AN INVESTIGATION INTO THE DEVELOPMENT AND CONTENT OF HIV
PREVENTION AND HARM REDUCTION POLICIES IN NOVA SCOTIA: DO THEY
ADDRESS THE NEEDS OF WOMEN WHO INJECT DRUGS?

by

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The undersigned hereby certify that they have read and recommend to the Faculty of Graduate Studies for acceptance a thesis entitled "AN INVESTIGATION INTO THE DEVELOPMENT AND CONTENT OF HIV PREVENTION AND HARM REDUCTION POLICIES IN NOVA SCOTIA: DO THEY ADDRESS THE NEEDS OF WOMEN WHO INJECT DRUGS?" by Susan J. McWilliam in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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For my mother and father, Barbara and Ken McWilliam,
who are exceptional parents and wonderful people.

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ABSTRACT

Background: Women who inject drugs continue to represent a disproportionate percentage of new cases of HIV in Canada (PHAC, 2006). However, in Nova Scotia, HIV has still not been conceptualized as a major health issue, especially among women (Gahagan, Rehman & Baxter, 2006). At the same time, recent research findings suggest that female injection drug users in Nova Scotia are engaging in unsafe injection and sexual practices and often lack access to harm reduction-based programming and resources (Ploem, 2000; PHAC, 2006; Jackson et al., 2010; Parker et al., 2011; Hodder, 2011). In a provincial context of high prevalence of injection drug use and HIV risk behaviours, preventing increasing rates of HIV infection will depend on the development of proactive and gender-informed HIV prevention policies.

Purpose: This study had two main aims. First, it aimed to chart the development of provincial HIV prevention and harm reduction policies and to identify how, and if, the policy development processes address the HIV prevention needs of women who inject drugs. Its second aim was to identify key barriers and facilitators to developing HIV prevention policy for women who inject drugs in Nova Scotia.

Methods: This study involved a review of key HIV prevention and harm reduction policy documents as well as interviews with 27 key informants directly involved with HIV prevention and/or harm reduction policy decision-making.

Findings/Discussion: The existing Nova Scotia-based policy development network, their policies, their processes and the context within which they have functioned over the past ten years do not appear to be supporting the development of HIV prevention and harm reduction policy which addresses the needs of women who inject drugs. Policy committee composition lacked inclusivity and organizations that work directly with women who inject drugs held less influence in policy processes. In addition, gender was not prioritized by decision-makers and therefore not comprehensively addressed in policy content. As a result, the needs of women who inject drugs have not been prioritized in policy processes and subsequently few targeted resources are going to the community-based organizations that provide services to these women.

LIST OF ABBREVIATIONS USED

ACAP	Atlantic Community Action Plan on HIV/AIDS
ACCB	AIDS Coalition of Cape Breton
ACNS	AIDS Coalition of Nova Scotia
AIDS	Acquired Immunodeficiency Disease
AIRN	Atlantic Interdisciplinary Research Network
ASO	AIDS Service Organization
CAS	Canadian AIDS Society
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
DHA	District Health Authority
GBA	Gender-Based Analysis
GOVT	Government
HAAC	Health Association of African Canadians
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HON	Healing Our Nations
HRM	Halifax Regional Municipality
I-Track	I-Track Enhanced Surveillance of Risk Behaviours Among Injecting Drug Users
NACS	Northern AIDS Connection Society
NAOMI	North American Opiate Medications Initiative
NEP	Needle Exchange Program
NGO	Non-Government Organization
NSAC	Nova Scotia Advisory Commission on HIV/AIDS
PHAC	Public Health Agency of Canada
SIF	Supervised Injection Facility
WHO	World Health Organization

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CHAPTER ONE: Introduction

This study is about HIV prevention and harm reduction policy in Nova Scotia, and how (and if) the organizations involved, the policy content and the policy development processes address the HIV prevention needs of women who inject drugs. Women make up a disproportionate percentage of new cases of HIV attributable to injection drug use in Canada (PHAC, 2006). In addition, women who inject drugs experience heightened vulnerability to HIV based on a variety of factors including power differences between men and women with regards to drug use and sexual behaviours (Whynot, 1998; McRae, 2000; Pinkham & Malinowska-Sempruch, 2008; Jackson et al., 2010; Fairbain et al., 2010), gender-specific stigma and discrimination related to injection drug use (Paltrow, 1998; Rutman et al., 2001; Cormier, Dell & Poole, 2002; Hoffman, 2003), and gender-related barriers (i.e. familial responsibilities) which can limit health service accessibility (Greaves & Poole, 2007; Leslie, 2007). In addition, Nova Scotia has been found to have growing numbers of people who inject drugs, high rates of reported unsafe drug and sexual behaviours among people who inject drugs, high rates of Hepatitis C (HCV) and high rates of sexually transmitted infections (PHAC, 2006). Each of these issues suggest the need to look closely at the HIV prevention needs of women who inject drugs in Nova Scotia, and determine whether or not HIV policy development and implementation is specifically addressing their needs. Although rates of HIV are currently relatively low among women who inject drugs in Nova Scotia compared to other provinces, in order to maintain these low rates of infection, HIV prevention and harm reduction policies that address the needs of this population are critical.

1.1 Why is it important to examine provincial HIV prevention and harm reduction health policies?

Examining provincial HIV prevention and harm reduction policies is critical because health policies developed by governments identify priorities, and can shape how public resources are distributed within nations, provinces and communities among competing interventions and populations (Patrick & Erickson, 1993). Government health policies are not value-free but rather reflect a set of values in terms of how and to whom health resources are distributed (Patrick & Erickson, 1993). For example, in 2009 the Federal Government of Canada was reproved by the Auditor General for not upholding their stated commitment to perform gender-based analysis (GBA) on government policy documents as a measure to ensure women's rights and gender equality (Auditor General, 2009). This is significant, as government health policies can hold a great deal of power in terms of shaping the types of programs that are funded, and groups targeted for funding. The federal government's lack of commitment to GBA was seen as a failure to prioritize and respond to sex and gender differences and to women's health needs (Auditor General, 2009).

In addition, policy analysis can be used to generate greater understanding of health policy not only in terms of policy content, but also the factors that influence the content, such as the role of stakeholders, their interests, their power and the nature of the processes used in policy decision-making (John, 1998; Walt & Gilson, 1994; Buse et al., 2007). This type of policy analysis can be instrumental in determining and addressing barriers and facilitators to the development and implementation of health policy (Walt and Gilson, 1994; Walker & Gilson, 2004). Drug-related policy development in particular

receives close public scrutiny, as the processes undertaken to develop these policies must often negotiate a complex political domain (Fraser & Moore, 2011). However, despite the political and media scrutiny surrounding drug-related policy, little scholarly attention to date has been paid to the area of HIV prevention and harm reduction policy development and implementation.

1.2 Injection Drug Use and HIV in Canada

Injection drug use poses significant health, social and economic harms for injection drug users, including the risk of HIV transmission (Health Canada, 2001; Tyndall et al., 2003; McCoy et al., 2004; Fischer, et al., 2005; CAS, 2007; Mathers et al., 2008). It has been estimated that between 80,000 and 125,000 individuals inject drugs in Canada (Fischer et al., 2005), with females accounting for approximately one third of the injection drug using population (Canadian Center on Substance Abuse, 2008). There is also evidence that suggests the incidence of injection drug use in Canada is increasing. For example, in a report by Health Canada and the Canadian Centre on Substance Abuse published in 2005, they stated that 175,000 Canadians reported in 1994 having engaged in injection drug use at some point in their lives, whereas in 2004 this number had increased to 269,000.

Over the last decade, a decreasing trend in the proportion of positive HIV tests attributed to injection drug use among men has been noted; however, an increasing trend among women has been documented since 2003 (PHAC, 2008). Surveillance data from 2009 indicate that 21.6% of adult positive HIV tests reported to the Public Health Agency

of Canada were attributed to injection drug use (PHAC, 2009). Recent figures from Health Canada indicate that between 55% and 80% of persons who inject drugs test positive for Hepatitis C (HCV), indicating that a high percentage of this population are engaging in unsafe drug-use activities that could also transmit HIV. The percentage of women testing positive for HIV in Canada who disclose injection drug use as a possible transmission route is increasing and has exceeded rates for men who inject drugs (PHAC, 2008). The sharing of contaminated injection drug use equipment represents the second highest exposure category route for the transmission of HIV to women in Canada following unprotected sexual intercourse (PHAC, 2008). Aboriginal women, and increasingly young women, make up a disproportionate percentage of new cases of HIV attributable to injection drug use (PHAC, 2008).

1.3 Gender as a Key Determinant of Health among People Who Inject Drugs

Gender has been identified as a key determinant of health influencing people's experiences of drug use, HIV risk and health service use (PHAC, 2003; Raphael, 2009; Jackson et al., 2010; Hodder, 2011). For example, women who inject drugs are more likely than their male peers to have experienced physical and sexual abuse, often have less decision-making control over their sexual experiences, are more likely to have injection drug using sexual partners, engage in sex while under the influence of drugs, and exchange sex for money, drugs or survival needs (Whynot, 1998; Inciardi et al., 2001; Flom et al., 2001; Braitstein et al., 2003; PHAC, 2006; Spittal et al., 2006; Shannon et al., 2008; Leonard et al., 2008). In addition, women who inject drugs are less likely than men to access addiction-related services (UNODC, 2006; Open Society Institute,

2009). Women have been found to experience more social stigma and less social support in relation to seeking treatment for their drug use (Pinkham & Malinowska-Sempruch, 2008). Furthermore, mainstream health care addiction-related resources are often not accessible to women with familial responsibilities (Finkelstein et al., 1997). Women with children are also often hesitant about disclosing any drug-related issues to health and welfare professionals out of fear of child custody services intervention (Dell & Poole, 2002; Pinkham & Malinowsk-Sempruch, 2008; Open Society Institute, 2009). These barriers act as strong deterrents to women wanting to access care, treatment and support related to drug use.

1.4 HIV Prevention and Harm Reduction Policy for People Who Inject Drugs

HIV prevention among people who use injection drugs is a federal HIV priority in Canada (PHAC, 2004). Since the early 1990s, national HIV policy documents have identified people who inject drugs as a 'high risk population'. Despite the identification of this group's elevated risk of HIV and the subsequent targeting of HIV prevention policies and programs toward this population, studies continue to document a high prevalence and incidence of HIV among people who inject drugs in both urban and rural settings in Canada (PHAC, 2009). Many researchers and advocates argue that one of the reasons why HIV prevention policies have been less effective at preventing HIV and other harms from injection drug users in Canada is because of the federal government's overriding emphasis on using criminal justice or enforcement-based approaches to managing drug use (Canadian HIV/AIDS Legal Network, 2007; Hwang, 2007; Wodak, 2008; Kerr et al., 2008).

Harm reduction is a public health approach which promotes the creation of accessible programs and supports to help people decrease the harms associated with particular behaviours and risk factors in their lives (CCSA, 2001; Erickson & Cheung, 1999; Inciardi & Harrison, 2000). Harm reduction programming can include needle exchange programs, opiate substitution programs (such as methadone maintenance), counseling, outreach, support, primary health care, emergency health care, advocacy, education and the distribution of resources such as condoms or safer crack kits. A major advantage of using a harm reduction approach to work with people who inject drugs is its emphasis on creating non-stigmatizing, accessible services for marginalized populations in order to facilitate the building of relationships between individuals and care providers which may promote ongoing program use (IHRA, 2009).

Harm reduction programs have been shown in numerous Canadian studies to lessen the health and social harms associated with using illicit drugs, including reducing HIV-specific risks such as sharing injection drug equipment, unsafe disposal of equipment and unprotected sex (Jackson et al., 2002; Kerr et al., 2005; Wood et al., 2006; Institute of Medicine, 2007; Millson et al., 2007; Leonard et al., 2008). In addition, a number of research studies have shown that individuals who regularly access needle exchange programs (NEPs) are less likely to engage in risky injection practices than other injectors, including those who receive clean equipment through their peers (Tyndall et al., 2002; Lorvick et al., 2006; Cooper et al., 2009).

Access to non-judgmental, flexible programs and supports is particularly important for women who inject drugs because of the gender-specific barriers that they experience around service use (Paltrow, 1998; Rutman et al., 2001; Cormier, Dell & Poole, 2002; Hodder, 2011).

1.5 Injection Drug Use and HIV Transmission in Nova Scotia, Canada

Nova Scotia is a small Atlantic province on the east coast of Canada with a population of approximately 944,000 people spread across 55,000 kilometers^2 (Statistics Canada, 2006). Approximately half of the province's population along with the majority of government and commercial services are located within the Halifax Regional Municipality; the province's largest urban center. Cape Breton Island, a large island in the northeast, is attached to mainland Nova Scotia by causeways and houses Sydney, Nova Scotia's second largest city. Formal health services in Nova Scotia are delivered by nine separate District Health Authorities (for a District Health Authority map see Appendix A).

Cases of HIV in Nova Scotia have always been officially reported together with cases in Prince Edward Island (PEI) as a measure to protect confidentiality. Between 1985 and 2009, over 770 people had been diagnosed with HIV in NS and PEI, although the actual number of people living with HIV may be higher since many people are not tested or are tested out of province (PHAC, 2010). There was a 50% increase in the number of HIV cases between 2000 (n=16) and 2004 (n=32) in Nova Scotia and PEI, as well as an increase in the proportion of those HIV cases that were attributed to injection

drug use in 2000 (n=1) and in 2004 (n=6). In addition, a HCV surveillance report from Nova Scotia published in 2004 found that injection drug use was identified as a risk factor in 59% of the 257 cases reported in 2003 (Nova Scotia Department of Health, 2004). Although HIV numbers are small in both provinces (1.1% of the national total by province, compared to 19.6% in BC and 44.2% in Ontario), HCV numbers are estimated to be high relatively speaking to their smaller, largely rural populations. For example, in 1999, estimates of unreported and reported cases of HCV included 4,000 cases in Nova Scotia (this estimate did not include PEI) (PHAC, 2006).

In 2006, it was estimated that there were at least 2000 people using injection drugs in Nova Scotia (PHAC, 2006). However, this estimate is derived from HCV testing rates and injection drug-related service use and may be a very conservative estimate, as many injection drug users do not access services, get tested, or test positive for, HCV. Qualitative studies with people who inject drugs and harm reduction service providers in Atlantic Canada indicate that injection drug use is a significant health issue in this region and that expansion of addiction and harm reduction services is urgently needed, especially in rural communities (Parker et al., 2011; Patten, 2006).

An environmental scan of injection drug use in Atlantic Canada conducted in 2006 by the Public Health Agency of Canada (PHAC) documented an increase in risky injection behaviours among the injection drug using population between 2000-2005, specifically sharing needles and other injection equipment (PHAC, 2006). PHAC also reported a lack of access to new, sterile injection equipment for people who inject drugs,

particularly in rural areas and small towns. This scan provides a list of policy and programming gaps and recommended actions for policy and programming improvement in order to increase program coverage and accessibility.

1.6 Purpose of the Study

This study has two main aims. First, it aims to chart the development of provincial HIV prevention and harm reduction policies and to identify how, and if, the policy content and the policy development processes address the HIV prevention needs of women who inject drugs. Its second aim is to identify key barriers and facilitators to developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia. A key rationale for conducting this study is that HIV has generally not been conceptualized as a major health issue in the province, especially among women (Gahagan, Rehman & Baxter, 2006), at the same time as recent research findings suggest that female injection drug users in Nova Scotia are engaging in unsafe injection and sexual practices and often lack access to harm reduction-based programming and resources (Ploem, 2000; PHAC, 2006; Jackson et al., 2010; Parker et al., 2011; Hodder, 2011). In a provincial context of high HCV rates, high prevalence of injection drug use and HIV risk behaviours, preventing increasing rates of HIV infection will depend on the development of proactive and gender-informed HIV prevention policies.

1.7 Research Objectives

The specific objectives of this study are to identify:

- The key organizations involved with HIV prevention and harm reduction policy decision-making for people who inject drugs in Nova Scotia.
- The key HIV prevention and harm reduction policies in Nova Scotia, how they were developed and how they address the needs of women who inject drugs.
- The key barriers and facilitators to developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia.

This study used policy document review and key informant interviews to answer these questions. Study participants included government and non-government policy decision-makers, and service providers who have engaged in provincial HIV policy development. Findings from this study are intended to support policy initiatives aimed at reducing the risk of HIV transmission among female injection drug users living in Nova Scotia.

CHAPTER TWO: Literature Review

This chapter offers a critical analysis of the literature relevant to this study's research questions to help contextualize the current project. The chapter begins with a general introduction to health policy in Canada. It then provides an overview of drug policy and a discussion of how the emergence of HIV created the need for harm reduction policy as a necessary part of the HIV prevention continuum for people who inject drugs. In addition, this chapter will discuss gender as a key determinant of health in relation to injection drug use; it will also outline how gender-based research has contributed to our understanding of the impact of gender on both drug use and HIV risk. Lastly, the use of inter-organizational theory as an approach to studying HIV prevention policy decision-making in context will be discussed.

2.1 Health Policy in Canada

In Canada there are two distinct jurisdictions for political authority over health: the federal government and the regionally-based provincial governments (Bakvis & Grace, 2002). Provincial governments are responsible for the management and delivery of health services to their residents (including the development of provincial health policy) and the federal government is responsible for national coordination of the provinces and national health policies. Policy documents provide direction to many different government agencies, ministries and branches at both the federal and provincial/territorial levels. Planning and implementing national policies and legislation requires an extensive, ongoing process of consultations with a broad range of government agency staff, researchers, service providers, program users and other stakeholders.

Health policy recommendations created at the national and provincial levels do not always translate to the community level as laid out in policy, just as community-based need does not always filter up into these policy documents; national, provincial and community-based health policy and programming are continuously influenced by shifting political, economic and social forces (Dickinson & Buse, 2008).

For example, research has shown that neoliberal public policies can have a direct impact on the health of a population (Wilkinson & Pickett 2009; Doborowlski, 2009). Neoliberalism is an ideology and set of economic policies that have dominated Canadian politics for the last 25 years (Broadbent, 2009). In a neoliberal state public services are ideally privatized to allow for less government intervention and spending (Brown, 2007). In this system individuals are 'responsible' for managing their own social risks, such as illness, poverty and unemployment with as little assistance from government as possible (Rose, 1998; Lemke, 2001). In Canada, neoliberalism has influenced cuts in spending in areas such as health care, post-secondary education, affordable housing, environment protection and infrastructure (Broadbent, 2009). These cuts have been linked to significant income inequality in Canada between the rich and the poor (OECD, 2008). A report by the Organization for Economic Co-operation and Development (OECD) in 2008, confirmed that inequality in Canada was growing at a faster rate than in other OECD countries due to lower spending on family and unemployment benefits. In 2009, United Kingdom epidemiologists Wilkinson and Pickett found that individuals living in more economically unequal societies generally experience poorer health, including higher rates of mental illness and illegal drug use (Wilkinson & Pickett, 2009).

2.2 Drug Policy Approaches

In order to situate a discussion of drug policy, it is essential to define the primary approaches to drug policy: Prohibition, Legalization, Decriminalization and Harm Reduction. Each will be discussed in the following section.

Prohibition-based drug policies endorse a 'zero tolerance' approach that criminalizes individuals for the manufacturing, use, supply and possession of drugs (Drucker, 1999). Public perceptions of prohibition have been shaped by media portrayals of dramatic police seizures of drug shipments, arrests of drug dealers, and a negative depiction of drug users as dangerous, immoral criminals or helpless victims (Cheung, 2000). Major criticisms of the prohibitionist approach stem from the repeated finding that it has been unsuccessful in decreasing drug supply from entering the country and decreasing the percentage of people who use drugs (Auditor General of Canada, 2001). Additionally, many critics argue that prohibition worsens the drug crisis by creating a lucrative underground drug market, as well as placing an enormous financial strain on government and taxpayers to fund enforcement activities and incarcerating people convicted on drug related crimes. From a health perspective, the abstinence-based programming that accompanies a prohibition policy approach has been found to have high attrition and relapse rates due to its lack of consideration of the social and structural issues that influence drug use (Canadian HIV/AIDS Legal Network, 2002; Galea & Vlahov, 2002; Iguchi et al., 2002). Despite these criticisms, the law enforcement and drug control strategies developed within a prohibitionist approach continue to be the primary strategies used in Canada to address drug-related issues.

At the other end of the drug policy spectrum, is the libertarian or "legalization" approach. This drug approach promotes personal freedom over social control, allowing illicit drug use without reproach (removal of criminal sanctions) so long as it does not pose a serious risk to others or society (Lyster, 2001). The basis of this policy approach rests on the principle of respect for personal autonomy. Proponents of the libertarian approach believe that the legalization of drugs will dismantle the underground drug market, lessen the financial strain of drug enforcement activities on taxpayers, unburden the criminal justice system and allow for the redirection of funds to care, treatment and support for people who use drugs. Critics of the legalization approach fear that it would result in an increase in the number of new drug users, especially youth, and increased use and lawlessness among those already entrenched in the drug scene. Because this approach has never been adopted in Canada, no local evidence exists to credit or discredit potential outcomes.

Decriminalization of illicit drug possession or use is another approach to drug policy. Whereas legalization involves the removal of sanctions, making a certain behavior legal, with no criminal or administration penalty; decriminalization involves the removal of sanctions under the criminal law, but can include administrative sanctions, such as fines or court-ordered therapy (Hughes and Stevens, 2010). For example, Portugal decriminalized the use and possession of all illicit drugs in 2001 (Babor et al., 2010). A study by Hughes and Stevens (2010) critically analyzed the criminal justice and health impacts of this policy decision against trends found in Spain and Italy and

concluded that the Portuguese decriminalization led to reductions in problematic drug use, drug-related harms and criminal justice overcrowding.

Also incorporated into the drug policy continuum, is harm reduction, a pragmatic approach that attempts to balance the competing goals of social order and personal autonomy by accepting that a small percentage of the population will continue to use drugs, and therefore, resources should be directed toward minimizing the health and social harms associated with drug use. The key features of harm reduction include a non-judgmental stance towards drug users and the provision of drug treatment and services to active drug users without requiring abstinence as a precondition for access or ongoing treatment (IHRA, 2009).

Although evidence exists to support the adoption of harm reduction as the most effective of the three approaches for decreasing the risks associated with HIV among injection drug users (WHO, UNODC & UNAIDS; 2009), harm reduction still faces opposition. The Canadian Centre for Substance Abuse (2006) suggests the lack of support for harm reduction may be linked to "a lack of clarity and a common understanding of what constitutes harm reduction" (p.2).

The International Harm Reduction Association (IHRA) (2009) has developed the following harm reduction principles, which can be used to assess whether a program or policy is harm reduction-based:

1) Harm reduction initiatives must target specific risks and harms.

2) Harm reduction initiatives must be evidence-based and cost-effective.

3) Harm reduction initiatives are facilitative rather than coercive and are flexible to accommodate the needs of individuals.

4) Harm reduction initiatives are non-stigmatizing and treat individuals with dignity and compassion.

5) Harm reduction initiatives acknowledge that human rights apply to   everyone and promote responses to drug use that respect and protect fundamental human rights.

6) Harm reduction initiatives challenge policies and practices that exacerbate the harms associated with drug use.

7) Harm reduction initiatives must be transparent, accountable and participatory.

Further complicating matters is the fact that support for harm reduction principles is likely to depend on the policy and/or program in question. Harm reduction, in other words, works on a continuum and the extent to which individuals support certain policies and programs depends on their ability to accept specific features and services for managing the harms associated with drug use. For example, fewer people object to needle exchange programs than supervised injection facilities (CCSA, 2008). Whether individual programs make sense to individual community members and how much influence these individuals have can influence policy and programming (CCSA, 2008).

Problems arise when harm reduction is seen as an all or nothing philosophy rather than a variety of services, which can be inclusive of other drug policy approaches. The discourse around harm reduction can create a dichotomy between supporters and dissenters where little progressive collaboration takes place. The fierce debate between the most vocal of the two groups has cast a negative pallor on the term in general which

risks compromising all the evidence-based success that has been demonstrated in individual harm reduction programs (CCSA, 2006). As such, it is crucial that the success of individual drug policies and programs be evaluated on an individual basis. As articulated by the CCSA:

> *We should neither unilaterally accept nor reject measures because of where they fit within our ideological perspective or because of the way the term "harm reduction" colours our perceptions of their intent. We urge policy makers and practitioners to advance evidence-based programs, policies and interventions regardless of the label applied to them and to work towards implementing a comprehensive approach for dealing with drug use based on their demonstrated effectiveness (CCSA, 2006, p.9).*

Historically, the Federal government has not demonstrated a commitment to effectively collecting or disseminating evidence on drug-related programs, policies or interventions (Auditor General, 2001). For example, Canada does not have a national, comprehensive set of drug programming guidelines, national data collection on drug programs, or a registry of harm reduction and other drug programs. This data could help the government monitor and evaluate policy and program need and efficacy. The Auditor General of Canada criticized the Federal government in 2001 for a lack of in-depth understanding of drug issues and mismanaged spending on enforcement-based drug tactics:

> *Key information on the drug environment, such as frequency and prevalence of drug use, and its impact on society, is either not available or not up to date. Of particular concern is the almost complete absence of basic management information on spending of resources, on expectations, and on results of an activity that accounts for more than $500 million each year (Auditor General, 2001, p.15).*

The lack of accountability, information, misinformation and misrepresentation have all been implicated in contributing to the stigmatization of drug users in Canada, a generally ineffective response to the management of drugs and drug-related harms, the development of overly punitive approaches to drug policy and a persistent resistance to harm reduction (Packer, 2004).

2.3 History of Drug Policy in Canada and Drug-Related Stigma

In the early 1900s, the Canadian government established policy and legislation which prohibited drug use and prosecuted drug users. This started with the development of the Opium and Drug Act in 1908, followed by the Narcotic Control Act in 1960, the Food and Drugs Act in 1985, and the Controlled Drugs and Substances Act in 1996 (Canadian HIV/AIDS Legal Network, 2002). These policies and legislation documents served to establish Canada's stance on drug issues as prohibitionist and introduced abstinence-only based approaches to drug abuse treatment.

Prior to 1908, restrictions on drug use did not exist and drugs, including opioids, cocaine and cannabis were distributed and used in an unregulated fashion (Boyd, 1991). Drug use was not seen specifically as a social or criminal issue, but rather as a sign of personal moral weakness (Solomon, Hammond & Langdon, 1986). Over time, social stigma toward drug use reflected racism and classism, as drug use became associated with specific minority populations and drug users were "pitied or despised depending on their ethnicity" (Csiernik & Koop-Watson, 2010). While opium use was initially seen as a recreational activity among the upper class white population, it eventually became

associated with the socially disadvantaged Chinese immigrant population in British Columbia (Csiernik & Koop-Watson, 2010). In 1907, there were racially motivated riots in Vancouver between white labour activists and Chinese labourers who were seen as taking jobs from Canadians. Then Deputy Minister MacKenzie King was sent to investigate and was shocked by the level of use and economic activity he found associated with the opium industry. His report on his experience in Vancouver described among other things, white women becoming addicted to opium and "falling victim" to Chinese opium merchants who introduced them to sex work to feed their addictions. Based on his report, a group of affluent clergymen and merchants petitioned him to make opium illegal, which quickly led to the passing of the Opium Act in 1908 introducing Canada to drug prohibition (Csiernik & Koop-Watson, 2010).

Unsubstantiated fears, fueled by racism, of white women succumbing to Asian men for opium or being attacked by Black men on cocaine, generated concerns over "mixing of the races" in the early 1900s (Gieffen et al., 1991). These fears lead to drugs being seen no longer as a recreational indulgence, but as a dangerous social problem. In 1911, Mackenzie King extended The Opium Act to make it illegal to be in an opium den, and to possess opium, morphine or cocaine. In the 1920s, the Narcotic Control Act replaced the Opium Act and Mackenzie King established himself in a leadership role in the international movement to criminalize the use and distribution of narcotics (Boyd, 1983). During the same decade, cannabis went from being available and legal to illegal and linked with sexual promiscuity, insanity and death (Csiernik & Rowe, 2010). Between the 1920s and 1960s, Canada's national police force, the Royal Canadian

Mounted Police (RCMP), became increasingly involved in drug-related law enforcement activities (Csiernik & Rowe, 2010).

The next significant national drug policy event occurred in 1969 when the Trudeau government created the Dain Commission to study increasing drug use rates (Gieffen et al., 1991). One of the most significant recommendations to come out of this commission was a call to decriminalize cannabis possession. This recommendation did not lead to a revision of Canada's drug policy, but it was significant in that it created debate around the issue and provided a discussion of the evidence behind drug policy (Erickson, 1992).

Despite calls for the inclusion of evidence in drug policy, decisions were still founded primarily on ideology and political motivations. For example, the Trudeau government tried again in 1974 and 1980 to decriminalize cannabis possession. The recommendation was met with resistance in the cabinet and was shelved (Boyd, 1991). In 1980, two days after American President Ronald Regan announced his War on Drugs, Conservative Prime Minister Brian Mulroney changed a prepared speech to state that drug abuse had become an epidemic in Canada that was undermining the country's social and economic fabric (Erickson, 1992). Following this speech, the government formed a new Canadian Drug Secretariat, a new Royal Commission and a new drug policy agency. Interestingly, the new policy agency, the Canadian Centre on Substance Abuse (CCSA) created in 1988, had as one of its organizational objectives to promote and assist in the development of realistic policies and programs aimed at reducing the harms associated

with alcohol and drug use (Csiernik & Koop-Watson, 2010).   Despite this early policy reference to harm reduction, prohibition remained the foundation of Canada's social policy on drugs.

