Themed Paper— Original Research

An interview project with native American people: a community-based study to identify actionable steps to reduce health disparities

J. Leston [a,*], C. Crisp [a], C. Lee [b], E. Rink [c]

[a] *Tribal Epidemiology Center, Northwest Portland Area Indian Health Board, 2121 SW Broadway, Suite 300, Portland, OR, 97201, United States*
[b] *University of West Florida, Department of Public Health, 11000 University Parkway, Building 38, Pensacola, FL, 32514-5750, USA*
[c] *Montana State University, Department of Health and Human Development, 318 Herrick Hall, Bozeman, MT, 59717, USA*

ARTICLE INFO

ABSTRACT

Objectives: The primary objective of this study was to work with tribal communities to define and develop their own healthcare services and strategies for positive change regarding injection drug use, human immunodeficiency virus (HIV), and hepatitis C virus (HCV) infection. The secondary objective of this study was to incorporate community capacity building strategies to develop and sustain programming and resources to optimize tribal communities' responsiveness to reduce health disparities.

Study design: Semi-structured qualitative interviews.

Methods: Interviews were guided by community-based participatory research (CBPR) principles to create programs, projects, and policy recommendations meaningful to American Indian and Alaska Native (AI/AN) people.

Results: The study generated a formative understanding of the context of AI/AN people who inject drugs (PWID) in three distinct AI/AN communities as well as developed local capacity for future programming, projects, and policy.

Conclusions: This study confirms CBPR methods should be part of an iterative cycle to inform policy and programs. CBPR has helped strengthen local research capacity and has formed ongoing relationships between study investigators, local liaisons, and the community that will be essential for next phases of program design and policy implementation. This cycle of CBPR could be replicated in other tribal communities to bring awareness of the opioid epidemic and its effects and to prioritize local indigenous and community-led responses.

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* *Corresponding author.* Northwest Portland Area Indian Health Board, 2121 SW Broadway Drive Suite 300, Portland, OR, 97201, United States.
E-mail address: jleston@npaihb.org (J. Leston).

Introduction

Current literature on community capacity building acknowledges the need for communities to collaborate in the research process to improve disparate conditions.[1,2] Specifically, research involving American Indian/Alaska Native (AI/AN) people must incorporate community capacity building strategies to develop and sustain programming and resources that optimize tribal communities' responsiveness to reduce health disparities among their peoples.[3,4] Community-based participatory research (CBPR) methods have emerged as a research framework supported by AI/AN communities. CBPR community–academic-practice partnerships can and should include tribal community members to effect structural changes by engaging tribal members, leadership, and organizations in the process of policy changes at the local, state, and federal levels.[5–7] Tribally driven best research implementation and practice are needed to provide foundational empirical findings to guide next steps of program planning and implementation among indigenous communities in North America.

Background

The United States has experienced a dramatic increase in opioid use and abuse nationwide, although data specific to AI/AN communities are limited.[8] Interrelated data, such as reports of acute hepatitis C virus (HCV) infection, suggest that injecting drug use (IDU) may be elevated in some AI/AN communities.[9,10] Several complementary interventions to reduce the prevalence and harm of opioid use have proven effective, including medication-assisted treatment (MAT), opioid treatment programs, and syringe service programs (SSPs), and while drug use is not eliminated for most patients in MAT, data suggest that patients enrolled in the programs have 40%–60% fewer instances of opiate injection and needle sharing events.[11–13] Yet, the availability of such programs is insufficient in the United States because of a combination of factors, including federal policy and funding.[14]

Addressing IDU is vital to address health disparities and inequities in Indian Country. In order to do so, it is necessary to better understand the context in which IDU is taking place and gather evidence to inform program design. The purpose of our study was to generate more information on the environment surrounding IDU using a social determinants of health lens and to elucidate the wider set of forces and systems shaping the conditions of daily life among people who inject drugs (PWID).[15] Our primary research aim was to work with tribal communities to define and develop their own healthcare services and strategies for positive change regarding injection drug use and human immunodeficiency virus (HIV) and HCV infection.

