THE ROLE OF NURSE PRACTITIONERS IN OUTREACH SERVICES AND FACILITATING ACCESS FOR MARGINALIZED ADULT WOMEN IN BRITISH COLUMBIA

by

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CHAPTER ONE

Introduction

In the course of my clinical work as a Registered Nurse in a suburban emergency department, I have had numerous interactions with marginalized women who use this department as their primary health care service. A number of studies indicate that marginalized women seeking primary health care through a hospital emergency department is not uncommon (Boeri, Tyndall, & Woodall, 2011; Browne, Smye, Rodney, Tang, & O'Neil, 2010). Lazarus et al. (2012) point out that this practice appears to further escalate the experience of barriers to health care services, and Browne et al. (2010) conclude that this practice of using emergency department services results in fragmented care and social suffering.

Working with marginalized women in the emergency department has prompted me to investigate the nature of the barriers women encounter when they do access the health care system. In order to learn more about these women's experiences, I arranged to visit the Warm Zone in Abbotsford, British Columbia—a facility that claims to be a place "where the women are loved for who they are" (Warm Zone Pamphlet, 2012). The women here have active addictions, and most are working in the sex trade on or near the streets, two significant risk factors for psychosocial and health-related outcomes. This facility offers rescue services: food, water, showers, laundry, telephone service to anywhere in Canada, computer access, couches to sleep on, clean needles and drug supplies, lockers for storage of personal items, and clothing. Public health nurses attend the centre once a month to offer outreach services. It can be said that there are minimal barriers to the women at the Warm Zone in the sense that they can continue to be active in their addiction. The only rule is "no violence."

However, after speaking at length with the program coordinator it became evident that a health care gap existed. Apart from the monthly visit of the public health nurse, there was no regular health care provider present to offer primary health care services to these women. In British Columbia, the role of Nurse Practitioners is to provide autonomous primary health care services to all populations (College of Registered Nurses of British Columbia, 2011). This means that they could readily work in outreach centers alongside marginalized women, thereby decreasing perceived barriers to health care access and improving health outcomes for this population.

The need for, and benefit of, health care services in outreach programs is well documented (Burr et al., 2014; Daiski, 2005; Deering et al., 2011a; Janssen, Gibson, Bowen, Spittal, & Petersen, 2009; Pauly, 2008). Outreach programs now generally go beyond harm reduction services, such as needle exchange, and will incorporate health care providers to fill important gaps in the delivery of health care services for marginalized populations (Burr et al., 2014).

Project Aim

The goal of this project is to gain a greater understanding of the current barriers marginalized adult women encounter when accessing health care in British Columbia. This discussion will consider the programs and mechanisms currently in place that attempt to overcome these barriers and facilitate access to health care. Consideration will be given to the ways in which differences can be effected, and the unique health care needs for this population will be addressed. The perspective of both marginalized women and their health care providers will be explored as a way of broadening the scope of this review. This integrative review will give primary health care providers, including NPs, a greater understanding of the issues that marginalized women encounter in British Columbia.

An investigation of the current role of NPs in caring for marginalized adult women will add to our understanding of where improvements can be made to achieve better health outcomes and increased access to health care for this population. Nurse Practitioners are in a good position to provide primary care to these marginalized women, inasmuch as they have a mandate to provide low-barrier, patient-centered care. An expectation underlying this review of the literature is that primary health care providers, as they consider these findings, will gain better insight into the lived experiences of marginalized adult women and consequently will re-examine how they currently treat these women in their clinical practice and feel compelled to make appropriate changes to better ensure that all people are treated equally and with respect.

The Canadian Health Act stipulates every Canadian is entitled to timely access to health care—one of the five principles that the provinces must meet to receive funding from the government of Canada (Government of Canada, 2014). On this basis, marginalized adult women are entitled to have access to NPs who foster a holistic approach to providing care; who acknowledge the individual's determinants of health while at the same time considering the lived experiences of these women and the factors that are likely to affect their health and well-being; who establish a therapeutic relationship that builds trust and respect; and who provide access to high quality, evidence-based health care.

The purpose of this integrated literature review is, ultimately, to identify how NPs can contribute to finding solutions to improving health outcomes for women in suburban settings. Two questions are posed here as a way of focusing this inquiry:

1. What is the ideal role of NPs in outreach services for marginalized adult women?
2. How can NPs facilitate access to primary health care for marginalized adult women who participate in high-risk lifestyles in British Columbia?

CHAPTER TWO

Background

Marginalized Adult Women

Marginalized adult women are defined, for the purposes of this project, as women who are older than 19 years of age, who participate in high-risk lifestyles, and who are embedded in social circumstances that have a negative affect on their health and well-being. The social risk factors include living in poverty, living on or near the streets, experiencing violence, discrimination, as well as the social stigma that inevitably comes with these circumstances. The health risk factors are those that come with working in the sex trade, including the risk of contracting the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), having a drug and/or alcohol addiction, suffering from mental illness and, finally, experiencing the inequalities and inequities in health care access and services. Many of these social factors and health risks are intrinsically linked and occur simultaneously within this population (Kurtz, Surratt, Kiley, & Inciardi, 2005). It is important to recognize that marginalized adult women encounter more adverse health outcomes and social circumstances than those considered in this review—for example, incarceration or multiple contacts with the police and the justice system, pregnancy, and/or parenting—but, the scope of this paper will be restricted to women's primary health care needs, not family or women in institutions.

Access

Access to health care in Canada is an ongoing concern, made evident in the 2002 Romanow inquiry into the future of health care, which examined the practicality of sustaining the current health care delivery system, the role of Medicare, and the question of improved access for all populations (Romanow, 2002). Although timely access to health care

remains a priority in Canada, studies indicate that Canadians are less likely than citizens of other countries to have same-day access to health care services, and that the wait for these services can take, on average, six days before they are to see their health care provider—which leaves many Canadians resorting to hospital emergency departments for their primary health care (Schoen et al., 2007). Numerous studies indicate that, if you are a marginalized woman in Canada, your access to health care is compromised ten-fold (Bloch, Razmotits, & Giambrone, 2011; Browne et al., 2012; Goodman, 2006; Krusi et al., 2012; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; Lazarus et al., 2012; Loppie & Wien, 2009; Salmon, Livingston, Browne, & Pederson, 2009; Tapp et al., 2011).

Using the emergency department as a way of gaining access to health care leads to increased costs for the health care system, added pressure on the emergency department, and fragmented health care. As a result of the multifactorial barriers encountered when seeking health care through ordinary channels, the health of marginalized women is compromised. Given this reality, this population has been the subject of extensive research in an attempt to understand and address these inequities and inequalities. While there is a substantial body of research on the health care needs of marginalized women—for example, looking at the barriers encountered by these women, and the role played by bridging services in outreach centers—few studies have examined the role of NPs in these practice settings, or the potential NPs have when it comes to facilitating access to health care for this population.

Access to health care can be conceptualized in a number of ways, across a variety of settings, and is associated with a multitude of variables. It therefore needs to be defined and narrowed for the purposes of this paper. Aday and Andersen (1974) have devised a framework to identify the key variables necessary for providing access to care for all members of the community. These variables are: *health policy*, which involves financial,

educational, and organizational aspects related to access, including manpower; *characteristics of the health delivery system*, which entails the volume and distribution of health care resources, and the organization of those resources; *characteristics of populations at risk*, which considers the determinants posed by individual when they access the system—such as age, gender, and the services wanted—rather than looking at the system itself; *utilization of health services*, which examines the type of service received, the location, the purpose of the visit, and whether a patient is able to have contact with a care provider, have continuity with that care provider, and be seen in a timely manner; and *consumer satisfaction*, which examines the convenience, costs, coordination, courtesy, information, and quality of care received.

All these variables are intrinsic to the ways in which health care becomes accessible (or not), and they are inevitably linked. At the same time, it is important to recognize that some marginalized women will have access to sufficient resources but nonetheless choose not to use the services due to negative experiences in their past. These remembered negative experiences leave them with the expectation that they will be treated with disrespect, that they will encounter discrimination, and be confronted by the social stigma associated with their circumstances (Kurtz et al., 2008). These additional variables compound the complexities of investigating access for this population. Donabedian (1972) emphasizes that the "proof of access is use of service, not simply the presence of a facility. Access can accordingly, be measured by the level of use in relation to need" (p. 111). This paper will investigate women's access to health care by way of examining the barriers they experience in the health care system, their level of satisfaction when they do access health care, and the role of the NP in facilitating and improving their access to services.

Outreach Services

In Canada, the nursing profession has engaged in outreach services as far back as the 1700s when the Grey Nuns formed an association to provide services to marginalized populations in Quebec (Hardill, 2006). More recently, the Street Nurse Program was initiated as an urban outreach program in the city of Vancouver as a way of addressing the inequity in access to health care, as redressing the compromised determinants of health in marginalized populations (Hardill, 2006). In 1996, when three homeless men froze to death in Toronto, hostels were organized to house the homeless during poor weather conditions (Hardill, 2006).

In 2005, Vancouver initiated the Four Pillars Drug Strategy, a comprehensive evidence-based approach aimed at promoting healthier and safer communities by improving access to outreach programs that are linked to primary health care services (City of Vancouver, 2012). The four main principals or "pillars" of this program are Prevention, Treatment, Harm Reduction, and Enforcement. As a result of this program, there has been a reduction in the occurrence of overdose incidents, the transmission of blood borne diseases such as HIV and hepatitis, and a reduction in drug use in the streets (City of Vancouver, 2012).

Other outreach centers across Canada provide access for marginalized populations to obtain harm reduction supplies, which essentially include clean needles, condoms, food, water, and telephone access (Krusi et al., 2012). In one Vancouver downtown eastside clinic—the Vancouver Women's Health Collective—primary health care services are delivered to marginalized women by four experienced NPs (Vancouver Women's Health Collective, 2014). Vancouver's WISH Drop-in Centre Society is another example of an outreach program that includes NPs in the provision of primary health care services to women who work in the sex trade (WISH, 2014). Despite the existence of these outreach

programs, there appears to be a gap in the examination of such programs in the literature; there appear to be no studies that have examined the role of NPs in outreach centers.

Outreach services and harm reduction are implemented in a variety of ways. For example, it has been demonstrated that InSite, a supervised injection site that opened in Vancouver in 2003, has resulted in a decrease in the incidents of overdoses and the transmission of blood-borne diseases, and, an increase the retention rates for people in detox and treatment facilities, along with an increase in the exposure of the marginalized population to the health care system (Small, 2012). It has also been shown that the InSite program has resulted in a reduction in injections taking place in public places, has kept dirty needles off the streets, and has reduced the use of emergency services, while increasing access to health care providers (namely nurses) and other resources, and generally keeping people alive (Jozaghi & Andresen, 2013).

The various ways in which outreach services have affected access to health care for the marginalized population will be examined in greater depth in the findings section of this paper. Outreach services, for the purpose of this paper, will be defined simply as a service that provides care to marginalized populations in non-traditional locations, such as the streets (Hardill, 2006). Good examples include facilities such as those in Vancouver (InSite, Vancouver Women's Health Collective, and the WISH foundation), and The Warm Zone in Abbotsford.

Health Care Needs and Risks

Numerous studies indicate that marginalized adult women encounter significant barriers in the process of gaining access to health care or services in both Canada and the United States (Bloch et a, 2011; Boeri et al., 2011; Browne et al., 2012; Krusi et al., 2012; Kurtz et al., 2005; Kurtz et al., 2008; Loppie & Wien, 2009; Peters, 2012; Salmon et al.,

2009; Zweig, Schlichter, & Burt, 2002). The barriers they encounter are either multifactorial or there are simply no services available (Boeri et al., 2011; Kurtz et al., 2005). Salmon et al. (2009) remind us that health care needs for marginalized adult women have been studied at length in an attempt to address their poor health status. Inequities in health care delivery mean that marginalized women experience health disparities, an increased risk for becoming victims of violence, and an increased risk for contracting an infectious disease (Boeri et al., 2011; Krusi et al., 2012; Kurtz et al., 2005; Salmon et al., 2009). Also, if they are injecting drug users (IDUs) marginalized women certainly face an increased mortality rate.

Substance abuse. Spittal et al. (2006), were able to show, on the basis of the Vancouver Injection Drug Use Study (VIDUS) undertaken in Vancouver, that there was an increased mortality rate due to injection drug use. The study found that adult female IDUs have an increased risk of death by 47.3% compared to non-drug users. The injection drug deaths were attributed to overdoses, HIV infections, homicides, and non-secure housing. As well, cellulitis and subcutaneous abscesses are more prevalent among women who inject drugs and also have unstable housing, who share needles, who have someone else inject for them, or who inject on a daily basis (Lloyd-Smith et al., 2008).

Many studies in both Canada and the United States attest to the high use of crack cocaine in marginalized populations (Butters & Erickson, 2003; Kurtz et al., 2005; Krusi et al., 2012; Salmon et al., 2009; Shannon, Bright, Gibson, & Tyndall, 2007). There is a strong correlation between the use of crack (the most addictive form of cocaine) and women who work in the sex trade, where they are using sex as a way of paying for their habit, or they are making a direct exchange for crack (Butters & Erickson, 2003; Kurtz et al., 2005; Shannon et al., 2009). The adverse health outcomes from using crack have been associated with increased STIs, pregnancy, depression, anxiety, respiratory conditions (e.g., asthma and

pneumonia), violence, and rape (Butters & Erickson, 2003). Salmon et al. (2009) enumerated a number of reasons why women abused drugs: to alleviate physical pain, to help cope with life challenges in general, to deal with the emotional consequences of depression, trauma, or loss, or to reduce harm to themselves. At the same time, this same study also found that many of the women were fearful of overdosing, especially as 17% of the women in the study reported having overdosed within the year in which the study was conducted. Kurtz et al. (2004) examined the perplexing question of why women do not seek help for their addictions, given their realistic fears around overdosing. They determined that marginalized women may not be connected to a realistic sense of their best interests because they are so deeply embedded in the drug scene that they are simply unable to acknowledge their need to seek help. This study also stresses that drug use, stress, violence, and poor living conditions contribute to mental health illnesses within this population; it documents an unfortunate example where two of the women in the study committed suicide due to unstable mental health. The need to address these concerns is clearly warranted, in the face of these overwhelming health care needs and multiple health risks, not to mention the serious health outcomes, including death.

Violence. Marginalized women are at a significantly higher risk as potential victims of violence, especially when considered in light of the high rate of homicide within this population (Miller, Kerr, Strathdee, Li, & Wood, 2007; Spittal et al., 2006). Salmon et al. (2009) remind us that violence is clearly associated with perpetuating a cycle of drug abuse, where drugs are used to alleviate the pain eventuating from a violent encounter, and where sex trade work is used to pay, not only for the drugs themselves, but for the increased need for drugs (Kurtz et al., 2005). Violence in the form of physical assault on women is not uncommon. Salmon et al. (2009) reported that 79.2% of the women in their study group had

recently experienced violence, and two of the women were killed in violent circumstances during the course of the study—thereby illustrating the profound cruelty to which this population is exposed. In the downtown eastside of Vancouver, over 60 sex trade workers have gone missing since 1980 (Janssen et al., 2009).

Salmon et al. (2009) also emphasize that women experience violence—not only from their peers, drug dealers, interpersonal relationships, and clients in the sex trade—but also from the health care system, and from the health care providers. This phenomenon will be discussed in greater depth in the findings section below.

Lack of screening. Women in the general population benefit greatly these days from the health screening process, which includes screening for HIV, sexually transmitted infections (STIs), tuberculosis (TB), cervical cancer (papanicolaou (PAP) testing), and breast cancer—all of which have been proven to reduce mortality for women in general. Despite these commonly available and regular screening tests, marginalized women often lack access to the most commonly undertaken PAP test (Bharel, Casey, & Wittenberg, 2009; Peters, 2012; Teruya et al., 2010). Bharel et al. (2009) found that this lack of access was not necessarily due to the women being unavailable or unreachable, but that the women resisted testing on the basis of past trauma, where they simply declined the service; the study found that 38% of women declined the service despite being in need of screening. Of the percentage of women who were screened, 18% had atypical cells (Bharel et al., 2009). Teruya et al. (2010) found that homeless women had low screening rates, not just for PAP testing, but for TB, and HIV as well. These statistics point to an urgent need to find better ways of approaching this population in order to more effectively promote their health, while offering prevention strategies in less traditional and more unique settings.

Sexually transmitted infections. Canadian research shows that STIs, specifically syphilis, gonorrhoea, and chlamydia, are becoming more prevalent among middle-aged adults, although youth are still disproportionately infected with both chlamydia and gonorrhoea (Fang, Oliver, Jayaraman, & Wong, 2010). Shannon et al. (2007) note that the occurrence of HIV has been correlated to sex trade work, Aboriginal ancestry, cocaine use, and unprotected sexual intercourse. They also point out that the rate of HIV occurrence among women who work in the sex trade in Vancouver has been reported to be as high as 26%, and that condom use among marginalized women is surprisingly low. Their study found that, out of 198 women who work in the sex trade in Vancouver, 26% of these women tested HIV positive, only 68% used condoms, and as high as 61% of their clients were willing to pay more money for unprotected sex. A Toronto study, looking at the use of crack from the perspective of the user, found that women felt the use of crack cocaine decrease their inhibitions and consequently increase their risks of STIs (Goodman, 2006).

Shannon et al. (2008) found that the location where women could have access to syringes and health care services also tend to be more violence prone and therefore have more police surveillance—a phenomenon they correlated with pushing women who work in the sex trade away from these resources and into industrial areas and back alleys where they are even more likely to be harassed or pressured to have sex without condoms. They are also more subject to risky injections, limited access to clean needles, and increased needle sharing (Small, Kerr, Charette, Schecter, & Spittal, 2006). The ability of women to negotiate the use of condoms is also decreased when the realities of urban geography further marginalize women, and as a result substantially increase their chances of STI and HIV infections (Shannon et al., 2009).

Sex trade work. When marginalized women are involved in sex trade work their health care needs and risks are significantly increased. Women who work in the sex trade are more likely to contract the Hepatitis C virus (HCV); they are likely to have experienced sexual abuse in their past, have been recently incarcerated, use cocaine, visit shooting galleries, share needles or have another person inject for them, be HIV positive, and live on or near the streets (Spittal et al., 2006). They are also more likely to have STIs, pelvic inflammatory disease, ectopic pregnancies, experience increased discrimination and violence, be in debt, and be subject to exploitation (Rekart, 2005).

The weekly income for women who work in the sex trade and abuse drugs in Vancouver is, on average, about $300.00 per week, but studies indicate that some of these women will spend as much as $400.00 per week on drugs and, if their drug use increases, there is a direct correlation to an increase in their sex trade work (Deering, Shoveller, Tyndall, Montaner, & Shannon, 2011b). This cycle of sex trade work and drug abuse is negatively correlated with an increase in health care risks. In 2012, the average cost of shelter in British Columbia was $15,811.00 per year, not including food or other necessities (Statistics Canada, 2014b). When comparing the cost of living in British Columbia to the average yearly income of women who work in the sex trade and spend their income on illicit drug use, it is apparent that this population is compelled to survive well below the poverty line. In this light, the high rate of homelessness in this population is not surprising.

Women in the sex trade in Canada face ever-increasing marginalization should the recently proposed prostitution bill—the "made-in-Canada model" put forward by Justice Minister Peter MacKay—be passed into law. The controversial Bill C-36 will criminalize prostitution, going after the buyers by making it illegal to buy, advertise, or communicate on the streets regarding sex work (Cossman, 2014). If this law passes the implications would be

devastating for women in the sex trade, pushing women even further into unsafe locations, such as industrial areas and back alleys. They would be more likely to get into cars without first negotiating how the transaction will occur—for example the cost of the sexual act and the question of safe sex and the use of condoms—and they would be less likely to have a say in determining location if the client's goal is to avoid being seen to communicate with someone in the sex trade for fear of criminal consequences. This bill goes against the weight of research, which calls for the removal of legal constraints in order to make sex trade work safer (Krusi et al., 2012; Lazarus et a., 2012; Rekart, 2005; Shannon et al., 2008; Shannon et al., 2009). An additional aspect to this controversy is the way in which the bill comes from a place that continues to objectify women's bodies as sex objects, rather than from a place of understanding women and their experiences, through the lens of the marginalized.

Poverty and homelessness. Poverty and homelessness contribute to further marginalization and disempowerment for the already marginalized populations. A recent study conducted by Mani, Mullainathan, Shafir, and Zhao (2013) showed that people experiencing poverty would also experience a reduction in their cognitive function due to poverty-related factors acting to deplete vital cognitive reserves, which means that poverty alone can alter a person's ability to make decisions. Impoverished women who are also homeless are at greater risk for health disparities than their non-homeless but also impoverished counterparts. For example, Teruya et al. (2010) found that being homeless (and having unmet health care needs) has a strong correlation with women who abuse substances, have a mental illness, were sexually and/or physically abused as children, suffer from poor self-esteem, and have a history of being in jail.