In December 2001, the Auditor General of Canada released a report that found that 93% of the $500 million spent annually by the Federal Government on illicit drugs was being allocated to enforcement strategies. This report argued that Canada's Drug Strategy should adopt a more balanced approach by significantly involving education, prevention/treatment and harm reduction to reflect a more health promotion-based perspective (Auditor General, 2001). A report issued by the House Special Committee on Non-Medical Use of Drugs a year later stated that reducing the harms associated with drug use must remain a long-term goal (House Special Committee, 2002). In May 2003, the government renewed Canada's National Drug Strategy (NDS) and recommended a significant role for harm reduction policies and programs.   All of this work was followed by the National Anti-Drug Strategy in 2007 which omits harm reduction and a report in 2009 by DeBeck et al. that found law enforcement initiatives continued to receive the overwhelming majority of drug strategy funding (70%), while prevention (4%), treatment (17%) and harm reduction (2%) combined received less than a quarter of the overall funding.

Drug policy impacts public perspectives on people who use drugs (Buchanan & Young, 2000; Lloyd, 2010).   Research has found that drug-related stigma and discrimination are associated with poorer mental and physical health among drug users

(Ahern et al., 2007). For example, Ahern et al. (2007) found that internalized shame associated with being seen as 'deviant' could discourage drug use in some, but also negatively affected the health of others by creating chronic stress which could serve as a barrier to care, treatment and support services. Harm reduction, with its emphasis on non-stigmatizing services and service delivery attempts to facilitate and support drug users' access to programs and services (IHRA, 2009). Despite this, the history of Canadian drug policy developments illustrates that a move toward harm reduction in drug policy will require more than a rhetorical endorsement of it as a concept. In the ten years since the Auditor General chastised the government for their mismanagement of drug control spending, enforcement-based drug control tactics remain the predominate position of Canada's spending on drug-related problems, despite increasing documentation of their ineffectiveness (Canadian HIV/AIDS Legal Network, 2009).

2.4 The Emergence of HIV and the Need for Harm Reduction

Once HIV was discovered and it was established that sharing injection drug use equipment posed a significant risk of HIV transmission, efforts were required to ensure that people who inject drugs were not sharing equipment. This led to the development of needle exchange programs (NEP). NEPs were begrudgingly adopted in Canada, primarily due to the efforts of activists in the community, social workers, some public health and addiction professionals (Riley & O'Hare, 1996; Csiernik & Koop-Watson, 2010). Further harm reduction programs followed with the expansion of methadone to treat opioid addiction (previously used in the 1950s) and the spread of methadone maintenance programs (Riley & O'Hare, 1996; Elliot, 1998). Funding for these

programs is often obtained in relation to their HIV or HCV prevention mandates, however, these programs generally do much more to address clients' broad health and social service needs. For example, Parker et al. (2011) found that NEPs were regularly used by people who inject drugs as an access point to ancillary services such as clothing, food, referrals, information and general social support.

In 2001, the City of Vancouver published its 'Four Pillars Drug Strategy' (2001). This strategy outlined a comprehensive approach to drug addiction that stresses the importance of delivering simultaneous programs in harm reduction, prevention education, treatment and law enforcement in order to offset drug-related harms. This four-prong approach was based on a harm reduction model first formally implemented in Switzerland and Germany in the 1990s, where subsequent dramatic reductions in the number of drug users consuming drugs on the street, overdosing and contracting HIV and hepatitis were documented (EMCDDA, 2004; Center for Addiction and Mental Health (CAMH), 2009). The identified need from the community for harm reduction and HIV prevention programs for active drug users, along with the City of Vancouver's Drug Strategy ushered in what would soon be the Canadian government's strong commitment to harm reduction-based approaches in drug policy and HIV prevention policy for drug users.

In 2003, Canada unveiled a national drug strategy that was based on the 'four-prong' model and a national, multi-year, multi-stakeholder consultative framework was created to support its integration. That same year, Vancouver opened Canada's first

supervised injection facility (InSite), a legally sanctioned, medically supervised facility designed to provide a safe, indoor space for people to inject previously obtained drugs. The opening of this facility, along with the new drug strategy, represented a strong national endorsement of harm reduction to the national and international community. By this time needle exchange programs and methadone maintenance programs were becoming internationally recognized as 'essential services' for curbing HIV infection among injection drug users and efforts were being made to improve program availability in Canadian cities (Health Canada, 2003). The opening of a supervised injection facility demonstrated that Canadians were willing to progressively take harm reduction interventions further and explore their utility and effectiveness. Various Canadian government departments and agencies, including the Public Health Agency of Canada, Health Canada, Canadian Institutes for Health Research and Correctional Services Canada reflected this movement toward harm reduction initiatives by including elements of harm reduction into their various mandates in response to the available evidence of its effectiveness (PHAC, 2004; Health Canada, 2003).

In 2006, after the election of Conservative Party, with Stephen Harper as Prime Minister, several harm reduction programs in Canada came under attack (ACT 2007; Canadian HIV/AIDS Legal Network, 2007; Hwang, 2008). Most notably, the federal government commissioned and then rejected the recommendations of an impartial review body that evaluated InSite and found that it improved health and social outcomes for injection drug users and the community at large. The federal government's decision was followed by a moratorium on SIF trials planned for other cities (Toronto and Victoria), a

loss of funding to do additional evaluation research (the need for which was specifically requested by the federal government), an attempt to close InSite through an appeal by the Attorney General of Canada to revoke its exemption, and many public statements by the Federal Health Minister, Tony Clement against harm reduction (Canadian HIV/AIDS Legal Network, 2008; Wood et al., 2008; Health Canada, 2006).

In 2007, Prime Minister Stephen Harper unveiled the National Anti-Drug Strategy (Government of Canada, 2007). This strategy abandoned the four-pillar approach to drug policy adopted in 2003 in favour of a new three-prong approach. The new three-prong drug strategy drops the harm reduction pillar, increases spending on law enforcement activities and allocates roughly the same amount as in previous years to prevention education and treatment. The Harper government has cited a lack of sufficient evidence to support harm reduction-based initiatives as the reason for abandoning the fourth pillar (Health Canada, 2006).

Removing harm reduction from the national drug strategy at the same time that several evaluation reports based on Canadian findings indicated the positive impacts of harm reduction-based programs has made drug policy in Canada an increasingly contentious issue (Wodak, 2008; Kerr et al., 2008). Claims of lack of evidence were refuted by academics and service providers collecting evaluation data in this field (Hwang, 2007).

Of the original four pillars, harm reduction has been found to have the most empirical, peer-reviewed evidence to support its utility and cost-effectiveness (Hwang, 2007; Wodak, 2010) and is endorsed by the World Health Organization (WHO), the United Nations Office on Drug and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) as an essential policy and programming component in the fight against HIV/AIDS among people who inject drugs (WHO, UNODC, UNAIDS, 2009). The Federal Conservative Government's 2007 Anti-Drug Strategy document not only marked a strong departure from Canada's 2003 drug strategy, but it also made a political and ideological statement about the current Conservative party's beliefs and values towards drugs and drug users and rebuked existing evidence-based research. This development was additionally inconsistent because the federal and provincial governments continue to support and fund specific harm reduction programs, namely needle exchange programs and methadone maintenance programs. It has been theorized that the existing Conservative government might be trying to slowly erase 'harm reduction' as a term used in national policy to distance itself from a concept it ideologically opposes (Canadian HIV/AIDS Legal Network, 2007; CCSA, 2008). Because harm reduction and drug use are controversial, political topics, the government can use these issues as a public platform to appear 'tough on drugs'. The existing Anti-Drug Strategy is an example of how political ideologies can be highly influential on policy, even trumping evidence.

While harm reduction has been widely debated in national drug policy, it still remains an essential component of national HIV/AIDS prevention policy. The resulting

disconnect is problematic for a variety of reasons. A lack of support for harm reduction from government at the national level sends an erroneous message to the public regarding best practices for drug control and disease prevention while potentially undermining existing harm reduction programs proven effective at reducing the risk of HIV and Hepatitis C transmission. Denying the significance of positive harm reduction evidence without being able to, or required to, provide contrary evidence has the potential to damage the Harper government's credibility in both the areas of public health and human rights. A suppression and obstruction of evidence infringes on peoples' right to health, by limiting their ability to make individual, informed personal choices about their health based on current knowledge and access the corresponding services. Additionally, this also infringes on policy-makers' and service providers' ability to provide policy and programming approaches which are evidence-based and reflective of the most recent health innovations (Office of the High Commission, 1966; United Nations, 2000). The disconnect between the current Anti-Drug Strategy and HIV prevention policies creates a situation ripe for policy maker, service provider and researcher frustration over their findings or experiences being ignored or misrepresented (Hwang, 2007). This may also lead to a general sense of mistrust or lack of accountability within the larger policy-to-programming system, creating disconnects and hampering its functioning. Lastly, and most importantly, it further marginalizes injection drug users by taking a value-based approach to drug policy which stigmatizes services that individuals use to lessen their personal vulnerability to HIV and that of their sexual and drug using partners. When people who inject drugs fear legal or social ramifications associated with the use of mainstream health services, they will avoid using them, creating lost opportunities for

education and disease prevention (DeBeck et al., 2008; Ronzani et al., 2009; Jackson et al., 2010). Community-based harm reduction services and programs have been uniquely successful in their ability to reach drug users (Jackson et al., 2011) including women who inject drugs, who have been traditionally and chronically underserved (Wilson & Kahn, 2003; Hilton et al, 2009; Weeks et al., 2009).

From a cost-effectiveness standpoint, decreasing the harms associated with injection drug use presents a major opportunity for decreased spending for government (Kuyper et al., 2004; DeBeck et al., 2010). A 2001 cost-of-illness analysis of a sample of illicit opioid users in Toronto found a social cost burden of $45,000 per untreated user per year (Wall, Rehm, Fischer et al., 2001). It is also important from a human rights or social justice perspective that proven effective harm reduction programming be made available to people who use illicit drugs. Under the International Covenant on Economic, Social and Cultural Rights, Canada has a legal obligation to take steps to realize the right of every individual to the best available health care resources as determined by current scientific knowledge. Specifically, the Canadian government cannot abandon financial or policy support for proven health protection measures, or impede the delivery of such efforts, by withdrawing any framework that facilitates them. Should they do this, they can be held accountable to human rights legislation. The Canadian HIV/AIDS Legal Network (2009) have pointed out that the federal government's pattern of disregarding evidence about the effectiveness of harm reduction-based health services for people who use drugs raises a case of discrimination. Specifically, Canadian-based health researchers

and advocates have argued that public health and harm reduction must take precedence over criminal drug laws which lead to harm and human rights abuses (Hwang, 2007).

On September 29th 2011, the Supreme Court of Canada made a landmark decision to exempt Vancouver's supervised injection facility (InSite) from drug laws which would prohibit its operation (CBC, 2011). In addition the Court publicly rebuked the federal government for taking a value-based, rather than evidence-based stance against the facility (CBC, 2011). This case is a ground breaking example of how criminal law and health care are not mutually exclusive when it comes to drug use and need to become aligned. This ruling is significant for HIV prevention among drug users because it re-validates the utility of harm reduction approaches, opens the door for more supervised injection facilities, supports evidence-based policy over value-based policy, upholds the human rights of people who inject drugs, and shows that the government can be challenged on policy and law.

2.5 HIV Prevention Policy in Canada and Injection Drug Use

National HIV/AIDS policy in Canada is outlined in several key policy documents (PHAC, 2004; PHAC, 2005; Federal/Provincial/Territorial Advisory Committee on AIDS, 2005). These documents are meant to frame the way the federal government conceptualizes and responds to the challenge of addressing HIV/AIDS among its citizenry and provide a framework to guide stakeholders (PHAC, 2004). In order to liaise between stakeholder groups, the Canadian federal government created the Federal/Provincial/Territorial Committee on HIV/AIDS (FPT AIDS) in 1992 to promote

intergovernmental, inter-jurisdictional, multi-level collaboration (PHAC, 2007). This action contributed to the actualization of one of the overarching roles of national government in HIV/AIDS prevention, which is to ensure a coordinated policy approach across all sectors, provinces and territories (PHAC, 2007). Other national-level responsibilities include promoting and supporting evidence-informed, accessible programming and allocating adequate resources, including funding (Health Canada, 2003). Because HIV/AIDS policy emerges from a complex interaction of stakeholders, ideas and interests and contexts (national, provincial, and potentially regional), it is dynamic and complex to coordinate.

One clear example of the complexity of the national policy-to-programming process can be found in the challenge of providing HIV prevention policies and programming approaches specifically aimed at meeting the varied needs of people who inject drugs. It is well documented that people who engage in unsafe injection drug use behaviours are at high risk of acquiring HIV (Canadian HIV/AIDS Legal Network, 2005; PHAC, 2006). Decreasing HIV risks associated with injection drug use is an important public health issue requiring tailored, comprehensive, evidence-based HIV prevention policy and programming. However, developing and implementing HIV prevention policy and programming for injection drug users is complicated by the fact that drug use is treated primarily as a criminal law issue in Canada, and secondly as a public health issue (CCSA, 2005). Policies and legislation for the management and control of drug use and its consequences exist in both criminal enforcement and public health silos; separate, but inextricably linked through overlapping concerns. Drug enforcement policy can be

detrimental to HIV prevention policy for people who inject drugs due to competing priorities between law enforcement and public health approaches to drug issues and the documented negative impact of certain drug enforcement practices on the health and well-being of people who use drugs (Canadian HIV/AIDS Legal Network, 2007 &2009; Werb et al., 2008; Shannon et al., 2008). For example, street level police crackdowns and 'red zones' have been found to displace people who inject drugs away from needle exchange programs and other health services, as well as exacerbate risky injection practices among street injectors including rushing injections and injecting with used syringes (Shannon et al., 2008; DeBeck et al., 2008). Additionally, national and international evidence exists showing that drug strategies that emphasize police enforcement and incarceration, the primary drug spending focus in Canada, lead to increased arrests for minor possession charges and increased rates of people becoming infected with HIV and Hepatitis C while imprisoned (United Nations Office on Drugs and Crime, 2006; Canadian HIV/AIDS Legal Network/PASAN, 2007; Werb et al., 2008). The Canadian HIV/AIDS Legal Network estimates that mandatory minimum drug sentences, passed by the Federal Conservative Government, will incur massive public and individual costs related to policing, incarceration and a rise in HIV and HCV infections among incarcerated drug users (Canadian HIV/AIDS Legal Network, 2006). Despite these serious, ongoing challenges, until recently both drug and HIV policy documents expressed a belief that HIV prevention initiatives must be based on existing evidence and that evidence supports the necessary inclusion of harm reduction-based programming. However, this commitment to evidence-based harm reduction has not been consistently reflected in position statements made by the current Federal

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Conservative Government, or practices among law enforcement bodies in Canada (RCMP and Canadian Police Association), or in support for sufficient harm reduction program availability and coverage for people who inject drugs (Wood et al., 2008; Canadian HIV/AIDS Legal Network, 2008; Wiessing et al., 2009). This is most obvious in the Federal Conservative Government's Anti-Drug Strategy in 2007 which excludes harm reduction and therefore directly affects HIV prevention targeted to people who inject drugs. This document has created an ideological and practical disconnect between national drug policy and national HIV prevention policy for people who inject drugs in Canada.

2.6 Women Who Inject Drugs, HIV and Harm Reduction

Access to harm reduction services and supports is particularly important for women who inject drugs. The percentage of women testing positive for HIV in Canada who disclose injection drug use as a possible transmission route is increasing and has exceeded the percentage of HIV-positive men who disclose injection drug use as a potential route of transmission (PHAC, 2008). Aboriginal women, and increasingly young women, make up a disproportionate percentage of new cases of HIV attributable to injection drug use (PHAC, 2008). Researcher and HIV activists have been calling for increased attention to the HIV-specific needs of women for many years (Gupta, 2000; Sherwin, 2001; Boehm, 2001; Carael et al., 2009).

Gender, as a key determinant of health, has been found to exert a powerful influence on drug use behaviours and their associated risks (Bryant et al., 2010). Women

who inject drugs have different drug-use behaviours (Leonard et al., 2001; Wood et al., 2003; Riehman et al, 2004; Leonard et al., 2008), sexual experiences (Booth, 1995; Leonard et al. 2001; Strathdee et al., 2001, Leonard et al., 2008) and HIV prevention needs than their male counterparts (PHAC, 2003; PHAC, 2006; United Nations, 2006; WHO, 2009). The sharing of contaminated injection drug use equipment represents the second highest exposure category route for the transmission of HIV to women in Canada (PHAC, 2008). Additionally, women who use drugs are more likely than drug using men to die prematurely due to violence (Spittal et al., 2006; Miller et al., 2007).

Studies examining female injection drug users' relationships reveal that they are more likely to be in relationships with men who inject than their non-injecting peers. Many women are introduced to injection drug use through their injecting male sexual partners (Kerr et al., 2006; O'Connell et al., 2005). Because of potentially uneven power dynamics within these relationships, women have more difficulty seeking treatment (Whynot, 1998; McRae, 2000). Women are more likely to use drugs in the presence of their drug-using sexual partner and have less control over the amount of drug used, method of use and a few studies have suggested that they may be more likely than men to be 'second on the needle' (to use a needle after their partner has already used it) (Whynot, 1998; Wood, 2003; O'Connell et al., 2005; Bryant & Treolar, 2007). It is often difficult for women and men to ask their partners to use new, sterile equipment each time, as it can imply a lack of trust (Fairbain et al., 2010); by extension, the use of shared equipment can also be seen as a way of demonstrating trust and intimacy towards a male partner (Fairbain et al., 2010). Women are more likely to initially rely on others,

primarily male sexual partners, to administer injections on their behalf, and some may continue to be exclusively injected by others (Wood, 2003; O'Connell et al., 2005). This behaviour was found to be associated with receptive (used) syringe sharing, HIV incidence, and a greater likelihood of physical violence (Wood et al., 2003; O'Connell et al., 2005; Marshall et al., 2008; Bryant et al., 2010). The ban on assisted injection in supervised injection facilities can therefore act as a barrier for women who wish to access these facilities and illustrates the need for gender-informed policy to show how women and men can be affected differently by programming features (Fairbairn et al., 2010). In some studies, women have been found to share equipment within their social networks more than males, however, evidence of this is inconclusive within the broader literature (Whynot, 1998; Riehman et al., 2004; The Power Study, 2011).

Many women who inject drugs also engage in high-risk sexual activities. Women, in general, have less control than their male counterparts in regards to whether condoms are used in sexual encounters (El-Bassell et al, 2005). Reported experience of past sexual and physical abuse, which is found to be more common among women who inject drugs than the general female population, can have a lasting impact on women's physical and psychosocial well-being and has been linked to drug use and an increase in number of sexual partners (MacRae & Aalto, 2000; Cedar Project Partnership et al., 2008; Bryant et al., 2010). The direct exchange of sexual favours for drugs or money for drugs can also increase a women's risk of HIV, as part of the agreement may include incentives such as higher pay for unprotected sex (Weeks et al., 1998; Spittal et al., 2003; Jackson et al., 2005; Cedar Project Partnership et al., 2008; Johnston et al., 2010). Women who are

engaging in sexual acts while under the influence of drugs may have lowered inhibitions, have less cognitive awareness of their situation, be at higher risk for sexual violence, and have less control over the use of safer sex options and tools (Bruneau et al., 2001; Pinkham & Malinowska-Sempruch, 2008).

Further complicating HIV prevention efforts is the finding that many women, as well as men, who inject drugs are poly-drug users. Drug of choice may vary depending on availability, cost, fluctuating purity and mode of administration (Leonard et al., 2008). Certain drugs such as cocaine often involve binge drug-taking episodes and a higher likelihood of unsafe sexual activity (Strike et al., 2006). Canada's I-Track Study, a pan-Canadian surveillance study, found that of 3,031 active injection drug users interviewed across the country, 63% smoked crack. Higher rates were documented in Toronto (89%), Edmonton (84%) and Winnipeg (75%) (PHAC, 2006). Both recreational and heavy use of crack cocaine have been linked to a variety of high-risk behaviours, including the spread of HIV and HCV due to sharing of smoking and injecting equipment and sexual risk-taking while under the influence or in exchange for money or crack (Leonard et al., 2006; PHAC, 2006; Safer Crack Use Coalition, 2005). Poly-drug use can complicate women's addiction management and HIV prevention, care and treatment needs thus strengthening the need for flexible, multi-faceted treatment options and the building of relationships with care providers.

Lastly, women who inject drugs experience a wide variety of social stigma, discrimination and barriers to service use that are different than those experienced by

males. Drug use among women is seen as 'doubly deviant' because it violates social gender expectations attached to 'femininity' (i.e. that women should be virginal or maternal) (Manderson, 1999; Hoffman, 2003). Hoffman (2003) argues that women will be stigmatized first for being drug users, and secondly for being women who use drugs. Because of the stigma surrounding women's drug use, women may feel guilt or shame associated with their drug use and service providers may also reflect stigmatizing attitudes that discriminate, deny or produce misinformation about women's drug-related service needs (Paltrow, 1998; Rutman et al., 2001; Cormier, Dell & Poole, 2002). Shame, guilt, self-blame and isolation are recurrent themes expressed by women who use drugs to describe their psychosocial experience with drug use (Dell & Poole, 2002; Boyd, 2004; Sharpe, 2005; Covington, 2008).

Pregnant women or women with children are especially likely to encounter stigma and discrimination if their drug use is uncovered (Pinkham & Malinowska-Sempruch, 2008; Open Society Institute, 2009). The threat of losing one's children to child custody services is particularly problematic for mothers and pregnant women trying to seek healthcare or treatment for addiction (Pinkham & Malinowska-Sempruch, 2008; Open Society Institute, 2009; Calvin & Moriarty, 2010). Programs that accept and care for both women and children are very rare, and in addition finding affordable, safe care for children while women seek treatment is very difficult (Finkelstein et al., 1997; Grella, 1997; Poole & Isaac, 2001). As a result, the opportunity to connect with these women and discuss substance use and pregnancy or parenting, provide practical support, such as methadone treatment or harm reduction services, are often lost (Burns et al., 2007).

In addition to gender as a key determinant of health, women who use drugs may accumulate additional layers of stigma based on poverty, minority ethnicity, disability, HIV status or criminal involvement. Women in prison and female sex workers who inject drugs experience additional layers of stigma creating further barriers to prevention, treatment and care (Canadian HIV/AIDS Legal Network, 2006). Limited access to harm reduction in prison settings (Gahagan, Rehman & DiCenso, 2003), the sometimes dangerous context of sex work (Jackson et al., 2009; Shannon & Csete, 2010), and aggressive or violent policing (Shannon et al., 2008) all increase women's vulnerability to HIV. Aboriginal women are most affected by the harms related to criminalization in Canada, as they represent a disproportionate percentage of Canada's female incarcerated population (Native Women's Association of Canada, 2007). Women and girls who are homeless and use drugs often find less available housing options than their male counterparts (Erickson, King & YWIT, 2007; Elifson, Sterk & Theall, 2007). This is exceptionally problematic as homeless women are at high risk for drug involvement, as well as sexual and physical assault (Elifson, Sterk & Theall, 2007). For women who inject drugs and are HIV positive, finding non-judgmental health care professionals to obtain antiretroviral medication and other HIV-related care can be difficult (WHO, 2005). All of these barriers to services can render HIV prevention programs, even poor quality, gender-insensitive options, inaccessible.

2.7 Current Policy and Programming for Women Who Inject Drugs in Canada

Drug-specific HIV prevention services and resources are often not adequately available to meet the expressed need, let alone the unique needs of women (Carael et al,

2009). Despite our understanding of gender as a key determinant of health in relation to HIV-risk, most prevention policies and programs that exist are not uniquely tailored to address the differences between male and female injection drug users (Wechsberg et al., 2008; Bryant et al, 2010). The majority of available HIV prevention-specific services are still modeled after the needs of men and run by men, particularly in rural communities where less HIV-specific resources exist (PHAC, 2006). A lack of female-specific service providers in HIV prevention roles, lack of childcare, lack of integrated sexual and reproductive health services and lack of women-only safe spaces create barriers to HIV prevention care for women (UNAIDS, 2006). Other barriers include household and familial responsibilities, lack of family support, lack of partner support, social or financial dependence on a male partner, lack of peer support, lack of finances and job opportunities, lack of housing, and fear of being identified, stigmatized, abandoned or physically harmed (Sterk, Theall & Elifson, 2002; Pinkham & Malinowska-Sempruch, 2008; Auerbach, 2009).

It has been suggested that programs must become more comprehensive and holistic in an effort to better meet the complex needs of women (United Nations, 2006; WHO, 2009). Most programs are not equipped to deal with addiction, HIV, violence, sexual trauma, and reproductive health collectively (El-Bassel et al., 2005). Additionally, few programs address broad social issues such as women's economic marginalization, even though low threshold employment programs and expansion of prescription or substitution therapies can help address women's economic dependence on others or on engagement in illegal income generating activities (DeBeck et al., 2007). Few programs

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include couple-based interventions to reinforce the message that HIV prevention is the responsibility of both partners (Gilbert et al., 2010).

However, examples of gender-responsive harm reduction initiatives for women are developing within Canada. One example is the Fir Square Combined Care Unit in British Columbia, the first in Canada to provide care for women who use drugs and their drug-exposed infants in a combined unit where mother and baby share a room. Guided by a harm reduction philosophy, this program provides non-judgmental assessment, detoxification, parenting education and addiction care and support for women all in one center with the end goal of helping mothers stay with their children once they leave the hospital (British Columbia Centre of Excellence for Women's Health, 2010).

Women who inject drugs need HIV prevention policies and services that both acknowledge and break down access barriers in addressing the social determinants of health as they impact HIV risk (UNAIDS, 2006; Pinkham & Malinowska-Sempruch, 2008; El-Bassel et al, 2010). Expansion of women-specific and gender-informed programs is needed to build a stronger evidence-base to lobby for adequate funding and resources to address women's unmet needs. Unfortunately, despite evidence to support the need for women-specific interventions, many communities in Canada lack the resources and capacity to focus on HIV as a women's health issue and consider women's risk, or implement gender-based analysis of existing policies and programs, including harm reduction programs (British Columbia Centre for Excellence in Women's Health, 2009).Groups such as the Status of Women, the Women's Health Bureau and the

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Secretary of State have fought for the integration of gender analysis into government policies and legislation. Although they have succeeded at ensuring its inclusion in many working documents, it rarely has been found to filter down into program planning and policies at the various sectoral levels (Sherwin, 2001). Unfortunately, a disconnect exists between the ability of government to enforce a GBA framework and the ability of community-based organizations to implement it as laid out in policy (Guenter et al., 2001). Lack of funding, resources and capacity to consistently implement and evaluate this level of analysis is often an issue in community-based projects. Additionally, the women most affected by HIV in Canada come primarily from marginalized communities and have less social power and voice to lobby for resources (Canadian HIV/AIDS Legal Network, 2005). In 2006, the Federal Conservative Government cut funding for the Status of Women Canada by 43%, along with cuts in funding for many other women's groups, which has seriously reduced federal and provincial capacity to carry gender-based research and advocacy forward (Canadian Centre for Policy Alternatives, 2008).

2.8 The Inter-organizational Response to HIV/AIDS

In the early days of the HIV/AIDS epidemic, many of the formal health and social service agencies that were accustomed to providing health care to people in need (such as clinics and shelters) were hesitant to become involved in HIV/AIDS service delivery (Perrow,1990). This has been attributed in part to the stigma associated with homosexuality and injection drug use, and a fear of contagion that resulted in an initial failure of organizations to meet the needs of people with HIV/AIDS (Perrow, 1990; Patton, 1993). Grassroots organizations responded to this gap by forming AIDS service

organizations (ASOs) that worked to meet the diverse health and social service needs of their clientele (Mechanic & Aiken, 1989). These grassroots agencies differed from traditional government health agencies, in that they were often advocacy-based, non-governmental, decentralized and direct providers of basic needs and services which often offered anonymous or confidential care (Cannon Poindexter, 2007). They were created out of a need to supplement the existing system, to ensure that the prevention, care, treatment and support needs of people living with HIV/AIDS were met. ASOs now exist all over the world and still play the central role in service provision for people living with HIV/AIDS. Over time, however, as the epidemic grew, more formal health and social services developed their own AIDS-specific services and networks of agencies working to both supplement and complement the existing system (Cannon Poindexter, 2007).

In Canada, the current organizations that provide HIV/AIDS-related services make up a large and diverse group, including hospital-based clinics, local health departments, and community-based agencies. National, provincial, regional and municipal government and non-governmental agencies create HIV/AIDS policy, education and advocacy work. The specific type or types of policy and programming services provided by specific agencies varies within this system, with some offering a wide variety of different services and others offering single, specialized care in one area. For example, one clinic or agency may provide primary health care, counseling, case management and support groups, while another will offer only respite care. Additionally, not all community-based agencies that provide HIV/AIDS programs are ASOs. For example, a needle exchange program, although not specifically an ASO, provides clients

with sterile injecting equipment and other harm reduction resources to decrease their chances of becoming infected with HIV. In this service system, individuals must often seek care from more than one organization to have their diverse needs met. For this reason many organizations and agencies have formed partnerships and networks for collaboration.