To achieve this aim, our team interviewed PWID and persons with a history of injecting drugs (PWHID) living on or near reservations, as well as other community stakeholders in AI/AN communities, to identify influential barriers and facilitators for those accessing prevention, harm-reduction, clinical, and treatment services. Our methods were guided by CBPR principles to create programs, projects, and policy recommendations meaningful to AI/AN people.[16,17] The study generated a formative understanding of the context of AI/AN PWID and PWHID in three distinct AI/AN communities, as well as their understanding of injection drug use and HIV and HCV infection.

Methods

Theoretical frameworks

This study utilized locally adapted qualitative CBPR research strategies with PWID and PWHID. The interviews were designed to explore four constructs developed by Cacari-Stone et al., consisting of context, processes, policy-making, and outcomes.[19,20] The Cacari-Stone logic model illustrates how context informs the CBPR process, which informs policy and in turn impacts outcomes (Fig. 1). This framework was chosen to make explicit the connection between our CBPR process and contexts with the next phases of our research that will include processes, policy-making strategies, and outcomes.

Using theories of implementation science, this project was also designed to promote integration and translation of qualitative research findings and evidence into healthcare systems and policy action.[21] By framing the project around contextual structural, organizational, personal, and project constructs, we were better able to conceptualize and measure hypothesized constructs affecting implementation and evidence-informed policy as well as plan for implementation of new practice.[22,23]

Research settings and procedures

Four geographically and culturally diverse tribal communities participated in the study. Tribal communities were selected based on expressed interest and willingness to participate. Each site was purposefully selected to represent different geographies and tribal experiences. A tribe's agreement to participate in this project was obtained from the Tribal Health Director and/or Tribal Council. Each tribe had the ability to decide how it would like to proceed with project review and approval. All confidentiality and data sharing limitations were set by participating tribes and honored by Northwest Portland Area Indian Health Board (NPAIHB). Letters of approval in the form of a Memorandum of Understanding, or other documentation as desired by participating tribes, were submitted to the Portland Area Indian Health Service Institutional Review Board for approval. Additionally, all tribes had the opportunity to review and approve all reports and publications—as well as guide future use of collected evidence.

We collaborated with local liaisons at each site during the development and design process. The community had the opportunity to be actively engaged in developing this project specific to their setting and developed ownership in the project. This co-ownership (based on CBPR principles) continued into each subsequent phase of the project. Additionally, field staff collaborated in-person with local health personnel, Tribal Council members, and other appropriate decision-makers. An advisory group was also assembled to guide the interview project.