Single room occupancy (SRO) hotels, well known in Vancouver's downtown eastside for having poor living conditions, are associated with individuals who have poor health, HIV,

and drug abuse issues (Shannon, Ishida, Lai, & Tyndall, 2006). In a study conducted in the downtown eastside, Salmon et al (2009) found that 61.2% of women living in SROs felt that their living quarters were a significant contributing factor to their poor health; 44.9% believed their home to be unsafe, and one woman was motivated to stay at a homeless shelter due to her concerns over the lack of safety in her SRO. Canadian women who are poor have an increased mortality rate and, according to the data, have the same probability of reaching the age of 75 as Canadian women did in 1956, or as women living in Guatemala in 2006 (Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009). In short, poverty and homelessness is not an uncommon combination for marginalized adult women, and it contributes significantly to both health risks and health care needs.

Aboriginal women. Although the focus of this paper is on marginalized adult women in general, it is important to note that in this literature review there is an over representation of marginalized Aboriginal women (Butters & Erickson, 2003; Deering et al., 2011a; Janssen et al., 2009; Kurtz et al., 2008; Lazarus et al., 2012; Marshall, Charles, Hare, Ponzetti, & Stokl, 2005; Salmon et al., 2009). For example, Marshall et al. (2005) found that, of the women using Sheway, the downtown eastside street-front service, 80.7% were Aboriginal. Another Vancouver study identified 42.5% of the street-based female sex workers as Aboriginal women (Deering et al., 2011a). This is alarming since Aboriginal people, in Canada in 2011, represent only 4.3% of the Canadian population (Statistics Canada, 2014a). Aboriginal women have a long history of being the most impoverished population in Canada (Canadian Council on Social Development, 2000; Kubik, Bourassa, & Hampton, 2009; Native Women's Association of Canada [NWAC], 2002; Townson, 2009). It has long been recognized that Aboriginal poverty and inequality are strongly correlated with the legacy of colonization (Beidler & Lynn, 2005; Fiske, Belanger, & Gregory, 2010; Kubik et al., 2009;

NWAC, 2002; Romanow, 2002). Colonization can be conceptualized as a kind of invasion, which in the case of Canada's indigenous peoples, came in the form of geographic and political intrusion, where land was taken over by various historical processes, and traditional systems of government were superseded by the dominant political forces of the time (Kubik et al., 2009). The poverty that came about by way of this historical legacy has led to numerous and complex health issues for Aboriginal women, not the least of which are mental and physical health disparities, prompting some women to resort to the sex trade and thereby further compounding their vulnerability (Kubik et al., 2009). This review will show that Aboriginal women are overrepresented in marginalized populations, given their relatively small population size in Canada—a factor that must be considered for its important practice implications.

Holistic Health Care

As already noted, marginalized adult women's health care needs and risks are multifactorial. The focus of holistic health care is to respond to all factors that affect an individual's health, including physical, psychological, social, and spiritual domains, in order to assist people to achieve optimal health outcomes (Wade, 2009). Because marginalized women are likely to suffer in all of these domains—physically (STIs, HIV, Hepatitis, trauma from abuse), psychologically (low self-esteem, mental illness, substance abuse, violence), socially (poor access to health care, discrimination/stigmatization, substance abuse/sex work), and spiritually (lack of hope, negative societal views, sense that no one cares)—they are likely to benefit from health care that incorporates a holistic health care philosophy.

Determinants of Health and Hierarchy of Needs

Hardill (2006), in her review of the history of outreach nursing in Canada, notes that it was Florence Nightingale who first began to address the core issues of marginalization in

her pioneering curriculum development which took into account the broad determinants of health. The determinants of health are defined by the World Health Organization (WHO, 2013) to include the social, economic, and physical environment, the person's individual characteristics and behaviours, along with their education, genetic background, access to health services, income and social status, social support network, gender, age, and culture. There is also the proposal that violence should be considered a determinant of health for women given that they encounter a disproportionate amount of violence in their lives (Benoit, Shumka, & Vallance, 2010).

Determinants of health are at the root of the many variables that compound marginalization, such as social location (homelessness, and poor or low income), and the availability of or access to resources within the community (Kennedy, Bybee, & Kubiak, 2012). As well, there are the immediate priorities that take precedence over health care needs, such as the basic need for food, shelter, employment, and clothing (Eby, 2004; Goodman, Smyth, Borges, & Singer, 2009). This pattern of setting priorities corresponds with Maslow's (1943) hierarchy of needs theory which proposes that, in order for individuals to turn their concern to their requirements for safety (which would include health care concerns), their fundamental physiological needs must first be met, such as food, water, bodily homeostasis, and sleep. Maslow notes that "if all the needs are unsatisfied, and the organism is then dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background" (p. 373). Maslow's hierarchy translates well to health care, in the sense that marginalized populations are unlikely to show concern for their safety (which for the purposes of this examination is construed as health care), if their physiological needs are not being met. Similarly, his hierarchy essentially sets out what we now identify as the

determinants of health. The implication is that a holistic approach to health is best suited to the complexity of health determinants presented by marginalized populations.

Feminism

Women present unique health determinants that are complex and multidimensional, and this review of relevant literature has therefore adopted a feminist approach to the examination of the research available for marginalized women. By using a feminist lens to look at the health care literature, it is hoped that the importance of women's lived experiences can be highlighted, and thereby insights into what women want and need from their health care providers can be gained.

The decision to examine the research using a feminist lens to synthesize the content was made for the following reasons. Campbell and Wasco (2000) enumerate several characteristics associated with feminist approaches to research in the social sciences. A feminist lens focuses on connecting women as a way of engendering agents of change without the hierarchical arrangements that only serve to further oppress women. This perspective carries with it a heightened awareness that multiple forms of oppression have had a significant impact on women's lives, where oppression is seen to result in disempowerment. A feminist perspective tends also to appreciate the importance of sharing personal information, and foregrounds research that is based on trust, respect, and an understanding of the lived experiences of women. Similarly, because this perspective takes into account the emotional aspects of these lived experiences, research conducted with this perspective is of a different quality and, it might be argued, no less scientific. Most important, perhaps, is that it provides a respectful platform for woman to tell their stories and be heard (Campbell & Wasco, 2000).

A number of sources emphasize the importance of methodology that ensures research be conducted in a way that allows women's voices to be heard in a respectful atmosphere, and in a non-hierarchical environment, and in this way ensuring high quality findings (Campbell & Wasco, 2000; Fontenot & Fantasia, 2010; Im, 2007). It is also clear that one cannot begin to assist marginalized women to address their health care needs without understanding their lived experiences by hearing what they have to say. For this reason, qualitative research was considered a highly valuable methodology for the purposes of this paper. The thought was that, if these variables were to be taken into consideration in the course of conducting the investigation required for this paper, more meaningful results with respect to improving the health of marginalized adult woman would emerge.

Finally, biological processes are different for men and women. In each, gender and sex interact and produce different health outcomes. Oliffe and Greaves (2012), in their examination of study designs that look at gender and sex, set out the complexity of variables that intersect to create different health outcomes for men and women. They emphasize that variables related to sex (sex hormones, genes, height, weight, lung capacity, and metabolism), variables related to gender (gender role, gender identity, gender relations, and institutionalized gender), and variables related to physiological processes (immunity, stress response, blood pressure, bone density, and gene expression) all intersect to create different health outcomes for people.

Through a Social Justice Lens

An examination of access to health care for marginalized adult women requires that the perspective of social justice be taken into account, in this way prompting the health professional to consider the bigger picture in their attempt to comprehend the root causes of inequality and inequity. Nurse Practitioners already do this in a variety of practical ways

when they implement programs designed to meet the needs of vulnerable populations and in the course of providing primary health care in outreach centers. According to the World Health Organization (2008), social justice is vital for rectifying inequalities in society. The Canadian Charter of Rights and Freedom (Department of Justice Canada, 1982) entrenches the principle of social justice, stating that all people have the right to equality and freedom without discrimination. The Canadian Human Rights Act (Department of Justice Canada, 1977) prohibits discrimination and was enacted to ensure that all Canadians would be guaranteed equal opportunity despite race, gender, and ethnic origin. It follows then that, if marginalized women receive inequitable treatment in the health care system, NPs have an ethical duty to minimize this imbalance in order to promote equality for all (Canadian Nurses Association, 2010c). The Canadian Nurses Association points out that an important root cause of inequality can be directly related to inadequate access to health services, especially delays in treatment, of the kind that marginalized adult women experience.

Kim (2009) points out that, in Canada, there are four million people who do not have a primary care provider. This lack of access to a primary care provider means that patients receive care from walk-in-clinics, emergency departments, or they go without health care, all of which result in poor health outcomes and a significant burden on government resources (Badger & Behler-McArthur, 2003; Kurtz et al., 2008). The role of the NP is situated within this gap in service and can be adjusted to facilitate access for all populations to a higher quality of health care.

Primary Health Care

The Declaration of Alma-Ata, adopted in 1978, and since accepted by the member countries of the World Health Organization is an influential document that underlines the importance of the primary health care approach as a means to promote and restore health care

for all (WHO, 1978). Primary health care incorporates health promotion and illness prevention through education and treatment and by looking beyond the individual patient and examining health policies, multi-sectorial collaboration with health care providers, and members of the community to meet the needs of all people (Shoultz & Hatcher, 1997). The primary health care approach would call upon the NP to address the inequalities faced by marginalized women and their families, and to look for ways to minimize and resolve the issues brought forward. Health care is considered a human right, as well as a responsibility that all people should be obliged to consider in order to rectify inequality and inequity in society (WHO, 1978).

Nurse Practitioners

In Canada, nurses have been acting in expanded roles—as a way of compensating for the gaps in health care experienced by vulnerable populations—for a very long time (Tarlier, Johnson, & Whyte, 2003). According to the Canadian Nursing Association (2010d), given the lack of primary health care providers to meet the needs of the Canadian population, and the inequities this creates, there is a distinct need to have more NPs incorporated into the health care system. Browne and Tarlier (2008) advocate a critical social justice perspective in their examination of NP roles with respect to marginalized populations, and argue for increasing their awareness of the impact of global neoliberal policies, such as cutbacks in social and health programing, and its association with increased inequalities in society that have affected health care access. Nurse Practitioners are expected to facilitate health promotion and illness prevention strategies by engaging in community outreach and harm reduction services to identify and fill service gaps within the communities (College of Registered Nurses of British Columbia, 2013a).

During the mid-1990s, health care reform was headway in Canada with its emphasis on increasing access to health care for all (DiCenso et al., 2010). The provincial government's goal at that time was to implement the NP role in British Columbia as a strategy to increase timely access to quality health care (Donald et al., 2010; Romanow, 2002). Nurse Practitioners have a protected title, and legislation allows them a great degree of autonomy in providing care for all population groups (Canadian Institute for Health Regulation, 2014). The scope of practice for NPs in British Columbia is unique among nurses in Canada. Nurse Practitioners are Registered Nurses who have completed advanced coursework and have obtained their master's degrees, granting them the autonomy to perform advanced health histories and physical examinations, diagnose health problems, order diagnostic tests and interpret and manage results, consult and/or refer to specialists, prescribe medication, manage chronic conditions, all in the context of providing holistic care (British Columbia Nurse Practitioners Association, 2014; Canadian Nursing Association, 2010a). With this enhanced scope of practice, NPs are able to take on leadership roles with the authority to care for and manage the health care needs for all populations in Canada (Canadian Nursing Association, 2010a). Many NPs have acquired approximately 20 years of experience as Registered Nurses prior to pursuing their master's degree (Sangster-Gormley & Canitz, 2014). On completion of their training, NPs bring a high level of competencies and extensive experience to primary health care.

The main Nurse Practitioner competencies—the knowledge, skills, and attributes expected of NPs—are set out by the College of Registered Nurses of British Columbia (2013a) and include the following features:

1) Ensure NPs establish and maintain a professional role, and be responsible and accountable for their practice.

2) Assess and diagnose clients to determine their health/illness status and needs.

3) Manage a client's health care using a therapeutic plan.

4) Ensure NPs promote, enhance, and restore health and well-being, and prevent illness/injury for their clients.

Numerous sources confirm that the role of family NPs has been developed to provide safe, high quality, evidence-based primary health care for all populations and, further, that the presence of these practitioners is known to increase patient satisfaction (Badger & Behler-McArthur, 2003; DiCenso et al., 2010; Donald et al., 2010; Feldman, Ventura, & Crosby, 1987; Heale & Pilon, 2012; Horrocks, Anderson, & Salisbury, 2002; Sangster-Gormley & Canitz, 2014; Seiler & Moss, 2012; Spitzer et al., 1974). Numerous sources agree that Nurse Practitioners fill the needs and gaps within the health care system by increasing access to health care in general (Kaasalainen et al., 2010; Newhouse et al., 2011). Other sources remind us that NPs work well in multidisciplinary teams (DiCenso & Bryant-Lukosius, 2010; Pirret, 2008; Sangster-Gormley & Canitz, 2014). Pirret (2008) highlights the role of NPs in producing effective documentation that allows a plan of care to be followed through, and in the timely recognition and intervention where patients appear to be unstable.

Currently, in British Columbia, NPs are employed across a range of geographic settings. 69% of NPs provide health care in community-based settings where they work with an array of health care professionals, and provide a range of services such as chronic disease management, palliative care, episodic care, and community outreach initiatives (Sangster-Gormley, 2012). There are 295 practicing NPs, and 24 non-practicing NPs in British Columbia at this time, an increase from 226 in 2011 (College of Registered Nurses of British Columbia, 2014). Although the NP population in British Columbia is small, it is rapidly growing; there are three family NP education programs in the province, at the University of

Northern British Columbia, the University of Victoria, and the University of British Columbia.

CHAPTER THREE

Research Methods

Integrative literature reviews have the potential to inform nursing practice by using a combination of methodologies to uncover evidenced-based knowledge (Whittemore & Knafl, 2005). This integrative review uses both quantitative and qualitative research articles to identify the role for NPs specifically in the context of outreach centers for marginalized adult women in British Columbia. In order to bring forward all the data available, a rigorous systematic process has been employed to consider the available research. The process used for this project has been adopted from the data analysis strategy outlined by Whittemore and Knafl (2005). Their framework sets out five stages to ensure the rigour and validity necessary to an integrative literature review: (a) identifying the purpose of the review; (b) gathering the literature available; (c) evaluating the relevance of the literature identified; (d) in-depth data analysis of the research selected on the basis of its relevance; and (e) the final presentation of the findings, in a form appropriate to the topic, for example matrices and charts.

Search Strategy

Whittemore and Knafl (2005) emphasize that using a methodical and systematic process in identifying relevant research will significantly reduce the risk of error for an integrative literature review. To enhance rigour and provide clarity, this review followed the process set out in the flow chart shown in Figure 1.

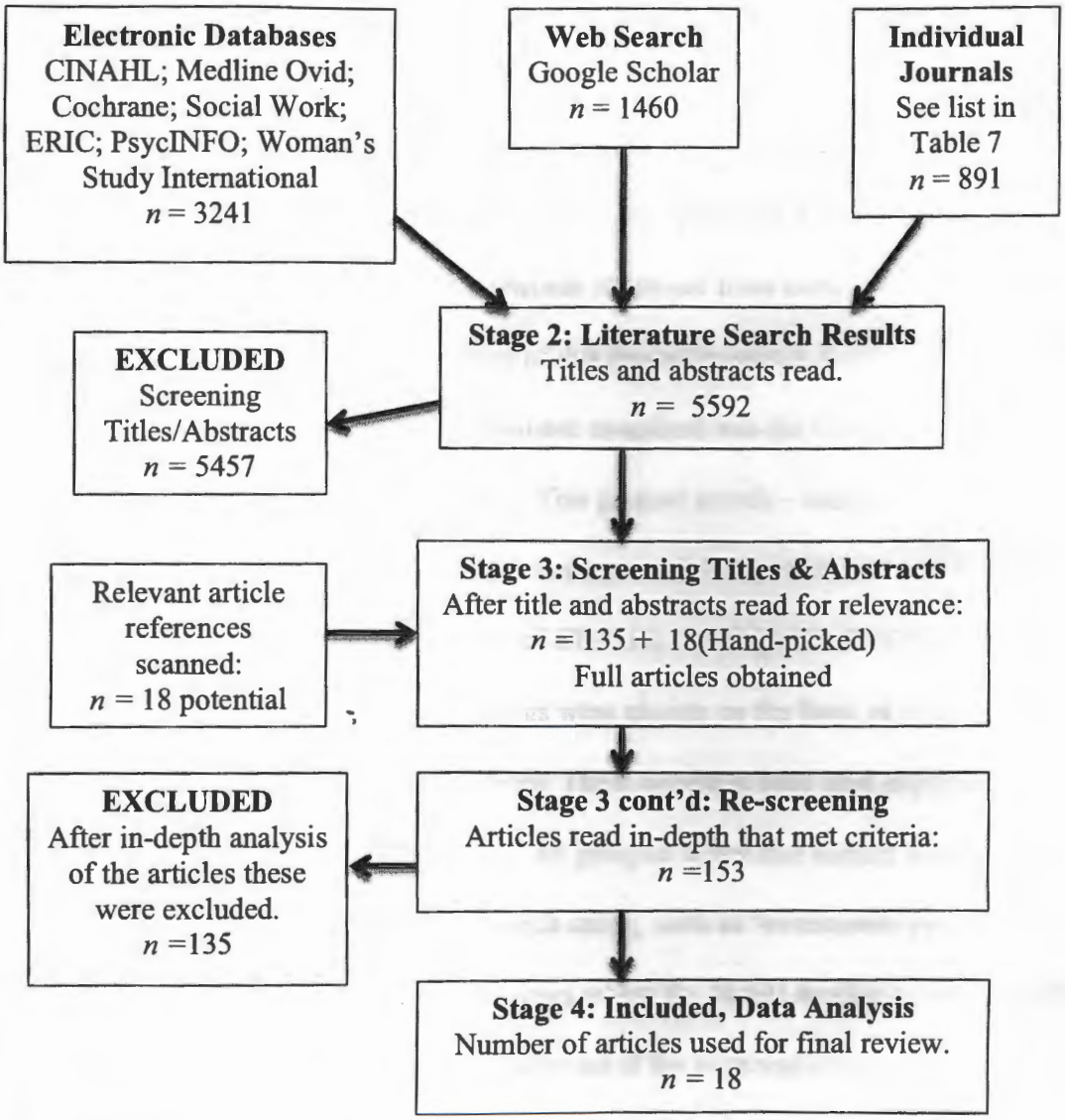

Figure 1. The literature search process

Stage One: Identifying the Purpose of the Review

Stage one, identified in the introduction, posed the following questions:

1. What is the ideal role of NPs in outreach services for marginalized adult women?
2. How can NPs facilitate access to primary health care for marginalized adult women who participate in high-risk lifestyles in British Columbia?

Stage Two: Gathering the Data

The literature search began by compiling a list of key terms that were identified as important and relevant to the topic of this project. Research conducted prior to this project identified a number of sources that looked at the barriers marginalized women face in the course of gaining access to health care. The keywords identified from these sources were added to the list of terms developed at the outset of this project to ensure that important articles were not missed. The first electronic database examined was the Cumulative Index to Nursing and Allied Health Literature [CINAHL]. This general search—limited to titles and abstracts—allowed me to familiarize myself with concepts and terms related to the research questions. These search terms produced a "tree" of CINAHL headings (Medical Subject Headings, or MeSH) from which relevant headings were chosen on the basis of their scope notes, and their relevance to the research questions. These headings were then expanded where possible to capture wider set of references, all grouped under that subject heading. Also, where the database suggested a term or search string, such as "community programs for shelter," it was added to the list of terms. In the cases where the MeSH headings did not provide relevant articles, the search was expanded to see if the term registered as a "keyword" in the keyword field. This was the only situation where a keyword search was used, because keywords have a narrow search scope, limited specifically to a particular term. These keyword searches took into account the potential for missing significant literature.

It should be noted that, before commencing with the literature search for this project, an initial practice search was conducted with the assistance of a librarian at the University of Northern British Columbia, which facilitated the identification of the best search strategies. This also allowed the development of insight with respect to the various concepts involved, along with an understanding of the hierarchy by which major and minor subject headings are

organized. In this way, common themes emerged and the list of search terms was finalized. The search terms included for Phase I of this project are illustrated in the Table 1 which displays the way in which major concepts were broken down into similar more specific related terms to better reflect the essence of the question posed.