Injection drug using populations are a specific subgroup of individuals with unique HIV prevention needs. Although considered a 'hidden population' many come into contact with community-based health and social service providers regularly, particularly if they are actively engaging in harm reduction practices. Harm reduction service organizations for people who inject drugs were created in the late eighties when this population's unique HIV prevention needs were identified (Riley & O'Hare, 1996). Similarly to the more general ASO field, service providers working directly with people who inject drugs often form networks consisting of a combination of formal (government) or informal (non-government, voluntary, nonprofit, alternative) organizations that work together to address the multifaceted needs of their client population. Harm reduction services for people who inject drugs are able to extend government mandated HIV prevention goals through a less formal system, which prioritizes a non-judgmental stance toward drug use and often allows for relationship building between service users and providers (Kwait et al., 2001). Non-governmental organizations specifically designed and staffed to work with this population represent a secondary system that can offer more tailored programs and services. For this reason, a distinction between government and non-government or formal and informal may be

attractive to people who inject drugs who may be hesitant to approach formal agencies. A needle exchange, for example, can serve as an important 'buffer' keeping people who inject drugs from having to work with potentially 'discriminatory' government agencies and keeping governmental staff from having to work with potentially 'difficult' clients (Berger & Neuhaus, 1996). Additionally, the harm reduction agency benefits the government agency by providing mandated HIV prevention work with people who inject drugs, in a relatively autonomous and inexpensive way; the government agency benefits the harm reduction agency by providing resources including funding and legitimacy (Walt, 1994).

Due to the potential benefits from collaborations, harm reduction policy decision-makers and community-based service providers often partner to form either policy or other issue networks (Marsh & Rhodes, 1992). These networks can also include a variety of other local health and social service agencies such as shelters, mental health service providers, social workers, employment agencies, housing, advocacy and food programs. Researchers have started to study these partnerships and networks in order to learn more about their inter-organizational structures and to evaluate their effectiveness in policy and program development and implementation (Kwait et al., 2001; Shumate et al, 2005; Wright & Shuff, 1995). For example, Shumate et al. (2005) looked at relationships between NGOs and government working in the field of HIV/AIDS over the course of eight years and found that past relationships, geographic proximity and common ties with government predicted patterns of alliances among ASOs.

2.9 Inter-organizational Theory and Health Policy Analysis

Inter-organizational relationships are increasingly being formed to coordinate HIV/AIDS policy, research and programming at the international level right down to the community level (UNAIDS, 2009). The complexity of these systems and the number of individuals and organizations involved sometimes results in fragmentation or duplication of services (Fleishman, Piette & Mor, 1990). The inter-organizational relationships between stakeholder groups (i.e. policy makers, service providers, researchers and clients) are being studied with the goal of uncovering barriers and facilitators to policy development and implementation.

Primary areas of interest in the field of inter-organizational theory specific to health systems are the inter-organizational differences between government and non-government agencies and the utility and effectiveness of collaborations in providing policy and programs (Walt et al., 2008). Community-based harm reduction agencies are unique from government health agencies, such as departments of health or regional health authorities, who administer more varied programs and have limited direct contact with specific sub-populations of clients. In addition, government and non-government organizational structures, hiring practices and operating procedures are often very different. For example, government health agencies generally hire formally trained staff, reinforce hierarchical structures within staff, work through structured interactions with clients, receive less client feedback and focus on specified outcome goals (Gidron & Hasenfeld, 1994). Non-government health and social service agencies tend to engage more volunteer staff, hire more staff with experiential knowledge over university-based

education, play a stronger advocacy role, emphasize horizontal relations, flexibility and inter-changeability of roles, work in a more participatory fashion with clients and learn more about clients lives and experiences (Gidron & Hasenfeld, 1994).

In 1981, Kramer created a chart describing the general differences between the two types of agencies. This chart presents a simplified look at the characteristics exhibited by, or attributed to, these groups. Lipsky and Smith (1989) stipulate that understanding the differences between the two groups is particularly important in light of the fact that most non-governmental health service agencies receive a significant amount of their funding from government and therefore relationships, shared objectives and common definitions are important. Henry (1987) has described the relationship between government and non-government agencies as more harmonious when contracting occurs and contracted agencies are able to comply with the requirements of funding.

Table 1. Characteristics of Government and Non-Government Agencies.

CHARACTERISTICS OF GOVERNMENTAL AGENCIES	CHARACTERISTICS OF VOLUNTARY AGENCIES
rigid, slow to change	flexible, adaptable
only well accepted services	experimental and pioneering
little citizen participation	voluntary citizen participation
mass, universal services	individualised, personal and selective services
diffuse contacts	intensive relationships
non-sectarian and non-partisan	religious and sectarian and reform-oriented
large, bureaucratic structure	small, non-bureaucratic structure

(Kramer, 1981:100-101)

Research into collaborations between government and non-governmental agencies has found that they can become strained due to scarce resources, competition, power dynamics, identity issues and differences in vision, objectives and operational approaches (Tantivess & Gill, 2008). In general, funding for public health or social services is always presented as scarce, which can make relationships between individual organizations competitive and power differentials between larger and smaller agencies more obvious (Tantivess & Gill, 2008).

Research looking specifically at collaboration has helped to shed light on these relationships and tensions. Gray (1985) defines collaboration as: "the pooling of appreciations and/or tangible resources, e.g., information, money, labor, etc., by two or more stakeholders to solve a set of problems which neither can solve individually" (p.912). In 1985, Gray created a theory of collaboration to explain how organizations interact. It is based on five key elements:

1. Collaborations are created by stakeholders in order to control turbulent environments through the regulation of exchange relationships.

2. Collaboration entails the adoption of "collected strategies" rather than individual strategies.

3. Collaborations entail a dynamic process by which domain becomes organized.

4. Over time collaboration can create lasting relationships.

5. Collaboration can lead to a more comprehensive understanding of a problem.

The potential advantages of collaboration are often seen as outweighing the potential disadvantages, however both exist. Schermerhorn (1975) outlines three potential concerns for individuals/organizations collaborating: loss of decision-making autonomy;

unfavorable ramifications for organizational identity; and expenditure of scarce organizational resources. Van de Ven and Walker (1984) hypothesize that the continued sharing of resources can lead to stakeholders' services becoming overly similar fostering the emergence of conflict and competition. Rossi, Gilmartin and Dayton (1982) outline several barriers to interagency collaboration, including organizational inflexibility, bureaucracy, turfsmanship, and politics.

To date, much of the research into collaboration has focused on determining how best to do it. Whetten (1982) argues that this approach is too rationalistic and value-free and ignores the influence of coercion or conflict of interest between collaborators. For example, Morrison's (1996) research into partnerships within the welfare system uncovered issues of status and power differentials within the collaborative process. Specifically, it uncovered tensions between partners due to occupational status, gender, race, language, professional training and public image. Other studies have looked at the importance of stakeholder legitimacy in understanding collaborative partnerships (McCann & Gray, 1986) and found that less powerful actors in a partnership have to work harder over time to establish a voice within the partnership.

Summary

In Canada, national HIV/AIDS policy has advocated for the scaling-up of prevention efforts, specifically aimed at those communities most vulnerable, by providing evidence-informed public health interventions tailored to communities' needs (PHAC, 2003; PHAC, 2004). People who inject drugs represent a population that is highly

vulnerable to HIV. Women who inject drugs in particular are at an increased risk for HIV, as they experience unique HIV risk factors and barriers to HIV prevention as a result of gender inequality and marginalization (PHAC, 2003). Harm reduction approaches have been found to reduce the HIV-risks associated with injection drug use and present a more accessible, non-judgmental approach to service provision for people who inject drugs (WHO, UNAIDS, UNODC, 2009). However, drug use, HIV and harm reduction are political, controversial issues, which elicit value judgments and create ideologies which can then influence policy development and implementation.

To date there has been limited attention to how provinces develop and implement HIV prevention and harm reduction policy for people who inject drugs. This study begins to address this gap by exploring the development and implementation of provincial HIV prevention and harm reduction policy for women who inject drugs in Nova Scotia.

CHAPTER THREE: Theoretical Framework

This chapter describes the two theoretical frameworks used to guide this study. Theoretical frameworks organize inquiry by identifying elements and relationships among elements that need to be considered for theory generation (Ostrom, 2007). Walt and Gilson's 1994 Policy Triangle Framework was selected as the primary theoretical framework for this study to inform the research questions and guide the research process, the analysis and interpretation of the findings. One early concern was the lack of specific consideration of gender as part of this framework. Therefore, the decision was made to modify Walt and Gilson's framework to incorporate a gender-based analysis lens. Gender-based analysis (GBA) was selected primarily because Nova Scotia's HIV prevention and harm reduction policies were all published by government and gender-based analysis is arguably the 'language' of gender in government. In Canada, GBA has been touted as the instrument to ensure gender equality in health policy since 1995 and it has been federally mandated since 1999 (PHAC, 2003).

The following sections will describe how both Walt and Gilson's theoretical framework and gender-based analysis were used to study the development and implementation of HIV prevention and harm reduction policy for women who inject drugs in Nova Scotia.

3.1 Walt and Gilson's Policy Triangle Framework (1994)

Walt and Gilson (1994) propose that much policy analysis focuses too narrowly on the content of policy, neglecting the various actors, processes and contexts involved. Their policy analysis framework is grounded in a political economy perspective and considers how all four of these elements interact to shape policy development and implementation (see Figure 1).

Figure 1. A model for health policy analysis

```
                        Context



                        Actors
                      • Individuals
                      • Groups
                      • Organizations

    Content                              Process
                              (Walt and Gilson, 1994)
```
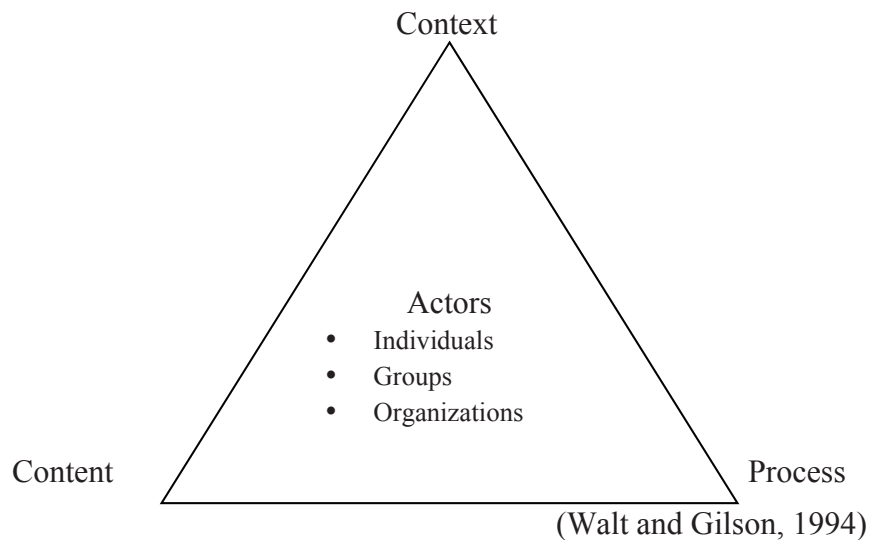
This analytical framework incorporates the concepts of actors, content, process and contexts as being instrumental in shaping health policy. Although it appears simplistic, this framework allows for the examination of a complex system of interrelationships between its four components, which occur during the development and implementation of policy. It argues that actors (as individuals or members of interest groups or professional associations) are influenced by the context within which they live and work (both the macro-national level and the micro-community level) and that context

is dynamic and subject to change based on a variety of social factors, such as governmental party change, economic change or shifting ideologies (Walt & Gilson, 1994 and 2008). The process of policy development and implementation (policy agenda setting, formulation, implementation and evaluation) is affected by actors; their position in power structures, their own values and expectations. And lastly, the content of policy reflects positioning of the issue (discourses, arguments and evidence) and statement of intent (Walt, 1994). Because the theoretical framework was chosen as a starting point in the design of this study, the primary research questions are based on Walt and Gilson's Policy Triangle Framework and are organized under subsections that include people, content, process and context.

3.2 Gender-Based Analysis (GBA)

It must be recognized at once…that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality (McIntyre. J. in Andrews vs. Law Society of British Columbia, (1989), 1 S.C.R.143, at 164).

In North America, we generally accept sex as biological differentiation between men and women and gender as culturally-specific roles and expectations that result from women and men's socially prescribed behaviours (INAC, 2006). A gender-based analysis is the study of the latter. Although gender-based analysis is presented as a pragmatic set of analytical questions or steps to ensure equity for both genders, it has been used in practice primarily as a way to ensure that androcentric policies and programs consider the differential impact they have on women and men.

Feminism and gender-based analysis share several key features, including challenging the status quo and attempting to improve social and structural conditions for women. The state in particular has been positioned in feminist research as perpetuating androcentricity and control over women's lives and bodies (Harding, 1991). In an effort to address women's health and gender inequality in government policies and programs, GBA was formally adopted by the Government of Canada in 1995 as a policy tool for working toward gender equality in research, policy, and practice (PHAC, 2003).

In this study, Walt and Gilson's framework was modified to include a gender-based analytic lens in order to identify barriers and facilitators to developing and implementing provincial HIV prevention and harm reduction policy that reflects the HIV prevention needs of women who inject drugs in Nova Scotia. GBA is an evidence-based process that uses statistical data on the determinants of health, research results, and/or consultations with diverse groups of women and men to consider the differential impact sex and gender have on individual health and well-being (Health Canada, 1995). Health Canada created a gender-based analysis framework in 1995 and has pledged commitment to use it as a way to help foster gender equality in health care. This involves ensuring that government policies and programs consider the needs of both men and women using gender-based analysis tools. According to the Public Health Agency of Canada (2003), GBA is based on four key principles:

1)   Gender equality can be achieved only by recognizing the different impact of norms or measures on women and men according to their diverse life situations.

2)   Gender-based analysis is an integral part of the substantive analytical process and must be applied at each stage of this process.

3)   Gender-based analysis focuses not only on results but also on concepts, arguments and language used in the work process.

4)   Gender-based analysis must lead to remedies to inequality.

<div align="right">(PHAC, 2003)</div>

GBA was used in this study in both the analysis of key policy documents and in the analysis of interview data. This framework was used to consider how HIV prevention and harm reduction policy in Nova Scotia meets the HIV prevention needs of women who inject drugs.

The following questions were used as a starting point for exploring the gender-based dimensions of Nova Scotia's HIV prevention and drug policies and the key informant interview data (INAC, 2006):

- In what ways are both women's and men's experiences considered in identifying the issue?

- Are available data disaggregated by sex at all levels of analysis?

- How are both men and women involved?

- Is diversity being considered? If so, how?

- What do women's organizations and gender-sensitive researchers say about this issue? Have these organizations and individuals been consulted?

- Has capacity building around gender-based analysis occurred among stakeholders?

- How might the outcomes of this policy or program be different for women and men?

- What other policy outcomes may be anticipated by looking at sex and diversity?

- How are differential consequences based on sex and diversity communicated?

- How will identified gender issues be dealt with?

(Adapted from Indian and Northern Affairs Canada, 2006)

CHAPTER FOUR: Methodology and Methods

This chapter describes both the methodological approaches and the tools used to address the research objectives. Methodology refers to the principles or approaches that determine how methods, namely the tools of research, are deployed and interpreted (Given, 2008). This study employed policy document review and key informant interviews to explore the development and implementation of HIV prevention and harm reduction policies for women who inject drugs in Nova Scotia.

4.1 Research Objectives

The specific objectives of this study are to identify:

- The key organizations involved with HIV prevention and harm reduction policy decision-making for people who inject drugs in Nova Scotia.

- The key HIV prevention and harm reduction policies in Nova Scotia, how they were developed and how they address the needs of women who inject drugs.

- The key barriers and facilitators to developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia.

4.2 Methodology

4.2.1 Qualitative Research

Qualitative research studies are informed by a wide range of methodologies and theoretical frameworks intended to explore the 'real-life or human' elements of a particular topic (Lincoln & Guba, 1985). Qualitative approaches are typically used to explore new phenomena or capture participants' thoughts or feelings about a topic that has not yet been studied in great depth. Such methods are central to research conducted in education, nursing, sociology, anthropology, and other disciplines in the humanities,

social sciences, and health sciences (Lincoln & Guba, 1985). The ability of qualitative

data to describe a phenomenon is an important consideration not only from the

researcher's perspective, but from the reader's perspective as well. As stated by Lincoln

and Guba: "If you want people to understand better than they otherwise might, provide

them information in the form in which they usually experience it" (1985, p. 120).

Qualitative research reports are typically rich in descriptive detail and include quotations

from participants making them read as explanations of a particular event or situation and

ideally making them "epistemologically in harmony with the reader's experience" (Stake

et al., 1978, p. 5). This research approach allowed for the use of participants' own words

in describing their perspectives on, and experiences with, working in HIV

prevention/harm reduction policy development and program decision-making for women

who inject drugs in Nova Scotia. The resulting data are detail rich, reflective of an

insightfulness that can only be achieved by speaking to key informants, and rooted in the

Nova Scotia context.

4.2.2 Reflexive Methodology

"Reality is ambiguous and different vocabularies and methods of
interpretation should be considered and explicitly accounted for" (Alvesson
& Skoldberg, 2004, p.305).

An important component of conducting qualitative research which attempts to

capture a 'real life' phenomenon is considering that one's interpretation of 'reality' is

subjective and dynamic. Reflexivity in research is the constant assessment of the

relationship between knowledge and the ways of doing knowledge (Calas & Smirich,

1992, p.240). Avelsson and Skoldberg (2000) suggest that in order to conduct research in

a reflexive way one must "pay serious attention to the way different kinds of linguistic, social, political and theoretical elements are woven together in the knowledge-development process, during which empirical material is constructed, interpreted and written" (2008, p.303). A researcher can become more reflexive by creating dialogue about their chosen approaches, being transparent throughout the research process, by actively expanding and considering their interpretive repertoire and by breaking down and challenging their biases (Alvesson & Skoldberg, 2004). This process must take place during the planning of the research project, throughout data collection and during analysis in order for the researcher to consider how the methods and material can be interpreted and re-interpreted. To avoid becoming mired in the endless number of lenses and methods which could be applied to a given project, Alvesson and Skoldberg (2004) suggest that a researcher has to be discerning and not consider all approaches as necessarily good or 'true' but rather chose those that logically match the empirical data and offer potential for "breaking new ground in terms of insights or theoretical ideas" (p.305). Given that no previous studies have been conducted on HIV prevention and harm reduction policies in Nova Scotia as they relate to women who inject drug use, the use of Walt and Gilson's Policy Triangle Framework with an embedded gender component offers a unique approach to understanding policy development and implementation through both system-based and gender-based lenses.

Considering that research is never "neutral, apolitical or ideology-free", and researchers are not "autonomous or value-free" (Alvesson & Skoldberg, 2004, p.9), it was essential to use a reflexive approach to situate researcher bias and recognize the

significance of how political and personal this topic of study was for both the researcher and the participants. For example, the following assumptions were part of the development of this project:

- That women who inject drugs in Nova Scotia may be poorly served by HIV prevention and harm reduction policy;

- That efforts should be made to explore whether women's needs are addressed by HIV prevention and harm reduction policy to redress potential inequities;

- That policies can prioritize, address and direct resources towards HIV prevention for women who inject drugs; and

- That document analysis and interview data analysis can potentially create new knowledge which will inform better policy development and implementation.

4.2.3 The Case Study

Case studies have long been used in the fields of sociology and ethics (Yin, 2003; Beauchamp & Steinbock, 1999) to create an in-depth, real-life, context-specific examination of an event or phenomenon (Lincoln & Guba, 1979/2000; Yin, 2003). Case study methodology provides a systematic way of singling out an event, collecting data on it, analyzing information and reporting the results. This method stipulates that a situation can best be understood if its analysis incorporates the meanings assigned to the situation by the actors involved (Hamel, Dufour & Fortin, 1993).

Although this study presents an in-depth investigation of the real-life context of HIV prevention and harm reduction policy development and implementation, it is not methodologically a case study in the strictest sense, as it was not longitudinal, does not

involve participant observation, does not have a pre-determined start point and end point and does not try to establish causality (Yin, 2004). Instead it represents a 'short horizon' approach which is sometimes necessary and appropriate to be responsive to fast moving political circumstances (i.e. political party turnover) (Walt & Gilson, 2008). A full case study methodology for policy evaluation would have required a longer timeframe than was available to the researcher. Sabatier (2007) has said that policy evaluation requires 'a decade or more' to fully comprehend policy cycles. In a field with high employee turnover rates, it would have been difficult to obtain key informants with the institutional memory to provide historical context to the issues of interest in this study. Therefore, this study took the position that the current political and economic context surrounding harm reduction and injection drug use in Canada presents a unique and dynamic period in Canada's health policy history which should be studied.

As discussed in Chapter One, the development and implementation of provincial HIV prevention and harm reduction policy have not been studied in Nova Scotia and warrant a focused inquiry. HIV prevention and harm reduction policy that is Nova Scotia-specific is either lacking (provincial drug strategy) or in the case of the two primary HIV policy documents nearly ten years old. In this project, Nova Scotia served as the geographical boundary that defined the study location and determined who would be interviewed as key informants. This particular case location was used as a springboard to discuss broader issues such as concerns with the role of Federal Conservative Government in responding to HIV prevention among injection drug users and conceptual questions about

the evolution of gender-based analysis and system theory as lenses to inform HIV prevention policy.

4.3 Methods

4.3.1 Literature Review

One of the four components of the Policy Triangle Framework is developing an understanding of policy within its context. As such, it was crucial that this study explore the historical and political contexts surrounding HIV prevention and harm reduction policy in Nova Scotia, so that this information was taken into account when analyzing the data. In order to obtain this information, policy documents, reports and research articles on HIV prevention and harm reduction in both Canada and more specifically Nova Scotia were located, followed by materials identified in their reference sections. This was followed by an internet search, which drew heavily on the Government of Canada and the Nova Scotia Government's websites and included all key literature related to national and provincial HIV prevention and harm reduction policy and programming. The final draft of the literature review was examined by the researcher's supervisory committee members, who have extensive expertise in the field of HIV and harm reduction policy and programming in Canada, addictions and health policy.

4.3.2 Document Analysis

The purpose of the policy document review was to:

1. Create a descriptive account of the relevant components of Nova Scotia's policy response to HIV/AIDS prevention among people who inject drugs; and

2. Provide context for analysis of the key informant interview data.

The first phase of document analysis involved a review of key policy documents published by the Government of Canada and the Nova Scotian Government on HIV prevention, harm reduction and addiction management. This phase was used to create context for a greater understanding of the Nova Scotian documents. The next phase involved focusing on provincial documents and analyzing them using the theoretical framework.

The purpose of examining provincial HIV and drug policies was to determine if viewing these documents through the lenses of Walt and Gilson's Policy Triangle Framework and gender-based analysis would not only change how we interpret the documents, but also provide information on how these documents could be framed to better meet the needs of women who inject drugs. Two provincial key policy documents: the Nova Scotia Strategy on HIV/AIDS (Nova Scotia Advisory Commission on HIV/AIDS, 2003) and the Standards for Blood Borne Pathogens Prevention Services in Nova Scotia (Department of Health Promotion and Protection, 2004); and one report (Environmental Scan of Injection Drug Use, Related Infectious Diseases, High-risk Behaviours, and Relevant Programming in Atlantic Canada (PHAC, 2006) were routinely suggested by the participants as the key policies and research report that address the HIV prevention needs of women who inject drugs in Nova Scotia. A fourth document, the Best Practices for Preventing Substance Use Problems in Nova Scotia (2008) published by the provincial Department of Health and Wellness's Addiction Services was

mentioned only by one participant, but was included in the document analysis due to its relevance to the topic (see Appendix C for a complete list of the policy documents and research reports reviewed). Guided by the study's modified Policy Triangle Framework, the documents were read with the following questions in mind:

- Who appears to have been involved in the development of this document? Were any relevant stakeholders not involved?

- Do these documents adopt a theoretical framework or approach and do they state values?

- How are the HIV prevention needs of people who inject drugs presented?

- What do these documents say they will do to address the HIV prevention needs of people who inject drugs?

- Were priorities or decisions justified and operationalized?

- Do these documents discuss harm reduction and if so, how is it presented?

- Do these documents discuss gender and if so, how is it presented?

- Are there gaps or disconnects between what is presented in these policy documents and the existing evidence-base on HIV prevention for women who inject drugs?

4.3.3 Key Informant Interviews

The goal for this component of the study was to obtain a sample of key informants from community-based organizations and government departments who participate in policy development and implementation which pertains to either HIV prevention and/or harm reduction for women who inject drugs in Nova Scotia.

a. Recruitment

Both purposive and snowball sampling were used to inform the recruitment strategy. Purposive sampling involves purposefully choosing a sample based on expertise on a particular research topic (Patton, 2000). Snowball sampling is a referral method used to find additional people with specific information on a particular topic who may not have been included through purposive sampling (Goodman, 1961). This approach is referred to as snowball sampling because as more relationships are built through referral, more participants are added to the group increasing the overall size of the group. Specifically, locating relevant participants was initiated by conducting an internet search for HIV/AIDS-specific organizations (ASOs) and by looking at an environmental scan of agencies doing HIV and HCV work conducted by the Atlantic Interdisciplinary Research Network (AIRN) in 2006. In addition, the Nova Scotia Advisory Commission on AIDS was asked for recommendations for government-based staff working in the departments with either an HIV or addictions component to their mandate. The preliminary search yielded a list of 29 potential key informant participants, of whom 16 were government staff and 13 were non-government, community-based staff. It was important to include representatives from both government and non-government agencies in order to compare and contrast their experiences of being involved in HIV prevention and/or harm reduction policy decision-making. Because Nova Scotia is a small province with a relatively low incidence of HIV, the number of individuals employed in work that involves HIV prevention policy is small. As such, it was reasonable to anticipate being able to talk to everyone involved; an objective which

would be difficult in a larger province. Potential participants were sent invitations to participate via email (see Appendix D) and follow-up calls were made one week later.

b. Interview Guide

A semi-structured interview guide modeled after Walt and Gilson's Policy Triangle Framework (inclusive of sections on people, content, process and context) was used in this study for key informant interviews (see Appendix E). Although an interview guide was prepared to ensure that participants were generally asked the same information, the use of probes provided the flexibility necessary to adapt the interview guide and explore different topics when introduced by participants.

Due to the anticipated volume of data collected through interviewing for this thesis, interviewees were asked to provide permission to the researcher to audio-tape interviews. This method of data recording held important advantages in regards to being able to focus on the interview and not lose valuable quotes or nuance around tone. However, this choice is debated in the literature as some researchers favour note taking because it is seen as less intrusive specifically when discussing topics that are political or personal (Lincoln & 1985). Because this research topic was focused on contested and politically sensitive issues, it is possible that the visible reminder of being audio-recorded and subsequently quoted (even with the assurance of a pseudonym) may have made some participants more reticent to discuss their opinions or experiences freely and without the need for self-censorship. For this reason, member checking was also used to facilitate participant comfort with, and feedback on, the data collected through interviews.

c. Member Checking

Member checking is a technique used in qualitative data collection to elicit feedback and alternative explanations from participants that can add to the reflexivity of the project. Member checking is used to help improve the accuracy, validity, and credibility of a study (Lincoln & Guba, 1985). In this study, individual participants were offered a copy of their personal interview transcript for review. Each participant was given an opportunity to review and discuss both the transcript and its interpretation prior to publication in the final dissertation. The participants' comments and feedback served as a check on the reliability of the researcher's interpretation of the findings. Member checks help to decrease the incidence of incorrect data or interpretation (Lincoln & Guba, 1985). Member checking also provides an opportunity to gather additional, volunteered information from participants which might uncover, confirm or challenge aspect of the analysis. The quality of member checks can be impacted by the relationship and level of trust that exists between the researcher and the participant or by circumstances which may have changed since the initial interview (Bryman, 1988). For example, a participant might not have the confidence to counter when his or her opinion is questioned or a participant might feel differently about the project after having additional time to reflect on the issues discussed. Nonetheless, it is useful to include member checking in qualitative research studies to avoid 'one sided interpretation', increase trustworthiness and minimize distortions in the data (Bryman, 1988). In addition, it provides an opportunity to summarize and discuss preliminary findings, lessens the risk of participants later reporting that they were misunderstood, and provides an opportunity for both the researcher and participant to practice reflexivity (Lincoln & Guba, 1985). In this

study, participants who consented were sent a transcript of their interview and when requested, a summary of how their responses were interpreted.

d. Data Analysis

Bogdan and Biklen define qualitative data analysis as "working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others" (1982, p. 145).

Analysis of the interview findings started during the transcription phase of the research study. All transcripts were typed by the researcher to facilitate a familiarization with their content. To avoid losing data in the process of translating audio to text, notes were kept on tone, voice inflections and body language to ensure transcription quality (Poland, 1995). Each transcript, along with its corresponding notes, was uploaded into a data management software program called Atlas Ti once it was transcribed.

The next step in data analysis involved 'open coding'. Open coding refers to the identification of emerging themes from raw data (Strauss and Corbin, 1990). Once the interviews were transcribed, they were printed and read in their entirety in order to get a sense of the similarities and variations in the data. They were then re-read with comments reflecting initial impressions made in the margins. On the third 'read through' conceptual categories were identified and tentatively named.

