prominently represents the Patient's (changed to

Innovation Recipient's) voice across all the domains. For example, four of the five primary domains now include assessing and acknowledging the perceptions of *Patients/Innovation Recipients.* Additionally, constructs were added to clarify and extend the theme of *Culture,* including *Human Equality-Centredness, Recipient-Centredness, Deliverer-Centredness,* and *Learning-Centredness* to "reinforce the importance of identifying and amplifying key voices and address issues related to oppression and equality at both a cultural and system-level" (Damschroder, 2022, p. 16).

These changes reflect an effort to allow *Patients/Recipients* to have a more influential role in the research. Issues still need to be worked out when applying the CFIR 2.0 to research. Further examples of the practical ways to engage *Innovation Recipients* ethically and equitably will be needed.

The CFIR emphasizes the interactive multilevel contexts that influence implementation. However, the focus is on the *Inner Context* with limited attention to how sociopolitical and structural factors operate in all domains (particularly the original CFIR version). CFIR 2.0 includes additional constructs in four of the five domains to describe how sociopolitical factors influence innovation implementation. For example, additional constructs in the *Outer Setting Domain* include *Critical Incidents* (describing how unanticipated events such as a pandemic can disrupt the *Outer Setting* during implementation) and *Local Attitudes* the sociocultural views that affect implementation). The *Inner Setting Domain* expanded the construct of structural characteristics to include *Local Conditions* described as the "economic, political, and/or technological conditions that enable the Outer Setting to support implementation and/or delivery of the innovation" (Damschroder et al., 2022, p. 9). While all these changes expand recognition

that broader sociopolitical contexts impact implementation and outcomes, how structural and system inequities (e.g., racism, poverty, misogyny) impact every domain—ultimately shaping implementation and outcomes—is ignored.

The construct of *Culture*, variably defined in different implementation frameworks but often referenced as affecting equity, was added to the *Inner Setting Domain* in the CFIR 2.0 (Damschroder et al., 2022). The four subconstructs—*Human Equality-Centred, Recipient-Centredness, Delivered-Centredness, and Learning-Centredness*— were added to "identify and amplify key voices and address issues related to oppression and equality at both a cultural and systems level" (Damschroder, 2022, p. 16). While this change was meant to clarify equity issues, the current explanations offered in the CFIR 2.0 need critical review. *Culture*, mainly when operationalized in many IS frameworks, tends to focus on the culture of individuals rather than broader sociopolitical understanding of *Culture*. Understanding culturally relevant factors associated with recipients and providers is particularly relevant as these factors shape access to and experience of the innovation. However, an expanded definition of *Culture* that includes the multiple layers of cultural understanding from individual to inner and outer contexts is required when addressing equity issues in healthcare delivery.

Recommendations for Further Integrating a Health Equity Lens into the CFIR 2.0

Our experience using the CFIR to study the implementation and impacts of prescribed safer supply in BC garnered insights into applying the principles of equity in Implementation Science (IS). The recommendations below pertain to the CFIR we specifically used in our research, but our findings are relevant for IS, generally.

Recommendation #1—Employ CBPR as a Potential Research Approach for Applying an Equity Lens.

To better attend to equity issues in our implementation efforts, requires a paradigm shift in conducting research. While community engagement is a common approach for enhancing implementation, how and to what extent stakeholders are involved in the research varies, as does the composition of those included on the research team (Key et al., 2019; Minkler et al., 2012). Operating from a health equity perspective requires authentic, collaborative stakeholder engagement. Community Based Participatory Research (CBPR) is a well-established research approach that emphasizes equity by utilizing principles of social justice and integrating community within every aspect of the research process with a goal of democractization of knowledge and reducing power inequities in the generation of knowledge (Israel et al., 2003). Recognizing the flexibility of the CFIR, we recommend integrating a CBPR approach as a potential strategy when using the framework to study topics with health equity considerations. Drawing on a CBPR approach values experiential knowledge where stakeholders can provide essential insights into the feasibility of an intervention. Perhaps most significantly, stakeholders can provide insider knowledge of the specific and unique context in which the implementation effort will occur. Using a CBPR approach can also help to identify and acknowledge the power differentials among academic researchers and other stakeholders, specifically those with lived and living experience. Equitable stakeholder engagement can increase the likelihood that implementation strategies are relevant, appropriate, and sustainable without reproducing or exacerbating health disparities (Shelton et al., 2021; Wallerstein & Duran, 2006). While a CBPR approach can be used to mitigate power differential and support equitable engagement among all stakeholders involved in the research, we acknowledge that there may other approaches that draw on different methodologies, for example, Indigenous methodologies, or anti-oppression methods

that also support equity in knowledge generation. Equitable stakeholder engagement can increase the likelihood that implementation strategies are relevant, appropriate, and sustainable without reproducing or exacerbating health disparities (Shelton et al., 2021; Wallerstein & Duran, 2006).

In our research studying the implementation of prescribed safer supply in BC, we used an overall CBPR approach and incorporated these principles in the CFIR. For example, people with lived and living experience of drug use were included as research team members in all phases of the study, including the study design, data collection, analysis, and translation of the findings (Beck et al., 2023). In the original CFIR, people with lived and living experience are often categorized as "patients" with a minimal role, i.e., asked to provide data to the researchers. While the CFIR 2.0 attempts to expand the role of *Innovation Recipients*, using a CBPR approach with the CFIR could help to ensure that *Recipients* are fully engaged in the design and delivery of services that are intended for them and that such services are safe, acceptable, and able to serve people who have various and differing needs.

Grounding CFIR evaluation research in a CBPR approach fosters equity by recognizing and attending to the asymmetrical power relations among stakeholders (research team members) (Israel et al., 2003). Extreme power imbalances often occur between academic researchers and collaborative stakeholders—especially when collaborating with structurally vulnerable and marginalized communities, as with our work with people who use(d) drugs (Pauly et al., 2022l; Urbanoski et al., 2020). A CBPR approach that openly discusses power differentials may be used to repair harm and build trust among research partners, especially *Innovation Recipients* who are often stigmatized in healthcare systems (Pauly et al., 2022; Urbanoski et al., 2020; Woodward et al, 2021.). CBPR grounding would encourage implementation researchers to develop acceptable

forms of support and compensation for all partners. For example, equity informed CIFR evaluation research should be coupled with adequate funding to pay partners for their time, expertise, and any costs incurred by participating in the research. Researchers should be clear about what types of training may be offered to stakeholders—for example, training on using the CFIR and other professional development opportunities.

Recommendation #2—Employ Language to Represent Equity

Written and spoken language is a powerful tool that can create a culture in which people feel included and respected. When our language and ways of communicating are not inclusive, people and groups can feel stigmatized, excluded, and undervalued (Diversity Council Australia, 2016). Research is no exception. In the CFIR 2.0, the shift in the language and definitions were meant to reflect more "*humanness"* but limited examples of the language to support this effort are provided (Damschroder, n.d.). Sharing working definitions or highlighting the important changes to the framework with respect to the language of equity or "humanness" would be helpful.