Table 1

Phase I: Summary of Major Concepts Identified and Similar Terms

MARGINALIZATION	ACCESS TO HEALTH CARE:	NURSE PRACTITIONER:	HARM REDUCTION CENTERS:
• Poverty • Homelessness • Homeless person • Homeless women • Sex trade worker • Prostitution • Sex for money • Sex work* • Survival sex • STD/STI • HIV/HCV/HBV • Substance abuse/use • Drug addiction • Drug use • Injection drug use • Addiction • Substance dependent • Barriers • Vulnerable • Vulnerable groups • Medically underserviced • Violence • Intimate partner violence • Rape • Sexually assaulted • Abuse • Emotional abuse • Structural violence • Disparities	• Health disparities • Health services accessibility • Health care needs • Health services needs and demands • Health care barriers • Access to care • Health inequalities • Safer environment intervention • Health services • Treatment • Treatment seeking behaviour • Trauma-informed care • Primary care • Primary health care • Help seeking • Barriers to service • Social justice	• Primary health care provider • Adult NP • ER NP • Health care providers • Family NP • Advanced practice nurse • Nurse led • Advanced nursing practice • Nurse-managed centres • Nurse care provider • Academic nurse manager • Practitioner	• Community health centers • Walk-in-clinics • Needle exchange programs • Harm reduction • Outreach centers • Shelters • Non-profit organizations • Critical care outreach • Risk reduction • Syringe exchange access • Intervention • Outreach nursing • Street nursing walk-in centres • Treatment programs • Community programs

MARGINALIZATION	ACCESS TO HEALTH CARE:	NURSE PRACTITIONER:	HARM REDUCTION CENTERS:
• Stigma • Social isolation • Marginalized populations • Marginalized women • Women • Hard to reach groups	• Barriers to accessing health care • Promoting access		

Once the final major concepts and their related terms were identified, the practice search was deleted and a new search was initiated in order to maintain the integrity of the process. Concepts and their similar terms were searched individually using MeSH headings or keywords. Following this, the selected results were queried using Boolean "OR" operators in order to produce one major concept, as shown in Table 2.

Table 2

Phase I: CINAHL Search Summary of Major Concepts OR Similar Terms Results

Searched February 9th, 2014	ARTICLES FOUND
1. **MARGINALIZATION OR** similar terms	214, 920
2. **ACCESS TO HEALTH CARE OR** similar terms	692, 275
3. **NURSE PRACTITIONER/HEALTH CARE PROVIDER OR** similar terms	44, 020
4. **HARM REDUCTION/PROGRAMS OR** similar terms	30, 884

This process was repeated for each of the major concepts and their similar terms. Once the four major concepts were queried in this way, they were narrowed down using Boolean "AND", as shown in Table 3. This process of combining major concepts in the different ways shown below was deemed to be more thorough, and ensured as much as possible that relevant articles would not be overlooked.

Table 3

Phase 1: CINAHL Search Summary for Combining Major Concepts with AND

COMBOS	**# Before inclusion**	**Inclusion criteria used**	**# After inclusion**
1 AND 2 AND 3 AND 4	78	None applied	78
1 AND 2 AND 4	3390	Adult, English, Female, 2004 -2014, Humans, Canada, Australia, USA	427
1 AND 2 AND 3	1507	Adult, English, Female, 2004 -2014, Humans, Canada, Australia, USA	241
2 AND 3 AND 4	404	Adult, English, Female, 2004 -2014, Humans, Canada, Australia, USA	32
1 AND 2	64, 722	Adult, English, Female, 2005 -2014, Humans, Canada/USA, had 5643, needed to narrow down more, used the subject heading "Health Services Accessibility"	357
2 AND 3	17, 756	Adult, English, Female, 2004 -2014, Humans, Canada only	44
3 AND 4	633	Adult, English, Female, 2004 -2014, Humans, Canada, Australia, USA	41
1 AND 3	2680	Adult, English, Female, 2004 -2014, Humans, Canada, Australia, USA	240
1 AND 4	5937	Adult, English, Female, 2004 -2014, Humans, Canada only	21
2 AND 4	12, 918	Adult, English, Female, 2008 -2014, Humans, Canada only	19
Total Articles Found	**Duplicates**	**After Duplicates**	**Used**
1500	118	1382	248

Once major concepts were subjected to these search combinations, applying inclusion and exclusion criteria narrowed the remaining large body of literature down. Inclusion criteria consisted of narrowing the date range to limit the results to research produced between 2004-2014; to include adult, human females, 19 and over; to research published in English, and relating to conditions in Canada, the United States, and Australia. The exclusion criteria removed from consideration was any articles published prior to 2004, relating to

males, not published in English, or published outside of Canada, the United States, or Australia, as well as articles that were commentaries, or editorial pieces.

Table 3 above shows that certain searches identified an unmanageable set of references, and therefore the inclusion criterion was slightly altered for each search. For example, one search was defined to identify all articles falling only under the major subject heading "Health Services Accessibly" given the relevance of their titles to the topic. At this stage, titles were read for their content, as it became apparent that the search was too broad, identifying numerous articles that had no relevance to the project, for example the large amount of literature relating to HIV treatment and disease processes.

Once the CINAHL search was complete, all 1,500 articles were exported to Refworks, where duplicates were eliminated, leaving a total of 1,382 articles to be screened on the basis of their titles and abstracts. This left 248 articles for further consideration. A similar search was then conducted in Medline (via Ovid). See Table 4 for the results of these searches. Following this stage—the identification of the relevant literature—the committee overseeing this project was consulted and Phase I was considered complete.

Table 4

Phase I: Medline Ovid Search of Major Concepts OR Similar Terms and Summary for Combining Major Concepts with AND

Searched February 10th, 2014			**ARTICLES FOUND**
1. **MARGINALIZATION OR** similar terms			442, 738
2. **ACCESS TO HEALTH CARE OR** similar terms			6, 046, 610
3. **NURSE PRACTITIONER/HEALTH CARE PROVIDER OR** similar terms			57, 956
4. **HARM REDUCTION/PROGRAMS OR** similar terms			534, 834
COMBOS	**# Before inclusion**	**Inclusion criteria used**	**# After inclusion**
1 AND 2 AND 3 AND 4	215	None applied	215
1 AND 2 AND 3	2259	Adult, English, Female, 2004 -2014, Humans, Canada	507
1 AND 2 AND 4	53630	Adult, English, Female, 2004	9188

		-2014, Humans, Canada	
2 AND 3 AND 4	8993	Adult, English, Female, 2004 -2014, Humans, Canada	1486

Phase II required careful reconsideration of both the search terms and the major concepts previously identified. The major concept "NP" was removed for the time being because no relevant literature was found in the searches described above. A decision was made to search for this concept at a later stage, and to include this strategy in the discussion section of this paper. The other three major concepts—marginalization, access, and outreach—were retained, but many of the similar terms, such as HIV, STIs, and community programs, were removed because they were either too specific or too broad. The revised list of major concepts and their similar terms is shown in Table 5. The 248 articles flagged for their potential relevance in Phase I was incorporated into Phase II.

Table 5

Phase II: Summary of Major Concepts Identified and Similar Terms

MARGINALIZATION	OUTREACH CENTERS	ACCESS TO HEALTH CARE
• Poverty • Social exclusion • Social isolation • Medically underserved • Social inequality • Hard to reach group • Marginalized populations • Homelessness • Prostitution/sex trade worker • Stigmas & discrimination • Vulnerable population	• Harm reduction • Shelters • Street nursing • Risk reduction • Needle exchange programs • Crisis intervention • Walk in centers	• Health services accessibility • Barriers to health care • Health services needs and demands • Promoting access to health care • Primary health care accessibility • Health care disparities • Primary health care

The literature search for Phase II was applied, again, to CINAHL and Medline (Ovid), and also included the CDSR (Cochrane Database of Systematic Reviews), the social

work database, ERIC (Education Resources Information Centre), PsycINFO (American Psychological Association), and the EBSCO hosted Women's Studies International database.

The searches followed the same methodical, systematic review process as that used for Phase I. At this stage, however, the inclusion criteria were only deployed if the search resulted in an unmanageable number of references. These criteria included research published in English, produced between 2004-2014, relating to adult females aged 19 and over, and relating to conditions in Canada and the United States. At this stage, Australia was not included, thereby making the results more applicable to the North American context. Table 6 shows the results of this search. Note that the asterisk in Table 6 indicates the application of the inclusion criteria.

Table 6

Phase II: Stage Two Search Results

	Databases						
Terms	CINAHL	Medline Ovid	Cochrane	Social Work	ERIC	Psych-INFO	Women's Study International
1). Marginalization **OR** similar terms	39,563	81,220	4883	5056	47,767	75,971	27,533
2). Outreach **OR** similar terms	11,951	16,753	5705	965	3806	13,439	2586
3). Access **OR** similar terms	50,612	196,405	956	9	28	32,705	259
1 **AND** 2 **AND** 3	121	148	10	0	0	97	2
1 **AND** 2	68*	143*	132	204	78*	385*	118*
2 **AND** 3	44*	98*	34	0	0	193*	8
1 **AND** 3	209*	704*	94	2	3	612*	35
Used from Phase I	248	n/a	n/a	n/a	n/a	n/a	n/a

Databases							
Terms	CINAHL	Medline Ovid	Cochrane	Social Work	ERIC	Psych-INFO	Women's Study International
Total number exported	690	1093	270	215	109	1287	163
Duplicates removed	87	182	51	14	7	203	42
Total viewed	603	911	219	201	102	1084	121
Total after titles and abstracts read	37	25	5	4	1	24	4

In this search phase, the exclusion criteria removed from consideration any articles published prior to 2004, not written in English, published outside of Canada and the United States, relating to children or youth, along with articles that were commentaries or editorial pieces—given that the aim for this project is to provide evidence-based knowledge to direct nursing practice in British Columbia. Articles referring to conditions in the United States were considered with caution given the different health care funding model in place there, one which further creates barriers to health care access that are not necessarily applicable to the Canadian context.

Each of the databases listed in Figure 1 were searched using the same systematic process described in CINAHL search. Similarly, the results were saved (in a file within the database), and exported to Refworks. Once searches were completed for all the databases, duplicates were checked using Refworks, and manually removed to ensure that computer error did not result in removing the wrong articles. Following this, an additional search was made using Google Scholar, and relevant journals were hand-searched to ensure that no pertinent research was missed. By searching the databases, Google Scholar, and

hand-searching relevant journals a total of 5,592 articles were identified using the method illustrated in Figure 1. The results are shown in Table 7.

Table 7

Phase II: Manual Journal Search

Terms	Harm Reduction Journal	Journal of Urban Health (Potential literature)	Google Scholar (Potential literature)	The International Journal of Drug Policy (Potential literature)	Hand Picked from References
Marginalization AND Outreach programs	n/a	n/a	n/a	299(9)	n/a
Outreach programs AND Access	n/a	n/a	n/a	60	n/a
Marginalization AND Access	n/a	n/a	n/a	273	n/a
Marginalization AND Outreach programs AND Access	5	254 (9)	n/a	n/a	n/a
The primary health care experiences of women who use drugs	n/a	n/a	1460(17)	n/a	n/a
Exported after Titles read	0 (2 were duplicates)	9	17	9	n/a
Used	0	4	2	1	3

Stage Three: Evaluating the Resources for Relevancy

Stage three involved evaluating the sources identified by the literature search. This required scanning the titles and abstracts for each of the 5,592 results and determining their relevance to this project. During Phase I it became apparent that none of the studies addressed all four of the major concepts identified as core to the concerns of this project. This meant that other aspects of the literature would have to be examined in light of the questions posed by this project. Additional questions were posed as a means to include or exclude

articles that could be considered relevant (or not relevant). At this point, articles were considered relevant if they addressed the following questions:

1. What barriers do marginalized adult women encounter in the course of gaining access to health care (from the perspectives of these women and the health care providers)?
2. How do outreach services facilitate access to health care for marginalized adult women?

By posing these questions, it was then possible to narrow the results of the literature search down to a manageable set for further investigation. If articles were found to be potentially valuable in providing background, but not directly pertinent to the review, they were set-aside in a folder. The process of scanning the titles and abstracts for relevance identified a total of 135 articles. Full-text articles were then obtained for review; if they were not available online at the University of Northern British Columbia, or by way of the world-wide-web, interlibrary loans were requested through University of Northern British Columbia.

Each of the 135 articles was examined to ensure that the studies were of high quality and relevant to the project. Critical appraisal of the literature is essential in order to judge the strengths, weaknesses, and significance of any study (Grove, Burns, & Gray, 2013). The articles were read quickly and evaluated on the basis of the research design, the authors' credentials, how or whether the research was funded, and whether there appeared to be any conflict of interest. Particular attention was given to the relevance of the material to the research questions, and the potential for the material to produce good insights into the challenges, barriers, and current health care access for marginalized adult women. If the articles appeared to be relevant, they were read more closely a second time, in order to ensure that the content was of good quality. Each article was rated according to its level of evidence

on the basis of a framework developed by LoBiondo-Wood, Harber, Cameron, and Singh (2013) (see Appendix A). Research location was also an important factor, given that the specific focus for this concerns NPs in British Columbia.

At this stage it also became clear that some studies were relevant even though they included males; the importance of the findings determined that these articles would be included, given that males certainly also experience marginalization. Studies including male subjects were analysed with care to focus only on the content that pertained to the wider human experience, and was not specific to male experiences. A total of five studies that included male subjects were used in the final review on the basis that the findings could be generalized to the broader purposes of this project.

The reference section of the articles that were chosen in the final analysis were carefully checked as well; this produced a further 18 articles for investigation. Hand-picking references in this way ensured that pertinent articles were not missed. For example, two relevant articles that were published in 2002 and 2003 were found this way; although they would have ordinarily been excluded on the basis of their publication date (having been published prior to 2004), they were nonetheless found to be pertinent and were included in this stage of the review. Finally, although similar articles were surfacing, the literature search appeared to have hit the point of diminishing returns when no new articles were being found. There followed an in-depth reading of a total of 153 articles that were identified as being pertinent, which in turn resulted in the selection of 18 articles to be incorporated here for the purposes of this review.

Stage Four: Data Analysis

Stage four followed from the selection of 18 articles chosen for their relevance to the research topic on the basis of a rigorous integrative review methodology. Following this data

collection process, the data was analyzed along the lines proposed by Whittemore and Knafl (2005), which include data reduction, data display, data comparison (to identify themes, relationships, patterns, and gaps), and drawing conclusions and verifying them in the form of matrices. The strength of this iterative process is that it allows data to be compared across the board; it minimizes the possibility of overlooking key concepts and findings, and provides the basis for a more complete analysis.

The columns within the matrix have been developed to provide a means to sort through the study methods, data collection, sample size and settings; they allow the methodological processes to be readily compared and contrasted for each study. Other columns identify the levels of evidence and key findings for each study, specifically the barriers encountered in health care, the ways to improve access, and how outreach services are being offered (see Appendix A).

CHAPTER FOUR

Findings

A total of 18 articles were identified—using a rigorous integrative search method—as being valuable and relevant for the purposes of this study (outlined in Chapter three). Twelve of these are Canadian studies, three are American, and three were conducted in Australia. Eight studies using data relating to British Columbia have been reviewed (Deering et al., 2011a; Janssen et al., 2009; Jozaghi & Andresen, 2013; Kurtz et al., 2008; Lazarus et al., 2012; Marshall et al., 2005; Salmon et al., 2009; Wardman, Clement, & Quantz, 2005). Four studies from Ontario were identified and included (Butters & Erickson, 2003; Daiski, 2005; Goodman, 2006; Woolhouse, Brown, & Lent, 2004). Three studies using American data were found to be relevant (Boeri et al., 2011; Kurtz et al., 2005; Zweig et al., 2002). A study that looked at Australian data was included (Rowe, 2004). And, finally, two Australian studies that looked at international data were reviewed (Islam & Conigrave, 2007; Islam, Topp, Day, Dawson, & Conigrave, 2012).

The research methodologies used in the studies included in this integrative literature review varied: there were seven mixed-method, six qualitative, three quantitative, one integrative literature review, and one systematic literature review. The material was assessed on the basis of its "level of evidence," a strategy adapted from LoBiondo-Wood et al. (2013), ranked from one to seven. The level of evidence contained in the selected material ranged between four and seven: two studies were ranked at level four, one study was ranked at level five, fourteen studies were ranked at level six, and only one paper was ranked at level seven (see Appendix A).

This paper places a high value on qualitative evidence, specifically as it emerges from taking account of the perspectives of marginalized women, and of the health care providers

who are involved with the care for this population. This kind of evidence is considered to be crucial to informing the practice of nursing.

The analysis of the findings of this review of the literature was focused on the role of the NP in outreach centers, with the purpose of exploring ways in which NPs in British Columbia might facilitate access to health care for marginalized adult women who participate in high-risk lifestyles. Due to the limited research available on this topic, different aspects of the literature were considered in order to identify the barriers that marginalized women encounter when attempting to access health care, and to examine how outreach centers facilitate access for these women. The major themes and subthemes identified in this review are illustrated in Figure 2.

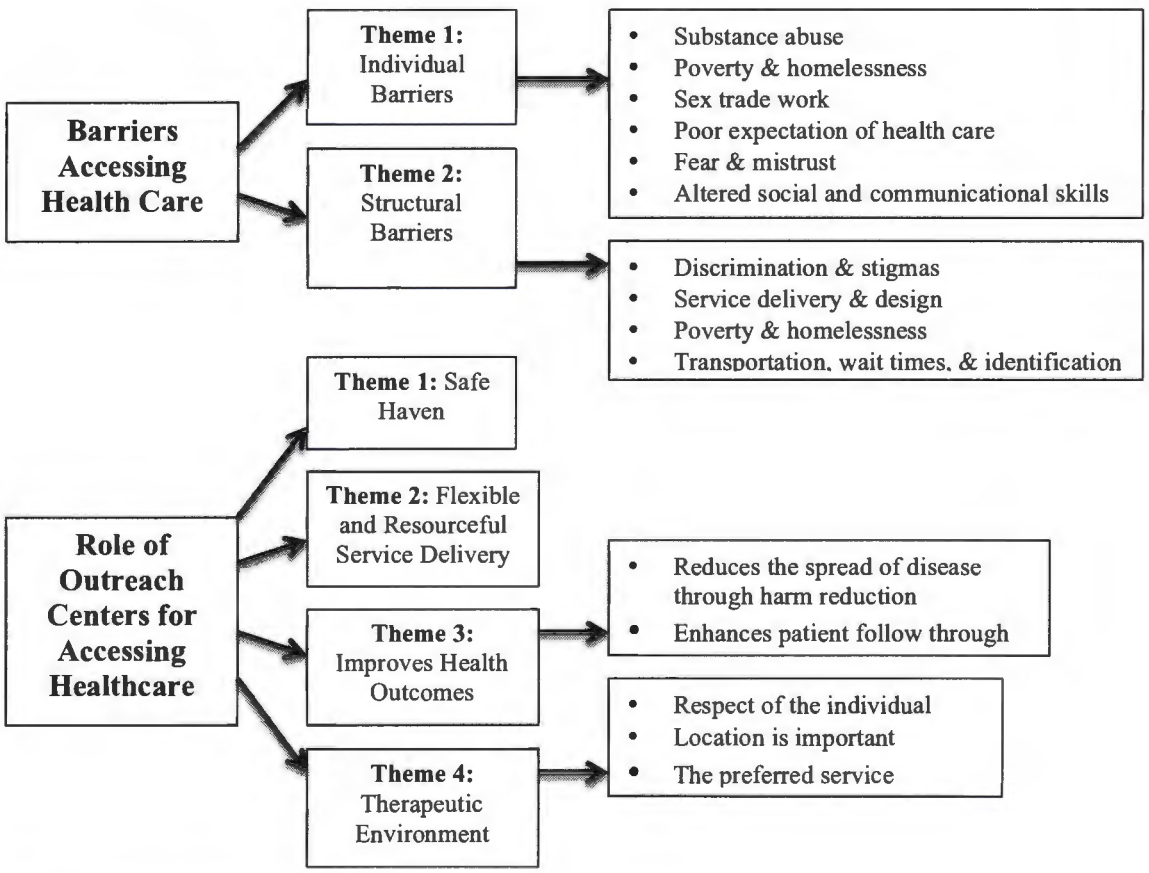

Figure 2. Themes and subthemes

In health care, the characteristic biomedical viewpoint focuses on disease and illness. The feminist lens broadens this viewpoint to include socio-political factors that influence the individual experience of ill health and wellness. In this review, I want to incorporate the viewpoints of women in order that NPs can better understand individual women's experiences in order to be better equipped to provide appropriate help. Further on, I will foreground the importance of respect, of establishing therapeutic relationships, person-centered care, and harm-reduction practices. I will look at ways in which power imbalances can be shifted, and examine ways in which health care can be provided that takes into consideration the context of women's lives. To begin with, however, an examination of the barriers marginalized adult women experience as they attempt to access health care will follow.

Barriers Accessing Health Care

Kurtz et al. (2005) identified barriers to health care access for marginalized adult women in terms of categories, conceptualizing them as either individual or structural barriers. The individual barriers are those emerging from women's lives, inherent obstacles that stand in the way of their access to health care, such as substance abuse, poverty and homelessness, along with poor expectations of health care services, fear, mistrust, and altered social and communicational skills. The structural barriers are those, which are outside and independent, barriers that are not a consequence of the women's circumstances. These include systemic discrimination and the consequent stigmas that come with it, inappropriate service delivery and design, access to transportation, length of wait times, and personal identification. These are multifactorial barriers that exacerbate the complexities already facing this population, making access to health care deeply problematic.

Individual Barriers

Substance abuse. Drug and/or alcohol abuse was commonly found to prevent many marginalized women from accessing health care services. The more vulnerable the women were the more barriers they faced in negotiating the health care system (Goodman, 2006; Kurtz et al., 2005; Lazarus et al., 2012; Zweig et al., 2002). The routine imperative to obtain substances dominated these women's lives, and it was apparent that time spent seeking health care services was not a priority (Butters & Erickson, 2003; Goodman, 2006; Kurtz et al., 2005; Rowe, 2004; Zweig et al., 2002).