After first impressions of the data and its themes were formed, the Atlas Ti data management software program was used to lend more structure to coding and analysis. Specifically, Atlas Ti helped with the development of an audit trail for tracking the speaker and the context of themes and specific quotes. The next step involved conducting thematic analysis as proposed by Ryan and Bernard (2003). This procedure involved generating themes from text through a process of interpretation completed using pre-determined steps. Specifically, it involves de-constructing the text in order to identify patterns through repeated words, phrases, sentences, stories, examples or metaphors. This helps the researcher detect categories revealed by participants that are independent of the researchers preconceived ideas and may reinforce, contradict or expand understanding of a particular topic. Data were additionally analyzed in relation to sex and job sector within the final participant group. The next stage of analysis involved re-examining the themes and looking for linkages between themes. This process is called 'axial coding' and is used to help a researcher assemble the data into meaningful arrangements that contribute to an understanding of both the details of the phenomenon and the ramifications of the phenomenon (Strauss and Corbin, 1990). Data analysis over several months involved repeatedly going through the transcripts and simultaneously coding and re-coding based on the use of three interpretive approaches: 1) thematic analysis; 2) Walt and Gilson's Policy Triangle Framework; and 3) Gender-Based Analysis. No conflicts were identified as a result of combining these three interpretive approaches.

4.4 Ethical Considerations

Ethical approval for the research was obtained from Dalhousie University's Research Ethics Board (REB) in January 2010.

4.4.1 Compensation

Individuals who participated in this study were offered a one-time $25 honorarium to compensate them for time spent away from their other responsibilities.

4.4.2 Informed Consent

In keeping with the Tri-Council Policy Statement on informed consent, each participant was provided with a copy of the Consent Form and asked to read it prior to commencing the interview to ensure they were clear about all specific elements of the study. Participants' questions were then answered prior to beginning each interview. For individuals participating over the phone, the consent form was read aloud and verbal consent was obtained. Verbal consent from participants was noted on the final page of each consent form for telephone interviews and written or verbal consent was obtained during face-to-face interviews. Prior to beginning an interview, participants were asked whether they consented to having their interview audio-taped. Their responses were recorded on the consent form. Twenty-five of the 27 key informants consented to having his or her interview audiotaped. Detailed notes were taken on the remaining two participants' responses, body language and tone. Prior to commencing the interviews and once again after each interview was completed, participants were asked if they agreed to have direct quotes from their interview used in publications and presentations. All

participants consented and their consent was recorded. Participants were additionally asked if they could be contacted for member checking and if they wished to receive an executive summary of the final report. A copy of the consent form is attached in Appendix F.

4.4.3 Confidentiality and Anonymity

At the beginning of each interview, the researcher discussed her inability to guarantee anonymity with participants, as the community of individuals working in this field is small and very familiar with one another. Because of this, many individuals made assumptions about who would be interviewed and gave suggestions for people to interview. Because of the fact that some individuals might perceive their responses as 'career limiting or endangering', it was decided before the study commenced that no one would be asked if they would like to be acknowledged for taking part in the study. All participants were told their quotes would be assigned a pseudonym in any publications and no one asked to be acknowledged. It was important to consider how the study community might be influenced by the results of the study or whether a breach in confidentiality could affect an individual's standing in the community or their job.

4.5 Overview of Participant Characteristics

The final participant group included representatives from Nova Scotia's 5 HIV-focused organizations as well as representatives from the Nova Scotia Department of Health and Wellness. Other participants came from agencies that work directly or indirectly with women who inject drugs, including government Addiction Services at the

District Health Authority level, community-based needle exchanges, opiate substitution programs (private and government), women's shelters, sexual health clinics, a sex worker support group, an outreach nursing program, and the provincial prison system. The final group was composed of 27 individuals: 13 government representatives (9 female/4 male, 4 HIV-focused/7 Addictions-focused/1 Infectious Disease-focused/1 Corrections-focused) and 14 non-government, community-based representatives (10 female/4 male, 5 HIV-focused/4 Addictions-focused/5 Street Health-focused). Two participants represented the needs of Aboriginal women, 2 participants represented the needs of young women and 1 participant represented the needs of Black Nova Scotian women. The majority of participants worked within the Halifax Regional Municipality, however, seven individuals working outside of HRM were interviewed: 3 individuals from Cape Breton Island, 2 individuals from Northern Nova Scotia, one individual from the Annapolis Valley and one individual from the South Shore.

4.6 Introduction to the Findings

The findings are organized in relation to the three research objectives and the key arguments that formed when interpreting participants' answers to these questions.

The first findings chapter, Chapter Five describes the key organizations involved with HIV prevention and harm reduction policy decision-making for people who inject drugs in Nova Scotia. The chapter provides a descriptive account of the current network of organizations involved in this work, including information on how these organizations are funded, program user characteristics (where relevant) and how they fit together to

form a network. The key finding for this research question is that a fairly large (given the size of Nova Scotia), variable group of stakeholders influence HIV prevention policy in Nova Scotia, many of whom have different degrees of focus on HIV or injection drug use and none of whom have a mandate or the resources to do gender-informed work.

Chapter Six describes the key HIV prevention and harm reduction policies in Nova Scotia, how they were developed and how they address the needs of women who inject drugs. The primary finding in this chapter is that policy decision-making processes and the resultant policy content are variable and depend on the specific policy and the players that are sitting at the table. The policies themselves are generally supportive of harm reduction, but without nuance or consideration of gender. The lack of a provincial drug policy limits the discourse around harm reduction and HIV prevention for women who inject drugs. In addition, power differentials within policy development committees negatively impact policy development processes.

Chapter Seven describes participants' understanding of the barriers and facilitators to the development and implementation of HIV prevention policy for women who inject drugs in Nova Scotia. Six barriers and two facilitators were identified that influence the development and implementation of HIV prevention and harm reduction policy that addresses the needs of women who inject drugs in Nova Scotia.

Summary

This project was a qualitative study conducted in Nova Scotia to explore the development and implementation of provincial HIV prevention and harm reduction policies for women who inject drugs. This study used a reflexive methodological approach to conduct document review and key informant interviews. These methodological approaches and tools allowed for the creation of an in-depth, context-specific examination of the network of organizations involved in HIV prevention and harm reduction policy development in Nova Scotia. Walt and Gilson's Policy Triangle Framework (1994) was embedded with a gender-based analysis lens to guide the study, most especially through its influence on the development of the interview guide and as a lens for data analysis. This chapter provided detailed information on the methodology and specific methods used in this study and concluded with an introduction to general participant characteristics and the study's findings which will be revealed throughout the following three chapters.

CHAPTER FIVE: An Overview of Key Organizations Involved in Nova Scotia's HIV Prevention and Harm Reduction Policy Network

This chapter addresses the first research question which asked: what are the key organizations involved with HIV prevention harm reduction policy decision-making for people who inject drugs in Nova Scotia? The chapter introduces the network of key organizations that have been involved in HIV prevention and harm reduction policy-making for people who inject drugs in Nova Scotia. The network is composed of a number of government and non-government organizations that have an array of mandates and varying degrees of involvement with HIV policy. It includes those groups who participated in this study through key informant interviews and who described themselves as the primary stakeholder groups. The key informants interviewed are not representative of the complete network, which at different times includes a number of other organizations such as the Department of Education and the Department of Labour. However, it does include key organizations that have been instrumental in the creation of HIV prevention and harm reduction policy for Nova Scotia.

5.1 The HIV Prevention and Harm Reduction Policy Network

This section offers an introduction to the key stakeholder organizations included in this study that have been involved in HIV prevention and harm reduction policy work in Nova Scotia for people who inject drugs. This network can be divided into four unique groups: HIV-focused organizations, drug-focused organizations, justice-focused organizations, and health and social service organizations that may work with people who

inject drugs. The following descriptions came from two sources: key informant interviews and the print materials and website content for the various organizations.

5.1.1 HIV-Focused Organizations in Nova Scotia

Nova Scotia has six HIV-focused organizations. Four of these organizations are community-based AIDS Service Organizations (ASOs): the AIDS Coalition of Nova Scotia (ACNS), the AIDS Coalition of Cape Breton (ACCB), the Northern AIDS Connection Society (NACS), and Healing Our Nations (HON). Two of the organizations are government-based, HIV-specific organizations: the Nova Scotia Advisory Commission on AIDS (NSAC) and the Atlantic Region Office of PHAC's AIDS Community Action Programme (ACAP).

a. Community-based Organizations

The AIDS Coalition of Nova Scotia (ACNS) is the primary, provincially-mandated ASO for the province. ACNS serves as the main information and programming resource for people living with HIV/AIDS in Nova Scotia. ACNS is the direct descendant of the original HIV movement in Nova Scotia and is still known for focusing on Nova Scotia's gay male population. According to several participants, ACNS is not a primary programming resource for women or the injection drug using population and does not house a needle exchange program.

The AIDS Coalition of Cape Breton (ACCB) is a community-based ASO located in Sydney, Cape Breton. ACCB has become a source of both information and

programming for people living with HIV/AIDS and the primary resource for harm reduction information and programs for Cape Breton Island. This organization provides needle exchange services through an in-house needle exchange office, a mobile needle exchange service and a peer distribution system across Cape Breton. ACCB does not offer gender-specific programming, but according to two key informants, more women who inject drugs are now using its needle exchange program. One key informant explained that an increasing number of women have been introduced to the needle exchange program through their male drug using partners in recent years.

The Northern AIDS Connection Society is a community-based ASO located in Truro, a town in central Nova Scotia with a population of 12,500 people (Census Canada, 2011). NACS serves clients throughout northern Nova Scotia. Employees conduct approximately 200 HIV education workshops and presentations each year to youth, college students, and prison inmates (including inmates at the women's federal prison, located in Truro). The organization houses an 'informal, but police supported' needle exchange, in partnership with Mainline Needle Exchange's outreach program and refers clients to a local government-run methadone program. According to one key informant, NACS has in the last two years become more interested in addictions and HIV prevention due to an environmental scan they conducted which identified pockets of drug use in their region.

Healing Our Nations (HON) is a community-based ASO formed in 1993 to work with people who are of First Nations descent, to prevent HIV and to support those living

with HIV/AIDS. HON have three staff members who travel across Atlantic Canada to conduct prevention workshops. The educational workshops focus on cross-cultural sensitivity, HIV, HCV and other sexually transmitted infections. HON does not house a needle exchange, but they provide referrals to needle exchange programs. HON is not currently engaged in targeted programming with injection drug users. However, according to two key informants, addiction is discussed in all presentations.[1] According to many key informants HON is currently the only organization in Nova Scotia that has a mandate to address HIV among an ethnic minority group[2].

b. Government-based Organizations

In addition to the community-based ASOs, there are two government-based HIV-specific organizations in Nova Scotia: the NS Advisory Commission on AIDS (NSAC) and the local office of the AIDS Community Action Program (ACAP). Located in Halifax, the NSAC is an 'arms-length' organization funded by the provincial government. The primary mandate of this organization is to advise the provincial government on HIV-related issues as well as manage and support the implementation of the Nova Scotia Strategy on HIV/AIDS. Key informants at NSAC indicated that this

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[1] Key informants indicated that they are currently experiencing a resistance within the Aboriginal Community in Atlantic Canada to openly discuss HIV and drug addiction. As a result, efforts are made to embed these discussions in more general presentations about health and well-being.

[2] According to several key informants, Nova Scotia does not have an HIV organization specifically by or for the African Nova Scotian community or any other ethnic or cultural group beyond Healing Our Nations. A 2006 report funded by the NSAC looked at ways to promote HIV/AIDS awareness in Black communities in Nova Scotia. This report found that racism, social isolation and racially insensitive services were creating significant barriers to the development and delivery of HIV programs and services to the African Nova Scotian community (David Divine, James R. Johnston Chair in Black Canadian Studies, 2006). In 2010, the Advisory Commission on AIDS focused on the theme of Black Communities and HIV and organized a panel on HIV in the Black Nova Scotian Community as part of their annual HIV/AIDS Awareness Week activities. This panel was seen as a way to bring attention to the issue of HIV in the black community, but was limited in its scope and impact as a week-long program. At present the Health Association of African Canadians (HAAC) is working on developing an HIV/AIDS project in Nova Scotia.

organization is most directly responsible for developing HIV/AIDS policy for the province.

The AIDS Community Action Program (ACAP) is the funding component of the Canadian Strategy on HIV/AIDS: Moving Forward Together, which is the federal government's framework to respond to AIDS in Canada. ACAP provides operational funding for programs in Atlantic Canada that are focused on HIV prevention, care, treatment and support. Currently ACAP provides direct operational funding to ACNS, ACCB and HON and indirect funding to NACS through an ACNS capacity building partnership. ACAP employees currently receive gender-based analysis training, but according to one key informant, current funding applications do not require applicant organizations to include gender-based analysis or gender-specific programming.

c. Government Organizations with Blood Borne Infection Prevention Mandates

The Infection Prevention and Control Program within the provincial Department of Health is also involved in HIV work through surveillance, legislation and public health outbreak management, but do not play a primary role in HIV prevention among people who inject drugs. According to one key informant, they do work with public health nurses through DHA offices on contact tracing when someone is diagnosed with HIV. HIV surveillance data are sex-disaggregated, but are combined for Nova Scotia and Prince Edward Island and do not capture data on people who were diagnosed with HIV outside of the province. Provincial government surveillance data on injection drug use behaviours related to HIV- and HCV-risk are gathered infrequently in the form of scans

conducted with community-based drug-focused organizations, but these data are limited to general trends that are often reported without gender-specificity. Individuals from the Infection Prevention and Control Program were members on the Coordinating Committee for one of Nova Scotia's key HIV prevention and harm reduction policy documents, the Standards for Blood Borne Pathogens Prevention Services in Nova Scotia.

5.1. 2 Drug-Focused Organizations in Nova Scotia

There are three community-based, drug-focused organizations and one government-based drug organizations (divided across 9 DHAs) involved in HIV prevention policy development in the province of Nova Scotia.

a. Community-based Organizations

The community-based organizations are located primarily in Halifax and Sydney and include needle exchange programs which offer mobile outreach services and community-based opioid substitution programs. There are two community-based, fixed site needle exchange programs in Nova Scotia: Mainline Needle Exchange and Sharp Advice Needle Exchange, located in Halifax and Sydney, Cape Breton, respectively. Both agencies distribute harm reduction information and equipment to reduce the spread of HIV, HCV and other blood borne infections, provide vein care education, HIV and HCV testing, conduct educational programming, counseling, referrals, and carry out advocacy work with government drug treatment programs, social services, housing, the criminal justice system, food banks, furniture banks, and landlords. In addition, both organizations provide mobile and peer outreach to other parts of the province, with

Mainline serving mainland Nova Scotia and Sharp Advice covering Cape Breton. Although both agencies were originally created to work with injecting drug users, they have many other drug-using clients. Mainline has been giving out safer crack smoking kits for eight years; Sharp Advice has been lobbying for the resources and support necessary to provide safer crack kits, but currently lack the necessary community stakeholder support. According to key informants, most of their clients are male, however the number of female clients has been increasing over the years. They have attempted to provide women-specific programming at various times, with little success due to low attendance.

Halifax also hosts one community-based low-threshold methadone maintenance program, Direction 180. Direction 180 has been open since 2001 and is located in downtown Halifax. They currently treat approximately 180 program users and have an extensive waitlist. They offer many support services and have been involved in over 25 research projects since opening. They have attempted to create an injection drug user network, as well as offer women-specific programming with limited success.

b. Government-based Organizations

The Provincial Department of Health and Wellness has an Addiction Services Department that oversees and manages policy, funding, research and programming related to substance abuse, alcoholism and gambling for the province. Service delivery of government-based addiction services programming is administered by the 9 individual District Health Authorities (see Appendix A for a DHA map) and the number of services

and their size is based on population size, funding and identified regional need. Community-based government programs are available in each region, however specialized services, such as opiate substitution, detoxification and residential rehabilitation facilities are only available in some regions. This department does not provide needle exchange services.

According to three key informants, Addiction Services' client base has traditionally been primarily male. However one informant also mentioned that in 2002 after the provincial government provided monies specifically for Addictions programming for rural women, Addiction Services client base became closer to 60% men, 40% women.

Addiction Services currently offers women-specific addiction education and prevention workshops and counseling, which tend to attract women with alcohol and prescription drug addiction issues, and rarely those who are street-involved or using injection drugs. As one participant explained, because Addiction Services do not offer needle exchange programming and their programs are generally not located as "store-front" services in high traffic drug use neighbourhoods, they work less with people who inject drugs. Their contact with this population is generally confined to detoxification programming and methadone maintenance programming and generally does not include a direct HIV prevention component. Addiction Services is more often represented on policy committee work by members of the provincial government department, rather than the individual DHA departments.

5.1.3 Justice-Focused Organizations

The Department of Justice's Correctional Services have been represented on HIV and harm reduction policy committees by members of their Offender Health Services team. Offender Health Services are the health services provider teams in each of the three primary prisons and two holding facilities in Nova Scotia. They are a health-focused organization within the larger justice-based organization. The provincial prison appears to have less capacity and fewer harm reduction resources relative to the federal prisons, which provide formal detoxification and methadone maintenance programming. As one participant explained, the detoxification unit in the provincial prison is not comparable to those outside of prison, in terms of dedicated space and formal support, nor is the provision of methadone; an inmate of the provincial prison will not be provided with methadone maintenance treatment unless she or he initiated this treatment prior to entering prison. None of the prisons located in Nova Scotia offer official needle exchange programs and, according to local researchers, condom access is limited (Gahagan & Rehman, 2004). Police officers were described by participants as working with community-based workers and government workers on drug-related working groups at the community level, but are rarely involved in provincial HIV or harm reduction policy development. The Department of Justice, which oversees the Department of Correctional Services and Policing Services, were one of the lead departments in the development of Nova Scotia's Drug Strategy, however, this document was abandoned before completion. Further details concerning this strategy document and its lack of completion will be described in the following chapter.

5.1.4 Other Stakeholder Organizations

Other stakeholder organizations involved in the HIV prevention and harm reduction policy network, but to a much lesser extent, include women's shelters, housing committees, sexual health clinics, street outreach nurses, and a local sex trade worker support program. Representatives from these organizations indicated that they were often invited to participate on HIV prevention policy committees because several provide services directly to women who inject drugs. However, they argued that they had less involvement and influence on policy decision-making than the HIV-focused, drug-focused and justice-focused organizations. It is noteworthy that Nova Scotia does not have a formal drug user network that participates in policy decision-making, although several community-based organizations have program user feedback mechanisms in place and report on behalf of program users during policy development work.

Summary

A diverse group of organizations shape and influence Nova Scotia's HIV prevention and harm reduction policies. The key organizations represent both government and non-government organizations and can be divided into four primary groups: the HIV-focused organizations, the drug-focused organizations, the justice-focused organizations, and the community-based organizations.

The HIV-focused organizations are involved in HIV policy development, but NSAC is the organization primarily responsible for HIV prevention policy development for the province, as the lead agency on the Nova Scotia Strategy on HIV/AIDS.

The non-governmental drug-focused organizations are regularly involved in HIV prevention or harm reduction policy development and are the primary channel for communicating harm reduction program user perspective. Several of the directors of these organizations have been working in this field for many years and have been involved in the development of several HIV and harm reduction-based policy documents.

The Department of Health and Wellness has a much broader focus beyond HIV, but the Department includes the Addiction Services Program, the Infection Prevention and Control Program and oversees the Departments of Public Health within each District Health Authority, all of whom are involved in HIV programming to varying degrees. Frontline workers in the Department of Health and Wellness interact with people who inject drugs primarily through emergency room visits, detoxification units, methadone maintenance treatment programs and, to a lesser degree, rehabilitation programs. Managers in the departments are involved in HIV policy development and often play leadership roles in these forums, despite being less likely to work with people who inject drugs and less involved in HIV-focused programming.

The Justice Department, through the Correctional Services Program have a significant influence on HIV prevention and harm reduction policy and programming for incarcerated injection drug users in Nova Scotia. Federal prisons in Nova Scotia have a wider range of HIV prevention and harm reduction programs than the provincial prison, but these are limited. None of Nova Scotia's prisons offer official needle exchange programs. Justice-focused stakeholder groups, including the Policing Services

Department and Correctional Services, have had a significant influence on past provincial drug policy and harm reduction programming for incarcerated populations in the province. Only Correctional Services, through their Offender Health Services Department, have been directly represented on provincial blood borne pathogen prevention policy development committees.

Other stakeholders include individuals that provide social and health services to people who inject drugs in the community through organizations such as shelters, street nursing programs and support groups who have a vested interest in HIV prevention and harm reduction policy. The same can be said about local academics who conduct research with people who inject drugs and are regular members of HIV policy development committees. As previously mentioned, Nova Scotia does not have a drug user peer network to provide representation on policy committees, however community-based frontline workers seek client perspectives on programming through a variety of feedback mechanisms.

In summary, none of the organizations included in Nova Scotia's HIV policy network have a specific mandate to create or implement programming specifically for women injecting drug users. Although there have been some efforts to create women-specific programming within these organizations, the clientele that use their services continue to be primarily male. At the same time, community-based, non-government organizations, such as ACCB, Mainline, and Direction 180, do have regular contact with women who inject drugs. These organizations, along with street nurses and private MMT

providers, appear to be well positioned to address women injecting drug users' unique HIV prevention needs. However, it is more often managers in government departments who play leadership roles in HIV and harm reduction policy development, despite being less likely to work directly with people who inject drugs and less involved in HIV-focused programming. As the following chapters demonstrate, all of the organizations involved have been unable to target HIV prevention among women injecting drug users in a systematic way due to a lack of resources. The following chapter identifies how the content of Nova Scotia's HIV and related harm reduction policy documents also includes several gaps that have a direct impact on the provision of harm reduction programming for women who inject drugs in Nova Scotia.

CHAPTER SIX: Nova Scotia's Key HIV Prevention and Harm Reduction Policies - Their Content and Development

This chapter addresses the second research question, which asked: What are the key HIV prevention and harm reduction policies in Nova Scotia, how were they developed and do they address the needs of women who inject drugs? The chapter starts by describing the content of the three key provincial HIV and harm reduction policy documents as they relate to addressing the HIV and harm reduction needs of women who inject drugs. The chapter then compares and contrasts the three key policy documents and discusses other relevant provincial reports and research documents which help inform local knowledge on the HIV prevention needs of women who inject drugs. Lastly, HIV and harm reduction policy development processes are described using data from the policy documents and from the key informant interviews.

6.1 Nova Scotia's Key HIV Prevention and Harm Reduction Policy Documents

This study identified three key provincial HIV or harm reduction policy documents: the Nova Scotia Strategy on HIV/AIDS (2003), the Standards for Blood Borne Pathogens Prevention Services (2004) and Best Practices for Preventing Substance Use Problems in Nova Scotia (2008). This chapter will provide a brief outline of how each document was developed, and consider how each addresses the HIV prevention needs of women who inject drugs in Nova Scotia.

6.1.1 Nova Scotia's Strategy on HIV/AIDS (1993, 1997 and 2003)

The Nova Scotia Strategy on HIV/AIDS was first created in 1993 but since that time has been revised on two separate occasions – 1997 and 2003. In 1997, the NSAC requested funding from the Department of Health (now called the Department of Health and Wellness) and several pharmaceutical companies to renew the document in order to update its content to make it more inclusive of the community perspective and more harmonized with the federal government's Canadian Strategy on HIV/AIDS, which was made public in 1998. The Nova Scotia Strategy on HIV/AIDS was again revised in 2003 based on stakeholder consultations held in 1999-2000 (NS Advisory Commission on AIDS, 2003). The Strategy Steering Committee included the NSCA, the provincial ASOs, representatives from the Department of Health and the District Health Authorities, sexual health clinics, Aboriginal health organizations and one African Canadian health organization.

The consultations held in 1999-2000 resulted in 92 recommendations which were organized under four strategic directions, each of which had its own working group. The four strategic directions are:

1. Mobilize integrated action on HIV/AIDS.

2. Build a broad research and information sharing strategy.

3. Build a coordinated approach to prevention and harm reduction.

4. Build a coordinated approach to care, treatment, and support services.

According to study participants, the NSAC, as the arms-length government department responsible for HIV/AIDS policy development, was tasked with leading the strategy development meetings and establishing the working groups for each of the four strategic directions. Working groups were asked to create action plans and the NSAC was responsible for monitoring and reporting to the Department of Health on the progress of each group. These working groups met quarterly for the first couple of years after the 2003 strategy was published but disbanded in 2006 due to low attendance at meetings.

The Nova Scotia Strategy on HIV/AIDS adopts a population health approach that recognizes the impact of the determinants of health on HIV/AIDS (NSAC, 2003, p. 8). Under their definition of a population health approach, they specifically mention health disparities influenced by income, education, employment, early childhood experiences, social and physical environments, and access to health services. Later in the document, gender and ethno-cultural diversity are also mentioned, but while ethnicity in particular is prioritized and elaborated on at various points in the document, gender is not. People who inject drugs are identified as a priority group based on their social marginalization and risk behaviours, and the Strategy supports harm reduction approaches to HIV prevention among this population. For example, it states that "a province-wide continuum of services, including services based on harm reduction, will build a coordinated and collaborative approach to HIV/AIDS prevention" (p.15). This policy document also specifically discusses the importance of making contact with marginalized populations through harm reduction-based service delivery. It provides an example of a successful harm-reduction-based program model by including a summary of Mainline Needle

Exchange Program's positive evaluation results. Specific subgroups of injection drug users are listed as having unique HIV prevention needs, namely street involved youth and prison inmates.

Despite the recognition of injection drug users as a priority group for HIV prevention in the Strategy and despite the fact that its third strategic direction is 'building a coordinated approach to prevention and harm reduction', the document largely overlooks the specific HIV prevention and harm reduction needs of people who inject drugs in terms of actionable items. For example, the prevention and harm reduction section of the Strategy is heavily focused on providing HIV primary prevention education to youth through the formal education system with little discussion of HIV prevention and harm reduction services to injection drug users. Moreover, responsibility for this harm reduction strategic direction is given to the Department of Health which does not work directly with either students or the majority of injection drug users who access community-based services for harm reduction resources (NSAC, 2003, p. 18). In addition, there is no mention in this section of gender-specific issues as they relate to injection drug use.

a. A Gender-Based Analysis of Nova Scotia's Strategy on HIV/AIDS (2004)

A post-hoc gender-based analysis document was created in 2004 to accompany Nova Scotia's 2003 Strategy on HIV/AIDS (NSAC, 2004). According to study participants, shortly after the 2003 publication of the Nova Scotia Strategy on HIV/AIDS, a few researchers pointed out that the Strategy Steering Committee should have asked

gender-specific questions in the community consultations to inform the strategy, its strategic directions and recommendations. As a result, NSAC worked with the Nova Scotia Advisory Council on the Status of Women to conduct a post-hoc gender-based analysis in an effort to ensure that differences based on gender were recognized and addressed in the Strategy. Since this document was created post-hoc, community consultation meetings could not be reconvened. Therefore, the analysis was based on a limited amount of sex-disaggregated data that the authors were able to locate, and literature regarding gender and the determinants of health. These data were used to inform the Strategy's recommendations, however, the resulting recommendations are very general and the GBA document does not directly address the issue of gender and injection drug use. According to three participants, the GBA document did, however, create a discourse within NSAC and its partner organizations around why this type of analysis should be included in policy documents in the planning and development phases of policy. Although the document ultimately did not discuss the specific HIV-related needs of women who inject drugs, it did discuss how gender and diversity are often systematically overlooked (for example in statistical evidence) (p.2) and presented ways to begin to address this problem (p. 2-13).

6.1.2 Standards for Blood Borne Pathogens Prevention Services (2004)

The Standards for Blood Borne Pathogens Prevention Services policy document was co-published by Public Health and Addiction Services, both within the Nova Scotia Department of Health, and was developed through what participants described as extensive collaborations with government and community (Nova Scotia Department of

Health, 2004). The Standards Development Group Membership list has over forty members from many different organizations and included a Coordinating Committee and five working groups. The five working groups were: Health Education and Social Marketing, Counseling/ Testing and Referral, Needle Exchange, Methadone Maintenance Treatment, and Standards Development/Coordination and Facilitation (p.38). The document promotes evidence-based decision-making, and has an accompanying document to support the standards that it recommends. For example, one recommendation is to consider the importance of social influences on health. This recommendation is supported by research findings that show there is a correlation between the spread of blood borne pathogens and poverty, homelessness, and discrimination (p. 9).

The Standards for Blood Borne Pathogens Prevention policy document explicitly states the necessity of using a harm reduction approach to prevent blood borne pathogen transmission (p.7). Harm reduction is listed in two of the three primary goals of the document (p.2). This document defines and operationalizes the social determinants of health, a population health approach, health promotion and harm reduction (p.6-7). Although the document does mention gender as one of the determinants of health and lists women as a vulnerable population, it does not prioritize gender or provide specific information on how to implement gender or diversity analysis (p.6 & p.40). The document discusses the challenges of providing accessible HIV prevention and harm reduction programs in Nova Scotia's rural communities noting that "people living in rural and remote areas of the province do not have easy access to needle exchange services"

(p.23) and argues for the creation of "reasonable access" to programs as a priority (p.10). Lastly, the document provides a plan for how capacity can be built within government and non-government organizations to facilitate the Standards for Blood Borne Pathogens Prevention's implementation and evaluation (p.10-11). Specifically, it states that DHAs, community-based organizations and the Department of Health will "participate in the development of a provincial health human resource strategy" that will identify core competencies and explore province-wide training opportunities (p.11).

