Integrating Reflexivity in Public Health Practice: A Proposed Framework for Autoethnographic Exploration to Strengthen Meaningful Engagement of People Who Use (d) Drugs

by

Manal Masud

BSc. Simon Fraser University, 2017

Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Health (Social Inequities in Health)

in the
Faculty of Health Sciences

SIMON FRASER UNIVERSITY
Spring 2019

Approval

Name:	**Manal Masud**
Degree:	**Master of Public Health**
Title:	**Integrating Reflexivity in Public Health Practice: A Proposed Framework for Autoethnographic Exploration to Strengthen Meaningful Engagement of People Who Use(d) Drugs**
Examining Committee:	
	Dr. Maya Gislason Senior Supervisor Assistant Professor, Faculty of Health Sciences
	Dr. Nicole Berry Second Reader Associate Professor, Faculty of Health Sciences
Date Defended/Approved:	April 12, 2019

Abstract

People who use drugs (PWUD) face significant stigma and are often excluded from or afforded little decision-making power in the development of services and policies that affect their health. This lack of agency has been recognized in recent years and engagement of PWUD is increasingly becoming best practice approach in Canada (Greer, Amlani, Pauly, Burmeister, & Buxton, 2018). However, special consideration needs to be paid to the process of engaging peers which can be addressed by integrating reflexivity at both interpersonal and institutional levels of public health practice. I will use this capstone paper to explore how public health practitioners who are cultural outsiders can operationalize reflexivity in their practice to ensure meaningful engagement of PWUD. I argue that when applied in an appropriate framework, autoethnography is a valuable methodological approach to practice reflexivity. I propose a framework for autoethnographic exploration to guide myself and potentially interested others to examine how the positionality of cultural outsiders working with PWUD can impact power relations, methods of engagement, representation of voice and production of knowledge within public health institutions. I draw from literature on reflexive practices, autoethnography, and peer engagement as well as my own work experiences to inform the framework. I hope this framework can serve as a tool for those interested in reflexive practice and shed light on ways each one of us can reshape our practices of working in health and social institutions as we aim to create more equitable spaces for meaningful engagement of PWUD in public health.

Table of Contents

1. Introduction

Public health practice often involves working across differences based on various intersecting social identities, cultures, disciplines and practice settings. As an emerging public health practitioner, I have been confronted with different notions of knowledge, power imbalances and cultural assumptions in my work. These epistemological variations are especially pronounced in contexts where public health practitioners are cultural outsiders — those who do not share social or historical connections and have not personally experienced the public health issue central to their work (Aronowitz, Deener, Keene, Schnittker, & Tach, 2015). As described by Aronowitz et al. (2015):

> Discourses of culture can work to justify and maintain health inequalities when actors in positions of power and authority—researchers, politicians, public health advocates, physicians—designate and take for granted their own social practices as legitimate, natural, or healthy while labeling the practices of other groups, particularly those that are marginalized, as illegitimate, unnatural, or unhealthy. (p. S403)

It is important for public health practitioners who are cultural outsiders to take stock of their actions, ways of knowing and recognize their position of privilege and power (afforded by their status within formal institutions, or via other sociopolitical means) by engaging in an ongoing reflexive process. This is vital to ensure that implementation and design of public health policies and service delivery is not based on stigmatizing assumptions but informed by local practices, historical and social conditions, and shared meanings. This practice of ongoing critical reflection to increase awareness of the

influences on knowledge production and connections between structural power and interpersonal relationships although not always referred to explicitly, can be understood as integrating reflexivity or being reflexive.

1.1 Situating this paper

I developed curiosity about the reflexive process during my work in opioid overdose response and peer engagement of people who used drugs (PWUD) to inform policy and service delivery at a regional health authority. I will be using the acronym PWUD throughout this paper to refer to people with lived and living experience of illegal drug use for reasons outlined by Belle-Isle (2016):

> The expression “people who use drugs” places emphasis on people first, as opposed to the expression “drug users,” which emphasises drug use. It is a simpler expression than “people who use illegal (or illicit) drugs. The term “people who use drugs” eliminates the words “illegal” or “illicit” and has been claimed to describe and re-inscribe the stigma associated with illegal drug use by groups of people who use drugs in Canada. (pp. 3-4)

However, it should be noted that ‘peers’, people who use substances (PWUS), and people who inject drugs (PWID) are also commonly used terms in literature.