Goodman (2006) found that societal discrimination prompted women who abused substances to sink more deeply into their addiction as a way of escaping the reality of their circumstances. Kurtz et al. (2005) found that the women used drugs to avoid physical and psychological pain from past or present traumas, a vicious cycle that inevitably resulted in a requirement for more money to pay for drugs, which in turn prompted them to resort to sex trade work in order to obtain funds. One woman explained, "I just want the pain to go away; reality comes flooding back—you want to go and do it [crack] again" (Goodman, 2006, p. 17).

Both Kurtz et al. (2005) and Goodman (2006) found that some women who were heavily involved in substance abuse were either unable to articulate their health care needs or were unaware of them altogether. It is likely that the need to obtain drugs becomes the dominating focus of some women's lives, crowding out their ability or desire to attend to their basic needs.

Kurtz et al. (2005) reported that, out of 586 women who were tested (for HIV, Hepatitis A, Hepatitis B, and Hepatitis C), 120 showed positive results for HIV/AIDS. Of these 120 infected women, 45% were unaware they were infected (p. 351). Similarly, out of

the 586 women tested, 158 women tested positive for HCV, and of these 65.8% were unaware of their status (p. 351). The same study found that 17.5% of homeless women felt they did not need any support despite having no place to sleep at night (p. 351). These findings indicate the potential for a much-compromised state of self-awareness for some marginalized women.

In contrast, Butters and Erickson (2003) found that some women had more insight and were able to describe making a conscious choice to not use health care services, or to not allow the health care provider to provide them with services. In any case, when women are intoxicated from having consumed substances, their decision-making ability is inevitably altered. As one woman said, "crack takes away your inhibitions, makes us more vulnerable to STDs [sexually transmitted diseases]. Guys never want to use condoms" (Goodman, 2006, p. 18). It is important that NPs are alert to this characteristic lack of self-awareness in marginalized women around their personal health care needs, making them significantly more vulnerable due to their altered perceptions. Here, the indication is for NPs to broaden their perspective to incorporate a sense of social justice; and, to concentrate their attention on this population by interacting in ways that will reduce the kind of harm that might befall the women as a result of their high-risk lifestyles.

Sex trade work. Studies indicate that women involved in sex trade work are at significantly greater risk for illnesses and violence, and that their profound sense of stigma often prompts these women to hide their health status from their health care providers (Kurtz et al., 2005; Lazarus et al., 2012). Women's health risks are multidimensional, complex, and vary depending on the context in which their lives are carried out. For example, when women who work in the sex trade also have substance abuse issues, their health risks are elevated and, as their drug use increases, their sex trade work also increases to meet the demands of

servicing their addiction (Deering et al., 2011a). Kurtz et al. (2005) observed that where homelessness and poverty are involved, some women would trade sex for shelter, attesting to the profound realities that women face when they attempt to survive on the streets. Substance abuse and sex trade work contributes dramatically to increased isolation, particularly from people who do not use drugs, an experience that has been shown to result in decreased self-esteem, distrust, and fear among women (Kurtz et al., 2005). These are realities that NPs will be obliged to consider when seeking to understand the lived experiences of marginalized women in their attempts to assist these women to gain better access to health care.

Women in the sex trade are generally seen in a negative light in the eyes of society, and this view has a negative impact on the way that marginalized women experience their lives. As noted above, Bill C-36, tabled in June of 2014, and dubbed by Canadian Justice Minister Peter MacKay as a "made-in-Canada" model, seeks to criminalize sex trade work despite strong opposition, including the December 2013 Supreme Court ruling that found Canada's prostitution laws unconstitutional. Should this come to pass, women working in the sex trade will be all the more demoralized and silenced; worse, they will be seen as criminals rather than as women trying to simply survive on the streets.

Research points to the importance of, and necessity for, shifting societal views so that women can feel safe to disclose the nature of their work, receive non-judgmental access to health and other services, and experience a reduction in their experience of the stigma long associated with this kind of work (Deering et al., 2011a). It behooves NPs to be aware of the ways in which the views held by the majority of society affects the lived experiences of women. The social context in which women's lives are set significantly affects the ways in which women access health care, and reveals one of the reasons why women may not disclose their greatest health risks. It is important that NPs engage with women to establish a

therapeutic relationship, one that is motived by a harm reduction philosophy and informed by a view that sees sex trade work simply as a means of survival and not as a criminal act. The idea is that, once marginalized adult women feel safe, an increased access to health care services and an improvement in their support network will follow.

Poverty and homelessness. The literature clearly indicates that poverty poses significant challenges for women when it comes to accessing health care services. The poor socioeconomic conditions for marginalized adult women are palpable. For example one study (Goodman, 2006) showed that 85% of crack users were homeless, while another study (Kurtz et al., 2005) found all of the 586 women that formed the foundation of the study lived in insecure housing situations. The authors of this study noted that "contrary to our expectations, these focus group discussions showed that the terms homeless and housed were of little utility in identifying needs and barriers because none of the focus group respondents lived in stable and secure housing" (p. 351).

As noted above, NPs would do well to consider Maslow's (1943) "hierarchy of needs" theory for the way in which it sheds light on some of the reasons that marginalized women are likely to be more concerned with food and shelter and less likely to see their health care as a priority (Kurtz et al., 2005). Woolhouse et al. (2004) looked at women living in marginalized conditions in Ontario and, found that the power imbalance present in the patient-health-care provider relationship to have a negative affect on the experiences of marginalized women.

Goodman (2006), looking at crack users in Toronto, found that they reported significant levels of discrimination against them due to drug use, poverty, disability, gender, and participation in the sex trade. Similarly, Zweig et al. (2002), found much the same in a

US-wide evaluation, based on interviews with staff from twenty programs—where discrimination accounted for one of many barriers faced by marginalized women.

Studies find that poverty will compel women to seek access to outreach services for basic necessities such as soap, shampoo, and underwear (Daiski, 2005; Kurtz et al., 2005). Studies also find that women with inadequate housing will suffer much-compromised health and overall well-being (Daiski, 2005; Marshall et al., 2005; Salmon et al., 2009). Salmon et al. (2009) enumerated concerns with respect to housing conditions, such as no running water, resulting in no indoor toilet facilities, no heat, insect infestations, and mould. Kurtz et al. (2005) found that, when women did seek shelter with friends and family, they encountered any number of stipulations made by their hosts. In one case, a woman reported having to trade shelter for sex with her male relatives. These findings again emphasize the importance of having NPs understand the kind of impact that poverty and homelessness will have on the marginalized women that NPs will encounter in the course of their efforts to provide health care. In the course of my own studies as an NP, I have personally observed the ways in which women make decisions when they need shelter for various reasons, especially when they are worried about their safety on the streets. Their reality is simply this: they are trying to survive. As NPs gain a greater understanding of the lived experiences of women, they will be better equipped to provide care appropriate for these women—with compassion, empathy, and support—all crucial to a person-centered approach. These findings also emphasize the importance of a multidisciplinary approach to the delivery of care to marginalized adult women who struggle with homelessness and poverty.

Poor expectations of health care. Studies show that many marginalized women have come to expect a poor quality of care in their attempts to gain access to the health care system in both Canada and the United States (Goodman, 2006; Kurtz et al., 2005; Salmon et

al., 2009). Salmon et al's (2009) study found marginalized women would generally access their health care through emergency departments, avoiding other health care services entirely, due to the stigma associated with their circumstances, and the discrimination they encountered. One woman reported, "I just expect it [poor care] all the time" (p. 22).

Numerous studies identify low self-esteem among marginalized populations. Some indicate that the prevailing low expectations of marginalized women, when it comes to receiving quality health care, may also result from the low self-esteem common to these women (Goodman, 2006; Kurtz et al., 2005; Salmon et al., 2009). Butters and Erickson (2003) note that this poor self-perception comes, in part, from women blaming themselves for their circumstances. Goodman (2006) reported the extent to which Toronto's crack users expressed "deep feelings of loathing and poor self-esteem" (p. 18); they described how they felt others saw them with words and phrases having extremely negative connotations, often as "worthless," along with "diseased, scum, garbage, thief, filth, liar, violent, dirt.... [and] specific derogatory terms such as 'crack-head' and 'crack-ho'" (p. 17). Goodman emphasizes that such attitudes and labels result in women feeling a sense of heightened isolation, and general anger at society. Women in this study also reported that they would keep secrets from their health care providers, presumably to avoid these feelings of shame (p. 18). Goodman's research represents the only study encountered in this broad integrative review that asked women about their perceptions—of how they are viewed by the wider community, and how these views affected them. These results illustrate how self-perception is manipulated by societal views and how self-perception affects women's sense of place in the wider community. The implication is that women value the opinions of others, and that how they are viewed influences how they see themselves. These findings, put together, underscore the importance of forming therapeutic relationships as a way of addressing feelings of low self-

esteem, isolation, worthlessness, and shame. In this way, it becomes possible to remind marginalized women that they are worthy of care.

A study undertaken by Boeri et al. (2011) indicates that, when discrimination is systemic, the health care system itself throws up barriers to health care services. They reported, for example, that women in a large metropolitan area in the southeastern United States were blacklisted from crucial support services such as those providing food and shelter, due to their having a criminal record or being users of illicit drugs. Similarly, Wardman et al. (2005), looking at Aboriginal use of health services in British Columbia, reported that 86.1% of the 267 Aboriginal clients surveyed felt that health care was accessible but that the barriers within the system, including stigmatization, were the real obstacles that needed to be overcome. Daiski (2005), in her examination of Toronto's "Health Bus," an alternative mobile healthcare unit, reported that marginalized women using this facility reported having found shelters to be unhygienic, regularly infested with insects, subject to frequent outbreaks of TB, all of which were seen by these women to further compromise their health in the process of gaining access to these resources.

In summary, when women have lowered expectations of the health care system due to having received poor care in the past, or they are held back due to poor self-esteem, they become subject to increased isolation. This will be exacerbated when the system itself throws up additional barriers that make access difficult or, in the case of the US example, impossible. Understanding the correlation between low self-esteem and a reluctance to use the available health care services will allow NPs to better understand the value of therapeutic relationships that foster a person-centered care approach, ones that are committed to a harm reduction philosophy. It seems important, given the research reviewed, that the health care focus be on the women themselves rather than on the life-styles in which they are caught up

in—which often appear to be outside the control of marginalized women. When women expect poor care they are less likely to seek access in the future which means that it is essential for NPs to reconnect and engage with these women in order to bring them back into the system of primary health care.

Fear and mistrust. Numerous studies indicate that fear and mistrust are common barriers that hinder women gaining access to the health care system, not just of the system itself, but also the health care professionals they encounter in the process (Goodman, 2006; Kurtz et al., 2005; Kurtz et al., 2008; Rowe, 2004; Salmon et al., 2009). Additionally, it appears that many women felt health care providers were incompetent, lacked both the ability and knowledge to provide appropriate care (Goodman, 2006; Rowe, 2004; Salmon et al., 2009; Woolhouse et al., 2004).

Despite this, or because of this, there is a desire for having a consistent health care provider. Salmon et al. (2009), looking at the primary health care of women using drugs in the downtown eastside of Vancouver, found that women would go to a number of different health care providers in order to obtain the care they needed but, at the same time, they expressed a preference for one consistent care provider feeling, rightly, that an ongoing relationship would provide them with the best care possible. Rowe (2004), examining the potential role of the Australian Needle and Syringe Program in addressing the obstacles to the use of health care services by street-based injecting drug users, found that this population wanted consistency when receiving health care.

Other misgivings that prevent access to health care are fear of arrest, mistrust that lack of confidentiality would lead to exposure, and fear of being embarrassed or labelled. Kurtz et al. (2005) found that women who abused drugs in Miami avoided health care services for fear of being arrested for loitering, solicitation and drug possession (p. 357).

Other studies showed women avoided health care services, anticipating that they would be labelled as drug addicts or drunks (Butters & Erickson, 2003; Goodman, 2006; Kurtz et al., 2008). Women also expressed concern that their health data and personal information would not be kept confidential, and feared they would be found out (Goodman, 2006; Rowe, 2004; Wardman et al., 2005). Rowe (2004) found that Australian women using injection drugs were too embarrassed to admit to their addictions which meant that they avoided obtaining health care services altogether.

These findings illustrate that women want consistent health care, and appreciate the potential value of a relationship with their care provider, but their fear and mistrust towards the health care system, and those who provide services, prevents these women from receiving care they clearly need. This unfortunate situation has important implications for health care providers: they are well advised to build relationships with women, and to reconsider the settings in which health care and services are offered.

Altered social and communicational skills. Once on the street, women's lives are shaped by their experiences of living and surviving there. One outcome is that their social skills and their ability to communicate will be altered by this experience, and the street skills they acquire do not always comply with societal norms. The research literature indicates throughout that, at times women, are well able to communicate their health care needs and to receive services accordingly, and that, at other times, they have difficulty articulating or even understanding their needs, and consequently do not receive services. For example, studies show that women will often show up late or cancel appointments, due to other pressing demands, and difficulty getting transportation—a complex situation that may be interpreted as unwillingness on their part to wait or to receive care (Kurtz et al., 2005; Rowe, 2004).

Similarly, Kurtz et al. (2005) found that street-based sex workers were unable to find shelter as a result of being preoccupied by street life. This study reported that women would smoke crack all night to prevent falling asleep which would leave them at risk of being raped or beaten while they were off-guard. Additionally, this study also reports that women are often refused assistance (and certainly employment) on the basis of their appearance, which is often due to poor access to showers, personal hygiene products, and their inability to safely store valuables and money.

Living on the street and habituating shelters produces different social skills and alters the way people communicate. Street conditions make it difficult for women not only to manage their lives, but also to develop an understanding of their own behaviours at times. Accordingly, it is crucial for NPs to be aware of the chaotic lives marginalized women live and, again, the importance of not focusing on the women's behaviours but rather concentrate on women as individuals in need of care. This will require that NPs working in outreach centers to be prepared to ask women directly about where they need help and, where communication skills are lacking, work with these women to help determine their needs.

Structural Barriers

Discrimination and social stigmas. A great deal of research shows that discrimination and stigmatization are the principle barriers to gaining access to health care for marginalized adult women (Boeri et al., 2011; Daiski, 2005; Goodman, 2006; Kurtz et al., 2005; Kurtz et al., 2008; Lazarus et al., 2012; Rowe, 2004; Salmon et al., 2009; Woolhouse et al., 2004; Zweig et al., 2002). Salmon et al. (2009) reported that thirty-two of the women in their downtown eastside study raised the issue of being refused health care services in cases where they were injured or suicidal, having a mental health crisis, or wanting HIV treatment (p. 16). Similarly, Butters and Erickson (2003) reported examples of female crack

users in Toronto being denied health care services when they attempted to use emergency services. In St. Kilda, in Australia, women told Rowe (2004) that when they attempted to access health care services they were treated unfriendly by staff. In yet other studies, women reported that services and providers were intimidating, dominating, and providing suboptimal services (Goodman, 2006; Rowe, 2004; Woolhouse et al., 2004). Numerous studies reported that the women surveyed felt they were ignored (Goodman, 2006; Kurtz et al., 2008; Rowe, 2004; Woolhouse et al., 2004). Women also reported that they felt unsupported, rushed, and unimportant (Goodman, 2006; Woolhouse et al., 2004). Often, because women's health complaints were seen to be a result of their illicit drug use, their symptoms were not treated as seriously or investigated as thoroughly as they might otherwise have been (Goodman, 2006; Kurtz et al., 2008; Salmon et al., 2009).

Kurtz et al. (2008) give an example where an Okanagan Aboriginal woman presenting with abdominal pain was treated as though it was all in her head (p. 57); she was diagnosed with cancer seven months later and ended up with a hysterectomy—a situation that may have been avoided, or at least handled in other ways, had the health care provider listened and responded in a different way. This assumption by the health care providers—that women are on drugs or abusing alcohol even when they are not—is not uncommon, nor is the poor treatment on account of physical appearance, drug use, and sex trade work (Goodman, 2006; Kurtz et al., 2005; Kurtz et al., 2008; Rowe, 2004; Salmon et al., 2009). These findings have significant practice implications for NPs. They demonstrate the risks when health providers act on their negative assumptions; and, where being judgemental can greatly affect sound clinical and diagnostic reasoning and the ability to provide safe, well-informed health care.

Salmon et al. (2009) reported that a number of women in Vancouver's downtown eastside described the treatment they experienced as "rough," where Aboriginal women in particular found that their providers did not respect their "bodily boundaries" (e.g., unnecessary demands to remain uncovered) (p. 16). Similarly, Kurtz et al., (2008) recounted an instance where an Aboriginal woman, living with the results of a stroke, was often asked by her health care providers if she had been drinking; another, suffering from a similar condition, recounted an instance where her health care provider doubted her assertion that she hadn't had a drink in many years, and even asked her: "Are you sure you put your own pants on this morning?" (p. 57). The frequency with which people come to health care providers having experienced this kind of treatment has important practice implications for NPs. Many Aboriginal women have endured acts of physical and verbal abuse; and some have been sexually abused as children, or sexually assaulted as adults.

Salmon et al. (2008) and Kurtz et al. (2008) both clearly indicate that this "structural violence" continues to be perpetuated by the health care system. Woolhouse et al. (2004) report that women's experiences with physician discrimination showed up as a recurring theme in their Toronto study (p. 1390). Rowe (2004) recounts an incident where a woman, on first presenting her symptoms to a primary care provider, found that he was concerned enough to order an ambulance, but when she disclosed she used drugs he promptly cancelled the ambulance and told her he could not help her (p. 53).

In all these examples, judgements by health care practitioners are being made on the basis of women's behaviours, status, and appearance—with treatment being given accordingly—rather than on the basis of an individual person in need of care and sometimes in need of crucial medical attention. Again, it may not always be clear what form of help is needed, but our clients are best served by empathy rather than pre-determined judgment; in

any event, suspending judgement will likely prove helpful in uncovering problems and enabling the women to effectively gain access to appropriate care, according to their preferences and needs.

Numerous studies reiterate that, as a result of encountering discrimination and stigmatization, many women postpone seeking health care until their health has deteriorated to the point that they require emergency services (Boeri et al., 2011; Daiski, 2005; Goodman, 2006; Kurtz et al., 2005; Kurtz et al., 2008; Lazarus et al., 2012; Rowe, 2004; Salmon et al., 2009). Similarly, the treatment received at the hands of health care providers contributed to many women not disclosing their drug use for fear of not being well treated and of being permanently labelled (Boeri et al., 2011; Goodman, 2006; Kurtz et al., 2005; Salmon et al., 2009). Not disclosing drug use to a health care provider has significant consequences, leaving the health care provider uninformed and therefore unable to fully understand the care needs (Kurtz et al., 2005). Kurtz et al. (2008) note that, where past discrimination was experienced, women would instead consult first with family members to measure whether their concerns merited seeking attention from a health care provider. Research indicates that seeking access to health care in the future is directly correlated to women's health care experiences in the past (Goodman, 2006; Salmon et al., 2009). It also indicates that stigmas arising from the circumstances of marginalized women—and the discrimination they encounter in the course of seeing health care providers—is by far the most detrimental barrier to gaining access to health care services. There is a great deal of value in having NPs establish a therapeutic relationship with the women they encounter in their practice; this kind of relationship is imperative if these issues are to be redressed. Nurse Practitioners may be unaware of the extent to which women have been poorly treated by their health care providers along the way. By considering the weight of evidence in this regard, they will come to understand why

women may initially be defensive and withhold their trust from NPs, or may not even want access to the services provided by NPs.

Service delivery and design. The service delivery and design of health care services are themselves factors that prevent women from gaining access to health care services. There are numerous accounts by women, recorded in the literature reviewed, that characterize health care services as inflexible. The most obvious example of this is the frequent instances where the hours of operation are completely inappropriate for women working in the sex trade (Kurtz et al., 2005; Rowe, 2004). Rowe (2004) reports that the best time for women in the sex trade industry to take advantage of health care services is during the slowest time for business—between 1800 and 2030 hours. The busiest time for women in the sex trade is between 0100 and 0500 hours, which means that women often sleep in the daytime when most health and social service agencies are open. Studies conducted by Daiski (2005) and Islam et al. (2012) found that outreach centers which were open in the evenings and on weekends provided greater access to health care services, and were actually based on the needs of the populations being served. Nurse Practitioners should be aware that women are often unable to engage with health services, or show up for their appointments, given the complexity of their circumstances, and the many demands on their time and energy, such as making enough money and surviving on the streets.

A number of other barriers surround the design of service delivery, which is reported in the literature. Kurtz et al. (2005) note that care facilities for marginalized women in Miami prohibit the use of drugs on shelter premises, making them unsuitable for women who are active in their addiction. Boeri et al., (2011) report service use caps on the number of times food services and homeless shelters (in a Georgia metropolitan area) could be used. Lazarus et al. (2012) reported that street-based female sex workers in Vancouver were unable to have

access to female doctors. Similarly, Wardman et al. (2005) found that Aboriginal women wanted to be treated by Aboriginal health care providers and would actively search for facilities offering this option.

