Through the Eye of a Needle:
Women Injection Drug Users in Winnipeg

By

Carla Pindera

A Thesis
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
for the Degree of

Master of Science

Department of Community Health sciences,
Faculty of Medicine,
University of Manitoba
Winnipeg, Manitoba

March, 2003

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

Through the Eye of a Needle:

Women Injection Drug Users in Winnipeg

BY

Carla Pindera

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SCIENCE

Acknowledgements

This research study was both challenging and enlightening. I am thankful to the eight women who shared their life stories with me. It was their hope that in sharing their life stories they could help others. Without them this thesis would not have been possible.

Many people contributed to the completion of this study. Foremost, I would like to thank Dr. Joseph Kaufert for his supervisory role. Dr. Kaufert provided excellent guidance, encouragement and unwavering support. I am also thankful to Dr. Lawrence Elliott, Dr. Karen Chalmers and Dr. Frank Plummer for their advice and critical feedback.

Special thanks to the staff and volunteers at Nine Circles Community Health Centre, Sunshine House and Sage House for their support during the early stages of this project. My fellow classmates, Tricia and Hannah, must also be thanked, your encouragement and listening ears were invaluable.

The financial support provided by the Canadian Nurses Foundation and the College of Registered Nurses of Manitoba is gratefully acknowledged.

Finally, I can not thank enough my husband Mark, and my daughters, Chloe, Lena and Jayne. Their encouragement, support, patience and understanding provided me the motivation to complete this thesis.

Abstract

Despite high rates of diverse and complex health needs, little is known regarding women injection drug users' (IDUs) perceptions of or context for their health needs. Women IDUs' behaviours are intertwined with the relationships they maintain and with the social-environment in which they live (Williams 1991). The risks they take are constructed by and within their social environments. In order to understand the risks associated with injection drug use for women, research is needed that considers the means in which the social context of these women's lives shape their risk.

The purpose of this research study was to describe the social context in which women injection drug users in Winnipeg live from their own perspectives. The study's primary emphasis was to give 'voice' to the understandings and experiences of the everyday lives of these women. A purposive sample of 8 women was selected for this study, the sample consisted of women who were knowledgeable about illicit injection drug use, had self-identified as injection drug users and were able to reflect on and provide information about their experiences and life histories. A qualitative research design using an approach adapted from Carolyn Wang's Photovoice Methodology was used to assist with the identification of how, from the woman's perspective, her context and life experiences functioned to create meanings for explaining her risk-related

behaviour such as injection drug use (Wang & Burris, 1997). Unstructured interviews, participant's photographs and life narratives were the data collection methods used. Over the course of data collection, several adjustments were made to the original methodology in order to make the research project more acceptable to the participants and to protect them from potential harm.

In this study, it was revealed that the women's drug use was connected to the personal and social circumstances in which they lived. Their drug use was linked to the process of managing losses and battling to survive and live with integrity under threatening life conditions. The women relied heavily on drugs as a means to escape the painful feelings resulting from childhood and on-going traumas. They took responsibility for their decision to use drugs; at the same time, they held a common perception that their social and physical environments played a role in limiting their ability to manage their drug use and find alternative coping strategies.

This study demonstrates that research that is sensitive to women's feelings about their social environment and, subsequently, the details regarding the context in which injection drugs are used, is required if researchers and practitioners hope to provide effective and meaningful services for women who use drugs. The knowledge gained from this study can be used to assist in the development of appropriate health and social services strategies and interventions.

Table of Contents

Acknowledgements i

Abstract ii

Table of Contents iv

List of Tables viii

List of Appendices ix

Chapter 1: Introduction and Objectives

Introduction 2

Purpose and Objectives 3

Sandy's Story 6

Chapter 2: Background and Literature Review

Historical Overview of the Research on Drug Use 13

Feminist Perspectives 16

Gender and Injection Drug Use 17

Psychological Issues 18

Social Issues 20

Women Drug Users and HIV 21

Sexual and Drug-Using Behaviours 22

The Sex Trade 23

The Context of Women's Drug Use 24

Methodological Limitations and Gaps in the Literature 26

Summary 27

Chapter 3: Research Design and Methodology

Research Design 30

Methodology and Implementation 32

Sample Selection 32

Recruitment 33

Structure and Implementation of Interviews 34

Dynamics of the Interview.....36
Patterns of Communication.....37
Levels of Disclosure.....38
Study Limitations.....38
Sample Limitations.....39
Adjustments in Methodological Design.....41
Focus Group.....43
Feedback Stage.....43
Public Forum.....44
Analysis.....45
Ethical Framework for Research Conduct and Protection of Participants.....46
Consents.....46
Photographs.....47
File security.....48
Issues related to illegal activities.....49
Issues related to violence.....49
Issues related to abuse/neglect of children.....50
Researcher Role.....50
Effects of Research on Participants and Transcriber.....52
Effects of Research on Researcher.....52
Effects of Research on Participants.....53
Effects of Research on the Transcriber.....53
Terminology.....54
Summary.....55

Chapter 4: Who are the Participants
Drug Use.....57
Family Background.....58
Adult Family Experience.....58
Education and Employment.....59
Involvement with Criminal Activity.....59
Drug Treatment Experience.....60

Chapter 5: The Social Context of Women's Drug Use
Life Before Drug Use.....64
Escape.....64
Family Problems.....64
Violence.....65
System Incompetence.....66

Engaging in Drug Use....68
Case Study – Elizabeth's Story....68
Experiencing Loss....71
Family Breakdown....72
Loss of Children....73
Loss of Relationships....74
Coping....77
Loneliness....77
Worthlessness....79
Reality....79
On-Going Drug Use....80
Street Skills....80
Money Skills....80
Survival Skills....83
Risk Environments....84
Case Study – Tara's Story....85
Isolation....88
Health Problems....89
Hope for the Future....91
Managing Drug Use....93
Duration of Time of Drug Use....93
Support....96
Family....96
Support Services....97
Peers....98
Relationships....98
Love and Companionship....100
Prayer....102
Addiction Servicess....103
Strategies to Mediate Control of Drug Use....105
Education and Employment....105
Basic Needs....107
Stigma....109
Summary....111

Chapter 6: Participant's Recommendations for Health and Social Services Strategies 114

Chapter 7: Discussion and Conclusions

Escape.....121
Traumatic Events.....121
Loss.....123
Self-esteem.....125
Skills 126
Risk Environments 127
Support.....128
Stigma.....130

Summary.....131
Research Methodology.....132
Indications for Further Research with Women Drug Users.....133
Implications for Policy and Practice.....135

References.....139

List of Tables

Research Methodology Flowchart 42

Figure Z Time-line.....63

List of Appendices

Appendix A: Project Information Sheet.....153

Appendix B: Photovoice Ethics: *Minimum* Best Practices.....155

Appendix C: Participant Information and Interview Consent.....156

Appendix D: Acknowledgement and release to be Photographed Consent.....159

Appendix E: Photograph release Consent.....162

Appendix F: Guidelines for Obtaining Consent.....165

Appendix G: Unstructured Interview Guide I.....166

Appendix H: Unstructured Interview Guide II.....167

Chapter One

Introduction and Objectives

Introduction

The National AIDS Task Force (1997) has stated: " Canada is in the midst of a public health crisis concerning HIV and AIDS and injection drug use, as the infection continues to spread to vulnerable populations, showing little respect for geographical boundaries" (p.1). Injection of illicit drugs has been linked to extensive personal and social consequences including family breakdown, trauma, violence, crime, homelessness and the transmission of communicable diseases, such as hepatitis C and HIV (Crystal, 1992; Haverkos, 1990). Drug use is a critical risk behaviour for women, and women injection drug users (IDUs) are becoming increasingly visible in Canadian society. Today, women who use illicit drugs are one of the fastest growing risk groups for HIV in North America (Schilling, El-Bassel, Gilbert, & Schinke, 1991).

Women IDUs' behaviours are intertwined with the relationships they maintain and with the social-environment in which they live (Williams, 1991). The risks they take are constructed by and within their social environments. Public health officials and other experts in the area of substance use in Canada

have been slow to respond to these problems. Only recently have service providers begun seriously to target women with prevention education and treatment interventions (Nutbeam, Blakey, & Pates, 1991). Service providers further suggest that the current focus upon individual behaviour does not go far enough to enable a person to deal adequately with everyday realities, or environmental contexts, that influence risks related to drug taking (Stern, 1992; Watters, 1989).

Relatively few studies have concentrated on the problems and issues specific to women who inject drugs (Whynot, 1998). Studies focusing on epidemiological assessment, while showing an association between behaviours and risk, do not provide information on IDUs' perceptions of their health needs or on the context in which they live (Spittal & Schechter, 2001). How gender roles and inequalities influence the lives of women drug users needs to be described. Moreover, in order to understand the risks associated with injection drug use by women, research is needed which considers the way the social context of women's lives shape their risk.

Purpose and Objectives

The purpose of this research study is to describe, from their own perspectives, the social context in which women injection drug users in Winnipeg

live. The study's primary emphasis is to give 'voice' to the understandings and experiences of the everyday lives of these women. The research project is designed to achieve four objectives:

- To work with women injection drug users to document and reflect upon their lives using photovoice and life narrative methodology.
- To explore how women IDUs perceive their environments, and what circumstances they consider important for explaining their risk conditions.
- To promote discussion about possible strategies for addressing women IDUs personal and community issues.
- To articulate to policymakers those issues of concern to IDUs.

This study adopted a qualitative approach to identify how, from the woman's perspective, her context and life experiences functioned to explain the meaning of her risk-related behaviour, such as injection drug use. Morse(Morse & Field, 1995) describes qualitative research as useful when we want to make sense of reality, to describe the social world and to develop explanatory models. Describing the circumstances in which women injection drug users live will help to develop insight into the nature of substance use problems for women in Winnipeg. This insight will provide policy makers, program developers, and service providers a deeper level of understanding as to why women use injection drugs and how their personal and social context influence their drug-related behavours. In the long term, such information could contribute to the

development of more women-centered, environmentally sensitive health and social services for women injection drug users.

The following case study introduces a life narrative exploring the everyday realities of women drug users. It illustrates some of the serious issues and health problems confronting women who use drugs. In order to introduce some of the issues brought forward by many of the women in this research project a compilation of: narrative passages taken from the different interviews, the women's 'free writes' about their photographs, as well as the researcher's field notes is presented as a composite life story of one person's experience. The life story is introduced to provide a sense of the participant's life narratives.

The following life story, entitled "Sandy's Story", describes the social and personal contexts of drug use. It captures the process of becoming involved with injection drugs. Initially, Sandy describes her earliest childhood memories and the impact of these experiences on her decision to leave home. Her story proceeds through her leaving home, becoming involved with the streets with the situations and events considered important to her life, leading to her eventual drug use. Sandy describes the process of "playing the game" of street life and drug use. Eventually, Sandy concentrates on the struggle and internal battle to maintain her lifestyle and manage her drug use.

Sandy's Story

I've always felt like I was stuck at a bottom of a well and couldn't get out. Even when I was a kid, maybe it was just a dream, but it's a feeling I've always had. I still feel like that. I have no control, my family makes me feel terrible for being a junkie, but all they do is drink all the time. Why am I more terrible? I think they like me to feel terrible, they always have.

Parental Home

When I was a kid I was scared all the time. My life was a struggle from day one, I had no childhood. My dad was drinking a lot and my mom spent all her time with her church friends. They took me away, I don't even know how old I was. I went to live with a white family. I was still scared all the time. I don't like to think about that time. They were supposed to keep me safe, well that didn't happen. They didn't want me as a daughter, they used me. I was as alone with them as I was with my own family. I went back to my own family, but they wouldn't look at me, you know really look at me in the eye. It was like walking around on egg shells, not knowing what to say or what to do. I wasn't beaten or anything then , just a lot of emotional abuse, a lot. I still felt alone. So I left.

Leaving Home

You know, when you first leave, you do it because you think you feel safer, feel better. Nobody leaves home thinking that they want to be a drug addict

prostitute. Nobody wants to be running crack or breaking into houses. But you meet people and you party. Somebody gave me some drugs, I'm not even sure what it was maybe Acid or MDA, it was no big deal really, it was just a party. But I got high, it was great. I didn't have to worry about anything, just feeling good and having fun with other people. Laughing a lot. The laughing was the best part. Laughing with other people. For a little while I had a real job, you know working 9 to 5. I had some important responsibilities. But I never really fit there. I was partying late into the night and was always hung over, I don't now how I did it.

I met a lot of people. People liked me and wanted to hang out with me. Some of the girls were working. I'd watch out for them. Make sure they were safe, like taking down license plates and watching for cops. I met some guys too. Guys were important to me, they made me feel wanted, being needed, feeling wanted is really important to me.

Drug Use

I can't even really explain how I got into the heavy drugs like, using needles. It can't really explain it, it kind of just happened, I didn't plan it or anything. I had seen lots of people using, sometimes it was at a party, sometimes it was some of the girls on the street. I just wanted to know what was so good about it, why people would spend so much money and time getting drugs. So I asked someone to do me. They said no at first, but then they did for me. I threw

up and fell asleep. It wasn't really great or anything. It was slow at first, just using once and a while, like at parties and stuff.

I got pregnant, I wanted to stop then, for the baby. I wanted a normal life, you know, the white picket fence. But I really needed to keep getting high. When I was high I was a part of something. I knew it wasn't good for the baby, I tried to use less. There wasn't anyone to get help from. When you told a nurse or doctor you use drugs, everything changes. They don't ask you about yourself anymore, they don't listen, they just tell you what to do. So, I kept using and the more I used the more guilty I felt. I was high when I went into labor.

They took my baby away. Everything got worse then. I got extra guilt. So, I started using to hide my guilt. And then life became more painful, I was sure my kid would grow up feeling neglected, would suffer like I did as a kid. She would know that her mom had chose drugs over her. Well how could I quit now. I didn't have my kid and I wasn't allowed to see her because I was using. I mean, you know it's like this cycle that's really hard to get out of, it's really, really hard to get out of.

Street Camaraderie and Survival Tactics

I only hung out with other users. I surrounded myself with those kind of people because people that don't use made you automatically feel inferior. They don't accept you, they look at you differently you know, they're scared to be

around you, they don't accept you. I stopped laughing. I didn't have a group of friends. I just had people I used drugs with. I was either high with someone or I was all alone. Pretty soon I needed drugs just to feel normal. I would wake up, head out with last night's make-up and hairspray, pull a trick, head to the dealers and get high.

I learned how to survive on the streets. I learned the rules. That's one thing you people aren't aware of is the rules, they are unwritten, but they are real and you have to know them. I learned how to take care of myself, how to survive. The day to day living that I had to do was just crazy. This one afternoon in rush hour traffic, there were thousands of people going by. Two people were stabbed to death, but nobody saw anything, that's the kind of neighborhood I lived in, and that's the kind of person that I was hanging around , that's the kind of person I had become.

The System

The cops started hassling me. The cops didn't see me as a person. They have no respect for anyone out there. I hate cops, they are hypocrites, I don't respect them at all. They have no understanding for what is really happening on the streets. They only see junkies, whores and criminals. They could offer us support and assistance, but instead they just fight us, push us out.

The Process of Exiting

Then I got hep C. I wanted to stop using. I was scared, I don't want to die. I tried to get help. I went for treatment. I was at rock bottom, I was suicidal, I was sick of using and I saw no way, but either kill myself or go to treatment; and I didn't wanna die. So um I was going in for my cocaine problem, and um I did the whole 30 days, well, I did 29 days in River House, and there was some discussion, and I told them yeah well I'll probably smoke marijuana in the future. And, that's not why, cus I was there for my cocaine problem, and they kicked me out, I had one day left to graduate, and they kicked me out. They said, well, we see no point in you continuing this program, can you leave. And I was devastated, I used as soon as, you know, I left. I was so upset, I felt like I had failed. Addictions place really don't understand what treatment is, it has nothing to do with being clean from drugs.

I got some help from some of the other girls that had been on the street, I also found people who wouldn't judge me. It was hard to accept the help, usually when you ask for help, they make you feel bad about yourself, really small. I did it myself, I asked for the help. But, people helped me find a place to live, bought me towels and sheets and a plant, taught me how to shop and cook. Listened to me. I want to go to school, to get my grade twelve.

I found my culture, the creator has been helping me get through the hard times. My culture taught me to believe in women's power, a woman's power is strong, to be suppressed because of gender is to die. And my new daughter, she helps me. Her happiness and growth are important to me. I feel like we are growing up together and finding the awe in simple things. She is helping me be a better person, helping me smile.

I still use, some days, I look for reasons to use. And some days I just watch tv. I still need to escape. I hide out from reality for a little while, because I don't like the way I'm living, I hate it and I just it's a way for me to get away even though I know it's not true and you know at least for a little while I can pretend. And that way I can keep going you know it sort of gives me a little push instead of just um instead of just um going at it by myself.

Sandy's story reveals how her injection drug use was not simply about experimentation with drugs. Rather, she describes how her life before drug use, an abusive home, a lack of connection to her family and culture, low self-esteem and the eventual need for money were all issues connected to her current drug use. Sandy's composite life story conveys a sample of how the participants shared their life experiences during the interviews. It demonstrates that in order to understand why some people use drugs, we need to examine the larger picture of

their lives. It also illustrates the need to look beyond the behaviours of populations deemed "at risk." Rather, we need to examine the social cause and contexts of drug use.

Chapter Two

Background and Literature Review

This literature review is divided into three parts. The first section provides an historical overview of injection drug users in order to facilitate an understanding of the evolution of drug related research and to show the ways in which the notion of gender has impacted recent research developments. Consideration will be given to the way societal attitudes around women's drug use are reflected in research and drug treatment programs, as well as how these attitudes have highlighted the need for feminist research on women's drug use. This is followed by a review of the literature documenting the specific harms and health risks experienced by women drug users. Finally, research on the social and cultural context of women's drug use is examined. This research emphasizes that while it is important to understand the patterns of drug use, particular consideration needs to be paid to the roots of substance use problems, instead of viewing drug use simply as an epidemic or disease.

Historical Overview of the Research on Drug Use

The typical image of an addicted injection drug user is usually a male. Studies on injection drug use has primarily focused on men and therefore have been based on male perspectives, thus neglecting the needs and concerns of

women. This dominant view presents male drug users as the norm, from which female drug users constituted deviations (Doweiko, 1990; Rosenbaum, 1981),

Historically, illicit drug use was thought to be restricted to the 'lower classes' in society. Therefore, little attention was given to the problems of drug addiction (Doweiko, 1990). However, the increased prevalence of heroin use following the Vietnam War sparked an increase in studies on the lifestyle of illicit drug users. The results of this research began to dispel the myths about heroin and other drugs users. Few of the studies, however, involved women (Taylor, 1993) In most cases, even when women were included in a sample, differences according to gender where controlled for rather than examined (Doweiko, 1990).

The issues and problems related to illicit drug use have been considered to be "male problems", therefore, much of the research and solutions considered have been directed towards male users. One effect of the research documenting the lifestyle of male drug users was that men were portrayed as "resourceful," responding in a pragmatic manner to social circumstances (Taylor, 1993). On the other hand, women who used illicit drugs were seen to be pathetic, immoral and weak (Blume, 1990; Taylor, 1993). This view is further explained by the following quotation:

> Drug dependent females are seen as characteristically pathetic, passive, psychologically and socially inadequate, isolated and incapable of shouldering responsibilities...These images are drawn from a view of woman's major role as centrally responsible for the 'private' side of life – housework, childcare, emotional support and family servicing...the illegal addict is seen as first rejecting and then being rendered incapable of performing these functions effectively by a lifestyle which is initially willfully perverse and then inescapably pathetic...Female dependence is a reality – female drug dependence is an inappropriate and undesirable side-effect to be redirected to more convenient and controllable forms of dependence. (Perry, 1970: in Henderson, 1999).

This quote provides a powerful example of the way women drug users have historically been considered within drug research. Women's drug use was considered a deviation from what was expected as 'their normal behaviour, and was worth attention only when it affected others, notably their children (Henderson, 1999).

