The Impact of COVID-19 on services for Indigenous People who use substances and are living with HIV in Winnipeg, Manitoba

by

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Abstract

Manitoba currently has the second highest rate of HIV in Canada. Among those recently diagnosed, Indigenous people and injection drug users are overrepresented. As the COVID-19 pandemic significantly impacted service delivery, Indigenous people living with HIV (IPLH) who use substances may have been disproportionality negatively impacted. This Master of Social Work thesis focuses on the stories shared within the Gigii-Bapimiin project by IPLH in Winnipeg, Manitoba who use substances and accessed health and social services throughout the COVID-19 pandemic. Stories from those with lived experience as well as service providers were gathered using semi-structured interviews to help facilitate conversation. The goal of the research was two-fold, firstly to advance the understanding of the impact COVID-19 had on service delivery. Secondly, to provide recommendations for change and inform post-pandemic service delivery and policies to optimally support IPLH who use substances in Winnipeg, Manitoba.

A decolonizing Two-Eyed Seeing approach and Indigenous Storywork were used as overarching frameworks to guide this research. A community guiding circle comprised of eight IPLH, many of whom previously or currently used substances, were involved in the research from design to dissemination. Elder Albert McLeod and Knowledge Holder Gayle Pruden ensured the project remained grounded in Indigenous ethical space and helped incorporate ceremony into the research process. Due to its epistemological alignment with Indigenous knowledges, stories were analyzed using thematic analysis. Through this process, three common themes were identified. Firstly, the deeply engrained colonial practices within health and social services and the barriers individuals experienced pre-pandemic having been exacerbated throughout the COVID-19 pandemic. Secondly, neoliberal narratives and polices were the

primary contributors to the harms linked to substance use rather than the personal drug use behaviours of individuals. Lastly, successful service delivery existed throughout the pandemic and was identified by participants as having been wholistic in nature and grounded within Indigenous knowledges. These organizations continued to offer support to IPLH in a meaningful way while adhering to public health orders. As a result, recommendations for social work practitioners, policy makers, advocates, and healthcare professionals are provided on how to enhance service delivery for IPLH who use substances.

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I would like to express my deepest gratitude to Elder Albert McLeod and Knowledge Holder Gayle Pruden for their teachings, guidance, and laughter throughout the Gigii-Bapiimin project. Each of you is the epitome of good medicine. To the Community Guiding Circle members, thank you for sharing both your time and wisdom. To my fellow Gigii-Bapiimin colleagues whom I worked alongside throughout the project, your endless support and laughter have been so very appreciated. I would also like to acknowledge each of the participants for taking the time to share their stories. Their openness to share has provided invaluable teachings regarding the impact of the COVID-19 pandemic.

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Dedication

To my baby, August Bear. May the good medicine we've encountered together throughout this journey ground you in a culture that will continue to provide belonging to you throughout your lifetime. Love always, mom.

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1.0 Introduction

1.1 Overview

The social and health inequities which exist among many marginalized populations have long been present within the neoliberal structures which currently govern mainstream Canada. These systems were purposefully created from the onset of European contact to divide and oppress through the intentional act of colonialism, and they continue to do so today. Acknowledging this historical context is imperative for understanding how, in the Province of Manitoba, Indigenous Peoples are 3.6 times more likely than the general population to contract the Human Immunodeficiency Virus (HIV) (Erikson, 2014). With Manitoba's HIV rate on the rise, it continues to have the second highest rate of infections in Canada (McClarty et al., 2021) with over half of new infections resulting from injection drug use (Challacombe, 2023). Drug poisonings in Manitoba have been on a steady incline as well since 2019, with fatalities having nearly doubled in 2020 according to the Chief Medical Examiner (Lefebvre, 2023). In addition to a global pandemic, Manitoba was at the centre of two other coinciding epidemics– HIV and drug poisonings.

A harm reduction approach to service has long been associated with a decrease in transmission of HIV/AIDS and has been grounded in a public health framework since the worldwide epidemic in the late twentieth century, later adapting to address overdose epidemics happening across the country. The largest mainstream health system in Manitoba by population density, the Winnipeg Regional Health Authority (WRHA), endorses harm reduction principles among their services. As the COVID-19 pandemic impacted the way services were delivered, understanding access to services during this time is essential to harm reduction efforts moving

forward as HIV infections and drug poisoning fatalities continue to rise in Manitoba. With Indigenous Peoples overrepresented within each of these epidemics, their involvement is imperative to understanding the impact the COVID-19 pandemic had on services. Furthermore, Indigenous Peoples have teachings that are relevant to the understanding of these issues and how to mitigate them at the individual and community level.

1.2 Terminology and Language

This paper will use the term *Indigenous* when referring to participants and specific knowledges utilized within the research. Throughout Canada, the term Indigenous is encompassing of all those who identify as First Nations, Inuit, and/or Métis. The writer recognizes that this is a colonial term that does not distinguish the vast number of unique nations which exist across this land and the differences in language, dialect, or cultural practices existent among them.

Below, are other terms utilized throughout the paper which not all readers may be familiar with. A definition of each has been included here for ease of understanding as well as to establish meaning which helped shape the research and findings.

HIV – Human immunodeficiency virus

IPLH – Indigenous people living with HIV

IPUS – Indigenous people who use substances.

Services – refers to any organization identified as being accessed by those with lived experience which offers health and/or social services.

Substances – this paper is referring to illicit drugs.

**As alcohol and cannabis are controlled substances with Canada the use of them is socially accepted and were considered essential service throughout the COVID-19 pandemic.*

1.3 Conducting research throughout a global pandemic

A global pandemic was declared due to COVID-19 on March 11, 2020 (Infection Prevention and Control Canada, 2023), and a provincial wide state of emergency was declared in Manitoba on March 20, 2020, lasting a total of nineteen months until October 21, 2021 (CBC News, 2021). Throughout this time various public health orders ensued including lockdowns (Kives, 2021) and mandatory masking in public spaces (CBC News, 2022). All public health orders were officially lifted by the Manitoba Government on March 15, 2022 (Government of Manitoba, 2022). Gathering in person was possible during the data collection process of this study, however, comfort level varied among participants with meeting in person and whether masks were worn. Although there were limited public health restrictions during this time, ethics approval required a section dedicated to developing a COVID-19 protocol to ensure public health orders would be followed should they have changed throughout the research process. Our process predominately included a shift to virtual or phone interviews if necessary. Regardless, some interviews were conducted via virtual platforms out of convivence and/or comfort for participants. Thankfully Elder Albert McLeod and Knowledge Holder Gayle Pruden had been involved with virtual teachings and programming throughout the height of the pandemic and were not only comfortable with this but recognized the importance of remaining connected to community by utilizing available resources. Virtual meetings included smudging and following Indigenous protocols for gifting, when necessary, items were dropped off after virtual encounters. Relationality, as will be discussed in detail later on, was actively cultivated when gathering both in person and virtually throughout the research process.

1.4 Location of self in the research

Placing oneself within the context of any work done is an imperative practice within the social work field. According to Hulko (2009), "[s]ocial location refers to the relative amount of

privilege and oppression that individuals possess on the basis of specific identity constructs" (p. 48). The importance of acknowledging one's own social location offers a recognition of the understanding of subjectivity that one brings with them based on personal experience and how experience may differ dependent on intersectionality. The practice of placing oneself is not only imperative within this context but is also a key component of Indigenous methodologies (Fast & Kovach (2019). Fast and Kovach (2019) discuss the self in relation to story and point out that the journey into this subjectivity allows for a greater understanding of one's existence. By sharing this story, it puts forth an individual's perception of one's beliefs. As such, I will begin with just that.

My ancestorial lineage is comprised of Scottish, Irish, English, and Métis; the latter having been concealed from me and my immediate family until approximately a decade ago. My great-grandmother (Marie Bridges nee Maheu) was a Métis woman forced to live in a mental health facility for over thirty years of her adult life. It is unclear when Marie lost her Métis identity and resultantly the opportunity to pass it along to my grandfather and subsequent generations. Marie's mother (Adeline Parisien) died at a young age, and it was Adeline's father (Pierre Parisien) along with other descendants within our lineage that were offered script between 1875 and 1876. I have since reclaimed my own Métis identity as a way of honouring my ancestors who had that right taken from them and I am now a proud citizen of the Manitoba Métis Federation.

I offer this prelude of historical context for transparency into the identities which I claim. Although I can check off the proverbial colonial box stating my Indigeneity; I have moved through over half of my life identifying and passing as a white woman; unaware of my own indigeneity up until the past decade. As a result, I have experienced white privilege to its highest

degree. Throughout my own problematic substance use as a young adult, this was evident as the significance of the barriers and stigma I experienced during that time were softened by that persona as well. It was never automatically assumed that I misused substances, I was not instantly suspicious when entering a store or walking in a neighbourhood, and I was given multiple chances by various people with the underlying belief that I did not belong in or deserve that lifestyle. Having discovered and reclaimed my Métis identity has helped me to better understand myself and the impact colonialism has had on my own family. This discovery along with my university education has been transformational to my understanding of the world. I share these details because my personal identity and experiences have shaped who I am and fueled my passion for working with Indigenous communities and those who use substances. However, I also recognize that my lived experiences do not equate to the intensity and level of discrimination many other Indigenous people and those who use substances experience when accessing services, including the participants and community guiding circle of this study.

From a professional standpoint, I see the importance of accessible harm reduction services daily. I had front line experience throughout the COVID-19 pandemic witnessing the rise of unsafe drug supply in Winnipeg resulting in an increase in drug poisonings. I also experienced an increase in the number of consults I received to engage folks in community recently having tested positive for HIV. I have noted that many of those individuals self-identified as Indigenous. As a practicing social worker in the mainstream health care system, the system in which I am employed continues to cause harm for these individuals. Although my personal practice is grounded in anti-oppressive, anti-Indigenous racism, decolonizing approaches, and I am someone who actively works to advocate for individuals and against oppressive and racist policies, my existence in this system ultimately perpetuates those harms.

The mere existence of social workers in these settings is to help folks navigate these unjust systems and without those injustices employment in this context would not exist for me.

On the front line the demands are high and there is little time granted for formal meaningful evaluative practice with those we work with; the COVID-19 pandemic having further intensified this. The mainstream healthcare system remains grounded within a colonial mindset that is based on individualism, efficiency, and financial management. From my experience, as a result IPLH who use substances are rarely directly involved throughout the duration of planning and implementation of services within these systems. Though we strive for reconciliation the time, cost, and resources realistically required for that to be meaningful and impactful are often not supported. From what I experienced, the work being done to shift towards client centred care within healthcare quickly reverted within the context of a global pandemic, potentially increasing the health inequalities already being seen among this population due to the deeply engrained oppression resulting from ongoing colonization.

These intersecting experiences and identities are what fueled a passion and need for me to engage in research that incorporated Indigenous knowledges and disrupted the typical westernized version of knowledge generation. I am someone who was raised with a colonizer mindset, one so deeply rooted that it did not question the missing pieces within my own family tree. I have spent over half of the past decade attempting to decolonize my own mind while working to reconnect to a culture stolen from my maternal grandfather to better understand myself and my own identity. As such, I had reservations regarding my abilities and the appropriateness of me engaging in this type of work. I knew that it must be done in a good way for it to be meaningful and not just another attempt at western research extracting knowledge from Indigenous populations. I was fortunate enough to join the Gigii-Bapiimin project led by

principal investigator Dr. Rusty Souleymanov and Elder Albert McLeod as a graduate research assistant in February 2022. This provided me with a unique opportunity to engage in a large-scale research project grounded in Indigenous knowledges and methodologies which I was able to also utilize for my Master of Social Work thesis.

From an academic and ethical perspective this opportunity eliminated the redundancy of me engaging in research very similar to that being done through the Gigi-Bapiimin project. The goal not being to extract knowledge and information from the community for the sake of simply completing research but to bring about meaningful change to a problem that has been identified by the community. All too often a westernized approach to research enters a community and takes what is needed with little reciprocity or benefit to those the research is being done to. Through working with the Gigii-Bapiimin team I was able to join a well-established project that had been engaging with community for well over a year and had identified a need within community for this work to occur. The Gigii-Bapiimin project looked at the impacts of COVID-19 on the health and well-being of Indigenous Peoples living with HIV in both Manitoba and Saskatchewan. By incorporating additional details regarding access to services and focusing on those who use(d) substances I was able to gather stories unique to these experiences for the purpose of my thesis. In turn, the same community will benefit from not only the knowledge generation of the Gigii-Bapiimin study but from that obtained from my own work as well.

1.5 Research Question and Objectives

My research project sought to explore *The Impact of COVID-19 on services for Indigenous People living with HIV who use substances in Winnipeg, Manitoba.* Objectives were:

1. To advance the understanding of the nature and extend of the impacts of COVID-19 on services Indigenous people living with HIV who use substances access in Winnipeg, Manitoba.
    a. To identify common themes through story to explore the wider health and well-being impacts of Indigenous people living with HIV who use substances during the COVID-19 pandemic.
2. To advance recommendations for change and inform post-pandemic service delivery and policies to optimally support Indigenous people living with HIV who use substances in Winnipeg, Manitoba.
    a. To generate calls for change to health and social systems based on the research findings to reduce the impacts of the current and future pandemics on Indigenous people living with HIV who use substances.
    b. To generate recommendations for effective and culturally safe initiatives, interventions, and services among health and social services in Manitoba.

2.0 Literature Review

As the COVID-19 pandemic continued throughout the duration of this study, research and coinciding literature is ever evolving. Below is a compilation of relevant literature available at the time of writing. Although there are several studies which address access to services throughout the pandemic, little research exists regarding the direct impacts to Indigenous peoples and even less exists regarding those living with HIV who also use substances. Intersecting factors such as these, are likely to interact with one another and intensify adverse health effects as pointed out by Rueda et al. (2022). Several studies have emphasized how other underserved populations - such as those within the LGBTQ2S+, youth, and older adults – have been impacted

by the COVID-19 pandemic (Souleymanov et al., 2023 & Craig et al., 2022 & Chu et al., 2020) suggesting that the impact of COVID-19 to services for IPLH who use substances may have also had a unique outcome for this population.

2.1 Socio-epidemiological context

Manitoba is a central Canadian province with a total population of approximately 1.3 million, the largest urban centre and the provincial capital, Winnipeg, is home to over 700,000 people (Manitoba Population, 2022). Winnipeg also has the largest urban Indigenous population in Canada (Statistics Canada, 2022). Manitoba has a diverse population; it spans across five treaties, is the homeland to the Métis nation, and has 63 First Nations with 5 distinct linguistic groups (First Nations in Manitoba, 2021). With most of Manitoba's population residing in the southern part of the province, the majority of the province's tertiary health care is delivered out of one location in Winnipeg (Manitoba's Clinical & Preventative Services Plan, 2022). As a result, those living in rural and northern Manitoba are often required to travel to Winnipeg to receive specialized care; HIV treatment included with two of the three clinics located in Winnipeg and the third in southwestern Manitoba (McClarty et al., 2021).

Understanding the inequities that Indigenous people face in the context of healthcare requires contextualization of the history of colonialism within both Canada and Manitoba. Through acts of violence and forced removal, Indigenous people in Manitoba, and across Canada, have faced displacement and discrimination since the arrival of European settlers. This structural violence, which Browne et al. (2016) refer to as "the disadvantage and suffering that stems from the creation and perpetuation of structures, policies, and institutional practices that are innately unjust" (p. 2), has persisted with Residential Schools, the 60's Scoop, and the modern child welfare system. These strategies directly impact the health of Indigenous people

and are deeply engrained in history and society both on a personal and institutional level (Browne et al., 2016). Health inequalities through quantitative data can be easily recognized; however, a comprehensive understanding of the causes of those inequalities and the subsequent outcomes impacting Indigenous people must be viewed through a decolonizing lens to meaningfully address them. There are a variety of social issues, such as HIV, substance use, and homelessness that plague Winnipeg due to the ongoing effects of colonialism and the perpetuation of racism and systemic oppression which I will discuss in further detail below.