Several key informants described using the Standards for Blood Borne Pathogens document after it was originally published as evidence of best practices in applying for funds, but said that now that it is almost a decade old, it of little use in applications for funding because it considered 'dated'. When representatives from the Department of Health and Wellness were asked if this document would be updated, they replied that since the re-organization of the Department of Health Promotion and Protection into the Department of Health and Wellness in 2011, there was a lack of departmental ownership for the document and that revisiting it was not currently a priority. They also explained that although it was listed in the Department's work plan, it did not have an allocated budget. ACCB, in collaboration with their local DHA have decided to reinvigorate this document in their region in response to the perceived need to address local drug use and its health impacts, specifically around blood borne pathogens. They have recently hired a coordinator to lead this project. This development is encouraging as a step to address the needs of people who inject drugs in Cape Breton, but may not be as relevant to women who inject drugs if gender and diversity analysis are not considered.

6.1.3 Best Practices for Preventing Substance Use Problems in Nova Scotia (2008)

This best practices document was written exclusively by an out-of-province research consultancy group hired by the Department of Health Protection and Promotion, and was reviewed by officials of Addiction Services, the Department of Health Promotion and Protection, and the District Health Authorities. This document was mentioned by only one participant in this study and is not considered by many participants as a 'key' harm reduction document. It is, however, one of the Government of Nova Scotia's two harm reduction policy documents that specifically addresses injection drug use (PHAC, 2008). The document includes harm reduction as one of its three best practice strategies for reducing substance abuse, alongside supply and demand reduction approaches (p.10). The Best Practices document operationalizes prevention as "preventing, delaying or reducing use or hazardous use through supply and demand reduction activities and by reducing the negative consequences of use through harm reduction activities" (p. 7). Of interest to this study, the document recommends the introduction of province-wide needle exchange programs saying they should be "fully available". However, needle exchange programming is not currently offered by Addiction Services despite government office locations all across the province which could possibly help expand needle exchange accessibility beyond the current two fixed-site non-government programs (p. 56). The Best Practices document also recommends offering supervised consumption facilities, heroin prescribing and housing programs for drug users within "a rigorous research framework" (p.46). According to participants, none of these three harm reduction approaches have ever been seriously considered

within the province. The document does not discuss methadone maintenance or needle exchange outreach through formal or informal (peer-based) networks.

As previously mentioned, only one participant listed the Best Practices document as a 'key' provincial harm reduction policy document. However, it is a government policy document that provides evidence to support harm reduction programming.

6.2 Comparing Nova Scotia's Three 'Key' Provincial HIV Prevention and Harm Reduction Policy Documents

Of the three documents, the Standards for Blood Borne Pathogens Prevention and the Nova Scotia Strategy for HIV/AIDS were routinely listed as the 'key' provincial HIV prevention and harm reduction policy documents by the majority of participants. Participants argued that the Standards for Blood Borne Pathogens Prevention document has the most potential for improving HIV prevention programs for people who inject drugs in Nova Scotia based on its focus and commitment to promoting a harm reduction-based approach to blood borne pathogen prevention specifically for this group. For example, two participants who work directly with people who inject drugs stated that this is the policy document that they have used in the past to advocate for increased resources for people who inject drugs. However, like the Nova Scotia Strategy on HIV/AIDS, several participants explained that the Standards for Blood Borne Pathogens Prevention have not been adequately implemented. This was attributed to a lack of funding, ownership and political will. Also, this document recognizes the importance of gender

but does not prioritize or operationalize it, which makes it less adept at responding to the diverse needs of women who inject drugs.

The Best Practices for Preventing Substance Use Problems in Nova Scotia document was not considered a 'key' HIV prevention or harm reduction policy document by the majority of participants, but is included because it is a government HIV prevention and harm reduction policy that speaks to issues related to injection drug use. Similar to the other policy documents, the Best Practices document recommends an increase in inter-departmental and inter-agency collaboration and joint action, but does not provide best practice directives for this work. Nor does the Best Practices document discuss any of the context-specific challenges which exist to the implementation of harm reduction programs in Nova Scotia (i.e., lack of funding) which could help explain why its evidence-based 'best practices' recommendations have largely been unimplemented. Similarly to the other documents, the Best Practices document identifies gender as an important determinant of health, but it does not address the intersection between gender and harm reduction or drug use, or discuss the importance of consideration of gender when developing policies.

6.3 Other Policy-Relevant Documents

Research centers in Nova Scotia such as the Atlantic Health Promotion Research Centre (AHPRC) and the Atlantic Centre of Excellence for Women's Health (ACEWH) have each carried out research specifically looking at HIV, HCV and harm reduction (Jackson et al., 2011; Parker et al., 2011; Jackson et al., 2010; ACEWH & AIRN, 2003).

Additionally, individual researchers have united through Atlantic Interdisciplinary Research Network on the Social and Behavioral Issues in Hepatitis C and HIV (AIRN) to carry out HIV and HCV-specific research across the region (AIRN, 2003, 2006 & 2010). This group of academics works closely with community groups to conduct policy scans, needs assessment, environmental scans and research in areas of primary and secondary HIV prevention, HCV prevention and harm reduction (AIRN, 2003, 2006 & 2010).

There have been several key research projects conducted in Nova Scotia by government, non-government and academics which are relevant to HIV prevention policy development and women who inject drugs. For example, an 'environmental scan' was conducted in 2006 regarding the needs of people who inject drugs (PHAC, 2006). This document was published by the Public Health Agency of Canada's Atlantic Regional Office and is based on extensive consultations with service providers who work directly with people who inject drugs. It updates a similar study that was conducted in 2000 (PHAC, 2000), providing an Atlantic Canada-specific snapshot of HIV and hepatitis C risk behaviours among people who inject drugs that can be used to determine priorities for action and inter-sectoral collaboration. Additionally, it strengthens the evidence-base in relation to the need for harm reduction policies by providing specific evidence on the high-risk injection and sexual behaviours of people who inject drugs in Atlantic Canada (p.19-23). For example, the majority (60%) of injection drug users interviewed in this study indicated that they know that sharing needles and equipment occurs within their community and that there is an increasing tendency for people who use injection drugs to inject together in 'shooting galleries' (p.20). Because regional patterns of drug use

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change regularly, two community-based participants stated they hoped that this document would be routinely updated in order to continue to monitor these developments. Several Dalhousie University researchers and students have also conducted research with women and men who inject drugs in Nova Scotia, providing insight into their HIV prevention needs. These studies have found that access to harm reduction programming is generally lacking in the province (Gahagan, Rehman, & DiCenso, 2003; Jackson et al., 2002, Jackson et al., 2010; Parker et al., 2011; Hodder, 2011).

6.4 Failed Policy Development

Nova Scotia does not currently have a drug strategy. As described by multiple participants in this study, a provincial drug strategy was being developed over the course of several years through collaborative work between the Department of Justice and the Department of Health Promotion and Protection. This strategy was abandoned despite the numerous resources dedicated to developing it prior to 2006. Although none of the government representatives included in this study were able to describe exactly what happened to the strategy, several key informants explained that it was originally based on a four pillar model for drug control that included harm reduction, but when the Federal Conservative Government came into power in 2006, its development was taken over by the Department of Justice and eventually shelved before completion. According to several key informants, the abandonment of the incomplete Drug Strategy meant a lost opportunity to create a formal Health and Justice partnership around drug policy in Nova Scotia. Both departments are now working on drug policy issues separately.

6.5 Policy under Development

In March, 2010, the Nova Scotia Government announced that it would be developing a Mental Health and Addictions Strategy Project to address concerns raised in the Auditor General's report earlier that year regarding limited access to services for Nova Scotians with mental health issues. This strategy is being drafted with the help of the Nova Scotia Health Research Foundation. At the time of data collection for this study, public forums were being held to discuss the content and direction of this document. Some of the key informants interviewed in this study expressed concern that they had not been formally involved in the strategy. Several people within Addiction Services felt that there are too few addictions experts on the strategy committee. Some participants maintained that there should be a stand-alone drug or addictions strategy and that combining mental health and addictions into one document would limit the breadth that could be addressed in either field. Some participants felt that it would ultimately be a mental health strategy with an insufficient addictions component.

6.6 HIV and Harm Reduction Policy Development Processes

During the key informant interviews, participants were asked specific questions regarding HIV prevention and harm reduction policy development processes. Many participants had little to say about these processes because, as they explained, policy work happened so infrequently and policy recommendations were implemented so slowly, that policy processes were of little relevance to their daily work. Community-based participants in particular wanted to shift the conversation towards talking about the

current needs of their program users and the challenges they experience in meeting these needs.

Most of the participants in this study indicated that provincial HIV policy development was typically government-initiated and primarily government-led, and included the voluntary involvement of a large number of network members from both government departments and the community. The process of policy development was described as formal and generally involving working groups and community/stakeholder consultation meetings to be followed up by a lead government agency writing and distributing the final policy document. A number of participants indicated that the three key provincial government policy documents mentioned above took approximately 2-3 years to create. They gave a number of reasons for this long policy development process, including the fact that many of the organizations involved had some interest in HIV policy development but they were not HIV focused or did not 'own HIV'. As one government participant noted:

> There's the Department of Justice, the Department of Community Services…but nobody owns it (HIV), and everyone has a role in it or a piece of it, you know? (Jen, Govt).

Another participant indicated that policy-development was slow and challenging because some of the government organizations had trouble relating to one another during multi-sectoral policy development given different organizational cultures and silos.

> Each department has their own philosophy and a way they operate…how they see people, how they see the community, how they see programming, and how they see the client. It's a culture and so this is part of the problem of why there are silos is because each of those departments has their own culture, they attract and keep people, or indoctrinate them (laughs). I know it's a

subtle indoctrination, on how the world is seen, and if you're always working inside that silo you have difficulty seeing the other perspective and even in meetings sometimes people aren't....they're speaking and listening from within their silo and they're not necessarily hearing and understanding what the other people are trying to say and it works both ways (Mike, Govt).

Some participants argued that although stakeholder organizations understood that there was an expectation to engage in collaboration as a necessary component of policy development work, taking time out from frontline work was particularly challenging for individuals working in community–based organizations. As one government participant made note of this issue in his discussion of collaboration and community involvement:

Everything you ask a CBO to help you out it takes away from their frontline time, we recognize that. But on the other hand, you can't have collaboration and you can't have improvement on policy and programming unless you do that collaborative work (Mike, Govt).

By extension, several participants working in the community-based organizations expressed concern over what they perceived to be increasing expectations to be involved in collaborative policy committee work without an accompanying increase in funding to help support their time away from their frontline work responsibilities. Several participants also believed time was wasted at some meetings; they discussed how capacity building was needed to determine what this collaborative policy work should look like in terms of direction and coordination.

Because policy work happens so irregularly, participants explained that stakeholder organizations are more likely to work together or form committees to respond to identified community-based needs such as disease outbreaks through time-limited

projects or emergency measures as they present themselves, rather than working regularly on formal policy work. Policy development work was said to happen only every several years. For example, the two primary HIV policy documents in Nova Scotia are almost 10 years old and, according to several key informants there are no immediate plans to revisit them. As one participant explained in relation to the Standards for Blood Borne Pathogens Prevention:

> So right now it's certainly not open on anyone's desk…..(Lynne, Govt).

Summary

Three key provincial HIV prevention and harm reduction policy documents were identified in this study: The Nova Scotia Strategy on HIV/AIDS, the Standards for Blood Borne Pathogens Prevention, and Best Practices for Preventing Substance Use Problems in Nova Scotia. All three documents are supportive of using a population health/determinants of health approach, but very little discussion of gender or gender-based analysis can be found in any of these documents, and mechanisms for adopting and mandating GBA are not discussed. According to three key informants, a post-hoc attempt to conduct a gender-based analysis on the Nova Scotia Strategy on HIV/AIDS was difficult because of a lack of capacity to re-convene community consultation meetings to obtain context-and gender-specific information on the needs of men and women. The resulting gender-based analysis document was based largely on limited sex-disaggregated data and general literature on gender and the determinants of health. In addition, both the Nova Scotia Strategy on HIV/AIDS and the Best Practices document fail to operationalize ways to address the unique needs of women and men who inject drugs, and focus more of their recommendations on providing HIV prevention education

for the general public. Other relevant provincial reports and research documents exist which are more tailored to the needs of people who inject drugs and these have helped inform local knowledge on the specific HIV prevention needs of women who inject drugs. Nova Scotia does not currently have a drug strategy, but the Nova Scotia Government recently announced it would be developing a combined Mental Health and Addictions Strategy. Several participants expressed concern over what they expect will potentially be a mental health strategy with a limited addictions component.

When asked to describe HIV prevention and harm reduction policy development processes, several community-based participants wanted to shift the conversation towards talking about the current needs of their program users and the challenges they experience in meeting these needs. As participants explained, policy work was so infrequent and policy recommendations so slowly implemented, many felt policy work was not relevant to making current programming decisions. When policy work occurred, approximately every 6-10 years, it was generally government-led, government-controlled (most notably by the Department of Health and Wellness) and each policy was developed over a long period of time (2-3 years). A few government-based participants explained that challenges related to working on policy included: many of the stakeholder groups' not being specifically focused on HIV; some of the government organizations having trouble relating to one another given the different organizational cultures and silos; and community-based organizations' competing priorities and limited availability to take time away from their frontline work.

The next chapter discusses the identified barriers and facilitators to the development and implementation of HIV prevention and harm reduction policy for women who inject drugs in Nova Scotia.

CHAPTER SEVEN: Key Barriers and Facilitators to Developing and Implementing HIV Prevention and Harm Reduction Policy for Women Who Inject Drugs in Nova Scotia

This chapter addresses the final research question, which was: What are the key barriers and facilitators to developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia? Six key barriers and two key facilitators were identified. The six key barriers are: a lack of federal and provincial government attention to HIV and the resulting impact in Nova Scotia; insufficient and insecure government funding for HIV and harm reduction policy; tensions between stakeholder groups involved in HIV and harm reduction policy; the current Federal Conservative Government's opposition to harm reduction; justice-based organizations' focus on drug use as a criminal/enforcement issue in Nova Scotia; and a lack of priority given to gender and gender-based analysis by stakeholder organizations. The two key facilitators are: champions who advocate for policy and programs for people who inject drugs in Nova Scotia; and relationships between frontline workers and people who inject drugs that promote service provider knowledge of program users' needs which can be used to inform policy.

7. 1 Key Barriers

7.1.1 Lack of Federal and Provincial Government Attention to HIV in Nova Scotia

Relative to other provinces in Canada, such as Ontario and British Columbia, there is a very low prevalence of HIV in Nova Scotia, and HIV appears to be relatively

low on the 'priority list' for the provincial Department of Health and Wellness. In addition, there is relatively little public attention, through the media, given to HIV. All of the participants interviewed who worked for HIV-specific organizations expressed concern over the lack of attention to HIV within Nova Scotia, and various interconnected explanations for this absence of attention were provided. One participant speculated that the lack of public attention to HIV is directly due to the fact that most of the people who are HIV positive in Nova Scotia are from socially and economically marginalized groups. She noted:

> ...it's [HIV] happening among people who are socially and economically marginalized. And they're not like the children you see in telethons, they're not the kind of people that the public give a hoot about, I don't mean to sound cold, but yeah. They're seen as deviant in some way (Jen, Govt).

This government participant further explained that the general public considers HIV to be a disease that affects "others", in "other provinces, big cities and Africa" but is not a disease that significantly impacts Nova Scotia. Other participants noted that there are few public HIV campaigns, a waning community-based HIV movement, long time lapses with little HIV policy development work being completed, and no 'powerful or funded' HIV research or advocacy organizations in Nova Scotia akin to the British Columbia Centre for Excellence in HIV/AIDS or the Ontario Ministry of Health and Long-Term Care's AIDS Bureau. Some participants also commented that there is competition with other diseases, with higher prevalence rates, for scarce public health resources in a time of fiscal restraint.

Of particular concern to participants working in the HIV-focused organizations was the lack of government support for public HIV education and prevention campaigns, as well as a lack of provincial surveillance and behavioural data specific to risk groups, such as people who inject drugs. As explained by several participants from community-based organizations, targeted HIV prevention and education programming exists in the province only because of the efforts of community-based organizations.

> *The only people that are getting the message out about HIV and the risks are the community groups that work in the trenches, it's not the provincial government, it's not the federal government, it's not happening there (Lee, CBO).*

A number of participants argued that there are grounds to reinvigorate HIV-specific work based on scans which reported unsafe drug and sexual behaviours in the province.

> *Yeah, especially with the high rates of IV drug use, we've got obviously increasing rates of chlamydia, so you know when you look at people putting themselves at risk for chlamydia, they're obviously putting themselves at risk for HIV too, right? So yeah, it (HIV) has to remain a priority definitely (Kelly, CBO).*

Some participants were frustrated by what they described as a lack of "forward thinking" around the cost-saving benefits of preventing new infections. Several participants from HIV-focused organizations maintained that the lack of HIV prevention campaigns in Nova Scotia kept the public disengaged from considering HIV as a local issue and made attainment of resources for policy implementation and targeted work with marginalized groups, such as injection drug users, more challenging.

In addition, many of the founders of the HIV movement in Nova Scotia have either passed away, retired or moved on to different pursuits, which a few participants argued has left a void in terms of a strong group of individuals advocating for HIV prevention policy and programming efforts. At the same time, HIV is now a chronic disease which means that the urgency related to prevention has been greatly reduced, which might explain why the younger generation is not taking up this cause. As one government participant explained:

> *It's (HIV) not a life or death sentence the way it used to be so people are moving on…(Mike, Govt).*

The organization primarily responsible for provincial HIV policy, the NSAC, was created to advise government on funding and management of provincial HIV resources. However, the amount of funding that NSAC receives for HIV prevention policy, and the amount of funding that other HIV-focused organizations receive for their work is ultimately determined by the provincial Department of Health and Wellness. According to one participant, NSAC has not been able to make "a whole lot of change" in advocating for increased funding for HIV/AIDS and this has frustrated many community-based organizations.

7.1.2 Insufficient and Insecure Government Funding for HIV Prevention and Harm Reduction Policy Development and Implementation

All participants described provincial government "cutbacks" and insufficient resources as one of the key challenges to HIV and harm reduction policy development and implementation. As one key informant explained, it has always been difficult to

secure government funding for both HIV policy development and implementation in Nova Scotia due to the low prevalence of HIV in the province, and the existence of many competing health issues to which the provincial government has to respond.

> *Even before the economic crunch came, there were scarce funds and that numbers for HIV are small in Nova Scotia compared to other issues and the government every day is getting lobbied, pressured by any number of other very legitimate, worthwhile issues and they have to make decisions [...] just to generally move the quality of care of work on the general issue of HIV, it's very hard to do that (Mike, Govt).*

According to a number of participants, the Nova Scotia Strategy on HIV/AIDS and the Standards for Blood Borne Pathogens Prevention lack adequate funding for implementation. As described by one key informant, the Nova Scotia Strategy on HIV/AIDS (2003) was developed without committed government funds to assist with the implementation of the recommendations because such funds were not available at that time. One participant indicated that the policy might not have received government support had there been demands, at the time of the development of the policy, for enough money to ensure implementation of all of the recommendations.

> *When we set up the Strategy there was no dollar amount attached and some people complained that there should've been. Our advice and what we were told was, um we'll work with you on issues that you bring forward, as the resources allow. It probably wouldn't have gotten as much support as it did if we had lobbied to say a certain amount of money had to be laid aside for the Strategy, it probably wouldn't have gotten approved, cause the funds weren't there (Mike, Govt).*

Given limited funding for implementation of the recommendations, the NSAC has worked on implementing specific policy recommendations one at a time using a small annual budget which they receive from the provincial government for "projects,

activities, and research initiatives". This annual funding has allowed the NSAC to conduct projects focused on HIV testing, and support services for people living with HIV/AIDS. Several participants expressed frustration over how slowly and incrementally the recommendations from the Nova Scotia Strategy on HIV/AIDS have proceeded due to limited funding.

Implementation of recommendations from the Standards for Blood Borne Pathogens Prevention has also been challenged by a lack of ongoing funding. The Standards for Blood Borne Pathogens Prevention were developed by the provincial government, in consultation with the DHAs and other stakeholder groups, but the DHAs were tasked with locating funding from within their existing budgets to implement and maintain the new HIV and HCV-specific prevention Standards. As one participant explained, because the DHAs were not given additional, targeted funding to maintain or prioritize implementing the Standards this work has not been consistent or comprehensive.

> *... there was no new money attached to that (the Standards) to give to the District Health Authorities, so the District Health Authorities said "we'll do the best we can, but we're not going to make any promises because we have all these other things to do and we'll incorporate it in the best way we can ", so if they can put HIV stuff in with what they're normally doing, they'll do it, but they're not going to do specialized stuff, because there's no extra funding to do that (Mike, Govt).*

Two government officials in the Department of Health and Wellness were asked if there were plans to update the Standards for Blood Borne Pathogens Prevention, and how future work on this document would be funded. They indicated that since the

restructuring of the Department of Health and Wellness in 2011, the status or current departmental ownership of this policy document was unclear and that no provincial government funding was earmarked for this work.

> *We have to look at the public health budget and, um, you know right now there's no line item that says implementing Standards (Lynne, Govt).*

Participants explained that there is no money to implement the policy recommendations and that community-based organizations are also stretched in terms of resources.

7.1.3 Frustrations and Divisions within Stakeholder Organizations

Participants described tensions between, and divisions within, the network of organizations working on HIV and harm reduction policy development in Nova Scotia. Two types of tensions were identified: a) community-based organizations frustrations with government decision-makers over a perceived lack of support, collaboration and perceptions that government decision-makers were unresponsiveness of program users' needs; and b) tensions between various members of the HIV-focused organizations over identity, roles and responsibilities. These various points of tension will each be discussed in more detail below.

a. Community-based Organizations Frustrations with Government Decision-makers

All of the frustrations described in this section were based on issues raised by community-based participants and participants from one government-based organization.

i) A number of participants spoke about community-based organizations' frustrations with what they perceived as government decision-makers' unresponsiveness to, and disconnection from, program user needs in policy development and implementation. Specifically, participants argued that government bureaucracy and hierarchies created a significant disconnect between government decision-makers and HIV prevention and harm reduction program users. As a result, policies are developed that are not reflective of the lived experience and needs of program users.

> *If you don't work on the frontline and you don't hear the everyday story, and you don't understand where individuals are coming from, it's very easy to make policy that has little relevance for people on an individual basis (Mike, Govt).*

Participants suggested that the 'disconnect' of at least some government decision-makers is because they work with 'reports' and 'data about people' and have little direct contact with injection drug users and their day to day lives.

Government-based frontline workers do talk with clients about their needs, but government decision-makers who are primarily responsible for policy development and implementation, do not have much client contact, if any. If government-based decision-makers are not working directly with program users and the only information they receive about program users' needs are through database reports it is not improbable that they might become detached from this group.

Community-based participants felt that regular, direct contact with program users was necessary to learn about their experiences and remain responsive to their needs.

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Several community-based decision-makers explained that they regularly create opportunities for information exchange between themselves and their program users. As one participant from an HIV-focused organization explained ongoing communication with program users helped her to make decisions about how best her organization could evolve to meet program users' needs.

> We have an open door policy here. People can come in here at any time of day and share with us any of their issues that they're having, if they have a problem with this organization or whatever. And often that's the type of feedback that you really need to hear, that's what helps us to change and move along, it's the people (Kelley, CBO).

Another approach community-based organizations use to stay connected with program users is to hire them in short or long-term employment positions within their organizations. Community-based participants described that by hiring program users they could benefit from service users' experiential knowledge and connection to the community. As one participant explained her community-based needle exchange had specifically hired staff from their program user community to facilitate the building of relationships between service providers and program users.

> You know our staff are people with real life experience, they are from this community, they are recovering people, I don't mean people that are actively using of course, but people that are HCV-positive, people that are HIV-positive, like them, so people have a kind of understanding, a connection, you know (Lauren, CBO).

One government-based participant explained that community-based organizations' ability to hire staff with experiential knowledge rather than academic qualifications differentiated them from government and resulted in the creation of a staff that he

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believed were better suited to connect with program users and be responsive to their needs.

> *That's one of the joys we've had with the community, is that they can respond, they can take care of the community much better, they can get the right people to work with the community, because it's more about personality, relationships and their life experiences than it is about paper qualifications (Mike, Govt).*

ii) The second cause of frustration for community-based organizations was their belief that government decision-makers engaged them in 'tokenism' on policy committees which did not result in the creation of policy that met the needs of their program users. Some community-based participants explained that they felt government-based decision-makers' invitations to them to participate on policy committees were not reflective of a genuine interest in their opinions on the HIV prevention or harm reduction needs of their program users. Other community-based participants argued that government-based decision-makers' were generally interested in hearing their opinions as a way to gather information on the community's activities and needs, but rarely acted on their recommendations in policy development and implementation. As one participant explains, her experience participating on policy committees led her to believe that government-based decision-makers generally had an agenda that was separate from genuinely listening to community issues and problem solving around how to address community need through policy.

> *Yeah, I've never felt that we were really taken seriously, I mean people sit there and they listen and then they kind of take over and do their own thing without the voice of the community, without the voice of the people that are actually being impacted by the policies that they develop, you know? (Jess, CBO).*

Another community-based participant argued that if 'government' was really interested in gaining insight into program users' needs they should conduct regular focus groups with community members, rather than inviting one representative for each 'affected' communities to attend infrequent policy meetings as a way of gathering knowledge on program users' diverse, complex needs.

> *Sometimes you feel like you're the token representative on these committees, you know what I mean? The people on boards, you know have to have an Aboriginal member and you have to have an IDU...you're just that token rep from the community and it's really only my views and my opinions that are put out there and there are many more in the community that I represent that would probably have a different opinion, right? (Kelley, CBO).*

iii) The third cause of frustration was described by community representatives as due to a lack of collaboration and support (including monetary support) in their dealings with government-based organizations. One community-based participant explained how she attempted to help her government colleagues save the costs associated with sending their public health nurse over to her organization to provide immunizations, by having her own nurses do the work. However, as she further explained, when she realized she needed to purchase a new fridge to help provide this service, the government department was unwilling to assist her in covering the cost.

> *When we first opened, the public health nurse used to come over and do the immunizations for hepatitis A and hepatitis B, and you know do testing. So we said well it makes sense that our nurses are here, so we'll do that, so we did that, and then they downloaded some other work, oh flu immunizations. So we were happy to do it, we do it, but then we were in a conundrum we needed a refrigerator for the vaccines, cause that needs to be kept cold. Well we couldn't even get a refrigerator from them, but yet they're saving resources! You know? So we're now picking up that cost, is there not some way we can share in those cost-savings?(Jess, CBO).*

This lack of collaboration frustrated the community-based participant who felt she could no longer trust the government-based organization. Similarly, another participant described a situation where his community-based organization provided patient treatment information free-of-charge to their government-based colleagues to assist when program users transitioned between their respective programs. He was extremely frustrated by not having this favour returned and by recently being told by government that he would have to purchase the same documents from them while he was voluntarily providing them for free.

> *We tried to be collaborative and supportive. Everyone who came in we got a release of information from (government organization) and tried to obtain their treatment history and we notified them of all our admissions. Now they have never returned the favour and given us that information, and then just about 6 weeks ago they sent us a lovely letter advising us that from this point on that we would have to pay $69 for every release of information letter that we want done, which of course we can't afford, so we would have to offload it to the client who is already financially strapped and strained (Jamie, CBO).*

b. Tensions among the HIV-focused organizations

Some tensions among the HIV focused organizations were characterized as stemming from a divide between the original community-based ASO groups and the newer 'government' (arms-length) HIV-focused organization. These two groups work largely independently from one another, and this has created a 'division' within the HIV-focused organization network. The two resulting groups are: i) the non-government, original descendants of the grassroots HIV movement in Nova Scotia, ACNS and the groups who chose to work most directly with them; and ii) the 'arms-length' government–appointed NACS and the groups they work most closely with. Some of the

tensions between the two groups were described as originating from the community-based ASOs resistance to having an 'arms-length' government-based organization created to represent the voice of people living with HIV/AIDS to government. Another source of tension was described as the community-based organizations' frustration with the NSAC over the slow implementation of the Nova Scotia Strategy on HIV/AIDS's recommendations. Lastly, several groups that support NACS expressed frustration over what they perceived as ACNS focusing too narrowly on meeting the HIV-related needs of the gay male population, which they believed was making local resources generally less accessible to other populations.

One participant explained that when the NSAC was created in 1989 as an 'arms-length' government agency designed to act as a liaison between government and community and create policy, it immediately created some concerns over ownership of HIV within the existing HIV grassroots community in Nova Scotia, specifically in relation to who would speak to government on behalf of the HIV prevention needs of Nova Scotians and on behalf of people living with HIV. As he explains in the following quote this tension was largely in regards to how the 'government' and non-government groups would work together and specifically who would represent the voice of the HIV community.

> *I think it's a shared responsibility of speaking on behalf of the HIV community, but I think there's been some tension around who should be speaking on behalf of PHAs, and raising the issues within the community and with government (Mike, Govt).*

Over the years a perceived division between the primary 'government' and primary non-government based HIV organizations continued. As one participant explained, this government/non-government divide has caused some groups to direct their general frustrations with 'government', over not providing sufficient HIV policy and program funding, towards NSAC.

Because we're somewhat the face of government to them [community], in some cases, I think they're just as frustrated with the silos and the lack of action or movement within some of the things that government could be doing or should be doing, but that frustration is placed on us because we're part of a system, even though we're just as frustrated (Mike, Govt).