Zweig et al. (2002) observed that health care services generally address a single issue at a time, noting that this is seen as a barrier by women who usually have multiple issues that need to be addressed simultaneously. When women did receive care, and their health issues were addressed, they described feeling ill-equipped to deal with the outcome, or to understand treatment explanations due to their lack of education (Goodman, 2006; Salmon et al., 2009). Goodman (2006) found that providers were described as having unrealistic expectations of marginalized people, not realizing the extent to which health care directives were difficult to understand and follow. Boeri et al. (2011) found that women were often referred to facilities that proceeded to refer these women elsewhere. Other studies found that these referrals were often inappropriate, not available, or poorly delivered (Goodman, 2006; Kurtz et al., 2005; Rowe, 2004; Zweig et al., 2002). Jozaghi and Andersen (2013) noted the lack of harm-reduction supplies (needles) in facilities in Surrey and Victoria, limiting the people who would be able to make use of these services, despite both the communities being known for their high rates of drug use. Significantly, a number of studies revealed, that many women were unaware of the services that were available to them (Islam & Conigrave, 2007; Kurtz et al., 2005; Wardman et al., 2005).

Service delivery and design are important considerations for NPs who are unaware that there are significant barriers to accessing health care for this population. These findings will indicate to NPs the importance of engaging with women to get to know them, to understand their needs, and to be better equipped to connect women to the most appropriate services in ways that will also increase their health literacy. These findings also point to the

necessity for NPs to know what resources exist in the community, and the crucial role that NPs play in facilitating health care partnerships that will better facilitate access to health care in ways that do not further marginalize women.

Transportation, wait times, and identification. Barriers that marginalized women face when it comes to gaining access to health care also frequently include a lack of transportation, long wait times, and the requirement to show identification prior to being seen. Numerous sources report that, in order to make use of health care services, many women expressed the necessity of being able to walk to a nearby facility due to a lack of having access to a vehicle for transportation (Boeri et al., 2011; Daiski, 2005; Goodman, 2006; Kurtz et al., 2005; Wardman et al., 2005; Rowe, 2004; Zweig et al., 2002). Many facilities required women to show identification in order to obtain health care services, a significant barrier given that many marginalized women simply do not have identification (Boeri et al., 2011; Butters & Erickson, 2003; Goodman, 2006; Kurtz et al., 2005). Kurtz et al. (2005) propose that this may be because many women do not have lockers or any ability to store personal items, and will likely have had their belongings stolen along the way. They also reported that women in the sex trade would sometimes spend all their money the same day to avoid being robbed. These barriers exacerbate the ways in which marginalized women are trapped in a cycle, leaving them unable to escape. The research clearly highlights the importance of having outreach centres offer basic necessities with minimal barriers and restrictions, and to structure access in ways that will facilitate the best use by the most people of the resources offered.

Marginalized women commonly expressed frustration at encountering prolonged wait times to see a care provider, which many felt was due to their impoverished status (Daiski, 2005; Goodman, 2006; Lazarus et al., 2012; Rowe, 2004; Salmon et al., 2009). Salmon et al.

(2009) noted that women in the downtown eastside saw this as controlling, a form of punishment, and that they were more likely to be made to wait compared to non-marginalized populations. Many women referred to long wait lists for services such as dental care, shelters, or safe housing, all of which created hurdles to gaining access to resources (Goodman, 2006; Lazarus et al., 2012; Rowe, 2004; Salmon et al., 2009). Excessive wait times, lack of transportation, and requirements for identification in order to be able to obtain health care, are significant obstacles that health care providers need to be aware of to help improve women's access and receive health care.

The Role of Outreach Centers for Accessing Health Care

Outreach centres have a significant role to play in alleviating a number of barriers currently faced by marginalized populations by incorporating the following features. These features have a demonstrably positive impact on facilitating and improving access to health care for marginalized women by providing a safe haven, flexible and resourceful service delivery, improved health outcomes, and a therapeutic environment.

Safe Haven

Outreach centers such as InSite, in Vancouver have been shown to save lives by reducing deaths from overdoses by simply monitoring drug users during injection episodes. Jozaghi and Andresen (2013) note that fears of overdose have been reduced since InSite was implemented. Outreach centers provide women with access to a variety of information, for example, when a bad batch of drugs hits the market (Janssen et al., 2009). These centres are also known to provide bad date postings, which circulate information to women—and through women—in the sex trade regarding clients who are known to be abusive and to be avoided (Deering et al., 2011a; Janssen et al., 2009). Outreach centres usually make available brochures setting out available resources for the women (Islam & Conigrave, 2007; Marshall

et al., 2005). Women consistently reported feeling safer once engaged with services (Deering et al., 2011a; Islam & Conigrave, 2007; Islam et al., 2012; Janssen et al., 2009; Jozaghi & Andresen, 2013; Marshall et al., 2005). Similarly, according to Janssen et al. (2009), women in the sex trade felt that having a mobile access van nearby made their work environment safer, an uncommon luxury for this population. For instance, Janssen et al. interviewed 100 female sex trade workers in the downtown eastside of Vancouver who had access to a nearby mobile outreach van; they found that making use of the van reduced sexual assaults by 10%—and that 93.7% of the women felt that the van gave them an increased sense of safety. Jozaghi and Andresen (2013) found that, when people who inject intravenous drugs accessed outreach services to inject drugs, they reported fewer experiences of robberies because they were less vulnerable while injecting. Safe injection sites, such as InSite, are described as places that are a "stress free, cop free, disease free, [and an] OD [overdose] free environment" (Jozaghi & Andresen, 2013, p. 6). This finding is significant, inasmuch as it indicates that women feel that their sense of safety has increased on the basis of these outreach initiatives. Outreach facilities have demonstrated success in fostering access to health services by providing safe environments for marginalized women, a population greatly in need of experiencing a reduction in their exposure to violence and their sense of fear.

Flexible and Resourceful Service Delivery

Outreach facilities are generally designed to deliver services that are flexible. Women are given enough autonomy in these settings to direct the services they receive without the pressure to abstain from drug use (Islam et al., 2012; Marshall et al., 2005). In this context, services are delivered with the overarching imperative to reduce the harm associated with substance use rather than being bound by a focus on abstinence (Daiski, 2005; Deering et al., 2011a; Islam & Conigrave, 2007; Islam et al., 2012; Janssen et al., 2009; Marshall et al.,

2005; Rowe, 2004). Rowe, (2004) looking at the role of the Australian Needle and Syringe Program, indicates that a harm reduction approach is more important than an approach that would promote abstinence from drugs, particularly when it comes to attending to the health of street-based drug users. Rowe's research was the only study in this literature review to openly stress this approach.

The implication that emerges from the research is the importance of supporting women while they are active in their addictions, as well as abstaining from judgement, fostering positive relationships, and gaining their trust (Rowe, 2004). Marshall et al. (2005) note that this form of flexible service has proven to successfully increase access to primary health care in Vancouver's downtown eastside with the initiation of Sheway, a comprehensive street-front service for pregnant women and mothers with a history of alcohol and/or drug abuse. While the women's health problems have been shown to increase over the years, the indicators of infant health showed improvement or at least stability (Marshall, 2005). Supporting marginalized women, even though they remain active in their addiction, as well as promoting and encouraging their autonomy even if they do not always understand their best interests, can be challenging for health care providers. The research put forward in this review will allow NPs to consider the importance of suspending judgement and holding back on their ideas around promoting abstinence, and in this way better facilitate access to health care services for at-risk women (and children). That is to say we, as NPs would do well to focuses on the needs of marginalized women, rather than get caught up in what we want for these women.

Research shows that, when outreach centres work on the basis of flexible health delivery models, women are not required to show identification in the course of seeking health care (Daiski, 2005; Deering et al., 2011a; Islam & Conigrave, 2007; Islam et al., 2012;

Janssen et al., 2009). There is also the necessity for services to be free where the populations served do not have medical coverage (Islam & Conigrave, 2007; Islam et al., 2012). In many cases, hours of operation are more flexible than mainstream health delivery services, providing services to women in the evenings and on weekends (Islam et al. 2012; Rowe, 2004). Outreach centers often offer drop-in services and free supplies to women, such as sterile drug paraphernalia, condoms, along with other necessities required to protect against STIs and blood borne diseases inherent to sex trade work (Rowe, 2004). These centres also offer a range of delivery services, such as outreach vans, which deliver services to the women on the streets and visit multiple locations in one evening (Daiski, 2005; Janssen et al., 2009; Islam & Conigrave, 2007). There are also examples of outreach centres that provide vending machines to dispense clean needles twenty-four hours a day (Islam & Conigrave, 2007).

Sheway, discussed by Marshall et al. (2005) and noted above, consider the benefits of having a single-access integrated health service program specifically designed for prenatal and postpartum women with a history of substance addiction. They emphasize the importance of having all health services in one location, thereby eliminating or reducing a number of barriers to health care access that this at-risk population normally encounters.

According to the literature surveyed for this project, there are a number of features associated with outreach centres that make them unique among the constellation of health services—features that make them particularly well suited to at-risk, marginalized women. These centres, first, provide access to health care providers, from first aid services to full-trained medical practitioners; they often provide women with basic necessities, such as toiletry supplies, and sometimes showers; they can provide referrals to addiction centres, and information (often in the form of pamphlets) describing other resources available in the community. In this way, and others, outreach centres assist women to navigate their way

through the health care system. These centres can also provide assistance with housing needs, and sometimes simply provide a gateway to other services.

Islam et al. (2011) conducted an integrative literature review to examine the operational models of primary health care centres that cater to injecting drug users. They found that needle exchange programs attract high risk populations, and therefore have the potential to provide the means to establish connections with marginalized individuals and, where possible in this way introduce them to a variety of services. Deering et al. (2011a), in a study that examined the ways in which women were using outreach services in the form of a peer-led mobile outreach program in Vancouver, found that this program plays a critical role in facilitating their eventual use of drug treatment centres. Islam et al. (2012) identified similar findings in their review of the literature. Other studies show that the use of outreach services reduces the frequency with which women resort to the emergency department at hospitals, a finding that has important financial and political appeal (Daiski, 2005; Islam et al., 2012; Jozaghi & Andresen, 2013).

The weight of research indicates that outreach centers are important for engaging with women, and reconnecting them back into primary health care services. Although they ultimately serve as a gateway allowing women access to an assortment of resources that can facilitate and improve their health outcomes, these centres meanwhile provide an alternative, interim setting where NPs can work to stabilize women, regain their trust, and improve their health outcomes. Ideally, these services allow women to be themselves, without experiencing fear or feeling judged. In summary, outreach centres improve health outcomes and facilitate access for marginalized women; they generally do not require identification; they facilitate autonomy, support women while they are active in their addiction by focusing on a harm

reduction philosophy, feature drop-in services, offer a variety of delivery models, offer flexible hours of operation, and engage in a multidisciplinary approach to care.

Improves Health Outcomes

The research clearly shows that outreach centres provide services that are a good fit for marginalized adult women, who are among the most vulnerable individuals in society. Those who inject drugs face a high risk contracting debilitating blood-borne diseases, sometimes with lethal consequences. Outreach facilities, with their focus on harm reduction rather than detoxification or cure, are able to minimize and help users negotiate the risks associated with drug use, especially those associated with sharing supplies and needles. For example, Jozaghi and Anderson (2013) note that, having access to these supplies has reduced the need to use puddle water to inject, a practice which has been associated with a number illnesses.

Numerous studies highlight the important role outreach centres play in the spread and reduction of the widespread infections and viruses common to marginalized women, particularly those active in the sex trade, and users of injection drugs. The spread of HIV, HBV (Hepatitis B virus), and HCV (Hepatitis C), rampant in this population, will be reduced when needles and equipment are not shared. As pointed out by Jozanghi and Andresen (2013), "in Canada, for example, one in four cases of HIV is attributed to sharing needles," a situation which they point out is particularly bad in Vancouver which has one of the highest outbreaks of HIV in the developed world. Similarly, making condoms available will help reduce the spread of STIs as well as blood-borne diseases. Islam et al. (2012) found that individuals who used outreach services were more likely to reduce the amount and severity of their drug use, thereby reducing their drug-related health problems. This study also found that outreach centers have also promoted an increase in the completion of vaccination series

(hepatitis, for example), a significant factor in improving health outcomes for marginalized populations.

These findings all indicate the importance of outreach centres in the constellation of primary health care, especially with respect to the ability of these centres to reduce the multifactorial barriers faced by marginalized women when attempting to gain access to health care services. It is therefore important that NPs understand the value of outreach centers in preventing illness and promoting health through harm reduction strategies and facilitating access to services that improve women's lives.

Therapeutic Environment

Respect for the individual. Outreach services generally intend to provide an environment that fosters respect by staffing it with individuals who are either trained or inclined to refrain from passing judgement. Studies show that marginalized populations are aware of the extent to which these centres minimize or remove some fundamental barriers to gaining access to primary health care services (Daiski, 2005; Deering et al., 2011a; Islam & Conigrave, 2007; Islam et al., 2012; Janssen et al., 2009; Jozaghi & Andresen, 2013; Marshall et al., 2005). Studies looking at women's perspectives indicate a perception that outreach centre staff were more likely to listen, were more trustworthy (with respect to patient confidence), and more likely to believe what they were being told. In this way, they are well suited to facilitating access to respectful health care for marginalized women.

Location is important. Location of mainstream, primary health care facilities has been identified by numerous subjects, in numerous studies, as a significant barrier to health care access. The strategic location of outreach centres is considered crucial to their ability to connect with at-risk populations, which means that many are mobile, and situated in areas

where women who are injection drug users or sex trade workers are likely to congregate, or are otherwise hard to reach.

With respect to issues of location, Rowe (2004) examined the feasibility of incorporating the Australian Needle and Syringe Program into primary health care clinics in Australia as a way of reducing the obstacles faced by street-based injection drug users. Rowe recommended these exchange programs be linked with primary health services in some way to reduce current accessibility and attitudinal barriers. Similarly, Islam et al. (2012) proposed that needle exchange programs should incorporate primary health care services as a way to improve health outcomes and reducing health care expenditure.

Otherwise, studies generally emphasized that the location of services offering primary health care for marginalized women should be within walking distance, given difficulties with access to transportation. Rowe (2004) noted that this was especially important for women in sex trade work, given the risk of losing business during time away from the street, especially if opening hours are unfavourable. Rowe's study also found that women in the sex trade would continue to work even after being assaulted. He cited one woman who explained that she would cover her bruises with make-up, and would not seek health care for risk of losing business.

The preferred service. A number of studies highlighted the fact that marginalized populations prefer to deal with outreach centers, for all of the reasons outlined above. Islam et al. (2012) specified that marginalized populations want their health care provided in outreach settings, given the emphasis on harm reduction and the increased likelihood of being treated without judgment, with greater respect, and less stigmatization. Jozaghi and Andresen (2013) showed that outreach facilities are also often seen as community centers, which foster a "sense of belonging… we actually feel like we exist" (p. 7).

Jozaghi and Andresen (2013), in their consideration of Vancouver's supervised injection facility, InSite, found that this facility provides participants with both a personal sense of empowerment, and the sense that they are empowered to help others. They note that many participants who experienced the "transformative power" of this facility expressed a desire for a change within their own community. They cite examples of participants taking boxes of syringes, water, and alcohol wipes from the InSite location out to Surrey, which has no such facility in place.

In summary, outreach services have been shown to improve the lives of many marginalized women at different stages of their lives. Whether services are provided during pregnancy, or after giving birth, or while actively using substances, outreach services clearly provide a means of entry to health care services and improved health outcomes for marginalized adult women.

CHAPTER FIVE

Discussion

The goal for this review was to uncover the role of the NP in outreach services and how they can facilitate access to health care for marginalized women in British Columbia. Due to the lack of research available, different dimensions of literature were examined using 18 studies and resulted in the themes and subthemes outlined in Figure 2 above. This section will synthesize the major themes that were identified to uncover how NPs can mitigate the issues using a wider body of literature to ensure a greater depth of knowledge is achieved. The process will be presented under the broader context of implications for practice, research, and education. Recommendations for NPs will be discussed throughout this section.

Identifying research gaps through this literature review process and the complex method of uncovering the data for this review illustrates the potential to miss pertinent information. This was illustrated when large amounts of literature were narrowed down to Canada and the USA. During the final steps of the literature search process, hand picking reference lists of key papers, Australia was found to have a relevant article, and therefore excluding Australia can constitute a limitation to this review. Men also encounter marginalization and were often found in the literature; consequently 5 of the 18 studies included men and pose a limitation to the gender analysis offered in this paper, as the focus is women.

Implications for Practice

The roles of outreach centers in providing safe therapeutic environments where woman feel respected and valued as a person have consistently been shown in studies. The constellation of barriers and health care needs have been clearly portrayed within this paper and call upon NPs to address these health concerns for this population from a social justice

perspective. By unravelling the key findings that identified the barriers women experience in the health care system and the role of outreach centers in facilitating access will assist NPs to understand their specific role with this population and how they can further facilitate access to health care and reduces barriers. Nurse Practitioners are well positioned to care for this population and will undoubtedly come in contact with marginalized adult women in their practices, as it has been shown in this review women access care from multiple providers. On this account it is essential that NPs have increased knowledge regarding the barriers women experience in order to know how best to approach and care for this population. The role of NPs in outreach centers and how NPs can facilitate access for this population are interlaced, as you cannot look at one without also addressing the other, on that account they will be represented together in this section. The major themes derived from the findings are:

- How to deliver primary health care with a harm reduction philosophy.
- How to address fear, mistrust, discrimination, and stigmas.
- Providing care in the context of women's lived experiences.

How to Deliver Primary Health Care with a Harm Reduction Philosophy

Delivering health care to marginalized adult women in British Columbia requires providing care with a harm reduction philosophy to facilitate access to health care and resources. When health care is delivered to women that focuses on abstinence from drugs, alcohol, or sex trade work this is viewed as a form of judgement towards women and further oppresses this population and creates barriers. When outreach services operate from a model of harm reduction this inherently attracts women to the service, who then want to visit these resources again, as they do not feel judged or pressured to stop their high-risk lifestyles. It creates a therapeutic environment where women can be free to be who they are without hiding their greatest health risks. The literature reviewed consistently illustrated how women

would hide their high-risk lifestyles from their health care provider for fear of feeling shameful, being labeled, found out, judged (Goodman, 2006; Kurtz et al., 2005; Salmon et al., 2009), and embarrassed (Rowe, 2004). The act of women not being forthcoming or feeling safe to share with their health care providers is an area of significant concern from a health care perspective that must be overcome to support women in their greatest time of need and can be addressed by adopting a harm reduction philosophy. When health care providers are unaware of the women's greatest needs it hinders their ability to receive comprehensive health care services and essentially creates barriers for women to access resources when they are ready to. Women need to feel they can disclose any issues to their health care provider and not be judged for doing so. This can be accomplished by supporting women while they remain active in their high-risk lifestyle while providing health care services. Women who abuse substances and work in the sex trade have been found to have lower inhibitions creating greater risks for blood borne illnesses and ill health demonstrating the profound need to adopt a harm reduction philosophy to promote health and prevent illness. This form of caring demonstrates respect for autonomy and has been proven in the wider literature to reduce the women's drug and alcohol consumption: notably also improving the women's housing situation from being homeless to living in homes or apartments (Bowser, Ryan, Smith, & Lockett, 2008). Harm reduction fosters a low threshold of support by helping women while they remain active in their high-risk lifestyle and focuses on engaging with women to minimize harm (British Columbia Harm Reduction Strategies and Services [HRSS], 2011). Remaining active in their addiction or sex trade work is supported in the wider literature that illustrates the importance of not trying to fix marginalized populations but rather reduce the harm from their lifestyle choices and in turn, you will increase their access to services (Pauly, 2008). Supporting women while they remain

active in their high-risk lifestyle while attending to their health care needs will reduce their barriers to accessing services, establishes contact with the women, and facilitates an environment where the women do not need to hide their risks or needs. Harm reduction philosophy is imperative to adopt not just for NPs in outreach centers but in all health care practices. Therefore when marginalized women chose to seek health care in settings outside outreach they do not have a sense of being inferior as a result of feeling shameful, judged, and embarrassed.

Harm reduction philosophy is a theoretical perspective on how to offer care for marginalized populations and can be incorporated in any NP practice. Harm reduction philosophy encompasses patient-centered care and "respects the right of individuals to address their immediate concerns and to set goals that are meaningful and realistic for them" (Non-Prescription Needle Use Initiative [NPNU], p. 25, 2007). Using a harm reduction approach to care does not look at the outcomes of care delivered but rather the process itself, health care providers assist people throughout this process but it is up to the patient how they arrive at their outcomes (NPNU). These are the key variables that are inherent in one's practice when a harm reduction philosophy is used: (a) make sure support is accessible; (b) get to know the patient and provide care for the whole person; (c) draw attention to what the person does well and do not focus on the behaviour but rather the person; (d) establish trust with the person by listening and be attentive for teachable moments; (e) assist the person to make realistic changes; (f) educate and share medical knowledge with the individual; and (g) identify the source of the patient's health illness (NPNU). When NPs incorporate these variables within their primary care practice they adopt a harm reduction philosophy that inevitably increases access to health care for women and demonstrates how NPs in outreach centers should function. The cycle of harm reduction illustrated in Figure 3 below

demonstrates the importance of all variables being present to foster a harm reduction philosophy.