The construct of *Human Equality Centredness* was added to the CFIR 2.0 to address issues of equal worth and the value of all peoples, but the difference between equality and equity should be emphasized. While equality means that all human beings are of equal worth, equity acknowledges the broader structural contexts in which values, beliefs, norms, and systems systematically benefit some people more than others. With this understanding, the implementation of equity must recognize that people and communities have different circumstances and needs. Without human equity-centredness, achieving equality would be difficult, if not impossible. We suggest replacing *Human Equality Centredness* with human equity centredness to more accurately capture equity factors that impact/influence our CFIR evaluation efforts. Again, our experience of

evaluating the implementation of novel harm reduction interventions in BC taught us that working with peer research associates was essential to understand language and terms, especially those that refer to topics and terms about using and obtaining substances.

Recommendation #3—Expand CFIR to All Structural and System Determinants in all Domains.

The CFIR ought to explore the full range of health determinants, including structural determinants. Without considering the structural and systemic determinants of health, we miss the social context that shapes implementation efforts and the entire research enterprise. The CFIR assesses multiple interacting contexts to foster a greater understanding of how to implement innovations across diverse settings. While the strength of the CFIR is that it is centred on assessing context, emphasis on assessing structural and systemic contexts is required. By structural and systemic context, we mean the "complex, integrated and overlapping social structures and economic systems that are most responsible for health inequities" (World Health Organization, n.d. para 1.). These structural contexts and system factors significantly contribute to the unjust treatment of specific populations (Braveman, 2006; Braveman, 2014). Explicitly assessing structural factors beyond economic, environmental, political, and/or technological conditions to include factors such as racism, poverty, ableism, heterosexism, stigma and all forms of discrimination, that indirectly influence healthcare delivery would provide a more fulsome understanding of implementation generally, and equitable implementation specifically. Such an approach would enable understanding about why certain innovations work for some and not for others, opening additional avenues for implementation to intervene or address such inequities (Chinman et al., 2017).

Conclusion

The purpose of our commentary was to unpack updates to the CFIR to consider their utility and potential for improving health equity in IS. We did this against the backdrop of our research evaluating novel harm reduction responses to North America's illicit drug overdose crisis. Our recommendations pertain to what we see as enhancing the CFIR's ability to address health inequities in the access and uptake of healthcare interventions, shifting IS studies to an equity orientation methodologies such as a community-based participatory approach, attending to language and conceptualizations of equity, and expanding the focus of CFIR to include a full range of structural and system determinants in all domains.

Many IS frameworks focus more on individual factors (e.g., innovation delivery, innovation recipients) than on structural factors, but health equity recognizes the effects of structural inequities on people's ability to access and receive health care and their determinants of health. Other investigators have incorporated health equity domains using other determinants frameworks (Woodward et al., 2021). Others have gone so far as to develop new conceptual implementation science (IS) frameworks with an explicit grounding in health equity (Eslava-Schmalbach et al., 2019). We chose to adapt the CFIR because we see this framework, specifically focused on multiple intersecting contexts, as uniquely positioned to attend to the structural and social contexts that influence health to understand and achieve population health equity. While evaluating the outcomes of prescribed safer supply initiatives to evaluate novel harm reduction initiatives to reduce illicit drug overdose in BC, Canada is a key objective of our work, understanding the ongoing implementation of these initiatives is paramount to understanding and interpreting outcomes and access to prescribed safer supply programs. We believe that an inherent

equity lens in the CFIR can support these aims. Understanding health equity is key to providing equitable access to safer supply and related services. Integrating health equity into the CFIR 2.0 offers new opportunities to refine interventions that promote harm reduction specifically and address health equity broadly.

We look forward to sharing reflections from our work to address health equity in the updated CFIR 2.0 and learning from the experiences of others who use the CFIR to advance the health equity agenda. We hope this commentary sparks continued discussion among implementation researchers to reflect critically on our collective efforts to achieve equity for different communities and populations so that our science ultimately serves people and populations.

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Chapter Four: Gender and Prescribed Safer Supply—Experiences of Women and Gender diverse Persons Who Accessed a Novel Harm Reduction Intervention During a Dual Public Health Crisis

Abstract

In British Columbia (BC), the ongoing overdose emergency, complicated by the COVID-19 pandemic, became known as a dual public health emergency. To reduce overdose deaths, the province implemented interim risk mitigation guidance (RMG) that permitted prescription of pharmaceutical alternatives to illicit substances, including opioids, stimulants, and benzodiazepines. Gender and other intersecting factors were critical in these dual public health emergencies. Current evidence suggests that women and gender diverse persons who use drugs experience gendered barriers to harm reduction services. This study explored the impacts and effectiveness of BC's RMG prescriptions for women and gender diverse persons who use drugs. Our study involved a qualitative dataset of semi-structured interviews with 21 women and gender diverse persons who accessed or attempted to access an RMG prescription from October 2020 to October 2021 in BC, Canada. Our analysis used interpretive description (ID) to identify key concepts and emerging themes about accessing this harm reduction intervention. Findings revealed that participants encountered intersectional gendered, structural, and interpersonal barriers when accessing RMG prescriptions, including concerns about physical and psychological safety, stigma, and child welfare. While women and gender diverse persons reported benefits of accessing RMG prescriptions, the intervention did not disconnect them from the toxic illicit drug supply. Interventions to improve the impacts of future prescribed safer supply initiatives must remove the gendered and intersecting barriers faced by women and gender diverse persons.

Keywords: Safer Supply, Gender, Pharmaceutical Alternatives, Harm Reduction, Canada.

Introduction

North America was already facing an unprecedented overdose crisis, which was made worse by the arrival of the COVID-19 pandemic. The significant increase in drug-related mortality and morbidity was attributed to an increasingly toxic illicit drug supply and to pandemic restrictions (Canadian Community Epidemiology Network on Drug Use [CCENDU], 2020; Nguyen & Buxton, 2021; Palis et al., 2022). In Canada, the situation posed a significant concern especially in the western province of British Columbia (BC) where a public health emergency due to overdose had been in effect since 2016. With the onset of the COVID-19 pandemic, the number of overdose deaths in the province more than doubled in in 2020 compared to 2019 (British Columbia Coroners Service, 2022); overdose compounded by COVID-19 created a uniquely challenging situation for people who use drugs in BC and elsewhere. While BC overdose mortality rates are significantly higher among males than females, females make up approximately 23% of overdose deaths (British Columbia Coroners Service, 2023). Overdose deaths were disproportionately higher for Indigenous women; in 2022, First Nations women died from overdose at 11 times the rate of other non-First Nations women in BC (First Nations Health Authority, 2022).

The emergence of COVID-19 demonstrated the ways in which existing gender inequities and other socioeconomic determinants intersect to increase risk of substance-related harms for women who use drugs, including overdose (Brabete et al, 2021). Aspects of social isolation, lockdowns, financial uncertainty, and attitudes about gender roles exacerbated interpersonal and structural violence and substance use in the context of COVID-19 (Brabete et al.). Women were three times more likely than men to face underemployment during the COVID-19 pandemic

(Gavrilovic et al., 2022). For women who used illicit substances, this resulted in a lack of resources to secure substances. Women who relied on the informal economy, especially sex work, lost their income when the pandemic hit or were forced to work in dangerous conditions (Benoit & Unsworth, 2022; Gavrilovic, 2022).