2.1.1 HIV

HIV transmissions have been on the rise in Manitoba in recent years and this trend has seemingly skyrocketed throughout the COVID-19 pandemic. According to the Manitoba HIV program (2022) between 2018 and 2021 there was a 52% increase in the total number of HIV cases within the province. With the largest Indigenous population in Canada (Statistics Canada, 2022) the rising rates of HIV are concerning. Erickson (2014) highlights the overrepresentation of Indigenous people among HIV-infected people in Manitoba, noting that the infection rate is 3.6 times higher than the general population. This reality remains the case with the most recent numbers released from the Manitoba HIV program (2022) who note that Indigenous peoples are disproportionately impacted by HIV with 7 out of 10 individuals who entered the HIV program between 2018 and 2021 identifying as Indigenous. Manitoba has the second highest rate of HIV infections in Canada with nearly three times the national diagnosis rate, second only to Saskatchewan (Public Health Agency of Canada, 2023).

Manitoba's growing HIV population is also becoming infected at a much younger age. According to the Manitoba HIV Program (2022), the percentage of those referred to an HIV program has increased among younger ages. In 2018 the most common age being over 50 for

both men and women and by 2021 having shifted to ages 35 -39 for women and 30-34 for men. According to Woodgate et al. (2017) the early onset further decreases the likelihood of accessing care due to fear of stigma and discrimination with many individuals facing this diagnosis on their own. The failure to connect people to HIV care is of particular importance given that in Canada, antiretroviral therapy (ARV) has significantly declined AIDS related infections and deaths with many health care professionals expecting those receiving ARV to have near normal life expectancies (Hosein, 2022). However, in Manitoba it has been found that many individuals experience barriers when accessing this treatment particularly due to substance use, geographical location, age, and race (McClarty et al., 2021) These barriers to HIV treatment are not novel, as research from over a decade ago highlights the need to address barriers to care for injection drug users. Wood et al. (2008) highlights the challenges for injection drug users seeking ARV due to ongoing social stigmatization, homelessness, and provider-based barriers in relation to prescribing. These same issues persist among the current HIV epidemic the province of Manitoba is facing.

Research highlights that those who use substances may be negatively impacted when it comes to accessing ARV, mentions of perceived cohesion as well as withholding of ARV meds from physicians have been noted (Nowgesic et. al, 2016 & Wang, et al., 2016). This may be in relation to the stereotypes and unique intersectionalities that Indigenous people who use substances (IPUS) experience when accessing health care. According to Browne et al. (2016) “racial discrimination is further amplified in the contexts of poverty, substance use, or stigmatizing conditions such as chronic pain, mental health issues, and HIV” (p. 3). When accessing health care, Indigenous people are likely to experience discrimination, further contributing to mistrust of health services and resulting in reluctancy to seek care.

2.1.2 Substance Use

In Manitoba**,** injection drug use has been cited as the main mode of transmission among those newly diagnosed with HIV (Challacombe, 2022). The intersecting factors of substance use, and risk of HIV are of particular importance given that Erickson (2014) points out that those with HIV who use substances are "less likely to adhere to treatments and more likely to have worse health outcomes, leading to increased comorbidity and mortality" (p. 1). The Tracks Survey of people who inject drugs (PWID) conducted by the Public Health Agency of Canada between 2017-2019 found that of the 2,383 participants surveyed, 42.2% identified as Indigenous (Tarasuk et al., 2020). Harmful stereotypes in relation to Indigenous peoples and substance use create barriers in relation to stigmatization and racism when accessing health care services which can lead to avoidance of accessing care entirely (Nowgesic et al., 2016). With substance use as an individualized risk factor among HIV research, the disproportionate harms that Indigenous people face due to problematic substance use is important. Comorbidities are also prevalent among IPUS and amid various chronic health conditions can include mental health, HIV, and hepatitis.

In addition to the rising HIV transmissions, overdoses have been on the rise throughout the pandemic as well. In the first six months of 2021 Manitoba had surpassed the total number of opioid related deaths than the entirety of the year 2020 (Unger, 2021). Additionally, in the year 2020 10,000 fewer HIV tests were administered, causing concern that HIV may be spreading undetected among vulnerable populations relaying on harm reduction services (Government of Manitoba, 2021). A study conducted with peers in Manitoba discussed, in addition to increasing overdoses, those who use substances were facing an unsafe supply, increasing drug prices, and increasing use throughout the COVID-19 pandemic (National Collaborating Centre for

Infectious Disease, 2022). These findings were found in various geographical locations across the globe. A systematic review by Munro et al. (2021) found multiple publications drawing attention to increasing drug related deaths and barriers to accessing substances throughout the COVID-19 pandemic (Munro et al., 2021; Ali et al, 2021). In addition to the unsafe supply contributing to increasing overdoses, increasing solidarity due to social distancing measures was also framed as a potential outcome (Schneider, et al. (2023). In Manitoba, social isolation was widespread throughout the pandemic with three separate lockdowns occurring: twice in 2020 and once in 2021 (Kives, 2021).

Throughout the COVID-19 pandemic, the Provincial Government faced scrutiny surrounding their ideological beliefs in relation to substance use. Multiple calls for the implementation of a safe consumption site from front line staff and people who use drugs were ignored during this time. The elected provincial government within Manitoba between 2012-2023 outrightly opposed safe consumption sites on multiple occasions, with a focus primarily on treatment and long-term recovery for addiction services (Hallmarsom, 2022). During this period, the Premier publicly referenced non-existent evidence of unintended consequences in California from safe consumption sites in relation to her opposition for one in Manitoba despite the rising number of drug related deaths (Caruk, 2022). A failure to incorporate harm reduction models into addiction care is a direct contradiction of the expressed needs of those who use drugs. Studies from Manitoba involving people who use substances highlight the overwhelming support for and need for safe consumption sites in Winnipeg (Marshall et al., 2019; Canadian Public Health Association, 2022). Front line service providers within Manitoba have also expressed the necessity of a safe consumption site (Marshall et al., 2019).

2.1.3 Unhoused Relatives

People who use drugs are often simultaneously experiencing homelessness. A survey conducted in Winnipeg in 2019 found that of the 406 participants experiencing homelessness interviewed, 72.9% identified as Indigenous. The increasing challenges found among First Nation communities such as housing, lack of resources, and supports lead to increased urbanization. Winnipeg has a large Indigenous population that is continuously growing. According to Brandon and Peters (2014) in addition to facing the housing crisis within Manitoba, Indigenous people are subjected to discrimination, higher rates of poverty, and complex intergenerational traumas in relation to colonialism. Winnipeg's Indigenous population is overrepresented among those experiencing homelessness. In Winnipeg, during the 2018 street census 1,519 people experiencing homelessness were interviewed and it was noted that 65.9% of these individuals identified as Indigenous. (Brandon et al., 2018). Intergenerational poverty and housing instability are linked to colonization through the residential school system and 60s scoop. As a result, Indigenous peoples are also overrepresented within the foster care system and the justice system. Both of which, according to Piat et al. (2014), were identified as pathways into homelessness.

The colonial notion of homelessness is defined as being any of the following: unsheltered, emergency sheltered, provisionally accommodated, or at risk of homelessness (Gaetz et al., 2012). This definition does not quite encompass the experiences of Indigenous peoples within Canada given the deeply engrained colonial history which has attempted to erase identity, culture, and language while displacing large groups of people. Thistle (2017) describes Indigenous homelessness using an Indigenous worldview resulting in something much more complex that intersects with the colonial version of homelessness. According to Thistle (2017)

Indigenous homelessness includes “individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities” (p. 6). The need for Indigenous supports and services among those experiencing homelessness and/or using substances becomes obvious from this viewpoint.

Lawson-Te Aho et al. (2019) discuss a framework for supporting Indigenous Maori in New Zealand experiencing homelessness, which highlights the necessity of self-determination and a more wholistic approach aligned with Indigenous knowledges at the forefront. Such a framework is aligned with many of the calls to action within the Truth and Reconciliation Commission’s final report asking all forms of Government to work with Indigenous communities to address and correct health inequalities. The Indigenous definition of homelessness defined by Thistle (2017) encompasses an Indigenous worldview, one that is wholistic in nature and requires a deeper understanding of Indigenous ways of knowing, doing, and being to fully comprehend its significance in the provision of care for Indigenous peoples in a variety of social sectors.

2.2 COVID-19 Impacts on Services

The consequences of public health orders (physical distancing, self-isolation, and decreased access to community and health services) during the COVID-19 pandemic disrupted access to many health and social services (Russel et al., 2021 & Seyed Alinahi, S. et al., 2023). For a group commonly facing a variety of marginalizing intersections in relation to accessing health services, changes such as decreased capacity within public buildings, the elimination of in-person group facilitations, and the shift to a focus on virtual care have worsened or intensified these issues throughout the pandemic.-According to Russell et al. (2021) the disruption to services for people who use drugs left folks “vulnerable to experiencing unintended negative

effects such as fluctuations in tolerance levels and substance use behaviours, increased withdrawal symptoms and overdose events, worse physical and mental health outcomes, and greater risk for virus exposure" (p. 7). Findings in other geographical locations such as Norway suggest that disparities in health care prior to the pandemic have widened among people who uses substances throughout the COVID-19 pandemic. Decreased mental health issues, increased substance use, and feelings of further stigmatization and perceived access to health services have been impacted (Leonhardt, 2021).

Several studies have been conducted looking at the impacts to overall health throughout COVID-19 because of widespread disruption to services. There is extensive recognition of the negative impacts this has had on those living with HIV who use substances, including increase in substances and reduced adherence to ARV (Hochstatter et al., 2012 & Baum et al., 2021). A study from Bonn et al. (2020) highlights the need for ongoing public health responses to harm reduction and substance use to address what they refer to as a syndemic – overdose, HIV, and COVID-19. Concerns surrounding a syndemic were reiterated by the National Collaborating Centre for Infectious Diseases (2022) who also expressed the vulnerability of Indigenous Manitobans within this context as well given the historical and ongoing oppressions associated with colonialism. The disruptions to services and health and well-being affects found elsewhere were present among First Nations people in Manitoba as well. Larcombe et al. (2023) reiterates similar challenges to reduced access to services throughout the pandemic and address the significance of the disruption to relationships between those living with HIV and healthcare providers.

Utilizing Indigenous knowledges can help to ensure a meaningful response with better outcomes for Indigenous peoples. Anderson and MacKinnon (2023) highlight the effectiveness

of the Indigenous leadership response to the COVID-19 pandemic vaccine roll out. They point to the 90.3% vaccine uptake among First Nations which they attribute in part to ongoing trust building and consistent cultural communication. These successes have been witnessed among other services as well. Watson et al. (2022) highlight that despite the challenges experienced by many Indigenous people throughout the COVID-19 pandemic, services which had pre-existing cultural supports were able to provide sustainable wholistic supports throughout the pandemic. The need for the incorporation of Indigenous knowledges into future pandemic services has been identified as a necessity to reduce the unintended consequences seen throughout the COVID-19 pandemic (Fleury & Chatman, 2023).

2.3 **Indigenous people who use substances and Indigenous Storywork**

Indigenous peoples have knowledges and perspectives that can help provide insight into challenges being experienced as well as an understanding for how to mitigate these issues. As narrative approaches can be valuable in determining the impact of a variety of issues (Larsson, 2019), utilizing the perceptions and voices of those with lived experience is essential to not only evaluating community needs but encouraging active involvement within the emancipation of the ongoing oppression being experienced. Based on my searches, limited research utilizing Indigenous Storywork when working with Indigenous people who use substances was available. However, there are many works from diverse disciplines which have used Indigenous Storywork for a methodology to facilitate decolonization within their studies. Archibald et al. (2019) compile a variety of Indigenous Storywork examples throughout Canada, Australia, and New Zealand.

Indigenous storywork, according to Archibald and Parent (2019), facilitates meaning making through and with Indigenous stories which may be traditional in nature or through lived

experience. The use of storywork within this context is not only a method of decolonizing research and incorporating Indigenous methodology but helps to enhance the qualitative data so often found within health care research. Goodyear (2021) points out that the medicalized model of harm reduction services has been helpful in past pandemics for mitigating health related harms associated with substance use but does not address broader historical and socio-cultural aspects that create and sustain health and social inequalities. Through story a more grounded understanding of how COVID-19 has impacted health and social services for IPUS can be understood and generate a more wholistic comprehension of well-being.

As social workers often consider their clients to be the expert of their own lives, when examining an issue that directly impacts those we work with, including them within knowledge generation and program planning should be considered an important part of measuring success. Greer et al. (2016) address the importance of people with lived experience participating in policy making, research, programming, and practice in relation to harm reduction. Through their evaluative review Greer et al. (2016) set out to describe and evaluate peer engagements that were undertaken by the BC Centre for Disease Control, who coordinate provincial distribution of harm reduction efforts. From here they discover the importance of supportive environments, equitable participation, capacity building/empowerment, and improved programming and policy. This resulted in recommendations for peer engagement in harm reduction initiatives.

2.4 Indigenous Harm Reduction

The harm reduction services currently known in Canada took root during the HIV/AIDS epidemic in the nineteen eighties and nineties. During that time public health institutions adopted harm reduction as an approach in attempt to slow the spread of HIV/AIDS (Boucher, L. M. et al., 2017). Research within the area of harm reduction among those who use substances has a

significant understanding of the benefits in relation to health outcomes and implications on the health system (Kennedy, Karamouzian & Kerr, 2017). From a more person-centered perspective, harm reduction is a set of principles aimed at reducing negative consequences associated with drug use (National Harm Reduction Coalition, 2020). The First Nations Health Authority (2023) describes Indigenous harm reduction as moving beyond this and addressing the harms associated by colonialism which place Indigenous people at a greater risk of harmful substance use. This is achieved through the connection to culture and incorporating a more wholistic understanding of oneself and the interrelations with mind, body, and spirit (First Nations Health Authority, 2023).

From my searches, the use of Indigenous harm reduction approaches within the context of the COVID-19 pandemic is a gap in literature. Few studies address how this was implemented throughout the pandemic. The Government of Canada (2018) describes harm reduction as strategies "that reduce the harmful health, social and economic effects of substance use". These strategies have relied heavily on ones that reduce medical harms such as overdose and infection rather than those that seek to address the ongoing social and health inequalities that people who use drugs experience (Goodyear, 2021). Moreover, harm reduction services are historically conceptualized by community. Incorporating the knowledge of IPUS is an important aspect of ensuring harm reduction services are meaningful and accessible. There is less of a focus on the impacts these sites have at an individual level for those accessing services (Oudshoorn, et al., 2021). Doing so adds to the knowledge base of harm reduction services and creates awareness of the benefits that move beyond those that serve only the immediate needs of the system.

Given that IPUS continue to face barriers and poorer health outcomes than non-Indigenous people (Nowgesic et. al, 2016 & Wang, et al., 2016) the incorporation of Indigenous knowledges to harm reduction services is imperative to overall well-being. For those who have had positive

experiences within these systems a relational approach to practice was identified as most meaningful. This was executed through the acknowledgement and understanding of the barriers and systemic oppressions experienced regularly and tailoring practice to help alleviate some of these issues (Smye et al., 2023). Culturally responsive services have long been an important part to Indigenous well-being (Lin et al., 2023). Understanding the philosophical importance of the incorporation and implementation of wholistic practices into services not only provides a pathway for decolonizing harm reduction strategies but provides meaningful and impactful care as well.

3.0 Methodology and Approaches

3.1 Research Methodology

3.1.1 Epistemology, Ontology, & Axiology

The epistemological assumptions of the overall research design incorporated two-eyed seeing which intertwines both Indigenous and Western knowledges. I have drawn on both Indigenous and decolonizing knowledges as well as critical components as there is an understanding of the need for decolonizing research especially when working with Indigenous populations. These combined approaches appreciate the knowledge that those with lived experience hold as well as recognize the oppression and inequality that exists for Indigenous peoples as an outcome of the ongoing colonization within Canada. The ontology, the nature of reality, incorporates wholism, and decolonizing worldviews. Through decolonizing worldviews, reality is viewed through wholism in that all facets are interconnected with one another and the whole is more than the sum of its parts. As such, there is a high value placed on centering the perspectives of IPLH who use substances and incorporating them into all aspects of this research. Lastly, axiology, the broader cultural values is grounded again in decolonizing and

participatory/community-based action research which has also incorporated indigenized ethical space. Challenges from the COVID-19 pandemic have been identified and generated calls to action in policy and service delivery while empowering those directly impacted to be involved in this process.