For society in general, the idea of a woman injecting drugs seemed somehow unnatural (Worth, 1990). This gender disparity created an environment where the issues and needs of women drug users were often underemphasized and their needs overlooked. It was not until the 1970's, within the context of a new

wave of the feminist movement, that these views about women with addictions was challenged. Feminist scientists asserted that there was a male-bias in addiction related research, and that programs were not suited to women's needs (Ettore, 1989; Reed, 1987; Rosenbaum, 1981).

Feminist Perspectives

Feminist researchers argued that factors influencing substance use cannot be understood independently from the various roles and statuses ascribed to women and men in our society. Our attitudes about women's drug use are bound by and caught up with attitudes towards women in general. Images of women's drug use stereotype women as emotionally weak, dependent, and exclusively responsible for the care and upbringing of children, the family and the home(Marsh, Colten, & Tucker, 1982). Consequently, more research on women's drug use from a feminist perspective was called for (Lex, 1991).

Reinharz (1992) explained that feminist research is not a research method, rather it is a prescription for inquiry that can be applied to a traditional disciplinary method to address the demands of both the discipline and feminist knowledge. In feminist research, it is assumed that women are authorities on their own lives. The investigation documenting women's lives is carried out by and with women rather than on women. It focuses on ways to empower the

participants and acknowledge the intelligence of women, and it values knowledge grounded in experience (Reinharz, 1992). It enables women to construct their own knowledge about themselves according to their own criteria as women, and they become empowered through the process of accruing this knowledge (Kramarae & Spender, 1992). The contextual nature of knowledge also must be considered. A feminist perspective recognizes that the social context, participation and perspectives of the participants are central to the research (Reutter & Neufeld, 1995).

This thesis describes a group of women who use drugs. Using a feminist perspective in drug related research acknowledges that women who use drugs are different from their male counterparts. The research focus of this thesis was specifically about women, based on the belief that they experience life differently than men. To date, less is known about the ways women who engage in injection drug use experience their world.

Gender and Injection Drug Use

In human culture, men and women inhabit different worlds in terms of culture, power and position in society. These differences extend into their health experiences and their typical illness reports (Clarke, 1992). While both male and female drug-users face numerous risks and health problems associated with drug-

use, women have unique medical and service needs. Women drug users often have gynecological complications, sexually transmitted infections, urinary tract infections, bladder infections, and irregularities in their menstrual cycles (Campbell, 1999). Female drug use has also been associated with breast cancer (Blume, 1990). The safe level of substance use for women is less than for men. One possible explanation is that, as compared to men's women's bodies contain different proportions of fat and water, which effects both the absorption rate and cumulative impact of drug use (Wright, 2002). A United States study of IDUs recruited from the community found that women drug users not only rated their health as poorer than male drug users, but also were diagnosed more frequently with endocarditis and pneumonia (Brown & Weissman, 1993). However, the impact of women drug users' health-related complications is under-studied. Some researchers even argue that the many of women drug users' drug-related harms are related to other environmental factors such as poor nutrition and traumatic experiences (Lex, 1991 in Wright, 2002).

Psychological Issues

Women drug-users also face psychological issues and a major disciplinary focus has been research by psychologists in dealing with these issues. One study of IDU women in the United States found a high prevelance of psychological

distress. This study found a significant sampling of women IDUs to be suffering from depression (Brown, Melchior, Reback, & Huba, 1994). Women drug users report more negative feelings about their bodies and are at higher risk to develop eating disorders(Nelson-Zlupko, Kauffman, & Morrison Dore, 1995). In general, women IDUs often feel hopeless, powerless, and depressed about their addiction (Reed, 1985). Women drug users are also more likely than their male counterparts to experience affective disorder (Blume, 1990).

Several investigators have found that violence is a significant factor in the lives of women drug users (Comfort, Shipley, White, Griffith, & Shandler, 1990; Fiks, Johnson, & Rosen, 1985; Lex, Teoh, Lagomasino, Mello, & Mendelson, 1990; Plumridge & Chetwynd, 1999; Theidon, 1995). The experience of violent trauma, whether childhood or adult abuse, is relatively high among women drug users (Blume, 1990). Plumridge and Chetwynd , (Plumridge & Chetwynd, 1999) in their study on the identity and the social construction of risk ,found that all the women IDUs depicted themselves as "having been damaged by the pain of living"; many recounted childhood histories of violence and abuse. A study conducted by Comfort and associates (Comfort et al., 1990) showed that 64% of the total participant sample reported experiencing abuse by someone during childhood. Verbal, physical and/or sexual abuse were reported. Theidon's (1995) study on pregnancy and drug use did not intend to focus on violence, yet she

concluded that the women's experiences of domestic violence demanded attention. Violence emerged as a central theme in the lives of the women she interviewed.

Social Issues

Although women IDUs face a myriad of social issues, women's social status and economic realities are seldom addressed in research. Lyons and Fahrner (1990) discuss how the majority of IDU women in the United States are minority women; live in poverty, insufficient housing, and lack access to adequate health care (Lyons & Fahrner, 1990). These women are more likely to have young children and to be the primary support to those children (Shaw & Paleo, 1986). They have fewer friends and are restricted in their employment or educational opportunities are confined (Rosenbaum, 1981). Many women experience a sense of isolation and have limited social supports. Some describe feelings of social isolation which they attribute to drug use and the associated lifestyle. Since the advent of HIV, the fear and stigmitization of AIDS has further compounded this feeling of isolation (Lyons & Fahrner, 1990; Williams, 1991). Very little Canadian literature is available regarding the problems and issues of women injection drug users. Whynot (1998) in her review on women drug users reported that most drug-addicted women live in poverty and that violence and fear of

violence are significant factors in the lives of women living on the streets and/or coping with addiction.

Women Drug Users and HIV

Since the beginning of the epidemic, cases of HIV disease in men have outnumbered those in women. This disparity has played a powerful role in creating a male profile of the AIDS epidemic. As a result of this male-centred bias, the impact of HIV in women has been underemphasized and sometimes overlooked. This has resulted in HIV disease being considered a relatively recent disease for women and, therefore, little research to date has explored whether or how the clinical progression of HIV disease in women differs from that in men (Campbell, 1999).

Yet drug use is a critical behaviour risk for women. In developed countries, women IDUs have been the group of women most at risk for HIV infection since the beginning of the AIDS epidemic (Campbell, 1995; Weissman & Brown, 1995). Risk factors for HIV seropositivity differ between male and female IDUs (Bruneau et al., 2001). Women in general, are at increased risk of exposure to HIV through gender-power relations (Reed, 1985; Wojcicki & Malala, 2001). Drawing on the work of Jean Miller, Amaro (1995) emphasizes the use of a gender-specific approach to prevention, especially when working with

poor and addicted women. She states that the risk of HIV infection must be viewed in relation to the broader social context of women's inequality in status and power. This unequal status has implications for policy and prevention strategies. Women are put at a disadvantage in both the negotiation of safer sex and in utilizing prevention programmes and health services. Gender-neutral programmes do not take into account the socialization process that influences women's HIV risk. For women IDUs, it is often difficult to separate the risk of HIV transmission due to drug use from that of sexual transmission. Both are significant risk factors for women drug users.

Sexual and Drug-Using Behaviours

The relationship between drug-use and high-risk sexual behaviour is complicated. Drug use is a barrier that prevents the user from altering his/her sexual behaviour in order to reduce his/her sex-partner's risks for HIV infection (Mane, 1997). Several studies conducted across the United States have found that IDUs are more likely to reduce the risks associated with injection than they are to change sexual risk behaviours (Lewis & Watters, 1991; Liebman & al., 1992). In particular, women are found less likely when compared to men to change sexual risks and more likely to change injection risks (Wolitski, Fishbein, & al, 1996).

Another consideration is that many women IDU also have IDU sex-partners (Weissman & Brown, 1995; Williams, 1991). The motivation to use

condoms or to perform less-risky sexual activities may be negligible when both partners are high on cocaine or other mind-altering substances. Further, negotiation of condom use is often left up to the women, yet this is very difficult for most women who are often in a position of having less power and control over sexual decision making than their male partners. Women have been socialized to need and rely on men, not to take on the role of sexual decision-maker. Asking a steady partner to use a condom could also be very difficult as it may imply lack of trust of that partner. Despite the knowledge of risk, the fear of being accused of not-trusting him or of cheating on the relationship herself or of being subject to violence, may outweigh the intention to use condoms.

A French study of risk behaviours among IDUs found that women tended to engage in behaviour that protected their partners more than themselves from HIV infection. The authors concluded that barriers to safer drug use among heterosexuals may lie more in the dynamics of male-female relations than in knowledge about HIV prevention (Gollub, Rey, & al, 1998).

The Sex Trade

Prostitution, which is often associated with drug use, places one further at risk for infection of HIV. In Winnipeg, over 70 % of female IDUs in the WIDE study reported exchanging sex for money or drugs (ManitobaHealth, 1999). Prostitution and life on the streets can lead to drug addiction just as drug addiction

and the need to obtain drugs can lead to prostitution (James, 1976). In either case, poverty appears to play a role in the life of a prostitute. The pragmatic choice for many of these women often is to sell sex for money or drugs. The significant risks associated with prostitution are sex without a condom, high-risk sexual activities, and multiple sex partners. Most women who "hustle" to support their own or their partner's drug habit report that they are able to negotiate condom use with their clients (Worth, 1989). However, despite this sense of control in the relationship with a customer, they may forgo the use of a condom if they are in a hurry to "score" drugs (Shedlin, 1990).

The role of female prostitutes in regard to the AIDS epidemic has been studied significantly. The perceived anti-social behaviour of prostitutes makes them an easy target and therefore have become the scapegoats for the heterosexual transmission of HIV (Lyons & Fahrner, 1990). Moreover, many prostitutes are also involved in injection drug use; it may be difficult to establish whether HIV infection and transmission are acquired through sexual contact or through injection behaviours.

The Context of Women's Drug Use

Very few studies, have been currently published from the true perspective of women drug users'. Rosenbaum (1985) was among the first to study women

injection drug users. Applying grounded theory techniques to examine women's experiences, she described a theory of "narrowing options" to explain the relationship of lived events to women's patterns of heroin use. Shedlin's (Shedlin, 1990) ethnographic study with drug using prostitutes concluded that the complex array of issues in their lives affected their ability to reduce their drug taking risks. Suffet and Lifshitz's (1991) ethnography of women addicts examined the threat of AIDS that is superimposed on an environment where the day-to-day demands of a life are constrained by poverty, powerlessness, and stigmatization. More recently, Taylor (1993) approached her research on women drug users in Glasgow Scotland, by using a street ethnography technique. Taylor concluded that the women in her study were a somewhat heterogeneous group, whose drug related behaviours were characterized by a purposive desire for fulfillment in the face of a variety of unattractive and sometimes threatening social circumstances.

Ramos's (Ramos, Aguilar, Anderson, & Caudillo, 1999) ethnotheoretical study with Mexican American female IDUs provided insight into the different roles they play. This information, from the reality of women, was useful for developing effective intervention strategies for this population. Rosenshine et al. (Rosenshine, Sowder, Weissman, & Young, 1990), in examining the Women Helping Empower and Enhance Lives (WHEEL) project, found that sensitivity to women's perceived needs and an understanding of the context of their lives are

key to providing effective services to women drug users. These studies, although slightly different, provide evidence of a link between personal and social experiences and women's risk taking behaviours. These research findings also provide support for the use of qualitative methods to study the relationship between women's environments and their perceived risk conditions.

Methodological Limitations and Gaps in the Literature

In Winnipeg, the WIDE study (Manitoba Health, 1999) employed exclusively quantitative measures of data collection to provide a glimpse of the health status and health care utilization of IDUs. While increasing our awareness of patterns of injection drug use in Winnipeg and the prevalence of blood borne pathogens within this population, the results did not provide any explanation of the perceived health needs nor the need for health services of this population. Furthermore, examining drug use as "behaviour" and ignoring its social causes and context provides no insight into long-term ramifications of the AIDS epidemic (De Zalduondo, 1991). It is notable in this review that no Canadian ethnographic study on women drug users was found. Documenting the social context in which women injection drug users in Winnipeg live would complement the WIDE study by providing insight into the issues of importance to IDUs from their own perspective. In order to develop effective programs and services for

women drug users, it is critical to acknowledge and understand the complexity and difficulties of their everyday life experiences and worldview. Moreover, understanding the perceptions of IDUs' health concerns would confront the central problem of research studies: "What researchers think is important may neglect what the community thinks is important" (Wang & Burris, 1997). Qualitative research can be used to assist in the development of appropriate strategies/interventions with women injection drug users. Health programs have a better chance of being successful when health services can be linked to community perceptions of health needs (Oakley, 1989).

Summary

In summary, this short review of the literature on women and drug use recognizes that simply being female is a powerful variable, negatively affecting the every-day lives and health of women who use drugs. Researchers assume that women are placed in an inferior position within society and that traditional gender roles continue to control and disempower women's lives. There is a sizable body of research available on the health status and risk behaviours of women IDUs. Researchers recognize that sexual and drug using behaviours are complicated by risk of HIV and other potential harms. Yet for drug users, health risks occur not

only because they are a drug users, but drug use is a consequence of the disadvantages in the worlds they live.

However, little research has been undertaken in Canada that applies a comprehensive respect to women IDUs own perception of, or context for, their heath needs. Drug use is a complex behaviour; an understanding of it will come only after it has been examined in the larger sociocultural context where it occurs. Qualitative research is appropriate for understanding the meaning and context of drug use (Sterk-Elifson, 1995). Qualitative techniques, such as photographic images and in-depth interviews, can help to unravel some of the complex webs of causation (Spittal & Schechter, 2001).

This study is based on interviews and photographic images with women drug users. The outcomes of interest to this study are the ways women explain the influences of the social environments to their drug use, and how they respond to these influences. Investigating the perceived needs of women IDUs, will strive to create more awareness of the realities in which women drug users in Winnipeg live. The contribution to public health knowledge will be significant at the field level and relevant for programme planning. A deeper level of understanding of the context of the lives of women IDUs will improve our understanding of the nature of substance abuse problems prevalent in Winnipeg, and of the services needed to support these women. There is a "critical need to develop responses that are sensitive to the needs and life circumstances of different groups of women to

address the underlying social inequities that affect their health status" (Health and Welfare Canada, 1990).

Chapter Three

Research Design and Methodology

Research Design

The study is a descriptive examination of the social environments in which Winnipeg women injection drug users live. Its purpose is to explore both how women injection drug users perceive their environments, and, what circumstances are considered important for explaining their risk conditions. A qualitative research design using an approach adapted from Carolyn Wang's Photovoice Methodology was used. (Ettore, 1989). Unstructured interviews, participants photographs and life narratives were used as data collection methods.

The Photovoice approach provides a framework where people can identify, represent, and enhance their lives through a specific photographic technique. It entrusts cameras to the participants to enable them to act as recorders and potential catalysts for change in their own communities. It uses the immediacy of the visual image to furnish evidence and to promote an effective, participatory means of sharing expertise and knowledge (Wang & Burris, 1997).

In this approach, participants select and photograph the images of importance to their lives. It integrates them into the process of identifying their

individual and community strengths and priorities. Wang and Burris, (1997) describe the photovoice approach to needs assessments as valuing the knowledge of the participants as an integral source of expertise. The photovoice method does not just 'count up' issues but draws on the community's active lore, observation, and stories in both visual and oral terms (Wang & Burris, 1997). The images produced through the participants' photographs act as a catalyst for critical discussion which may stimulate social action (Wang, 1999). The process of community involvement in this way allows for research participants to increase control over and take action to improve their own health (WHO, 1986).

Individual, in-depth interviews with women IDUs living in Winnipeg were completed for this research. Interviews were unstructured in format and incorporated both life stories, the participants' photographs, and perceived needs. The interviews were unstructured in order to articulate connections and associations which are logical to the participant, but not necessarily to the researcher (Tait, 2000). Due to the illegal nature of illicit drug use and the possible distrust of others, individual interviews were essential to allow the participants toraise important personal experiences and to maintain a level of confidentiality.

These research methods were chosen because unconventional approaches geared to community needs are necessary to successfully reach out to under-

served communities who have been marginalized from society (Stevens & Hall, 1998). Photography can promote specific concerns of a marginalized populations whose voices are not heard in society. The visual images we create help to shape how we see ourselves, how we define and relate to the world, and what we perceive as significant. How we interpret our images teaches us about how we define our health status differences and outcomes (Wang, 1999). Through photographic images, and the stories voiced around them, populations who are marginalized in society have the opportunity to reach those in power who are responsible for health planning and decision making. It allows the most vulnerable people in society to convey their own vision of the world (Wang & Burris, 1994).

Methodology and Implementation

Sample Selection

The original research design involved a purposive sample of 8 to 12 women who identify themselves as injection drug users. The target sample consisted of women who were knowledgeable about illicit injection drug use, had self-identified as injection drug users, who were able to reflect on and provide information about their experiences and life histories. The sampling design took into account the diversity of backgrounds found in the population in order to

ensure that the study was not limited to one social network within the larger population of injection drug users. Therefore, efforts were made to represent a range of demographic factors found within the community of injection drug users, including age, education, and ethnicity. Participants were included who had been born and raised in both urban and rural settings as well as First Nations and non-status aboriginal communities.

At the outset, the design was to include eight to twelve individuals that would form the sample, with the possibility of adding individuals as required to achieve thematic saturation. Thematic saturation was achieved with eight participant interviews so the study design was adjusted accordingly.

One of the eight participants chose not to return her camera or participate in her third interview due to personal reasons. However, data from her first in-depth interview was included in the findings and analysis.

Recruitment

Women IDUs can be a difficult sub-population to identify. By definition, they are people who inject drugs, but they are neither a group nor homogeneous in terms of background and present adaptation. Trusted service providers were asked to support the research project and to negotiate access to this marginalized population and refer participants to the study. Agencies who participated in

recruitment included Nine Circles Community Health Centre, Kali Shiiva AIDS Services, Sage House and Sunshine House.

Written material describing the project and the purpose of the study were provided to the referring service agencies, key informants, and the potential participants (See Appendix A). Methods of contacting a participant for the initial interview varied based on the preference of the individual. Potential participants either contacted the researcher by phone or met the researcher in an environment mediated by a key informant.

Structure and Implementation of Interviews

Plans were made to conduct a minimum of three interviews with each individual. The first interview served as an introductory interview, the second, a brainstorming and life narrative interview and the final interview was designed to allow participants to discuss their photographs and to follow-up on points raised in the previous interview. All interviews were audiotaped.

The purpose of the study, reasons for the interview, as well as the interest, experience, and objectives of the researcher were discussed during the first interview. Issues about the concept of the photovoice method and use of photographs to tell their life stories and to identify their health service needs were reviewed. Many concerns of the participants were addressed, including potential risks to them and methods to minimize these risks. Each participant was informed

that they would own their photographs and that they were to choose those images they wished to show to the researcher. Also, each of them were informed that due to the illegal nature of illicit drug possession, no photographs possibly depicting any illegal behaviour would be accepted for discussion during the interviews. Simple instructions regarding the use of cameras and the creative expression of photographs (e.g. how to avoid putting the center of interest in the middle of each photograph) was also discussed. Written consent was obtained from all participants and they were advised that they could withdraw from the project at any time.

During the second interview, ideas were considered as to the themes they could photograph which would represent and enhance their lives. (See Appendix G). It was during this interview, while considering important events in their lives, that the participants began to reveal life histories. Cameras were distributed and a discussion was held regarding the length of time needed to take a roll of film and when to return it to the facilitator for development. Instructions and purposes were given for obtaining written consent from all subjects photographed. (See Appendix D and F). Copies of the project brochure were provided to the participants to give to the photographed subjects or any other interested community members. A time was set for a subsequent meeting to view and discuss their photographs and the life stories and issues emerging from them.