The division between these two groups has also impacted the ways in which the entire HIV-focused organization network communicates and works together on HIV policy. As one participant explained, individual groups often work with either NSAC or ACNS, but not both. Similarly, participants from both organizations discussed how a lack of collaboration between the groups has sustained confusion over the two groups' similarities, differences and roles. As explained by one participant:

Um, I think on a very basic level, people who are engaged with the Commission and might not be engaged with us, don't know about us and think that they're the one AIDS organization, or they consider them to be an AIDS organization, or they're it for the province, and then there's people who work with us and are on our periphery who don't acknowledge or understand that the Commission exists, and what it's role is (Morgan, CBO).

Participants also described how NSAC's recent shift to become more involved in community-based projects, has created additional tensions because some organizations

feel it represents a departure from NSAC's original purpose and role as an advisory group. As explained by one participant:

> *I think that they should really be working more in partnership, hearing what our concerns are from the community and how do we through them acquire additional funding from the province, you know how do they speak on our behalf? Because that's really what the Commission should be doing, and it's what it started out being in the beginning, it was an arms-length advisory group, advising the province, or the provincial Department of Health (Lee, CBO).*

Several other participants explained that they appreciated the value of NSAC's work in the community and believed the tensions were more specifically related to 'ownership of HIV' and a general lack of regular communication between the groups which affected how they work together. As one participant noted, all of the groups participated together in working groups during the development of Nova Scotia's Strategy on HIV/AIDS. However, the working group meetings were disbanded because of low attendance, which some participants attributed to frustration over the lack of funding to support implementation of the Strategy's recommended actions. As one participant stated, there was no established forum for communication between organizations since the working groups had stopped meeting.

> *Since the working groups have ended I haven't been really clear about where we fit in working together, what does that look like, how will community be engaged by the Commission to inform what the Commission is doing? (Morgan, CBO).*

A final source of tension was reportedly because ACNS was perceived by some as focusing primarily on the needs of gay, white men to the exclusion of other groups in Nova Scotia. One participant suggested that this 'bias' was not an intentional attempt to

be exclusive, but rather the product of ACNS being started as a grassroots movement by and for gay, white men, and due to ACNS being responsible for speaking on behalf of the PHA population who in Nova Scotia are predominantly gay, white men. However, as one participant argued, this situation is problematic because the epidemic is evolving and other groups require HIV-related resources and policies that address their needs. As one participant commented, if the diversity of people is not recognized and addressed, individuals from other groups such as women or ethnic minority groups, might not find the existing resources accessible or culturally-appropriate.

7.1.4 The Federal Conservative Government's Opposition to Harm Reduction

Participants perceived the Federal Conservative Government's movement away from harm reduction as having an impact on harm reduction policy development and implementation at the provincial level. Several participants described the Federal Conservative Government's implementation of the Anti-Drug Strategy, introduction of mandatory minimum sentences for drug offenses, and multiple attempts to close Vancouver's supervised injection facility, as clear examples of the current government's opposition to harm reduction. Participants identified three issues that they believed resulted from the Federal Conservative Government's opposition to harm reduction: **a.** funding cuts at the provincial level to harm reduction policy development and implementation since the election of the Federal Conservative Government with new funding being redirected towards enforcement-based approaches to drug policy; **b.** the abandonment of Nova Scotia's drug strategy which participants felt ended collaborative drug policy work between health-focused stakeholder groups and justice-focused

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stakeholder groups in Nova Scotia; and **c.** several community-based groups perceiving that although decision-makers within Nova Scotia's Department of Health and Wellness supported harm reduction, they were stifled in their ability to advocate or promote the adoption of new or increased support for harm reduction policy within government.

a. Several participants described experiencing either funding cuts or no new funding for harm reduction policy development and implementation since the election of the Federal Conservative Government. Some participants explained that new funding was being directed towards enforcement-based approaches to drug policy and away from health-based or harm reduction-based approaches to drug policy. As one participant explained, it was her understanding that the Federal Conservative Government's opposition to harm reduction was to blame for decreased funding available for harm reduction-based initiatives.

> *Cause I know there were monies that were coming from the federal government to the province for drug prevention and treatment and the way I understand it is that none of that money could be used for anything resembling a harm reduction program or approach (Jen, Govt).*

Another government-based participant articulated how the Anti-Drug Strategy resulted in less federal money for government drug-specific health projects. She also discussed how money was taken from provincial Health Departments and redistributed to provincial Justice Departments to address drug use as a criminal issue first and a health issue second.

There was less money available to the provinces through the drug strategy community initiatives fund, there was less focus on health and it became more of a criminal justice focus, so there was less funding available for national projects, local projects and provincial projects, and no new money for our contribution agreement which currently supports treatment systems (Pat, Govt.)

b. Several participants believed that the abandonment of Nova Scotia's almost completed drug strategy was influenced by the Federal Conservative Government's opposition to harm reduction. A few participants maintained that the provincial drug policy document was abandoned specifically because it contained harm reduction as one of its key pillars. The abandonment of this policy was said to end collaborative drug policy work between health-focused stakeholder groups and justice-focused stakeholder groups in Nova Scotia. As one participant argued, a great deal of time and resources were put into the development of the drug policy which she believed 'disappeared' as a result of the Federal Conservative Government's position on harm reduction.

Yeah basically the guts of harm reduction were pulled out of any part of Federal drug policy and in fact the provincial government was developing, a lot of time and effort, two departments were involved, Health Promotion and Protection and Justice, a provincial drug strategy and that's seemed to disappear. It's just, yeah, I suspect, you know, the influence of the Federal government's position on harm reduction, and we all know what that is (laughs), it's not good, probably had a lot to do with that too (Jen, Govt).

c. Several community-based organizations indicated that the provincial Department of Health and Wellness remained supportive of harm reduction but were unable to advocate for harm reduction to the federal government. This was not attributed to 'ill will', but rather understood as the result of competing priorities and harm reduction's lack of popularity with the existing Federal Conservative Government. As

one participant explained, she felt most provincial government workers were supportive

of harm reduction but could not voice this opinion.

> *There's only been one lady that I ever had as the liaison person with Department of Health that I felt didn't fit into this position, you know, she was the one who really wanted us to fight for every dime we got. The majority of people that I've worked with, are very harm reduction-based although you know we can't talk about that right now, let's talk about health promotion, and it's just things like that you know, they can't say a lot, but I know that they feel a lot (Lauren, CBO).*

Another participant described a conversation she had with a government-based decision-

maker who told her not to attempt to advocate for harm reduction–based initiatives while

the Federal Conservative Government was in power.

> *So I ended up at the table with (public health official), and of course my big things are drug treatment courts, safe injection sites and community detoxes and he said "Don't at this time, don't get into safe injection, don't waste your time on that or these things as long as this [federal] government is in power, it isn't going to happen, you're wasting your time. Try to advocate for things that you may be able to do". So that was the thing and you know, work towards that, cause it's not going to happen, so you know, yeah. Don't waste your time (Lauren, CBO).*

7.1.5 Justice-Based Organizations are focused on Drug Use as a Criminal/Enforcement Issue in Nova Scotia

The majority of participants in this study described justice-based organizations

(specifically Policing Services and Correctional Services) in Nova Scotia as centered on

drug use as a criminal/enforcement issue rather than a health issue. They felt this resulted

in relatively little collaboration between justice-focused stakeholders, on the one hand,

and health-focused stakeholders (including the drug-focused organizations), on the other

hand. As several participants explained, the two groups' opposing positions on responses to drug use are negatively impacting their ability to collaborate on HIV prevention and harm reduction policy development and implementation in Nova Scotia.

Several participants explained that although addiction was recognized primarily as a health problem in most government departments, the Department of Justice, most notably through Policing Services and Correctional Services, treated addiction as a criminal enforcement issue which affects collaboration on policy development and implementation.   As one participant explains, she believes the Department of Correctional Services is generally less focused on the health needs of inmates in correctional facilities than they are on preserving an image of safety and security.

> *If you go into the Corrections side of it, opinions will vary, but their emphasis is on security and you know, the public perception, and this is my opinion….concern that you don't want to make these places (correctional facilities) too comfortable…even with methadone. I don't know if there's an officially 'no harm reduction' position, I wouldn't say that, but with the emphasis being so much on safety and security…it's difficult to focus on health and health issues (Jen, Govt).*

Although differences over the positioning of illicit drug use as primarily a health or criminal issue have a long history, several participants expressed concern that the Anti-Drug Strategy, through its dismissal of harm reduction, widened the gap between Health- and Justice-focused stakeholder groups, discouraged collaboration and prioritized enforcement-based approaches. Several participants provided examples of how they felt enforcement-based approaches to addiction were currently receiving priority over health-based approaches to addiction within their communities. For example, one participant

described how she noticed a significant increase in enforcement-based approaches to drug use in her community in recent years, but no response to public outcries for a new youth drug treatment center.

> *In our area, we've seen quite the crackdown on drugs, right? There's been a lot more enforcement. One year they hired 18 new police officers, yet people are hollering for a youth treatment center, and not getting it because we don't have the numbers. But we do have the numbers to justify 18 new police officers (sarcasm)(Kelley, CBO).*

The same participant described her experience participating on a working group to address local drug use and how control over policy content and development processes were taken over by one organization. She explained that what started out as a partnership between stakeholders from different groups with different perspectives on drug use, resulted in an enforcement-focused partnership lead by justice-focused organizations.

> *There was the partnership of you know, academics, health care, community and individuals, we came together on a monthly basis to make recommendations and policy around drug use, right? It had a couple tiers; enforcement was one of the big ones, you know eventually the whole partnership became enforcement, (laughs). It dismantled and became enforcement, the whole partnership, that's the bottom line (Kelley, CBO).*

7.1.6 Lack of Priority Given to Gender and GBA among Stakeholder Organizations

Participants' responses to questions about gender and gender-based analysis revealed that gender is generally not a priority among the organizations that collaborate on HIV prevention and harm reduction policy in Nova Scotia, and it has not been successfully implemented as a priority by federal government funders. Because no one is currently prioritizing gender, it has not become mainstreamed into the work of these

organizations and therefore continues to be overlooked in policy development. One participant suggested it will require turning it into a job competency measure in order to make sure it is regularly considered and prioritized.

Throughout the key informant interviews, when asked about whether they conduct gender-based analysis, almost all of the participants defaulted to talking about women's health or conflated the terms 'gender' and 'sex'. Some participants talked about gender-differences and only those involved in managerial government positions spoke of GBA as a lens. Although several government managers had attended workshops on gender-based analysis, they were not required to implement it when involved in policy development and implementation and therefore it was not prioritized.

Participants from community-based organizations described being too under-resourced to either offer gender-informed programming or consistently gather sex-disaggregated statistics on program use. As such, they did not have these data to contribute to the development of HIV prevention or harm reduction policy development.

As one participant explained, GBA was not being systematically conducted in her organization and when gender was considered in relation to programming or policy it was the result of intuition rather than intentional use of a gender-based framework during program evaluation.

Hmmm….we…maybe….yes and no [do GBA]. So my question is often around, who's successful (in a program), who's not and why. And so one of the things we were seeing is that the young women who were participating were often less successful than the young men. And so my question back to my staff person was okay what is it in the design of the program that is making it inaccessible to the young women? [….] Do we keep stats on that…not really (Hannah, CBO).

When asked about GBA as a theoretical model or framework for policy, a few government-based participants stated that they believed the provincial and federal governments were 'fickle' in their support for various frameworks, which impacted framework prioritization and implementation. One participant stated that in her organization discussion regarding GBA had reached its peak of popularity several years ago, but government was now more interested in promoting diversity and social inclusion frameworks. However, as another participant describes, the government's support for a particular theoretical model or framework was also vulnerable to competing issues and priorities and in particular economic issues. As he explained, his organization has been waiting on the provincial government to move forward with a diversity lens document for some time, but that this work is not being prioritized which delays making policies more inclusive.

Yeah, and so the government, the current government is supposed to be working on some type of diversity lens…what we've heard recently is that they haven't been working on it because they've been so focused on this economic stuff. So that's good and bad - one, we haven't missed the boat, (laughs), so there's more opportunity to have influence on it, but the sad thing is again that economics trumps inclusion, and that's what happens all the time (Mike, Govt).

Several participants discussed how they suspected that the lack of prioritization of gender consideration in health policy development was symptomatic of a larger societal

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devaluation of the importance of gender which perpetuates status quo androcentric organizational cultures. As one participant explained, doing gender-analysis has not been normalized as a mainstream component of people's jobs, which result in policy that does not consider program users' diverse needs.

> *I don't think there's any ill intent, you know, it [gender] just hasn't been… I just don't think it's[gender-based analysis] a mainstream way of thinking…and everybody hears about it, but it's a mindset too right…it has to become a part of the way you do things and it isn't that way yet, it's very homogenized (Jen, Govt).*

Another issue that was raised was the fact that GBA was not required of organizations as a condition for funding. Despite Health Canada's stated commitment in 1999 to implement GBA into all programs, services, policies and research (Health Canada, 1999), most participants in this study had not heard that GBA had been federally mandated. When asked if gender-based analysis was a systematic pre-condition in federal funding calls for Nova Scotia-based ASOs' operational funding through ACAP, one participant explained that although PHAC had created a sex and gender working group to discuss building GBA into funding applications, this was not yet happening.

> *At the PHAC there is a big move now, it's called the sex and gender-based analysis working group, and part of their role is to try to basically make sure that sex and gender is taken into consideration in all the work we do. So when a solicitation is written, for example, even before you write it you ask is sex and gender considered…..it hasn't happened yet at our funding level, but it has for some others…(Steph, Govt).*

When participants were asked for feedback on how gender-based analysis could be mainstreamed for HIV prevention policy development in Nova Scotia, one participant

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recommended that in order for it to be implemented it should become a component of decision-makers' performance appraisals.

> *Making it part of performance appraisals with managers….right now there are 8 different competencies you're evaluated on, and certainly diversity or gender competency could fit under some of those…..if you're not held accountable for something…if it's made part of your job or something you know you're going to have to answer to…that makes it become part of that mindset, you know that's one of the things that needs to happen (Jen, Govt).*

7.2 Key Facilitators

7.2.1 Dedicated Champions

Several participants described the contribution of dedicated advocates who have been advancing HIV prevention and harm reduction policy development and implementation for people who inject drugs for many years in Nova Scotia. They explained that a committed group of individuals in the community as well as several individuals in government and academia had made significant strides in improving HIV prevention and harm reduction policies for people who inject drugs in Nova Scotia.

As one participant describes, in the harm reduction field there have been specific individuals who have worked very hard at creating relationships with both program users and other stakeholder groups to facilitate policy development for people who inject drugs.

I think in the harm reduction field we've had the (individual), (individual) and (individual) who have been around long enough and work well together ...and their personalities are such that they collaborate and understand the people they work with. So I think that we've been very lucky in Nova Scotia that we have good people, and not just those three, but the staff they hire to work with them. They work very hard at personal relationships and relationships with organizations (Mike, Govt).

Key champions were identified not only in community-based organizations, but also in government frontline positions, among government decision-makers and also in academia. One participant provided examples of individuals she has worked with from all of the various stakeholder groups, who she believes have contributed significantly to supporting HIV prevention and harm reduction policy development work in Nova Scotia.

If there was EVER a woman of excellence to me in this community it would be (Individual Academic) you know, I think she's terrific. Ah so many, (individual) at (CBO), um, even (Individual Govt Decision Maker), he is excellent. I mean (Individual) who I work with at the Department of Health, at the AIDS Advisory, (Individual), you know, there are so many champions that I believe are right here in this community (Lauren, CBO).

One participant discussed how individual champions within government had at times facilitated the attainment of much needed funds for policy development for people who inject drugs. She describes a situation where a particular individual was appointed to the provincial government who was a supporter of the harm reduction approach and how this individual's influence within government resulted in new funding for the Standards for Blood Borne Pathogens Prevention policy document, a document which the participant then used as evidence to obtain program funding.

And then we got (individual) who was the (government appointment), so she came in to play and she kind of, she got it (snaps her fingers). She just got it. And through her, we got the province's Nova Scotia Blood Borne Pathogens Strategy Standards (Jess, CBO).

Lastly, one participant discussed how individual champions within the Department of Addiction Services who focused on women's services and gender-specific programming had made large strides in advocating for the importance of this work twenty years ago. He explained that it was particular, senior level women staff that had both the interest in looking at gender and the power to influence change that resulted in changing departmental perspectives and priorities regarding gender. He expressed concern over what he perceived as a lack of 'gender champions' within his organization today to continue this work, and what he described as a paradigm shift away from women-specific programming, to more gender-neutral programming.

We had a number of staff that were very connected to women's services, who were really champions and pioneers of looking at gender-specific programming, well ahead of the learning curve in other parts of the province, and…I think with the fact of their position in the agency, I mean quite frankly they had the power and the initiative to implement a lot of this stuff …but as we've gone through the, I think, the evolution of Addiction Services[…]….and we now have a majority conservative government, so I mean political tides have come in and out, I think there's been a real challenge to maintain some of the impetus, now it's very challenging to have women-specific programming (Charlie, Govt).

7.2.2 The Relationships between Frontline Workers and Injection Drug-Using Program Users

The relationships formed between frontline workers and injection drug-using program users were described as a facilitator to developing HIV prevention and harm reduction policy for women who inject drugs in Nova Scotia. These relationships were

said to foster the exchange of information that is invaluable for understanding how policy meets the needs of program users and also for exposing how policies fail program users.

In Nova Scotia, drug-specific frontline service providers employed by community-based organizations (needle exchanges, opioid substitution programs), private practices (opioid substitution programs) or through government departments, such as Addiction Services, work directly with injection drug using clients and may have previous lived experience with addiction themselves. Through their work, frontline workers develop a strong understanding of the experiences, challenges and needs of their client population. Their proximity to program users results in the development of relationships with this population that provides them with a level of contextual understanding of program users' needs that is generally not found among other members of the HIV prevention and harm reduction policy development network. Because women and men who inject drugs are generally not included on policy committees, the inclusion of frontline workers on policy committees is essential for providing context-specific information on issues such as drug use and trends, policy relevance and program accessibility.

One reason why community-based frontline workers often become very familiar with program users' needs is because their organizations are designed to offer a number of services under one roof. As one community-based frontline worker explained her agency has become more of a general 'support' agency rather than just a needle exchange.

What started out as just a needle exchange…it's turned into much more. We're more of a supportive agency now, more referrals to detox, to treatment. You know… advocating for people to get on to the methadone programme, social services, housing, the criminal justice system, food banks, furniture banks. We seem to do much more…I always tell people at the end of the day, needle exchange is pretty much the last thing we do (Lauren, CBO).

When program users access various types of programming from an agency, for example health care, addiction treatment, HIV testing, legal support or housing support, they may be in contact with service providers regularly in order to access these resources. This arrangement can facilitate the development of relationships between program staff and program users and can make frontline workers acutely aware of the challenges their program users experience when trying to access programming.

Yeah, it's a hard one. I had a guy come in yesterday, "look at you, I haven't seen you in a while" I said. "No, I've been in jail. Did you know how long I've been trying to get on that program (methadone)? It was five years". He's angry, of course, he's frustrated, and I don't blame him. I can almost tell you stories of everyday that people need help that aren't getting it (Lauren, CBO).

Several frontline participants explained that by working with program users regularly they routinely saw examples of how the existing social service and health system in Nova Scotia "fails" their program users, or "sets them up for failure" by not providing adequate supports such as housing, available and accessible spots in drug treatment programs, sufficient social insurance benefits or even reliable public transportation. Frontline workers can provide this knowledge as members of policy committees and advocate that these particular issues be addressed through policy in an attempt to allocate resources. For example, one participant spoke of the unacceptable waitlists to access methadone

maintenance and other drug treatment programs in Nova Scotia and how detrimental waiting for these programs could be. As she explains, the quality of peoples' lives and their health could drastically worsen while they were waiting for a position in a methadone program to become available to help them stop using injection drugs.

> *You know cause our waitlist is horrific, in that…you know when people first present, they may still have housing, some may be employed, they may have contact or custody of children, by the time we're able to accommodate them, you know, there's crimes committed, children are lost, you know housing is lost, their health…you know we don't know their status, whether they have HIV or whether they have HCV, we don't know that until they come in, but there's still that window of risk, you know, their lives decompensate drastically, it's not like you're waiting for a knee surgery, because there are just so many facets of that life (Jess, CBO).*

Several drug-focused frontline workers discussed being members on a number of community-based policy committees with different foci, such as housing, poverty or youth, as a necessary measure to help meet the complex, sometimes competing, layered needs of their program users.

One issue that was repetitively mentioned by rural-based frontline participants was the need to develop policy that addresses the challenge of providing services to people who inject drugs in locations with limited service availability and an inefficient transit system. As the following quote illustrates, due to a lack of available public transportation (and insufficient means often to access other modes of transportation), program users were put in a situation where they had to spend all day traveling to and from harm reduction programming.

If they make one bus they have a four hour wait to go back, so literally they spend their entire day getting methadone (Jamie, CBO).

This participant went on to say that this transportation issue had been described in the Standards for Blood Borne Pathogens Prevention policy document, but that a lack of funds to implement recommendations for improving public transportation and specialized drug treatment access, resulted in little change.

Lastly, several frontline worker participants explained that they felt provincial policies often differentially 'failed' women who inject drugs. This insight was gathered from experience working with women, rather than intended efforts to collect information on gender and women's different experiences related to accessing programs. For example, one participant explained how Addiction Services' methadone maintenance program required individuals to have previously been in detox several times prior to being admitted to the methadone program. As he explains if a woman is a mother, this admission criteria was often impossible to meet, as she would have to repetitively secure childcare.

One of the criteria for Addictions [government methadone program]is… you have to be in detox 5 times, now depending on who you ask, the figure is 3 to 6 times…as a mother you're already on the other side of the hill looking up because you can't drop your child somewhere to get into detox (Jamie, CBO).

Summary

This chapter described participants' perspectives on the key barriers and facilitators to developing and implementing HIV prevention and harm reduction policy

for women who inject drugs. The key barriers are: a lack of federal and provincial government attention to HIV and the resulting impact in Nova Scotia; insufficient and insecure government funding for HIV and harm reduction policy; frustrations between stakeholder groups involved in HIV and harm reduction policy; the Federal Conservative Government's opposition to harm reduction; justice-based organizations focus on drug use as a criminal/enforcement issue in Nova Scotia; and a lack of priority given to gender and gender-based analysis by stakeholder organizations. Key facilitators include: champions who advocate for policy and programs for people who inject drugs in Nova Scotia; and relationships between frontline workers and people who inject drugs that promote service provider knowledge of program users' needs which can be used to inform policy.

The next chapter will discuss what all of these findings mean in relation to developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia.

CHAPTER EIGHT: Discussion

This chapter presents a discussion of the specific objectives and key findings of this study. The specific objectives of this study were to identify: 1) the key organizations involved with HIV prevention and harm reduction policy decision-making for people who inject drugs in Nova Scotia; 2) the key HIV prevention and harm reduction policies in Nova Scotia, how they were developed and how they address the needs of women who inject drugs; and 3) the key barriers and facilitators to developing and implementing HIV prevention and harm reduction policy for women who inject drugs in Nova Scotia. The discussion is organized using Walt and Gilson's Policy Triangle Framework as an organizational model.

Walt and Gilson's 'Policy Triangle Framework' was designed to help policy analysts think systematically about the many factors that influence policy decision-making (1994). Walt and Gilson contend that most discussions about health policy focus on the content of policy documents, without considering other influences such as how the context and stakeholders influence the development and implementation of policies. Walt and Gilson's framework was critical to this study as it helped uncover the complexities of policy development and implementation. Ultimately, the greatest contribution of this framework was found in its ability to highlight issues that are often overlooked. For example, a cursory read of any of the three key HIV prevention and harm reduction policy documents that were identified in this study would give a reader the impression that these documents address the HIV prevention needs of women who inject drugs by being supportive of harm reduction and inclusive of gender consideration.

Given this, it could also be assumed that these documents are the product of collaborative work by committees who possess action plans (and implied resources) for implementation. However, upon closer inspection, it became clear that these policies are not meeting the HIV prevention needs of women who inject drugs in Nova Scotia for a variety of interconnected reasons. The addition of a gender-based analysis lens to the theoretical framework allowed for an exploration of gender inclusion, and lack thereof, in policy development and implementation. This modified framework helped to guide the researcher's understanding of the issues at hand; specifically the interconnections between relationships, resources and power in developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia.

8.1 People: The Organizations and their Engagement/Disengagement from the Policy Network

As Lindberg and Haynes (2000) suggest, differences between drug policies across various countries can be attributed in part to the relative position of power among different stakeholder groups in drug policy formulation, and by extension, implementation. Specifically, they argue that 'elite' groups within a policy network will have more power than other groups and will therefore control the policy discourse and disregard analyses of an identified problem that is unfavourable to them. In contrast, 'neoelite' theory (Gray, 1994) argues that power is not exerted by a specific group, but that the relative power of different groups will depend on who is part of the network at any point in time.

The current study found evidence to support Lindberg and Haynes' theory that there are 'elite groups' holding the majority of the power both in terms of policy committee composition and the roles assigned to people and organizations working on HIV prevention and harm reduction policy in Nova Scotia.   For example the 'Best Practice for Preventing Substance Use Problems in Nova Scotia' document was written exclusively by an out-of-province research consultancy group hired by the Department of Health Protection and Promotion, and was "reviewed by officials of Addiction Services, [the] Department of Health Promotion and Protection, and [the] District Health Authorities"(p. 2).   The local service providers who work most directly with women who inject drugs in Nova Scotia through community-based organizations were not consulted for this policy document despite their knowledge and experience, and the Nova Scotia focus of the document. This helps to explain why only one government-based participant involved in the development of this document mentioned this Best Practice guide as a relevant provincial policy document, as there was no involvement by community-based groups or other government-based participants.

The same explanation cannot be offered in the case of the Nova Scotia Strategy on HIV/AIDS and the Standards for Blood Borne Pathogens Prevention, as these documents were developed through a process of extensive working group meetings that involved both governmental and non-governmental organizations. However, the theory of 'elite groups' governing policy development and implementation, does hold for the Standards for Blood Borne Pathogens Prevention document.   This document was developed by a Department of Health Coordinating Committee that was composed

entirely of government-based employees in director- or manager-level positions. Sub-level working groups included a variety of government-based management and frontline worker representatives, and community-based representatives, the majority of whom worked as both administrators and frontline-workers within their organizations. The document explains in its 'Development of Standards' section that working group members were asked to commit to participating on one of four specific areas of focus which were pre-established by the Coordinating Committee (p. 1). This suggests that the community-based organizations had less decision-making power to establish the documents' 'focus areas' and therefore to determine priorities and content direction.

Unlike the Standards for Blood Borne Pathogens Prevention document, community-based groups made up approximately 50% of the composition of the Strategy Steering Committee for the Nova Scotia Strategy on HIV/AIDS. This document appears to more closely resemble an attempted 'neoelite' power theory of policy development; that is, there was an attempt to create a more equitable distribution of power and decision-making authority among stakeholder groups.

In the case of both the Standards for Blood Borne Pathogens Prevention and the Nova Scotia Strategy on HIV/AIDS policy documents, the Steering or Coordinating Committees were ultimately responsible for organizing and drafting the final documents. This synthesis and writing phase took 2 years for each document. During this time, contact with working groups was minimally maintained. Within 3 years after the publication of the policies, both sets of working groups disbanded which meant that

fewer people were engaged with the published documents in terms of continued involvement with implementation of the recommendations.

Looking back almost ten years on their experiences of developing these policies, several community-based key informants described feeling as though they had less power than the lead agencies in the policy development processes. Several described their role as 'tokenistic' and explained that they became increasingly disengaged from the policy process due to this fact. Others noted that policy recommendations largely remained unimplemented. As a result of this, many had become accustomed to developing programming separately from policy, focusing instead on letting identified client need inform programming. For this reason, when community-based organizations were asked to describe the role of policy in their work, most explained that it had little bearing; they were much more interested in discussing how the needs of their clients were currently unmet due to insufficient programming resources.

Like community-based organizations, the government organizations involved in HIV prevention and harm reduction policy have also become disengaged from the policy network over time since the publication of the policy documents. For example, due to a lack of implementation funds for the Nova Scotia Strategy on HIV/AIDS, the NSAC now focuses less on the development of policy and spends more time involved in community-based projects as their annual 'projects' budget will allow. These time-limited projects were developed to address issues raised in the Nova Scotia Strategy on HIV/AIDS, but because they are not being overseen by a 'strategy committee', their association with

specific recommendations are not apparent to some ASO members of the original Nova Scotia Strategy on HIV/AIDS policy development network. Some participants felt that the NSAC had become more like a community-based organization that carries out research and public education projects rather than an advisory commission that focuses on lobbying the government for additional resources.

The group that created the Standards for Blood Borne Pathogens Prevention document, specifically the Department of Health Coordinating Committee, described a lack of ownership of this policy document. Many people who had been involved in the Standards' development were shifted to new roles and positions when the Department of Health was restructured in 2009. One participant explained that after the restructuring, no one knew exactly which department or individuals would take the lead responsibility for managing the Standards for Blood Borne Pathogens Prevention document in the future.