Each of these components tie together to create the project's overall methodology. Although there are varying teachings and beliefs among the vast differing nations which encompass the term Indigenous, from a generalized standpoint there are several aspects of knowing which overlap among these shared knowledges. Perhaps one of the most profound differences between Indigenous and Western worldviews is that from an Indigenous perspective, there is not one truth that is sought after as there can be many truths based on individual experience. Another differing perspective is the wholistic nature of Indigenous worldviews and the interconnections which exist among all beings, compared to the compartmentalization within a Western perspective (Indigenous Corporate Training Inc., 2023). Utilizing Indigenous knowledges, I have strived to uphold these worldviews while also incorporating more Western approaches as well to create a methodology that honoured those perspectives and the teachings that I have received throughout this work.

3.1.2 Indigenous and Decolonizing Approaches

3.1.2.1 Etuaptmumk (Two-Eyed Seeing). This research was guided by the concept of etuaptmumk (Two-Eyed Seeing), a guiding principle for walking in two words – Western and Indigenous – a term coined by Mi'kmaw elder Albert Marshall (Marshall, Marshall, & Bartlett, 2015). Given the harms Indigenous people have been subjected to in both research and healthcare, decolonizing methods are of particular importance for partaking in ethical research and establishing trust among Indigenous communities. In addition to the ongoing health

inequities IPLH and IPUS face within health care, historically Indigenous people have experienced Indian hospitals which were a form of segregation and functioned similarly as residential schools. In them, Indigenous peoples were often held against their will and faced experimental and unjust medical procedures (University of British Columbia, 2021). Additionally, unethical research was often conducted within residential schools some of which deprived children of adequate nutrition and dental care (MacDonald et al., 2014). Including Indigenous peoples at the centre of any research that involves their communities is essential to avoid a repetition of history and ensuring their voices are heard and engaged with in an ethical way.

Marsh et al. (2015) addresses some strategies that can be implemented as a way of enriching the Two-Eyed Seeing research process and enhancing credibility. These include consulting and working with elders, the development of ethical relationships, the establishment of an Indigenous advisory group with community members, training of the sharing circle facilitators, settings, and demographics of participants, and conducting seeking safety sharing circles. This research study has considered and adopted each of these into the research design. Elder Albert McLeod guided the Gigii-Bapiimin project and provided valuable guidance and teachings throughout. There was also an adoption of Indigenous Ethical Spaces, discussed further in section 4.5. Additionally, a community guiding circle helped guide research design, implementation, and analysis. The guiding circle consisted of eight Indigenous people living with HIV, many of whom currently or previously used substances.

3.1.2.2 Indigenous Storywork. Indigenous storywork, according to Archibald and Parent (2019), facilitates meaning making through and with Indigenous stories which may be traditional in nature or through lived experience. Larcombe et al. (2020) explain that “[s]torytelling is an

Indigenous way of sharing information about relationships, resilience, insights, revelations and/or reflections" (p. 7). The use of storywork within this context is not only a method of decolonizing research and incorporating Indigenous methodology but helps to enhance the qualitative data so often found within health care research. Through story a more grounded understanding of how COVID-19 has impacted services for IPLH who use substances can be understood and generate a more wholistic comprehension of well-being.

The seven principles of Indigenous Storywork described by Archibald (2008) include respect, responsibility, reverence, reciprocity, wholism, interrelatedness, and synergy. Each of these components has remained at the forefront of design planning throughout the research project. Stories shared by participants were treated with the utmost respect and was demonstrated by incorporating IPLH into all aspects of the research. Each person on the research team shared responsibility to ensure the stories that were shared were authentic and accurately reflected. This was done through the use of a sharing circle where initial findings were presented to the community guiding circle for input and feedback. According to Archibald (2008) reverence for storytellers is displayed through ceremony. As such, our project incorporated various ceremonies throughout the research process including a pipe ceremony, feasts, and sharing circles.

Through capacity building within the community, discussed further in the following section, reciprocity was shown. Having community heavily involved throughout the research process and working diligently to establish and sustain relationships wholism was practiced. Through ongoing reflection throughout the analysis process to better understand how my own life and stories shape my understanding of the shared stories interrelatedness was upheld. Lastly, providing space for these other principles to take hold throughout the storytelling processes the presence of the synergistic story power highlighted by Archibald (2008) was possible.

3.1.3 Community-based participatory research

Historically, research has created a power imbalance between researcher and participant, decolonizing approaches work to rebalance some of that power by directly involving those with lived experience throughout the research process. Bartlettt et al. (2007) point out that Indigenous communities are demanding that their voices and perspectives be included within any research involving them, while Indigenous researchers also call for more decolonizing methodologies. The research process incorporates the knowledge from those with lived experience as well as working to develop explicit and tangible benefits for the community (Larcombe, 2020). Doing so helps to ensure that the focus remains on strengths and resilience of those with lived experiences as all too often negative stereotypes prevail with a fixation on deficits within a community. Respecting the knowledge and wisdom of those directly impacted by these issues places the power back within the community and helps contribute to an ethical space for research to grow from.

The study incorporated community-based research (CBR) to ensure community members impacted by this issue were directly involved in all aspects of the research from start to finish. The three core principles of CBR as outlined by Strand et al. (2003) are: 1) a collaborative approach among academic researchers and community 2) accessibility to knowledge through various ways of knowing and multiple methods of dissemination 3) it is social action oriented with the purpose of achieving social change. Collaboration is the thread that intertwines each of these and an ideal CBR project involves community among all elements of the research including problem identification, research design, data collection and analysis, making recommendations, and dissemination. The participatory nature of CBR is also relevant to the harm reduction facets of services as one of the fundamental principles to harm reduction is that it

empowers people who use drugs and strive to meet the actual needs identified by the community (National Harm Reduction Coalition, 2020). Making the research process useful for participants upholds self-determination and self-governance principles for Indigenous people.

Ways in which the team has incorporated CBR throughout the research is highlighted below.

1. Community Guiding Circles: The project included an active Community Guiding Circle (CGC) comprised of 8 Indigenous people living with HIV/AIDS many of whom had current or past experience with substance use. The CGC met six times in person between April 2022 and February 2023. In addition to the honourarium provided to each CGC member's cost of transportation and childcare were covered and a meal was shared each time. Initial meetings focused on fostering relationship and incorporated sharing circles and teachings from the team's Indigenous knowledge keepers. The CGC provided input on developing interview guides and advised on recruitment and promotion of the study. Many CGC members chose to participate in the study by partaking in the interviews. Involving the CGC throughout the study helped to ensure that: 1) the research team conducted the project with the community's best interest in mind; 2) action plans associated with the research were appropriate to the community's needs and concerns; 3) the study was culturally appropriate for the diverse communities involved.
2. Capacity Building: Opportunities throughout the project were available for community members to build capacity. Two of the CGC members worked on the project more closely as paid research associates and helped conduct interviews. All CGC members were provided with opportunities to sit with Indigenous knowledge keepers to build cultural competency. Additionally, sharing circles were held to discuss research design

and application skills as well as multi-disciplinary and multi-sector collaborative teamwork.

3. Study Development: Within the larger context of the Gigii-Bapiimin project, the study was developed working closely with community partners serving this population and their social networks from the Manitoba HIV Collective Impact Network, Waniska Centre, Canadian AIDS Treatment Information Exchange (CATIE), The Feast Centre for Indigenous STBBI Research, Ka Ni Kanichihk, All Nations Hope Network, Harm Reduction Network of Manitoba, and Communities, Alliances, and Networks (CAAN), as well as community members who may access services through these agencies. The extensive collaboration between the principal investigator of Gigii-Bapiimin (Dr. Souleymanov) and partners from the community had already begun (e.g., identifying the research objectives and questions and implementation of the project) prior to my joining the team. The scope of the thesis project existed within a small subsection of data collection that focused specifically on substance use and service access. This collaborative process which had already begun extended across each subsequent stage of the research project and culminated in knowledge transfer and exchange.
4. Knowledge Mobilization & Translation: This research blended qualitative inquiry with social action by creating knowledge that is relevant to the needs and interests of community. The goal of the knowledge mobilization and translation phase of the project was to promote tangible benefits to the community among whom the research is conducted. With partnerships among Indigenous communities, community-based organizations, academia, healthcare, and policy makers findings from the study have the potential to impact direct service delivery now and for future pandemics. Partners have

hosted presentation of the results of this study including community forums, sharing circles, and webinars. The knowledge, translation, exchange and mobilization (KTEM) strategy of the Gigii-Bapiimin project has developed a knowledge exchange network to engage broader Indigenous communities and share learning, subsequently the findings and recommendations in relation to the scope of my project as well. The findings of this project will be included within community reports and peer-reviewed publications.

3.2 Theoretical Frameworks

The following theoretical frameworks are a combination of Western and Indigenous theories which align epistemologically, ontologically, and axiologically. Each has helped to inform research design, contextualize data, guide analysis, and interpret findings.

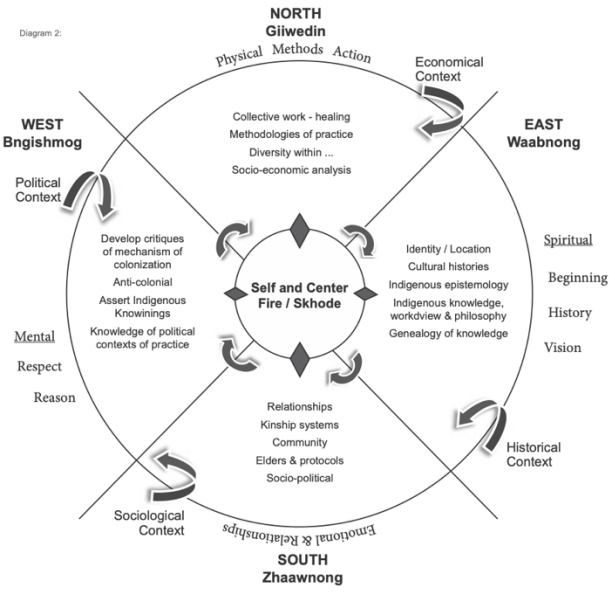
3.2.1 Indigenous Wholistic Theory

Wholistic theory is rooted within an Indigenous framework; however, some Western ways of knowing have begun to incorporate this as well. According to Adekson (2017), an Indigenous wholistic belief model recognizes that health may be impacted by unwellness in either of the mind, body, or soul and as such, health and well-being are known to be much more than simply the absence of disease. Though these concepts have become more prominent within mainstream health literature and practice, the understanding of their interconnectedness can at times be overlooked (Reading & Wien, 2009). This research remained grounded within a wholistic approach by exploring the meaning of wellness within the IPLH community, understanding the individual as a whole, and how different facets of health intersect to make up wellness. The use of wholistic theory in a more Westernized health paradigm aims to strengthen primary healthcare through interprofessional care focusing on a range of psychosocial health issues in addition to physical ones (Ashcroft et al., 2017). However, according to Ashcroft et al.

(2017), western wholism tends to focus on an individual within their own environment and fails to incorporate the structural and social components that contribute to well-being.

Through this, it is possible to develop a more thorough understanding for areas of enhancement within the healthcare system and identify the resiliencies and strengths which already exist among community members. Absolon (2010) uses the medicine wheel – seen in Figure 1 below - to depict the interrelation of wholeness, describing different facets within each quadrant. The use of this illustration was helpful to my own analysis process, as I will discuss further in section 4.3, as I used an iterative process for meaning making. The use of wholism within this work will continue to uphold the awareness and understanding of the ongoing impacts of colonization on well-being. With a high Indigenous population among people who use substances accessing health and social services in Manitoba, the incorporation of Indigenous models of wholism is essential to develop culturally safe spaces and incorporate culturally relevant supports and services.

Figure 1. Absolon (2010) depiction of Indigenous Wholism



3.2.2 Critical Theory

Critical theory is something that has always resonated with me as both a researcher and practitioner. Knowing that Critical theory is historically grounded within western ways of thinking, considering how to incorporate this within my research while striving for incorporating Indigenous and decolonizing approaches required a great deal of consideration. Morris (2006) describes critical theory as "an ideologically oriented approach to studying human phenomena. . .. Critical theorists begin by taking an ideological stance, and more, their research aims to actively address the oppression identified in that professed ideology" (p. 131). Burnette and Figley (2016) draw on Pablo Freire's work in relation to historical oppression and point out that colonial and historical oppression often becomes embodied, with dehumanization occurring through the ongoing imposition of choices, exploitation, and possessive consciousness. When considering health and social services, without the incorporation of a wholistic viewpoint and a grounding in Indigenous resilience, despite efforts to accommodate and reduce barriers, services risk perpetuation of continued oppression by upholding the status quo of the larger healthcare system. Barriers among these services still exist and many factors such as discrimination, environmental, financial, and structural barriers are still experienced by those accessing services (Campbell et al., 2015). As such, my critical theory analysis utilized necropolitics as a way of providing meaning to shared stories.

Necropolitics was coined by Achille Mbembe (2019) and builds on Foucault's (2008) concept of biopolitics through racism and colonialism. Necropolitics examines how current structures determine who has the right to live and die through violence, racism, and fascism which creates an othering of people driven by colonialism. Considering the intersectionality that exists among IPLH who use substances, there are a variety of systems in which they must

interact with when seeking care. There are barriers that exist across these domains including service providers, organizational policies, and with the complex social systems that require navigation to find services. Given the history and ongoing oppression of Indigenous people in Canada, Martensen (2021) points out that necropolitics is an excellent analytical tool to understand the inequities between Indigenous and non-Indigenous people in Canada. Although health and social services strive to eliminate inequalities, the reality is that they still exist within the larger system that continues to construct barriers and strategically oppress marginalized groups such as IPLH who use substances.

A study conducted in India reviewing the state response to COVID-19 utilized necropolitics to highlight how this response protected middle- and upper-class folks while disregarding the lives of lower-class individuals (Jagennathan & Rae, 2021). In Canada, inequities among IPLH who use substances have been created and maintained through colonialism and neoliberalism. In Canada, it is through the use of neoliberal policies and systemic responses that these inequalities were worsened throughout the COVID-19 pandemic (Bryant et al., 2020). Modern colonial occupation is described by Mbembe (2019) as a combining of biopolitics and necropolitics and "the capacity to define who matters and who does not, who is disposable and who is not" (p. 78) which is ultimately achieved through the othering of certain groups. In Canada, intersecting forms of identity which do not align with westernized neoliberal ways of knowing can intensify harms experienced by the system. Analyzing the neoliberal response to service delivery throughout the COVID-19 pandemic can help to highlight these impacts. This analysis process also draws attention to the systemic factors which make up health and social systems which perpetuate the ongoing eradication of Indigenous people in Canada. Doing so helps provide

meaning to the intentionality of service delivery policy and move beyond othering of this group through neoliberal individualization.

3.2.3 Etuaptmumk (Two-Eyed Seeing)

As discussed within the methodology section, Two-eyed seeing is the overarching framework which guided this research. Two-eyed seeing uses the strengths of Indigenous worldviews and Western worldviews to solve problems. Researchers are required to weave back and forth between these various viewpoints and acknowledge that in some instances one perspective may help us better understand a situation more than the other. This approach is said to be a thoughtful integration of the best each perspective has to offer. As these constructs are not static researchers and communities are expected to build upon and expand to suit their unique needs (Wright, Gable, Ballantyne, Jack & Wahoush, 2019). Two-eyed seeing recognizes that Indigenous peoples have a distinct way of knowing (epistemology) and includes that alongside Western knowledge (Marsh, 2015). Larcombe et al. (2020) highlights that this approach challenges the assumption that there is a single objective truth. Two-eyed seeing also works towards including, trust, respect, collaboration, understanding and acceptance of the strengths that reside in both worldviews (Marsh, 2015).

As mentioned, the practice of weaving back and forth between Western and Indigenous worldviews is done so to utilize the strengths of each and therefore these approaches may vary dependent on particular circumstances (Cape Breton University, 2023). Marshall et al., (2015) caution that Two-eyed seeing is difficult to defend to academics as it does not belong to any specific subject area or discipline and is about life, a way of knowing the world. Marshall et al. (2015) explains the importance of the incorporation of Indigenous knowledges into meaning making, highlighting the significance of story throughout time. It is explained that through story

one has a responsibility to reflect on its meaning and each time it is shared richer meanings are obtained through personal journey and a sense of wholeness and interconnectedness. Unlike many Western approaches, ongoing meaning making is essential within Two-eyed seeing given the intrinsic connection to subjectivity.