During the final interview, the photographic images and stories produced by the participants were used as the catalyst for discussion (See Appendix H). By sharing and talking about the their photographs, the participants used the power of the visual image to communicate their life experiences and perceptions (Wang, Cash, & Powers, 2000). Where health and social problems/issues were identified, the meaning of these conditions and their perceptions and explanations of them were explored. This interview was also used to explore the strategies and services the women use for self-care and their satisfaction with these strategies and services. They were also asked to consider priority issues for themselves and their community and to identify potential solutions and strategies to deal with these issues. The participants' narratives documented in the following chapters are life histories shared by the women across all of the interviews.

Dynamics of the Interview

All interviews were conducted face-to-face by the researcher using an open ended, unstructured interview guide. With the participant's permission, an audiotape recorder was used during the entire interview. The researcher also took notes throughout the interview. Informants were instructed at the beginning of the interview that they could request the audiotape recorder be turned off at any time. Occasionally during an interview, the audiotape recorder was turned off so that the participant could answer a phone call or respond to a child.

The participants could choose from a variety of locations to conduct the interviews. Several social and health services agencies allowed their sites to be used for the participant interviews. Three of the eight participants requested that the interviews be conducted in their homes. The reasons given for this request related to transportation, childcare and level of comfort. The five other participants chose to be interviewed at one of the social services sites available.

Patterns of Communication

In each of the interviews, participants broke down and cried at different points in the interview session. In each of the cases, crying followed the telling of painful stories. In four cases, women apologized for their displays of emotion.

Laughter was also common throughout the interviews. In most cases, laughter was used to ease the emotion after telling an uncomfortable, distressing story. One of the participants identified her ability to find humour in any situation as her strongest coping mechanism. At other times, anger was evident. Participants would bang on the table and swear when recalling life events. Some identified that their quick anger has lead to misunderstandings with social services professionals and law enforcement officers in the past.

Levels of Disclosure

Many of the participants appeared to be completely open with the researcher at the outset of the study. They were willing to share their life stories and experiences. They explained their willingness to participate as wanting to make a difference to other women and young girls, hoping that in some way, their experiences could prevent others from similar experiences.

Deeper and more emotional levels of disclosure occurred during the third interview, and in some instances, during the feedback stage of the study. The willingness to share life experiences increased as the level of comfort and trust increased between participant and researcher.

Clearly, not all participants shared as openly as others. Some had difficulty recalling their own life events, and deflected the focus towards giving suggestions to address community issues. In one particular case, the participant came into the project with her own very specific agenda about service needs for street involved women and did not appear open to giving details about her own life history.

Study Limitations

Reliability and validity are concepts commonly considered in research. These concepts are more difficult to apply in qualitative research than quantitative research. Reliability relates to the reproducibility of a study method. Reliability in qualitative research is enhanced when the central assumptions, informant

selection and and values and biases of the researcher are well documented (Creswell, 1994).

Internal validity assesses the accuracy of the information provided and whether the information matches reality (Merriam, 1988) One of the most important steps for the provision of validity in qualitative research is the selection of the sample (Morse & Field, 1995). In this project, a purposive sample was selected to incorporate the participant's level of experience (the amount and type of the participant's knowledge). In order for the data to be 'rich', attempts were made to invite participants at various stages in their injection career to participate. The recruitment interviewing process continued until the data was saturated. Feedback was also received from the participants in order to enhance accuracy of the data. Construct validity was established by the participatory nature of the project and by verifying the themes that emerge from the data with the participants. Furthermore, catalytic validity was considered by determining that the process of participating in the research project was consciousness raising for the participants (Lather, 1991).

Sample Limitations

As indicated earlier, the sample selection was based on observations of significant differences among women IDUs. The women who volunteered to participate were knowledgeable about illicit injection drug use, had self identified

as injection drug users and were able to reflect on and provide information about their experiences and life histories. In several ways, however, the sample of women IDUs drawn was not representative of all women IDUs in Winnipeg. There were two factors that limited the representativeness of the sample in this study in terms of the generalizability to the broader population of IDUs:

- Age

The first factor is age. While there was an attempt to identify participants from a whole range of ages, no women under the age of 29 volunteered to be part of this study. There were two potential reasons for this. The first is simply that the majority of young injection drug users may not have been connected with or hadn't developed trust relationships with the social services and health agencies used to recruit participants. In addition, young IDUs may feel less empowered to reflect on and provide information about their experiences, and therefore willing to share this information with the researcher.

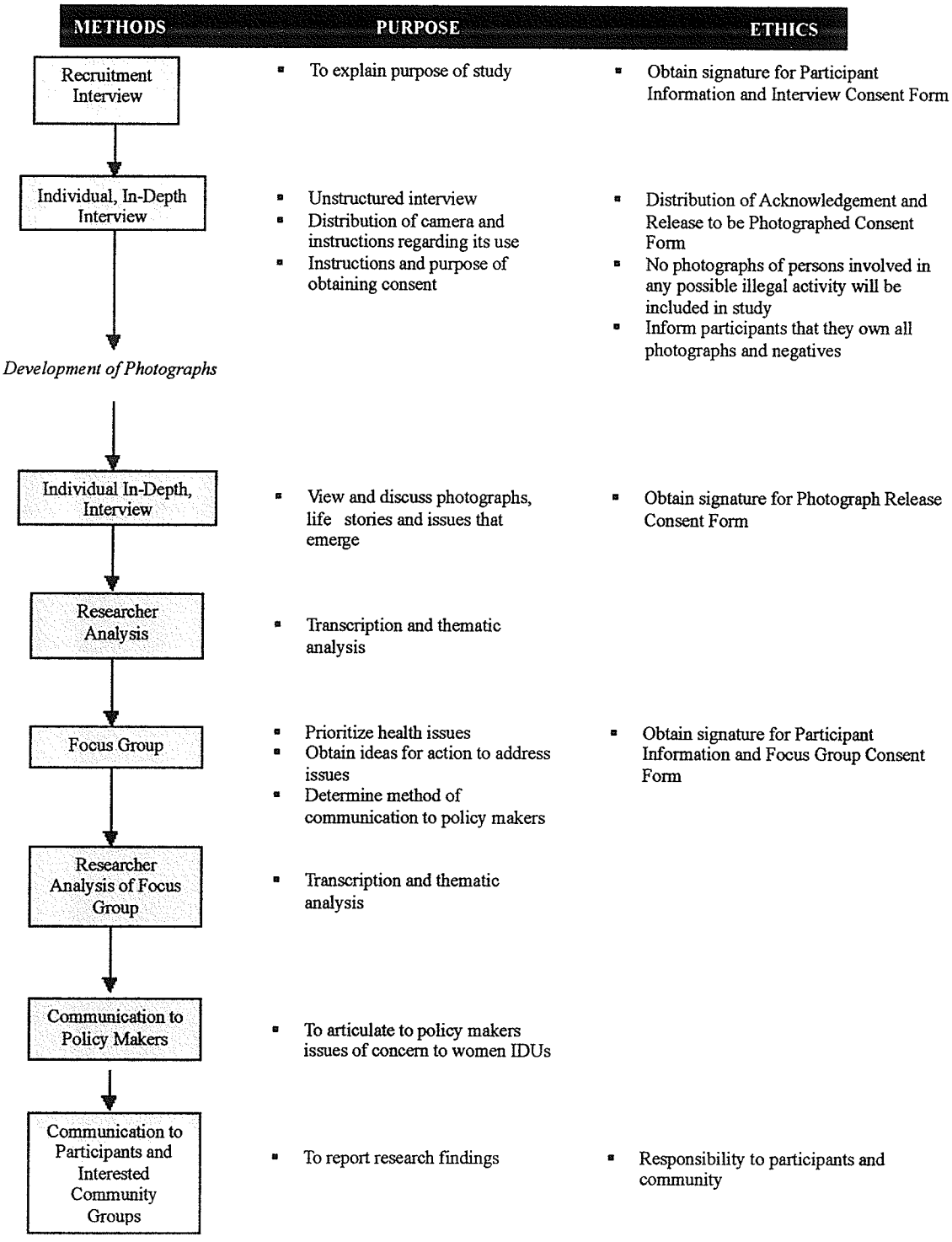
- Self selection

There is the possibility in this research that those who chose to participate did so because they wanted to talk about their issues. Some of the participants may have had personal and/or political reasons for providing information about their experiences and life histories. Others may have participated because they wanted someone to talk to, to use the

interview process as a therapeutic counseling session. Some of the responses of the participants at the completion of the interviews suggests that this may have been a factor in their participation in the study. Further, all of the participants in this study identified that their drug use was a problem in their lives, all identified wanting to change their drug-related behaviours, to gain control of their drug use. Had any of the participants been ambivalent or resistant to change regarding their drug-related behaviours, the themes and issues that emerged may have been quite different.

Adjustments in Methodological Design

The following research methodology flowchart outlines the intended project stages, purposes and ethical considerations associated with this research study. Over the course of data collection, several adjustments were made to the methodology in order to make the research project more acceptable to the participants and to protect them from potential harm.


METHODS
PURPOSE
ETHICS
Recruitment Interview
To explain purpose of study
Obtain signature for Participant Information and Interview Consent Form
Individual, In-Depth Interview
Unstructured interview
Distribution of camera and instructions regarding its use
Instructions and purpose of obtaining consent
Distribution of Acknowledgement and Release to be Photographed Consent Form
No photographs of persons involved in any possible illegal activity will be included in study
Inform participants that they own all photographs and negatives
Development of Photographs
Individual In-Depth, Interview
View and discuss photographs, life stories and issues that emerge
Obtain signature for Photograph Release Consent Form
Researcher Analysis
Transcription and thematic analysis
Focus Group
Prioritize health issues
Obtain ideas for action to address issues
Determine method of communication to policy makers
Obtain signature for Participant Information and Focus Group Consent Form
Researcher Analysis of Focus Group
Transcription and thematic analysis
Communication to Policy Makers
To articulate to policy makers issues of concern to women IDUs
Communication to Participants and Interested Community Groups
To report research findings
Responsibility to participants and community

Focus Group

At the outset, the design was to include a focus group for all the participants to discuss the themes arising from their photographs and interviews, and to make recommendations for strategies to address their individual and/or community needs. Six of the eight participants declined participation in the focus group. The participants cited 3 reasons for their refusal to participate. The first was a clear tension around street history and their own suggestion that there would not be open sharing in the group. Secondly, those women attempting to gain control of their drug use, feared that discussing drug use with other drug users would romanticize it. The third reason was lack of anonymity; while many drug users are open about their current and history of drug use, others were fearful in making their drug use known to others.

Feedback Stage

Following analysis and writing of the draft report, individual participants were asked to review the findings. The research design originally did not include this feedback stage. This stage was added once it became apparent that the participants did not want to participate in a focus group. The purpose of this meeting was to ensure that the participants' was comfortable with the information being included in the report. They were given the opportunity to review individual quotes and descriptions to be included in the report, and to ensure that the

participant's experiences were accurately represented, and that no identifiable information remained that could cause them concern. The participants were also given the opportunity to provide additional or clarifying information. At this stage, the researcher was only able to locate 4 of the 8 participants.

Public Forum

The photovoice methodology encourages use of photographs to depict the individuals and community concerns/needs in a public forum. Wang recounts how participant photographs have been used in slide shows, or published in books, photo essays, the internet, and in journal articles. Using photographs in this manner purports to heighten the publics', policymakers' and program developers' awareness of community issues. This use of Photovoice is considered a participatory action strategy.

Throughout the data collection and analysis of this study, I became aware that using the participants' photographs in this manner would risk their anonymity. As the participants had been instructed to take pictures that would represent and enhance their lives, many of their photographs were of family and friends. As a researcher, I felt that displaying the participant's photographs publicly could result in individual participants being identified, thus creating more harms to the individual participant than benefit to the wider population of women drug users.

Analysis

Banonis (1989) describes qualitative data analysis as "preserving the uniqueness of each participant's lived experience while permitting an understanding of the phenomenon under investigation." The audiotapes from the interviews were transcribed verbatim and field notes recorded. Transcriptions of interviews were undertaken by a transcriptionist. Analysis took place simultaneously with data collection, allowing for constant comparison of data.

The participants' life narratives, descriptions of their photos and the discussion raised from them were read and re-read in order for the researcher to become immersed in the data. The analysis of the interviews consisted of organizing the data and by coding it line-by-line. Patterns and unique textual data (events, experiences, and/or reported behaviours) that emerged were coded, grouped into categories, and abstracted into themes. In addition, these categories were further refined in the writing of the first draft of this report. This facilitated a higher level of analysis resulting in themes being placed in chronological order along a timeline of the women's life and drug using careers. A microcomputer and word processing program was utilized in the analysis, however the actual coding and development of categories was done manually by the researcher.

Ethical Framework for Research Conduct and Protection of Participants

Several ethical issues have been addressed in the design of this research. This research was conducted with full considerations for the human rights of the participants. Formal ethics approval was obtained from the Research Ethics Board, Bannatyne Campus, University of Manitoba. Only women over 16 years of age were invited to participate in the study. Those persons agreeing to participate in the research project were introduced to the objectives and methods of this study, asked to sign an informed consent form and advised of the voluntary nature of the project. All participants were informed of their right to withdraw without penalty from the project at any time.

In addition to these requirements, additional precautions were taken to ensure both individual confidentiality and accurate representation of the target population's issues. The injection drug using population in Winnipeg is a relatively small group, therefore great care was taken to ensure that the participants understood the purpose of the research study. Several strategies were used to protect client confidentiality such as the use of pseudonyms, a composite case study and alteration of characteristics.

Consents

Three types of written consent were developed for use in this research project. (See Appendices C,D,E). The first consent, was obtained by the

researcher from the participants, outlining the participants' rights and responsibilities. The second consent was obtained by the research participant and whereby subjects agreed to have their picture taken. Participants were not required to obtain consent if they took a picture of a group so large that individual faces were not recognizable or if the participant was focused on an object, such as a building, or if the photograph includes a person who just happened to walk by. The third consent (See Appendix E) could be used only after all the pictures are developed; its purpose was to document the participants' willingness to permit any photographs, or only certain specified photographs, to be published or used as part of the project. Although the majority of the participants were willing to have their photographs used as part of this project and willingly signed the third consent, due to the ethical and methodological considerations precluding the public display of the participant's photographs, this option was not taken.

Photographs

Due to the possible risks associated with research using photographic image, the Photovoice Ethics: Minimum Best Practices, (Appendix B) as developed by Carolyn Wang, (Wang & Y, forthcoming) were adapted to guide this project. Potential risks of participation in research photography, including potential viewing audiences, were explored with all participants by the researcher.

One possible risk of photovoice is that the process of discussing community change is a political act and that political processes may create uncertain outcomes (Wang & Burris, 1997). This risk was made explicit to all participants.

The safety and well being of the participants was paramount. The facilitator led a discussion with each participant, regarding the participants' responsibility when carrying a camera. This process was emphasized to ensure that the privacy and rights of others be respected, and that no picture is worth taking if it begets the photographer ill will or harm (Wang, 1999).

The photographs and negatives taken by the participants are 'owned' by the participants. The participants chose to store their photographs and negatives with the researcher for safe keeping during the project, but understood that the photographs and negatives were theirs to keep. All participants were provided with an extra set of photographs to return to the people they photographed. Any possible future uses of the research photographs were discussed during the informed consent process.

File security

Participant files were assigned codes (e.g.B3(A)) and the participants' names were stored separately from their interview transcripts. All tapes, transcripts, photographs, and field notes were kept in a secure location, locked in a filing cabinet in the researcher's home. The researcher's microcomputer was

not networked into any system. Tapes were destroyed at the completion of this study.

Issues related to illegal activities

In a study such as this, which examines the social environments and perceived needs and concerns of women injection drug users, there is the potential to identify and discuss issues related to past and present illegal activities. Although the study was designed in such a way as to encourage the sharing of information on all health and important personal related experiences, at the outset of the study all participants were informed that photographs that depicted any illegal activities would not be included in the research study.

Issues related to violence

This type of research has the potential to touch on issues of violence, both historical and ongoing. In order to protect the participants, no questions were asked directly about experiences involving violence in order not to trigger memories of events the participants did not wish to disclose. During the process of telling life histories, if a participant demonstrated distress related to past and/or present violence, the researcher explored supports and services already in place for the participants. In some cases the researcher made specific referral suggestions.

Issues related to abuse/neglect of children

At the outset of the study, the possibility was identified that a study participant might reveal past or present child abuse. All participants were informed that if any current incident of child abuse became apparent, that the researcher would be bound to report the incident to Child and Family Services. No current incidents of child abuse emerged from the interviews.

Feedback stage

As it was possible that individuals in a small community might still be identifiable from details provided in the interviews, as many participants as possible, 4 of the 8, were contacted to review their individual narratives and to validate or provide further elaboration of descriptions to be be included in the report. This process was used to ensure that the participant's experiences were accurately represented and that no identifiable information was included in the thesis that would cause concern to the participant.

Researcher Role

As this is a qualitative study where the researcher is utilized as the research instrument, it is important that the author's background and prior connection with the target population be reviewed.

The researcher has been involved professionally with this population in her role as an inner-city public health nurse (1992-present). The researcher has had the opportunity to work with diverse and marginalized populations and has developed a reputation for being a trusted health care provider. At the time of the study, the researcher was working as the Coordinator of Street Connections Harm Reduction Services with the Winnipeg Regional Health Authority, Public Health Program. All participants were informed of the researcher's professional role at the onset of the first interview. As well, it was explained that the researcher conducted the interviews in the context of a research role and not as a care provider. The researcher chose not to recruit any study participants directly through the Street Connections program and therefore had no role in the provision of care or case management of any of the participants.

In many ways, the researcher came to this study as a respected outsider. The researcher has extensive experience in working with diverse communities in inner city communities and has been afforded a level of trust and comfort with the target population. This experience of working in the community may have contributed to credibility and trust, and in turn facilitated participation in the project. The researcher had access to specific information and knowledge on the social culture of this community not available to most researchers. Nonetheless, the researcher was also acutely aware of being an outsider in this community. The

researcher has never injected drugs nor was she personally familiar with the lived experiences of the participants.

Effects of Research on Participants and Transcriber

The literature is beginning to take note of how exposure to painful and emotional narratives can have an impact on both the researcher (Dunn, 1991) and on transcribers (Gregory, Russell, & Phillips, 1997). This section will consider the observed effects of participation in the study on researcher, participants and transcriber.

Effects of Research on Researcher

Both the process of planning for and carrying out this study had profound effects on the researcher. As noted earlier in this chapter, the researcher was familiar with the issues faced by this target population on a professional basis. The life stories, while disturbing, were not unexpected. What was suprising to the researcher, was the extent to which the participants openly shared their life stories and were eager to keep the researcher "up-to-date' on their lives. Several of the participants continued to keep in touch with the researcher well after the interviews were completed making comments such as "you are the first person who ever really asked me about my life, about me." Comments such as these highlight for the researcher how many people working in the health and social

services profession have difficulty seeing beyond drug use, reducing people to what they do rather than who they are.

Effects of Research on Participants

The actual interviews themselves had some clear effects on the participants. All the participants both laughed and cried at different stages of the interview. One participant reported that through her participation in the study she became aware of how much her drug use was controlling her life. She informed the researcher that she was choosing to attempt to "go clean" and stop injecting drugs. Another participant chose to enter addiction treatment at the end of the study. While not all the participants revealed that their involvement in the study has had direct personal value, none described their involvement as negative and/or damaging.

What appeared to have a significant impact on some participants was the feedback process, where actual quotes and their utilization in the report, were presented back. Many of the participants were emotionally moved and broke down into tears. One described the findings as "powerful" and "right on."

Effects of Research on the Transcriber

One woman assisted the researcher in transcribing all the audiotaped interviews. This transcriber has a University degree in Women's Studies and was familiar with issues related to women's health. During the transcription process

she frequently met with the researcher to discuss and debrief issues arising from the interview transcripts. On several occasions she noted that the participants' narratives were emotionally powerful and occasionally disturbing (Gregory et al., 1997).

Terminology

The term injection drug use (IDU) primarily refers to intravenous injection use of illicit drugs such as cocaine or Talwin and Ritalin. Participants at times use other substances, but the focus of this study was essentially their use of illicit injection drugs. Definitions of terms such as addiction, drug use, and environment have been left purposely vague. Given that there are various paradigms effecting the meaning of these terms, and that a study objective was to elicit the personal reality of the women, terminology was kept in the form originally used by the narrator. This was done so that the meaning could be inferred from how each woman contextualized or defined the term.