PWUD face significant stigma and discrimination in society as well as when accessing healthcare (Ahern, Stuber, & Galea, 2007; McNeil, Small, Wood, & Kerr, 2014). PWUD hold expertise and experiential knowledge to best understand the realities of illegal drug use, local risk environments and are often the first to respond in the event of an overdose (Damon et al., 2017; Greer et al., 2018). However, they are often excluded

from, or unrecognized within the development and implementation of health services, policies, and research as well as often afforded little to no decision-making power in social structures that affect their lives. Historically, PWUD have also been marginalized and criminalized in society and are often tokenized if included in research and service provision (Damon et al., 2017; Greer et al., 2018; Mccall, Mollison, Browne, Parker, & Pauly, 2017). The inequitable agency of PWUD over matters that affect their health has been recognized in recent years and engagement of PWUD is increasingly becoming best practice approach in Canada when designing and delivering mental health and substance use programs, services and policies (Greer et al., 2018). However, special consideration needs to be paid to the *process* of engaging peers to ensure that inclusion of PWUD is empowering, leading to a shift "from power *over* to power *with* people with lived experience" (Belle-Isle, 2016). It is important to take measures beyond just inclusion and create safe spaces for engagement to ensure that involvement of PWUD is not paternalistic or harmful, leading for example, to tokenistic representation, social exclusion and the perpetuation of stigma against people who use drugs.

I did not have much guidance on how to meaningfully include people with lived experience of drug use as part of decision-making in public health settings when I became involved in this work. I navigated my way by learning about the involvement of PWUD in community based participatory research settings and applying those teachings to my practice. However, not everything from research is applicable as there are a lot of time and budgetary constraints as well as shifting priorities and the need to produce quick deliverables while working in a health authority. PWUD who I have met and worked with have been instrumental in transforming my practice as they shared their experiences of

times when they felt “like a check list item” during the engagement process as well as times when they felt valued and shared equal decision-making power. These accounts reinforce for me the importance of being reflexive as a public health practitioner as we embody and bridge the space between an institution and the individuals with whom we work. These experiences and my position as a cultural outsider have motivated me to explore how to practice reflexivity in public health settings where employees represent institutions but work with individuals with complex needs who have little recourse to social and institutional voice and power.

As a cultural outsider in communities of PWUD, I am very cognizant of the privileged position I occupy. I consider myself an outsider as I do not have the lived experience of drug use and addiction. I am a cis-gendered, able-bodied person from the middle class with a nuclear family pursuing higher education and working in the Global North. My social position has afforded me to not know all the realities, circumstances and consequences of drug use and addictions. My lack of lived experience of illegal drug use also privileges me to bring idealistic ideas from research and other professional practices to my work − although I always strive to be realistic. For instance, I do not know how it feels to go to a doctor and be constantly questioned about the legitimacy of my concerns; I have the privilege to not be afraid to reach out for help due to fear of losing the custody of my children; and, I do not have to explain long pauses in my employment history among many other things. These are some of the many gaps in my knowledge around the actual realities of drug use and addictions that I am learning, unlearning and relearning. However, it should be noted that people who use or used drugs have diverse and intersecting social identities, there is no one homogenous culture of drug users and there

are many instances when I feel like a cultural insider. For example, I feel very connected to the peers and PWUD I work with when we share experiences of marginalization while navigating our healthcare needs as queer people, women, members of racialized groups and immigrants. In reality, I occupy the positions of a cultural outsider *and* insider but in my role at the health authority and as a graduate student without any lived experience of drug use and addictions working on this issue, I feel like an outsider. Therefore, I approach my actions with a high degree of skepticism and question the position, motives, cultural expectations and subjectivities that I operate within when working with PWUD. I am critical of the quality and legacies of methods I use, the seemingly objective knowledge I draw from and the work I produce. I am seeking to minimize and repair harm towards PWUD as a result of the work I am involved in by constantly engaging in a reflexive process of questioning my ways of knowing and cultural assumptions. I recognize the importance of reflexive work especially when working with PWUD, as toxic ideologies around drug use are pervasive in society and play out across interpersonal interactions and institutions.