3.2.4 Indigenous Storywork

The stories shared by those with lived experience are essential to understanding the resilience among Indigenous people. Archibald (2008) acknowledges that many First Nations storytellers use personal life experiences as teaching stories similarly to how traditional stories are used. Although participants of the study may not consider themselves traditional storytellers, their knowledge and experiences are honoured and held in high regard. The value of lived experience is also consistent with a harm reduction approach which works to ensure those with current or historical experience with substances are active agents in the creation of programs and policies (National Harm Reduction Coalition, 2020).

Throughout social work education there is a foundational awareness that people are the own expert of their lives. As general practitioners we rely on folks to share their stories and guide us to the areas they are seeking support with. Narrative approaches in research can be valuable in determining the impact of a variety of issues (Larsson, 2019), utilizing the perceptions and voices of those with lived experience is essential to not only evaluating community needs but encouraging active involvement within the emancipation of the ongoing oppression being experienced. Within Indigenous research there is an understanding of the significance and necessity of story when working with Indigenous peoples. Storytelling is a central component to Indigenous epistemologies by engaging historical traditions, knowledge, and cultural resources that align with traditional worldviews (Iseke, 2013).

3.3 Research Methods

3.3.1 Sampling

The Gigii-Bapiimin study used purposive sampling which Patton (1990) describes as an approach which identifies a group of people who have experience with a specific social phenomenon. The sampling strategy utilized within this was snowball sampling; after each eligible participant completed the interview, they would be invited to recruit other individuals from their networks who may be eligible. The larger study consisted of Indigenous people living with HIV/AIDS, healthcare/service providers that serve IPHA, and community advocates/leaders working with Indigenous people or in the HIV/Health sector, with representation from both Manitoba and Saskatchewan. As such, for the purpose of my thesis I was able to utilize convenience sampling drawing from the larger sample. Drawing from the participants within the larger context the eligibility for my data collection included: 1) identification as First Nations, Inuit, or Métis, 2) self-report HIV positive status and/or provide services to IPUS, 3) be 18 years of age or older, 4) live or work in Winnipeg, 5) for those with lived/living experience; current or past substance use in the past four years – the beginning of the COVID-19 pandemic in 2020. My total individual sample was N=20, consisting of those with lived experience (n-11), service providers (n-7), and elder/knowledge holders (n=2).

3.3.2 Recruitment

Participants were recruited using printed flyers, social media, and peer recruiters. Given the relatively small community of IPLH in Winnipeg snowball sampling proved to be the most effective approach. Members of the community guiding circle played a key role in facilitating participant recruitment and many chose to participate in the study themselves. This approach to recruitment also helped to establish trust and credibility within the community with peers being

able to vouch for the study from their own personal experience having personally interacted with researchers. Although online recruitment through social media yielded a high response rate it was determined through the screening process that many of these individuals were not eligible to participate in the study. In consultation with Elder Albert McLeod additional screening questions were implemented to determine the Indigenous community in which individuals were claiming to belong to. Further discussions regarding identity were two-fold, ensuring that individuals were eligible for participation in the study as well as beginning to foster relationships with participants early on by developing an understanding of where each were coming from.

3.3.3 Participants and Sample Characteristics

The figure below provides a breakdown of demographics for participants with lived experience (n=11).

Figure 2. Participants with lived experience demographics

Indigenous Identity	
First Nations	11
Inuit	0
Métis	0

Age	
20-29	1
30-39	3
40-49	4
50-59	3

Employment Status	
Employed	0
Unemployment	11

Substance Used*	
Crack	4
Cocaine	3
Meth	6
Undisclosed	1

**5 individuals identified more than one substance being used*

Gender	
Woman	8
Man	3
Non-binary	0
Other	0

The figure below provides a breakdown of demographics for service providers (n=9).

Figure 3. Service Provider Participant Demographics

Indigenous Identity	
First Nations	2
Non-Canadian Indigenous Person	1
Non-Indigenous	6

Gender	
Woman	6
Man	0
Non-binary	1
2S	1
Other	1

Personal Experience with Substance Use	
Yes	6
No	3

Role	
Social Worker	3
Nurse	2
Nurse Practitioner	1
Case Worker	1
Indigenous Consultant	1
2S Grandmother	1

Age	
20-29	1
30-39	0
40-49	4
50-59	1
60-69	2
Not disclosed	1

3.4 Data Collection Procedures

Stories were collected using semi-structured interview guides. The guides were constructed with the help of the community guiding circle. The Gigii-Bapiimin project facilitated a one day gathering with the community guiding circle as a way for them to provide input on key areas for questioning relating to the overall research question. During this time members were guided through a body mapping exercise. The use of body mapping has a long-standing connection to the field of HIV. In the early 2000s body mapping was used as a therapeutic tool for women

living with HIV as part of the memory box project established by Jonathan Morgan in Cape Town, South Africa (Skop, 2016). According to Greene et al. (2019) “body mapping enables participants to tell their stories in the face of intense HIV/AIDS stigma”. Since the work done with the memory box project, body mapping has been used as an arts-based approach for a variety of community-based education, advocacy, and research projects. These guides helped facilitate conversation throughout each interview that were aligned with the overall research question. Participants were asked about the impact of the pandemic on their access to services including ceremony as well as impacts on substance use and coping strategies. As a way of reducing power imbalances within the research process and to develop trust each interview was conducted with a fully disclosed IPHA present. Each story was audio recorded and transcribed verbatim.

Individual interviews were conducted with IPHA (n=11) as well as service providers (n=7) and knowledge holders (n=2). Within the current context of the COVID-19 pandemic the project’s safety plan protocol included a hybrid of in-person/virtual interviews. Throughout the time of data collection public health orders had relaxed and gathering in person was possible. However, some participants chose to conduct their interviews online via the Zoom platform for a variety of reasons ranging from personal convenience to level of comfort in gathering with others with others following the loosened public health orders. Those who did choose to participate in person were offered interview space at local community organizations that participants had familiarity with and felt comfortable accessing.

3.5 Approaches and Techniques for Analyzing Data

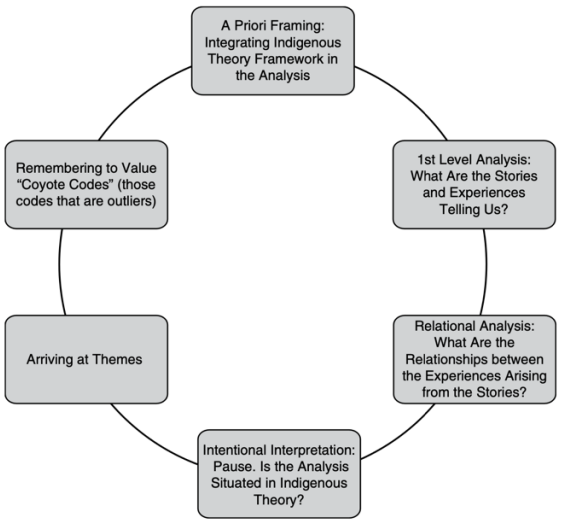
The analysis process utilized thematic analysis (Braun & Clarke, 2006) with Kovach’s (2021) considerations of strategies of applying Indigenous methodologies within this. Kovach

(2021) explains that "[i]f a theory frames a research study at the outset, it should influence all phases of the study" (p. 202) and therefore the analysis process remained grounded within the principles of Indigenous Storywork. Kovach (2021) cautions that though coding is relational in that it catalogues ideas, events, objects to make meaning it can also fragment knowledge. By remaining grounded within Indigenous storywork throughout the analysis process it helped to hold me as the researcher accountable to continue to uphold those seven principles of respect, responsibility, reverence, reciprocity, holism, interrelatedness, and synergy which helped my thematic analysis keep the story whole throughout the meaning making process rather than fragmenting it.

Though thematic analysis is an inherently western academic approach it is aligned with an Indigenous conceptual framing (Kovach, 2021). Braun and Clarke (2006) utilize a six-phase approach to thematic analysis: familiarizing self with data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes and producing a report. This process is said to be flexible with no prescribed rulebook provided if it is applied in a systemic way which is clearly outlined by the research. This flexibility lends itself to Indigenous methodologies in that the analysis process can be more cyclical than linear and allows the researcher to move back and forth between reflexivity and analysis throughout the meaning making process. Below in Figure 4 we see that process as described by Margaret Kovach when using thematic analysis with Indigenous methodologies.

Figure 4. Kovach (2021) Thematic Analysis Strategy for Indigenous Methodologies

Figure 9.1. Thematic Analysis Strategy for Indigenous Methodologies



Using the terms defined by Kovach (2021) in Figure 4 along with components of Braun and Clarke's (2006) six-phase approach, I embarked on the thematic analysis journey. I began with a Priori Framing - grounding myself within Indigenous Storywork and considering how the seven principles would be upheld throughout analysis. Jones (2019) offers guiding questions for meaning making within story such as asking who is involved, key values/principles, identifying the central message, and looking for relationship within the story. This was a key understanding when ascribing meaning to stories from both service providers and those with lived experience. as stories are from an individualized perspective it is important to understand any differences through an Indigenous lens, one that acknowledges that the story changes based on who is in control of telling it (Christian, 2019). To understand a story and how it fits within a belief system one must become a member of the community (Archibald, 2008). Realities and beliefs about certain issues are in part shaped by experience, though some service providers have lived experience with substance use none are entrenched in the current scene in Winnipeg, and none identify as an Indigenous person. Archibald et al. (2019) describe Indigenous Storywork as giving voice to those entrenched within oppression and "reclaim our ability to story-talk, story-

listen, story-learn, and story-teach" (p. 7). Although the stories shared by service providers are an important aspect to the overall story of the impact on services for IPLH who use substances throughout the COVID-19 pandemic, recognizing these differences simultaneously enhances the **synergy** and **interrelatedness** between these two counterparts and offers an opportunity to better understand these experiences and apply a more wholistic level of care from an Indigenous perspective.

Each time I engaged in analysis, whether reading transcripts or in deeper theoretical analysis I began with a smudge to ground myself in the work and ensure I engaged with the stories in a good way. This **reverence** was also utilized during member checking by sitting in circle with the community guiding circle and knowledge holders. **Respect** was given to the stories identified within the knowledge shared by and affirmed by community. Taking the common stories that were arising among community and service providers participants back to the community guiding circle allowed for further discussion, clarification, and input into the stories I had identified. Ensuring the story told through my analysis is grounded in and led by community voices. This iterative analysis process helped capture the **holism** of individual stories shared throughout this research project. Lastly, as a researcher incorporating Indigenous methodologies, I had the **responsibility** to uphold these principles throughout the entire analysis and meaning making process.

Managing the large collection of data from the Gigii-Bapiimin study was more easily done through an initial deductive process. By weaving in Braun and Clarke's (2006) six phase approach I began with familiarizing myself with the data. This was imperative for me to condense down the data that was pertinent to my research question. Having completed the interviews I was very familiar with the data which helped with a deeper understanding of the

transcripts. I read the transcripts in full two times before beginning formal analysis within the software. I initially thought I would begin the deductive approach by sorting out data based on specific questions that related to my research question. Keeping Indigenous Storywork in mind, I quickly realized that doing this would result in a loss of context and wholistic understanding of the overall story in relation to my specific research question. Once the transcripts were uploaded to the MAXQDA software that I utilized for analysis, I began rereading each transcript. Still using a deductive process, though now utilizing the whole story, I went through and began sectioning large sections that coincided with my research question, such as impacts on services, substances, and service delivery strengths.

Using the sections identified through the deductive process for the primary focus specific to my research question, I began a more inductive process of analysis, generating initial codes within those sections such as access to harm reduction, access to ceremony, and effects of COVID-19 on services. A process Kovach (2021) would describe as open coding, "identifying the main ideas or concepts that arise from data" (p. 213). I also did this for substance use impacts, and service delivery strengths. Using a reflective process and utilizing Kovach's (2021) relational analysis as indicated in Figure 4, I began to search for relationships among the codes identified within the first level analysis. This was done by looking at each of the stories and using a reflective process to interpret the common story being shared. I considered teachings shared from Elder Albert McLeod and Knowledge Holder Gayle Pruden as well as the seven principles of Indigenous Storywork throughout this meaning making process.

This process is best illustrated within Table 1 below. I looked at all the instances across the transcripts coded as loss of person/human connection and thought about my interpretation behind those stories. Such as, the context in which the interviews occurred, my own experiences, and I

thought about the knowledge and teachings provided, often informally, from the larger project's elder and knowledge holder throughout the last year while generating meaning for these stories. Through that, I arrived at the description of the relationship among them which for this example looking at Table 1 was a diversion from a wholistic health approach. I continued this process for each code within the first level analysis, repeating the reflective process to identify relationships among them. Kovach (2021) explains that it is at this point within thematic analysis for Indigenous methodologies that one would pause to ensure this analysis was situated within an Indigenous way of thinking. It was at this time that these emerging findings were taken into circle with the project's community guiding circle and knowledge holders. This was a valuable experience as it not only helped affirm my interpretation of the stories were being represented accurately for the community, but it provided an additional layer of information for me to incorporate and consider into my reflexive process when finalizing themes.

I returned to the analysis process to identify the themes within the research stemming from the patterns and meaning previously identified and discussed with community. I looked at all the relationships identified within each section and began to consider what shared commonalities each of those had with one another. Again, I thought of the conversations and teachings shared with me throughout this research project both formally and informally. I drew on the seven principles of Indigenous Storywork to remain grounded within the stories and ensure the themes identified were rooted within them. Kovach (2021) notes that "[i]f you are intentionally staying close to Indigenous theory, community guidance, and the personal and particular, the themes will have relevance to Indigenous communities" (p. 209). From here, three major themes were revealed among the stories. Each of which are noted in Table 1 below and discussed in detail in section 4.0.

Table 1. Illustration of Analysis Process

Deductive Sectioning of Data	1st Level Analysis	Major Theme 1	Relational Analysis
Impact on Services	Loss of personal/human connection	The COVID 19 Pandemic revealed the depth of colonialism among health and social service delivery	Diversion from wholistic health approach
	Supports in place pre pandemic – two different experiences dependent on this		Emphasis on individualism vs collectivism
	Additional barriers to accessing services		Reduced access to. services/supports
	Reduced access to ceremony/medicines		Neglecting the significance of ceremony/medicines in overall wellness
Deductive Sectioning of Data	**1st Level Analysis**	**Major Theme 2**	**Relational Analysis**
Substance Use Impacts	Increased use	Harms associated with substance use throughout COVID-19 stemmed from neo-liberalism, not individual use	Wide-spread isolation
	Individualization (Personalization)		Othering of those who use substances
	The value of substances		Differing narratives
Deductive Sectioning of Data	**1st Level Analysis**	**Major Theme 3**	**Relational Analysis**
Service Delivery Strengths	Indigenous led with Indigenous service response	A wholistic approach to service existed within community and offered meaningful and targeted supports throughout the COVID-19 pandemic	
	Agencies 'on the ground' in community		Meeting people where they're at
	Innovations		Indigenous lens of wholistic response

3.6 Credibility of Data

Working withing the larger study of Gigii-Bapiimin provided me with an opportunity to triangulate data from the initial analysis with another research assistant and the principal investigator. This process helped ensure that similar coding was being done throughout the data sets prior to delving into more thorough analysis. More importantly, the credibility of the data was enhanced through member checking. Initial findings, including those of my thesis, were presented to the Community Guiding Circle for feedback and discussion. This process provided an opportunity for further dialogue regarding the stories that were emerging within the data. This information was used for reflection and further analysis as discussed within section 3.5.

3.7 Ethical Considerations

This research study has adopted the use of Indigenous ethical space. Ermine (2007) describes ethical space as an analogy of the space between two entities, such as Indigenous and Western worldviews. Ermine (2007) discusses the superficial level of encounters that often occur among Indigenous and Western societies. Without addressing the deeper levels of thoughts and assumptions between these two entities this will inevitably influence the type of relationship the two can have. Given the harms that have been inflicted onto Indigenous peoples by colonization it is understandable there would be a lack of trust regarding the intentions of research from outsiders. Ermine (2007) advises that the creation of ethical space begins with engagement through a collaborative understanding with Indigenous peoples of what is needed. It is also imperative that Indigenous knowledges are understood and incorporated in any work to achieve ethical space.