We hired and trained local liaisons who helped recruit participants and facilitate interviews. By training local staff to
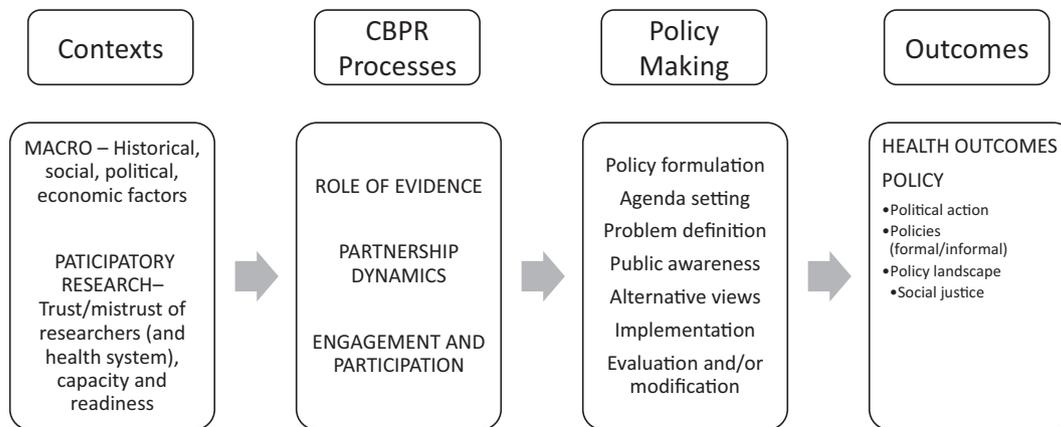
Fig. 1 − **Context** consists of both the macro level factors as well as the situation of the participatory research itself. Societal and community-level factors, such as inadequate education, disproportionate poverty, discrimination (including in the delivery of health services), trauma, and cultural differences create the context in which AI/AN people live and in turn determine many of the health outcomes that AI/AN face. Inquiry for any purpose must address the continuing effects that colonialism has on the framing of projects, when they are initiated by partners outside into AI/AN communities. Including 'context' in the model acknowledges that adverse outcomes themselves need to be determined by the community themselves and that they can only help do this if they are truly involved in the research process and understand underlying assumptions and methods. The **process** phase is focused and adaptive. Assumptions must rely on the understanding that populations are complex and dynamic systems and that the current picture of health is characterized by both historical effects (such as historical trauma), current states (underfunding/broken health systems), and emergent issues (trends in opioid use). This step addresses the role of evidence as it relates to the policy-making process. In this light, evidence from research must be useful and available to the community. To be effective, partnership dynamics between the community and outsider must be reciprocal and driven by local decisions. Engagement transcends the typical CBPR process, in which community partners and researchers participate in shared decision-making, policy-change, and advocacy. **Policy** addresses the co-creation of the problem definition and the steps of policy-making that community partners can actively engage in to improve local polices. In this stage, the community is actively analyzing and using collected evidence to make changes. Lastly, **outcomes** are focused on the actual policy change process and health outcomes as they relate to the discovered project evidence. CBPR, community-based participatory research; AI/AN, American Indian and Alaska Native.

conduct and co-lead the project on-site, the project continued to build relationships, skills, collaboration, and local infrastructure. Site staff also reviewed interview results and provided feedback, helped identify ways to communicate findings back to local stakeholders, and weighed in on next steps for the project, promoting future commitment to the work and powering community-driven action.

Eligibility and recruitment

The research team sought to recruit PWID to participate in key informant interviews for qualitative research. To be eligible, participants had to report current or former injection drug use, living on or near one of the four identified tribal sites, and aged between 18 and 40 years. Although the project's goal was to enroll AI/AN people, participation in the study was not limited to AI/AN people, as we knew the community of PWID is diverse. In this way, the sampling method was purposive.

Positive experience and social influence during the sampling process promoted further recruitment. All enrollment activities were determined on a community-by-community basis since different communities required and/or permitted different outreach strategies.

Interviews

Interview questions were written to incorporate methods of implementation science to encourage the integration of research findings and evidence into policy and change. By mapping questions to the causal factors that influence implementation (innovation, personal, provider, organizational, and structural), study personnel were able to better conceptualize constructs affecting implementation and create evidence-informed policy for IDU.[21−23]

Semistructured in-depth interviews were conducted with one-to-two participants in a private space at each setting. Interviews in this study were done with two subsets of participants. Interviews lasted approximately 60 min. Participants were provided with an information sheet and a verbal description of the study. The participants then signed an informed consent form to agree to participate in this study. The participants received a $25 gift card as an incentive for participation. Interview questions can be found in the appendix.