In general, there was consistency in the usage of these terms. Drug use commonly referred to simply the use of drugs, while addiction tended to denote a state of heavy use and was frequently referred to a label that a participant had received from a health or social services provider, rather than being self-defined. Addiction treatment referred to the complete range of options currently available

to assist with the process undertaken to rely less on drugs. For the purposes of this research, environment was defined as the personal and social conditions surrounding individuals.

Summary

This report attempts to describe the participants' perspectives on the social environments in which they live and how these contexts effect their health and drug using behaviours. Narratives outlined in the following two chapters selected to represent the frequency and intensity of the issues as presented. Narratives presented also represent integrated life histories the participants shared across all of the interviews. Repetitive words, ums and uhs have been maintained in all of the narratives in order to provide emotive context.

Chapter Four

Who are the Participants

Before turning to the thematic analysis of how the participants perceived their social environments and described how their contexts and life circumstances effected their risk-related behaviours, a brief summary of the participants' demographic and aggregate picture is presented. Eight women who self identified as injection drug users were interviewed for this study. All participants were adults between the ages of 29 and 43. As indicated in an earlier chapter, the women who volunteered to participate were knowledgeable about illicit injection drug use, had self identified as injection drug users and were able to reflect on and provide information about their experiences and life histories. The experiences and life histories of these eight women were examined and a collective profile of the women emerged. The following participant profile reveals important information about the experiences of the participants within the broader context of their life circumstances. Some of the information and experiences revealed here will be illustrated in more depth in the following chapter, where the themes that emerged from their narratives are presented in detail.

Drug Use

Of the eight women interviewed, six had begun injection drug use in their youth and the two others in mid-adulthood. Of the six that started using in their youth, two had begun using by age 12 and the other three between the ages of 15 to 21. Of the two who started using intravenously in their mid-adulthood, one started at age 29 and the other at age 40. Five of the eight women had started injecting drugs shortly after running away from home, while living and working on the streets. The other three women started their injection careers after being introduced to drugs by colleagues, friends or a partner. Cocaine, Talwin and Ritalin (T's&R's) and Morphine were commonly the first drugs used intravenously. All eight had a history of substance use prior to their use of injection drugs. Drugs used prior to first injection included alcohol, marijuana, amphetamines, Valium, LSD, and other hallucinogenics. The women continued to take these drugs and used other drugs throughout their injection drug using careers. Heroin and Crystal Methempetamine were other drugs used intravenously during their injection drug using experiences.

At the time of the study, six reported being active injection drug users. Of these six, one claimed to be using only very infrequently. One participant reported having been clean for six months and another had not injected in eighteen months.

Family Background

Of the eight participants, only one of the women was born and raised in Winnipeg. Four of the participants were born and had previous residence in First Nations reserves in Manitoba. Of these four, one was apprehended from her family at a young age by social services and adopted out to a Caucasian family in Winnipeg. The other three were born and raised in small towns, two in Manitoba and one out of province. A history of substance abuse by a parent was reported by five of the women. Seven of the women discussed their siblings, and five of these reported substance misuse by their siblings. Five of the women reported having run away from home due to family discord. Another woman reported being kicked out of her home by her father at age 15, after becoming pregnant. Three women described themselves as white, three as aboriginal, and two as Metis.

Adult Family Experience

All eight participants had reported being in a "serious relationship" prior to the study. Three of the participants had been legally married and were now divorced. At the time of the study, two women identified themselves as single, and the other six as having boyfriends. Only one of the six identified herself as "living in a common-law" relationship.

Seven of the women reported having children. Of these seven, three were currently parenting at least one of their children. One participant reported being disowned by her children due to her current drug use.

Education and Employment

Only two of the women had completed high school within the usual time frame. Of these two, one had a college diploma. Three of the other women received their high school diplomas after many years of working on the streets, of which two had since participated in post secondary courses. The remaining three women had grade 10 or less education.

At the time of this study, four of the women revealed that they were receiving governmental social assistance and two as receiving disability assistance. Two of the participants were employed part-time.

Involvement with Criminal Activity

Six of the eight participants self-reported having been charged with a criminal offense at some point during their drug-using careers. These charges frequently were related to procuring drugs. Three of the women had been charged with crimes related to prostitution. Three of the women had histories of being charged with serious crimes, including assaulting a peace officer, murder and

robbery. One of the women had served time in both a provincial and federal prison for women.

Drug Treatment Experience

All eight women reported that they had received some form of addiction treatment at least once. One of these women reported having attempted drug treatment at least 15 times. Of the eight women, seven had turned to formal addictions treatment programs.

Women also sought help for their drug use from social services providers, physicians, family and friends. Two of the women sought aboriginal spiritual counseling. The women also attempted to "clean-up" on their own. Often, the women reported leaving town to get away not only from drugs, but also their friends and family who also used drugs.

The following chapter entitled "The Social Context of Women's Drug Use" presents the data from the unstructured interviews and will discuss the themes that emerged from the participants' narratives in greater detail.

Chapter Five

The Social Context of Women's Drug Use

The central goal of this study was to describe the social context in which women injection drug users live in Winnipeg and thus explore with the women how they perceive their environments and what contexts and life circumstances are considered important in explaining perceptions of risk and risk-related behaviour. Another purpose was to promote discussion about strategies for addressing their personal and community issues.

Throughout this section the narrative data will be presented with the women's explanations for initiation and continuation of drug use, how their on-going drug use affected their lives, as well as their efforts to manage their drug use. Analysis of the interview data shows the variables which impact upon the health and well being of the women are situated within the broader context of their life circumstances. An emotional response associated with their life circumstances was directly related to the reasons the women turned to drug use, continued to use drugs, and eventually, attempted to manage their drug use. A complex but clear link between the women's social environments and their drug use is constructed.

A summary of the relationship between events and circumstances in the participants' lives and their movement into drug use is shown in Figure Z. The timeline illustrates a chronological order of events significant to the women's drug using and life careers. Themes and sub-themes emerging from the women's narratives are plotted within this timeline. These themes are not mutually exclusive as there are areas of overlap and dependence between them. Some themes reoccur during each stage of the timeline.

The timeline further illustrates how an interaction between the social environment and a woman's decisions about drug use occurred at different phases in the women's lives. Four phases of drug-using were depicted: the time leading up to the onset of injection drugs use; their experiences around engaging in drug use and their ongoing drug use; and finally their experiences with attempts to manage and take control over their drug use.

The time span covered in the interviews ranged from early childhood to the present, based on what the women felt were important events in their lives deemed as relevant to their drug use. The names of participants appearing throughout this text are pseudonyms used to preserve their anonymity. Names of significant others and places have also been changed to maintain anonymity.

Before Drug Use	Engaging in Drug Use	On-Going Drug Use	Managing Drug Use
Themes: - **Escape** Family Problems Violence System Incompetence	- **Loss** Family Breakdown Loss of Children Loss of Relationships - **Coping** Loneliness Reality Being Needed Worthlessness	- **Street Skills** Money Skills Survival Skills - **Risk Environments** Violence Police Involvement - **Isolation** - **Health Problems** - **Hope for the Future**	- **Duration of Drug Use** - **Support** Family Support Services Peers Relationships Love and Companionship Prayer - **Addiction Services** - **Strategies** Education and Employment Basic Needs - **Stigma**

Figure 2. Time-line depicting a summary of the relationship between events and circumstances in the participants lives and their movement into and through drug use.

Life Before Drug Use

The personal and social conditions influencing the "lived" experiences of the women varied; however, family-life events presented issues that were central to all eight women's drug use. This section looks at the women's life experiences before they started to inject drugs.

Escape

Escape is a theme that pervades the narratives of most of the women. Participant narratives demonstrated a desire to escape their life circumstances. Childhood family problems, histories of violence, abuse and/or emotional rejection and system incompetence were each articulated by the women as reasons for their desire to escape.

Family Problems

Doris started using drugs as a young child. A number of circumstances in her home life gave rise to painful feelings. She began taking drugs as a way to deal with the problems at home. She explained:

> **Doris:** Yeah, I started taking pills when I was a kid and than ah ended up with pills being the way out, always trying to OD.
> **Researcher:** How old were you?
> **Doris:** Ah, when I first started eight.
> **Researcher:** What was going on in your life?
> **Doris**: My parents drank a lot and I met up with the wrong kind of people. The people that I met up with ah they were adults, like you know ah you don't give no 8 year old pills.
> **Researcher:** Tell me more about the pills.

Doris: They were sleeping pills. I remember when I was a kid. But you know you don't give kids pills and back then well eh, the mother used to give me smokes too, and I thought that was cool too. (pause) I was in and out of the hospital, my mom didn't like them, she drank a lot so half the time she not always home, or she didn't care really because she was too drunk. And then she'd come pick me up at the hospital, they'd phone her to come pick me up and ah, that was from an early age.

Elizabeth also describes her home life as troubled:

Elizabeth: My dad is an alcoholic and I remember feeling scared, I was scared of my dad when he was drunk because he was violent and abusive not just physically but emotionally. He used to tell us we were no good, and we would never amount to anything and when I got pregnant ah, I was um, I brought shame to the family. Because I was only, I was 14 when I got pregnant.

Family problems in both of these narratives were described within the context of alcohol. Of the women interviewed, several included in their stories a history of drinking by parents that had created problems for the family. In Elizabeth's case violence was also linked with her father's drinking.

Violence

Similarly, two other participants also reported childhood conditions of physical violence. Kendra and Tara having been apprehended by their families of birth, recollect abuse stemming from their adoptive families.

Kendra: You know, like I was adopted by this family to have a better life and excuse me that didn't happen, you know. I, I have spent an entire lifetime trying to trying to, to, to ah fix my childhood, what was done to me and, then ultimately what I did to myself (long pause).

Tara: Child and Family Services took me away from my adoptive family when I was 12 years old. I was being abused. It was just all bad, I got caught with smokes and got a beating, it was totally unnecessary. I kept running away from home, I couldn't handle the shit going on.

In addition to physical abuse, other conditions affected the women's lives. Some participants reported a sense of rejection from their families. This emotional rejection left them feeling unloved, unwanted and angry. Laurie and Kendra described this well:

Laurie: Yeah, it was um, there was never any sexual abuse, or any physical abuse, there was extreme amounts of emotional abuse. Extreme amounts, like I'm surprised I'm not balling my eye balls out right now. (laughs) But I've you know control that by humour, and just by strong wits I guess (laughs). You know. Half the people in their town don't even know that my parent's have a daughter (laugh) so you know, whatever (laugh long pause) having your parents telling you you're fat and lazy and you're never going to amount to anything.

Kendra: It hurts sometimes. (silence) I've been disconnected from them for so long that ah it's like I never had a family. I don't know if I was ever wanted or loved. Growing up in our home was totally chaotic and that's why I took off. And then, I've been gone so long, I don't know what a real good family is. I mean like you watch the Waltons and you go well that's t.v. and that's it. It doesn't really go like that (pause) I don't know.

<u>System Incompetence</u>

In addition to describing painful home lives, the women also described living with system incompetence and cover-ups. The social support and care

provision systems that were designed to protect them were viewed as ineffective and/or inappropriate.

> **Kendra:** Well, just with my life I like I I fell through every freakin crack you know like when I was being abused it was it was covered up very well by professional people, a lot of professional people, and you know that's not supposed to happen.

System incompetence was seen as being directly related to eventual life on the streets and drug use.

> **Tara**: Drugs were my way out.
> **Researcher**: Way out of what?
> **Tara:** I was um, like I was born to a native mother, my mother was an addict, and then I was ah apprehended from her at four months old because in the hospital the I was in drug withdrawal. Placed in the hospital, and then placed up for adoption, and I got adopted at age 2 or 3. And then I lived with those parents until I was 12. I kept running away from home and social services kept asking me what was going on. So I told them. They took me away and wanted me to testify against my dad. I was a kid, I was scared, they didn't seem to realize that, or care anyway. So, I ran away from social services. I mean how could I trust them, they fucking took me away from 2 homes, where would they put me next. And then I ended up on the streets with an addiction problem. The addiction was fun and games at first and it was you know the glory and the fun of being out on the street and yada yada ya

Most of the women described leaving home at an early age because of family problems, emotional rejection and/or abuse. One woman reported getting pregnant as a teenager and being forced by her father to leave home. The participants felt that their childhood experiences compromised their sense of worth. The majority of women had started experimenting with some form of drug

before they had left home. Upon leaving home the women became involved with regular drug use while living with a partner, becoming further entrenched in a social services agency, and/ or becoming street involved.

Engaging in Drug Use

The environment and the relationships the women developed within that environment played a major role in the their decision to engage in injection drug use. Participants recalled that entering into the drug scene made them feel "a part of something." The following narrative is of one participant's experiences around engaging in drug use. This case study is offered as an overview to explore the impact of the decision to use drugs. It is presented as an extended sequence of narratives to provide a more integrated summary of initial and subsequent discussions around drug use. This case study also serves to introduce several of the themes and issues brought forth by the participants around engaging in drug use.

Case Study – Elizabeth's Story

Elizabeth explained that the drugs helped her to cope with loneliness. She described feeling completely isolated from her family after being "kicked out of her home." Drugs helped her to fit in:

Elizabeth: You start because it makes you feel like somebody, feel better than what you really got, makes you forget everything.
Researcher: Can you tell me more about that, what were you trying to forget?
Elizabeth: Um, well my boyfriend, my boyfriend used to drink all of the time. After I left home ah with him and our baby, we had an apartment and he was working at XXX, XXX Industries. He got paid every Friday, and he would bring a case of beer home, and we, we would go grocery shopping. And he would stay home and drink, all weekend he would drink, and he'd always ask me you know you wanna have a beer or do you want me to buy um vodka or wine or something else to drink with him. But um, I didn't wanna drink because I seen my dad, my dad is an alcoholic and I remember feeling scared, I was scared of my dad when he was drunk. He kicked me out when I got pregnant, even though I was only 14, so we were living away from all my family, My boyfriend, he made 21 something an hour, an that's why we moved to Regina. My family was in Manitoba all of them lived in the city, and I lived there for 31/2 years. I ended up um, starting to drink over there because I got lonely, ah I missed my family. And his, he had his sister, his brother and his um nieces and nephews, his family part of his family lived in Regina, and they all drank, all of them. And ah, at first I was the only one that would drink ah orange juice, Pepsi ah apple juice and rootbeer and you know ice tea. And ah they would always ask me you know why don't you have a drink, why don't you have a drink and it got to the point where I just ah, I got tired of ah watching them drink, and I was lonely and kind of vulnerable, I felt left out because ah I couldn't go to the bars um because I had my baby. I had, I had, I only had J, but I had P and I had Je, I had three, and I did not want my kids to see me drunk, because I remember seeing my dad drunk, and I didn't want my kids to see me drunk

Researcher: So then tell me about the day you took your first drink.

Elizabeth: Ahh, it was a Sunday and we were having a barbeque, it was somebody's birthday or anniversary. Um, my boyfriends ah sister, it was her birthday I think. And they were having a barbeque and there was a a lot of liquor, beer there was wine there was vodka, there was rye, gin, they had everything. And um they kept offering me drinks and um, and ah one of them, his sister said oh you should have one, at least have a drink it's a special occasion you know you're making everybody feel ah, feel bad

because you're not drinking with us. And ah, and it's kinda rude when ah, when you go to a special occasion to somebody's house and you don't have a drink. Everybody, you're making everybody feel awkward. And ah I wanted to leave, I, me and my boyfriend, we had a, we had a fight and, he told me ah, I told him everybody knows I don't drink, I shouldn't ah, I felt like I was being forced to drink. And out of anger I took ah, beer, I had a beer, I drank a beer. I had a beer and it tasted awful, I did not like it, I didn't enjoy it but I forced it down anyway. And I had ah, then I had another, and ah, after my second beer ah, I felt um giggly, and ah um giggly and ah relaxed, and ah I could talk more, because I was usually quiet. And here after two beers I was talking to everybody instead of ah just yes and no and was actually ah having a conversations with ah his whole family, well part of his family. And I started dancing when they started dancing, um and I never danced, I ah wasn't allowed to go to a school dance when I lived at home. And ah nobody laughed when ah they all knew that I didn't know how to dance. And I had a, I had fun actually, I had, I had fun.

But it got out of control. It ah used to be just Saturday's, and then it ah would start Friday, Saturday, Sunday, and then during the week because his sister, his sister um, um, her husband and my boyfriend they both worked at ah GE Rail, and ah, they worked ah nights, so me and her ah, we would stay home during the week. Tuesday's she always drank Tuesdays, and at first I didn't drink with her. But she would come over to visit, she always brought a 26 of vodka or a whisky, or wine, but she always brought something to drink.

And ah, at first I didn't drink with her but then after I had that, those two beers when I danced and talked with everybody and I ah started drinking along with her.

Researcher: Can you tell me about then the first time you used, what made you decide to use needles?

Elizabeth: Because I caught my boyfriend in the bathroom, he was doing it. And I've never been with anybody who did drugs before.

Researcher: So, when you caught him what did you do?

Elizabeth: Oh I got mad, I freaked, I threw ah, we had a big argument and I threw all that he had a spoon, and he had forgotten to lock the door, and I walked in and he was shooting up. And I seen the spoon, and it was black

on the bottom, and it was on the, he put ah Kleenex so it wouldn't leave any marks. He put the spoon there and ah I walked in just when he was doing it, and I freaked and I'd never lost my temper that that bad. Because to me I never, well nobody well nobody no body ever ah ever things they're gonna do drugs, first of all, they don't, cus I never planned on ever ah doing drugs.

I took, I um told him well if you, if you, I wanna know why you like it, why you do it, why you like it, Like what's it, what's so good about it. That you would ah put that into your body, and ah he ah at first he said no I don't want you to ah do that. Ah, and I told him well either you ah, either you ah give me some ah or else I'll go and get somebody else. So he did it for me. Now I was like him, him and his family. Now I had something too.

Elizabeth's narrative describes the pain in losing her family, the desire to have fun and a need to fit in and belong to something. This case study conveys a sense of how the participants shared their life experiences during the interviews. In many ways, it also represents the themes brought forward by many of the participants. The experiences of loss created painful existences for the women, and the women hoped to cope with these experiences through drug use.

Experiencing Loss

Loss appeared early in the lives of the participants. As indicated in the earlier chapter, a number of childhood conditions gave rise to painful feelings of loss, including physical and emotional abuse. Loss emerged from the narratives as

the dominant theme when discussing events that led to their initial drug use. The participants discussed losses associated with family breakdown, failed relationships, and losing their children to social services.

Family Breakdown

Many women reported the impact of dealing with family breakdown. One participant described feeling blamed for everything that went wrong in her home. She reported that her parents sent her to Winnipeg to get "professional help" from a social services agency when they could no longer cope with her adolescence. She felt alone and abandoned, and it was under these conditions that she turned to the streets.

> **Laurie:** I'd like for them to stop blaming me for everything. I've got a brother who blames me for everything that went wrong in my family; and I've got two parent's who can't take the blame for anything that they did wrong, you know like, sure o.k. I ran away at 15, but I also came back and told you that you know, I wanted to try to make this work and this is what is wrong, and you know how do we work that and what did they do, ship me off on the next bus to Winnipeg (laughs).
>
> I was still stuck in the middle of a part I wasn't prepared for, and I hadn't allowed anybody to get close to me really. I didn't know who I was and my parents didn't want to know who I was, besides other people who were the same age as me, going through lock up facilities like I was, you know, in the same group they let me be part of them, party with them.

Charmaine also shares her perceptions of how her poor family relationships have affected her drug use.

Researcher: What about your family, you said you don't really talk to them or anything.