Community engagement and relational accountability have been at the forefront of the project from the beginning. The research has been guided by Indigenous Elder and Knowledge Holder (Albert McLeod) who has shared his wisdom throughout and ensured the project was grounded with culture, ceremony, and Indigenous philosophies. The project also included the Community Guiding Circle who advised on all aspects of the research, design, implementation, and analysis. Several ceremony-related elements were included throughout the project as well. The core research team participated in a Sundance (observers) and a pipe ceremony. Not only did these ceremonies help facilitate relationship building among the research group but provided a deeper appreciation and understanding of Indigenous culture and ways of knowing.

From a western perspective ethics approval for the Gigii-Bapiimin study was obtained from the University of Manitoba and adhered to the First Nations Principles of ownership, control, access, and possession. As my work was conducted within the larger context of the Gigii-Bapiimin study, standalone ethics approval for my thesis was not required. As a Graduate Research Assistant on the Gigii-Bappiimi project I worked closely with Dr. Rusty Souleymanov on the ethics approval process.

4.0 Findings

As previously discussed, three major themes emerged throughout the analysis process, each of which are discussed in more detail below.

4.1 Theme One: The COVID-19 Pandemic Revealed the Depth of Colonialism among Health and Social Service Delivery

Both those with lived experience as well as service providers were asked about the effect of COVID-19 on services, experiences accessing services (or providing), as well as access to

traditional medicines and ceremony throughout the pandemic. In addition, all participants were asked to share what would have been helpful throughout the pandemic, what was the most challenging, and ways in which they coped. Despite the differing perspectives between those with lived experiences and service providers, there was a cohesive theme which emerged in relation to access and level of care being received during the COVID-19 pandemic. There was also a consensus of services shifting from a wholistic approach, a strong emphasis on individualism with one's health and well-being, and the lack of availability to services and cultural practices.

Service providers addressed the inequity of care prior to the COVID-19 pandemic. As one service provider pointed out "I would say that [HIV] testing was a huge problem and predates [COVID-19] it got worse, access to testing is a huge issue. And then getting people their test results is also a huge issue. And then getting people connected to high barrier health resources also an issue" (GBS-MBSP-008). The sentiment of barriers predating the COVID-19 pandemic was echoed when discussing the current state of health and social services "I think that this would have been the trajectory regardless. . . .it took a very bad situation, and it just made it unbearable" (GBS-MBSP-006). Those with lived experience also noted the inequity for social services that existed pre-pandemic that became more amplified with experiences encountered throughout the pandemic. Challenges with the Employment and Income Assistance system and difficulties accessing basic needs due to long standing policies were expressed. One participant noted "I guess [COVID-19] just brought me a lot more awareness of what needs to be changed a little bit with people that are sick and having to deal with social assistance. Because really, there has to be something changed about that because the reality is when you do get sick, you can't

just get up and go walk around and look for clothes, look for new blankets, and you don't have enough money if you're getting sick almost every day or every week" (GBS-MB-014)

Service delivery throughout the pandemic intensified these inequities making it more challenging for certain groups to access the care and supports they were seeking. A comment from a service provider highlighted how the impact of service delivery varied dependent on social status. "People weren't getting access to care; they were being turned away at the door. . .. Folks who had privilege, who had access to computers, who had access to a cell phone, those folks they probably saw the provision of care shift as in how it was provided, but they still got access to service. Folks that didn't have that, our more marginalized populations just didn't have access to much care at all" (GBS-MBSP-004). Those with lived experience encountered this at various organizations. One person acknowledging "we weren't allowed to go into those buildings. We have to stay out. And you could only go in if you had like an appointment or something" (GBS-MB-006). Another expressing the additional barriers in place when attempting to access services, "[emergency shelter] was very strict. Very, very strict. We had to wear a mask at all times. Sanitize everything. At some point, I think they said if you don't have the vaccines, you're not allowed to come in" (GBS-MB-020). All additional hurdles to overcome before connecting with care, something that was already a challenge as noted earlier.

A diversion from a wholistic health approach was seen throughout the COVID-19 pandemic as noted by the loss of personal and human interaction from services. The COVID-19 pandemic seemed to quickly revert service delivery back to a heavily medicalized system comparative to the biopsychosocial model that had been adopted. An example of this explained by one participant who noted "I have a really good support system when it comes to. . . like being HIV positive the same team of doctors since I was 18 years old. And prior to COVID if I had any

concerns I could walk in there and access the social worker that's there. . .. However, during COVID I found myself not able to access these resources as I was able to prior to COVID" (GBS-MB-026). Many had a strong reliance on service providers and their consistency of care with detrimental impacts to well-being when these ceased. Emphasised by one individual who noted, "[t]he pharmacy guy didn't ever come around. And he was usually at my apartment every Thursday. But then, all of a sudden, the pharmacy stopped sending my pills. And I was kind of in the middle of a relationship. And then, I just dismissed it. So, I wasn't on the medications for three months" (GBS-MB-020). Another individual discussed changes to visits with their health care provider: "I have to sit on the phone and talk to them. Didn't talk too long" (MB-GBS-006).

This shift in service delivery was witnessed by service providers as well, a direction given to front line staff according to this participant: "I think we probably had visits that lasted a little less than they could have because it was just. . .everyone was uncomfortable, almost trying to keep it to just the facts, and so there was a little less niceties and a little bit less kind of softer side. Because it was just like, let's get this done. That was another direction we got, was to try to keep the visits to less than 15 minutes, if at all possible, just for. . .both sides, for the patients and for us as far as exposure goes" (GBS-MBSP-005). Others experienced the challenges of redeployment of essential staff. One individual noting "[w]e didn't have outreach workers available to provide transportation for people or just check in with people. And when people would come here, they couldn't just drop in" (GBS-MBSP-001).

The shift away from wholistic care also left behind important aspects to overall well-being such as access to ceremony and traditional medicines which play a significant role in the health and well-being of many Indigenous people. Some of the service providers interviewed didn't offer much in relation to connection to ceremony or medicines pre-pandemic, one noting their

knowledge was: “extremely limited. I would love more exposure to all of it because I know an embarrassingly little amount” (GBS-MBSP-005). However, the limited services that were available previously were reduced to almost nothing. Others noted challenges pre-pandemic regarding access to ceremony, one individual highlighting varying beliefs among the Indigenous community when asked about accessing ceremony: “No, never because one of the elders thought it was witchcraft or whatever. They were a residential school survivor” (GBS-MB-005). Another participant discussed the difficulty with finding ceremony to participate in even with the absence of public health restrictions: “[t]here were no ceremonies to go to and even if they did have ceremonies, they would only allow a certain amount of people there so you were lucky to even get in” (GBS-MB-014).

The findings regarding service provider’s lack of cultural knowledge is of particular importance given the significance traditional medicines and ceremony those with lived experience highlighted as a way of coping throughout the pandemic. One individual described this in relation to playing their drum: “I play my drum when I feel down, when I hear a loved one passed away in my reserve. And that’s when I play my drum. [Sage and sweet grass] makes me feel good. Makes me feel like, so I can breathe, I let out the bad feelings and then I hold it in for a bit and then I blow it out. . .. I smudge every morning and before I go to bed” (GBS-MBSP-011). Another person expressed the importance of medicines and ceremony to healing saying: “I think the plant medicines were a very important part of the initial response in the early days of the pandemic making medicinal teas, hanging medicinal plants, gathering medicinal plants, smudging and those kinds of things were a part of that response. And then ceremony, again was another part of that response. I think this generation is very in tune with a traditional healing knowledge and it is kind of a requirement or expectation in working with IPHAs” (GBS-

KH008). However, this contradicted many of the stories shared by service providers ranging from those who felt they knew very little in relation to Indigenous culture to those who had some familiarity but felt they needed to know more: “I have probably not as much as it should be. I have some understanding of process. I have certainly attended powwows. I have attended sweats. I think certainly smudging and that sort of thing I have experience with” (GBS-MBSP-004).

The move from a wholistic wrap around model of care placed a strong emphasis on individual responsibility. People were left to manage their own care and those who already had formalized supports established were able to better navigate the changes to service delivery brought forth with the COVID-19 pandemic. Both food and harm reduction supplies remained easily accessible for these individuals: “I used to deal with the ACT program during that time, so they brought my food, they brought my medication, they brough me supplies. Then when I had to do appointments, they would take me” (GBS-MB-012). Another noting, “[harm reductions supplies] was still easy for me to get because I can just make a phone call and my workers would drop it off” (GBS-MB-006). Service providers were aware of the advantage of pre-established supports with navigating changes to service delivery throughout the pandemic, noting the disadvantage others were at: “. . .for people who were diagnosed during COVID-19 or had the HIV transmission happen during COVID-19, I’d say that they were even more impacted because they didn’t have those connections to sort of bully them through. And so, they didn’t necessarily have other people they knew they could ask questions to about, like what does it mean, how do I prevent transmission or what does this mean or what is this med or what’s that side effect or whatever. So, I think that people diagnosed during COVID have been deeply impacted by the barriers to service” (GBS-MBSP-008). The failure to consider a more wholistic response to

service delivery highlights the neoliberal systems which IPLH who use substances are required to navigate regularly.

4.2 Theme Two: Neoliberalism Intensified Harms Associated with Substance Use Throughout the COVID-19 Pandemic

The emphasis on individualism created several social factors, particularly social isolation, that many participants with lived experience credited their increased substance use to. Highlighted here by one individual: "yeah, I started using more than I was before because I was lonely. I was all by myself, even though my partner was there, so yeah, I did use more, and I went out more because I figured maybe I'd be able to run into other people to keep me company so that's what I did" (GBS-MB-014) Another confirmed their use went up throughout the pandemic describing it as their rock bottom: "it went way up. . .that was rock bottom for me" (GBS-MB-005). This participant who used both meth and alcohol throughout the pandemic described their increased use in relation to assistance with not leaving the house: "I actually drank more and stuff, and now, I actually quit drinking. After COVID slowed down I quit. I used to drink 24/7. I used to make my own alcohol just to get drunk. Just to keep myself in the house. I wouldn't have to go out. And now I don't even drink at all" (GBS-MB-006).

Service providers who see a wide range of people, often some of the most marginalized folks in community including those who use substances and who are houseless, also had a strong recognition of increased substance use among those they serve. This individual describes what they have been experiencing on the front line: "[p]eople started using more. I don't know if it's correlated to COVID-19 or not, but I feel like people started using more. That might be related to their lack of connection and coping with that isolation" (GBS-MBSP-001). Others also associated substance use as a form of coping, this individual describing conversations had with

clients: “Yeah, I think substance use, we’ve talked about it as a coping mechanism with people being scared and isolated and retraumatized, and that sort of thing” (GBS-MBSP-005). Another reiterated the idea of substance use as a form of coping: “[p]eople are coping. If you don’t have a place to live or you have a lot of trauma, you’re going to cope with that if that’s the only way you can cope, right?! It’s very difficult. I’ve lost a few clients to overdose because of not being able to cope and feeling isolated” (GBS-MBSP-001).

Service providers expressed concern for the lack of care that many folks using substances are receiving within the health care system. One individual noted the lack of clinical exploration for those using meth: “substances are blamed for a lot of the presentation in some people. There are so many people that access Emergency, and even are admitted for a good amount of time, and they’re clearly displaying psychosis symptoms, and it’s chalked up to meth induced psychosis. There’s really not a lot of exploration for underlying psychiatric disorders that could be treated” (GBS-MBSP-005). Another individual reiterated this concern stating: “nobody’s getting the mental health help they need, because we’ve got meth-induced psychosis. We don’t have Schizophrenia and meth use we have meth use. And so, even though people have been incarcerated, or they’ve had long stints in somewhere, and they’re clearly not well and haven’t used in three months, it’s still meth induced psychosis” (GBS-MBSP-003).

This disregard for the health and well-being of individuals who use substances was explained by another service provider who identified the service restrictions they have witnessed; an exiling of those who use substances to conserve resources and determine worthiness through a lens of perceived readiness: “I’d say that the other thing that happens when services, so community agencies not just systems work, when people go into crisis mode, they pick on people who use drugs. Because they want to focus on people who are ready to do the work or

who are orientated or who know how to behave in quotations properly, or are predictable, show up on time, blah, blah, blah. And so, people will narrow their focus to the people who are easiest to serve instead of turning, in crisis, towards the people who need the most support and keep the flexibility there. And so, I've seen a lot of programs that used to be less barriered and focus more on people who are actually high-needs folks and instead turning to what I would call moderate-need folks and calling them high needs and kicking the other people out" (GBS-MBSP-008).

With the identification of increasing substance use, many of the service providers expressed concern with increasing overdoses as well, highlighted here by one individual who expressed: "the increase in drug poisonings is concerning and that I feel happened shortly after the pandemic started, for sure. I have seen an increase" (GBS-MBSP-001). Those with lived experience also expressed concern for increasing drug poisonings but associated these with a lack of safe supply. One individual here spoke of a recent experience with purchasing drugs: "Need to get rid of the Fentanyl. You need to get rid of the problem of people selling it and making it. Oh my god, I just had an experience the other day where one of my good friends almost died because some guy gave her down" (GBS-MB-015). Another expressed skepticism regarding the quality of drugs available: "So that's the only thing I do whether if it's salt or fucking whatever they want to throw out there to sell. But it's not always real so it's not always real drugs or real dope because it's hard out there" (GBS-MB-023)

The narrative 63urroundding substance use varied between service providers and those with lived experience varied somewhat as well. While the former emphasizing the hardships experienced by those using substances, described here: "I do have people that started using meth a lot more, as an example, that's their drug of choice, that weren't really using it. It was just like,

oh, I'll use it once in a while, and now they have substance use disorder. It's just chronic. They just can't. And I feel that increased after COVID for sure, because they lost their housing because everything went up in price, but Employment Income Assistance rates didn't. They're still stuck" (GBS-MBSP-001). The latter spoke more pragmatically regarding personal substance use. One individual highlighting here the trajectory of events leading up to them starting to use: "I was going to Bingo and the Casino every now and then, living on my own, and then all of a sudden, I couldn't do anything. It was really scary. . .. And I had money. And so, at some point, when I was in my apartment, I started dating this guy, he's HIV-positive, we were smoking Meth" (GBS-MB-020). Another described their substance use as a form of harm reduction, switching their choice of substance: "[b]ecause meth it would last so long and crack when you have a piece it's just a few minutes and you try to get another one. But meth you could have it for all day and I did not like that. Because when I slept, I used to sleep for two three days. And I used to sleep my days away and I didn't like that" (GBS-MB—006). Another individual simply attributed "being high all the time" (GBS-MB-00) as their form of coping throughout the pandemic.

Those with lived experience also shared more systemic considerations surrounding increasing substance use, several having pointed to the financial burden placed on those using throughout the COVID-19 pandemic. This individual noted the difficulty they had finding drugs and the outcome of that when they did: "Well, I had a hard time finding drugs. I don't know drug dealers. And so, I had to Facebook my friends and stuff like this, until I finally found a dealer. And they charged me, like, a very large amount of money. Lots of money, just for a little small amount. But it was the only person that I knew" (GBS-MB-020). Another participant shared this sentiment when asked about changes to substance use throughout the pandemic, stating: "yeah, it

seemed kind of harder to find. Prices went up" (GBS-MB-014). Details that those who do not belong to this community, such as service providers, may not fully comprehend the scope of challenges that were being encountered.

4.3 Theme three: A Wholistic Approach to Service Existed within Community and Offered Meaningful and Targeted Supports Throughout the COVID-19 Pandemic

Not all available services were created equally. Despite the individualistic response from many mainstream services, some operated from a more Indigenous perspective. By honouring the perspective of our interconnections and relations, some services – many Indigenous organizations – cared for others throughout the COVID-19 pandemic as their relatives. When discussing N'Dinawemak - an Indigenous led emergency shelter - one individual noted: "They have really good staff there. When they say our relative's home, they really treat you like a relative there. They burn themselves out trying to help you. That's the best centre I've been to" (GBS-MB-015). While many mainstream services were closing and redeploying staff many community-based organizations were developing ways to remain in touch with folks. One individual noting that some of these particular organizations, even when closed, offered personalized care packages to their homes: "I think they were closed for a little while, but they did send out packages too so we got one. We had a whole bunch. Yea, name-x she helped get some stuff to us during that time and then plus they created the Zoom meetings and stuff like that so that was really good. That helped a lot" (GBS-MB-014).