Reflexive practices are well embraced in qualitative research where the researchers turn a critical gaze towards themselves as actors in positions of power whose social background, assumptions, positioning and behaviour influence the research process. However, there is a paucity of literature on what reflexive practice looks like in a public health setting (outside of research) working with PWUD. Critical reflections by public health practitioners that examine how positionality (sociopolitical identity that shape one's ontological and epistemological assumptions) and power relations inform meaningful engagement when working with PWUD remain largely unexplored. Therefore,

I will use this paper to explore how public health practitioners as cultural outsiders can operationalize reflexivity in their practice when working with PWUD.

I will begin by clarifying the terrain and providing a brief overview of what it means to be reflexive as it is a contested term with various meanings and describe how I conceptualize reflexivity. I argue that when applied in an appropriate framework, autoethnography is a valuable methodological approach to practice reflexivity that can be used by cultural outsiders who work with PWUD in a public health setting. By the end of the paper, I hope to develop a framework to guide myself and potentially others interested in doing similar work to examine how the positionality of cultural outsiders working with PWUD can impact power relations, methods of engagement, representation of voice and production of knowledge within public health institutions. I have drawn from literature on reflexive practices, autoethnography, and peer engagement as well as my own work experiences to inform the framework. It is my view that this framework can serve as a tool to practice reflexivity and shed light on ways each one of us can (re)shape our practices of working in health and social institutions, broaden our ways of knowing and help us grow as reflexive, emotionally aware practitioners committed to strengthening the meaningful involvement of PWUD in public health practice.

2. Clarifying the Terrain

This section will provide a brief overview and describe the theoretical and methodological perspectives that I drew on for this capstone. I will introduce the concept of reflexivity including the various ways it has been described and practiced in literature. Ideas on how reflexivity can be used by public health practitioners within institutions to analyze how power and oppression shape their practice will be presented. I will then turn to the qualitative research method of autoethnography as tool to practice reflexivity and explore the common characteristics of autoethnographic works to inform the development of my own autoethnographic framework in the subsequent section.

2.1 Overview of Reflexivity

Reflexivity is a contested term and there is a rich dialogue on what it means to be reflexive. ‘Reflection’, ‘reflexivity’, ‘critical reflectivity’ are often used interchangeably in literature and are conceptualized differently by various authors. Generally, reflection is based on the idea that there is a reality from which we can separate ourselves from to see the objective truth in our work and is usually practiced after an experience or critical incident has occurred. In contrast, reflexivity is grounded in the notion of the socially constructed nature of reality and is based on the idea that we continuously negotiate the meanings of our world which is manifested in our actions (Pässilä, Oikarinen, & Harmaakorpi, 2015). D’cruz, Gillingham, & Melendez (2007) further differentiate between critical reflection and reflexivity and state:

> In critical reflection, the use of a critical incident as the basis for knowledge generation can be considered as ‘reflection-on-action’ rather than ‘reflection-in-action’ (Schön, 1983). The critical incident is firmly in the past and is represented

> as a learning opportunity for the future from this selected incident. Reflexivity, in contrast (in its various conceptualizations), can be described as a critical approach to the generation of knowledge that operates 'in the moment' (Sheppard et al., 2000); the reflexive practitioner or researcher is constantly engaged in the process of questioning (self-monitoring) their own knowledge claims and those of others as he/she engages in social interaction and the micro-practices of knowledge/power. (p. 83)

As a concept, reflexivity can mean introspection, but as a practice it brings into question interpersonal relationships and broader contextual issues and can be used as a way to increase accountability and improve professional practice (D'cruz et al., 2007). Reflexivity is well embraced in qualitative research and has been described as the "process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject locations, personal beliefs, and emotions enter into their research" (Hsiung, 2008, p.211). Research in health sciences is often claimed to present objective truths and to not be sullied by subjectivities and personal opinions. However, research does not exist in isolation and is enabled by ideas, individuals and institutions that all exist within a social context full of privilege, biases, cultural assumptions and oppression (Wilson, 2000). Reflexivity has challenged these positivist ideals of science that strive for objectivity over subjectivity and helped researchers to unpack their personal and professional practices (Finlay & Gough, 2003).