Within this context, federal and provincial governments responded by implementing policies and clinical practice guidance to counteract the anticipated harmful effects of the COVID-19 pandemic for people who use substances (British Columbia Centre on Substance Use, 2020; Health Canada, 2020). In March 2020, the BC government released interim risk mitigation guidance (RMG) as a harm reduction response to the toxic drug supply and to support people who use drugs to physical distance and self-isolate (British Columbia Centre on Substance Use, 2020). The RMG provided clinical direction for the prescription of opioids (tablet hydromorphone and sustained-release oral morphine), stimulants (dextroamphetamine and methylphenidate), and benzodiazepines (clonazepam and diazepam) to persons who were actively using substances or who were at high risk of withdrawal, overdose, and transmitting or contracting COVID-19 infection.

While the provincial government and health jurisdictions continued to develop and implement models of prescribed safer supply, very little attention had been paid to ensuring that these models met the needs of women and gender diverse persons. Prior to COVID-19, women and gender diverse persons often remained underserved by harm reduction programming and overdose prevention initiatives (Boyd et al., 2018; Collins et al., 2019). Women, especially marginalized women, and gender diverse persons were differentially impacted by substance-related risks and harms compared to cisgender men (Boyd et al., 2020; Collins et al., 2019; El-

Bassel & Strathdee, 2015; Thumath et al., 2021). Research specific to women who use drugs largely focused on proximate level concerns and harms such as the increased likelihood of facing injection-related harms, high rates of immune-deficiency virus (HIV) and Hepatitis C transmission, and risks of interpersonal violence (Collins et al., 2019; Shannon et al., 2014; Shirley-Beavan et al., 2020). While not discounting the significance of this research, emphasis on the individual obscured understanding of the broad structural contexts that intersect to shape women's and gender diverse persons' substance use and the harms they experience.

Gender discrimination—the inequitable or inferior treatment based on gender—is present in the institutions, societal practices, and interpersonal relationships that impact the lives of women and gender diverse persons and intersects with other structural inequities including racism, colonization, poverty, and ableism that create barriers for women and gender diverse persons in accessing the support and health care services they require. Several researchers have generated evidence that acknowledges how women and gender diverse persons who use drugs tend to navigate these types of systemic social or economic disadvantages (Austin et al., 2023; Boyd 2004; Boyd et al., 2020; Bungay et al., 2010; Thumath et al., 2021; Xavier et al., 2021). Research with structurally vulnerable women who use drugs in Ontario found that the majority of women who accessed safe consumption services (SCS) also experienced homelessness and that housing insecurity resulted in their increased vulnerability to physical and sexual violence (Xavier et al., 2021). Historical and ongoing colonization has rendered Indigenous women susceptible to overdose and other related health and social harms (Benoit et al., 2010; Boyd et al., 2018; Bungay et al., 2010; First Nations Health Authority, 2022; Martin & Walia, 2019; Thumath et al., 2021). Boyd et al. (2022) found that racism and gendered violence (punitive policies and discriminatory

child welfare practises) influenced mother-child separation and overdose risk among mothers who used drugs, with Indigenous women being the most affected. Despite repeated calls for substance use and harm reduction initiatives to take gender into account, only two gender-specific harm reduction services operate in BC, both described as women-specific overdose prevention services (OPS)[5] for women and gender diverse persons (Atira, n.d.; Austin et al., 2023; Bardwell et al., 2021). The women-specific OPSs are located in the highly populated Vancouver area, making access prohibitive to those who live in other areas of the province.

RMG in BC provided a novel harm reduction strategy to reduce overdose (McNeil et al., 2022). However, intersecting gendered barriers during the dual public health emergencies hampered access to health and harm reduction support for women and gender diverse persons. Recognizing the need for gender-sensitive harm reduction services, this study used an intersectional feminist approach to seek insight into the influence of gendered structural determinants that shape women's and gender diverse persons' access to and experience of prescribed safer supply in BC during 2020-21 (Collins, 2019). Our study was driven by the research question: "What are women's and gender diverse persons' experiences when accessing or attempting to access RMG prescriptions in BC during dual public health emergencies?" Understanding the potentially nuanced ways that the dual emergencies may differentially impact women and gender diverse persons has implications for the implementation and impacts of prescribed safer supply.

[5] OPS are similar to SCS as the purpose is to provide a safer space for people who use drugs to use pre-obtained substances. Often, the difference between OPS and an SCS is the lack of permanency of an OPS (PIVOT, n.d.).

Methods

This research was part of a larger mixed methods evaluation conducted in collaboration with people who use drugs with the overall purpose of evaluating risk mitigation guidance (RMG) implementation and impacts in BC. The full evaluation (Noysk et al. (2021), employed province-wide mixed methods evaluations using primary and secondary data sources, including population-level administrative health data, a prospective and cross-sectional survey among people who use drugs, and semi-structured interviews with people who use drugs, prescribers, and health planners to assess the implementation and impacts of the RMG. By conducting a secondary analysis of a subset of 21 women and gender diverse persons we focused in this study on the experiences of women and gender diverse persons who use drugs and their experience of accessing or attempting to access RMG prescriptions across BC during 2020–21.

Data Collection

Between October 2020 and October 2021, participants were recruited by the RMG research team through community networks of people with lived/living experience of drug use, flyers posted at support services, health clinics, and social media (Nosyk et al., 2021). A sub-sample of participants was invited to participate in qualitative interviews. These interviews were conducted from November 2020 to September 2021, either in person or over the phone by an RMG post doctoral fellow (Marion Selfridge). Participants were women and gender diverse persons who were at least 19 years old, had used illicit drugs in the past six months, and had tried to receive an RMG prescription. Selection was based on willingness to participate and knowledge about RMG. The Consolidated Framework for Implementation Research (CFIR) was used to develop the interview guide, as the framework has been used successfully in substance use

interventions (Pauly et al., 2021; Wallace et al. 2020). The interview guide was developed by the RMG qualitative research team and the questions were organized around the five CFIR domains: intervention characteristics, outer setting, inner setting, characteristics of individuals, and process of implementation (Damschroder et al., 2009). Appendix C presents the interview guide questions, a proportion of which were used in this secondary analysis. Interview durations ranged from 45 to 80 minutes. All interviews were audio recorded, transcribed, anonymized, and imported into NVivo12 to facilitate coding. The study received ethical approval from the Research Ethics Board at the University of Victoria (#20-0293).

Data Analysis

An interpretive description (ID) approach, rooted in the naturalist and constructivist orientations to knowledge generation, guided the secondary analysis of qualitative data for this study (Thorne, 2016). ID data analysis relies on inductive reasoning to describe and interpret the meanings gleaned from the data, which involves examining transcribed text and determining preliminary codes or patterns that reveal categorical grouping. Often the groups are developed into primarily analytic concepts that highlight the relationships among the patterns. ID is unique because few prescriptive guidelines dictate the methods investigators may use to gather and analyze data; thus, it was an appropriate method for secondary analysis. Interview data was analysed with specific attention to gender and access and impact of accessing RMG prescriptions.