Service providers also recognized this different approach in service delivery from some agencies compared to others. Many noting the adaptations some Indigenous led organizations made for services throughout the COVID-19 pandemic. This individual highlighted the opening of a new shelter: "there were some really brilliant moments of collaboration. I'm thinking like

[N'Dinawemak]. What a beautiful thing for that shelter to open in the midst of all this stuff and just hit the ground running. They didn't even have a phone and they opened their doors and started bringing people in in December when it was a very cold winter" (GB-MBSP-008). Another noted the use of technology: "I think part of it has been a response virtually because of a lot of the social isolation that came over the last 2 ½ years and just the fears of exposure to COVID-19. And I think how the internet and virtual meetings were used. And that's when the project Ka Ni Kanichihk had actually, for two years, a weekly meeting on Zoom since March of 2020" (GBS-MBKH-008).

Of course, not all community members would benefit from the online innovations which emerged. The divide between those who benefited and those who did not expressed here by one service provider: "It was hard for some, right, especially the ones that didn't have phone or internet, didn't have a home. It was hard to connect with them and lose touch and later find out that they had passed away because of whatever" (GBS-MBSP-001). This individual describes the innovations of Ka Ni Kanichihk to help service users remain connected to services: "so what name-x did is she gave us a heads up that she was dropping off supplies and stuff like that, and she even helped us get a tablet in order for us to be connected to the meetings, as long as we had the wi-fi at home, so she dropped off a tablet for me. . ..[t]hen they got food delivered to the house and stuff like that" (GBS-MB-014).

In addition to virtual programming options, many of those with lived experience described organizations on the ground in community continuing to provide services throughout the COVID-19 pandemic. One individual described an outreach van in regular circulation as well as a walking patrol group: "Well, there is Street Connections and there is Bear Clan because they walk around, and they give out food or the van comes around with supplies and stuff like that

whenever you need them" (GBS-MB-014). Another described health care services in the shelters: "they came to MSP, like Main Street Project every Monday and then they would move to 190 Disraeli. So, the nurse comes here to help people out with HIV and Hep C and stuff" (GBS-MB-015). Service providers recognized the importance of health care in shelter as well noting the low barrier aspect of these services: "We even had the SUAP clinics in our shelter, so that helped with just like meeting people where they're at regardless of if they're using substances or not" (GBS-MBSP-006).

This presence of services in community and the ability to meet community where they are at physically was a key feature identified as accessible service throughout the pandemic for those who use substances. One service provider highlighted the importance of having social workers available for folks once they are in the door: "It's basically any place that has an open-door policy. Then I think that's where social work becomes crucial because they have a lot of access to, I guess knowledge about some of the other things, like getting people on social assistance a little bit quicker, trying to get them a health card, ID . . ..there's no way we could survive without the social worker" (GBS-MBSP-00). The mobile overdose prevention van along with Go Ask Auntie were two services identified as filling much needed gaps in service and having opened their doors during the COVID-19 pandemic. One service provider points out what this means for community:" the aunties is probably like the model that seems to make the most sense for me actually in terms of what people need" (GBS-MBSP-008). Services such as these continued to respond to community needs in a way that considered a more wholistic approach while continuing to adhere to public health orders.

5.0 Discussion and Concluding Remarks

5.1 Reflexivity on Research Process

This study utilized Two-Eyed Seeing to incorporate Indigenous and Western research approaches to explore the impact of COVID-19 on services for Indigenous People who use substances and are living with HIV in Winnipeg, Manitoba. The prolonged colonization of Indigenous peoples in Canada have created countless harms and inequities in a variety of health and social service sectors which are often perpetuated through research. Research conducted which seeks the truth through a western lens has at worst, thrust upon Indigenous peoples through Indian hospitals and residential schools (and at best failed to take into Indigenous worldviews to provide meaningful outcomes and tangible actions to mitigate health and well-being inequities experienced by Indigenous people.

The research conducted throughout the Gigii-Bapiimin project, which I worked as a graduate research assistant on and utilized the data for my thesis, was done with the involvement of an Indigenous Elder (Albert McLeod). Elder Albert began the work by sharing the significance of the project name, Gigii-Bapiimin, a name gifted by the late Roger Roulette. It is an Ojibwe term that reflects survival, resilience, and overcoming adversity. Elder Albert shared this as being a concept filled with optimism and strength with a grounding in the Anishinaabe Life Model. This name and its meaning set the tone for the work to be done throughout the Gigii-Bapiimin project as it provided a foundation for all researchers to look for the strengths and resiliencies within story. Despite the undeniable challenges experienced by IPLH who use substances throughout the COVID-19 pandemic, Indigenous people survived and continue to thrive as they have done throughout history.

In addition, Indigenous people living with HIV many of whom also use substances made up the community guiding circle which provided consultation and feedback throughout the project and were integral to the research design, data collection, and analysis processes. Relationality is

an integral component to Indigenous epistemologies (Antoine et al., 2018) and is something that was at the forefront throughout the research design and implementation. Through a meaningful exercise using body mapping the community guiding circle set the trajectory of questions to guide interviews conducted with participants. Each interview was conducted with both a relationality and trauma-informed approach. This was done by ensuring each interview had a person with lived experience present and actively involved to reduce the power imbalance often experienced within such a setting, offering opportunities to smudge for those interested, and providing supports and resources following the interview recognizing the impact some questions may have had on individuals. The goal was to engage with community in a good way and give back from the research rather than extracting knowledge without a purpose.

Stories were gathered using Archibald's (2008) seven principles of Indigenous Story work - respect, responsibility, reciprocity, reverence, holism, interrelatedness, and synergy - as a grounding. The stories shared during the interviews became much more than the transcribed words which resulted from each of those days. Each story belonged to an individual yet as the analysis process occurred, common threads within each one began to unfold becoming woven into one which created a collective story. Maintaining the foundation of Two-Eyed Seeing, both western and Indigenous methods were utilized for analysis. Thematic analysis helped me to organize data and recognize stories initially. The flexibility of the thematic analysis procedures lends itself to an Indigenous epistemology in that this process is cyclical rather than linear. The stories identified sat with me, the researcher, through ceremony and reflection as part of the meaning making process. The story was then shared with the community guiding circle and elder to ensure its accuracy.

Each of the stories shared were analyzed individually while maintaining a wholistic focus through an Indigenous lens. Utilizing Indigenous Storywork Archibald (2008) points out that "[s]torytelling honours and respects the individual and the group [and] many elders teach that one should not simply accept the outward meaning of a story as an absolute given" (p. 125). Meaning making behind each story required a much deeper probing than the transcribed words. Through deep reflection along with my own personal and professional experiences I was able to analyze each story to gain a more thorough understanding of how exactly the COVID-19 pandemic impacted services for Indigenous people who use substances and are living with HIV. Once an understanding of the story was achieved a critical lens was used to apply meaning in the context of social work practice.

5.2 Summary of Research and Findings

The three overarching themes that arose formed a wholistic story that did not just address the impacts of COVID-19 on services for Indigenous people who use drugs and live with HIV but orient us to the realities that these folks' experiences daily. Although disruption to services was widespread with many negative impacts to health and well-being for IPLH who use substances, it was apparent that the pandemic simply intensified issues that were already deeply rooted into colonial structures that oversee many health and social services within the province. Stories revealed the nuances of substance use between service provider perspectives and those with lived experience. With the application of a critical lens throughout the meaning making process the harms associated with substance use are intrinsically linked to the neoliberal discourse and framing of these issues and resulting systemic structures compared to the individual drug user themselves. Remaining grounded within an Indigenous perspective and utilizing Indigenous Wholistic Theory, the under tone throughout each story is one of resilience,

kinship, and community. Though operating in a different capacity throughout the COVID-19 pandemic, there were several services that tended to the needs of IPLH who use substances.

5.3 Connection to Literature Review

The findings from this research project are consistent with those of the literature review. Access to services were disrupted by the COVID-19 pandemic resulting in decreased capacity and reduced in person visits (Russel et al., 2021 & SeyedAlinahi, et al., 2023). Based on stories shared by participants, the shift away from more relationship-based care had detrimental impacts on the health and well-being of IPLH who use substances. Many participants noted struggling with mental health due to reduced services and social isolation. These impacts correspond with research findings focusing on other marginalized groups such as those within the LGBTQ2S+ community, youth, and older adults (Souleymanov et al., 2023 & Craig et al., 2022 & Chu et al., 2020). Although access to services throughout the COVID-19 pandemic were widely disrupted, the consensus among those with lived experience and service providers was that many barriers to service access existed prior to the pandemic. These barriers to service for IPLH are addressed widely throughout the literature, noting that factors such as race, poverty, and stigmatization of HIV impact the level of care folks receive (McClarty et al., 2021 & Browne et al., 2016).

IPLH who used substances throughout the pandemic faced additional hardships in relation to services. Increasing overdoses, lack of safe supply, and labeling among health care providers resulted in inadequate care. The literature addressed the harms associated with stigmatization those who use substances faced among health services prior to the COVID-19 pandemic, noting this often resulted in an avoidance of care and slower uptake to anti-retroviral treatments (Miller et al., 2006 & Erickson, 2014 & Nowgesic et al., 2016). Increasing substance use resulting in rising cases of drug poisonings were also widely noted throughout the literature

(National Collaborating Centre for Infectious Disease, 2022 & Unger, 2021). These overarching issues were within the context of other challenges faced for those using substances throughout the COVID-19 pandemic including access to substances and increasing solitary (National Collaborating Centre for Infectious Disease, 2022 & Munroe et al., 2022 & Ali et al. 2021). Those with lived experience expressed an increase in personal substance use as a result of loneliness as well as ongoing needs for social isolation. The shift in service provision experienced throughout the COVID-19 pandemic aligned with the Government of Manitoba's pre-pandemic response to harm reduction and supports for those who use substances in that needs were not being met prior to the additional barriers experienced throughout the pandemic (Hallmarson, 2022 & Caruk, 2022).

Participants also acknowledged the additional challenges to service access experienced throughout the pandemic for those without phones or internet, creating additional barriers to health and social service supports. Service providers most often referenced these challenges in relation to those experiencing homelessness, which they defined as houseless individuals. Although an additional intersecting analysis of homelessness is beyond the scope of this project given that none of the participants with lived experience identified as having experienced homelessness during this time, from a wholistic perspective this facet aligns with the literature as well. Thistle (2017) describes Indigenous homelessness as much more than a person being unsheltered but also encompassing a disconnect from land, people, and culture. The literature highlights that culturally responsive services are an essential part to Indigenous well-being and work to address the harms inflicted by colonialism (First Nations Health Authority, 2023 & Lin et al., 2023). This is consistent with findings given that participants highlighted isolation, loss of

personal connection, and loss of connection to ceremony as having had negative impacts on their well-being.

The wholistic service response by organizations in community, many Indigenous led, were most meaningful to those with lived experience and offered consistent support throughout the COVID-19 pandemic. This is congruent with the literature in that findings expressed despite the increasing challenges experienced by Indigenous people; relief was found among agencies that previously utilized Indigenous ways of knowing (Watson, 2021). Viewing Indigenous wellness as a wholistic entity (Thistle, 2017) is essential for understanding the imperativeness behind these services. Many of those with lived experience relied heavily on these wholistic supports to get through the pandemic. Additionally, service providers witnessed the flexibility and responsiveness of these services. These findings are consistent with the literature's suggestion of the need for Indigenous knowledge led services to help reduce negative impacts of future pandemics (Fleury & Chatman, 2023).

5.4 Theme One Discussion: The COVID-19 pandemic revealed the depth of colonialism among health and social service delivery

Both service providers and those with lived experience expressed various changes to services that were experienced throughout the COVID-19 pandemic. Those with lived experience expressed reduced access to support systems they had for over a decade, noting that gaining access to resources such as social work was not as easily done prior to COVID-19. Others noted additional barriers to services such as masks, sanitizing, and even noting at one point proof of vaccination being required to access some emergency shelters. However, a commonality among stories that arose between both service providers and individuals was that barriers to services existed prior to these restrictions. Some folks acknowledging inequitable

policies with social assistance regarding financial support for unexpected expenditures that arise when someone is sick. Described by one participant as having to walk around for clothing and other personal needs items when feeling unwell as the funds provided by social assistance are not adequate to cover unexpected costs and no additional supports are offered for assistance. Service providers also highlighted intensifying barriers, some drawing attention to the challenge prior to COVID-19 with connecting newly diagnosed individuals to high barrier health care. Another noting that the changes to services with COVID-19 took an already bad situation and made it unbearable for many folks.

In a society so deeply entrenched within capitalism which not only perpetuates but requires a class divide to operate, these types of policies overlook the reality of those they impact the most. In these instances, such as the one described above by this participant, harm is perpetuated onto some of the most disadvantaged groups. One must consider if these types of policies are unintentional or are they, as I am suggesting, a revelation of the deeply engrained colonialism that exists within our systems continuously working to eradicate Indigenous people, systems, and knowledges. Under the guise of an age of reconciliation in Canada, we are asked to believe that colonialism is behind us and that the injustices of the past are not being carried out today. An analysis with a necropolitics lens considers the implementation of these types of policies as a more indistinct form of determining who lives or dies. As Mbembe (2019) points out "weapons are deployed in the interest of maximum destruction of persons and the creation of death-worlds, new and unique forms of social existence in which vast populations are subjugated to conditions of life conferring upon them the status of living-dead" (p. 92).

The subtilties of necropolitics are present among these shared stories and can be seen in the diversion from a wholistic health approach as well as the emphasis on an individualized

responsibility for health and well-being rather than a collective one throughout the COVID-19 pandemic. From an Indigenous Wholistic understanding, health encompasses many facets of one's self. As the Gigii-Bapiimin study sought guidance from the Anishinaabe Life Model and ancestors within my Métis lineage are of Anishinaabe decent I use the medicine wheel as a depiction of this interrelation, an image utilized within many Anishinaabe cultures. Absolon (2019) explains that the "medicine wheel, four directions, and circles have been used as an effective and appropriate means and tools to develop healing strategies" (p. 25). From a colonial perspective, this idea of health beyond the physical realm has taken form into what is known as the social determinants of health. The social determinants of health are broader social and economic factors that impact health and there is recognition of the inequalities that factors such as race and income play in a person's overall well-being (Government of Canada, 2023).

Although there is a commitment from the City of Winnipeg's major health authority to eliminate inequalities in health outcomes and create opportunities for individuals to reach their health potential (Winnipeg Regional Health Authority, 2023) stories shared by those accessing services throughout the COVID-19 pandemic reveal that more wholistic aspects of health were the first to be stripped from care. This shift in care was highlighted by a service provider who described clinical direction received to significantly scale back appointment times to in hopes of reducing risk of exposure to COVID-19. Those with lived experience also experienced this shift and loss of personal connection, this individual discussed visits with their health care provider during the COVID-19 pandemic noting that they were often subjected to phone visits and as a result did not speak long to their health care provider. Adekson (2017) described Indigenous wholistic beliefs with health and well-being as much more than simply the absence of disease, with an understanding of this an acknowledgment of the importance of the incorporation of other

facets of health are essential for overall well-being perhaps even more so during a global pandemic.

However, not all individuals were affected equally by these changes to services. Some folks whom we spoke with were able to acknowledge the changes to services but felt little personal disruption to the care they received. This was often attributed to the formal supports they had established prior to the pandemic. Those with case workers from community organizations felt supported amidst all the changes to services. One individual who was involved with intensive case management programming noted that all supplies and medications were brought to them, and they were escorted to any appointments. Many service providers expressed their concern with challenges of remaining connected to folks, primarily those without phones and stable shelter that relied heavily on drop-in services which were no longer operating. Outreach staff were redeployed and were no longer available to check in with folks or provide transportation. These restriction to service caused by public health orders at the time were working to curb the influx on COVID-19 transmissions (Government of Manitoba, 2021) but did not consider the harms associated with reducing and eliminating supports for those who relied heavily on them for other aspects of their well-being. During a global pandemic, services quickly reverted to the colonial biomedical model of health so deeply engrained within our system (Horrill et al., 2018).

From an Indigenous perspective, a shift from a more wholistic model of care within a colonial system that does not understand the philosophical meaning behind such a model is not surprising. Though the health care system in Canada expresses knowledge of the social and economic factors of health such as those identified with social determinants of health, there seems to be a disconnect of how to properly address these issues. When speaking with Elder

Albert McLeod he shared the challenges of the uptake of Indigenous models, noting: “the uptake is very skewed because a lot of people take it from an intellectual point of view and don’t understand sort of the philosophical world view that is required to understand or apply these models” (GBS-KH-008). For me, this teaching accentuates the lip service surrounding much of the reconciliation efforts within health and social services. Ultimately, there does not seem to be a solid foundation within services that address the challenges that IPLH who use substances experience when accessing service or acknowledge the benefits of wholistic well-being.