All interviews conducted during the study were audio-recorded by local liaisons. Transcription occurred at an outside venue. Transcribed data were analyzed systematically by a two NPAIHB contractors using ATLAS.ti software. Content

analyses were used to identify the presence, intensity, and frequency of topics and themes generated by groups and individuals; however, a grounded theory approach was utilized primarily, allowing themes to emerge from the data, prior to the development of the code book.[24]

Results

A total of 32 interviews were completed with PWID/PWHID. Three sites completed their targeted number of interviews, including two sites with non-indigenous local leads who resided within and had strong relationships with the community. A fourth site had notable difficulty and was excluded from the analysis; the liaison at this site was indigenous but not local and had no previous relationships with the tribe, which may have created barriers to fulfilling CBPR principles. In this article, we will report findings related to perceived contextual structures that prevent PWID from engaging in risk reduction, health promotion, and health service utilization that can be directly applied to the Cacari-Stone logic model. Other findings will be discussed in future papers.

Themes from the interviews were grouped by the causal factors impacting implementation, innovation, patient, provider, organizational, and structure (Table 1). For each, implications for implementation are explored. We included this

Table 1 — Interview results — from factors to policy-making.			
Casual factors	Interview guide example question	Themes	Implications for policy-making
Innovation	What types of partnerships are in place here to support PWID services/treatment?	Overdosing	Good Samaritan laws should be enacted at the state and tribal levels-without such laws in place, fear of incrimination provide a barrier to PWID who observe other PWID overdosing from seeking medical treatment. In addition, these laws should be all encompassing to include both alcohol and drug overdoses.
		Partnerships to address IDU in the community	Education in schools and in the community should be provided to address the following: destigmatizing the terminology surrounding addiction and the social and biological factors that can contribute to persons with substance use disorders. In addition, education curriculum should include information on resources in the community for individuals who are seeking help with their addiction. Community and school level education initiatives should be implemented.
Patient	Describe the things you see people doing while they are using?	Risk taking behavior vs protective behavior	The levels of frequency of IDU had a direct impact of the likelihood of PWID engaging in risk-taking behaviors (i.e., needle sharing, unhygienic injecting). The increased use of IDU increased risk-taking behaviors while functional PWID engaged in protective IDU behaviors (not reusing needles, not sharing needles, etc.). Functional PWID in this context refers to PWID who are successfully able to maintain a steady job and home life while still practicing IDU.
		Impact of addiction	Most respondents identified IDU as a coping mechanism for deep-rooted emotional issues, thus greater collaboration with behavioral health services was identified as needed in the community.
Provider	What is your perception of how providers feel about PWID? How do you see providers treating PWID?	Interactions with PWID	Lack of openness to new practices, awareness of innovative and evidence-based practices and negative attitudes, they relate to IDU contributed to barriers for PWID to seek treatment. Among current agencies and programs, trainings on cultural competency and addiction need to be provided in order to bolster positive interactions between PWID and these entities and to better provide the healthcare and social services PWID need.
Organizational	Who provides leadership for treatment for PWID here?	Perceptions of services available	Larger structural level funding for PWID treatment is needed, as well as an increase in education and implementation of MAT services and programs. If they do not already state laws and policies need to be changed to permit such programs to exist.
Structural	What kind of resources are there in the community for PWID? How do agencies here implement programs for PWID?	Barriers to accessing clean needles	The direct impact of policies and formal and informal interactions from both the structural and organizational level of implementation can be altered in a way to alleviate barriers in PWID attempting to seek treatment for their addiction. State laws regarding paraphernalia need to be revisited-in some states these laws provide an additional barrier for PWID to seek treatment because of fear of legal repercussions.
MAT, medication-assisted treatment; IDU, injecting drug use; PWID, people who inject drug.			

discussion in the results section, rather than the discussion, as the study was based upon models for action.

Innovation

Overdosing. Many respondents had experienced overdosing or witnessing someone overdosing while IDU; which usually occurred because they had impaired judgment from drugs or from injecting tainted drugs.