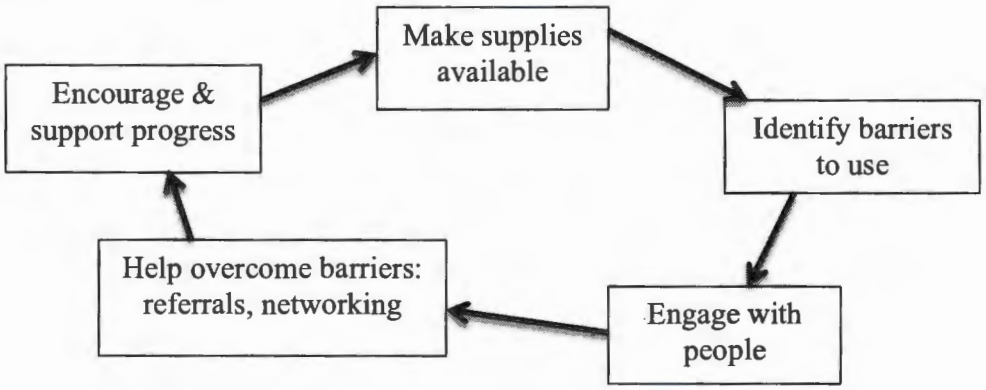

Figure 3. Harm reduction continuum/cycle. Adapted from the "*Harm Reduction Training Manual*," (BC Harm Reduction Strategies and Services, 2011, p. 21).

Engagement with the person is essential to increase access to resources, as illustrated in the figure above, it helps to link women to services and allows for relationships to be established, when women are ready they can access services with greater ease and minimal barriers. Engagement allows NPs to provide health promotion and illness prevention strategies such as dispensing harm reduction supplies. Harm reduction is an essential ideology to facilitating access to health care but it does not address the underlying social circumstances that are creating inequities, such as housing, homelessness, and poverty (British Columbia Centre of Excellence for Women's Health, 2010; Pauly, 2008). Therefore NPs need to also consider how to support marginalized women in the context of their lived experiences.

Table 8

How to Deliver Primary Health Care with a Harm Reduction Philosophy

Recommendations for NPs	Solution/Action to be taken
Ensure harm reduction philosophy is a priority in your practice to facilitate access for marginalized women (Pauly, 2008).	
Use the 7 constituents below to ensure harm reduction is inherent in your practice setting (NPNU, 2007).	
1. Ensure support is accessible to the patients.	▪ Offer services where women gather, in outreach centers, drop-in centers, churches, shelters, homeless camps, or/and in health care settings.
2. Support the whole person and get to know them.	▪ Engage with the person, ask them about their living arrangements, relationships, daily needs, where they work, how their feeling, and determine how they cope. ▪ Ask them what they need help with. ▪ Ask them if they have any questions. ▪ Do not promote abstinence of their high-risk lifestyle rather foster a low threshold services approach and try to reduce their harm (HRSS, 2011).
3. Draw attention to what the person does well and do not focus on the behaviour but rather the person.	▪ Understand the person is in charge of the changes in their lives. ▪ The NP is there to provide education and support; the patient is the driver of their health care. ▪ Do not use judgemental language. ▪ Understand marginalized populations rely on their gut instinct to survive, be kind, genuine, and be highly aware of your demeanour.
4. Establish trust with the person by listening; be attentive for teachable moments.	▪ Bring awareness to the patient's risks without displaying judgement. ▪ Listen attentively to their stories and be genuine in your response. ▪ Offer pamphlets on how to inject with less risk when they collect needles or any form of education that is easy to follow and straight forward. Offer handouts on how to reduce risks, such as the ones in Appendix B and C for women in the sex trade (Rekart, 2005).
5. Assist the person to make realistic changes.	▪ Address the person's top concerns as well as one step further, if they are there for an abscess, talk about how to obtain clean needles.
6. Educate and share medical knowledge with the individual.	▪ How to inject drugs properly. ▪ The importance of condom use and how to use. ▪ What to do if others need help, such as if their friend stops breathing.
7. Identify the source of the patient's health illness.	▪ Connect them to appropriate services, for instance if they were sexually assaulted as a child, refer them for counselling when ready.

How to Address Fear, Mistrust, Discrimination, and Stigmas

Women have extensive histories of enduring discrimination and stigmas due to their lifestyles, appearance, and behaviours when they access the health care system in Canada. As a result of being treated with disrespect, judged, and labeled women keep their high-risk lifestyle a secret, become isolated, and fear and mistrust develops towards the health care system and/or the providers within it. The literature has described how women will often wait to access health care services until their health has deteriorated and they require emergency care: where there are often barriers and is not an ideal place to receive adequate primary health care services. Women often lack care that is patient-centered as demonstrated by women explaining their health care providers were dominating and their health complaints were assumed to be related to their drug abuse and not investigated as a result (Goodman, 2006). The value of therapeutic relationships has been demonstrated in the wider literature to attract patients and increase access to care (Pohl et al., 2007). This review clearly describes how NPs play a key role in addressing the barriers women experience in the health care system. Overcoming these barriers begins with the NP reflecting on how they currently treat marginalized women in their practice settings to ensure they are creating a safe environment for women to access health care. Also NPs can help women overcome fears and mistrust as a result of stigmas and discrimination by establishing therapeutic relationships with women and encompassing a person-centered care philosophy in their practice.

Establishing a therapeutic relationship with women. Establishing therapeutic relationships requires an in-depth consideration of what components are required to build relationships. Tarlier (2004) illustrates the importance of nurses having relationships with patients that are built on respect, trust, and mutuality to improve patient outcomes. *Respect* includes being honest, generous, and selfless and is considered a prerequisite to formulating

trust within a relationship (Tarlier, 2004). Browne's (1995) study found respect was an essential component to providing care and disrespectful treatment was associated with discrimination and prejudice. Browne's study conceptualized respect with six characteristic: treating people as equal and worthy; accepting of others and their choices even if we do not agree; a desire to actively listen to patients; sincere attempts to understand a person's lived experiences; ensuring the patient is provided with adequate information to make decisions regarding their health care issues; and displaying honesty, which can be portrayed through one's demeanour and actions. By examining the key variables that conceptualize respect it becomes apparent marginalized women who are represented throughout this review experience profound amounts of disrespect in the health care system. Therefore if NPs are to provide respect for marginalized women they need to consider all the above key variables that define respect and foster them within their practice.

Trust is the second component to establishing a therapeutic relationship and has been found in the wider literature to be one of the key roles nurses encompass when working with marginalized populations (Hilton, Thompson, Moore-Dempsey, & Hutinson, 2001). Hilton et al. (2001) found trust encompassed displaying a nonjudgmental attitude, remaining open, and not intimidating to ensure the patient feels respected and accepted for whom they are.

Mutuality was the third aspect to foster when establishing therapeutic relationships; this encompasses a two-way avenue of trust and respect between two people, an iterative process (Tarlier, 2004). Establishing therapeutic relationships with marginalized adult women is imperative to overcome the mistrust and fear that has developed as a result of discrimination and stigmas they experience. The role of NPs in all practice settings needs to encompass respect, trust, and mutuality within their relationships with marginalized adult women if they want to facilitate access to health care for this population.

Encompassing a person-centered care philosophy in practice. Person-centered care allows NPs to understand the significance of women being the center of care. In this section a framework will be offered to provide a systematic approach to improve the way care is delivered to marginalized adult women. This framework is adopted from McCance, McCormack, and Dewing (2011) and can be seen in Appendix D. The concept of person-centeredness is important to foster as it looks at creating a therapeutic environment not just for the patient and the health care provider but also impacts relationships between staff and the ability to produce effective outcomes for patients (McCance et al., 2011). Having a therapeutic environment for women that is safe has been found in this review to be essential to increasing access to services for women.

Person-centered philosophy moves away from the medical model and focuses on holistic care, collaboration, and is relationship centered (McCance et al., 2011). Person-centered care is composed of four overarching concepts and due to the length of this paper a brief synopsis of key points will be provided here: *prerequisites*, which encourages the health care provider to reflect on themselves; *the care environment* looks at how and where care is delivered, the staff's relationships, and collaboration; *person centered approaches* allows us to see the importance in delivering care in a variety of ways such as holistic care and sympathetic presence; and *the person-centered outcome*, which tells us the effectiveness of this process by measuring patient satisfaction (McCance et al., 2011). This review has clearly demonstrated the current way care is being provided to women who are marginalized is still creating barriers to woman accessing primary health care services. In fact, it is affecting and worsening their health outcomes. This review urges NPs to adopt a person-centered approach to caring in all practice settings to ensure the patient is in the center of our focus.

Table 9

How to Address Fear, Mistrust, Discrimination, and Stigmas

Recommendations for Primary Health Care Providers	Solution/Action to be taken
Establishing a therapeutic relationship with women.	▪ *Demonstrate respect:* introduce yourself and wear a name tag so patients know who you are; ask patients what name they would like to be called by; ensure you obtain consent prior to physical examinations and only expose the body part that needs to be assessed; engage with patients that demonstrates your desire to listen and understand their needs (Sheldon, n.d.). ▪ *Build trust:* listen to your patients; allow them to feel cared for and heard; be honest and constant with the care that is being provided; treat the patient with respect; have an open mind and accept all the information the patient provides you with; allow them to be comfortable in sharing anything with you; and be dependable, if you say you will do something, do it (Sheldon, n.d.).
Encompassing a person-centered care philosophy in practice.	▪ Examine your current practice to ensure you are using the four overarching concepts to foster a person-centered care approach (McCance et al., 2011). (See Appendix D for the framework) 1. *Prerequisites:* Critically reflect on your own values, your commitment to the job, and skills you bring. Are you able to do the job well? 2. *The care environment:* Is your environment safe for marginalized adult women, do you have a good variety of skill-mix in your place of work, do you foster shared power with your patients? 3. *Care process:* Do you provide holistic care, do you engage with your patients, do you promote shared decision-making while working with the patient's own beliefs and values, and are you sympathetic to your patients? 4. *Person-centred outcomes:* Are your patients happy with the care they receive, are they involved in their care, do they achieve a sense of well-being with you, and did you create a therapeutic environment?

Providing Care in the Context of Women's Lived Experiences

Poverty, homelessness, substance abuse, violence, sex trade work, and many other contextual factors have been shown in this review to be a common concern among marginalized adult women. Being poor and having secure housing can be found at the root of many marginalized adults women's health problems (Kennedy et al., 2012) and can increase

barriers to health services (Hwang et al., 2009; Kubik et al., 2009; Shannon et al., 2006; Shannon et al., 2009; Teruya et al., 2010). This review has provided a greater understanding of women's experiences that have been affected by a variety of circumstances such as poverty and homelessness. Marginalized women will present to NPs at a variety of different stages in their lives, which may be seen as complex and overwhelming to the practitioner. This review has provided the context of women's lived experiences to inform the NPs and increase their knowledge base to be more equipped to provide safe competent care for this population. Women may present with multiple health concerns and it will be imperative that the NP understands the context of the women's experiences that will allow care to be tailored to the women's needs. For instance, knowing that basic physiological needs such as food, water, and shelter are considered women's priority at times over their health care needs informs NPs of their role in connecting women to services and engaging with women to understand and uncover what their needs are. How to provide care in the context of women's lives will entail providing primary health care through outreach centers and creating a person-centered treatment plan.

Provide primary health care through outreach services. The practice setting in which health care services are delivered to women can influence how care is received and delivered. This has significant practice implications as studies have found that outreach services can be the first contact marginalized women have with the health care system (Butters & Erickson, 2003; Boeri et al., 2011). A major finding of this review is that marginalized adult women prefer accessing resources from outreach centers and accordingly should have primary health care services offered in these practice settings. The broader literature themes support the notion that to overcome barriers to access for health care services, care needs to be delivered where marginalized populations convene (Pfeil & Howe, 2004). These non-traditional

service delivery options are desirable for women and where they want to receive care (Whitzman, 2009). This review has shown marginalized adult women lead chaotic lives as a result of street life and at times do not know what their health care needs are. Due to these circumstances it is vital to offer health care services to women in locations where they access basic supports such as phones, water, and food to engage with them to determine if there is anything they need, to offer a physical place where they are able to come to their own realization of their needs. Having NPs in outreach centers allows women to be reconnected to primary health care services where they can become stabilized to move to the next steps in improving their lives. For these reasons NPs who use the philosophical perspective of social justice to inform their approach to care can best provide primary health care services where the women prefer to access care – in outreach centers.

Nurse Practitioners identify gaps within services such as the lack of a primary health care provider noted at the Warm Zone in Abbotsford and consequently are obligated to mitigate these issues to ensure social equality and address barriers to health care services. These forms of service delivery can assist in reducing barriers to accessing health care and allows NPs to engage with women who are clearly in need of health services and establishing relationships. Meeting and facilitating the needs of marginalized adult women will require offering primary health care in outreach centers and NPs are well positioned to do this.

Create a person-centered treatment plan. When NPs provide care to women in outreach centers it will be essential to formulate a person-centered treatment plan that focuses on the woman and her specific individual needs. In order for this to occur women must first be engaged with the center, whether women are brought into the center by outreach workers, street nurses, or community partners a multidisciplinary approach will be required to reach out and care for women (Zweig et al., 2002). Once women have made a connection the goal

should to be to increase women's health literacy that will allow them to be reconnected back into the primary care setting. The wider literature concurs that outreach needs to engage with women to increase their knowledge surrounding health care issues (Mikkonen, Kauppinen, Huovinen, & Aalto, 2007). This can be done by establishing therapeutic relationships that foster a harm reduction philosophy that allows women to feel safe and valued when they do access health care services. The importance of offering health care that has low-barriers, as evidenced by the significance of using a harm reduction philosophy in practice, has been clearly articulated in this review. Low-barrier model of care is defined by reaching the most vulnerable people in need, whether mentally ill or with addiction problems and aims to ensure access, safety, and engagement with this population (Gilmore, nd.). When NPs provide low-barrier care they offer services to women at all stage of their lives without barriers. Once women are engaged and connected to outreach centers it will be imperative for NPs to maintain this relationship, which can be accomplished with a person-centered treatment plan.

Nurse Practitioners can formulate a person-centered treatment plan by first obtaining a greater understanding of the context of the woman's experiences. This can occur with effective communication and relationships with women. Also after reading this review NPs will be more informed of a perspective that is not well understood– the context of women's experiences in order for NPs to provide effective care. The importance of considering a woman's context in order to provide effective care is clearly supported in the wider literature. For instance, if practitioners focus on the woman's issue alone, such as addiction, rather than the woman in her actual situation this ignores the woman's contextual factors and consequently further marginalizes her (Smyth, Goodman, & Glenn, 2006). Equally important if practitioners fail to "understand a woman in a comprehensive, contextual way [it] may

actually undermine the long-term success of the intervention and the woman herself (Smyth et al., 2006, p. 490). When practitioners do not consider the woman's context related to her presenting complaint or issue this disempowers her and she experiences a loss of control. For instance "a woman must choose between a version of herself that trims away aspects of her situation deeply interwoven with the 'presenting problem' or risk losing services" (Smyth et al., 2006 p. 493). In order for women to receive care that is meaningful to them practitioners need to use strategies that tailor care to the context of their patient's lives by considering their demographic, cultural, social, and gender influences (Browne et al., 2012). If NPs formulate a person-centered treatment plan with special consideration of the woman's contextual factors this will empower the woman to tell her story, allow the woman to gain a sense of control, and ultimately will facilitate access to health services.

Nurse Practitioners are a gateway to services and can be seen as care coordinators that facilitate access to a range of services to help minimize barriers to health care (Pohl et al., 2007). This means NPs must be acutely aware of the resources available for women and to ensure those resources are able to meet the women's needs as this review has shown women expect poor care as a result of being referred to resources that are poorly delivered, inappropriate, or further marginalizes them. By connecting with women and getting to know the context of their lived experiences: NPs will be able to work with the women to formulate individual treatment plans that will assist and connect women to the appropriate resources. For instance, NPs can ensure women have registered for Fair PharmaCare and are enrolled with Medical Services Plan to avoid the barriers associated with having no identification or the lack of money to pay for basic necessities such as medications. Nurse Practitioners can assist women in ensuring they apply for social assistance to have basic housing and assist women to get off the streets to prevent the ill effects of unstable housing or homelessness.

Nurse Practitioners work alongside women preparing them for the next steps in obtaining services, providing a platform where women can build skills that can improve their health and well-being. Nursing from a feminist perspective allows NPs to consider how unique women are and that they may need a wide-range of services to improve their health and guide them on the journey of healing (Fontenot & Fantasia, 2010). It is imperative that women do not become dependent on the NP but rather an environment is created for women so they can come to realize their own needs with the support of the NP. Nurse Practitioners provide different options for women and stand beside them helping them decide which path is best for that women in that specific time in her life. Creating a person-centered treatment plan will be different for every woman as it will originate from the context of her own life experiences, it will reflect a harm reduction philosophy, and will reflect the woman's individual needs.

Many marginalized women have endured a life of violence, which when viewed through a feminist lens the NP is informed of the value of empowering women. Empowering women begins by providing women with tools to regain control and this can be done with sharing of knowledge that will assist women to make decisions, however, knowledge alone will not ascertain the women's ability to manage her health as her contextual circumstances will also strongly influence her ability to make decisions (Anderson, 1996). Nurse Practitioners can further empower women by assisting them to identify their strengths and weaknesses or challenges to enhance their problem solving abilities (Trasher, 2002). Empowering women also entails actively involving them in their care plan, which will shift the power imbalance back to the women (Fontenot & Fantasia, 2010). Fontenot and Fantasia further explain by directly and purposefully involving women in their care plans, women will be encourage to reclaim some of the power and control they have lost through violence. When NPs empower women by actively engaging them in their care this will also flatten the

sense of hierarchy, which has been shown to be a barrier, as women often feel intimidated and dominated by their health care providers (Goodman, 2006; Rowe, 2004; Woolhouse et al., 2004). Acts of paternalism has been shown in this review to produce unrealistic care plans and resulted in women having to access services from multiple providers to obtain the care they need. The role of the NP is informed by the woman's life experiences, and the NP is able to develop a plan of care that takes into account the woman's perspective without taking on the power position, the NP's goal is to return power and give the woman a voice in her care. This is a delicate balance that requires the NP to frame the care questions in a way that the woman can make decisions without making the woman feel she is being abandoned or overwhelmed with decisions she does not feel equipped to make.

Table 10

Providing Care in the Context of Women's Lived Experiences

Recommendations for NPs	**Solution/Action to be taken**
▪ Create a person-centered treatment plan.	▪ *Engage with women*: reconnect women back into the primary care setting and increase their health literacy. Tailor services to their specific circumstance considering all contextual factors. ▪ Allow women to tell the whole story surrounding their issues. ▪ Establishing therapeutic relationships prior to routine invasive examinations. ▪ If women have a history of being sexually abused or violence offer multiple choices to allow women to regain control. For instance offer to perform a gynaecological exam without using the foot rests, offer different positions that do not allow women to feel vulnerable. Ensure she is covered at all times, go slowly talking in a soft tone informing her of all your steps so she is not surprised by your actions, using gentle touch pausing at times and asking how she is doing. And ensure the woman knows the process can be stopped at any time. ▪ Consider all domains of health when caring for women: mental, physical, spiritual, cultural, social, and emotional. ▪ Sit at eye level, do not be rushed and ask how you can help them. ▪ *Use a multidisciplinary approach* to ensure women have access to all the care they need; work with community partners – you will not be able to do it alone. ▪ Connect women to resources that are accessible, low-barrier, and

Recommendations for NPs	Solution/Action to be taken
	trusted; know the resource you are referring the woman to. ▪ *Empower women:* encourage women to ask questions, let the patient help formulate the treatment plans and ask her if it is doable and realistic for her (Alexander, 2009). ▪ Educate women about where they can find information on their own such as Internet, support books (Alexander), and libraries (Anderson, 1996). ▪ Offer positive feedback when women engage in their care by asking questions (Alexander, 2009). ▪ Assist women to register with Medical Services Plan, Fair PharmaCare, and income assistance if not already done. ▪ *Flatten Hierarchy:* sit with woman at eye level, encourage questions, encourage stories, actively involve women in their care, and be acutely aware of your tone, demeanour, and facial expressions. ▪ Critically reflect on power relationships within the center among staff and how patients are treated (Browne et al., 2012).

Implications for Research

Through a rigorous process of uncovering literature, I did not find any research that described the role of NPs in outreach centers during this review. For this reason further research needs to be done that examines the role of the NP in working in outreach centers with marginalized adult women. Also further research needs to evaluate the value of NPs in providing services to this population. The wider literature has a vast amount of research that focuses on the needs and ill health of this population. The focus for NPs should be on how NPs can help to mitigate these issues. As clearly portrayed within this review, marginalized women are in dire need of effective health care, if research confirmed the significance of NPs in outreach centers, marginalized women would have increased access to NPs.