Charmaine: My brothers and I have never really had much in common, I have two brothers. The only thing my brother that's two years older than me and I had in common there for a short little time was using. But now we stay away from each other, I don't like him when he's using, and he drinks, and I don't like him when he drinks. My other brother is not a user, he has no drug problems at all, but chemical dependency is really but he's just a snot. It's just the way he acts, I don't like him. Ok so that's my two brothers, I have no sisters. Um, my mom passed away two years ago or last summer I forget when. Whatever she did, it didn't matter it doesn't matter because I hadn't talked to her for like two years before. And that's a shame and guilt thing. I just didn't want to have anything to do with her. And she has a husband, she had married a guy about 20 years ago, so my step dad. But he is not my dad and I never had anything to do with him really, not much. No close relationship. And I have two kids. My son he won't talk to me when I'm using, so he avoids me. And my daughter who is 23, my sons 20 my daughters 23 and she lives in Victoria. And I did something that fucked up our relationship about three years ago, and I haven't talked to her since. So, that's the extent of my family, I just avoid them. So that's family. Now, friends are not really friends, they're users, and before that they were drinkers. And when I drank I very often drank alone. So, I never, never got into any good friendships at work and I worked there for like 20, 20 something years. Just don't make friends easily. I think that is really where my drug use stemmed from, it was so I could hang out with people. I wasn't gonna make it in life otherwise, no matter what.

Loss of Children

Two participants described the loss of their children to Child and Family Services as having an overwhelming impact on their lives. They describe turning to heavy drug use as a means to "numb out" the guilt and shame associated with

these losses. Doris described moving from alcohol and pills to injecting drugs as a means to cope after having her children apprehended:

> **Researcher:** How, how old were you then when you started using needles?
>
> **Doris:** Ah, when I first tried ah needles , ah lets see 18, I think. 17, 18 I think. No, no it wasn't it was um 19, I lost my kids. They took them away. The booze just didn't fucking cut it anymore, I needed something else. One of those junkies was doing that at a party, and kind of introduced me to it eh.

For Kendra, her first child was taken from her because of her drug use. She recalls this incident as being devastating to her. Her drug use escalated as a means to escape her guilt:

> **Kendra:** I mean like how many how many women addicts you know have children. And then they lose their children, and then they got that that extra guilt, and so they're using to hide the guilt and what not. And and then um that becomes more painful, and then um all the kids suffer and they grow up and feel neglected, oh my mom has chose drugs over, well how can how can she quit if she doesn't have her children, or she's not allowed to see her children because she's using. I mean, you know it's like this cycle that's really hard to get out of, it's really really hard to get out of. I ah I lost my first daughter because when I went into labor with her I was high. I just started using more and more, it was the only thing that helped me feel better.

Loss of Relationships

Failed relationships and continued physical and emotional abuse also emerged as on-going losses according to the women's narratives. For Billy,

rejection by her husband when she was pregnant with his child was the most significant factor contributing to her drug use.

Billy: I started doing needles about a year ago.
Researcher: About a year ago.
Billy: (deep breath) ahhh , my husband (long pause, tears) The needles helped me feel high, feel good. What happened with him, was ah, we were just fighting a lot, like all the time but with him um he was a real pothead eh, he was into marijuana. So I went to work everyday the trusty little girlfriend, and wife whatever, supported his ass basically for 7 years, um we bought a house, and I knew like he was an outreach worker, it was just an excuse for a job basically. (Laughs) For him that's what I'm saying. He didn't have no degrees or nothing he just like got lucky ok. And ah so he was working with all these young girls in QQQ Park, and ah one, and I just knew, you know had the gut feeling that he was screwing around on me and I I tried phoning a private investigator actually (laughs) and they were way too expensive (laugh) it's like holy shit. Even if I tell you like I'm telling you exactly where to find him and it's still like no way, so I did it on my own and I I found him like the first time I went out ta check up on him at work he was with his girlfriend. And ah, then a he suggested marriage counseling. I kicked him out, whatever, he called the cops on me. And ah, they took him, they removed him from the home (pause and sigh). And ah I got a lot of mental abuse in the relationship eh like big time. Some physical but mostly mental. Like everything was my fault and he had a way of convincing me. And just calling me down and saying nobody else would ever want me and ah that I'm no good and like with my physical appearance like with with my my mental state, like just calling me like, calling me down every chance he had. Like, and it ya ya have a person doing that for so many years, you believe it. You know, I couldn't leave my house for the first 3 months after I kicked him out, I couldn't leave my house, I couldn't eat I did sleep, I slept on my couch for about a year after. But um my family actually my sister, my mom and my sister showed up on my door one morning and ah because I couldn't go ta, I didn't go to work, I just a stopped living.... This person was everything to me, he was my world for 7 years, I mean he was my world, he was my everything. Like it revolved around him. When he left, or

when I left, kicked him out and then when I found, and I got, found out I was pregnant two weeks after I kicked him out (cough)

Billy described feeling abandoned, hopeless, angry and desperate after her husband left her for another woman. For her, drugs were a coping mechanism and a means of self-medicating.

Laurie also describes being devastated by a crisis in her relationship. She recalled the shock of finding out her partner was HIV positive while pregnant with his child:

> **Laurie:** I used to party a lot, I used to go to bars a lot. When I had my baby my life changed completely too. I got pregnant, I couldn't party and work and what not. But unfortunately being a mom wasn't in the cards. My daughter was six months old when I got into using intravenous drugs, and, you know changed my life in a totally different way....(tears)The father was HIV positive. (Laughs). You know, and that was the biggest thing for me. You know having to deal with that all of that shit was a huge thing. Like the father of my kid came to me when I was four months pregnant, you know and told me (laughs), you know. He made love to me took me to the bar and told me he was HIV positive, I stood up dumped the beer pitcher over his head and whacked him with the jug. For a long time I was so scared (long pause) I kept getting tested and it was like negative, but I couldn't understand how I couldn't get it. It was so much pressure, I knew was going to die and I was killing my baby (tears). I was so scared, she was born and they said everything was ok but I just couldn't take the pressure. One night I got really drunk and asked someone to shoot me up. The next day I didn't even remember if I got high because I had been so drunk, so I asked someone to do it for me again. It all went downhill from there. When my daughter was six months old I had to call my parents, tell them I had a drug problem and ask them to take my baby.

Laurie's sense of powerlessness is evident in these passages. Like her, many of the participants reported that they had few resources to deal with the losses confronting them. The women frequently described feeling alone, or even rebuked, when having to deal with their problems. While the support of family and partners seemed to be out of reach, drugs were not.

Coping

The street provided a new life for the women. While their childhoods had been filled with violence and rejection, drugs were easily accessible and the streets were a source of excitement and adventure. Getting high was the main strategy the women used to deal with loss. Getting high felt good and, as one participant described, "most days it's the only thing that makes me feel good." Drugs were used as a means of creating pleasure and to cope with the realities that the women often found too physically or emotionally difficult to bear.

Loneliness

Charmaine, describing a picture of herself walking down a street alone with her back turned to the camera, explained how getting high helped her to cope with her loneliness:

> **Charmaine**: Drugs. It's me being alone (long pause) Everything I do is alone, I go to AA meetings alone. I go alone, I leave alone. I go to Bingo, I go alone I leave alone.

Researcher: How does this make you feel?
Charmaine: I think it's a problem because I'm very much a loner, I have no group of friends. (Laughs) My worker asked me today, said is there anybody out there who you know who isn't a user, and I said well there is this researcher, no I'm just kidding. (laughs). No I don't not outside of AA or those self help groups. Outside of that I don't know anybody who isn't a user. I haven't got friends from school I haven't got um family really, not much anyway, I don't have, I don't have anything to do with most of my family. Um, I don't know. I think that the fact that I'm alone all the time is, ah I don't know I don't know why it is... I just, it's just how things happen, but I don't know why, why am I alone. I go to church by myself, I hate that, I wish I could find somebody to go to church with me but no, people just, I don't know why.

Laurie recalled how initially it was her involvement in the sex trade that helped her feel good. Men's willingness to pay for sex made her feel desired and needed.

Laurie: Loneliness, I I hate being alone, it just drives me batty. Feeling, feeling wanted and and being needed, you know is a major thing. Like that was why I was on the streets because I felt like you know there is all these other girls out there, and these cars are driving around, they could have anybody, you know probably for a lot less than what I was charging when I was out there you know, and they'd stop and they'd pick me up. It was, you know, you make me feel good by doing something like that.

Eventually, her experiences in the sex trade resulted in her carrying a sense of guilt and shame. Drugs were used to help her escape those feelings.

Worthlessness

Laurie and Marcie describe how they both soon began to see themselves only as 'street whores', undeserving of love. They recalled how drugs numbed out these feelings:

> **Laurie:** I was feeling pretty bad about myself, and went back to using and like I've lived in in Winnipeg for 15 years, and 10 out of those years I was on the street, 8 of those years I was an intravenous drug user. So pretty much my whole life in this city has been nothing but prostitution and drugs. So it's it's so easy for me just to fall back into my old my old groove to think I'm not worth shit. You see, we tend to get stuck in a point where you know we feel like we're useless what's the world ever gonna you know want from us, you know. Why they already think we're scum, they already kick us to the curb every chance they get. When I was living on Main Street what I had was a bed a table a chair and a lamp. Lots of spoons, lots of cups you know because I needed those to get high, but that's all I had. And basically what I had was nothing, so it made me feel like I was nothing.

> **Marcie:** mmm hmm. Um well, you know I've been working the streets since I was twelve and ah, I just don't feel good about it. It helped numb me. Um, it's a coping mechanism, something to hide behind.

Reality

Drugs also were the answer when day-to-day life became difficult. Getting high functioned as a means of escaping reality:

> **Charmaine**: Well, when you get high you get high because you don't wanna face reality.

Researcher: Tell me more about that.
Charmaine: I don't wanna face things. Like my ah tires were slashed a couple of weeks ago. And ah, I just didn't want to deal with it. I just didn't want to deal with it, I didn't want to fix my tires, I didn't want to do nothing about it, so I found dealers that would deliver to me, and I got high. I was high for like a couple of days.

The women began to see themselves as worthless. The further they became immersed in drug use, the further they saw themselves as being undeserving of love. The more worthless they felt, the more they would turn to drugs in order to escape the depths of their painful life circumstances. The women began to feel confused; they no longer were sure of their right to feel angry over their experiences of childhood and youth or to feel guilt and shame over what they had turned to. This confusion overwhelmed their ability to cope. Seeing few alternatives for themselves, drugs became the most efficient and available way of dealing with life. Once again, the women saw a need to escape their life circumstances. Drugs became the answer.

On-Going Drug Use

Street skills

Money Skills

Eventually, day-to-day survival on the streets became the focus for most of the women. Money and energy was often spent on obtaining drugs and little

was left for basic needs. New skills were required in order to survive. The women recounted that they felt like they had very few options available to them to make money. Elizabeth described the only means she felt she had to make money:

> **Elizabeth**: There is two or three ways to make money when you are addicted. Ok., selling, selling drugs, um the other one is stealing. Um stealing from stores. I know a lot of, I know a lot of people who do that. They all get caught, but that's how they support their habit, um, stealing from stores, or selling drugs or ah selling yourself, prostituting. Those are the only three ways that I'm, that I know of or have heard of. I even tried that once (prostituting) but I couldn't do it.
>
> **Researcher:** So what have you done to support your habit, how have you managed?
> **Elizabeth:** Um, selling a little bit. I sold a little bit out of my house. That didn't last long because I was too scared, um the risk was too great, my kids, when I realized that I could lose my kids I stopped. When I first started I thought it was great, I'm making all this money and you know I'm not gonna get caught, but that's the biggest lie that you could put in your head. My boyfriend, he still sells sometimes.

Elizabeth went on to explain how she managed her money on a day-to-day basis. She needed to consider how to budget for herself and her family's needs as well as her own drug related expenses:

> **Elizabeth:** Oh, I plan, planning my, my budget (laughs). I'm really good at the budget.
>
> **Researcher:** It sounds like it.
> **Elizabeth**: Cus I've been ah grocery shopping since I was 7. I started babysitting since I was 7 for my mom, helping my mom. I used to do laundry, grocery shopping, cooking and baking. And diapers, cloth diapers

too. They didn't have pampers then, I wish they did. But now, it is very hard.

Researcher: Tell me about that, why do you think it's hard.
Elizabeth: (Coughs) Well, you have the kids, you have the kids, you have to think of them first, and you have to make sure, you have to budget, always budget. And you have to make sure you buy enough food until your next cheque comes, and I get mine split. That way I get a cheque ah in the middle of the month, around the 12, then I get my child tax on the 20th, then a week later I get my ah, my ah other cheque.
Researcher: So tell me how does that affect your ah drug use?
Elizabeth: Well sometimes I have to sometimes I have to, I buy less, less drugs, um but if things are on sale, I'll buy, I'll buy them and I'll buy them in bulk. I'll buy meat packs, and then I'll have extra money, and then I I don't have to um, I don't have to run around and and steal or um, I haven't ah worked on the street. I tried it once, I did try it once but when the car pulled up I couldn't do it.

Billy also used creative means to obtain her financial needs:

Billy: Like I'll go and ah sometimes we we ah ah (cough) we'll um collect scrap, scrap metal. And you know hey shit you can get like ten bucks for in one (laugh) morning, and that's enough for a pizza you know (laughs) at this place on Sargeant, and it's good pizza, and it's like wow. Whereas before it was always Pizza Hut, and nothin but. Now it's like just to have a slice of pizza is an amazing big deal.

Other women turned to the sex trade for money. These women described initially turning to prostitution as a purely economic means of survival. Laurie described how the sex trade was enmeshed with her drug use. She worked the street in order to pay for her drugs, and she used drugs in order to numb out the reality of working the streets. She felt trapped in the routine of working the sex trade in order to make money. A vicious cycle ensued with few alternatives.

Laurie: I'd wake up, if my hair still looked ok go to work, if it didn't do my hair go to work. Get high go back out to work. That's just the routine I had for so long. But then again like I said I had nothing. And the inner the inner self had nothing

In other situations, sex was traded not for money, rather for drugs, shelter or food. Kendra described having sex with her dealer in order to obtain drugs :

Kendra: Well, it was in um, I was in B. C. And I was very I was very, very addicted, and um, this guy, this, one of the dealers I knew he ah, he liked me. And kept saying you know, he'd give me some free 'dadada' if I slept with him. I never did never, did until one day I was absolutely broke, I was sick, and desperate and so I did it.

Survival Skills

In addition to learning new skills to obtain money, street involvement required that "survival skills" were also earned. Many participants recalled acquiring a sense of "toughness" and "bravado." One woman described herself as "down right mean on the outside." These skills were described as necessary in order to protect one's self from harm and violence. Tara recounted how street smarts were obtained from living and working on the streets:

Tara: I know myself very well, and I'm not a stupid woman by any means. I'm a very intelligent woman, and some of the most intelligent people in this world are us drug addicts and us con artists that can con you out of just about anything. You know, we're not just all drug addicts are stupid or idiotic whatever, but no they're not, they're actually pretty intelligent people. I mean they can get what they want, when they want it, they will have it. Plain and simple. Now if that doesn't take intelligence, I don't know what does. Wheew (drags on a cigarette?) But that's (pause) is all I have to say about that. Except that I have a you know a 16 year old girl on the street that knows way more then any of those people would know about street kid culture. Cus it is, it's a different culture all together. You have to learn how to survive, survival instincts. You have to know how, you know to remember things, like just even the color of a car, or scars, marks and tattoo's on people's bodies. These things all have

to be kept, you know, in mind when you're out you know risking your life every night of the week. And this skills just come to you, they're not really learned. They just come to you, but they're they're unwritten, but they're rules and they're definitely there eh.

Risk Environments

In order to survive the women often found themselves living in environments they considered to be demeaning and dangerous. Doris remembers nights sleeping outside in boxes throughout the winter. When she finally had enough money for a place to live, the apartment was one room; small, smelled foul, dirty, and the walls were riddled with holes. Often she would turn to social services agencies or churches for a place to sleep. Each of the women described their environments as being fraught with dangers. Kendra explained:

> **Kendra**: You know the neighborhood I lived, and this, I I remember this distinctly. This one afternoon in rush hour traffic, there were thousands of people going by. Two people were stabbed to death, but nobody saw anything, that's the kind of neighborhood I lived in, and that's the kind of person that I was hanging around with.

The following case study describes the perceptions of risk in the street and drug environment for one participant. It offers an overview of the impact of living in a high risk environment and explores the influence of the environment on her on-going drug use.

Case Study – Tara's Story

Tara discussed the danger and violence in her social network:

> **Tara:** I found my friend hanging dead in a closet, I watched my other friend have his head shot off, and my other friend was strangulated in the same house, just a different suite. And my girlfriend had a cocaine seizure, had a heart attack and died in front of me, so all of these things put together, the homicide detective kept showing up and going hey you again hmph... what are you doing here. Well you know, I was just there you know doing drugs, and doing shit you know, like banging drugs or whatever, and well hey, it happened, nothing you can do about it. But Brad, the friend who I found hanging dead; I cut him down, I gave him CPR. His family thought I murdered him, by giving him CPR, even though the autopsy result came back negative that it was a su suicide, not a homicide. (Sigh) But they put a gun down my throat and said look bitch you tell us what the fuck happened to my brother and you tell us now, and so homicide came busting through the door and took us all to jail, and they said you know Tara you gotta get the fuck outta here, or you're gonna be next on the slab with a toe tag on.

She explained further how these incidents have continued to affect her life:

> **Tara:** I have a severe depression problem, that's what they diagnosed me with. But I also have post traumatic stress disorder, panic disorder, and anxiety attacks from what happened. I mean you can't watch a friend have his head shot off and not have some sort of repercussions, and you know, I have um dreams, I have cut somebody's throat, I mean from here to here and their head was hanging off just by this much. I had another dream where I'm whacking away at my hand with a knife and I'm doing it on a bone, and I'm not doing it where the vein's are, I'm doing it right where the bone is and hacking away. I had another dream I got beaten up walking down the railroad track, panty and shirt on. And, by warehouse workers, I get home and this guys sitting there and the doors all ajar, and he gets up and he says you owe me money for drugs, and slash, off comes my drug dealers head and his pinky and I go bolting down this corridor and I jump over a railing to my death. And I gotta figure out what's going on in my head, and why these things are reoccurring. Like, it's been like

well (mumble) everyone I talk to is dying. My girlfriend, her friend in ,in the basement dead. It just doesn't end, and my mind just doesn't have time to recover from one before it relapses into another. And then you use the drugs, hey man let's just forget about it skeeew skeew (sound effects) stick another rig in your arm, and that's what it became. I have to get this out of my mind, and the only way I know of getting it out of my mind is digging a rig in my arm. All this shit is coming from somewhere, I don't know where it's coming from, but boy I don't want to live my life like this, it's going to drive me insane.

As the violence escalated in Tara's life, so did her involvement with the police. She considered manipulation and violence as a much a part of her interactions with the police as with her drug using friends. She described situations where she was put in danger because of police attitudes and where her concerns were ignored because of her criminal history. Tara elaborated:

Researcher: So, you wrote down here on this picture, I hate cops, they're hypocrites and I don't respect them at all.

Tara: No I don't.
Researcher: Why does that problem exist?
Tara: Well because I mean ah I'll give ya, well how many examples you want (laughs).
Researcher: As many as you wanna give me.
Tara: O.k. I'll give you three, how's that, things come in three. Example number one, police officer, ah friend of mine J, he lives at the _____ hotel, picks me up down on the Ellice (Sniffle) or Sargeant or one of the streets, anyways, and ah the cop sees him pick me up, so he stops the car. And kicks me out, and makes me walk. Like this is a friend, this is not a john, this is not, I'm not working, he just invited me over for a couple drinks. And then, this police officer, got his number ####, (laughs) I got his badge number maan. Anyways, (the police officer) proceeds to lean in

the window and say, do you know she has AIDS, after kicking me out, making me walk, them, and then leans in and says that shit. So to me (banging on table) that shows me how ignorant you are. I do not have AIDS, I have HIV which is the virus that causes AIDS. So, you're just showing how ignorant you are, and he had said that, I can't remember how the conversation went, but it went along this line, ah he goes you know she has AIDS, and I says I do not, and he says yes you do. And I said you're a liar, and he said no I'm not. I said see that's just how ignorant you are, and I walked away. So that's one case scenario where the police's ignorance is is very unbecoming of them, considering they're on the front line and they're working with these people on a daily basis. Their ignorance should not be something that they can use, be used against them. I went into this police station to report the hookers and the drug dealers were using my last apartment for um drug activity and what not, and they said, well get the landlord to do something about it. I'm like excuse me I've already told the landlord, we've already had this discussion, and there's people breaking into my place and you guys don't give a shit. Why is it just because I'm a hooker or what. Like what's the problem here officer, I said don't you care about these things. Oh we care, and I said obviously not and I walked out. I mean that really pissed me off (sniffle).