> *Yes. I myself, I went, like you aren't supposed to mix some drugs with some other stuff, otherwise it's turns to poison, and I didn't know that and I stopped breathing, it felt like somebody was taking my throat and crushing it, you know, it swelled up to where I couldn't breathe and I didn't know what was going on. (Transcript 13).*

Partnerships to address IDU in the community. Respondents did not generally know of existing partnerships occurring among schools, hospitals, non-profit organizations, law enforcement, or tribal governments. Respondents identified numerous barriers with a heavy concentration on organizations functioning solitary with the lack of communication among them. Future recommendations include more communication among organizations, increased funding for resources, and more diversion of individuals from the criminal justice system integrated into treatment.

> *We always see the tribes trying to partner with everybody, but you know they just I don't know I don't even want to speak on them they just. I don't think they really have a plan. (Transcript 15).*

> *Well, they do work together and the skill that they have would be I guess their communication in trying to solve this problem, which is going to be a very hard problem to solve. But just their communication, being able to communicate with one another and trying to help the people so we can help the city or just help the people, so they can help themselves. (Transcript 9).*

Implications for implementation. Community-level education initiatives should be implemented, and Good Samaritan laws should be enacted at the tribal level.

Patient

Risk-taking behavior vs protective behaviors. The levels of frequency of IDU had a direct impact of the likelihood of PWID engaging in risk-taking behaviors (i.e., needle sharing and unhygienic injecting). The increased use of IDU increased risk-taking behaviors while functional PWID engaged in protective IDU behaviors.

> *And as far as sharing amongst each other, I suppose it's only in desperate situations where people don't have one and they're probably withdrawing and really sick and they're just trying to get high right this second and that's the only option. (Transcript 2).*

Impact of addiction. Addiction has long lasting physical, mental, and emotional effects. Some PWID experienced adverse physical reactions to IDU, contracted a disease, or withdrawals from drug dependency, all of which were primary reasons they deferred addiction treatment. Others found themselves socially isolated and withdrawing from others.

> *And when it gets to the point where you're so desperate for a high that you're shooting up you're a little more desperate to do different things to get that high. (Transcript 1).*

> *They are trying to mask their emotions. They're trying to numb themselves from everything that has either gone wrong with their life, their own mistakes, what they do not want to feel. It's a numbing effect. (Transcript 27).*

Implications for implementation. Most respondents identified IDU as a coping mechanism for deep-rooted emotional issues suggesting a need for greater collaboration with behavioral health services.

Healthcare providers

Provider interactions with PWID. Respondent interactions with healthcare providers ranged from positive (i.e., compassion, non-judgmental) to negative (i.e., stigmatized, judged). Respondents recommended that healthcare providers need additional training on effective communication, addiction, substance abuse disorders, and cultural competency. Improving community and provider attitudes toward PWID was one of the most discussed topics from respondents.

> *I think it's, I think people are either very arrogant healthcare providers are, or ignorant. They're either super anti-drug usage and have no compassion for it or you know so it's like people reach out and they don't really help you know like my own partner. (Transcript 1).*

> *Like you're still being shamed, you know, people are still telling you that you're a shitty person because you did the things you did. (Transcript 4).*

Implications for implementation. Openness to new practices, attitudes, and awareness of evidence-based practices as they relate to IDU should be further explored. These concepts overlap with structural and organizational levels of implementation that are discussed next.

Organizational

Perceptions of services vs available resources. PWID had mixed responses to treatment adequacy depending on their geographic location. Scarcity of resources, limited scope of services, and inaccessibility were key barriers that were mentioned. Recommendations from respondents included expanding the number of services, service types, service hours of operation, and increasing awareness and knowledge about addiction in the community.

Each location had different services and political structures for PWID. In one community, there was an established SSP, and there was consensus that services were adequate. In the same community, there were responses that indicated that there needed to be a wider range of MAT services offered.

It just means like, you know, 'unnamed' is a very conservative state, we've had the same things for a like a very long time, you know. We're so conservative that we don't know anything about addicts or what they need or, you know, how to treat them. You know, I feel like we're kind of still stuck in the dark ages a little bit. (Transcript 3).