It also appears that the election of the Federal Conservative Government in 2006 influenced the current lack of ownership of the Standards for Blood Borne Pathogens Prevention document. Several community-based organizations described what they perceived to be their government colleagues' inability to advocate for the advancement of HIV-related, harm reduction-based policy in the current political climate. It should be noted, however, that the provincial government published the Best Practices for Preventing Substance Use Problems in Nova Scotia document, which endorses a four pillar approach to drug issues, in 2008 after the election of the Federal Conservative Government, albeit with little fanfare. It is also worth noting that ACCB, in collaboration

with their local DHA, have decided to reinvigorate the Standards for Blood Borne Pathogens Prevention document in Cape Breton in response to the perceived need to address local drug use and its impacts on the spread of blood borne pathogens. The ACCB and their DHA recently secured funding and hired a coordinator to lead this project. This development is significant as it suggests that attention and support can be rallied to address disease prevention among people who inject drugs in Nova Scotia. At the same time, this development is not provincial in scope.

Another significant finding in this study that relates to the people and organizations involved in policy development and implementation are those individuals and groups who are missing from the network. Although efforts were made to create working groups representative of the populations most directly affected by HIV and other blood borne pathogens in Nova Scotia, significant gaps exist. For example, no women's organizations were involved in the original development of these documents. In 2004, the Nova Scotia Advisory Council on the Status of Women was invited to work on a post-hoc GBA document to supplement the Nova Scotia Strategy on HIV/AIDS, but it received little attention and was described by participants as "too general in scope". In general, women's organizations are missing from the policy network and none of the organizations generally included in Nova Scotia's HIV policy network have a specific mandate to create or implement programming specifically for women. Likewise, the only group involved in the development of the Standards document representing an ethnic minority population was HON, and only two groups, HON and the Health Association of

African Canadians (HAAC), represented the needs of ethnic minority populations on the Nova Scotia Strategy development network.

In addition, the Department of Justice was only represented on the Standards policy network as a working group member. Department of Justice representatives, police, local politicians (i.e. the Mayor) and high-level public health officials (i.e. Minister or Deputy Minister of Health) can all influence policy for injection drug users, but none were included on the development committees of either document. In Vancouver, individuals in these positions have been instrumental in influencing policy for people who inject drugs (Portland Hotel Society, 2011). More significant was the absence of people who inject drugs on either policy development committee.

8.2 Content: The HIV Prevention Needs of Women who Inject Drugs are Stated, but Not Meaningfully Addressed or Supported

The key argument in this section is that although the health of women who inject drugs is stated as a priority in Nova Scotia's three key HIV prevention and harm reduction policy documents, their needs are not meaningfully discussed in policy content, and policy implementation goals are not created specifically for this group. This results in a lack of targeted resources for this population and consequently a lack of capacity to address HIV risk among women who inject drugs. Overlooking or disregarding the specific (and heterogeneous) HIV prevention needs of women who inject drugs in provincial HIV policy is likely a reflection of the position and experiences of those

individuals and organizations involved in HIV prevention and harm reduction policy development in Nova Scotia.

All three provincial policy documents, the Nova Scotia Strategy on HIV/AIDS, the Standards for Blood Borne Pathogens Prevention Services and the Best Practices for Preventing Substance Use Problems in Nova Scotia, include and promote gender as a determinant of health. However, all three documents fail to meaningfully discuss its impact on women who inject drugs or to operationalize how gender-based analysis or gender-informed evidence could be used to inform the development and implementation of HIV prevention and harm reduction policy.

The recommendations within the three documents, with regards to injecting drug users, identify both 'women' and 'injection drug users' as 'vulnerable populations', but fail to discuss the overlap between these two groups. This is consistent with a general tendency in all three documents, to list the determinants of health but fail to discuss how these determinants interact and potentially 'layer' or compound risk and marginalization. This is most obvious in the Nova Scotia Strategy on HIV/AIDS Gender-Based Analysis document, which discusses sexual transmission of HIV among the general population but provides no recommended actions specifically for people who inject drugs.

Another problematic finding related to policy content is that in all three provincial HIV prevention and harm reduction policy documents, injection drug users are 'lowly

ranked' in the list of HIV prevention priority groups. For example, in the 'Recommended Action on Prevention and Harm Reduction' section of the Nova Scotia Strategy on HIV/AIDS (section 3.7, p. 15) the section's focus is on preventing HIV among high school students in Nova Scotia, with only a small final section that mentions the HIV prevention issues of people who inject drugs. This is incongruent with evidence on the two groups' respective risk for HIV transmission in Nova Scotia (PHAC, 2006).

Another obvious example of the low priority given to injection drug users in provincial policy is the lack of a provincial drug policy. The almost complete, but now abandoned, four pillar (enforcement, prevention, harm reduction, treatment) provincial drug strategy signaled an attempt to create a formal partnership between two key government sectors – health and justice. Both departments are now, however, working on drug policy issues separately. This unfinished drug policy document could have emphasized harm reduction for women who inject drugs in Nova Scotia, and created or sustained a discourse between Justice and Health-focused stakeholders on the issue of harm reduction. Instead of re-visiting the idea of creating a provincial drug policy, the Nova Scotia Government recently announced that it would be developing a combined Mental Health and Addictions Strategy. Several participants expressed concern over what they expect will be a mental health strategy with a limited addictions component. Many participants felt a combined document would not be able to address the various drug policy issues with the necessary breadth and scope. Participants generally felt that there should be a stand-alone drug or addictions strategy.

As mentioned in the opening paragraph of this section, overlooking the specific (and heterogeneous) HIV prevention needs of women who inject drugs in provincial HIV policy content is likely a reflection of the position and experiences of those individuals and organizations involved in HIV prevention and harm reduction policy development in Nova Scotia. As the previous section discussed, women who inject drugs and representatives from women's organizations are generally not included in policy development processes. Consequently, there is likely no one on policy development committees who routinely raises the issue of gender or describes the influence of gender on injection drug use. Perhaps as a result, there are currently no programs offered throughout Nova Scotia specifically for women who inject drugs.

In addition, most drug-focused programming attracts a primarily male clientele, which means that even the representatives from community-based organizations who work directly with people who inject drugs are working with a clientele where women are underrepresented. That being said, some community-based organizations in Nova Scotia do hire female staff with past injection drug use experience who could promote consideration of the specific needs of this population. As the previous section explained, however, the voice of community-based organizations is less prominent in policy development and thus in final policy content.

In summary, while all of Nova Scotia's HIV prevention and harm reduction policy documents mention gender as a determinant of health, none discuss how an analysis of gender could be used to inform HIV prevention and harm reduction policy for

women who inject drugs. None of the documents include a nuanced discussion of men and women's different HIV prevention needs as they relate to injection drugs use or discuss the heterogeneity found within Nova Scotia's male and female injection drug-using populations. This is not to say that an understanding of women's HIV prevention needs is lacking in Nova Scotia; to the contrary, many of the front-line workers who participated in this study were keenly aware of these needs. However, this type of knowledge has not been incorporated into the policy documents. Although policy documents must be succinct in their coverage of specific issues in order to cover a broad range of issues and recommendations, it is nonetheless possible for policies to provide a more comprehensive discussion of how men and women engage in behaviours that put them at risk for HIV and other blood borne infections. No organization involved in policy development and implementation is currently mandated to do this work.

8.3 Processes: Deemed Irrelevant by Community-based Organizations

When participants were asked to describe the processes involved in developing HIV policy for people who inject drugs, several community-based participants wanted to shift the conversation away from discussing policy development processes, towards talking about the current needs of their program users and the challenges they experience in meeting these needs. As they explained, they feel largely disengaged from the policy process as it does not play a regular role in their work. Policy work was so infrequent and policy recommendations so slowly implemented, that many participants felt that it was not relevant to making current programming decisions.

According to participants HIV prevention and harm reduction policy development work only occurs approximately every 6-10 years in Nova Scotia. Several participants felt that HIV prevention and harm reduction policy development was slow and incremental because of a general lack of interest in and resources for HIV work or work targeted towards marginalized populations.   For example, it has been suggested that the provincial government did not allocate sufficient funding for the development of the Nova Scotia Strategy on HIV/AIDS, and as such the resulting gap was subsequently filled by other funding sources such as for-profit companies.

The lack of sufficient and secure funding for policy implementation was also a regular source of frustration for many participants. Many explained that ad hoc meetings were currently arranged to address issues as they arose in the community, because of the lack of effective policy implementation. These informal, ad hoc, less inclusive meetings were helpful for addressing individual issues, but less useful as a way of assembling the larger network to lobby or advocate for future resources for HIV prevention and harm reduction programming.

Several participants also pointed out that when significant policy issues specific to injection drug users receive attention and funding in Nova Scotia, it is sometimes as a result of media pressure on government, not through policy development or implementation. For example, during the writing of this thesis, the Nova Scotia government was pressured into creating a new methadone program in the Annapolis Valley, after multiple deaths from prescription drug overdoses were identified (Nova

Scotia Department of Health and Wellness, 2011; Chronicle Herald, 2011). Once the story was widely publicized government convened a working group, recommendations followed, and plans for a new methadone clinic were announced (Chronicle Herald, 2011). As one participant explained, despite policy network members being regularly told there were no resources by their government funders, resources for additional harm reduction programming could be found if enough media attention and public scrutiny was directed at local politicians.

When participants were asked whether they anticipated any of Nova Scotia's HIV prevention or harm reduction policy documents being revisited and updated in the near future, a few said that they had not heard of plans to do this. One participant mentioned that since the Nova Scotia Strategy on HIV/AIDS was coming up on its tenth anniversary, it might be time to revisit it. A few participants explained that it would be dependent on whether or not government stakeholders decided to do this work. Some community-based participants questioned the utility and effectiveness of future policy development collaborations, yet stated that they would continue to be involved as they felt it was important to participate both as a networking strategy (to "stay in the loop") and because they believed it could affect their future funding.

8.4 Context: The Federal Conservative Government and HIV Prevention Policy for Women who Inject Drugs in Nova Scotia

Several of the barriers to HIV prevention and harm reduction policy development and implementation identified in this study were discussed in relation to the current

Federal Conservative Government. Specifically, participants discussed the Federal Conservative Government's lack of financial support for HIV prevention initiatives (including policy development and implementation), and their opposition to harm reduction as a drug policy approach, as having a significant negative influence on HIV prevention among women who inject drugs in Nova Scotia. It appears that the Federal Conservative Government's prohibitionist agenda, neoliberal priorities and lack of commitment to gender mainstreaming negatively impact HIV prevention for women who inject drugs at the provincial level.

Several participants in this study spoke of the Federal Conservative Government's lack of financial commitment to HIV, and how this impacts the ability of governmental and non-governmental agencies and organizations to engage in HIV prevention work. The lack of financial commitment to HIV also limits resources for policy development. As explained by one participant, very limited funds were available for HIV policy development in Nova Scotia and no resources have been earmarked specifically for the implementation of policy recommendations. In Canada, federal funding for HIV has not increased since 2007, and it is anticipated that there will be additional cuts in upcoming years (Canadian HIV/AIDS Legal Network, 2011). The Federal Initiative on HIV and AIDS promised to double funding for HIV/AIDS from $42.2 million annually in 2004 to $84.4 million by 2008 (PHAC, 2005). However, this commitment has not been met, and cuts have been made to the Public Health Agency of Canada's AIDS Community Action Programme by the Federal Conservative Government. Cuts to funding dramatically impact community-based organizations' ability to provide prevention and support

services, to engage in research and to participate in policy development and implementation. Further, as several participants explained they believe a lack of funding has reinforced a misconception among the general public that HIV prevention is not a priority issue, both nationally and provincially. As a few participants explained, the lack of resources to mount national and provincial HIV prevention campaigns has negatively impacted efforts to promote HIV as an important health issue in Canada in general, including Nova Scotia. Participants argued that a lack of funded HIV prevention education campaigns, combined with Nova Scotia's low HIV prevalence, has maintained the public's (and arguably the provincial government's) detachment from HIV as a local issue. In addition, women are also less likely than men to access both AIDS service organizations and harm reduction programs where they might learn more about their risk.

Participants who worked in government-based, drug-focused organizations also spoke about funding cuts and they specifically attributed the cuts to the Federal Conservative Government's opposition to harm reduction. As two participants explained, money was taken from Addiction Services budgets and redirected into Justice Department budgets for enforcement-based initiatives. In addition, several participants specifically linked the Federal Conservative Government's National Anti-Drug Strategy with the abandonment of Nova Scotia's four pillar provincial drug strategy. Participants argued that since the policy groups for the drug strategy had disbanded, the two groups worked on drug issues separately, and participants described this as problematic because the two groups have important overlapping policy issues and interests that require collaboration. Since the abandonment of the provincial drug policy document there has

been a lack of collaborative provincial policy development between these two groups to deal with key policy issues such as the availability of harm reduction services not just in the community but also in prisons. As previously stated, the City of Vancouver has achieved some success in creating collaboration around harm reduction between police, politicians, health and social service organizations (Vancouver Police Department, 2008). However, in Vancouver where injection drug use is a significant, visible problem there has developed a remarkable network of individuals and organizations engaged in HIV prevention and harm reduction advocacy and policy development (PHAC, 2006). Vancouver has many world-renowned individual researchers (i.e. Dr. Julio Montaner, Dr. Thomas Kerr, Dr. Evan Wood), social services and health organizations (i.e. the Portland Hotel Society and Vancouver Coastal Health), research institutes (i.e. the British Columbia Centre for Excellence in HIV/AIDS and the International Centre for Science in Drug Policy) and a peer drug user network (the Vancouver Area Network of Drug Users) all dedicated to creating a public discourse on drug use and promoting the importance of HIV prevention and harm reduction policy and programs for people who inject drugs (British Columbia Centre for Excellence in HIV/AIDS, 2011). Whereas, in Nova Scotia there are limited HIV or harm reduction lobbying efforts and less public discourse to promote the necessity of cross-sectoral collaboration and policy implementation.

The participants in this study argued that government shifts would likely continuously bring change around the political and social acceptance of harm reduction. They all believed that harm reduction was 'here to stay', despite the current Federal Conservative Government's position, but many were angry over what they saw as

interference in harm reduction's building momentum and acceptance, misdirected funds towards failed enforcement tactics, and safety and security trumping harm reduction in the provincial prison system.

8.5 Neoliberal Priorities and their Impact on Injection Drug Users

As mentioned in the literature review chapter, neoliberalism refers to an ideology or a set of economic policies that aim to cut government spending by privatizing public services (Brown, 2007; Broadbent, 2009; Dobrowolsky, 2009). In a neoliberal state individuals are ideally 'responsible' for managing their own (and potentially family members', friends' or community members') social risks, such as illness, poverty and unemployment with as little assistance from government as possible (Rose, 1998; Lemke, 2001). While this approach can save governments money, it has been found in Canada and elsewhere to increase income and health inequality between the rich and the poor with dramatic social and health implications for those in lower income categories and the poor, such as higher rates of mental illness and drug use (Wilkinson & Pickett, 2009; Dobrowolsky, 2009). Despite this, a neoliberal ideology has been supported by all of the federal governments in power in Canada since the Liberal party took over in 1993, at which time social spending decreased from approximately 53.3% to 39.5%, making Canada the weakest welfare state in the North Atlantic region (OECD, 2008; Broadbent, 2009; Dobrowolsky, 2009). The cuts in spending were taken from areas such as health care, post-secondary education, affordable housing, environment protection and infrastructure (Broadbent, 2009). This ideology continues to be supported by the current Federal Conservative Government (Broadbent, 2009).

Support for neoliberal public policies has significant implications in terms of the social, health and economic wellbeing of injection drug users (Burt, 1997: Friedman et al., 2001; Teghtsoonian, 2003; Dobrowolsky, 2009). Friedman et al. (2001) argue that neoliberalism is particularly detrimental to the injection drug user as this ideology sets them up as 'bad citizens' who make individual decisions that burden the health care system, essentially 'othering' and vilifying them. Several researchers have further argued that neoliberalism benefits government in terms of depoliticizing social issues, for example by placing the responsibility for drug use and ill health on the individual and away from social and structural issues (Rose, 1998: Lemke, 2001; Raphael et al., 2008; Friedman et al., 2001). Raphael et al., (2008) argue that despite the Federal Conservative Government's stated commitment to using a determinants of health approach to inform the development of population health initiatives, the structural determinants of health still routinely remain on the fringe of the mainstream health discourse. These researchers argue that this is in part due to the fact that the people in Canada who have the financial means to run for political parties generally come from the business class and have values and interests in line with the views from this position, making them disconnected from the health and social issues experienced by marginalized groups.

Several of the negative social and health impacts identified as symptomatic of a neoliberal state, are clearly present in Nova Scotia. Nova Scotians experience lower incomes, higher rates of unemployment, higher than average rates of crime, and a smaller proportional share of the national wealth than much of the rest of Canada (GPI, 2008). As previously stated, Nova Scotia also has a serious drug problem insofar as rates of drug

use are high relative to the population size (PHAC, 2005). Cape Breton, which has the highest rates of unemployment for the province (GPI Atlantic, 2008) was described by participants in this study as having an especially significant drug problem, fuelled by poverty and a lack of sufficient drug treatment resources. In this study participants unanimously identified a lack of health and social service funding as a major barrier to addressing the needs of socially disadvantaged populations. Participants working in community-based organizations described the current federal and provincial governments as increasingly providing them with less or the same amount of operational funding while simultaneously expecting them to do more work, offer more programming, and participate in more meetings.

Interestingly, in a political climate where the federal government is focusing on cost-efficiencies, one would expect harm reduction initiatives to enjoy government support due to its proven cost-efficiency (Wood et al., 2006) and emphasis on self-managed care (Friedman, 2001; Broadbent, 2009; Dobrowolsky, 2009). However, the social stigma surrounding injection drug use appears to create a differential standard for the acceptance of evidence. Friedman et al. (2001) argue that governments are fully aware that harm reduction initiatives save the lives of people who inject drugs and save money, yet they wilfully choose to oppose the adoption of these approaches because they are looking to appear tough on drugs and crime. As such, one can argue that the Federal Conservative Government's opposition to harm reduction is likely a more direct reflection of their interest in supporting a prohibitionist agenda, and less a neoliberal interest. However, both have the potential to negatively influence, and together

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compound, HIV risk. With a prohibitionist agenda motivated to limit injection drug users' access to harm-reduction based programs and services (Government of Canada, 2007), and neoliberalism contributing to social issues which may exacerbate drug use (Wilkinson & Pickett, 2009).

Zibbell (2004) argues that neoliberal governments also negatively impact people who inject drugs because they fail to allow this population to be meaningfully involved in government-led approaches to policy decision-making. Zibbell argues that a neoliberal system positions all individuals, including drug users, as 'experts of their own health' but then simultaneously ensures drug users are kept outside of the public arena in terms of policy development because they often do not hold the social position or paper qualifications required to be employed by government or asked to accept policy decision-maker positions. This generally gives drug users limited or no representation and decision-making power at the level of policy development. It is possible that this same argument could be extended to the representatives of community-based organizations themselves, who are invited to participate but often feel their contributions are taken less seriously and given less weight in policy processes and content.

8.6 The Government of Canada's Lack of Commitment to Gender Mainstreaming

When participants in this study were asked if they were familiar with gender-based analysis (GBA), many were not and defaulted to talking about women as soon as

gender was mentioned[3]. After being given a definition for the term, most community-based participants said that they were not actively engaging in GBA (or the collection of sex-disaggregated data) primarily due to time, resource or capacity constraints. Government-based participants were more likely to be familiar with GBA and several in management positions had been involved in GBA workshops several years previously. Participants were generally not aware that GBA had been formally adopted and mandated by the federal government and few were familiar with the Status of Women Canada's GBA Action Plan (2009). One federal government employee explained that she was on a national gender and social inclusion committee, but had not seen GBA work filter down to the provincial level in calls for funding or in program appraisals. These findings are supported in the literature which argues that the Canadian government has been largely unsuccessful at implementing GBA (Hankivsky, 2009).

Groups such as the Status of Women, the Women's Health Bureau and the Secretary of State have fought for the integration of gender-based analysis into government policies and legislation since 1995. Although they have succeeded at ensuring its inclusion in many working documents, it rarely has been found to filter down into policies at the various sectoral levels, and has not been 'mainstreamed' within government in the sense that GBA has not been systematically implemented across government department and agencies (Sherwin, 2001). In Nova Scotia, with no women's organizations currently involved in HIV prevention or harm reduction policy there were

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[3] However, this focus on women during discussions of GBA was potentially biased by the fact that participants were told prior to beginning their interview that the study was looking at the HIV prevention policy needs of women who inject drugs.

no stakeholders regularly pushing this agenda forward. Even women's organizations working for the federal government no longer have the resources to mainstream gender in a significant way (Hankivsky, 2006). In 2006, the Federal Conservative Government cut funding for the Status of Women Canada (SWC) by 43%, along with funding for many other women's groups, which has significantly reduced federal and provincial capacity to carry gender research and advocacy forward (Canadian Centre for Policy Alternatives, 2008). In addition, as noted by Hankivsky (2006) the SWC's goals were changed at the same time from 'promoting and protecting gender equality or promoting political justice' to 'facilitating women's participation in Canadian society by addressing their economic, social and cultural situation through Canadian organizations' (Hankivsky, 2006, p. 54). Hankivsky argues that this move reflects national neoliberal priorities placing responsibility for health on individuals and discouraging social justice agendas. This rewording also delineates the work of GBA to women's organizations, which is problematic since these organizations have received such significant funding cuts, meaning there are no agencies in government that are sufficiently funded or trained to do this work. The rewording of their mandate is also problematic because it erases 'men' from the equation of gender mainstreaming as a way to promote and protect gender equality and political justice for all.

That being said, several researchers have argued that since gender is not the only determinant of health, government should promote lenses that look at the inter-sectionality or 'layering' of determinants, such as diversity or inclusion lenses, that position determinants of health in relation to one another as a way of promoting equality

in health policy (Williams, 1999; Hankivsky, 2006; Sherwin, 2001). Several researchers have argued that GBA in practice has narrowly focused on women (despite this not being its original intention), and presents members of the same gender as having homogenous needs (Williams, 1999; Sherwin, 2001; Hankivsky, 2006). As such, they argue that it is essential for governments to consider the use of broader lenses. However, this begs the question: Would a more complex lens that requires the study of several types of systematic marginalization succeed where GBA failed, especially in a neoliberal state? Likely not, as the resources and cross-sectoral collaboration required to mainstream a broader lens would be much more extensive and it would highlight additional systemic and structural problems which the government would then be pressured to address. Williams (1999) further points out that because many issues of diversity are not captured in statistics (i.e. sexual orientation) government would have to fund extensive qualitative research to see if the diversity of women's experience is reflected in policies or programs (Williams, 1999).

Summary

The existing Nova Scotia-based policy development and implementation network, their policies, their processes and the context within which they have functioned over the past ten years do not appear to be supporting the development of HIV prevention and harm reduction policy which addresses the needs of women who inject drugs.

Although HIV prevention and harm reduction policy development in Nova Scotia appears relatively inclusive in terms of having representation from both government and

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community-based organizations, the positioning of key organizations and their subsequent level of influence on the finished policy document was not, according to participants in this study, equal across stakeholder organizations. Committee members who work directly with women who inject drugs were placed in a subordinate policy decision-maker position to government-based managerial-level committee members, which decreased their influence on the policies' content and processes. In addition, several key stakeholder organizations that could have been instrumental in promoting the issues and needs of women who inject drugs (i.e. women themselves and representatives from women's organizations) were not represented on these committees. As a result, the needs of women who inject drugs do not appear to have been prioritized in policy processes or content and subsequently there do not appear to be targeted resources going to the community-based organizations that provide services to these women. The lack of engagement of community members with significant public lobbying power, for example politicians or senior health officials, appears to have limited the profile of the documents, which are not currently a significant feature in public debate and discussion.

The various points made in this section are not intended to place blame on the stakeholder organizations who led the development of the key policy documents. Instead, the aim of this discussion has been to identify the challenges of decision-maker membership and roles within the current policy development system. It is also not intended to imply that local 'government is bad' and that they orchestrate a dysfunctional system with little concern for policy development and implementation outcomes. Several community-based participants in fact identified government decision-maker champions in

the development of these documents. However, participants from the community-based organizations, like several of the government-based participants, did express frustration with the 'system', and the seeming inability of a bureaucratic system to generate timely change and make improvements for local program users. As it stands, most participants believed that the 'system' is not functioning in a way that meets the needs of people who inject drugs, although few recognized that it was especially not meeting the needs of women who inject drugs.

In addition, this discussion is not meant to imply that government should not lead or initiate policy development or implementation, as they are often the only group with sufficient resources to undertake this work. Rather, this discussion suggests that the representation, positioning and use of member expertise, needs to be reconsidered. This can be clearly demonstrated and potentially reconsidered if one looks at the ways in which stakeholder organizations were positioned differently on the three key provincial policy documents. To be precise, the Best Practices Guide to Preventing Substance Use Problems in Nova Scotia was not inclusive of community voice, its authors were not situated in Nova Scotia and only a few government-based workers in management positions reviewed the document prior to its publication. Consequently this document did not resonate with local community-based organizations. In contrast, the Standards for Blood Borne Pathogens Prevention Services included high level government staff on their steering committee and community-based organizations on working groups. Despite the lack of equal positioning between these groups while working on this document, community-based groups felt that the final document was useful as a tool to

lobby government for resources, in part because it was government-endorsed. As one community-based participant explained, she felt that document carried a bit more 'weight' with provincial government funding decision-makers because it was published as one of their own departmental documents, so they may have felt a responsibility to support its recommendations. The NSAC created a Nova Scotia Strategy on HIV/AIDS steering committee with equal representation from government and community, yet the final document received little support perhaps related to NSAC's arms-length government status. This scenario would suggest that it is advantageous to have the provincial government actively involved in leading development and implementation of HIV prevention and harm reduction documents as a tactic for greater government-based support for implementation. Maintaining provincial government-based organizations as the lead organizations in policy development and implementation could therefore be a good idea, at least in the short term, while resource allocation is a key barrier and key source of inter-group tension. However, effort should be put into determining ways to address the causes of these inter-group tensions. This could help build policy development committees and processes that are inclusive and promote the equal positioning of stakeholder organizations, and that focus on creating policy that is directed by the identified needs of women who inject drugs.

At present it appears that the Federal Conservative Government, through their neoliberal public policies, opposition to harm reduction and lack of support for GBA, is affecting HIV prevention and harm reduction policy for women who inject drugs. Promoting harm reduction as an evidence-based approach to HIV prevention among people who inject drugs and incorporating GBA systematically as a government-led

gender equality measure is needed in order to ensure the development of HIV prevention and harm reduction policy that addresses the needs of women who inject drugs. Advocacy and political commitment, leadership, and adequate resources for policy development and implementation are also needed to address the current situation. These efforts could be greatly supported by encouraging and financially supporting research that looks at national, provincial and community-based social, political and economic influences on health policy development and implementation.

CHAPTER NINE: Conclusions

This study explored how, and if, HIV prevention and harm reduction policy in Nova Scotia addresses the HIV prevention needs of women who inject drugs. This exploration was carried out by looking at the organizations involved in policy development and implementation, the policy content, the policy development processes and by applying GBA. The following chapter will demonstrate that the three key provincial HIV and harm reduction policy documents that have been developed since 2003 are not inclusive of the voice of women who inject drugs, and are largely overlooking the HIV prevention needs of this population for a variety of reasons.

Policy development network members in Nova Scotia come from a variety of organizations, both governmental and non-governmental, with diverse mandates and different degrees of focus on HIV and harm reduction. Most of the representatives from the participating organizations have limited or no direct work or professional contact with women who inject drugs. Individuals working in organizations that do work directly with women who inject drugs recognize the influence of gender on their program users' HIV risk, but they generally have significantly more male program users (the ratio of men to women being approximately 70-30). There are a number of factors that may explain why fewer women are accessing services, including women receiving more social stigma and less social support in relation to seeking treatment for their drug use (Pinkham & Malinowska-Sempruch, 2008) or familial responsibilities (Finkelstein et al., 1997). Having significantly fewer female service users might make it more difficult for these

service provider organizations to rationalize a focus on women and their specific needs. In addition, according to participants in this study, these organizations are chronically underfunded and lack the time, resources and capacity to consistently collect gender-specific information or offer gender-specific programming. As a result of these various organizational characteristics and issues, women who inject drugs in Nova Scotia are often overlooked as a group requiring unique, targeted HIV prevention policy initiatives. The lack of inclusion of representatives from women's organizations may also contribute to the network having less capacity to build gender-based considerations into policy development in a comprehensive way. Lastly, and most importantly, women who inject drugs in Nova Scotia were not directly or consistently consulted in the development of Nova Scotia's key HIV prevention and harm reduction policy documents.

The significance of gender as a determinant of health is stated in all three documents, however it is not meaningfully integrated into the policies' content, and none of the documents contain recommended actions for GBA or recommended actions specifically for women who inject drugs. In 2003, after the publication of the Nova Scotia Strategy on HIV/AIDS, local researchers pointed out that the document should have included GBA as a framework in its development. A supplemental post-hoc GBA document was created, providing no opportunity to engage women from high risk populations in its development.

At present, Nova Scotia's HIV prevention and harm reduction policy content insufficiently addresses the HIV prevention needs of women who inject drugs and there are no current plans to revisit or renew these documents. Participants explained that there was currently no funding to renew the Nova Scotia Strategy on HIV/AIDS and no clear departmental ownership within the provincial government to renew the Standards for Blood Borne Pathogens Prevention document.   However, as previously mentioned stakeholders in Sydney, Cape Breton are working on revisiting the Standards document in their specific health region through a community-based organization and DHA collaboration.