Initial secondary analysis consisted of the first author (GS) sharing initial themes related to gender, harm reduction, and experience of the RMG with the senior author (BP). The analysis followed an iterative process as the emerging and final themes were shared and discussed with all authors. Throughout the analysis process, focus was given to the gendered structural factors that

shaped the participants' experience of and access to RMG prescriptions and other harm reduction services. Locating participant experience within a structural analysis allowed us to explore the ways gender discrimination influenced their experiences, needs, and concerns. We further drew on an intersectional feminist lens to elucidate how gender discrimination intersects with other identities including race, class, and ability.

Sample and Population Characteristics

A sample of 21 women and gender diverse persons who used drugs and attempted to access or accessed a RMG prescription participated in this study. Participant characteristics are presented in Table 1.

Table 1 Characteristics of Participants (n=21)[a]

Age in years, Mean [SD]	38.5 [10.4]
Identify as Indigenous, n (%)	
Yes	8 (38.1)
No	13 (61.9)
Missing	0
Education, n (%)	
Did not complete high school	9 (42.9)
High school degree or equivalent	5 (23.8)
Some college/university	7 (33.0)
Missing	0
Relationship status, n (%)	
Partnered, living separately	5 (23.8)
Partnered, cohabiting	10 (47.6)
Single	6 (28.6)
Missing	0
Children, n (%)	
Yes, with some custody or visitation	7 (33.3)
Yes, with no information about custody or visitation	1 (4.8)
Yes, with no info on custody	2 (9.5)
No children	11 (52.4)
Missing	0
Residence, n (%)	
Smaller centre/rural area	4 (20.0)
Large urban centre	16 (80.0)
Missing	1
Unstable housing, n (%)	

Yes	9 (42.9)
No	12 (57.1)
Missing	0
RMG prescription, n (%)[b]	
Opioids	13 (61.9)
Stimulants	6 (28.6)
Benzodiazepines	1 (4.8)
No prescription	5 (23.8)

Note. This table denotes characteristics of interview participants.

Results

Most participants self-identified as White (13), with a smaller number identifying as Indigenous (8), Black (0), and Indigenous/White (2). Two people identified as non-binary, and the remainder as women. All reported use of criminalized drugs and varying degrees of socioeconomic marginalization. Over half (57.1%) indicated that their current housing was stable, and others lived on the streets, in a shelter, or stayed with friends or family (42.9%). Nearly half of the participants had one or more children under the age of 19 (47.6%).

Three themes arose in relation to participants' experiences of drug use, overdose, and accessing or attempting to access prescribed safer supply:

(1) Lack of safety;

(2) Desire for peers and other supports; and

(3) Reduced criminalization and increased autonomy.

"It Isn't Safe"

Many participants experienced barriers to physical, emotional, and psychological safety. Several indicated that they did not feel safe accessing or attempting to access a risk mitigation guidance (RMG) prescription, describing that the term safe(r) supply was misleading and inaccurate because "it isn't safe" (Participant 3552). Fear of institutional violence, specifically

parent-child separation, was common among participants who described how "even asking" for an RMG prescription could jeopardize child custody agreements or lead to a child welfare investigation:

> *I wanted to try and ask my doctor [about RMG], but I'm a little chicken to do that. I don't want to—I hate seeing my doctor. I'm always scared if I have been using because I have a daughter. I don't like telling them anything, one side of them say, you know, it's confidential. But there is a huge poster on the wall that says, "I'm a mandated reporter" [laughs]. So, I know many women and mothers that won't tell anybody anything… Even to get counselling or help. They're scared out of their mind. (Participant 2890)*

Two participants specifically raised concerns that staff and prescribers had an unclear understanding of parental concerns around RMG prescriptions. When asked what they would like changed for future prescribed safer supply initiatives, one participant explained:

> *As far as this program [RMG], I would definitely do a lot more to get information to people. I would help women with—or women and men—with kids be more comfortable coming in and talking to somebody. Because it's really scary for women. And I know, I can't even go talk to a counsellor. The social worker wanted me to go talk to a counsellor … but then she tells me in the next sentence that everything that I tell her is going to be reported!* (Participant 2890)

Participants' sense of safety was shaped by past and ongoing experiences of structural and interpersonal stigma. Many described previous experiences with health providers who did not appreciate that their past experience of trauma (interpersonal violence, sexual and physical abuse) resulted in having "their boundaries trampled on" (Participant 2333). Participants recommended

that staff and providers should be trauma-informed when working with people who want to access prescribed safer supply as "Many of us have experienced trauma and if staff are not aware, it is a huge trigger" (Participant 2333).

A lack of access to privacy and specifically private spaces intensified safety concerns among participants. Several mentioned feeling unsafe when picking up the prescription from the pharmacy. One participant explained that she felt "very uncomfortable" when going to pick up her RMG prescription at the pharmacy because there "was no privacy" (Participant 2333).

A smaller number of participants, notably those who identified as White, felt that their privacy and dignity were respected. One of these participants described a positive experience where pharmacy staff removed identifying information on the medication bottle to maintain privacy:

> *Like no judgement whatsoever. Actually, a couple times they even [pharmacist] edited the writing on the pill bottle so that it doesn't say "risk mitigation" so that it's not obvious that I'm taking them for that reason. (Participant 3463)*

In conjunction with safety concerns several participants described experiences of racialized marginalization when attempting to access prescribed safer supply:

> *When I walked into that doctor's office, the way he looked at me, I knew right away: I'm not going to get what I need…. And I already knew before he even said anything. Like, you go to a doctor's office and I'm First Nations. And as soon as I walked in there, he looks at, up and down. Like, with this look on his face, "Well let's see what she's going to ask for today." You know? Kind of thing…. That there's that stigma and discrimination right there. . .but it doesn't surprise me much. You know, I am brown.* (Participant 2565)

Racism intersected with gender discrimination and framed the experiences of accessing prescribed safer supply across settings, specifically for women who also identified as Indigenous.

Desire for Peers and Other Social Supports

Although not directly asked about gender-specific supports in relation to prescribed safer supply, several participants described accessing women-only services, including shelters, OPS, and other treatment services. Over half of the participants felt peer support was lacking in the current prescribed safer supply services and specifically described a desire to include women who use drugs in these services. As one participant recommended shifting to a model that included "*women [who use drugs] as part of the [RMG] program"* (Participant 2333). Interestingly, several participants described their desire to volunteer with harm reduction and drug user organizations in their communities to help support other women because the experience of peer support was helpful for them and they wanted to offer the same form of support to others. One participant described how reaching out to a person in an urban drug user organization led to getting access to prescribed safer supply and connecting to a peer organization in her community.