And another example of what the cops did to me that I could probably say. They picked me up right. And they say get in, so I get in, and they say show my partner your tits. It's ah his birthday, and I'm going, and they did this to me two nights in a row (bangs table). So anyway, the second night I said I thought it was your partner's birthday last night. Oh he has a blah blah whatever. They couldn't fish any information out of me, what they were trying to do is get me to rat on somebody, and I just went no. And who on God's green earth ever gave you the right to talk to me like that. And these are just some of the issues with the police. Why should I respect them when they're doing, pulling shit like that? (Silence) That's not right, I mean, and then another cop his name is S and he's telling me oh yeah he's still got it for a woman at 34, and yada yada yada, you're beautiful , blah. Hello, the lights are on but no one's home, it's over. Trains or brains, you took the first one out of town eh. ... well yeah, the police arrest you they put you in jail, you don't even have time

the charges are so petty you know, they're just petty, there's no reason they're even doing them.

Tara's narrative describes the violence and trauma associated with the social environment in which she was living. The violence was associated not only with the physical danger of living and working the streets, but also the institutional violence associated with becoming involved with the police. This case study is representative of the themes brought forward by many of the participants. The experiences of violence and involvement with the law were sub-themes that continually emerged from the participants' narratives when discussing their risk environments.

Isolation

The women soon realized they had very few people to whom they could turn, as they became further alienated from their families and non-drug using friends. They soon realized that they had very few real friends, as their street friends could not always be relied on or trusted. Charmaine describes a photograph she took:

> **Charmaine:** This is the living room of this guy that I met very recently. But um, what I got here is this is the living room of a friend, but is he really a friend because the only contact that I have with him is when we're using drugs. It's always drug related. So he's not really a friend, it's just, he's a nice guy and he's easy to chat with and he's fun to get high with.

> There's not too many people out there that are fun to get high with anymore, you know. Everybody gets wickedly paranoid. You see, friends are not really friends, they're users, and before that they were drinkers. And when I drank I very often drank alone. So, I never, never got into any good friendships at work and I worked there for like 20, 20 something years. Just don't make friends easily.

For Tara, even the women she had known and worked with on the street for years turned against her:

> **Tara:** I had a hooker throwing rocks at me because this other hooker told her I have AIDS. And, it's really none of their fuckin' business. Never mind I use protection every time I am with a person. They can not contract it, and she's chucking rocks at me. You know, you wouldn't even do that to a dog, and here I am a human being, and I feel just totally degraded, and I'm tired of it.

The isolation felt by the participants created a sense of vulnerability The streets, which had initially offered them a place to hide, were no longer welcoming to them. They were no longer sure where they could go and with whom they could make contact. They identified feeling both physically and socially isolated.

Health Problems

The participants' narratives revealed that eventually injection drug use began to present new problems. Many of the women soon found their health deteriorating. The fun and excitement of the high was being replaced by the reality of an addiction and diagnoses of HIV and/or hepatitis C:

> **Tara:** The addiction was fun and games at first and it was you know the glory and the fun of being out on the street and yada yada ya. And then it became a little bit more serious afterwards where it almost took my life on several different occasions. And then I guess all the fun and games were completely depleted when I found out that I was HIV positive with hepatitis C and hepatitis A, and hepatitis this, and holy o.k. now I have gallstones and everything else, and my liver's shutting down and this is no longer funny. This is, this is not a fuckin' game anymore. My choice was you can quit or you can die. (Silence). Not much of a choice.

Billy also recognized that for her, continued drug use was a potential death sentence:

> **Billy:** And if I keep using, I'll die. A lot sooner than, you know, if I cleaned up, I mean but there's a there's a double side on that, like, this is a lot of negative but it it's not a very positive lifestyle, you know. Like, with my hep now, and this is like, you know maybe because I'm not educated enough about it. Maybe that's why the feelings are there, but um it's like what's the use now, you know, in cleaning up. I may as well just ah like, to have, to have your using being one of the only good things that that you look forward to every day is a sad thing, you know. Like, but you know, when I was clean for like three weeks or whatever there, sitting in a park in the afternoon like, wow, it was just like the greatest thing ever, you know.... And I think maybe just not wanting ta, like I don't wanna die, you know. Some days I wanna die but in general I don't wanna die.

The benefits of drug using had come to be outweighed by the real and potential problems associated with drug use. Their social environments were dysfunctional and hurtful. Any sense of self-assurance and power gained through drugs was entangled with health problems, crime, violence, and ultimately, self-destruction. This was the observation surrounding all eight women's recognition of the need to manage their drug use. They all identified wanting a life that was

not controlled by their drug use. Elizabeth, describing a photograph she took, concluded:

> **Elizabeth:** The tv and the vcr.
>
> **Researcher** :So tell me about this, why is this picture to be included?
> **Elizabeth:** Um, well because ah um ah the tv because I can lose myself in the program, um make believe program. Um, something that um a way to escape, my tv is a way to escape. And a hide out from reality for a little while, because I don't like the way I'm living, I hate it and I just it's a way for me to get away even though I know it's not true and you know at least for a little while I can pretend. And that way I can keep going, you know, it sort of gives me a little push instead of just um instead of just um going at it by myself. And, well I've been wanting to,(quit) I've been wanting to for a long time. And when you started coming around you made me think more. Christmas is coming up and I don't wanna be addicted to anything. I'm tired of ah having to um take pills you know to be normal, um I'm just sick of being sick. I'm sick and tired of having something control me. My, I haven't realized how bad I was, how much ah, how much of myself I've lost. And the biggest lie I had, in my head was ah I'll be ok and I can handle it, you know that was the biggest lie. Ah, (sigh). I don't like um not being in control. I um, I feel like I'm stuck ah like I'm in a, like I'm in a river, or or I'm at the bottom of a well. And I can't get out, every time I time I try and climb a little bit up and I'm almost there I fall back down again.

Hope for the Future

Deep down, each of the women recognized that despite their drug use, and the environmental and social conditions in which they were living, they were still good, valuable persons, deserving of respect and human dignity. Each of the women carried with them a sense of hope, a desire for the future. The women's

resilience and the support of community programs assisted in this desire. As Kendra expressed:

> **Researcher:** This next picture, it says "it's important being able to always dream, and know what, that whatever I dream can be made possible, so long as I believe and keep trying. When I stop dreaming of better things to come, and the possibilities that I can offer my daughter, then it will be a sad day. It's always within me to make real my dreams."
> Tell me about this, this idea of dreams.
> **Kendra:** Oh, you know when I was writing, I was thinking you know ah I'd be - it would be so easy to be in a back alley, shooting up whatever, and then and then come around the corner and look and see, and look and see the mountains and then go, you know, someday I'd like to, you know, go skiing or go see those mountains and sit there being high, you know like. Or ah here, thinking you know, like you're all sick and thinking, well some day some day, when I'll have something better and um I'll own a business, and I won't have to live this way and um. Just believing, believing in dreams and, that anything is possible. And the only thing that comes between you and dreams is you, you know. And I'm a big believer in that, hope you know.

Laurie recalled how her sense of hope was sustained through the encouragement of a community outreach worker:

> **Laurie:** What's helping me to stop, I woke up one morning and I had track marks on both sides of my neck, both sides of my ankles, I was bruised from head to toe. I ah, I weighed a hundred and forty pounds. I had no meat on my body but I still had the flabby skin (laughs). I looked disgusting, and I had so many people telling me how much of a beautiful person I really was, that I was worth something.
> **Researcher**: So was that, the people who told you that were beautiful, believed in you?
> **Laurie:** At that time it was POWER. They, you know, constantly showed me that they cared about me and um one of the staff um XXX, she has been like a mom to me. You know and I've even I introduced her to my

> mom, when um my mom came in for custody of my second kid, and I went to court and everything um, XXX came with me, and um it was funny cus I, I said, mom, this is mom (laughs). And my mom kinda looked at me like, what are you talking about, I'm your mother (laughs). You know, it's like, you don't like it, it's too bad. It's not like you've been here, (laughs) you know.

All eight women had a sense of hope for the future. They all recognized that they themselves and their children were deserving of a good future. While affirming that injection drug use allowed them to numb their pain, the women also realized that injection drug use was not the solution to the violence and marginalization in their lives which they sought to escape. Injection drug use was not the answer.

Managing Drug Use

Once the women acknowledged that their drug use was self-destructive, each of the eight women sought ways to control their use. A number of conditions served to intervene, facilitate and/or constrain the women's actions to manage their drug use.

Duration of Time of Drug Use

Duration of time of drug use appeared to be a factor influencing the strategies the women devised to manage their drug use. Long-term users reported a strong desire to reduce or quit their drug use. They reported the need to "move

on with their lives" and some recognized the need to "quit or die." Those women who had become involved with drugs more recently, while still desiring to quit, admitted they were afraid to quit because they would miss the high. Billy, who had been injecting cocaine for 1 year, stated:

> **Billy:** I use because I still enjoy the high. I'm not gonna lie. Ah, some days it's the only thing that makes me feel good. Most days it's the only thing that makes me feel good.

Charmaine, who had started injecting cocaine 3 years ago, had been in and out of rehab three times in the past year. While she stated she wanted to gain control of her cocaine use, she didn't want to quit using because she liked being high. She was struggling with her goals for treatment:

> **Charmaine:** Um, all I can tell you is that everything I do, I do, as far as recovery goes, I find it myself. I don't know how to, how to get help for that. How to get help, go to the Addictions Foundation. I did, in December of 1999. I go to the Addiction Foundation, I phoned them and I said I'm using cocaine and it's a problem. Do you wanna quit? No. Well, if you don't wanna quit there is nothing we can do for you. And I don't wanna quit because I like being high. So, once I don't, if I don't, ah where I can I learn, where can I get the strength to want, not want to be high, how can I do that? I don't know, but I sure wish somebody would tell me, because I'm trying. I guess I'm just not worth it.

Charmaine and Billy both realized that they still "wanted to get high" as much as they "needed the high." Despite recognizing that they were "trapped" by their drug use, they were not ready to move on into a life without drugs. They

both described the conflict between the desire to "be normal" and the desire to "be high."

None of the women accepted that on-going drug use was their fate in life. Each of the women desired to, if not quit, control the amount and type of drug they used. Laurie, who had been a heavy injection drug user for eight years, was now only using occasionally and in moderation: She claimed:

> **Laurie:** O yeah, in the last five years, like it's been what, 5 years, I only use once in a while, none of the times have been you know, more than a few days, and they don't like interrupt whatever I have going on in my life, and stuff, I don't allow that, and well I keep it basically maintained.
>
> **Researcher:** How do you do that?
> **Laurie**: I make sure I pay all my bills and everything first (laughs). And then, if I've got extra money then I'm able to spend it on whatever I want right, but it doesn't happen very often so. Um, there is people in my life that make it possible that I could use more. But, like I said I, - I keep all that you know maintained, as far as I look at it it's maintained. Because, there is always, there is always that way of me getting to do more. It's never far from home.

Laurie believed in the philosophy of harm reduction. She felt that her ability to maintain her drug use had more to do with the support and structure in her life rather than drug use itself. She was aware of the environmental and social factors that caused stress in her life, and had developed a network to turn to for support rather than using injection drugs as a coping mechanism.

Support

Each of the women sought to control their drug use. The presence or absence of support in their lives was an important condition that promoted or curbed the level and frequency of drug use and the women's sense of control over their use.

Family

Only one of the women turned to her family of origin as a source of support while trying to manage her drug use. Even in this case, Billy stated that they were willing to help only as long as she followed their rules. She complained that whenever she spent any time with them they would monitor her: "I went and stayed at my mom and dad's farm for five weeks, that was like being in Alcatraz, you know I couldn't even walk to the barn without somebody beside me". After failing to complete a rehab program, her sister turned her back to her:

> **Billy:** She wouldn't even open the door for me, she wouldn't even let me in the house, because I left the program, and how could you do that? And, and look at what you're doing to mom and dad. Or I'd get, or I'd get messages on my answering machine, can you put down your pipe or your, you know, whatever, long enough ah to come to mom and dad's funeral, because that's where you're putting them. Stuff like that. Like that doesn't make me feel like that support is there, you know, it makes me feel like they have this idea of me even though they've known me the longest. And I mean, I've been through more with them then anybody, right, I mean that's your family.

Billy's family continued to show little understanding about the circumstances surrounding her behaviour and life decisions. Eventually she concluded that she would get little help from her family and she turned to a community health nurse for support.

Support Services

The other women all claimed that their families were "not there for them" or were "no better themselves". These women all identified social services agencies or community outreach workers as their support network. Tara explains:

> **Tara:** My mother was always there, but now that my mother's dead, I don't know, like it's totally a different scenario for me right now, and I don't know where my footing is or where I stand with my adoptive dad, and I wrote him a letter and I asked him to respond to it, but he hasn't, so what can I do. So, I mean, I guess that's another option to look at like for people that don't have family support, where are they gonna go, and that family support is not always an option. That you know, sometimes whether it be for their own health risks, or their own health safety, that these people need another avenue, like the community, to have as a means of support. Because that's what I had to do, I had to rely on community supports. Places that would give me some idea as to like personal health care even, you know, like you have to get up and have a shower every day, and that's something that I wasn't used to doing out in the street. I could go 3 or 4 days without having a shower, just wash my hair, or do a real quick wash in the bathroom or something like that, you know. And that's, you know, a different culture, it's a different lifestyle all together. So just even having the people in the community show you and demonstrate to you what, you know, you need to do to enhance your lifestyle, is a little bit better too, eh (silence).

Peers

Marcie, who had been living on the street since she was 12, found it very difficult to trust social and health services agencies. She felt that, in most instances, the support workers were more interested in keeping their jobs than actually helping anyone. Instead, she has tried to rely on other women in similar circumstances for her support:

> **Marcie:** Um, we have a group. But it's just a bunch of us um girls who have been involved in the sex trade and have addiction problems. And ah we just all get together bi-weekly, and talk about what we need to talk about.

Relationships

The women who were able to maintain good relationships with their partners and/or children appeared less angry than the women who had poor or non-existent relationships with loved ones. They identified being lucky to have supportive boyfriends and blessed by being able to parent their children. They, too, experienced a number of chaotic life circumstances, but the structure and responsibility of maintaining their family and love in their lives helped them to sustain a degree of control over their drug use:

> **Doris**: He helps, helps to keep me happy and keep me out of pain. He doesn't make me want to go use that needle. He doesn't want to make me pick up that bottle, you know he just helps me feel better, my partner helps me. Everything is my partner. With YYY, I told him right out of the blue, and I told my old man. That's it, I'm HIV positive. I mean I'm HIV and

> Hepatitis C. And ah, he's always there, no matter what. If I'm feeling down, he's always there. If I need to cry I cry. And I can talk to him, tell him what's going on. Instead of having to hide it from him. I am really lucky.

While many of the other women revealed numerous failed and violent relationships with men, none of the women blamed men for their introduction or continued use of injection drugs. While recognizing that men had influenced their lives and their decisions to use drugs, the women made it clear that they did not want to be considered victims to men. Rather, if they found a relationship detrimental or harmful, they ended it and moved on. They continued to seek out other relationships, hoping to find love:

> **Tara:** If your relationships are positive then I think that everything else will, will start to flourish around you as well. This is important to have those relationships and if it's not working to break it off or to go get the proper counseling that you need to deal with the issue. The problem is that it is not so easy (long pause) I mean we all want to be with someone, we all want to be needed it's really lonely out there.

Kendra, with a child to support, was working hard to control her drug use. She felt that being able to parent her daughter was giving her a second chance at life:

> **Kendra:** Ah, I just can't believe it (Laughs). You know, you know, like um she's beautiful, we have fun together, I think ah, I do, I don't ever want to see her go through anything I went through as a child, and she isn't. Ah, she just ah she helps me grow. I see things for the first time, or make, you know, like seeing, walking down the street and seeing, she's all

> frickin' amazed by butterflies and things ah, (mumble) just amazed, it's like I've never ever saw that in my life before. And ah, she inspires me every day, to, to have a good day, and be good. And two years ago I, I was homeless, addicted, and I'm building her a home now. And we have fun (laughs).

Love and Companionship

The women each described the influence of love and companionship in helping them manage their drug use. Women who stated they felt in control of their drug use engaged in more social and recreational activities. They reported having friends they trusted and could turn to when life circumstances became difficult.

Marcie describes the sense of balance she gets from taking time out from prostitution and drug use:

> **Researcher:** So, you talked about the need for some activities and structure, what do you mean by that?
> **Marcie:** Just, you know, things that people take for granted; like going on outings, you know going to the Forks or going to the Zoo and looking at the animals. Just being human again instead of being out there and selling yourself and getting high. So you can forget about selling yourself. You know, just some normal things, some normalcy to their lives. It brings a lot to us.

Doris revealing a photograph of a friend, discusses the importance of having a friend that will respect and accept you as you are:

Doris: This picture, Jack, he's a little friend of mine.. And ah good friends from two years back. I enjoy talking to him, like when he talks to us, he talks to me, talks to like my old man. He ah's not out there to pick me up like as a girlfriend. He has respect, he has respect and he, he, he respects, he respects me as I am. He knows I have a boyfriend, and he's not always trying to hit on me like my other male friends. I guess a lot of male friends, I've had a lot of male friends in the past and that's what they're always trying to do, is hit, hit up on me and this guys always been there, and crazy with me all of the time. And he just loves me like a little sister, just thinks I'm a little nut because his daughter, just she adores me. Got really close to him and ah his old lady.

Laurie, who is tentative about developing relationships with people, turns to her pets for companionship:

Laurie: And these two are of my cats. This picture is of the two, my cats. They're my unconditional love bear. They love me no matter what and I love them (laughs). You know, but you know I can't do much for them besides feed them (laughs) and change their cat litter you know. This is my boy, he always knows when I'm feeling down, it's like (laughs). You know, and that's him right there. He's always with me, when I'm at home he's always with me. You know, if I'm crying or anything he'll come right up to me he's not afraid to say, hey mom, I'm here. (laughs). It's so cool. I used to think that crying in front of people would just scare them away, or let them know that you're hurting. Even if he can't well yeah I think he can understand me, my boy, I think he understands me. You know, it may seem strange and a lot of people may think I'm totally loony or something, but, you know I can talk to my cat. He doesn't answer back or anything and I don't make him answer back (laughs) whatever, but, you know. I can sit there and just let things go or I can walk around my house if I'm mad at somebody, right, and instead of taking that frustration out yelling down that person or yelling down the next person that walks in the door or whatever, I can just be there by myself with my cat and I can yell at him. You know and he just brushes it off (laughing).

Prayer

Some of the women identified turning to a higher power for support. God was a non-judgemental being that helped the women feel better about themselves and deal with guilty feelings surrounding the decisions they had made in their lives. Women turned to prayer to help them gain control of their drug use. Billy describes the strength she gains from prayer:

> **Billy:** Just saying the serenity prayer, like I still say it, I say it daily, sometimes 10/20 times a day, I don't know if you know the serenity prayer.
> That prayer is just like wow, and I talk to God all the time. And God never used to be, phew, important. I always believed in him, but I always believed there was a higher power or God, a creator, but I never um like we didn't practice religion in my family, growing up. We didn't go to church every Sunday and all that, you know, but ah, now it's like, and I still don't go to church, but I, I talk to him all the time, and I believe he's listening, and and sometimes that gets me through a day (pause) or an hour. Whatever it takes, you know, but like when, when you got this sense of doom like everything is just too much, like cus I, oh you're supposed to deal with past issues, shit I can't. If I'm, if I'm high, yeah, I'll talk about it any time. But, dealing with like just everyday issues is just too difficult some days, like. Talking to God helps.