Many of the service providers who shared their story didn’t offer much in relation to connection to ceremony or medicines prior to the pandemic. The majority of those who did not identity as indigenous expressed their lack of cultural awareness when discussing Indigenous ceremony. Yet, Elder Albert McLeod noted that “this generation is very in tune with a traditional healing knowledge, and it is kind of a requirement or expectation in working with Indigenous people living with HIV”. This certainly rang true for those with lived experience many of them describing the healing powers of medicines and drumming and the significance of these items to their well-being throughout the COVID-19 pandemic. If Indigenous well-being is contingent on the interrelations of the physical, spiritual, emotional, and mental realms with traditional medicines and ceremonies as methods of healing the lack of systemic incorporation of this into health and social services seems intentional. Estevez (2021) highlights that Mbembe’s (2011) necropolitics exist within the US and Canada through factors such as social marginalization, racism, class and gender. In the context of a global pandemic the colonial systems in place which make up our health and social services no longer fully concealed these oppressive structures. The COVID-19 response to services did not need to revert to a more biomedical model of well-being,

it already existed and has been causing ongoing oppression for Indigenous people living with HIV who use substances pre-pandemic.

5.5 Theme Two Discussion: Neoliberalism Intensified Harms Associated with Substance Use Throughout the COVID-19 Pandemic

Much like the systemic policies that work to uphold colonialism and eradicate Indigenous peoples previously discussed, the ideology surrounding substance use sets forth a collective narrative which devalues the lives of those who use substances. The basis of necropolitics described by Mbembe (2003) examines how current structures determine who has the right to live and die through violence, racism, and fascism which creates an othering of people driven by colonialism. This concept can be applied to the War on Drugs and the neoliberal and neocolonial policies and subsequent ideologies associated with substances and those who use them. The notion of this was present among the stories told by both those with lived experience and service providers.

The restriction to services throughout the COVID-19 pandemic created widespread isolation. Increased substance use was part of the collective story shared by those with lived experience and service providers. Many of those with lived experience confirmed their personal substance use increased. Some simply felt they got through the pandemic this way, others increased their use out of loneliness, and some to help combat the reality of remaining isolated in home. Service providers also observed an increase in substance use among those they serve. Many described the increase in substances that they encountered and attributed this to a form of coping with isolation and other social factors being experienced throughout the COVID-19 pandemic.

The combination of isolation and reduced services placed those who use substances at greater risk, with reduced access to harm reduction supplies and increased risk of overdose when using in isolation (Nguyen & Buxton, 2021). Service providers and those with lived experienced noted the concern with drug poisonings, one service provider sharing that this is something they had noticed following the COVID-19 pandemic and another stating they have lost clients to overdose since the pandemic began. Border closures throughout the pandemic also reduced the quality of drug supply, increasing toxicity of available drugs (Canadian Centre on Substance use and Addiction, 2020). Those with lived experience spoke to this, noting the poor quality of drugs currently available on the street. One had recently had a close encounter with a friend who nearly overdosed and another noting that drugs were not necessarily what they claimed to be when buying them.

This all coincided with a redirection of public health services to address the COVID-19 pandemic. As typically under a neoliberal state substance use has been regarded as a choice (Atkinson, 2020), it is not surprising that substance users were not at the forefront of decision making and the harms that these choices of worthiness for services would inflict on the community. A knowledge holder interviewed for the study expressed this stark reality when discussing impacts to those who use drugs stating that: “who knows how many of them passed away, we don’t know. I don’t know and I don’t think anybody really cares either. Even though, like I said, everybody’s equal, but society is so bitter. If society were to really care and reach out to these people, there wouldn’t be that problem. But everybody is for their own” (GBS-MBKH-009).

Greensmith (2022) describes helping professionals as providing a level of care that is based in power dynamics that “emerge from social, political, and cultural contexts” (p. 81) and

ultimately uphold white settler colonialism. As a frontline service provider, myself, I recognize the reality of this while working in the mainstream healthcare system. The individualization of those who use substances creates an othering effect. This is described by one service provider when discussing the restriction of services throughout the COVID-19 pandemic: They describe the shift in services they witnessed as a response to lack of resources resulting in the further marginalization of those who use drugs with a justification of serving those who are considered ready and willing to put in the work. Services operating in this manner help to determine who receives support and who does not. There is the idea of choice surrounding substance use and its effects which dehumanizes individuals and alleviates any cognitive dissonance that may occur due to the lack of care being provided. This othering for those who use substances creates differing levels of care. Service providers pointing out that a label of being a meth user is often ascribed. Several service providers expressing concerns for how this then impacts the care individuals receive. It was noted that substances are often blamed for patient presentations resulting in poor exploration of psychiatric disorders. The discourse surrounding substance use and the engrained beliefs of worthiness create a dynamic where folks who use substances are not getting the care, they deserve which creates harm for them.

The creation of worthiness plays out through the seemingly arbitrary level of social acceptance of substances within our society. Controlled substances such as alcohol and marijuana were deemed essential services in Manitoba and were made available throughout the COVID-19 pandemic. However, those using illicit substances were faced with increasing prices and difficulty with obtaining substances. Gordon (2006) draws our attention to the intentionality behind neoliberalism and the war on drugs and the role in which race and capitalism play when targeting those using illicit substances. In Winnipeg, during the 2018 street census of the 1519

people experiencing homelessness that were interviewed, 65.9% identified as Indigenous and 32.5 % cited addiction/substance use as the primary reason for their first experience with homelessness (Brandon et al., 2018). When considering a response plan to COVID-19 in relation to service delivery, the neoliberal ideology which exists would place Indigenous people who use substances at a low priority of ensuring equity in support throughout the pandemic.

If society were to care, as was previously expressed by the knowledge holder interviewed for the project, there wouldn't be a problem. Perhaps an overly simple solution to a complex problem, or one that is just seemingly unattainable through a colonial lens. From a critical standpoint, if we begin to shift the narrative of substances and those who use them we could begin to think of substances from a more wholistic perspective and address not only inequities that existed within the COVID-19 response to services but which exist regularly. Critical drug studies caution us to avoid binary thinking of substance use which lead to stigma and marginalization (Dennis, 2017). Askew and Williams (2021) discuss critical drug studies and the reframing of substances to life enhancements, whether that be through mood or physical health through the alleviation of withdrawal symptoms. They argue that performance and cognitive enhancing drugs are much more socially acceptable and if this shift in narrative were to occur there would be less discrimination towards those using drugs deemed less desirable within society.

Many of those with lived experience were using substances as form of socialization during peak isolation throughout the pandemic. One individual spoke about increasing their use out of loneliness and another expressed hoping to run into others while out trying to score. Another, fearful to contract COVID-19 due to being in higher risk category as someone living with HIV, used substances to help manage in home isolation with the hope of maintaining their

physical health through reduced risks perceived with going out in public during these times. From a Wholistic perspective these strategies were fulfilling various quadrants associated with the medicine wheel previously discussed. From the considerations brought forward by Askew and Williams (2021) these uses could be thought of ways substances enhanced the lives of these folks during a difficult time.

Shifting the narrative surrounding substance use can then offer insight into a more wholistic lens of one's life. Considering the enhancements that substance use brings to those using is aligned with a harm reduction approach; respecting those who use substances, following evidence-based approaches, and avoiding stigma (Simoneau, 2022). Unfortunately, the neoliberal policies and response to the COVID-19 pandemic double downed on individualism failing to take into account the other aspects of wellness in people's lives. By not considering the needs of those who use substances loss of personal connection created widespread isolation, leaving people to use alone placing folks at risk of accidental overdose. The closure of borders and increased policing tampered with the quality of supply and drove street prices up, resulting in an unsafe supply increasing overdoses and leaving folks more financially strained than previously. Applying necropolitics within this context is best described by Perezts (2021) who points out, these deaths are anything but accidental and are an intentional design of the system in place which views some individuals as disposable.

5.6 Theme Three Discussion: A Wholistic Approach to Service Existed within Community and Offered Meaningful and Targeted Supports Throughout the COVID-19 Pandemic

Not all services operated within the context of othering IPLH who use substance during the COVID-19 pandemic such as the othering Mbembe (2019) highlights within necropolitics that has previously been described. Many participants expressed the significance of services in

community that continued to provide meaningful and caring supports during this time. Places such as Sage House, N'Dinawemak, and Ka Ni Kanichihk were organizations identified by many participants where folks felt safe and well supported throughout the COVID-19 pandemic. Other programs such as the Street Connections van and the Bear Clan patrol were identified as important for being on the ground and meeting individuals where they were at, both literally and figuratively, in community. Places which offered interdisciplinary services were important to community having been identified by both service providers and those with lived experience as essential to overall well-being.

Many of the services throughout the province shifted to virtual delivery to comply with provincial public health orders as did many of the agencies identified above. However, some agencies identified by those with lived experience developed these innovations from a more wholistic understanding, one that contradicted the mainstream neoliberal service response. The individualism of neoliberalism relies heavily on everyone to be responsible for themselves and not rely on the state for support (Brown & Baker, 2012). Furthermore, the widespread class divide created and maintained by colonialism consistent with Mbembe's (2019) view of necropolitics, placed certain individuals – particularly Indigenous folks who use substances and live with HIV – at a greater disadvantage throughout the COVID-19 pandemic. To participate fully in online programming, one must have the means to do so, when many individuals do not have access to technology required for this. This was expressed by a service provider who pointed out that those without phones, internet, or houses were nearly impossible to stay connected to.

One Indigenous organization highlighted by someone with lived experience recognized this exclusion and provided some community members with iPads so that they could participate

in virtual programming. This response is consistent with an Indigenous perspective of relations. Wilson (2016) describes Indigenous reality as relationships and highlights that relationships is who Indigenous people are. Within a colonial system and mindset this can be difficult to disentangle from the notion of individualism and providing folks with whatever it is they need for them to thrive. However, as Tynan (2021) explains, relationality is of utmost importance to Indigenous people and where "nature is understood as full of relatives not resources" (p. 603). It is through this that Tynan (2021) describes relationality as a practice based on obligation or responsibilities. It is understandable that many organizations that provided the care needed to IPLH who use substances throughout the COVID-19 pandemic were grounded within Indigenous knowledges and this relationality mindset.

Other ways in which organizations with a more wholistic perspective responded to changes in services was going out into community. With public health restrictions reducing and at times eliminating in person services, many of those with lived experience highlighted organizations dropping off traditional medicines and care packages at their homes. Another individual acknowledging when accessing services at N'dinawemak, an Indigenous led emergency shelter, how well they were treated by staff and feeling as though they were truly considered a relative there. Kennedy-Kish Bell (2019) explains that Indigenous wholism is a way of seeing and the interrelations of the mind, body, heart, and spirt and working to find balance within these. We can see the difference to service response throughout the COVID-19 pandemic through this lens, mainstream services were fixated on protecting the body from the virus. The western healthcare system is rooted in a biomedical foundation which resulted in disregard for the other aspects of well-being. This larger service response placed IPLH who use substances at a greater disadvantage than their non-Indigenous counterparts.

Indigenous organizations and those that understand and appreciate the philosophical importance of wholism were able to meet community needs throughout the pandemic while complying with public health restrictions. This speaks to the larger systematic policies that actively work to perpetuate harms to Indigenous people. As previously highlighted, there is recognition through the acknowledgement of the social determinants of health as well as the Truth and Reconciliation Commission of Canada of the harms done to Indigenous people and the inequalities that those harms have caused. Furthermore, there are 94 calls to action that provide a roadmap for ways to begin to mitigate these inequalities (Truth and Reconciliation Commission of Canada, 2015), yet, during a global pandemic with the potential to further increase these inequalities aspects of wholistic well-being were not taken into consideration with changes to services.

Again, this failure to consider the experiences and needs of IPLH who use substances throughout the COVID-19 pandemic can be understood through the application of necropolitics. Mbembe (2019) builds on Foucault's (2008) understanding of biopolitics, which highlights racism as a political tool to divide and addresses the justification of life through colonizing genocide. Stories shared by those with lived experience call attention to not only the possibility but the effectiveness of an alternative response to service provision throughout the COVID-19 pandemic, one that provided ongoing meaningful supports to IPLH who use substances. With mainstream health and social services operating within a highly colonial system, this created divide could be viewed as an intentional way to uphold western essentialism, creating an othering effect. This othering can be viewed through a critical lens of necropolitics (Mbembe, 2019) and the ascribing of worthiness to lives, services being delivered to those deemed worthy to live and further marginalizing IPLH who use substances. In some cases, as pointed out by

service providers, loss of life following inability to connect with those without access to phone or internet. Regardless of the intent behind changes to service delivery, Indigenous resilience prevailed. Through the application of Indigenous knowledges and ways of doing, being, and seeing these services provided meaningful and intentional supports to IPLH who use substances throughout the COVID-19 pandemic.

5.7 Addressing the Study's Research Question and Objectives

This research sought to advance the understanding of the nature and extend of the impacts of COVID-19 on services Indigenous people living with HIV who use substances access in Winnipeg, Manitoba. Through story those with lived experience as well as service providers were able to provide insight into these impacts. Indigenous people living with HIV who use substances experienced many changes throughout the COVID-19 pandemic to the services they access. These changes included complete closure of businesses, redeployment of staff, and reduced in person visits with health and social service providers. Although many Manitobans experienced similar changes to services, Indigenous people living with HIV who use substances had a unique experience based on the historical and ongoing impacts of colonialism. This group was further marginalized throughout the pandemic as a result of substance use and the ideologies which surround the use of substances within our society.

A common theme identified which explored the wider health and well-being impacts of Indigenous people living with HIV who use substances included widespread isolation. This led to increasing substance use resulting in a rise in overdose deaths. A diversion from wholistic health supports within the mainstream health system placed those without formal supports in place prior to the pandemic at a disadvantage. With less supports available to connect folks to, many were left to rely on themselves to navigate complex systems. Amidst a global pandemic

the rigidity of service policy revealed deeply rooted strategies of oppression. With the existence of such structural inequalities, the reliance on individual resources continued to disadvantage Indigenous people living with HIV who use substances. There was also a disregard from the mainstream health care system of the significance of the incorporation of traditional medicines and ceremony, something identified by many with lived experience as an essential component to their overall well-being and a source of resilience throughout the COVID-19 pandemic.

Through shared story agencies with a more wholistic service response were identified by participants. These organizations ensured medicines and ceremony were available for folks and those using services felt as though they belonged and were treated relationally. Some of the organizations identified addressed socioeconomic disadvantages of a shift to virtual programming and provided some with required technology. Others were on the ground in the community continuing to provide direct services, meeting people where they were at. Many of these organizations were Indigenous led or have adopted Indigenous knowledges into practice prior to the pandemic. These programs simply continued to offer services as they always do with Indigenous ways of knowing, doing, and seeing.

Given these findings and the increasing rate of HIV diagnoses among Indigenous people there are several calls to action and recommendations to make for more effective and culturally safe initiatives within health and social systems. The first being the implementation of Indigenous knowledges into services. Any organization servicing IPLH who use substances should be increasing capacity among direct service providers surrounding Indigenous knowledges and healing. Based on the effectiveness of many Indigenous led community-based organizations identified by participants I call on the Manitoba Government along with health and social service policy makers for an increase in funding for Indigenous led community-based

organizations that serve IPLH who use substances. I would also call for an increase in capacity for Indigenous health services within the mainstream health system as well as an increase in designated Indigenous positions across the health and social service sector. Additionally, it is apparent that those with lived experience have a vast knowledge surrounding these issues and therefore I call on health and social agencies to incorporate more peer involvement into their services and supports. The implementation of these recommendations will incorporate more culturally responsive services and be pre-emptive of future pandemics helping to alleviate inequities created by services.

5.8 Implications and Recommendations for Social Work Practice

These findings provide valuable insight into community needs and assets. Burnette (2016) highlights the work of Paulo Freire who suggests that social problems emerge from chronic oppression and results in people feeling resigned or helpless to effect change. By shifting power back to the community through empowering voices and developing an action plan the project incorporates community-based and decolonizing approaches. For the social work profession, the basis of this is grounded within the foundational understanding that people are the experts of their own lives. To determine the most relevant approach and understanding of any given issue individuals and community must be at that the centre of that work. This also helps highlight the need for social work practitioners to not become complacent within the systems in which we are employed, there is a need for ongoing advocacy and engagement in anti-oppressive practices. According to Baines (2011) social workers must not only provide services to people seeking it but also help clients and communities understand the larger social inequalities at play and how to fight for change.