Many participants in our study described how accessing prescribed safer supply offered them a point of access to other health care supports and that accessing a RMG prescription "*finally"* provided them with a doctor (Participant 3253). Several participants used the opportunity of starting on an RMG prescription to talk with prescribers about other primary health concerns e.g., planning for pregnancy, accessing overdue blood work, and restarting HIV medications. One participant described:

> *My mom had thyroid cancer quite a few years ago … so I like to just check it every once and a while. And, I needed a pap test. So I asked her [RMG prescriber] if she could do that*

for me, and, and she's more than happy to do that kind of stuff as well, so that's good. (Participant 3263)

While participants felt that prescribed safer supply offered a point of access to connect with providers about health care supports, structural barriers created other socioeconomic concerns. Several expressed a need of support for housing (e.g., navigating affordable housing options) and employment opportunities:

> *So many people are homeless…the housing crisis is such a huge problem…. You know? Like if you get a place to rent, you have to live with so many other people and they're usually well there is issues with them, and you know? So housing, help with that. It's what we need. (Participant 2524)*

Reduced Criminalization and Increased Autonomy

Our study participants described how having access to an RMG prescription decreased criminalization. For example, several participants explained that after accessing a prescription they no longer had to steal or "*trade"* (Participant 2565). Several participants said they sold the alternatives to avoid engaging in illegal activities or sex work:

> *I've actually managed to make it through the system and I'm not even on probation anymore or anything. And that's been the case for a year and a half now … that was from safe supply. So, I'm like super-duper grateful for that. Um, I am not committing petty crime…. And also, um, I'm not having to do sex trade work either.* (Participant 3918)

One participant described that in the past she had engaged in sex work as a means to earn money but explained that when the pandemic started, she did not feel safe to work. She explained that she "*used half and sold half"* of her RMG medications, which in turn meant that she did not

have to "*do sex trade work"* (Participant 3918). She further explained the broader impacts pharmaceutical alternatives had on the sex trade industry in her local community:

> *I mean it's actually hard to find a sex trade worker on [Local Street Name] these days*. (Participant 3918)

Several participants described that having access to a RMG prescription offered some stability in their lives. Since starting her prescription one participant was able to "*spend more time with her mom and son" (Participant 2565).* She used half of her RMG medications and sold half to buy food:

> *I took half of it [RMG prescription] and I spent half of it on the down and then half to buy food and snacks and stuff for the night. And when I came home carrying some snacks and stuff, I felt so good. Like, I get to put this little bit of food that I have in my fridge and in my cupboards. And it felt … well empowering—well yeah, empowering. I felt like I had more control.* (Participant 2565)

Participants described how accessing pharmaceutical alternatives led to an increased sense of autonomy as they no longer had to "*hustle"* and could organize their drug use in ways they could not before (Participant 2565). Several described that having access to RMG medications—even though in many cases it was not their drug of choice, the correct dose, or their preferred route—offered a sense of control over their use by *"just having it"* when "*there is such an unreliable illicit supply"* (Participant 3282). Others described using the RMG medications to organize and determine their own goals around their substance use. Several participants used the RMG medications as a bridge to reduce and eventually stop illicit drug use "*without having to be part of the system* (healthcare)" and *"doing it their own way"* (Participant 3282).

Discussion

In this this study we explored the perspectives of women and gender diverse persons who accessed or attempted to access prescribed safer supply during dual public health emergencies of drug overdose and the COVID-19 pandemic in BC, Canada. While the participants identified both positive and negative impacts while accessing RMG prescriptions, the intervention did not disconnect them from the toxic illicit drug supply. They also offered insights into potential improvements for safer supply programming, including offering gender-responsive models that focus on physical and psychological safety, formats that include women and gender diverse persons as peers in the delivery model, supports to address socioeconomic structural barriers, and the autonomy of women and gender diverse persons who use drugs. Building on previous evidence that suggests current harm reduction approaches are often do not consider the gendered structural and interpersonal barriers faced by women and gender diverse persons who use drugs, we document how similar shortcomings were present in the RMG responses and models in BC (Austin et al., 2023, Bardwell et al., 2021; Boyd et al. 2018).

Our study participants experienced intersecting gendered dynamics that impeded their access to pharmaceutical alternatives. Our participants who were parenting felt especially vulnerable, which is similar to findings of other research that explored women's experiences of accessing supervised consumption services (Boyd et al., 2022; Shirley-Beavan et al., 2020; Thumath et al., 2021). Many participants expressed fears and concerns that prescribers and staff would report their drug use to child protective services. It is well known in the existing literature that child apprehensions are among the most significant barriers to women and parenting people accessing harm reduction services (Boyd et al.; Shirley-Beavan et al.; Thumath et al.). Prescribed

alternative medication initiatives are no exception. Despite the clear evidence that child apprehension fears are a barrier for women who use drugs, little has been done to address these concerns and support this population. To our knowledge, no guidance exists on how mandated reporting may impact prescribing pharmaceutical alternatives for parenting people. While no one in our sample identified as pregnant, there may be similar surveillance concerns for this group when attempting to access a pharmaceutical alternative.

Numerous studies with women who use drugs identify the need for harm reduction measures to address how gendered social and structural violence impacts women's overall health and well-being (Austin et al., 2023; Bardwell et al., Boyd et al., 2018; Boyd et al., 2022). Multiple intersecting structural and interpersonal dynamics influenced women's and gender diverse person's access to RMG medications. Structural and interpersonal harms (e.g., gendered violence, systemic racism, poverty) were ever-present in the lives of the women and gender diverse persons we interviewed. The participants in our study expressed that to help navigate these harms, safer supply models should involve peers—women who have living or lived experience of drug use—as this form of support helped to provide needed physical, psychological, and social support. This finding supports existing knowledge that harm reduction services employed by people who use drugs play a critical role in interventions for people who use drugs, specifically in overdose prevention and response (Mercer et al., 2021). However, a study by Austin et al. (2023) explored the experiences of peers working at women-specific OPS in Vancouver and found that while peer support was considered pivotal to care for women accessing the OPS, peers faced challenges within their role, including their own socioeconomic barriers (poverty, racism, stigma) and the overwhelming care demands that led to vicarious trauma and burnout. Future prescribed safer

supply programs must consider how to better support women and gender diverse persons who engage in peer work to strengthen these roles in safer supply programming.

Racism and ongoing colonization are especially present in BC for Indigenous women and gender diverse persons who use drugs and more intense for those who are pregnant and/or parenting. Despite the recent calls for culturally safe substance use care/healthcare, little evidence of these models has translated into the prescribed pharmaceutical alternatives initiatives. Our findings expand on previous research that suggests harm reduction services need to be designed using a framework that draws specific attention not only to gender but other social-structural drivers of overdose, specifically the ongoing colonial oppression and systemic racism experienced by Indigenous women in BC and Canada.

While several participants in our study reported selling or trading their prescribed safer supply or a portion of the prescription, they did so to support their basic needs. Several participants described selling prescription medications to buy food; others explained that using the money received from selling the prescription prevented them from having to engage in sex work. While selling or diverting prescribed safer supply is a commonly cited concern with regard to safer supply initiatives, it is clear in our findings that such actions were in response to structural inequities for women and gender diverse persons who use drugs and, as a result, forced them to make decisions between medications or meeting basic needs such as food.