Reflexivity plays an important role in research, professional practice and beyond. Reflexivity bridges the gap between self (replete with identities, social locations, epistemologies, experiences etc.) and Other (not the self) to create curiosity, empathy

and understanding between self and Other. It enables individuals to interrogate intrapersonal relationships to grow and transform personally as well as professionally. As practitioners change, the potential to resist toxic ideologies and transform institutions and social structures arise. At the institutional level, reflexivity can then challenge practices, roles, beliefs and values of practitioners and promote ongoing learning and redevelopment of practice (Bolam & Chamberlain, 2003).

There is no canonical way of practicing reflexivity and it has been operationalized in myriad ways. On practising reflexivity, Finlay & Gough (2003) state:

> Different perspectives and methodological traditions exist, including humanistic-phenomenological and psychoanalytic emphasis on self-knowledge, 'critical' traditions such as feminism which prioritize socio political positions, and social constructionist and 'postmodern' approaches which attend to discourse and rhetoric in the production of research texts. (p. 1)

Numerous typologies on reflexivity and reflexive practice have been published. Although it is important to distinguish between different variants of reflexive practices, these typologies are categorized subjectively each with its own strengths and limitations and they are not always mutually exclusive. I have presented ahead some conceptualizations of reflexivity that have resonated with me. The four styles of reflexivity offered by Marcus (1994) include reflexivity as self-critique and personal quest, objective reflexivity as a methodological tool, reflexivity as 'politics of location' and feminist experiential reflexivity as the practice of positioning. These four styles gradually build upon each other going from micro to the macro and aid in understanding how reflexive practices can be expanded upon. Edge (2011) categorizes reflexivity into two types, first is "prospective

reflexivity", which enables researchers to build capacity to understand the significance of their perspective (knowledge, feelings, biases and values) on the research process and their findings. The second type is described as "retrospective reflexivity" which acknowledges the transformation of the researcher through the research process itself. This categorization has helped me conceptualize reflexivity as ongoing and transformative process that has the potential to challenge, change and move practitioners towards new understandings. Attia & Edge (2017) present recommendations to aid in the pragmatic implementation of reflexivity which lend well to integrating reflexivity in public health practice. They highlight the importance for researchers to 'step back' from actions to theorize what is taking place and then 'step up' to be actively involved in the contextualized action.

After reviewing the literature on various conceptions of reflexivity, I have developed my own working definition of reflexivity. I sense reflexivity in my practice as an ongoing process of critical self-awareness that analyzes how my personal experiences (knowledge, values, positioning) and structural power relations (organizational norms, policies and laws within which I work) shape my work with PWUD. I see reflexivity as expanding my capacity to engage with PWUD in safe and equitable ways that give them more decision-making power over health processes that impact their lives. Integrating reflexivity will allow me to understand drug use from multiple lens and also enable me to embody these understandings into action. I also understand that reflexivity can operate at an interpersonal *and* institutional level. In addition to integrating reflexivity in my own practice, I believe part of being a reflexive practitioner is to advocate for institutional reflexivity that addresses structural barriers to inclusion of PWUD, redistributes decision

making power and builds capacity for meaningful engagement of PWUD in public health programs, services and policies.

Reflexivity has emerged as a central concept in autoethnographic work as it analyzes the personal in relation to the social and structural context within which one is situated. Autoethnography has been described as a reflexive methodology that highlights the need for critical reflection and embraces key ideas that inform the concept of reflexivity such as subjectivity and the influence of self on production, interpretation and translation of knowledge (Ettorre, 2013). In the following section, I will turn to autoethnography as an appropriate tool to practice reflexivity.