Implications for implementation. Among current agencies and programs, trainings on cultural competency and addiction need to be provided to bolster positive interactions between PWID and these entities and to better provide the healthcare and social services PWID need. The success of this implementation strategy is dependent on funding from the larger structural level (laws and policies). In addition, there needs to be increase in education and certification for MAT services and programs.

Structural

Barriers to accessing clean needles. Collection of personal information, prescription requirements, and pharmacy store hours deterred PWID from accessing clean needles. Societal labels among the community and health providers (i.e., stigma, shame, guilt, and judgment) were social barriers that respondents experienced that deterred them from obtaining clean needles. Scarcity of funding for resources were highlighted as an observation as to why partnerships among different agencies and organizations did not exist and why most programming was limited in multiple areas. The lack of awareness or policies of current treatment services and harm reduction services were barriers in individuals attempting to obtain sobriety. In addition, state laws on drug paraphernalia presented a barrier in seeking treatment for fear of being reported to law enforcement.

Well, I guess pharmacies, they apparently have some regulations. I know I have bought syringes where they have actually made me write down my name, address and stuff, personal information. Most people that are using are not very open to that. Nobody wants to write their personal information down just to get these… It's on record or something. (Transcript 2).

You know you feel that guilt you think people know when you're going to buy those needles that they know you're a junkie. (Transcript 1).

Implications for implementation. The direct impact of policies and formal and informal interactions at the structural and organizational levels can be assessed to reduce barriers for PWID seeking IDU treatment. Among them, state and tribal laws should not criminalize paraphernalia, a strong deterrent for encouraged help-seeking behavior.

Discussion

Limitations

Our study had several limitations. Owing to inherent challenges locating participants (a highly-stigmatized population) to enroll in the study, we did not exclude non-AI/AN

participants if they fit all other enrollment criteria and resided in our tribal communities. One site did not obtain participants due to participants not wanting to disclose their status in a small tribal community. We also did not distinguish between AI/AN PWID living on or off a reservation. It is possible that the experiences of AI/AN PWID living on a reservation differ from those who live in urban settings with regards to addiction resources and treatment programs. Consequently, our findings do not reflect all PWID living in Indian country; however, they do describe a range of attitudes and behaviors that exist in Indian country and the social and structural context that shape PWID decision-making.

Strengths

Despite these limitations, our study had several strengths. The CBPR process successfully engaged a hard-to-reach, priority population. AI/AN experience significant health disparities and limited access to health care because of geographic isolation, cultural barriers, and experiencing a history of legalized discrimination and segregation.[25] The CBPR process itself has strengthened local research capacity and has formed ongoing relationships between study investigators, local liaisons, and the community that will be essential for next phases of program design and policy implementation. In addition, this process could be replicated in other tribal communities to bring awareness of the opioid epidemic, its effects, and to prioritize local indigenous and community-led responses.

This research has helped better understand the social context of injection drug use among AI/AN in rural communities and to identify barriers and facilitators for those attempting to access prevention, harm-reduction, clinical, and treatment services. Our research findings are being used to inform local responses and have illuminated significant barriers that were noted to exist across all sites: the existence of or access to MAT programs, agency policies regarding program hours and financial resources for MAT, availability of SSPs, state and federal policies and laws that inhibit or prevent harm reduction services and programs (lack of Good Samaritan and/or strict Paraphernalia Laws), lack of PWID knowledge of protective laws, and perception of healthcare provider opinion of PWID. The knowledge generated from this project demonstrates the importance of turning research into decisions and action to address the barriers to implementing harm reduction services in AI/AN communities.

There has been an increasing amount of literature citing the importance of policy focused CBPR to address health inequities.[19,26–30] However, there has been little in the literature about how to take the steps to bridge CBPR research into policy recommendations and program implementation. This article adds to the literature by providing an example and outcomes of a process-focused and -driven CBPR research project. Research for research sake is unethical in communities experiencing stark health inequities. Instead, research in underserved communities should focus on helping to provide the direct action needed to make changes to promote health and services to promote health equity.