Similarly Charmaine describes the support she attains from prayer:

> **Charmaine:** Spiritual, spiritual help is is I think where my relief is gonna come, turning your will, over to the care of God as you understand him. So you can pray, and it does work. I don't know if I'm praying to God or if I'm just praying and relaxing my brain and letting my subconscious work. Whatever it is it works, I get answers, by just sitting back and saying help I need direction. I did that on the way here and I'm too wired, I'm too wired to relax enough to to let it work. If you don't believe pretend to believe because if you can pray and you can get the answers, and if you get the answers you start believing. And that's how it

works for me, and it does work, even when I knew the problem I can pray and get answers or or get solutions to the problems that I have.

Kendra also, identified her native spirituality as a sense of support:

> **Kendra:** You know I belief, my belief in my culture gets me through hard times, and um well it's kinda hard to explain. And ah, I believe so much, so much in the creator you know, another, something greater than myself, that um I rely on when, when everything is really, really bad. I believe, in my culture it says that that things happen so we learn lessons so, so you, so you learn something from it. Well some days it's like ok, just tell me what the freakin' lesson is. (laughs) Cus I'm tired of this, but um it's ah, everything has happened for a purpose, is happening for a purpose. That ah, I just, I just really strongly believe that you got ah, there is a creator out there and, so long as I live those traditions and stuff, things will be ok, and they are turning out ok.

Addiction Services

While the church and other social services agencies were described as supportive and helpful, addictions treatment agencies and other government agencies were viewed as non-supportive and judgemental. All eight women had been in residential or day treatment programs at least once; all eight women found them to be generally unhelpful. Marcie explains:

> **Marcie:** Yeah, well when I was in River House, I was, I was at rock bottom, I was suicidal, I was sick of using and I saw no way, but either kill myself or go to treatment; and I didn't wanna die. So um I was going in for my cocaine problem, and um I did the whole 30 days, well, I did 29 days in River House, and there was some discussion, and I told them yeah, well I'll probably smoke marijuana in the future. And, that's not why, cus I was there for my cocaine problem, and I believe in the harm reduction philosophy, which they don't , and they kicked me out, I had one day left to graduate, and they kicked me out. They said, well, we see no point in you continuing this program can you leave. And I was devastated, I used as soon as, you know, I

left. I was so upset, I felt like I had failed. You know, so that was really upsetting. Um, I don't really care for their treatments (weepy).

Tara complained about the treatment staff's general ignorance and judgmental attitudes while in care:

> Tara: I can tell you the AFM sure doesn't help. Dr. XXX at that place, because I had all these picking heroin scabs when I first got here, they needed to be administered ah salve or something or anyway. I asked the nurse to do it and she said you have to ask the doctor, and the doctor said, well what do you want me to do put my staff at risk for you ? You have HIV. I went, holy shit man, this is coming from ah medical doctor an addictions service! I mean this should not be happening, and that made me feel like a piece of shit ok, yup.

Some women felt that they received emotional support from Narcotics Anonymous (NA) and Alcoholics Anonymous (AA). In these situations, NA and AA were seen as spiritual support groups rather than addictions treatment. Doris found her spiritual support this way:

> **Doris:** NA gave me support. I used to just enjoyed the atmosphere, very beautiful, people friendly. I could talk to everybody, whenever I needed. And, I just like to live more, I enjoyed meetings because it was something, it was like me, reminded me a lot like me and like it's hard for people to stop using, they see a needle and they're, you know, it's like gives you a high.. The atmosphere was nice, the people were nice. I enjoyed going there. It was kind of like belonging to a church.

Strategies to Mediate Control of Drug Use

Several strategies were sought when attempting to establish a new lifestyle. The participants' narratives revealed that they felt they were in need of a sense of purpose and order in their lives. They were looking for means to gain competencies beyond the streets.

Education and Employment

Education and employment opportunities were identified as desired conditions which would assist in positively managing their drug use. Women who were able to return to school and receive some increase in education reported more control over their drug use. They attributed this to the educational opportunities providing them with a higher self esteem, which in turn assisted them in attaining their lifestyle aims. Marcie describes how she was helped by returning to high school and graduating:

> **Marcie:** You know, if you can get hooked up with some education, and, and employment that is a big deal because it is a big gap. Education and employment is a big gap for um people. Like there's the XXX program which is a year long but, they - they have it run, set up a little different now but I was in the, the first year program and it was great, you know, they helped me a lot. Well, I never thought I'd graduate and I worked hard all year um my using was very limited, cus I didn't want it to disrupt what I was trying to achieve. And, you know, I was very proud of myself, I never, you know, thought I could do it. And then I was so happy, and proud and all my friends and supports were there for my graduation.

Similarly, Laurie discusses how obtaining her high school diploma helped to redirect her life:

Laurie: Ok, this is the first photo , this is a picture of my diploma.
Researcher: Ok. So tell me what am I - what am I seeing here?
Laurie: You're seeing the beginning of a change in my life. (laughs).
Researcher: What do you mean by that?
Laurie: Well, my diploma, I strongly believe that if it wasn't for this, my life would have been real changed, like without it I wouldn't of been able to get a job. Without it, I wouldn't have, or even going to get it, you know, spending a year, three months or whatever getting it um, made such an impact on my life that, you know, if it wasn't for doing that or getting it, then I probably would have just left my life where it was.
Researcher: Ok. So, how does this relate to your life as an injection drug user?
Laurie: Like it gave me, you know, the acknowledgement that, you know, I do have a brain (laughs) it does work (laughs) and it doesn't need to be subdued by drugs. Because, you know, that's basically all I did for 8 years, get high, you know.
Researcher: So do you think a picture like this relates to other women who use drugs?
Laurie: Yeah, I um actually, when I got my diploma, um it encouraged a few other people to go get theirs. They actually told me that it was because they saw me walk down the, the aisle and get my diploma and everything, but you know, it encouraged them to go and do it. And it gave them a piece of, you know, hey my brain can actually work (laughs). Kind of thing.
Researcher: what do you mean by "my brain can actually work?"

Laurie: Well, we tend to get stuck in a point where, you know, we feel like we're useless - what's the world ever gonna, you know, want from us, you know. Why they already think we're scum, they already kick us to the curb every chance they get. So, you know, with this then I can say look I've achieved something. I, I can qualify for jobs you know and not be a whore, because now a days, you know, the smallest jobs you wouldn't even think of it, but they want your grade 12.

Basic Needs

Those women who reported that their drug use was out of control, they looked for simpler solutions to manage their lives. For them, gaining control, involved learning new skills, finding food and shelter. These women were either heavy users, multi-drug users, had little support in their lives, were in and out of jail, and/or were frequently homeless. Doris describes what she needs to help keep herself "in control":

> **Researcher**: So, what do you need?
> **Doris:** a stable home life, it's, it's stability, ah.
> **Researcher:** What do you need for stability?
> **Doris**: Nice home, I wanna have a nice home. I love my house clean, you know, I like to dress nice, dresses, not all this kind of sort of clothes I got. I like to get dressed nice and you know go places, I like to go to church.
> **Researcher**: So, what do you think you talk about needing stability and wanting a nice home and things. What are the steps that would take you there.
> **Doris:** Step one, no booze, no drugs. Getting out of here. Like don't always do the crooked way like I do. Like I do a lot of crooked things ah, it's all in the brain. It's not like crooked, crooked, but it's a scam. You know, but it is the way I know how, it keeps me safe.

While Doris desired a stable home- life, she was also fearful of the burden of this responsibility. The demands of finding shelter, food and clothing were often too overwhelming. She considered it easier to cope day-to-day by doing what was familiar to her, living on the street and "scamming" others to fulfill her basic needs.

Charmaine describes feeling in control of her life and her drug use when she is able to provide herself with basic needs:

Charmaine: Hmm hmm hmmm hmmm (sings the hmm's) what makes me happy, it makes me happy just to be content, I guess. To ah have what I need, the basics. Ummmm , ahhhhhh, having gas in my car and the bills paid and cigarettes and food and in control (pause) I want to be able to manage my own needs day to day...I'm not stupid, When I can't do that (pause) it makes me uncomfortable. (Laughs). And when I'm uncomfortable what do I wanna do, I want to get high.

Both Tara and Kendra, who had been on the streets since they were 12 describe how they needed to turn to social support agencies to assist them with meeting their basic needs and to teach them basic skills:

Kendra: I got myself a mentor, and she helped cus when I was trying to get off the drugs, I didn't know nothing about nothing, like I knew how to survive on the street, but I didn't know how to live normally. I knew that when you got your welfare cheque, you blew it all on drugs, and worry about where to live later. When I tried to straightened out, I was pregnant you had to, you know, get your welfare cheque and I had to, I had to learn how to ah, how to shop. At 33 years of age I had no idea how much bread was or nothing. Cus I'd been eating free soup and sandwiches. Didn't know how to cook. So she has taught me how to budget and how to go shopping cus I was uncomfortable shopping. Cus ah, if I was in a store I was shop lifting (laughs). So, you know it's like ah I had a, she helped me get rid of that paranoid feeling, that ah, it was ok to be in a store. And ah basically she's just ah (silence, tears). But, you know, ah she helps me get around with the baby because ah I get stressed out really easy. And um if I got too many things to do then she comes and helps me out, and we just go and deal with everything later and ah go for coffee or something and then deal with life.

Tara: My family can not be of assistance to me. I need the assistance through community resources.
Researcher: So what, what do they do that is helpful?
Tara: Um (mumble) got me a volunteer to come into my home and help me fix up my apartment. She helped me do laundry. Like um, the place that I lived before, um, the police came in and raided it and they went

through everything of mine, and it was just like ahh it was all just filthy, you know, and it all had to be done. I never did it because ah ah ah you know, you get feeling down and you don't feel like doing the stuff, so it was neglected for a long, long time, and she came in helped me do that, and she helped me get the furniture rearranged and helped me get a desk arranged at my home that I can do my office work in my home. She helped me hang curtains, to make it look like a home. Taught me to cook. She brought me a plant, I mean, just things to make me feel like hey man this is like cool, I can be, function in my own home. Ah, XXX, she arranged that, and she also gave me a T.V. set for my home so I have something to keep my mind occupied in the home. Ah, XXX gives me all kinds of stuff to help me, like bedding and towels and stuff that are needed in my home, so that I can function in of my own home.

Stigma

Each of the eight women looked for strategies to manage their drug use and attempt to make lifestyle changes. The women acknowledged that they had some personal responsibility for improving their future. At the same time, they encountered barriers to change. They described having little opportunity to make improvements because they lived environments that were disrespected. Few resources, judgemental health and social services providers and general ignorance were all named as road-blocks. Tara reveals a recent experience she had in an emergency room following a suicide attempt:

> **Tara:** I kinda keep away from the hospital because I, I don't know why - they just weren't treating me nicely. When they said, sit down and talk. I got half way through a conversation, they said o.k. we'll talk later bye, you know, whatever. I'm not finished saying what I have to say, lady, and then they discharged another fellow, and he left me in emergency ward that night. Just ignored me, the junkie whore. Like, you're not God, and you haven't got the right to treat people like this, and I got really upset about it, I don't know why I got that upset about it, but I bolted, I went see

ya, I walked out the door, I gotta get away from this. I felt like killing one of them. Like who the hell do you think you are? But, I couldn't handle that, so I just walked away.

The limited understanding, lack of sensitivity and stigmatization shown to these women gave rise to deeper feelings of unworthiness. The women felt that they would only be valued if they conformed to the "straight world's" concept of "normal" behaviour. No credit was given to them for the years they had learned to survive nor to the insights they had gained. Ultimately, the women all knew that they were decent individuals, deserving of a better life, but were often overwhelmed by how difficult it was fitting in to the "straight world." The women wanted more respect and understanding from the systems ostensibly organized to help them. They disliked feeling forced to choose between the drug using and the straight worlds. Rather, they envisioned a society that would enable them to make choices for themselves, without the judgements extended by society. Kendra concludes:

Kendra: Geez, there there has, there has to be, say, if, say if, unjudgmental places for people. I mean like um people know when they're being judged. And when you're being judged, you get angry, and you fight, fight, it's like you're fighting against the tide, and um (silence) ah, it's just like a lot of people when they're in situations where they're actively using can't get out of it. But, if their, if their heads are held above ground, then I think that um sooner or later you gotta, you gotta be able to, to like, I don't know any addict that really really wants to be there, that really wants to die, they're just stuck, you know, and, for myself, and a lot of people I've seen is that, yeah, you know what you have to do to get out,

but until that moment comes where you're willing to do it, you gotta keep somebody above level until they get to that point, you know. You got treat people like they are worth it, ya know, we are all human beings, we are all worthy of respect.

Researcher: So, what kind of things would help them get above level?
Kendra: Ah, just availability of, you know, food, the basics. Addicts don't buy food, right, um, personal hygiene things that I mentioned to you before for women. The same thing, the same thing, you know, like a woman, an active addict woman is not gonna go and spend 10 bucks on, on tampons and what not, right? So, what do they do, they're already prone to diseases and stuff and there's enough money in the health care system to provide free to those street women, you know. Also, you know, you gotta treat people ok, just even smile at them. If you believe in them, sooner or later, sooner or later they might, they might, if they don't die first, you know. Give people hope, you know even if somebody's come back for the thousands time after a slip (laughs). I'd say, hey right on, it's good to see you back. You know, and good to see you alive, you know, your worth it.

Summary

This chapter described the social and environmental circumstances surrounding women's injection drug use. The reasons why the participants began to use injection drugs, the affects of drugs on their lives, and the participants' efforts to gain control of their drug use were the foci. Conditions associated with the women's onset of drug use included childhood abuse and violence, emotional abuse and rejection. In turn, these events gave raise to painful feelings of rejection, loneliness, guilt and shame, and unworthiness. A vacillation between

guilt and anger ensued. The women turned to injection drug use to cope with these feelings and life circumstances. Getting high was seen as one of the most accessible and reliable means for finding temporary escape from their life circumstances.

In the context of the drug scene, the streets initially proved to be an exciting escape. The women drifted into more regular use as they remained for longer periods of time within the environment of the drug scene. The participants learned new skills in order to survive on the street, to earn money and to procure drugs. They soon found themselves involved in street violence, criminal activities and frequent encounters with the law. Ongoing injection drug use continued to help numb out the reality of their lives. Many of the women soon found themselves with health problems. The risks associated with injection drug use were seen as outweighing the benefits. Subsequently, drug using was associated with a relentless battle to survive and to live with integrity under ominous environmental conditions.

Drug use was mediated by a number of intervening conditions. These included duration of drug use, the presence or absence of support, loving relationships with partners or children, education and employment opportunities, and support in attaining basic needs. These conditions also influenced the women's ability to gain control over their lives and their drug use. The women

used a number of strategies in order to manage their drug use. The women turned to family, friends, social and health services, sought out education and employment opportunities, and utilized prayer. The women acknowledged that they had some personal responsibility for their behaviour; however, the women also encountered barriers to change. The attitudes of health, social services and addictions treatment providers further stigmatized the women, rather than providing a positive support network. They want to see improvements in "the system" and a society that values them as human beings. The women were looking for respect and understanding and opportunities to care for themselves and their loved ones whether they used drugs or not. They wanted hope for the future.

Chapter Six

Participant's Recommendations for Health and Social Services Strategies

Throughout the interviews, the participants were encouraged to identify actions and/or strategies for addressing their personal and community issues. Each of the eight women gave several recommendations for services and approaches that could be used in order to better serve their own lives and those of other women drug users. Several of the women's recommendations were around educating current and future health and social services providers about the "real" issues facing addicts. Most of the women acknowledged that much of the stigma they felt was due to professionals' judgmental attitudes towards them. Marcie suggests:

> **Marcie:** Professionals need maybe just a better understanding that they're human people, they're human beings, you know, just like everyone else, they live and they breathe. Um, just for people not to think that they're better than them just because they're not using drugs. You know, everybody has the same feelings, I think more awareness that we're all human. Lots of people will look down on you because you're a drug user, or a sex trade worker, and you know they're no better than you are. I don't think that anyway.
>
> People (professional) need to be educated. They um, they probably think of intravenous drug users how I used to think of sniffers, that they weren't worthy. That they're just sniffers and they don't give a fuck about any, about themselves so why should we give a fuck about them. But and I, I'm passed that now.

Researcher: How did, what do you do to get passed that?
Marcie: I actually sat down and talked to, you know, a young girl who'd been sniffing since she was a kid, and she told me some stuff about her life. And, ah it took, ah my blinders came off. You know, I realized this is just, you know, a young girl who had some really rough times in her life, and this is the way she copes. You know. That's what the professionals need to learn, to really listen to people.

As all of the women had reported negative experiences with addictions treatment, they were asked what would have been more helpful. The women identified that what they really needed was in-depth counseling. They noted that very little time was spent examining why they had turned to drug use and the real problems in their lives. They were searching for support in dealing with the linkages between their life circumstances and addiction. Billy explains:

Billy: I think like, for one, some circumstances is like dealing with it, actually like going to counseling and and dealing with it, like or having closure with that person directly. Like with some of my issues, anyway, like with my ex-husband. Having closure, there was never closure there, um that might help. Really looking at my problems. Having, having somebody, like, listen and, and be as open to me as I am to them might help to, like not always just pretend to care,(sniff) cus I'll admit, I can admit when I'm wrong and I can I can handle that you know. But, um, there's been a lot of things in my life that have happened, that people have never said sorry for. And that's all it will take sometimes eh, just to be able to sit in a room and face that person directly and like, you know, I don't want them to like make up for everything they've done, but maybe just explain why. Might help, you know, cus right now it's just in my head, like, wow you know, how can people be so cruel. Um being able to say what is in my head to some people, and have them actually believe me, that would be cool too, like.

The women also recommended strategies which would support women that were on the streets and using heavily. Places where women could go and feel safe and have their basic needs met were identified as important. Kendra explains:

> **Kendra:** I know that they're doing stuff out of this, out in the van, but there's gotta be somewhere else too, but they're ah (pause) It sounds bad and everything, but until you've been there it makes such a good idea. Have a place where women can use safely. You know, go in, have a little boost, shoot up, leave. Make sure they're not dying, make sure they're not re-using rigs and what not. For the woman, that is important, you know, have a safe place to use, it sounds crazy, but it works (laughs).

Marcie also feels support is needed for women on the street as well for those women ready to transition off the street:

> **Marcie:** I think there needs to be more opportunities for adult people that were involved in the sex trade. They focus everything right now, everything's on the youth, the youth, the youth, they're putting all this money into funding for the youth. Well, we were all youth's too, and now we're in our 30's and we're all still in the sex trade, and addicted; and there's nothing for us. There's you know, there's Sage House and New Directions, but they're open a couple hours out of the day. Yeah, and, and there's no safe houses for an adult woman to go to if she is on the streets; or a transgender, Well, it could be a place where that um, you know, a place where they can live, you know like a transition house. Where they can, you know, because you can't expect them to quit working the streets, go on welfare and live in a rooming house. Why bother, you know, there's no, there's no reward there in it for you. No reason to say, oh this is great.
>
> **Researcher:** So you're saying you want a transition house, a place to live and then what and then what, then what do they need. You know, how is that different than a rooming house on welfare.
>
> **Marcie:** Well because in a transition house they would have supports, they would have someone to talk to. They would have a councilor if they needed a councilor, you know. They could work on, if they're parents,

they could work on their parenting skills. They can work on either getting their children back or if they do have their children, living a stable life for their children. You know, they can get hooked up with some education, and, and employment is a big gap. Education and employment is a big gap for um people. And you could be working on, you know, what's really inside you.

Laurie suggested that more support and resources are needed for families and youth. She feels that families need access to counseling and other support services in order to resolve conflicts. Families need to be taught how to communicate:

> **Laurie:** ... if the kid can't talk to the parent then maybe a third party needs to be present, right, either a counselor or even a friend of the family that, you know, is able to you know calm things down, or you know your mom's not gonna freak out on in front of, or you know, whatever. Even a mediator (laughs), something. You know, just a third body sometimes in the room breaks the tension, you know, breaks the stress levels.