2.3 Autoethnography: A Method for Practicing Reflexivity

Autoethnography is a research method that "describes and systematically analyzes personal experience in order to understand cultural experience" (Ellis, Adams, & Bochner, 2011, p.273). It is a form of ethnography — a qualitative social science practice of writing about or describing people and cultures. Studies of ethnography seek to understand groups of people (cultures, institutions etc.) by having the researcher immersed in the same context as the participants in the study. In general terms, ethnography "seeks to build theories of culture and society, theories of human behavior and attitudes, and to appreciate what it means to be human in particular social and cultural contexts" (Madden, 2010, p.17). As a form of ethnography, autoethnography more specifically strives to connect 'the personal' with 'the social', Ellis & Bochner (2000) explain the personal-social connection that autoethnography bridges using a triadic model where culture (ethno) represents the social, the self (auto) refers to the personal and the method (graphy) bridges the two.

Autoethnography is rooted in postmodernism and emerged from questions about the objectivity of social scientific inquiry. Kuhn (1996), Rorty (1982) and other scholars identified how knowledge produced in research was linked to the vocabularies and paradigms of the researchers. Privilege of researcher over subject was increasingly recognized and there was movement to "resist colonial, sterile research impulses of authoritatively entering a culture, exploiting cultural members, and then recklessly leaving to write about the culture for monetary and/or professional gain, while disregarding relational ties to cultural members" (Ellis et al., 2011, p.273). Scholars from a wide range of disciplines turned to autoethnography to explore personal positions and understand relations between the self, context and production of knowledge within research. Ellis et al. (2011) report:

> Scholars wanted to concentrate on ways of producing meaningful, accessible and evocative research grounded in personal experience, research that would sensitize readers to issues of identity politics, to experiences shrouded in silence, and to forms of representation that deepen our capacity to empathize with people who are different from us. (p.274)

Autoethnography as a method has been used across disciplines to explore connections between race, bodies, gender, illness, health and healing as well as many other subjects (Clarke & Olesen, 1999; Jones, Adams, & Ellis, 2013). Autoethnographers have used this method to examine painful or uncertain experiences and centre the voices from the margins around subjugated cultural experiences such as racism, gender-based violence and the systemic disempowerment of PWUD (Ettorre, 2013; Jones et al., 2013). Autoethnography aims to create space for a diverse author and readership especially for

those outside of academia who are, or feel, silenced by dominant discourses and cultures (Tsalach, 2013). Badenhorst, McLeod, & Joy, (2012) state that autoethnography enables marginalized groups to reclaim their position “according to their own agenda and their own lived experiences” and “draws on Friere’s conscientization which involves the individual becoming aware of his/her own position and creating a space to transform as the self is reiteratively constructed, deconstructed and reconstructed.” (p.9).

Generally, autoethnographers draw from tenants of both autobiography and ethnography for their work. One’s personal experience is used as the primary source of data and can take various forms such as memories, personal documents, photos, interviews, artifacts, conversations, memos or journals (Chang, 2013). Evocative autoethnographers emphasize development of emotionally and intellectually rich narratives that resonates with a diverse readership over a specific, analytical sociological process (Bochner & Ellis, 2016) whereas analytic autoethnographers prioritize the social scientist approach highlighting the importance of developing a research topic, methods, collecting data and analyzing (Anderson, 2006).

There are various forms and approaches to autoethnography such as duo-autoethnographies, layered accounts, reflexive autoethnographies, Indigenous autoethnographies, community autoethnographies, personal narratives and many more (Ellis et al., 2011). Despite these variations, generally all approaches strive to understand the personal relation to sociocultural processes.

Ellis et al. (2011) raise the issue of “relational ethics” in autoethnography and state that autoethnographers not only implicate themselves but intimate others such as communities and other people central to their work who maybe identifiable. In order to

address ethical concerns of confidentiality and privacy, Tullis (2013) has developed an ethical guideline for autoethnographers based on the principles of non-maleficence that emphasizes the need to de-identify data, provide pseudonyms and obtain informed consent from implicated others. Additionally, Ellis et al. (2011) encourages autoethnographers to “show their work to others implicated in or by their texts, allowing these others to respond, and/or acknowledging how these others feel about what is being written about them and allowing them to talk back to how they have been represented in the text.” (p.278).