There are many dimensions to consider when discussing women's health care needs, but due to the scope of this paper, marginalized adult women who are pregnant and/or mothers was not discussed here and due to the significant role of mothering and pregnancy that can further create health care concerns for this population further research is warranted.

The specialized needs of this population are apparent by an outreach center in Vancouver, Sheway, dedicating its entire services to pregnant and/or new mothers who partake in high-risk lifestyles.

This review made reference on the fear women experience when police are present in locations that offer outreach services and as a result push women deeper into unsafe geographical locations and circumstances. Due to the added risks associated with this more research is warranted to overcome this negative correlation.

The scope of this paper did not address the added stigmas associated with marginalized women with mental health illnesses or the increased health risks that accompany women who are older and consequently require further investigation. And finally further inquiry is required to examine what specific services and programs women require in outreach centers, such as the role of conducting a needs assessment, program evaluations, and how to submit a proposal to obtain funding for NP implementation into outreach centers that currently have no health care providers.

Implications for Education

Nurse Practitioners who work in outreach centers need to be aware of the resources for assisting them in providing quality care for marginalized populations. In British Columbia HRSS (2011) have put forth a harm reduction training manual, which includes extensive literature for NPs as well as handouts that can be printed for patients that provide a variety of education activities such as: vein and abscess care, how to correctly use drug supplies, information on different immunizations, STIs, and much more.

This review has demonstrated that Aboriginal women represent a large group of high-risk population in British Columbia and illustrates the importance for NPs to increase their cultural awareness to further understand the history and lived experiences of this population.

Nurse Practitioners have an obligation to maintain competencies and continue to enhance their knowledge to meet the needs and competencies of their standards and ultimately to provide quality health care to patients. In British Columbia NPs can achieve cultural awareness by enrolling in the Indigenous Cultural Competency Training Program (Provincial Health Services Authorities, 2014). Also educators within all nursing programs should be providing cultural awareness within their curriculum to produce culturally competent NPs (Canadian Nurses Association, 2010b). The University of Northern British Columbia is an example of this by their NP program focusing on Aboriginal populations. The importance of including Aboriginal people in both educational curriculum and policy making to produce effective and safe health care is clearly supported in the literature (Kurtz et al., 2008). Nurse Practitioners have the skills to understand patients at different stages in their lives and what is important to them by listening to stories and learning about cultural practices that are significant to their patients. Doing so will create a platform that acknowledges the important role culture has in health and well-being.

Discrimination and stigmas are a significant area of great concern within this review. Ways to reconcile these issues will be with education, for instance this paper will provide a greater depth of knowledge for the reader to the extent discrimination and stigmas have on marginalized women's lives and the importance of reflecting on one's own practice to remove these negative behaviours and attitudes. Nurse Practitioners must be aware of their own personal views in order to provide safe care without personal judgment and stigmas (Canadian Nurses Association, 2008). Effective communication with patients is vital to promote positive therapeutic relationships in practice (Canadian Registered Nurses of British Columbia, 2013b). Marginalized women may assume health care providers will discriminate against them therefore it is imperative to take the time with women to build relationships,

demonstrate respect, remove these assumptions, and to start the process of regaining the women's trust.

Education is essential to overcome the barriers women encounter in the health care system, as it is often a lack of knowledge that leads people to misunderstand marginalized women. It is imperative NPs are aware of the vicious cycle that further oppresses women deeper into the trenches of marginalization as a result of the treatment they receive, such as women not wanting to disclose their greatest health risk – substance abuse or sex trade work. How can health care be delivered if the NPs do not know the risks associated with their patient's life-style?

Limitations

The focus for this integrative literature review was to examine the role of the NP in outreach centers in British Columbia and how they can facilitate access to health care. Due to the dearth of evidence that examines the NP in these practice settings this is seen as a limitation and calls for more research to be conducted with a focus on the NP. Also due to this population's complexities such as substance abuse, their lack of trust in health care providers, and the difficulties associated with locating some hard to reach women, some women may not be represented in this paper and needs to be considered.

Some of the studies had small sample sizes, which can be a limitation but as these studies were qualitative they were used in this review and considered valuable. Due to the complex nature of this topic it is hard to generalize specific findings to all marginalized women, as previously discussed, not all marginalized women are alike and highlights the need to provide individualized health care for this population. This review used 14 studies from urban centers and 2 from rural settings, which described the experiences of marginalized women living in urban/suburban centers, consequently a limitation in this

review is the emphasis on urban settings and therefore the findings cannot be generalized to rural marginalized women. More research is needed when caring for women who live in rural settings to determine how their experiences are similar to or different from marginalized women in the urban context.

Conclusion

The purpose of this paper has been to investigate the role of NPs in outreach centers and how they can facilitate access for marginalized adult women in British Columbia. While marginalized adult women constitute a population in great need of quality health care, they often fall far behind in the quality they receive. Their access to health care is affected by a constellation of barriers that further marginalize and compromise their health and well-being. This review uncovered how NPs can approach this population to ensure they facilitate access to quality health care and overcome both structural and individual barriers. Outreach centers are a platform in which NPs can engage, reconnect, and establish therapeutic relationships to rebuild trust with women. Nurse Practitioners practice encompasses holistic care as a foundational quality inherent in their profession with the added benefit of medical management (British Columbia Nurse Practitioner Association, 2014; Canadian Nurses Association, 2010a). Using a feminist perspective the role of NPs in outreach centers is informed by the lived experiences of women, meaning the NP's role with each woman will vary and will be tailored based on the woman's contextual factors and needs. This review has provided the NP with an understanding of the context of women's lives in order for NPs to identify the wide-range of services required to support marginalized adult women. Nurse Practitioners facilitate access to health care for women by adopting a harm reduction philosophy, establishing therapeutic relationships that are built on respect and trust that are mutual, and formulating treatment plans and care that are specific to what women want and

need help with. Nurse Practitioners have an opportunity to empower marginalized adult women to build skills and use tools to bring them to the next steps in regaining control in their lives while being supported to navigate the complex health care system. Nurse Practitioners encourage women to be actively involved in their care to shift the power balance back to the women, to provide a space where women's voices are heard and fear and mistrust as a result of discrimination and stigmas can be reduced. Nurse Practitioners should be implemented in outreach services in British Columbia to help better align the overarching goal of increasing access to primary health care for the most vulnerable population in our society. It is time to give the women their voices back; Nurse Practitioners can help.

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Appendix A

Level of Evidence/Literature Review Matrix

Level 1: Evidence for a systematic review or meta-analysis of randomized controlled trials (RCTs) or Evidence informed clinical practice guidelines based on systematic reviews.
Level 2: Evidence from a well-designed RCT.
Level 3: Evidence from a controlled trial without randomization (quasi-experimental study)
Level 4: Evidence from single non-experimental studies – case-control, correlational, cohort studies.
Level 5: Evidence from systematic reviews of descriptive and qualitative studies
Level 6: Evidence from single descriptive or qualitative study
Level 7: Evidence from the opinion of authorities and/or reports of experts committees

Note. *Adapted* from "Chapter 3: Critical reading strategies: Overview of the research process," by G. LoBiondo-Wood., J. Harber., C. Cameron., and M. Singh, 2013, *In Nursing research in Canada: Methods, critical appraisal, and utilization,* p. 48-64.

Studies Addressing Health Care Access and Barriers

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
Boeri et al. (2011) USA	6 Qualitative 2-year study. Snowball and theoretical sampling Participant observation Face to face interviews Focus groups Women were provided with resources and health	To identify the health care needs and service barriers for marginalized suburban women who abuse methampheta mine. The long-term goal is to provide services to this population to prevent harm, transmission of disease, and violence.	n = 31 Female > 18 years Used Meth. Involved 12 counties in southern USA. Interviews conducted in private location.	- Due to stigmas they deny drug use to HCPs and postpone seeking care. - Often referred to another agency for service, list of services is long. - Many of the women stated they used drugs to escape emotional trauma such as rape and abuse as a child. - Many used the ER for primary health care. ***Barriers:*** *Restrictions (by service agency):* - Identification requirements - Minimum fees for dental, psychological, and health care services (these are related to Medicaid). - Wait list for treatment, health care, shelters, dental service, & domestic violence shelters. - Service caps on the number of times you can use a service. - Blacklisted if criminal record or drug use, from food bank and shelters. *Limitations (women's personal limited resources):*	The barriers act as a vicious cycle that further subject the women to harm. - Need to educate ER staff regarding the needs of this population and connect them with social workers for further follow-up. - Remove lengthy wait times. - Remove stigmas - Prevention & intervention needs to occur in public health with experienced professionals. - Women should be offered treatment. - HCV patients should be followed for continued care. -Increased fiscal allocation to suburban settings.

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
	care then they were followed-up to determine the barriers they encounter.			- Lack of transportation - Having no phone number to leave a message. - Fear of government involvement such as drug tests at shelters for mom and child. Fear child taken away. ***Consequences to barriers:*** - Injuries not taken care of; violence: domestic issues; infectious disease	
Kurtz et al. (2005) USA	6 Mixed Method 2 year study Audiotape focus groups Snowball sampling Urine drug test to confirm criteria. 20$ incentive	To assess the health needs and the barriers to access for women in the sex trade.	n = 586 women Interviews and focus group Women 18 years and older Only 27.5% had health insurance (Medicaid)	***Barriers to health services:*** *Structural barriers:* - Availability of services. Program structure (hours or restriction: no drug use) - Social stigmas (poor hygiene & drug use). Women frequently hide their sex work from health care providers due to stigmas. - Transportation. Communication by staff - Legal requirements (ID to access health care) - Program target population (available to only certain populations) *Individual barriers:* - Awareness of service but do not seek help due to expecting social marginalization. - Drug use; disorientation due to drug use, unable to make decisions for self. - Fear of arrest. Appearance and dress - Generalized fear and anxiety - Mental/emotional stability - Minimal tolerance to wait	Need to bridge the gap with outreach services, training staff, & more research needed. Need to recognize some of these women do not know what they need. Know they have a significant level of distrust, fear, and loss of self-esteem due to social isolation and violence. Individual case management approach is suggested. Staffs need to be educated on how to care for this population. Empower these women to help them to navigate through the complex health care system.
Salmon et al. (2009) Van. BC	6 Mixed Method 2-year study Participatory action research 32 women from the study	To understand the inequalities & barrier's to health care for marginalized women in order to improve the primary health care experience for women of the DTES.	n = 150 Females > 20 years old 62% Aboriginal 3 died during the study (suicide, overdose,	**Women's primary health care experiences, what worked:** - Good listening skills from HCP. - Having a positive relationship with HCP. - Providing practical education. - Some women preferred women HCP. **Women's primary health care experiences that didn't work:** -39.6% stated when they ask for pain control from HCP but were denied. - 90% had issues accessing	- We need to understand that accessing multiple providers is a way they seek safety and care. - Provide adequate pain control to reduce harm. - Take concerns at face value; don't assume they are related to drug use. -Use former STWs or addicts as peer supporters. - Poor care delivered means increased harm for them. - Hire staffs that have non-

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
	developed the research design. 11 members were trained to be peer interviewers		health conditions, and violence).	medications needed. - 70% experience stigmas commonly in health care, and as a result avoid seeking care; poor treatment was expected. - Being disrespectful, judged, punished, refused care, condescending, or lacked concern. - Women's past experiences shaped future access to care. - Treated with disrespect. "Respect fosters respect" (p. 9). - Being known by provider both worked to decrease stigmas and increase access but sometimes it created refusal of care. - Some women hid drug use from HCP in order to not compromise health care. **How they use/view primary care services:** - Multiple care providers to have their needs met. Some did so to be 'known' in case they need care in the future. - Transportation was an issue. - 86% stated waiting was a large barrier to care, being shuffled around, or turned away after waiting. Waiting was viewed as punishment. 64% were refused care or services. - Dismissal of their symptoms and being told its related to drug use. - Being handled roughly by HCP; this further enhanced their feelings of being violated in the health care system. - Women felt they were ill equipped to deal with their health care due to a lack of information provided by the HCP. - Women withheld their sex trade work from their HCP to avoid judgment. - Need to know the inequalities arise from social, political, and economical interplay.	judgmental attitudes and their beliefs match the needs of these women. - Address the long wait times by improving their experience while they wait. - Have bookable appointments available if women want this option. - Triage according to the need. - Be non-judgmental. - Provide more women HCPs.
Kurtz et al. (2008) Okanaga	6 Qualitative Participato	To uncover the barriers faced by Aboriginal women when	N=13 Females	**Barriers encountered:** - Stigmas, some women were seen as unfit mothers and feared HCP would take their children away.	How to overcome these barriers: - Provide culture education for HCP. - Allow more time with

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
n BC	ry study	they access the health care system.		- Discrimination: feeling judged just by being Aboriginal. Assumptions that they were drunks. - Communication Barriers: Many women do not feel listened too, and are told it is 'all in their heads'. They feel ignored when they have a complaint. -Many women would consult family members first to ensure there health care concern was valid before they made an apt to have it addressed. - Many women seek Aboriginal providers for these reasons. - These barriers to communication mentioned above are seen as structural violence.	patients to be able to hear their story. -Provide more primary health care services other then walk-in-clinics or ER. - Treat all people equal, despite their race. - Listen with ears and heart. -Women are often the providers of child and this can impact the children's health care, awareness needs to happen for many reasons. -HCPs must create an environment where women can be heard. -Ask about culture preferences. - Educational curriculums should encompass cultural education. -Aboriginal people should be involved in this policy processes.
Woolho use et al., 2004 Toronto	6 Qualitative study 5 focus groups	To examine the health care experiences of women who are poor & abused when they access care from their doctor.	N = 30 Females Average age 34.5	**Barriers experienced:** *Power imbalance within the relationship between the patient and physician:* discrimination, they provided suboptimal care, demeaning to the patient; the doctor was paternalistic, dominating, and intimidating. Patients felt rushed, as though their concerns were not important, which further marginalized the women. Not listened to. Questions not answered. Felt unsupported. **What worked:** *Positive collaborative relationships and the outcomes:* Took time to listen, invitation to ask questions, provider was empathetic, had a trusting relationship, long-standing relationship increased trust. Having these relationships resulted in the following: improved health-promoting and preventative behaviours; patients advocated for themselves; even if transportation barriers were present women still made apt and	Women need to be asked directly what their health care needs are, there fears, and expectations of their relationship with their care provider. Treating the women as a collaborative member of the team in their care is paramount. If women feel supported, have trust in their provider, and involved in their care they are more likely to have continuity of care. If the relationship is good, women will overcome other barriers to maintain that relationship. Management plans must be individualistic and must incorporate the context of the patient's lives. HCP must advocate for their patients, such as filling out paperwork for housing or writing to child societies to explain the patient's efforts in meeting the child's needs

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
				sought routine encounters; felt safe to take the providers advice; women felt they could express their concerns to their provider. Having good relationships with providers is related to the patients improved ability to articulate them.	during challenging times. Support and empower the patient. Need to find a common ground with the patient.
Lazarus et al., 2012 Van. BC	4 Quantitative Open prospective cohort study 2 year study	To assess the how stigmas associated with sex trade work are associated to barriers to accessing health care.	n=252 Adult Females > 25 years old	**Barriers to access:** Barriers defined: long wait times; poor care by health care provider; language barrier; not knowing what services are available to them; limited hours of service available; & unable to have health care provider who is female. -55.9% of women experienced stigmas related to their work. They hid their jobs from family, communities, and friends. -If women hide sex work due to stigmas they were more likely to experience barriers & poor access to health care. -If women worked in alleys and industrial areas they were more likely to experience barriers. -If the women had accessed the ER or had a higher level of education they were more likely to face barriers to accessing health care services. -Being pressured into unprotected sex and a history of violence was related to increased barriers to services.	**What can be done:** -Political shift needs to occur to legalize sex work- this would improve health, safety & decrease stigmas. -Peer based models that allow women to disclose their work to friends and families. Need to involve the women when formulating targeted approaches to increase access for this population. -Urgent need to have innovative access with non-judgemental health services for this population. -Flexible hours for services. -Use empowerment models.
Zweig et al., 2002 USA	6 Qualitative study	Examines the services provided to women who are marginalized and face many barriers to accessing services and how to address these barriers.	n= 20 programs Interviewed the staff who work there Perspective from staff.	-Programs servicing marginalized women with many barriers (Sex trade work; substance abuse; incarcerated; cognitive delay; mental health issues). -Many of the programs that claim to care for marginalized women did not meet the basic inclusion criteria for this paper. **Barriers to access as noted from staff:** -Substance abuse, having lack of transportation, poverty, relying on abuser for money, lack of education, housing & employment issues. -Women who are battered have	**How to meet their needs & overcome the barriers:** -Advocate: Programs need to advocate for their patients, such as accessing services like legal & medical issues, getting them into treatment centers, mental health services, support groups, follow-up with clients, allow women into shelters who are active in addictions. -Outreach: Community education, develop community referral system with other agencies-have a

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
				limited services in community – re-victimized by services or lack thereof. -Women's credibility are questioned, women are blamed for their situation and not taken seriously. -Services providers are not educated for special issues and are unaware of the special concerns of these women. -When services are provided they address only one issue not all of them- having more issues to deal with makes it more difficult to provide services. -When women in sex trade report rape, the criminal justice system does very little for them. -If women are in sex trade some providers refuse to care for them due to being criminals. -Women with cognitive delay are considered to be poor witnesses and often do not understand what is happening to them or how to articulate their concerns. -If women abuse substance they are less likely to report sexual assaults. -Women who are incarcerated often past violence come out in-group sessions but there is no follow-up care for this. -Community barriers can be criminal justice system, health agencies, such as hospitals, shelters (due to strict policies), social services, mental and substance agencies due to insensitive and poor communication skills; lack of trust between agencies; and lack of training for staff.	network of support. -Advertise: flyers, posters, newspaper, TV & word of mouth. -Go out and approach women in sex trade, provide condoms, business cards, and let them know you care – you must go to them. -Training: Staff needs to be trained about the barriers women face and need to educate other agencies. -Collaboration: Need to collaborate with law enforcement both front line workers and agency leaders; other agencies that work with the women. Close collaboration is important for instance if a women in the sex trade is assaulted they could be examined and statement collected in the agency where the women feels safe not at the police station – this requires an agreement. Other important areas for collaboration: health agencies, substance treatment centers, mental health, social services, & other community services centers – must have a multi-disciplinary team approach. -Be persistent but patient; keep an open mind; have all agencies have a common goal; address all concerns for the women not just one; bring in trained staff; bring services to the women; believe the women when they tell you something; do not expect unrealistic things from the clients; tread lightly with other agencies you will need them (build trust); have creative teaching and training within the service; perform a needs assessment to determine the needs of the population.

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
Goodman, 2006 Toronto	6 Mixed Method Surveys and focus groups	To examine the experience for a person who uses crack cocaine when accessing health and social services to help determine how best to provide care and change policy.	n=108 49% female 44% Male 7% Transgender 16 years or greater Perspective from clients Data was broken down into gender at times	**Barriers encountered when accessing health care:** -Unable to afford medicines prescribed, refused services from HCP, transportation to appointments, discrimination & stigmas encountered. -Females had high levels of discrimination when involved in sex work. -The top five greatest barriers to health care access for females were in order of greatest barrier: discrimination due to drugs, no transportation, having no health care card, discrimination due to poverty, and having a negative experience in the past. -Other barrier identified by all groups: don't trust the HCP. -Impression that they are worthless, assumed to be a crack-whore if female, many negative words to describe how they think people see them. As result of this they feel a heightened sense of isolation, shame, alienated, depressed, angry, and secretive as a result. Major themes: discrimination & inaccessible services; attitudes from HCP and unfair access to medical services – they were denies services or made to wait because they were addicts. -HCP had a lack of knowledge about drug issues, demanded ID for service, lacked confidentiality, and services are not convenient. -Directions from HCP are too complex and hard to follow. -Fear of being "found out". -People wanted more choices in services such as harm reduction services. -HCP assume problems are r/t drugs. -HCP assume clients bring on their own troubles. -Major social barriers are police harassment, violence, homelessness, discrimination, & poverty.	**Recommendation from clients:** -How to improve their overall health: Increase access to health care, especially mobile services, where all services are at one place, more counsellors, access to food, have policy changed so that rent is paid directly by government agencies. -Want to be viewed as a person not an addict. -Do not assume the health problem is r/t crack use. -Remove discrimination. -Reduce violence and risk of violence. -Offer safe crack kits. -Harm reduction approach is the desired intervention. **Recommendation from researchers:** -Health care services need to work together. -Staff workers need extra training. -Substance abuse should not be viewed as criminal but a health illness. -Health services offered need to improve to enhance access, such as not requiring ID for service, and showing respect to the client. -Address mental health issues without further stigmatizing the client. -Harm reduction should be incorporated into all health care services. -Safer inhalation rooms without being arrested. -Prisons need harm reduction services as well. -More outreach and counselling needed. -Lack of housing needs to be addressed. -More research is needed. -Advocate for this population.