Our study contributes to the body of literature reporting on the need for connecting women and gender diverse persons who use drugs with a continuum of wrap-around services. While the existing evidence mostly suggests that wrap-around supports ought to include services such as withdrawal management, counselling for substance use, and mental health, reproductive, and

primary care services, the participants in our study also included approaches such as peer supports, wellness, and socioeconomic considerations (e.g., navigation of housing and employment opportunities). While many harm reduction strategies originate in the community (often among people with lived/living experience of drug use) these strategies are taken up by healthcare actors and the result is often a revised version of the strategy or service offered in a highly medicalized model. Women and gender diverse persons who participated in our study challenged the medicalized model and saw the potential for expanding pharmaceutical alternatives to holistically meet their needs by addressing structural barriers they faced, as well as a desire for increased connection to peers and improved overall wellness. Our findings support other research with women and gender diverse persons who use drugs in the need for planning and implementing low barrier, non-medicalized harm reduction approaches. Pharmaceutical alternatives should include a diversity of approaches that include gender-specific services and low-barrier models.

Several studies with women who use drugs have identified the need for harm reduction measures to address how gendered social and structural violence impacts women's overall health and well-being (Bardwell et al., 2021; Boyd et al., 2018; Boyd et al., 2020; Thumath et al., 2021; Xavier et al., 2021). Structural and interpersonal harms (e.g., gender discrimination, systemic racism, inequity, poverty) were ever-present in the lives of the women and gender diverse persons we spoke with, who described their experiences of structural and interpersonal violence and their desire for physical, emotional, and psychological safety. Based on our conversations with participants, there appears to be a tension regarding the term prescribed safer supply. According to participants the term *safety* can be misconstrued as they described experiences that threatened their physical and or psychological safety when accessing or attempting to access the RMG

prescriptions. Consultation with women who have lived and living experience of drug use is needed to determine that the language used is appropriate.

Two participants in our study identified as gender diverse. Policies that attend to the unique contexts, constraints, and concerns of people of all genders, particularly those who do not identify as cisgender, was identified as an important and ongoing gap to address. Research and consultation with those who have lived and living experience of drug use are urgently needed to plan and implement prescribed safer supply models to support people who experience transphobia and gender discrimination that intersects with the other structural harms that affect people who use drugs.

Our study adds to the body of literature reporting on the unique challenges women and gender diverse persons face in accessing harm reduction supports. To our knowledge, this is the first study that has examined the gendered aspects of pharmaceutical alternatives responses. Our study provides critical insight into the tangible and intangible factors that influence women's and gender diverse persons' access to a lifesaving intervention.

Limitations

This study has several limitations. Findings from this analysis are specific to a prescribed safer supply model—risk mitigation (RMG) prescriptions implemented in British Columbia (BC), Canada, during a dual public health crisis of overdose and the COVID-19 pandemic—and not representative of all women and gender diverse persons who access forms of safer supply medications. Finally, gender diverse persons were underrepresented and, as such, our findings may not adequately reflect their specific experiences. Because this secondary analysis did not set

out to specifically examine the gendered impacts of accessing RMG prescriptions, a primary study that had such a focus could have provided a more nuanced perspective.

Conclusion

Currently, the model of prescribed safer supply available in BC does not specifically address women's and gender diverse persons' needs. Gendered dynamics intersect with other social-structural inequities, specifically racism, colonization, poverty, and criminalization, which impede access to RMG prescriptions. These dynamics are especially present for Indigenous women and those who are pregnant and/or parenting. Although RMG prescribing was implemented as a temporary emergency measure to address dual public health emergency of overdose during the COVID-19 pandemic, future initiatives should offer diverse approaches, including low-barrier, gender-specific, and non-medicalized models. The development of future prescribed safer supply policies and programming should be planned and implemented with the leadership of people who use drugs, including women and gender diverse persons. Finally, to effectively intervene to address overdose risks, it will be necessary to address the broader structural inequities that limit the safety of women and gender diverse persons who use drugs.

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Chapter Five: Nursing Implications

In the following sections, I discuss the implications of my findings for nursing practice, education, policy, and research. While I focus on the potential disciplinary implications of this research, I offer many applications to the broader multidisciplinary area of harm reduction.

Practice

Findings from my dissertation research indicate persistent gaps and missed opportunities within current harm reduction models in BC (specifically prescribed safer supply) in meeting the needs of women and gender diverse persons who use substances. While all nurses can and ought to use a harm reduction approach in their practice, caring for women and gender diverse persons who use drugs is a specialty area that requires specific and specialized education. In BC (and elsewhere in the country), training around harm reduction, including prescribed safer supply, should be offered with and from women and gender diverse persons with lived and living expertise of drug use. Such training could include sensitivity and stigma training, protocols and care for pregnant and parenting people who wish to access harm reduction supports, and awareness of additional community resources and referrals. While specific training and education for nurses about prescribed safer supply are needed, the ability of nurses to offer comprehensive, ethical and gender-responsive care is influenced by available resources and institutional regulations. Providing such care is difficult given the current medicalized model of prescribed safer supply in BC. Ideally, additional non-medicalized models of harm reduction services are needed that are designed and developed with the leadership of people who use drugs.

According to a recent evaluation of risk mitigation guide guidance (RMG) prescribing practices in BC during dual health emergencies, NPs were three times more likely to prescribe

RMG medications than physicians, which suggests that they play a key role in current and future prescribed safer supply initiatives (Pauly et al., under review). Expanding registered nurse prescribing to include a full suite of pharmacological therapies, including medication alternatives for safe supply, is an urgent step needed to support people, including women and gender diverse persons, who use drugs in the continuing overdose emergency.

Education

Ongoing professional development and lifelong learning are expectations for the professional performance of nurses (Qalehsari et al., 2017). Learning and education often begin with formal training in a higher education setting. Once nurses complete this formal education, they continue to engage in informal and formal learning opportunities as part of their professional practice. Findings generated from my dissertation research suggest that several steps should be considered to improve nursing students' understanding of harm reduction, specifically gender-responsive harm reduction. Thus, the following discussion focuses on formal pre-service education.

Currently, in Canada, baccalaureate nursing programs are not required to include specific harm reduction content. The result is that many nurses enter practice unequipped to provide effective, ethical care to people who use substances. Nursing programs across the country have been unattentive to the shifts in substance use patterns among people who use substances, specifically the increase in opioids and contaminated illicit drugs that, in turn, has led to a healthcare system that is not appropriately responsive to the overdose emergency (Gagnon et al., 2020). Without foundational knowledge of harm reduction, it is unlikely that graduates will

demonstrate practice that reduces potential harms associated with substance use, let alone care that is also gender responsive.

Given that the overdose emergency persists across the country, it can be recommended that nursing programs be required to include specific educational preparation and experience about harm reduction—specifically equitable responses (including gender-response models) and novel responses, including prescribed safer supply. Recommendations for specific strategies include:

(1) Content on harm reduction and related topics in foundation nursing courses, e.g., basic knowledge of substance use, criminalization and the corresponding impacts, supervised consumption services, legal intersections of illicit substance use, overdose prevention and management, and rights for people who use substances;
(2) Clinical practice experiences with people who use substances, e.g., clinical placements that offer a strong focus on harm reduction, such as on harm reduction outreach teams;
(3) Training that is specific to gender-responsive and trauma-informed nursing practice; and
(4) Educational experiences that include the knowledge and expertise of people with lived and living experiences of substance use.