Social workers must demand more from the systems in which we are employed and recognize the tokenizing policies and practices that exist. This research helps provide voice to IPLH who use substances in Winnipeg, Manitoba and highlights the impact of COVID-19 on services utilized by IPLH, in turn providing social workers with a better understanding of community needs. The findings reveal possible shortcomings in social services, particularly regarding the lack of cultural competency, safety, and supports. Awareness surrounding this should provide a basis for areas of advocacy within the workplace and the importance of practitioners drawing on these protective factors when working with IPLH who use substances. Social workers working within this field have an ethical responsibility to have a comprehensive understanding of available supports, where to access them, and at very least the language to hold conversations regarding individual interest in connecting to traditional ceremonies and medicines.

The participatory nature of this project involves praxis; reflection and critical dialogue coupled with social action to enhance service delivery and develop more culturally safe spaces within healthcare (Burnette & Figley, 2016). Conceptualizing these issues within a wholistic understanding of health and well-being can help lead to advocacy within healthcare practices that are more aligned with social worker's values (Ashcroft, 2017). Through this process social work educators can also better prepare social workers entering the healthcare field for what role they play in health-focused environments and how to advocate for and incorporate all facets of health into service delivery. This critical dialogue is not only essential to front line practice but is a staple within policy change as well. For social workers at all levels, understanding theories of change can help transform systems. Policy Learning is a theory of change which results in changes in thoughts and behaviours, where goals are adjusted as a result of experience or new

information, which can occur through social learning (Cerna, 2013). Through this process, the data gathered can help to inform policy and service delivery changes going forward by learning the facilitators and hinderances to accessing services during this time and can help reduce barriers and inequalities for future pandemics.

5.9 Strengths & Limitations

Utilizing Indigenous methodologies contributes to the knowledge and legitimatization of these within research. Incorporating Indigenous voices, knowledge, and experiences and conveying these in a wholistic way through story helps to identify areas of resilience and healing within these communities. Through storytelling, participants are open to share their truth and have a direct impact on developing a plan of action. The participatory nature of the project fits within social work values such as respect for inherent dignity and worth of persons as well as the pursuit of social justice. In addition, it recognizes and addresses key aspects of the National Truth and Reconciliation Commission of Canada calls to action, particularly aspects of number 19 and 22 listed under the health heading which respectively address calls to action to address the inequity in health and recognize the value of Indigenous healing practices (Truth and Reconciliation Commission of Canada, 2015).

Archibald (2008) addresses how Indigenous story is thought to have implicit meaning, having lost educational and social value due to colonization. As a result, a limitation of this work may be that decolonizing methods may not be considered as credible as other more commonly used methodologies within westernised institutions. As with any research time is a limited resource, in the context of Indigenous Storywork, Archibald (2008) describes how to understand how a story fits within a belief system the listener must become a member of the community. I am on a journey of reconnecting back to my own Métis culture and understanding what that

means to me. Although I have built life-long connections through my involvement with the Gigii-Bapiimi project and will continue to build on those, I would not yet consider myself as having become a member of the community. To be recognized as part of a community takes time and commitment to build that authentic relationship and there has simply not been time for that. Marshall et al. (2015) explains that when returning to a story over and over each time deeper understanding can be made based on one's personal journey. This teaching was shared from Elder Albert McLeod multiple times throughout the project, noting that understanding and meaning is only revealed when the listener is ready. As such, the meaning making I have done throughout this research project is limited to the understanding and knowledge I hold at this moment in time.

5.10 Concluding Remarks

The findings throughout this project amplified much of the information we, as individuals who lived through the COVID-19 pandemic may have been aware of such as the specific changes to service provision throughout Winnipeg, Manitoba. Throughout the COVID-19 pandemic many services were reduced or ceased entirely. For many mainstream organizations a shift to virtual care was offered, failing to recognize the privilege required to access these types of services. Findings have also highlighted the ongoing oppression Indigenous people living with HIV who use substances are experiencing on a regular basis despite health and social systems supposedly being in an age of reconciliation. The intersecting factors of substance use, Indigeneity, and HIV status create a multitude of challenges created by neoliberal policies and ideologies. The narratives which exist surrounding substance use within our societies fail to address the ongoing impacts of colonization which continue to oppress and exclude Indigenous peoples. As many service providers highlighted, they have witnessed, those that use substances –

predominately meth – being ascribed labels within the health system which impacts the quality of care they are receiving. Given the rising HIV numbers in Manitoba due to injection drug use, this is of particular concern. There is a need for health and social care providers who serve IPLH that use substances to offer more culturally responsive care and incorporate Indigenous ways of knowing, doing and being into services as a way to enhance wholistic model of well-being.

As always, Indigenous resilience continued to uphold community even among a global pandemic. Organizations operating from Indigenous lens provided the most meaningful supports to those with lived experience. These organizations were able treat community as relatives and adhere to public health requirements throughout the pandemic. The concept of relationality was evident among these services; meeting folks where they are at both figuratively and geographically, addressing inequities in pandemic response such as providing necessary technology, and bringing medicines and other care packages to individual homes. As highlighted by one of the project Knowledge Holders, a lack of understanding surrounding the philosophical Indigenous worldview results in the lack of widespread uptake for these models. This response speaks to the importance of the widespread incorporation of Indigenous-led models into health and social services to address current inequities and help reduce negative impacts of future pandemics.

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Appendix A

GIGII-BAPIIMIN INTERVIEW GUIDE

Interview screening and consent instructions

Please approach all potential participants with the utmost of respect and thoughtfulness. At no point in time should anyone feel coerced into participating in this study or answering a question that they do not want to. Remind the participants of their rights to withdraw at any time. They can withdraw their participation during or after the interview. State the name and purpose of the study:

- **Thank you for taking the time to speak with me.**

- ***The Gigii-Bapiimin* study looks at how Indigenous people living with HIV/AIDS have had their mental health, wellbeing, sexual behaviours, and access to healthcare and other services, impacted by the COVID-19 pandemic.**

- **You have been invited to participate in this study because we are interested in learning more about you, and your experiences, perspectives, opinions, and views relating to the most important issues in the community related to COVID-19, as well as finding out about how your health, wellbeing, and social habits have been impacted by the COVID-19 pandemic. We are also interested in what kept you strong during these times, and how access to health and social services within the community may have changed (or not changed) in your everyday experience.**

- **I'd like to remind you that your responses will be confidential and used as data for this research study and Thesis project only. One research assistants on the team will be gathering data for her Master of Social Work Thesis and is interested in exploring how low-threshold services for Indigenous people living with HIV/AIDS and use substances have been impacted by the COVID-19 pandemic.**

- **Please keep in mind that you do not have to answer any questions that make you feel uncomfortable. Just say if you feel uneasy, and we can move on to another question**

- **Do you have any questions?** [wait for verbal affirmation]

- **The interview will last approximately 2 hours. Once you have consented to participate in the interview, we will give you $100 compensation for your time. The discussion is confidential. We will not ask for your name or any information that will identify you, thus no identifying information will be connected to the transcript of the interview discussion. The Interview will be audio taped and then transcribed. Only the research assistants /coordinators (give your name), and the research advisor (his name is Rusty [Dr. Rusty Souleymanov]) will have access to these tapes and associated transcripts. Your involvement is totally voluntary, and you can withdraw at any time.**

- **Would you be interested in participating in this interview?**

If they are interested, please then explain that we have a few screening questions to make sure they are eligible to participate.

The screening questions are:

- **Are you at least 18 years of age?**

- **Do you identify as Indigenous (First Nation, Metis, Inuit)?**

- **Are you a person living with HIV?**

- **Would you feel comfortable answering personal questions about your health and wellbeing, access to health care, health status, experiences of oppression, and experiences with low threshold services in Manitoba?**

If they are eligible, please have them review verbally and in writing the consent form and to mark the form (actual signature is not required of participants, and an "X" mark is enough).

Start the audio recorder.
When starting the interview, state date, time, and interview number.

Interview Guide

Demographic Question

- **How long have you lived in Manitoba?**
- **Community ties: Which community are you from?**
- **Education: What is the highest level of education you completed?**
- **What city/town/community do you most often access services?**
- **Current employment and/or community role: Do you currently have paid employment? What is your occupation? What is/are some roles you have in the community? (Mother, aunty, counsellor, elder, support person, educator, volunteer, sister, Whatever role you have or identify with in the community)**
- **What gender do you identify as?**
- **What is your age?**
- **Do you have children?**
- **Who do you live with?**
- **Do mind if I ask you as question on substance use? Do you use substances?**

Interview Questions

1. **How have you dealt/coped with COVID-19? How are you dealing/coping with COVID-19?**

2. **How do you feel COVID-19 impacted you: physically, emotionally, spiritually, and mentally?**
    a. **How did the COVID-19 pandemic affect your relationships?**

3. **As an Indigenous person living with HIV, how do you feel COVID-19 directly impacted you?**
    a. *The following question is ONLY for those with lived/living experiences of substance use:*
    As someone who uses substances, how do you feel COVID-19 directly impacted?

4. **As a person living with HIV, what were your fears during the COVID-19 pandemic?**
    a. **How have these changed throughout each wave?**
    b. **How did you cope with these fears?**

5. **Did you choose to get the vaccine when it became available? What was the reason you made your choice?**

6. **Where do you access HIV, health, or harm reduction services?**
    a. **As someone living with HIV, what service are most accessible to you?**
    b. **In what ways do you feel your HIV status impacts the services you receive?**
    c. *The following question is ONLY for those with lived/living experiences of substance use:*
        i. **As someone who uses substances, what services are most accessible to you?**
        ii. **In what ways do you feel your substance use impacts the services you receive?**

7. **How did COVID-19 affect your access to your HIV care and supports?**
    a. **In what ways did you compensate for those changes?**
    b. *The following questions are ONLY for those with lived/living experiences of substance use:*
        i. **How did COVID-19 affect your access to harm reduction supplies?**

ii. **In what ways did you compensate for those changes?**

8. **What were your experiences when accessing services throughout COVID-19 pandemic?**
    a. **What was the most challenging?**
    b. **How have these changed throughout each wave?**
    c. **What, if anything, would have been helpful throughout the pandemic in relation to service delivery?**

9. **Are you a person that uses ceremony as part of your life?**
    a. **What were your experiences when accessing ceremony throughout COVID-19 pandemic?**
    b. **How have these changed throughout each wave?**

10. **What were the most pressing/important issues and needs in your community(-ies) throughout COVID-19?**
    a. **How have these changed throughout each wave?**

11. **What helped you get through this pandemic?**
    a. **What were your supports during COVID-19?**
    b. **What role if any did ceremony play in this?**

Ending Interview

- **Is there anything else you would like to add that was not addressed?**
- **Thank you very much for your time.**

Appendix B

GIGII-BAPIIMIN INTERVIEW GUIDE - Service Providers

Please approach all protentional participants with the utmost respect and thoughtfulness. At no point in time should anyone feel coerced into participating in this study or answering a question that they do not want Remind the participant of their right to withdraw at any time. They can withdraw their participation during or after the interview. State the name and purpose of the study:

- **Thank you for taking the time to speak with me.**
- **The Gigii-Bapiimin study looks at how Indigenous people living with HIV/AIDS have had their mental health, wellbeing, sexual behaviours, and access to healthcare and other services impacted by the COVID-19 pandemic.**
- **You have been invited to participate in this study as someone who provides services or advocacy to Indigenous people living with HIV/AIDS. We are interested in your experiences, perspectives, opinions, and views relating to providing services to IPHA throughout the COVID-19 pandemic as well as finding out how the services provided have been impacted by the COVID-19 pandemic. We are also interested in the strengths identified during this time and how access to health and social services within the community may have changed (or not changed) in your everyday experience.**
- **I'd like to remind you that your responses will be confidential and used as data for this research study and Thesis project only. One research assistant on the team will be gathering data for her Master of Social Work Thesis and is interested in exploring how low-threshold services for Indigenous people living with HIV/AIDS and use substances have been impacted by the COVID-19 pandemic.**
- **Please keep in mind that you do not have to answer any questions that make you feel uncomfortable. Just say if you feel uneasy and we can move on to another question.**
- **Do you have any questions?** [wait for verbal affirmation]

- **The interview will last approximately 2 hours. Once you have consented to participate in the interview, I will give you $50 compensation for your time. The discussion is *confidential*. We will not ask for your name or any information that would identify you, thus no identifying information will be connected to the transcript of the interview discussion. The interview will be audio taped and then transcribed. Only the research assistants/coordinators (give names) and the research advisor (Dr. Rusty Souleymanov) will have access to these tapes and associated transcripts. Your involvement is totally voluntary, and you can withdraw at any time.**

- **Would you be interested in participating in the interview?**

If they are interested, please then explain that we have a few screening questions to make sure they are eligible to participate.

The screening questions are:

- **Are you at least 18 years of age?**

- **Do you provide services/advocacy to IPHA?**

- **Do you live and work in Manitoba/Saskatchewan?**

- **Would you feel comfortable answering personal questions about services provided to IPHA, access to health care, experiences with oppression, and experiences with low-threshold services in Manitoba?**

If they are eligible, please have them review verbally and in writing the consent form and to mark the form (actual signature is not required of participates, and an 'X' mark is enough).

Start the audio recorder
When starting the interview, state date, time, and interview number.

Interview Guide

Demographic Questions

- How long have you been providing services to IPHA?
- Do you provide services to those who use substances?
- Community ties: Which community are you from?
- Education: What is the highest level of education you completed?
- Current employment and/or community role: What is your occupation? What are some roles you have in community (volunteer, advocate, support person, whatever role you have or identify with in the community)
- What is your age?
- What gender do you identify as?

- Do you mind if I ask you a question regarding lived experience? Are you First Nation, Metis, or Inuit? Do you have experience with substance use?

Interview Questions

1. How do you feel IPHA you provide services to have dealt/coped with COVID-19? How are folks dealing/coping with COVID-19?

2. How do you feel COVID-19 impacted IPHA you serve: physically? Emotionally? Mentally? Spiritually?
    a. As a service provider, how did the COVID-19 pandemic affect your relationship with IPHA?

3. How do you feel COVID-19 directly impacted Indigenous people living with HIV?
    a. How do you feel COVID-19 directly impacted Indigenous people living with HIV who use substances?

4. As a person providing services to IPHA during the COVID-19 pandemic what were your fears?
    a. How have these changed throughout each wave?
    b. What were the fears you were aware of, if any, that IPHA had throughout COVID-19?

5. What was the uptake in vaccine among IPHA you serve when it became available? What do you feel contributed to this?

6. What services are available to IPHA [and those who use substances] through your organization?
    a. What services do you feel are most accessible to someone living with HIV?
    b. In what ways do you feel HIV status impacts services individuals receive?
    c. The following question is ONLY for those who provide services to IPHA who use substances:
        i. What services do you feel are most accessible to someone who uses substances?
        ii. In what ways do you feel substance use impacts services individuals receive?

7. How did COVID-19 affect access to HIV care and supports?
    a. In what ways did your place of employment compensate for those changes?
    b. In what ways did you compensate for those changes in your personal practice?

   c. *The following question is ONLY for those who provide services to IPHA who use substances:*
      i. How did COVID-19 affect access to harm reduction supplies?
      ii. In what ways did your place of employment compensate for those changes?
      iii. In what ways did you compensate for those changes in your personal practice?

8. What were your experiences providing services throughout the COVID-19 pandemic?
   a. What was the most challenging?
   b. How have these changed throughout each wave?
   c. What, if anything, would have been helpful throughout the pandemic in relation to service delivery?

9. What is your knowledge and/or experience of Indigenous ceremony? What is yours and/or your organization's role, if any, in connecting those you serve to ceremony?
   a. What were your experiences of access to ceremony and culturally safe programming for IPHA throughout the COVID-19 pandemic?
   b. How did this change throughout each wave?
   c. What role does ceremony play in the health and wellbeing of IPHA?

10. What were the most pressing/important issues and needs in the community throughout COVID-19?
   a. How have these changed throughout each wave?

11. What helped those you serve get through this pandemic?

Ending Interview

- Is there anything else you would like to add that was not addressed?
- Thank you very much for your time.