Discovering the contextual factors from this research will help the process and policy phases of the project. Results from this study will be used to help guide policy formation (in relation to MAT, SSP, and Good Samaritan Laws) and create public awareness and alternative views (in relation to the impact of addiction and perception of PWID). Perhaps most importantly, the CBPR process and Cacari-Stone model has helped generate local leadership and capacity to address these issues. Community-level reports were crafted with detailed findings from the research and were made available to the community for future discussion and planning.

Decisions as to the next phase of the process will be locally driven and co-created to further engage the community to improve local polices. Reflective inquiry around health programming and policy implementation by local liaisons and researchers has generated questions for next steps:

- How do we utilize leadership at the local organizational level to start conversations about the barriers and facilitators of local healthcare systems for PWID?
- What actions can tribes take to help PWID in accessing health services?
- How can existing healthcare systems better provide support to communities?
- How can healthcare systems create a shift in social norms for providers regarding IDU? Using a top-down approach, how can society begin to change the narrative and reduce the stigma around addition disorders, PWID, and IDU?
- Can we learn from other examples of healthcare events that have needed and achieved a drastic shift in thinking (including philosophical components)?
- If we create opportunities to develop trust with PWID, there may be more likelihood at early interventions (screening, SSP, and MAT).
- Can tribes use sovereignty rights to create their own Good Samaritan laws for its tribal members?

These questions will help transition this project to the policy and programing phase in local communities while continuing to support engagement at the local level.

Conclusion

While widespread documentation of health disparities is an essential element when formulating a public health response in AI/AN communities, it has proven insufficient to achieve equitable public health resources. Research in indigenous communities must include practical planning and associated policy change to improve underlying contexts. This study confirms CBPR methods should be part of an iterative cycle to inform policy and programs. Our research findings have already informed the design of new services and policy amendments that may impact health outcomes for PWID. The next phase of this project will help generate policy formation, agenda setting, problem definitions, public awareness, alternative views (perspectives), implementation, and evaluation.

Author statements

Ethical approval

Each tribe had the ability to decide how it would like to proceed with project review and approval. All confidentiality and data sharing limitations were set by participating tribes and honored by NPAIHB. Letters of approval in the form of a Memorandum of Understanding, or other document as desired by participating tribe, was submitted to the Portland Area Indian Health Service Institutional Review Board for approval. Additionally, all tribes had the opportunity to review and approve all reports and publications—as well as guide future use of collected evidence.

Competing interests

None declared.

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Appendix

Section 1: Treatment services

1. How acceptable are the treatment services for PWID here?
2. What sort of treatment services do PWID use?
3. What are the strengths and weaknesses of the treatment services for PWID here?
4. Do you believe the current treatment services for PWID is appropriate? Why or why not?

Section 2: PWID culture

1. Describe the things you see people doing while you are using?

   Follow-up if necessary.
   What drugs are mostly injected here?
   How are they prepared?
   Where do people get their needles?
   Do they tend to re-use or share? Why or why not? I.
   Do PWID have any concerns about sharing injecting equipment?
   Is injecting usually done in a bigger group or alone or in smaller groups?

2. What types of things do you see people do that seems unsafe or dangerous or hurtful to them?
3. What efforts do you see people taking to protect themselves from unsafe, dangerous, or hurtful situations or drug-use behaviors?
4. What is the cost of needles and 'works?'
5. Does the cost impact how much you buy?
6. What are barriers to get clean/new needles/works?
7. How do people get clean/new needles/works?
8. Is it easy to get clean/new needles/works? Why or why not?
9. How do PWID treat each other? How do they behave with each other?
10. How do you decide who to trust when buying/trading and also injecting/sharing?