Integrating gender and harm reduction content into nursing education is often considered important but not prioritized (Gagnon et al., 2020; Yang, 2020). Nursing educators must serve as leaders to ensure such opportunities exist to help improve nurses' understanding of gender-affirmative and life-saving harm reduction care.

Policy

Health policy can be understood as a set of overarching principles and goals that direct how health (and other forms of care) is planned, organized, delivered, and accessed within a

specific context (Government of Canada, n.d.). Health policy in Canada is often organized at federal, provincial, and territorial levels. The BC Ministry of Mental Health and Addictions (in collaboration with the BC Ministry of Health) develops, implements, and monitors provincial policy standards and guidelines governing mental health in the health authorities. The Ministry of Mental Health and Addictions is responsible for leading the response to the toxic drug emergency. Policy developed in response to the drug emergency has helped to establish the roles and expectations for different health actors, including nurses.

While nurses in BC (and elsewhere in the country) have been directly involved in determining and implementing harm reduction policy, the policies and practices developed to operationalize risk mitigation guidance (RMG) for prescribing during 2020 and 2021 were developed primarily by physicians (BCCSU, 2020). Findings from my research and others evaluating these responses reveal that these emergency harm reduction responses were offered through a highly medicalized model that did not attend to the specific needs of women and gender diverse persons. A shift in current policies that require prescriptions to access pharmaceutical alternatives needs to extend to other low-barrier approaches to a safe and regulated drug supply. Such models should be developed and implemented in consultation with people who use drugs, specifically including women, gender diverse persons, and Indigenous women to enhance uptake and reduce barriers. Nurses can be influential in advocating for these policy and practice changes.

Findings from Study One in Chapter Two of this dissertation—the critical analysis of existing BC safer supply policies—revealed that the policy documents were primarily gender-silent. When gender was mentioned, it was in the context of reproduction and pregnancy. None of the documents mentioned specific considerations for women or gender diverse persons about

prescribed safer supply (e.g., training for prescribers or other providers on gender-responsive programming). Lack of attention to gender and other intersecting factors in prescribed safer supply policy documents, not surprisingly, translated into services where the needs of women and gender diverse persons were overlooked or unmet. Specifically, findings from Study Three in Chapter Four of this dissertation—the secondary analysis with women and gender diverse persons who attempted to access prescribed safer supply during the dual emergencies—revealed an unmet need for prescribed safer supply initiatives to provide gender-responsive and gender-specific support.

Taken together, these findings suggest that provincial governments in consultation with women and gender diverse persons who use drugs should take steps to refine prescribed safer supply policies to include**:**

(1) A gender-responsive framework on safer supply services for women and gender diverse persons who use drugs;
(2) Specific child protection considerations including training on grounds and processes for trauma-informed mandatory reporting;
(3) Practice guidance on pregnant people accessing prescribed safer supply;
(4) Culturally safe and trauma-informed principles when providing care to women and gender diverse persons; and
(5) The BC College of Nurses (and other nursing colleges across the country) should expand the practice of prescribed safer supply.

Such policy recommendation should be alongside additional recommendations that address the socio-economic barriers women and gender diverse persons face. Such examples include policies supporting assured minimum income, universal childcare, and access to stable low-

barrier housing. While provincial policy shifts can be made, repealing current federal government prohibition policies can produce the most significant change for women and gender diverse persons who use drugs. Despite growing recognition of the current drug policy failures, the burdens of prohibitionist policies on women, gender diverse persons, and their families have frequently been overlooked (Boyd et al., 2004; Boyd et al., 2022; Canadian HIV Legal Network, 2020). A rights-based and gendered approach to drug policy would repeal policies that criminalize people for drug use and uphold the rights of women and gender diverse persons to the highest attainable standard of health by ensuring that all drug policies, including safer supply, are informed by evidence, and are developed in collaboration with women and gender diverse persons themselves.

Research

The overall purpose of this research was to provide a gendered analysis of prescribed safer supply during dual public health emergencies of substance overdose and COVID-19 in BC, Canada. Findings from this study have applications for nursing knowledge generation as well as harm reduction research. Further research is required to explore the impacts of prescribed safer supply on women and gender diverse persons who have limited access to care. Participants in this study may be considered to have a greater amount of support in accessing health and harm reduction services in comparison to findings from previous research conducted with women who use drugs (Bungay et al., 2010; Thumath et al., 2021). Specifically, most participants identified as white cisgender women and over half described their housing situation as stable. While this study was informed by critical and feminist (specifically intersectional) theoretical frameworks, future

studies should investigate the experiences of women who have never reached this point of intervention and pay special attention to race and ethnicity.

Racism and gender discrimination are key factors in the overdose emergency. While this research included Indigenous women and gender diverse persons who use drugs, most participants identified as White. Future studies focused specifically on the experience of Indigenous women who use drugs in accessing harm reduction services is particularly important because First Nations women are overrepresented among BC toxic drug deaths (First Nations Health Authority, 2022). This research should be led by Indigenous scholars in conjunction with Indigenous community partners.

Given the contextual limitations in which this research was conducted—during a pandemic—there was limited opportunity for primary data collection apart from document analysis. Yet, an important opportunity exists to further explore the impacts of prescribed safer supply for women and gender diverse persons who use drugs. Findings from the larger provincial mixed method evaluation of RMG prescribing of which this dissertation research is a part, contributed to the development of a new policy direction on prescribed safer supply. This policy direction enables the provision of pharmaceutical alternatives to illicit drug for people who are at risk of overdose outside the context of COVID-19 and has added additional options for pharmaceuticals, including the prescribing of fentanyl patches (Government of British Columbia, 2021). Research evaluating the implementation of prescribed safer supply is ongoing and thus there is a unique opportunity to explore gaps in these policies and programmes for women and gender diverse people who use drugs. Finally, research exploring the impacts of harm reduction

services and safer supply specifically with gender diverse persons who use drugs is urgently needed.

While harm reduction and substance use topics are best studied through multiple approaches by multiple investigators, I acknowledge the importance and influence of my experience as a nurse researcher in this work. Nurses have a responsibility to practise using current evidence and, as a discipline, nurses also have a responsibility to generate their own evidence. Nurse researchers in collaboration with people who use drugs are well positioned to study the impacts of safer supply. Nurse practitioners who prescribe pharmaceutical alternatives are uniquely positioned to provide insights into the impacts of these initiatives for people who use drugs, and specifically for women and gender diverse persons who use drugs. Further research exploring the role of nurses in safer supply initiatives and responses is required.

Conclusion

Harm reduction policies and practices that are developed or planned without women and gender diverse persons in mind cannot meet their needs. The purpose of this research was to offer a gendered analysis of prescribed safer supply during dual public health emergencies in BC, Canada. This dissertation encompassed three linked studies covering different aspects of harm reduction implementation and impacts to explore the impacts of harm reduction policies and practices for women and gender diverse persons who use drugs. Important stakes impel a good research project. While we continue to lose people at a rate of seven deaths per day in BC and an increasing number of these deaths occur in women, I question whether our efforts make an impact. Yet, I do believe that sustainable social change is possible. Over this five-year doctoral journey, I have been privileged to meet activists, nurses, researchers, and policy leaders who work towards a

rights-based, gendered approach to drug policy and practice. My hope is that the findings from this research will contribute a small piece to solving this larger puzzle.