In this section I aimed to describe the concept of reflexivity and the method of autoethnography as a tool to practice reflexivity. I see many parallels between the two approaches which are discussed in the next section. I am drawn to autoethnography to practice reflexivity as it strikes a good balance of providing a systematic approach to develop critical self-awareness in relation to others and social structures while also allowing room for creative and evocative narrative inquiry into embodied experiences. Moreover, I am committed to sharing my work in accessible ways with interested others (community members, researchers, practitioners, decision makers etc.) and I perceive autoethnography as the best way to immerse myself in this community engaged scholarship. I will now draw from reflexivity as a concept and weave methods of both evocative and analytical autoethnography to develop my own framework for autoethnographic exploration to strengthen meaningful engagement of PWUD in public health programs, services and policies.

3. Proposed Framework

As discussed in the last section, autoethnography has been used as a critically reflexive method in research settings. However, reflexivity can also be operationalized in the form of an autoethnography to be used in practice settings. Autoethnographers do not live through experiences to write narratives about them but these experiences are examined in hindsight (Ellis et al., 2011). Autoethnographic methods of data collection such as field notes, artifacts, interviews and dialogic exchanges, observing ways of knowing and negotiating power lend well to practice settings. Analyzing data for the purposes of autoethnography provides an opportunity for public health practitioners to engage in an ongoing reflexive process. It has the potential to compel practitioners to develop an anti-oppressive practice by being mindful of their work, thinking through their methodological approaches to produce knowledge, and being accountable to the communities they work with. It should be noted that autoethnography is merely a tool and its potential lies in *how* it is applied which led me to research and develop a framework for autoethnographic exploration to strengthen meaningful engagement of PWUD in public health practice settings.

It is my intention that this framework will help guide cultural outsiders like myself who work with PWUD to interrogate their practices and ultimately contribute to an increased space within public health for PWUD to meaningfully engage and share power in processes and decisions that impact their health. This framework is meant to be a living document that will evolve beyond the pages of this capstone project as I gain more experience and grow my understanding of realities of drug use and the health needs of PWUD. In its current form, the framework is informed by a targeted review of literature on

reflexive practices, autoethnography and peer engagement of PWUD. However, I plan to develop it further and validate it with feedback from academic supervisors and insight from PWUD and peers whom I work with.

I have drawn from elements of both evocative and analytic autoethnography as well as the works of Heron (2005) and Attia & Edge (2017) on practising reflexivity to develop this framework. The two clusters of questions below provide a proposed framework for autoethnography for cultural outsiders to practice reflexivity when working with PWUD in public health settings. The first set of questions examines how the positioning of practitioners as a cultural outsider shapes their interpersonal relationships with PWUD. The second set of questions allows practitioners to zoom out and understand the institutional values and power relations that enable or hinder meaningful inclusion of PWUD. Both sets of questions prompt practitioners to explore how power differentials and stigma against PWUD may be reproduced in their engagement practices and explore ways to resist as well as circumvent this inequity. The focus of this framework is to enable both interpersonal *and* institutional reflexivity. While it is valuable for practitioners to be reflexive within their own work; it is equally important to also call institutions to collectively redistribute decision-making power and move towards equitable inclusion of PWUD in public health policies and services. The ten questions that configure this framework have the potential to foreground reflexivity in public health practice when working with PWUD and are listed below.

I. Interpersonal Relations & Practices

- How do my assumptions and values influence the ways in which I engage with PWUD?
  - What do I know about my conscious intentions when I interact with PWUD?
- How do my actions and methods help to build trust and respectful interactions and relationships with PWUD, their families and communities?
  - How can I make my engagement with PWUD be more inclusive, representative and authentic?
- In what ways are PWUD most affected by the project/policy/issue already involved in addressing it?
  - How can I support these efforts?
- How has my identity:
  - Placed limitations on my work? What will I do to rectify this?
  - Provided me insights, opportunities and helped me identify new areas of growth for working with PWUD?
- How am I and the PWUD with whom I work empowered and disempowered in this relationship?

II. Institutional Relations & Practices

- What are we doing at the institutional level that might contribute to the structuring of inequitable engagement opportunities for PWUD?
- Are there any social ties or locally produced knowledge that is overlooked not prioritized by the institution?