Section 3: Programs/services for PWID

1. What types of services are available or PWID here? What services would be the most helpful?
2. How successful are programs/services for PWID?
3. How do agencies here implement programs for PWID?

4. What is your perspective on the opportunities for creating and establishing services in particular harm-reduction services for PWID here?
5. What types of treatment and support services do you think would be successful here? Why?
6. What services do you need to stay clean?
7. Do you have access to naloxone?

Section 4: Social context

1. What is the social setting like here for PWID?
2. Who are PWID here? Describe a 'typical' PWID?
3. How does the tribal council/tribal governance body support or not support services for PWID?
4. What are the treatment policies for PWID?
5. What kind of funding do you have to services PWID? Where does it come from?
6. What kinds of resources are there in the community for PWID?
7. How do PWID impact the community here?

Section 5: Organizational resources for PWID

1. What is the drug treatment culture like here?
2. Who provides leadership for drug treatment for PWID here? How does this person/these people do that?
3. What kinds of resources are there in the community here for Harm Reduction programs for PWID?
4. Describe the interactions you see both formal and informal that PWID have in the community? What types of relationships to you see them having?
5. What kind of support is/are there within the drug treatment programs for PWID?

Section 6: Providers

1. What is your perception of how providers feel about PWID? How do you see providers treating PWID?
2. Do you think providers here would be supportive of harm reduction services for PWID?
3. How open do you think providers are to having PWID as their regular patients?

Section 7: Drug-using behavior

1. Tell me a bit about how and when do you use?
2. Can you tell me about any times you thought it would be good to quit using or reduce your use?
3. How likely do you think it is for you to stop using or reduce your use?
4. Tell us about what you know about drug treatment programs for PWID?
5. Tell us about what you know about harm reduction types of services/strategies for PWID?
6. If you did want to stop using, do you know if you have access to
   a. Syringe exchange service?
   b. Methadone?
   c. Anything else?

7. How do you feel about using services here to help you with your drug use? What are some of your challenges when you try to use services here?
8. What is it like for you when you do to these services? Is it a comfortable place for you? Why or why not? What is it like for you to try and navigate the system here if you need help?

Section 8: Partnerships

Building relationships

1. What types of partnerships are in place here to support PWID services/treatment? (Probe if necessary): police, schools, medical, spiritual organizations, and NGOs
2. What other types of partnerships are needed to support PWID services/treatment?
3. Describe the relationships you see that providers have with PWID here? What are the strengths and weaknesses you see in these relationships?

Building skills

4. What kinds of skills do providers have for working with PWID? What other skills do they need? How can this be supported within your agency?
5. What kind of skills do PWID have for quitting or reducing their drug use? What kinds of skills do PWID have for accessing services here? What are some of their challenges to using services here? What is the best way to build the skills you have just mentioned within the PWID population here?

Working Together

6. Describe how the different agencies here work together to support PWID? What are some of the barriers to the different agencies working together here? What are some of the things here that make it easy of the different agencies to work together here?
7. In what ways can providers work together with PWID to support PWID either quitting their drug use or reducing their use?
8. In what ways can tribal government and other agencies here work together to support treatment programs for PWID?
9. (If no harm-reduction program) What is the best way to do about getting support for and implementing an harm-reduction program here for PWID? (If there is a harm reduction program here) What were the steps taken to implement the harm-reduction program here? What made this work? Who supported the harm-reduction program and how was it implemented here?

Promoting commitment

10. Describe what you see as the type of commitment agencies and services providers and tribal governance has here to work with PWID?
11. How would you recommend strengthening the commitment to work with PWID here?

Section 9 − HIV/HCV specific questions

1. What do you know about HIV?
2. What do you know about HCV?
3. What do you know about HIV in your community?
4. What do you know about HCV in your community?
5. What do you know about HIV prevention efforts in your community? Specifically for PWID?
6. What do you know about HCV prevention efforts in your community? Specifically for PWID?