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Appendix A: Intersectionality-Based Policy Analysis Guiding Questions

Descriptive

1. What knowledge, values and experiences do you bring to this area of policy analysis?

2. What is the policy 'problem' under consideration?

3. How have representations of the 'problem' come about?

4. How are groups differentially affected by this representation of the 'problem'?

5. What are the current policy responses to the 'problem'?

Transformative

6. What inequities actually exist in relation to the problem?

7. Where and how can interventions be made to improve the problem?

8. What are feasible short, medium and long-term solutions?

9. How will proposed policy responses reduce inequities?

10. How will implementation and uptake be assured?

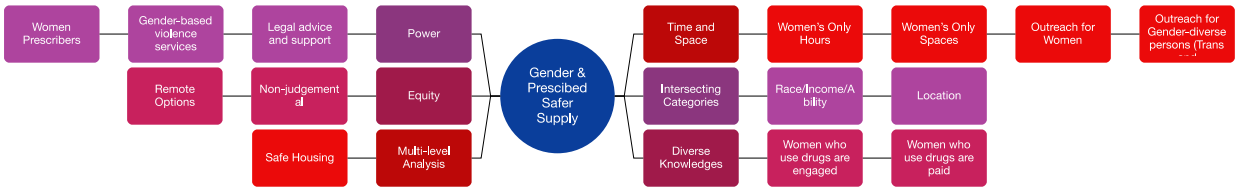
11. How will you know if inequities have been reduced?

12. How has the process of engaging in an intersectionality-based policy analysis transformed the following:

• Your thinking about relations and structures of power and inequity? • The ways in which you and others engage in the work of policy development, implementation and evaluation? • Broader conceptualizations, relations and effects of power asymmetry in the everyday world?

Adapted from Hankivsky et al., (2012).

Appendix B: Coding Mind Map to Represent Coding Framework created in NVivo 12



Adapted from Hankivsky et al., (2012).

Appendix C: People with Lived/Living Experience Interview Guide

Preamble: *This interview is about prescription medication alternatives to illicit substances or drugs. By this, we mean access to drugs by a prescription from a doctor instead of buying them through the illicit drug market (for instance, from a dealer or friend). Recently, because of COVID-19, a new guideline was released in BC that makes it easier for doctors to prescribe these substances. We want to hear about your experiences with these prescriptions. It is ok if you have tried but not been able to access a prescription, or if you got one but have not taken the drugs (for instance, if you have sold or given them away). We would still like to hear from you. All your answers will be kept confidential. If you do not want to answer a specific question, let me know and we can skip it. You can also stop the interview anytime you would like.*

[Implementation domain: Characteristics of the Individual]

1. Tell me a bit about what you know or understand about this initiative to prescribe medications as an alternative to illicit substances or drugs, because of COVID-19.
    a. What do you think of this initiative in general?
2. What have you heard or know about programs in your community?

[Implementation domain: Characteristic of the Intervention]

3. Have you received a prescription yourself through this initiative?
4. Who do you think needs or would benefit from this initiative?
5. In general, how do you think these programs are working for yourself or others?

[Implementation domain: Process of Implementation]

6. Thinking back, what was or has been your experience in trying to get a prescription?
    a. Who did you talk to?
    b. Were you successful or not?
    c. [If unsuccessful] Why do you think you weren't successful in getting a prescription? What type of medication did you want to get?
    d. Tell me about any barriers (personal and systemic) that you encountered (if needed, examples: don't have a car, live remotely; not available in my community).
7. [If successful] What medications were you able to get through a prescription?
    a. Were you prescribed what you feel you need or want?
    b. How satisfied are you with the drugs you have been prescribed? Did it/they have the effect that you wanted?
    c. How satisfied are you with the dosage? Is it enough?
    d. Are you satisfied with how you can use this medication (for instance, smoking, swallowing, injecting)?
    e. If you are injecting, do you feel confident in your methods for filtering the medication? Why or why not?
8. [If successful] How long have you had this prescription now?
    a. How long will you be able to keep getting this medication by prescription?
    b. How long would you like to?
    c. If you no longer receive it or are cut off, what will you do?

[Implementation domain: Impacts] [If person has not received a prescription, skip to Outer Context]

These next questions are about impacts of having this prescription on your health and wellness. You may have also experienced changes in your health and wellness because of COVID-19 (unrelated to having the prescription). For this study, we are most interested in what the prescription has meant for you.

9. How has having this prescription impacted your use of other substances (specifically, illicit substances)?
    a. Are you using the same as before/less then/more than before?
10. How has having this prescription affected your risk of overdose? Any changes in overdoses (e.g., more or less?
11. How has it impacted who you use with? What about where you use (e.g., has it changed whether you use or alone?
12. How has it affected withdrawal and dope sickness?
13. How has having this prescription affected your overall health?
    a. How has it been positive? Can you describe examples?
    b. How has it been negative? Can you describe examples?
14. How has having this prescription affected your ability to practise physical distancing during COVID-19? This includes your ability to stay at home, self-isolate and physically distance.
15. Has having this prescription impacted your access to housing? If so, in what ways? What about income supports? Other health or social supports?
16. What about changes in stress? Anxiety? Sleep patterns?
17. What about survival crime, sex work, involvement in the criminal justice system?
18. What about experience with health and social care services, etc.? E.g., Specifically ask re impact on stigma.
19. Any other benefits or challenges we haven't discussed?

[Implementation domain: Inner setting]

20. How do you get your prescriptions?
    a. Where do you get them?
    b. What are your thoughts on accessibility (e.g., hours of operation, mode of delivery, wait times, travel times)?
    c. Acceptability (wait room, clinic space, physician office)?
    d. Affordability (costs)?
    e. Thinking about the physical space where you see your doctor and pick up your prescriptions, how do these facilitate or hinder your ability to safely physically distance from others?
21. Is the medication that you get through a prescription a brand name or generic? Tell me about any differences you're aware of between the two.
22. What do you think is working well? What is not workng? What would you change?
23. How would you describe the vibe of the organization, clinic, office, or pharmacy where you get your prescription?
    a. How does the space feel?
    b. How are you treated there?
24. What is the impact of the organization's/clinic's culture on the implementation of this program for prescription alternatives to the illicit drug supply (e.g., general beliefs, values, assumptions that people embrace)?
    a. Can you describe an example that highlights this?
25. What kinds of supports, resources or policies should providers and others have to improve implementation of this program in your community (e.g., online resources, training or organizational policies)?

[Implementation domain: Outer context]

26. To what extent were drug users in your community consulted about their needs and preferences around this initiative (prescription alternatives to the illicit drug supply)?
    a. Can you describe specific examples? What was done well? How could this be done better?
27. What kinds of resource barriers or limitations have hindered or prevented the uptake of this initiative in your community? What facilitated uptake?
    a. Please provide examples.
28. What kind of local and provincial policies, regulations or laws facilitate or hinder the implementation of this initiative?
    a. Can you describe specific examples?
29. What do you think is the future of this initiative? What are your recommendations for the future?