        - Does the time and experiential knowledge of PWUD gain the same compensation and decision-making power as others doing similar work who do not identify (publicly) as PWUD?
    - What power relations are operating here? Are there power imbalances or tensions between PWUD and institutional authority or within groups of PWUD (such as recovery versus drug user groups)?
        - What can be done to redress these power imbalances?
    - In what ways are PWUD able to exercise leadership and power within the institution?
    - What institutional practices, policies and norms am I and/or PWUD resisting? In what ways is the resistance occurring?

This set of reflexive questions provide an appropriate framework for the autoethnographic approach and may deliver value to practitioners without lived experience of drug use who are seeking to engage in processes that create equitable engagement environments for PWUD. Engaging in this reflexive process acknowledges that as cultural outsiders our knowledge of ways in which substance use and addictions are understood are primarily informed by those in positions of authority (Aronowitz et al., 2015). Therefore, we have the potential to misrecognize the reasons why some public health practices, methods, programs, services and policies that we perceive to be 'right', 'healthy' or 'gold-standard' are not adopted by PWUD or do not align with the actual realities of drug use.

The questions in the framework may lead practitioners to recognize and uncover opportunities to change the normalized structural injustices against PWUD that pervade

community engagement practices in public health. This could include integrating new ways of knowing and producing knowledge, adopting or advocating for equitable participation and sharing (or giving up) decision making power and fostering a supportive and safe environment for PWUD to meaningfully engage in public health initiatives and policy forums that ultimately affect their lives. The questions in the framework can also be used by practitioners as prompts to reflect on in their autoethnographic narratives which can be shared with wider audiences interested in similar work. The goal of this framework and any resultant autoethnographic work is not to speak for PWUD but is to help center the knowledge and priorities of PWUD as well as challenge the conventional paradigms of how public health policy and services are developed.

I profoundly value being reflexive as a public health practitioner to avoid unconsciously using stigmatizing or exclusionary practices in my work with PWUD. It is my hope that public health practitioners like myself will be able to utilize this framework to practice reflexivity and collectively increase space for PWUD as well as transform and redistribute decision-making power in social structures that affect the lives of PWUD. Genuine and authentic relationships with PWUD are integral for the successful application of this framework. This process will take time (and will never be entirely complete), require vulnerability, humility and at times may be uncomfortable. Learning about reflexivity through the work for this capstone paper has allowed me to embrace this complexity. I know there will be times when I stumble but this framework will help me think through the gaps in my knowledge and inform my everyday practice. It will help me show up authentically to work and create alliances with PWUD to collectively advocate for institutional practices that facilitate social inclusion and equity.

I approach this work from a place of humility and recognize that PWUD and other underserved groups (such as people with disabilities, sex workers) have a long history of advocating for social inclusion practices that equitably include and share (or give) decision making power to them in social and health processes that impact their lives. The ideas presented in this capstone are not new, but it is my intention to bring them to the forefront and learn robust ways to implement them in my practice as I commence a full-time career in public health.

I developed this framework for autoethnographic exploration from the perspective of an ally who works with PWUD. It is my hope that interested others will find this framework useful or adaptable to their practice. I foresee myself using this framework (or later iterations of the framework) for the next few years to write an autoethnographic piece about negotiating power and advocating for meaningful inclusion of PWUD in public health (or adjacent) institutions. Future areas of inquiry building on this work could include a duo-autoethnography with my PWUD colleagues and community members. I am also interested in exploring autoethnographic performance as an emancipatory method of inquiry that can be used for community engaged scholarship with PWUD.

4. Limitations

In its current form, the framework is informed by a targeted review of literature on reflexive practices, autoethnography and peer engagement of PWUD. However, this first iteration of the framework is not informed by PWUD in a formal capacity, besides the anecdotal conversations I had in passing with my colleagues who identify as PWUD. After feedback from academic supervisors, I plan to develop and validate this framework further by inviting PWUD and peers whom I work with to share their insights. This framework is primarily derived from literature produced in North America, United Kingdom and my experience working with PWUD in the province of British Columbia, Canada. Therefore, it may not be generalizable to other contexts and could be informed better by other knowledge systems.