Author, date, & location	Level of Evidence	Study Purpose	Population	Key Findings	Recommendations
Butters & Erickson, 2003 Toronto	6 Mixed Method	Investigate the health care needs and experiences of women who use crack and work in the sex trade.	n= 30 Female 22-52 years old	**Barriers:** -Lack of health care card prevented them from receiving care. -Being judged by care providers as drug addicts. -In Ontario you need an address for a health care card. -ER labeling the women as drug addicts and refusing services. -Women blamed themselves for their poor health, not the system. Some stated their health was poor because they did not try to access the system. -Their drug use acted as a barrier.	**Women wanted more support with the following:** -mental health, such as counselling, 24 hour drop in centers, and 24 hour hot line staffed by former users. -Drop in centers can at times be the only interaction these women have with health care services.
Wardman et al., 2005 BC	6 Mixed method	Investigates the health care access, utilization, and barriers for Aboriginal population residing on and off reserves in BC.	n=267 7 different communities >20 years old Female 51% Male 49%	**Barriers to health care services:** -Did not know about services available to them. -Transportation was an issue. - Fear of racist treatment. -Fear their concerns would not be confidential. -Uncomfortable with health care setting. -Need to travel outside their community for care. **Access:** -86.1% felt they were able to access health care they needed except when they needed dental, mental health, and specialists. -45.3% had to travel for health care **Utilization:** -58.4% had a GP -22% used a walk-in-clinic -72% saw an Aboriginal provider	**Recommendations** -Create awareness of the available resources. Collaboration between health care providers and Aboriginal leaders. -Cultural training to staff to reduce stigmas and discrimination. -Increased services such as outreach, telehealth, and specialists to visit communities. -Cost of traveling can be a significant barrier to health care (people were paying for their traveling expenses when they were actually covered by the federal medical plans). There needs to be increased awareness regarding service plans. More research is needed to investigate funding for Aboriginal populations.

HCP = Health Care Providers

Studies Addressing Outreach and Facilitating Access to Health Care

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
Daiski (2005) Toronto Canada	6 Mixed Method Qualitative, descriptive, and exploratory. Semi-structured interviews and focus groups	Examines how effective nurses and staff are at meeting the needs of marginalized people using a health bus, what is working, what are the unmet needs, and how these can be improved. Perspective from people accessing the bus.	n = 58 Female (18) Male (39) Not specified (1) > 25 years old	**What does not work:** -Some people are waiting until their health illness is more acute to seek medical attention, which causes increased costs on systems and human suffering. -The disrespect & attitudes in mainstream health care was the biggest barrier to health care identified. -Second biggest barrier is lack of access to services and being more flexible in providing that services. - Staffs who work on the bus are unable to prescribe medications. **What worked:** - The clients did not have to go to ER for care. -Clients felt they were cared for with respect and dignity, having high quality care by professionals (nurses & support workers), and able to access care without barriers. -People accessed the Bus for: first aid, basic supplies such as shampoo, clean needles, over the counter medications, referrals such as dentists, harm reductions services. -This form of outreach allowed them to be cared for, known to someone, listened to, and someone to consult to verify if they needed to see a HCP. -Location of Bus was important to remove barriers. Bus "came to them". Evening and weekend access was important. -No health care card required. - Confidentiality and anonymity.	**From the clients:** -Mental health services need to be more available -More counselling for addiction by the staff - Triage pts according to their illness - Help with transportation when referring a pt, or have an NP or GP on site - More supplies to give out - Advertise about the Bus - Longer hours, more staff, more stops -Involve pts with regards to running the Bus. **From research findings:** - Trust between the pt and HCP is paramount -Need more intense medical services -HCP should not be blaming the pt for their circumstances -Peers counselling can be effective -Provide outreach services to improve access to mainstream services -need to address the health determinants, such as shelter, adequate welfare, wages etc.
Deering et al., 2011a Van. BC	4 Quantitative Prospective cohort study 18-month	Examined the use of a peer-led mobile outreach program and how this relationship shaped the use of addiction services.	n = 242 interviewed n=479 were observed All female > 14 years	-42.2% of the observed sample used the mobile van. -The women who used the van were more vulnerable; they were more likely to inject cocaine, have more than 10 clients a week, to solicit clients in alleys/side streets and industrial areas, performing services outdoors, accessed WISH in last 6 months, and accessed drug treatment.	-Outpatient treatment facilities for women in the sex trade work are urgently needed. - The importance of safer environment for the women was stressed. - The health care arena needs to engage with female sex workers. -Peer involvement is

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
	study Semi-structured questionnaire		old Staffed by driver, support worker, and peer support worker.	-Using the mobile van was significantly associated with accessing inpatient addiction Tx. -Women < 24 were less likely to access the van. -The van proved to reduce barriers to accessing harm reduction supplies and access to health/social services. -Results suggest mobile van has ability to improve quality of life and reduce HIV/STI through distribution of resources, such as offering the women food, water, bad date reports, condoms, drug paraphernalia, and referral to health services.	imperative. -Need to tailor services to also reach youth.
Janssen et al., 2009 Van. BC	6 Mixed Method Study	To determine the effectiveness of a mobile outreach services with women who work in the sex trade in regards to safety and the uptake of harm reduction behaviours.	N=100 All females > 16 years old 43% Aboriginal	**What worked:** - Being accessed more each year; 963 in 2004 to 1496 women in 2006. -Preventing violence (both physical, sexual) - Used van for first aid and health care - Used van for information on bad dates, "be on the lookout for" when friends were missing, drug services, shelters, bad drug alerts, accessing medical services, legal assistance, housing issues, referrals to health care providers, food, educational services, and other community resources. - A form of harm reduction, such as having access to condoms, needles. -Women who used the van did not share needles. -90% of the women felt safer with the van present. -The van reaches the more hard to reach populations.	- The success may be attributed to the services coming to them and having peer workers in the van. -Outreach services are vital in reaching women who work in the sex industry. -Other communities should have mobile access to services such as first aid, condoms, shelter, information about predators, and access to community resources.
Jozaghi & Andresen, 2013 Canada, BC	6 Qualitative Study	To assess the effectiveness of Insite and uncover if it should be expanded to other communities.	n=31 n=16 from Van. Female(6) Men(10) n=9 from Surrey Female(4)	**How did Insite improve outcomes for IDUs?** **Vancouver** -Fear of death from overdose was less once Insite was implementation – all participants have overdosed at Insite and witnessed an overdose. -Less overdoses seen in the alleys. -Injection outside was associated with increased death, so patients	-Outreach provides a refuge for IDUs. -Outreach can change their behaviours and roles – empowers them to not share, improve their health and assist others. -Outreach increases the people to be more active

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
			Men(5) n=6 from Victoria Female(3) Men(3) Adults	preferred to use Insite. -Less syringe disposal in public. -Reduced ER visits and ambulance use. -Less sharing of needles -Participants advocated for other IDUs to use Insite if they were seen injecting outside. -Feel safer at Insite, less episodes of robbery while fixing in alleys. -Less hassle by police -Called "refugee camp for junkies" -Other resources are available also. Do not need to use puddle water, get clean supplies. -Staff help to navigate the health care system -Nurses help with medical problems, abscesses, and rashes. They feel staff is respectful and non-judgemental- feel human again. -They feel empowered to help others -People would like Insite to expand hours and locations. **What it is like without Insite in a community (Surrey/Victoria):** -Constant ambulance use -All participants knew a person who died of overdose. -Most overdoses result in death, due to IDUs not knowing what to do when someone stops breathing or not having a phone to call for help. -More sharing of needles and increased exposure to blood borne illnesses. -Public injections. -Desperation leads to using dirty needles found on the ground. -Daily robberies while fixing	in their community and allows them to feel sense of empowerment. -Outreach services need to be expanded to reduce the wait times for stalls and need to be expanded to other communities.
Islam et al., 2007 Multiple countries	7 Literature review	To examine the evidence available internationally on the effectiveness of mobile van/bus and syringe vending machines for	n=18 papers on vending machines n= 22 papers on mobile vans	**How does this form of outreach facilitate access:** *Vending machines:* -It was proven to offers services to a population that is hard to reach and at high risk. -Less risks of blood borne diseases with easier access. -People can access it anytime throughout the night. -It offers more than syringes,	**What are the barriers that this overcomes:** -Many IDUs want to be anonymous and therefore avoid contact in fear of being found out. -More privacy, less judgement. -Provides a bridge to other services. -Hours of operation are

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
		the hard to reach IDU.		condoms, pamphlets, and health supplies. -No cost for staff, no risk for staff. No staff to display judgmental attitudes. -Privacy, confidential, especially in small communities where they know everyone and they do not want to access the pharmacies. *Mobile Vans:* -Less privacy -Able to cover more ground & adapt to changing atmospheres. -Provides shelter, security for clients and staff. -Many clients are unaware of available resources available to them. -Increased access to women, frequent injectors, and many in the sex trade. -Increased access to other services. -Minimizes sharing of needles. -Demonstrated large numbers accessing the vans.	not a factor with vending machines. -Reduces the distance for this population to go to receive services. -Ensures all kinds of clients are being offered services. -Overcomes barriers of transportation and money for the client. **What does not work:** - Vending machines do not allow contact with the client to provide support or services.
Author, date, & location	**Level of evidence**	**Study Purpose**	**Population**	**Key Findings**	**Recommendations**
Islam et al., 2012 Multiple countries	5 Integrative literature review of 35 paper	To assess the accessibility and acceptability of primary care centers that offers services to IDUs and determines if they are cost effective and improve health. There are no systematic reviews of this kind.	35 articles focusing on outreach facilities This paper was unable to focus on outreach that also provided primary health care, as there are not many to assess and there is no literature on this.	**What services were offered:** -There is a multitude of ways to deliver services noted in each facility. For instance, one stop shop to referrals. -Different facilities' offered different services. Services offered: Wound care, needle exchange, consultations with nurses or doctors, STI screening and blood borne illnesses, pregnancy tests, urine tests, counselling, and vaccinations, while some also offered dentistry, mental health, and HIV treatment, most offered telephone services, food, snacks, internet, welfare and social services. -1/3 offered medical services within their clinics. **Accessibility:** -The centers are located were this population migrates to. It was described by many studies to be	-Provide services that are free, non-judgemental, good location, free of police harassment, drop in style of service, and appropriate opening hours. -Outreach services have the ability to overcome barriers currently being encountered for this population. -Outreach is cost effectiveness, as evidenced by decreased ER visits. -Having referrals onsite is not enough; having onsite services have the potential to produce better outcomes. -In order to reach this population the services need to be non-

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
				very important to provide access. -Most centers offered clean needles to clients and saw this as a way to engage with the clients to offer health services to them. -The population felt safe in places that offered needles. -Completing vaccines series were more successful in outreach facilities. -There were no appointments, walk in basis. -Care was provided anonymously in all the articles, which was shown to remove barriers to health care. -Hours of clinic tried to address the population, such as evening clinics to target sex trade workers. -Services are provided free of charge, and some services are mobile, such as vans. -Did not need to have care card for service. **What makes outreach more accepted:** -Client anonymity, staff behaviour, having harm reduction services, drop in available services, confidentiality and non-judgemental attitudes. -Do not feel pressured to use services. -They could obtain health care there, did not have to go to GP, some did not want this. -Acceptance was demonstrated by the high rate in return. **How was health impacted:** -If patients are accessing care from these clinics who have drug related medical conditions it was shown to significantly reduce their substance use and was shown to improve their health. -Many referrals were made, but it was not clear if the patients went to the apts.	judgemental, and client centered. -Being able to offer health services as well as harm reduction can be more attractive for this population.
Marshall et al., 2005 BC	6 Quantitative	Data was collected from client's files and reviewed over 9 ½ years	n=1247 all charts were reviewed over the last 9 ½	**How this form of outreach looks like:** -Sheway is the only place in the DTES serving pre- and postnatal services to these women.	

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
		to determine the health and social problems encountered by women who use the services, also looked at their pregnancy outcomes, and how this is related to the well-being of the children of Sheway.	years Females 14-55 Up to 80.7% were Aboriginal	-It provides services both health and social at one single access point. A one-stop shop. -A form of harm reduction that allows the women to set their own goals without enforcing the disease or criminal model of treatment, it looks at reducing the harmful consequences of substance use instead of forcing abstinence on the clients. -Women choose the services they want and the staff they want on their team. This is seen as a respectful way to engage with the client and empowers them in their own health care decisions. -The intake process is done to ensure they women are appropriate for the services (pregnant, live in Vancouver) and they have enough staff to care for the women. -They provide many services between Monday to Friday 0830-1700 and drop in services where food is provided. -Physicians and nurses provide prenatal medical care. Access to food, vitamins, and nutritional counselling. They also receive help with housing, clothing for infants, legal or social support and counselling. -Postnatal services are offered up till the child is 18 months. -Immunizations occur in the clinic. -Assistance with childcare and early intervention services is available if needed. -Speech, occupational, and physical therapists visit one a month. -There are 21 staff: social workers, receptionists, peer support workers, outreach workers as well as Aboriginal workers, addiction counsellors, physicians with methadone training, community health nurses, infant development consultants, and dieticians. Multiple different agencies at work. **Who is being served:** -Aboriginal women	

Author, date, & location	Level of evidence	Study Purpose	Population	Key Findings	Recommendations
				-Substance abuse issues -Family violence -Mental health issues -Inadequate housing -Poverty Health illness: HIV; HCV; HBV -Poverty **What benefits were shown from use of these services:** -Decreased incidence of low birth weight babies. Increased use of Sheway by the women was associated with higher birth weights. -There was no decrease in child removals from moms. -Provides a safe environment and access to services for a population with multiple issues and needs.	
Rowe, 2004 Australia	6 Qualitative	To investigate the linkage between a needle exchange program and delivering primary health care for marginalized adult people to uncover if their needs are better met.	n=150 surveyed n=32 interviewed Females & Males Sex trade workers Homeless IDU	**Barriers to health care:** -Received unfriendly services -Lacked trust with health services -Embarrassed to use services -Excessive wait times -Unable to attend appointments due to demands of drug use -Services had restrictive hours of operations -Cost of services Location of services was important to be able to walk to -No time to wait for services in the ER, would rather put make-up over bruises and continue working. -Wanting consistent provider -Wanting a service that is flexible and drop-in -Experienced discrimination while accessing service	-Need for staff to be aware of the services they refer too, such as hours of operations -People want a consistent care provider -Have drop in appointments -Needle exchange programs can be a pathway to health care -Outreach centers such as needle exchange programs need to be located in the heart of where marginalized populations congregate

HCP = Health Care Providers

Appendix B

Handouts for Women in the Sex Trade

Personal Coping Strategies For Women in the Sex Trade
• Maintain separation from working and personal lives
• Prioritize roles that are important to you such as motherhood
• Dissociate mentally and physically from work and clients, such as removing condoms from purse, not using drugs if not working etc.
• Have rules that allow you to separate work sex with non-work sex, such as no kissing or cuddling at work only with your regular partner
• Keep track of your time and space with each client, establish a routine
• Maintain professionalism and a positive outlook towards work
• Tell your clients you are a sex worker, making condom use easier to negotiate with clients
• Ensure to maintain good genital hygiene
• Have regular check-ups for STIs, and examine STI risk in clients
• Use a generous amount of lubrication and more than one condom at the same time
• Try to perform non-vaginal sex practices when possible

Note. *Adapted* from "Sex-work harm reduction," by M. Rekart, 2005, *Lancet, 366,* p. 2125.

Appendix C

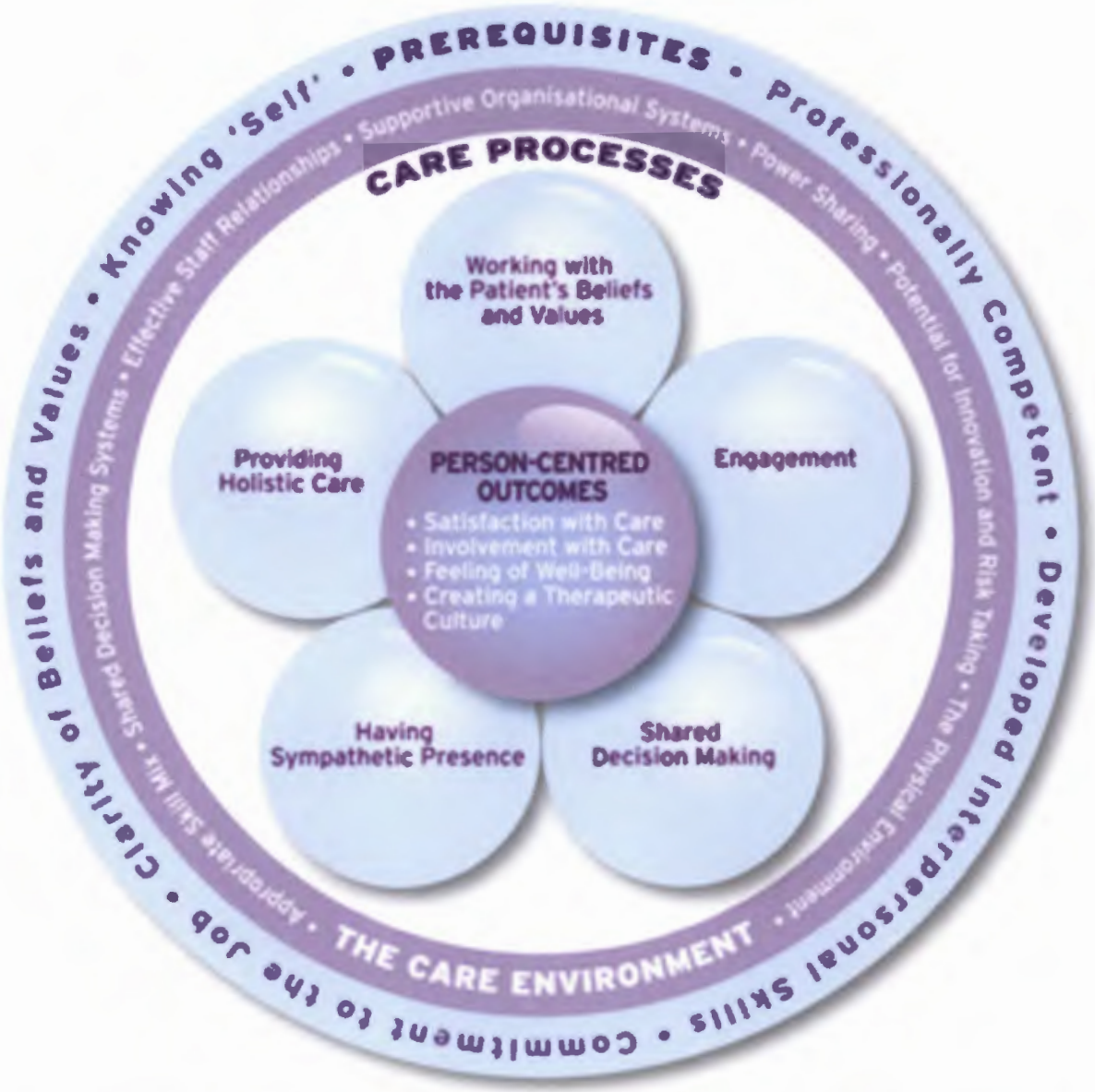
Handouts for Women in the Sex Trade

Safety Tips for Sex Work	
Appearance	• Wear comfortable shoes that you can run/escape in, no high heels • Avoid objects around your neck such as, necklaces, purse straps, or shawls that could be used to strangle or hold you down. • Leave some clothes on during sex so if you need to flee you can.
Negotiations	• Let your clients know your set price and time limit right away. • Pick your own location and know it well. • Always carry condoms and lubricant, never rely on the client • Have a policy where you get money before services. • Use the same location so you know your surroundings well.
The Car	• Always approach the car from the driver's side • Discuss location before getting in the car • Try to negotiate where you do not have to get in the car. • Circle the car looking for other people hiding in the back. • Take down the license plate or pretend to. • Seat belts will prevent quick escape, do not fasten your seatbelt • Wave goodbye to a friend or pretend to, even calling out the window you will be back at a certain time.
Oral Sex	• Practice putting a condom in your mouth for oral sex. • During ejaculation, ensure you apply pressure around the base to prevent leakage. • Gurgle with mouthwash or liquor; do not brush your teeth afterwards.
Vaginal Sex	• Ensure you use birth control • Maintain lubricated genital with water-soluble lubricant, to prevent trauma and open sores. • Do not use drying agents or douche. • Take the top position, facing customer; prevent being trapped underneath. • Place hands on the base of penis to keep it hard and to prevent any spillage after ejaculation; immediately remove the penis from vagina.
Anal Sex	• Try to avoid this • Set the price of anal sex too high, so they cannot afford it • Ensure the use of extra lubricant • Use a female condom with anal sex
Self-defense	• Do not carry any weapons that could be used on you • Scream or hit the horn if in trouble • Attack areas of the body that cause significant distress, such as the throat, eyes, and testicles; run towards the traffic and people. • Plan to work with other workers to watch out for each other • Report any bad dates to other workers

Note. *Adapted* from "Sex-work harm reduction," by M. Rekart, 2005, *Lancet, 366,* p. 2127.

Appendix D

Person-Centered Nursing Framework



Note. *Adapted* from "An exploration of person-centredness in practice," by T. McCance., B. McCormack., & J. Dewing, 2011, *The Online Journal of Issues in Nursing, 16*(2), Manuscript 1.