By exploring the policy development and implementation processes this study also identified several barriers to creating policy informed by women who inject drugs. Currently none of the organizations involved in this network applies GBA, as none have it as part of their mandate or are required to do it as a funding stipulation or as a part of performance appraisals. Those individuals who play the more influential roles in policy development (managers or directors in government) often have no contact with this population, which renders them generally less familiar with injection drug using women's HIV prevention needs.   The stakeholders with the most direct understanding of these needs were usually subordinate in policy decision-making processes, positioned on working groups rather than steering committees that pre-determined the focus of the working groups. As a result, many felt that their participation was tokenistic and tension developed between some stakeholder groups.   Several participants from community-based organizations questioned the utility of their involvement in these processes, but felt

bound to participate as a necessary function to remain 'in the loop' and to not miss out on possible funding discussions or opportunities. Responsibility for finalizing and writing the policy documents fell to government-based organizations and many community-based participants felt this process took too long and was not responsive to the urgency of community members' needs. After the documents were published, few recommendations were implemented due to a lack of dedicated funding. Participants attributed this to the Federal Conservative Government's lack of priority and attention to HIV as well as a lack of support for harm reduction initiatives, both resulting in less funding.

Although rates of HIV are currently relatively low among women who inject drugs in Nova Scotia compared to other provinces, local research findings suggest that female injection drug users are engaging in unsafe injection and sexual practices and often lack access to harm reduction-based programming and resources, particularly in rural parts of the province (Ploem, 2000; PHAC, 2006; Jackson et al., 2010; Parker et al., 2011; Hodder, 2011). In a provincial context of high HCV rates, high prevalence of injection drug use and HIV risk behaviours, preventing HIV infection will depend on the development of proactive and gender-informed HIV prevention policies. A truly effective approach to addressing the needs of this group will require a concerted effort on behalf of all stakeholders to ensure this group is engaged in policy, prioritized in policy and targeted for resources.

9.1 Recommendations

By not purposefully including the issues and concerns of women who inject drugs, as well as creating opportunities for women injection drug users' participation in policy development and implementation, it is likely their HIV prevention needs will continue to lack priority in policy documents. Federal, provincial and DHA-level government organizations and community-based organizations should position affected populations at the forefront of development and implementation of the policies that most directly affect them. Documents such as the Canadian HIV/AIDS Legal Network's 'Nothing About Us, Without Us', can help organizations understand why this is an important goal and determine how best to meet it (2005). In the realms of HIV/AIDS policy and drug policy, the promotion and acceptance of the Greater Involvement of People Living with HIV and AIDS (GIPA) principles and the Vienna Declaration (2010) also provide precedent and direction (Leading Together Document, PHAC, 2005; International Centre for Science in Drug Policy, 2010). In addition to the practical benefits of including women who inject drugs in the development of HIV prevention and harm reduction policy, there are ethical and human rights imperatives that require greater involvement of people who use drugs. Specifically, the rationale is that all people should have the right to influence decisions that affect their lives (Roy, 1999). The Government of Canada committed to 'the greater involvement of people living with HIV and of people from marginalized communities" when they signed the UN General Assembly's Declaration of Commitment on HIV/AIDS in 2001 (UN General Assembly, 2001). This declaration urges states to involve representatives of groups vulnerable to HIV/AIDS, including people who use drugs, in

consultations and in the planning and delivery of services (Canadian HIV/AIDS Legal Network, 2005).

Future policy work should hold stakeholders accountable to creating gender-informed HIV prevention and harm reduction policy. Since women who inject drugs have been identified in local, national and international documents as a population with unique HIV prevention needs, this signifies the need for ongoing engagement in gender-based analysis to inform policy. In addition, the federal government must be held accountable for promoting GBA, but not providing the resources (i.e. funding cuts to women's organizations) to allow this work to proceed. Lack of 'meaningful' attention to gender perpetuates androcentric policy and programs and sustains gender-insensitive, inaccessible or exclusive policies that increase women's HIV risk.

It is the responsibility of all stakeholder groups to be accountable to the development and implementation of HIV prevention and harm reduction policy by determining how best to work together collaboratively. This will require identifying, discussing and addressing power differentials within policy networks and also national-level barriers which influence provincial policy development and implementation. Considering that a lack of funding will likely continue to be one of the most pressing barriers and the situation may in fact worsen, the policy networks should generate ideas about alternatives to government funding sources, perhaps exploring the potential utility of engaging private organizations for financial assistance. However, this strategy should be used for supplemental funding, as organizations must remain mindful that provincial and federal

governments are responsible for providing financially support to HIV prevention and harm reduction programs for women who inject drugs. In addition, network organizations should consider the potential benefits of identifying provincial or national organizations with whom they could collaborate to bring more attention to the need for improved funding for HIV prevention and harm reduction policy and programming in Nova Scotia. A few of the community-based organizations identified the Canadian HIV/AIDS Legal Network in Toronto and the Vancouver Area Network of Drug Users, among others, as organizations they admired and worked with in a limited capacity. Perhaps these ties could be strengthened, and others, particularly some with organizations with a women's health agenda focus (i.e. the Women's Action Coalition of Nova Scotia), could be forged to create partnerships that might bring more attention to the HIV prevention needs of women who inject drugs in Nova Scotia.

Lastly, future research should focus on the need for Hepatitis C-specific policy development and prevention programming resources in Nova Scotia for women and men who inject drugs. Rates of Hepatitis C continue to increase among injection drug users in Nova Scotia at an alarming rate (PHAC, 2006). At present there is little policy organizing specifically around Hepatitis C prevention in Nova Scotia, as most disease prevention programming and policy targeted at people who inject drugs is funded using HIV-earmarked resources. The majority of the individuals and organizations involved in HIV policy development in Nova Scotia are also invested in Hepatitis C prevention and should be supported in this work.

9.2 Methodological Issues

Acknowledging several methodological issues in this study and discussing various study limitations is important to inform future research. This section looks specifically at the researcher's 'position' in relation to participants and study limitations.

'Positionality' refers to the researcher's position as either an 'insider' or 'outsider' to the participants under study, and can influence access and interpretation (Shiffman, 2007). With respect to positionality, the researcher in this study was an outsider. However, the network of individuals working on HIV prevention policy and programming in Nova Scotia is few in number and therefore individuals in the academic community and service providers are often known to one another. As such, several of the participants were familiar with the researcher's committee members and had worked with them on various projects and working groups. These relationships possibly influenced their perceptions of the study and of the researcher's inclinations toward being supportive of harm reduction and gender-informed research. Member checking was included as a way to check whether the researcher's position as an 'outsider' limited her ability to ask valuable questions and interpret results. All participants were offered the opportunity to review their transcripts, 22/27 agreed to review their transcripts, and 9 sent back questions, revisions or comments.

9.2.1   Limitations

The researcher was limited in the amount of time and access she had in observing the network's functioning, and may not have been able to develop the level of trust with

key informants that would facilitate disclosure of their perspectives.   As Buse (2008) describes, it is difficult to study policy decision-making as an outsider because of the many subtle or hidden manifestations (or non-decisions) involved in policy development. Long-term participant observation may have allowed for the development of a more nuanced understanding of each theme. However, in spite of this, the findings are quite credible because time was taken to ensure that each interviewee was able to ask questions during the interview process, review his or her interview transcript, and each participant was told they could contact the researcher or her committee members to discuss the study to ask questions and clarify any of their responses.

Although an almost equal number of government and non-government key informants participated in this study, community-based participants provided significantly more detailed responses to individual questions.   Despite this, the differences between the two groups' responses became valuable data as they highlighted some of the organizational differences between government and community-based organizations: specifically that community-based participants are more involved in the overall operations of their agencies and more directly involved in advocacy work, they feel more able to use 'free speech' when discussing political topics, and have narrower 'portfolios', which allows them to focus more specifically on HIV and/or drug use.   In addition, the nature of the questions asked of participants possibly introduced a response bias in terms of participants who were concerned with appearing to be supportive of harm reduction. Indeed, several community-based participants, believed that their government-based colleagues were less able to talk about harm reduction as a result of the current

Federal Conservative Government's lack of support for harm reduction-based initiatives and policy.

In an effort to include stakeholders who could speak to the diversity of the female injection drug using population in Nova Scotia, participants were sought who could discuss the particular HIV prevention policy needs of women injection drug users who fell into one of four subgroups of women in Nova Scotia: namely rural women, young women, Aboriginal women and African Nova Scotian women. Because the number of identified representatives from each of these various communities was small in this study, their data were included in the overall findings, but not singled out as relating to a specific sub-population of women who inject drugs in order to protect the individuals' identities. It is recommended that future studies on this topic focus on diversity in order to present a more thorough discussion on the varied needs of women who inject drugs. Poverty, sexual orientation, and ability level, in addition to race, ethnicity, age, and location should be explored more specifically in relation to their impact on women's HIV prevention policy needs.

Lastly, this study only engaged one participant from a justice-focused organization. This was the result of there being very little representation from this group on previous HIV prevention or harm reduction policy committees, and consequently few people with the experience to respond to questions. Had the researcher known at the outset of the study how significant this group's perspective might be on the research findings, she would have tried to identify more representatives to talk about the

abandoned provincial drug policy. Future studies on HIV prevention and harm reduction policy in Nova Scotia should seek greater justice-focused representation to gain a greater understanding of their perspectives on this issue.

9.3 Contributions of the Thesis Research to New Knowledge

An analysis of HIV prevention and harm reduction policy development in relation to women who inject drugs had not previously been conducted in Nova Scotia. As such, this thesis contributes new knowledge about the people involved, the content, the processes and the context surrounding this policy development work. In addition, to the researcher's knowledge, Walt and Gilson's Policy Triangle Framework has never been used to frame this issue anywhere in Canada. Using this study as an example, future research could apply this framework to study policy in other locations and on other health issues to learn more about the various influences on policy development and implementation. In addition, this thesis adds to the literature that demonstrates there is utility in applying inter-organizational theory to study policy development and implementation. Lastly, this thesis demonstrated how qualitative research methods can produce detail-rich information on the complex issue of policy development.

9.4 Plans for Dissemination

It is well recognized that research is often conducted without feedback to participants, and 'uptake' by policy makers (Lomas, 1997). It is important that the results from the current study do move beyond the walls of academia because otherwise opportunity for knowledge exchange and solution generation is lost. Ensuring research

uptake in policy development requires communication between the researcher and the policy decision-makers. This communication must occur with consideration of the realities facing policy decision-makers (competing issues, funding limitations) when they are trying to interpret and implement research findings (Lomas, 1997). As a result, the research will anticipate that the dissemination of the results of this study will require targeted and ongoing effort.

The first step will involve disseminating the dissertation's executive summary to all interested study participants and offering to meet with individuals to discuss the research findings. Next a general, overview presentation on the project will be offered to participating organizations, AIDS service organizations, community-based organizations, government departments and in university classes. Results of the study will also be presented at conferences and papers on the findings will be submitted for publication in peer-reviewed journals. An overview presentation and briefing note will also be prepared for policy decision-makers in other fields. Lastly, it came to the attention of the researcher during this study that Halifax has a newly reconvened Women's Action Coalition, a committee formed of representatives from various women's organizations across the province. It is the intention of the researcher to ask to join this group so as to exchange ideas about the current study and how it relates to other local women's equality and social justice issues.

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Appendix A

NOVA SCOTIA'S DISTRICT HEALTH AUTHORITIES
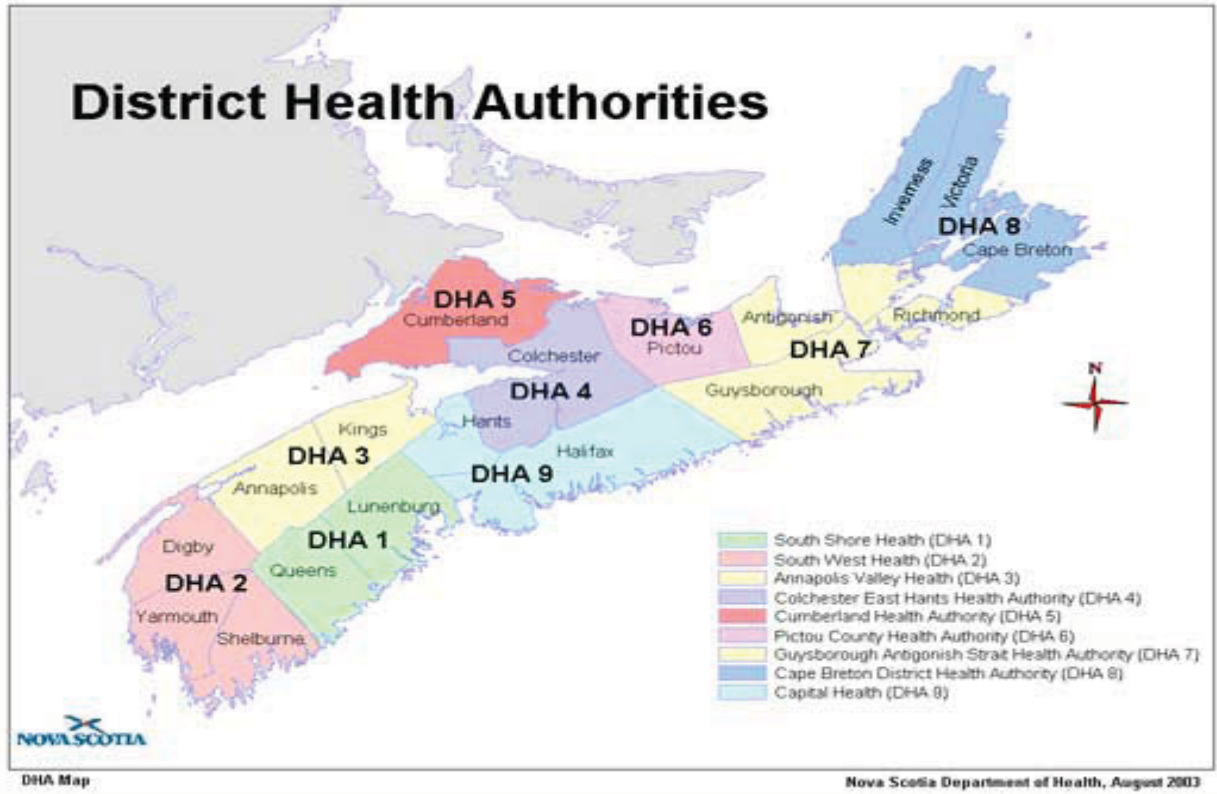
Appendix B

Principles of Harm Reduction
(modified from IHRA, 2009)

1) **Harm reduction initiatives must target specific risks and harms through an assessment of the risk and harms associated with specific drugs, their causes and how they can be reduced.** Attention must be paid to factors that may render people who use drugs vulnerable, such as age, gender, and incarceration.

2) **Harm reduction initiatives must be evidence-based and cost-effective**. Harm reduction initiatives should be low-cost/high impact. Specifically, they must be easy to implement, inexpensive and demonstrate evidence of their ability to improve individual and community health.

3) **Harm reduction initiatives are facilitative rather than coercive and are flexible to accommodate the needs of individuals**. The benefits associated with harm reduction initiatives are often incremental and can be measured in small gains. Keeping people alive and preventing irreparable damage is considered a more urgent priority than abstinence.

4) **Harm reduction initiatives are non-stigmatizing and treat individuals with dignity and compassion**. Terminology, language and stereotypes that marginalize people who use drugs and create barriers to support and care are considered and challenged.

5) **Harm reduction initiatives acknowledge that human rights apply to everyone and promote responses to drug use that respect and protect fundamental human rights**. People who use drugs have a right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from inhuman or degrading treatment.

6) **Harm reduction initiatives challenge policies and practices that exacerbate the harms associated with drug use**. Harms can be increased through a variety of interrelated factors including individual behaviours, environments in which drugs are used and drug control laws and policies. Institutionally-supported practices and laws, such as abusive policing, restrictive and punative laws, denial of life-saving medical care and harm reduction services or more general social inequities such as stigma and discrimination can perpetuate the harms associated with drug use. International, national and local institutions, laws and policies must be challenged to avoid exacerbating risky drug using environments in favour of creating environments where people who use drugs will be supported in achieving positive change.

7) **Harm reduction initiatives must be transparent, accountable and participatory**. Harm reduction interventions must be open to evaluation, consultation and debate to help practitioners and decision-makers determine successes and failures. All stakeholders,

including people who use drugs, program administrators, police, community members, researchers, etc. should be meaningfully involved in policy development and program implementation, delivery and evaluation. People who use drugs must be involved in decisions that affect them in order to promote program suitability and use.

Appendix C

LIST OF POLICY DOCUMENTS AND RESEARCH REPORTS REVIEWED

Provincial Policy Documents and Research Reports

Nova Scotia's Strategy on HIV/AIDS (2003) and its accompanying documents
Standards for Blood Borne Pathogens (2004)
Best Practices for Preventing Substance Use Problems in Nova Scotia (2008)
Environmental Scan of Injection Drug Use, Related Infectious Diseases, High-risk
Behaviours, and Relevant Programming in Atlantic Canada (2006)

Appendix D

INTRODUCTION LETTER TO POTENTIAL PARTICIPANTS

Research Study

An exploration of the relationships between harm reduction policy and community-based HIV prevention programming for women who inject drugs in Nova Scotia.

Student Researcher:	**Supervisor:**
Susan McWilliam	Dr. Jacqueline Gahahgan
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Purpose: The purpose of the study I am conducting is to explore the relationships between harm reduction policy and community-based HIV prevention programming for women who inject drugs in Nova Scotia. Specifically, I am interested in exploring how policy content, context, processes and actors have shaped harm reduction and HIV prevention policy and programs in this province in the context of diminishing support for harm reduction at the national level. I believe that government workers in HIV policy and programming and service providers who work with women who inject drugs are well-positioned to discuss what elements of existing policy and programming work in Nova Scotia to meet the HIV prevention needs of women who inject drugs, what elements do not work and what changes are needed to improve policy and programming in the future.

Methods: I am currently seeking individuals to interview as key informants for this study. I will be conducting key informant interviews with people engaged in employment (paid or volunteer) in both the policy setting and programming spheres of HIV prevention work throughout Nova Scotia. Interviews will take place as one-on-one interviews either face-to-face or over the telephone depending on the participant's preference. Interviews are expected to last between 1 and 2 hours.

Tentative Timeline: I will be conducting interviews throughout March and April 2011.

Researcher: My name is Susan McWilliam and I am currently completing my Doctorate at Dalhousie University in the Interdisciplinary PhD Programme. My research background and interests include health promotion for marginalized women, HIV policy and programming relating to prevention, care, treatment and support, drug policy and programming and qualitative research methods. My research is funded through the Atlantic Interdisciplinary Research Network (AIRN).

Appendix E

INTERVIEW GUIDE

Themes to be discussed in all individual interviews:

1) Actors involved in the provincial policy development and implementation system.

2) Processes involved in policy development and implementation.

3) Context surrounding harm reduction and HIV (local and perceived impact of national context).

4) Content of local HIV prevention and harm reduction policy and programs.

5) Impact of these four components on HIV prevention and harm reduction policy and programming for women who inject drugs in Nova Scotia.

Interview Guide Questions:

Introduction and General Harm Reduction Questions

- Please tell me a little bit about your job.

- How has your work been connected to harm reduction and/or HIV prevention for people who inject drugs in Nova Scotia?

- You mentioned your involvement in _____, can you tell me more about how you were involved?

- How has your work involved harm reduction tools, programs or services?

- What is your perspective on harm reduction? How has your work influenced your perspective on harm reduction?

- Has your work involved using harm reduction tools, programs or services with both men and women?

- What specific policies and/or programs do you consult and which do you work on and in what capacity?

- Do you feel harm reduction is supported politically, legally and socially in your community?

- How is your agency funded? Do you fund/support other agencies?

Local Actors

- Who is involved in developing and implementing HIV prevention and harm reduction policies and programs in your community? In other NS communities?

- Who is involved in developing and implementing HIV prevention or harm reduction policy in your community? In other NS communities?

- What other agencies does your agency partner with? Please describe these relationships and how often and in what manner you collaborate?

- Do you sit on any HIV prevention or harm reduction committees or working groups? Please describe any additional memberships you hold within harm reduction or HIV interest groups, committee, or professional associations.

Local Process

- Please describe how decisions about HIV prevention an d harm reduction policy and programming are made in Nova Scotia?

- Please describe how HIV prevention and harm reduction policy agendas are set in Nova Scotia?

- Please describe how HIV prevention and/or harm reduction policies are formulated in Nova Scotia?

- Please describe how HIV prevention and/or harm reduction policies are implemented and evaluated in Nova Scotia?

Local Content

- What provincial/municipal HIV prevention/harm reduction/drug policy documents exist and do you use them to guide your work?

- How do these documents describe harm reduction?

- How do these documents address the HIV prevention needs of women who inject drugs?

- How has the content of these documents changed since you've worked in this field?

- What influences content change in these documents (related to harm reduction or HIV prevention for women who inject drugs)?

- Do you see policy and programming disconnects for harm reduction?

- What role do you think ideology plays in decision making around harm reduction?

- What role do you think evidence plays in decision making around harm reduction?

- What do you think this all means for future policy and programming for injection drug users in NS?

Local Context

- How do you think decisions about HIV prevention and harm reduction policy are made in your community/city/province?

- What was going on in your community at the time that you think may have influenced these developments?

- How do you think geography and resources determine how HIV prevention and harm reduction policy and programs are implemented in Nova Scotia?

- Do you think HIV prevention and harm reduction programs are accessible across the province?

- How would you describe the provincial government's stance on HIV prevention and harm reduction policy/programmes?

Gender-Based Analysis

- How do you think national drug and/or HIV strategies affect women who inject drugs in Nova Scotia?

- Do you think women and men who use drugs have different HIV prevention and harm reduction needs? If so, please provide examples.

- What specific policies and/or programs do you work on that are specific to women?

- Do you think the delivery of HIV prevention and harm reduction services and/or tools could be improved for women who inject drugs? If so, how?

- Do you feel the existing policy addresses, ignores or influences the social determinants of health for women who inject drugs in Nova Scotia?

- How might your policy/program link with other women-centered harm reduction policies/programs?

- How is the role of trauma understood in your policy/program? How does this translate into policies and program development?

- Do your policies/programs address/accommodate women with substance use problems at overcoming access barriers? (i.e., for pregnant women or mothers)

- What do you perceive are the strengths and/or weaknesses of your policy/program for addressing the HIV prevention needs of women?

- Does your policy/program address issues of stigma and discrimination?

- Does your policy/program incorporate a determinant of health lens? How might this impact your policies/programs? (i.e., greater involvement with other groups?)

- Does your policy/program incorporate gender-based analysis?

- Do you have resources to support gender-based or harm reduction training for your staff?

- What are your views in regards to gender-based analysis? The Social Determinants of Health? Harm reduction? Rights-based approaches?

Possible Summary Questions

- Overall, what do you think Canada should be doing to address HIV prevention among drug users? (at the national level) And what would you like to see happening in your city? Your province?

- Is there anyone else you think I should be talking to about this topic?

- Are there any key references I should be looking at?

- Is there anything else you'd like to add about HIV prevention and harm reduction in Nova Scotia for injection drug users?

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CONSENT FORM FOR INDIVIDUAL INTERVIEWS

Study Title: **An exploration of the relationships between harm reduction policy and community-based HIV prevention programming for women who inject drugs in Nova Scotia.**

Student Investigator: **Susan McWilliam**

Contact Information: **School of Health and Human Performance**
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Phone: (902) 446-1664

Student's Supervisor: **Dr. Jacqueline Gahagan**

Supervisor's Contact
Information: **School of Health and Human Performance**
Dalhousie University
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Phone: (902) 494-1155

Introduction

You are invited to take part in a qualitative research study looking at the relationships between harm reduction policy and community-based HIV prevention programming for women who inject drugs in Nova Scotia. This study is being conducted as part of Susan McWilliam's PhD degree requirements through Dalhousie University's Interdisciplinary PhD Programme.

As a participant in this study, you will be interviewed by Susan McWilliam, either in person or by telephone. The interview will be tape recorded and transcribed. Your participation in this study is voluntary and you may withdraw from the study at any time. The study is described below. Please discuss any questions you have about this study with Susan McWilliam. Please keep a copy of this consent form for your files.

Purpose of Study

The purpose of the study I am conducting is to explore the relationships between harm reduction policy and community-based HIV prevention programming for women who inject drugs in Nova Scotia. Specifically, I am interested in exploring how policy content, context, processes and actors have shaped harm reduction and HIV prevention policy and programs in this province in the context of diminishing support for harm reduction at the national level. I believe that government workers in HIV policy and programming and service providers who work with women who inject drugs are well-positioned to discuss what elements of existing policy and programming work in Nova Scotia to meet the HIV prevention needs of women who inject drugs, what elements do not work and what changes are needed to improve policy and programming in the future.

My specific objectives include describing:

- The key organizations/agencies involved with HIV prevention/harm reduction policy decision-making for people who inject drugs in Nova Scotia.

- The key HIV prevention and harm reduction policies in Nova Scotia, how they were developed and how they address the needs of women who inject drugs

- The key barriers and facilitators to developing and implementing HIV prevention policy for women who inject drugs in Nova Scotia

Study Design

All participants in this study will be asked to participate in an individual interview. During the interview, participants will be asked to share their experiences related to provincial HIV prevention policy and programming. If you wish to participate in a second individual interview, to clarify or add to information in your first interview, this can be arranged.

Who can participate in the study?

You may participate in this study if you have been involved in policy and program development for people who inject drugs in Nova Scotia. The study will include between 20-30 people.

Who will be conducting the research?

All aspects of the research will be conducted by Susan McWilliam as part of her Interdisciplinary PhD Programme. Mrs. McWilliam's PhD Committee will have access to the data that is collected during the study, although they will not be conducting any of the research. My PhD committee consists of Dr. Jacqueline Gahagan, Dr. Lois Jackson, Dr. Renée Lyons and Dr. Fiona Martin.

What you will be asked to do

Interviews will take between 1-2 hours to complete. During the interview, you will be asked to talk about your experiences with harm reduction policy and HIV prevention programming in Nova Scotia. You will be asked to describe your role and any changes that have occurred while you have worked in this field.

Before the start of the interview, the researcher will ask for your permission to audio record the interview using a digital recorder. If you are okay with this, the recorder will be turned on. If not, the researcher will take notes throughout the interview.

Audio tapes of interviews will be kept in a secure, locked filing cabinet in the School of Health and Human Performance at Dalhousie University. The tapes will be transcribed verbatim by Susan McWilliam and personal identifiers will be removed. You will be asked for permission to be identified in the study, but your name will not be specifically attached to particular ideas or quotes.

Possible Risks and Discomforts

Although there are no anticipated direct risks associated with participating in this study. You can refuse to answer any questions you choose, stop the interview at any time or withdraw from the study.

Possible Benefits

You will not receive any direct benefits from participating in the study. Indirectly, you may learn something with respect to your views towards HIV prevention and harm reduction in Nova Scotia. Additionally, the research might indirectly benefit others in your community and communities similar to yours by raising awareness of the HIV prevention issues faced by women and men who inject drugs at the community, municipal, provincial and national levels. It is the hope of the researcher that the information gathered will enhance HIV prevention for women who inject drugs throughout Nova Scotia.

Compensation/Reimbursement

Participants will be offered a one-time payment of $25 for their participation in the study. Susan McWilliam is not being paid to complete this work and has no conflicts of interest related to employment or the topic of this research project.

Anonymity

Your participation in this study will be anonymous. Given the small population size of people who work in this field in Nova Scotia, you may be asked whether or not you have chosen to participate by colleagues. The researcher will not disclose this information.

Should you desire, you will have the option to be recognized as a contributor to the research. If you would like to have your name acknowledged in any future publications or presentations, you will be asked to sign an Agreement that acknowledges you as a contributor.

Confidentiality

All of the information that you provide will be treated as confidential. The researcher will not discuss the interview with other people and the notes and audio-recording will all be kept on a password protected laptop computer. When the researcher returns to Dalhousie University, the information will be stored in a locked filing cabinet when not in use. The only people that will have access to the information will be Susan McWilliam and her PhD committee. All data will be kept in a locked filing cabinet for five years, post publication, as is required by Dalhousie University's Policy on Research Integrity. At the end of the five years, all raw data will be destroyed.

Questions

If you have any questions about the study or your role as a participant, please contact the researcher, Susan McWilliam. Her phone number is (902) 446-1664. She can also be reached by email at smcwilli@dal.ca.

Termination

Although unlikely, this study may be terminated by the researcher at any time without notice.

Problems or Concerns

Should you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, patricia.lindley@dal.ca.

Verbal Consent Page

Study Title: An exploration of current national drug and HIV prevention policies and the provision of HIV prevention programming among women who inject drugs in Nova Scotia.

After reviewing all of the information about the study, the following paragraph will be read to all participants:

Please let me know if you agree or disagree with the following statement:

"All aspects of the study have been explained. You have been given the opportunity to discuss it and your questions have been answered to your satisfaction. You hereby consent to take part in this study. However you realize that my participation is voluntary and that you are free to withdraw from the study at any time".

- Participant agrees to take part in the interview: ___ Yes   ___ No

- Participant agrees to have the interview audio-recorded: ___Yes   ___No

- Participant agrees to have quotes from the interview
  used for future research publications or presentations.   ___Yes   ___No
  (This will be re-confirmed once the interview is over).

- Participant agrees to be recognized as a contributor to the
  research. (The participant and the researcher will receive   ___Yes   ___No
  copies of the Contributor's Agreement).

_____   _____
        Participant's Name   Date

_____   _____
        Researcher's Signature   Date