I used the method of autoethnography to operationalize reflexivity primarily because it has explicit strategies and methods developed to contribute to community engaged scholarship. However, autoethnography has its limitations, it is criticized for "either being too artful and not scientific, or too scientific and not sufficiently artful" (Ellis et al., 2011, p.280) and there have been issues raised around transparency and accountability as personal memory and experiences can involve recall bias which may affect the integrity of the work. To address this, it is encouraged that data be triangulated form various sources rather than memory alone and research methods be explicitly reported. I would also like to recognize that autoethnography is one approach to integrating reflexivity and encourage interested others to explore various alternate strategies to engage in reflexive practice.

5. Conclusion

As an outsider in communities of people who use drugs, I realize that my practice may be clouded by toxic ideologies around drug use that are pervasive in society and play out across interpersonal interactions and institutions. In this paper, I intended to explore how public health practitioners who are cultural outsiders can operationalize reflexivity in their work to ensure meaningful engagement of PWUD. I came to understand reflexivity as an ongoing process of critical self-awareness that analyzes how personal experiences (knowledge, values, positioning) and structural power relations (organizational norms, policies and laws) shape one's practice. I also conceptualize reflexivity as operating on both interpersonal *and* institutional levels. I believe part of being a reflexive practitioner is to advocate for institutional reflexivity that addresses structural barriers to inclusion of PWUD, redistributes decision making power and builds capacity for meaningful engagement of PWUD in public health programs, services and policies.

I turned to autoethnography as an appropriate tool to practice reflexivity as it strikes a good balance of providing a systematic approach to develop critical self-awareness in relation to others and social structures while also allowing room for creative and evocative narrative inquiry into embodied experiences. I proposed a framework for autoethnographic exploration to guide myself and potentially interested others to examine how the positionality of cultural outsiders working with PWUD can impact power relations, methods of engagement, representation of voice and production of knowledge within public health institutions. The framework challenges practitioners to explore their own positions and power, interrogate their personal and institutional practices as well as explore ways to resist structural inequities, marginalization and the silencing of PWUD. I

am looking forward to using and further developing this framework after feedback from supervisors and PWUD whom I work with. I am excited by the prospect that the process of addressing questions in the framework could lead to a better understanding of what I have known intuitively to be the appropriate method to foreground my practice but have not previously articulated it in a scholarly sense. It is my hope that this framework can serve as a tool to practice reflexivity and shed light on ways each one of us can transform our practice working in health and social institutions to create more equitable spaces for meaningful engagement of PWUD in public health.

6. Reflection on the Capstone Process

Completing this capstone paper has been a challenging but a rewarding experience. I used this opportunity to develop a deeper understanding of what it means to be reflexive in a public health practice setting. I felt it was really important for me to understand reflexivity as my work in public health is around substance use and addiction, which is a highly stigmatized topic where often voices of people who use drugs are silenced or given little power. As an outsider in communities of people who use drugs, I realize that my practice may be clouded by toxic ideologies around drug use that are pervasive in society. Therefore, I believe it is critical for me to integrate reflexivity in my practice in order to support public health efforts that are genuinely aligned with the social and structural needs of people who use drugs.

I completed this capstone project in the middle of an unprecedented overdose crisis in North America. The number of overdose and overdose related deaths remain staggeringly high due to a toxic, unregulated street drug supply. At times, I have had to pause my work to support and grieve with community members and friends who have lost loved ones in this crisis. While my work may in some small way contribute to advocate for centring the perspectives of people who use drugs; it is still embedded with a system that prohibits drug use and criminalizes people who use drugs and people struggling with addiction. This perpetuates stigma, fosters hostile societal attitudes toward people who use drugs and further marginalizes illegal drug use. It can also make access to services and the meaningful engagement of people who use drugs in public health extremely difficult. While strategies to equitably engage PWUD at interpersonal and institutional levels are important, the broader goal to advocate for evidence-based legislation and drug

policy reform should not be forgotten. Therefore, I stand in solidarity with people who use drugs and call for sensible drug policy that approaches drug use through the lens of public health instead of criminal justice.

7. References

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