She also desired to see more support for youth. She suggested mechanisms to help kids stay in school and/or return to school in order to complete their high school education:

> **Laurie:** Make it a lot easier to get kids back into school. Especially ones that have been out of school for so long, like I was out of school for 11 years. And I had to fight tooth and nail to even get welfare to even allow me to go back to school. You know, they were like, no get a job, no get a job. They took me through a training program to work at Salsbury House. I had a problem at Salsbury House with the manager. They told me no you can't quit your job to go back to school. No you can't do it, you can't I'm sorry. (laughs). You know, I purposely walked in to get fired (laughs), you know, said ok now I'm going back to school (laughs). You know, they still at that time did not want me to do that, they wanted me to go work at another Salsbury House. I didn't want to flip burgers...Help

people like welfare workers realize that you know without the education, without people having the opportunity to go back to schools that, you know, you pushing them into the workforce, they're going to end up in jobs their either not going to like and they're just going to screw around with for x amount of time and then be back on welfare or whatever, they ain't even gonna bother. You know, like it gave me the incentive to actually go out and look for work because I could say I've got a diploma backing me, you know and that was a big change for me.

Tara concludes by summarizing how the specific needs of women injection drug users needs to be addressed:

Tara: Oh yeah, just the fact that there needs to be more community based organizations and programs in order to get these females off of the drugs and off the prostitution and into a normal quote normal unquote lifestyle in ah society's eyes. I mean, they have these poor girls, and they're working the street and then they live in the area where they work. So, they're living in the problem, trying to solve the problem. That doesn't work. More housing needs to be available to them, outside the core area where they can live. I mean this is just giving them poor judgement, and influencing their lives. And you take them away from it, if you really wanted to, you know. And there needs to be more social programs for parenting. Parenting before it starts. Teach the parent, for the parent to teach the child. Hence, there wouldn't be anymore problems. There needs to be more social programs to get people educated and you give them a chance, you send them to jail, you let them out of jail, they have to take an education program. At least education is required, skills will be learned and they have a better chance. I don't know what the system thinks they're doing now, but they're totally screwing it up (Laughs). O.k., chasing these girls and pushing them into everybody else's backyard is not gonna help. It's not gonna solve the problem, and these poor kids are picking up used condoms and rigs and everything else and causing the whole community to become sick. Now, there is a way that we can have peace and tranquility in our neighborhoods if we just learn how to acknowledge the problem in a more consistent manner.

The participants identified several actions to address their individual and community's needs. Some of these strategies were being met in part, by agencies or organizations, other suggestions were unmet but considered necessary and desirable conditions by the participants. These suggestions will be considered more fully in Chapter Seven: Discussion and Conclusions.

Chapter Seven

Discussion and Conclusions

The focus of this study was to describe the social context in which women injection drug users live in Winnipeg. Its purpose was to explore how they perceive their environments and what contexts and life circumstances are considered important in explaining perceptions of risk and risk-related behaviour. In this study, it was discerned that the women's drug use was connected to the personal and social circumstances in which they lived. Drug use was linked to the process of managing losses and battling to survive and live with integrity under threatening life conditions. The women relied heavily on drugs as a means to escape the painful feelings resulting from childhood and on-going traumas. They took responsibility for their decision to use drugs; while at the same time held a common perception that their social and physical environments played a role in limiting their ability to manage their drug use and to find alternative coping strategies. These key findings, of an intimate relationship between person and environment are supported in the literature (Nyamathi, Bayley, Anderson, Keenan, & Leake, 1999; Roberts, 1999; Taylor, 1993; Young, PBoyd, & Hubbell, 2002).

Escape

Participants described using drugs as a means to escape painful feelings related to personal, social and environmental circumstances. This finding is consistent with the results from other research where drug use or "the high" were reported by women to describe why they turned to drug use (Brown, Gauvey, Meyers, & Stark, 1971; Henderson, Boyd, & Mieczkowski, 1994; Marsh & Simpson, 1986; Nyamathi et al., 1999). In a study conducted by Nyamathi et al(1999), emotional, psychic and physical scars created by childhood abuse fueled the need to "escape" life. Women turned to drugs as a means to self-medicate. Van Den Bergh (1991), in her feminist analogy on addiction, also hypothesized that addiction as a way to escape dealing with painful and difficult emotions. She described the use of substances by women as a means to "deal with life on life's terms" (Van Den Bergh, 1991)(p. 7).

Traumatic Events

Every participant recalled traumatic experiences in their pasts. Generally, these events occurred in the context of family. Experiences included verbal, emotional and physical abuse, neglect, and family break down. Multiple trauma, including physical and sexual abuse, death of loved ones and family breakdown, have been documented in the literature (Dembo et al., 1988; Groeneveld & Shain,

1989; Ladwig & Andersen, 1989; Nyamathi et al., 1999; Paone, Chavkin, Willets, Friedmann, & Des Jarlais, 1992; Raine, 2001; Roberts, 1999; Rohsenhow, Corbett, & Devine, 1988; Rosenbaum, 1981; Rosenbaum & Murphy, 1999; Teets, 1994; Thompson Fullilove, Lown, & Fullilove, 1992; Young et al., 2002). Early childhood abuse in particular, has been related to later drug use and dependency (Groeneveld & Shain, 1989; Nyamathi et al., 1999; Raine, 2001; Roberts, 1999; Rohsenhow et al., 1988; Rosenbaum, 1981; Rosenbaum & Murphy, 1999). Nyamith et al. (1999), in their study on drug and alcohol use among homeless women, describes how drugs were used to cope with past histories of childhood abuse, family dysfunction and low self-esteem. Similarly, Wallace (1990) (Wallace, 1990)describes parental alcoholism, parental death, and childhood separation from parents as causal experiences for behavioural problems for crack cocaine smokers.

Although the women in this study described some degree of emotional, sexual and/or physical abuse either as children or adults, they did not consider themselves as helpless victims. The women did not specifically relate their engagement and on-going use of drugs as coping mechanisms for their experiences. Young et al. (2002), in their study of sexual trauma among women who smoke crack, described similar findings. They concluded that the lack of

connection between sexual traumatic experiences and substance abuse may be because women who have been sexually abused are not conscious of the process of self-medicating, even though the processes are occurring. Further study is required to gain a better understanding of the link between the perceived effects of traumatic experiences and substance use.

Loss

Participants in this study acknowledged that traumatic childhood experiences left them feeling "hurt" and/or in "pain." However, they didn't necessarily relate these experiences to their reasons for initiating drug use. In this study, the women described engaging in drug use to cope with their feelings around their on-going experiences of losses. Women turned to drugs to deal with: family breakdown, the apprehension of their children from child protection agencies and the loss of romantic relationships. Drugs were convenient and easily obtainable to them. Drugs had the effect of numbing out the anger, guilt and shame they felt about their past and present life events. Drugs enabled the women to move forward in their lives when they felt bad, rejected or hurt. Similarly, Roberts' (1999) study described women's engagement in drug use as a process of "managing losses." Loss was related to the experiences of desertion and rejection which occurred in conjunction with death of loved ones, removal of children from homes by child

protection authorities, violent home lives, unsatisfactory employment opportunities, and social isolation. Losses resulted in the initiation and the escalation of drug use.

The participants also described how losses caused a sense of emotional distress. This study did not attempt to identify or diagnose mental health disorders. The focus instead is on determining what circumstances they consider important for explaining their risk conditions. However, many of the participants described periods of emotional distress as depression, anxiety and stress. Depression was most commonly reported in relation to a loss of a child or relationship. Anxiety and stress was reported following a violent experience, a reaction to an encounter with "the law" and/or related to the risk environments in which they lived and worked. The participants reported that that they would turn to drugs and/or increase their drug intake in reaction to these sources of distress.

The women in this study also described drugs as providing them with a new sense of belonging and connection to other people. Women described becoming involved with drugs as being a positive experience. They emphasized the initial positive effects of using drugs and the importance of the social element of drug taking. Drugs provided excitement, a way to gain acceptance from friends and to"belong" to a social group. These findings are similar to those of other

researchers (Nyamathi et al., 1999; Raine, 2001; Roberts, 1999; Taylor, 1993). where drugs were used as a means to provide excitement and fun, and to become connected with others, and to be accepted by social groups.

Self-esteem

Self-esteem emerged as an important concept in the process of becoming involved with illicit drugs. The women in this study described feelings of "guilt and shame" and of having no "self worth". Frequently the women viewed themselves as "bad' and deserving of the pain and risks associated with their drug use. To a certain degree, they accepted what was happening in their lives, including their reliance on drugs in order to cope. At the same time, they expressed anger about their past and present experiences. This anger commonly was linked to a sense of injustice. The women vacillated between the emotions of guilt and anger. They questioned the treatment and lack of acceptance they received from society. They began to see themselves as "bad" people and felt personally responsible for creating a better life situation in order to become a "good" person.

A significant amount of research has been done examining the relationship between self-esteem and drug use. Low self-esteem has commonly been found among women who engage in drug use (Binion, 1982; Dembo et al.,

1988; Dufour & Nadeau, 2001; Ladwig & Andersen, 1989; Nyamathi et al., 1999; Roberts, 1999; Thompson Fullilove et al., 1992; Wasson & Anderson, 1995; Young et al., 2002). Moreover, the relationship between self-esteem and drug use appears to be complex. For example, Young (2002) describes women crack users' perceptions of the effects of sexual abuse on their mental health and drug use. In this study, the most commonly reported effects of sexual abuse were feelings of shame and responsibility for the abuse. Yet, the participants did not directly relate their drug use to their exposure to traumatic events. Researchers have concluded that the mechanism linking self-esteem and drug use is complicated by a variety of emotions. The feelings of anger and its association with life events, self esteem and drug use need to be considered in addition to the feelings of powerlessness and anxiety stemming from traumatic events.

Skills

The women in this study describe developing new sets of skills, in the sphere of drug use itself. For example, most learned to inject themselves as well as occasionally inject others. They learned to raise the money needed to procure drugs, and they learned where and how to obtain food and shelter. The women made pragmatic choices about how they raised money and interacted on the streets. Similarly, Taylor's study (1993) described women learning skills to take

control over their career in drug use. She describes these skills as providing the women in her study with self-esteem, social identity and status within the community.

There has been much written on the association between illicit drug use and criminal activity (Hser, Anglin, & McGlothlin, 1987; Jackson, 2002; Rosenbaum, 1981). These authors sometimes conclude that drug use and involvement in criminal activities are an unavoidable reality. While some of the women in this study described resorting to crime to maintain their habit, this was often the last resort when other methods of obtaining money failed.

Risk Environments

The women in this study identified the sense of feeling isolated. They described having very few friends or family to turn to for support. As well, few women felt that they had social or health services providers to whom they could turn. Addictions services agencies, in particular, were experienced as unhelpful. Treatment service agencies were associated with negative experiences and contributed to the women's sense of being "alone out there" and failing to conform to society's expectations. Roberts (1999) found that the women in her study also identified health and social services providers as persons to distrust.

Despite the initial benefits associated with injection drug use, the women in this study all reached a point where they realized that drugs were not going to provide them with lives that they wanted. Rather, the risks associated with the drug-using environment were perceived as being too harmful. Violence, crime, involvement with the police, hepatitis C, HIV, and other health problems linked to drug use led the women to view their drug use in a negative light. Moreover, it appeared to be the cumulative effects of these negative outcomes that led the participants to consider their drug use as negative, rather than the specific risk of contracting HIV or hepatitis C. Even those women who self identified as being HIV and/or hepatitis C positive, considered their diagnoses as one harm in an environment of many insurmountable harms. Similarly, Taylor (1993) describes the women in her study as concluding that the numerable costs eventually outweighed the benefits of injection drug use.

Support

In this study, a support network and love and companionship were shown to influence the women's use of drugs. Having someone to turn to during times of stress and loss gave the women a sense of control. These factors appeared to be extremely influential in helping some of the participants manage their drug use. The women used a variety of strategies both to access and avoid support.

Women identified turning for support to family, peers, support services and loved ones. As well, prayer and spirituality were sought after as a means to cope, specifically when the women could not identify any close friends or family to turn to. These findings are mirrored in Roberts' (1999) study where social support was considered a major influence in helping women maintain control over their drug use.

The women who identified having control over their drug use also identified having supportive and loving relationships The findings of this study were not able to rule out the possibility that women who were in control of their drug use were simply better able to choose more supportive partners. Nevertheless, a partner who is able to provide support, such as facilitating an overall sense of well-being, may be an asset in facilitating efforts made by the woman to maintain or control their drug use (Galaif, Nyamathi, & Stein, 1999).

The women in this study all took responsibility for their drug use. The women who identified "being in control of their drug use" had initiated attempts to move away from the drug using scene, upgraded their education, found employment and joined peer support networks. The women who identified as attempting to gain control of their use identified reaching out to meet their basic needs. They attempted to find places to live and to keep food on the table.

Stigma

The women in this study described the limitations and barriers which affected their ability to manage their drug use. They recalled feeling "unaccepted" and "judged" by health, social services and addiction services providers as well as by society at large. Ettoirre (1992) in her book examining women and substance abuse, raises the concern of how "addiction professionals" have had the power to represent the definition of women who use substances. This definition has traditionally viewed the women as "diseased, polluted and/or bad" (p.2). She emphasizes that this definition creates a reality of stigmatization, marginalization and demoralization for women who use substances.

Research examining the meaning of stigma for women drug users is sparse. The literature does recognize that the severe stigma attached to women substance abusers tends to delay their recognition and treatment of their substance using problems (Adrian & Kellner, 1996). Society's reactions to women who use drugs are generally negative, and in most cases, are fueled by the public's reactions to drug use and motherhood. Women drug users are demonized and thought to be abusive to their children. Literature on drug use and motherhood typically lapses into condemnatory judgement on women's behaviour (Klee, 2002).

The women in this study describe how their vulnerability to drug use is linked to an inability to find acceptance in society. This social stigma added to their

sense of low self-worth, guilt and shame. Women describe looking for services that would assist in empowering them within safe respectful environments. More research is required about the stigma experienced by women drug users and its effects on services for women.

Summary

Drug use for women in this study enables them to meet the demands and cope with the stresses encountered in their social environments. It also serves as a coping mechanism for the guilt associated with the many losses the women experienced and continue to face. Rather than considering themselves victims living in chaotic worlds out of their control, these women represented themselves as capable, pragmatic women, meeting life's demands, although in socially unacceptable ways, in a society that seems neither able to recognize nor meet their needs.

The findings from this study build on the growing body of literature around women's use of illicit drugs. The social context of women who use drugs in Winnipeg have been described to assist in the understanding of the factors impacting the women within the context of their environments. This study demonstrates that research that is sensitive to women's feelings about their social environment and, subsequently, the details regarding the context in which

injection drugs are used, is required if researchers and practitioners hope to provide effective and meaningful services for women who use drugs.

Research Methodology

Generalizations based upon this small sample must be made with caution. The feminist perspective facilitated the development of a relationship with the women that encouraged them to share information about their culture with the researcher as well as their circumstances and their lives. The qualitative methodology facilitated the uncovering of the details regarding the context in which injection drugs are used. It provided a reality-based understanding of issues that influence the health and well being of women drug users in Winnipeg. These findings build knowledge about the impact of the social environment and the life circumstances important in explaining risk-related behaviours. However, this type of research methodology also posed important limitations to the study.

The findings from this study relied on participant controlled data collection. The interviews with the participants were unstructured in format, and incorporating life stories, participant's photographs, and perceived needs. While the unstructured interviews allowed the participants' perceptions to be made, it may have limited the participants' abilities to consider views outside of "their own boxes." For example, when participants were invited to consider strategies to

address a self identified issue, often simple "do for me now" suggestions were made rather than possible prevention strategies. Further research utilizing a more structured approach, such as grounded theory, may allow for a greater understanding of the complexities of the various life issues women injection drug users have and are currently facing.

Indications for Further Research with Women Drug Users

Several of the indications for future research have been described throughout this study. These includes the need to focus on individuals and their environment when attempting to understand women's drug-related behaviours. The complexity of the relationship between person and environment requires further study to provide a clear picture. Further study is required to gain a deeper understanding of the influences of both positive and negative events on the function and meaning of drug use. This knowledge is particularly important in order to assist women drug users, themselves, to learn from their past experiences.

In this study, a loving relationship was identified as a factor that helped influence one's ability to manage drug use. It is noteworthy that while many participants identified their partner's influence around their decision to use drugs, none of the participants considered their partner is being causal to their initiation into injection drug use. The influence of relationships on drug use is complex,

thus,further study is required which examines the effects of relationship and drug use, specifically initiation to drug use.

Deeper research is needed to examine the resilience and strengths of women drug users. Recognizing individual and community strengths would not only assist in planning effective services for this community, but also assist in challenging society's perceptions of those who use drugs as women "gone bad."

The drug using community itself must find solutions for these needs. So that activities and strategies relating to women drug users become acceptable to the community, the users themselves must define them as important. This study has brought forward several recommendations for change, as identified by the participants. These suggestions warrant further action at a deeper level of analysis. Moreover, one participant identified the need to "hold peoples heads above water until they wanted to help themselves." What was not clearly identified in this study were suggestions or strategies that would expand an individual's ability to accept support. Further, many of the participants' narratives identified solutions for their needs in angry terms emphasizing "do for me" strategies rather than considering solutions that would come from within the community itself. Further study is required that would consider how interventions and solutions can be developed at a community level, to build community capacity and honour community values and strengths.

Implications for Policy and Practice

Although this study was descriptive, several of the findings reveal a number of implications that might assist health and social services professionals in planning and providing services for women who are currently using drugs and accessing treatment. Although all of the women in this study identified a preference not to use drugs to cope, many identified either being unable to stop using or else desiring to maintain their drug use rather than abstain. Health and social services professionals traditionally believe that interventions with drug users must have the goal of abstinence. With this in mind, there appears to be an urgent need to develop and test interventions aimed toward reducing drug-related harm. Services need to be designed and expanded: including needle distribution, education, outreach, and practical support such as housing and food programs. These services need to be accessible and acceptable to communities, delivered in safe environments in a respectful and sensitive manner. Spiritual support and prayer were also important strategies utilized by the women in this study. Therefore, services that include a spiritual component should also be incorporated into service plans.

Beyond these services, women drug users need opportunities to talk about their past and current painful experiences. Special support is needed in times of

pregnancy, loss of child custody, family violence and crisis. Women who are parenting require support to maintain their families. The large percentage of participants whose children were in foster care or being cared for by other family members reflects the on-going losses for future generations. These children are at risk of becoming among the next generation of drug users.

The description of isolation and having no person or place to turn to was alarming. In this study, when women sought help, only once was a health professional named as a possible option for support. Moreover, the women identified lack of trust and judgment by service providers as issues that created increased stress in their lives. Specifically, the failure of and negative attitude towards addictions treatment services was made clear. This fact coupled with the participants desire to want to talk about their experiences, should be an important consideration in developing programs for drug users. It will be important for health and social services professionals to be respectful, non-confrontational and non-judgmental when providing services. Non-traditional services delivery models in non-traditional venues should be considered. Service providers will need to be sensitive to and educated about the circumstances which affect women drug users. Efforts for consideration should build on established and trusted resources that utilize practical harm reduction strategies and feminist approaches.

Healthy public policy is intended to function within the wider context of peoples' lives and be planned in collaboration with those people directly affected (Blackwell, Thurston, & Graham, 1996). With this in mind, women drug users must be allowed and encouraged to take the lead in policy making and planning services related to substance use. From a feminist policy perspective, services, including treatment programs, should be planned with the whole woman in mind. This includes taking into account her social and emotional history and life circumstances and not just her drug use. Considerations must be made that take into account the context in which women lives (Blackwell et al., 1996). The social environments in which women drug users live, need to be accepted and valued as communities within society, rather than merely as risk environments. The strengths of those environments must be considered in planning a range of services. Ettorre (1992) argues against looking at women simply as substance abusers; she argues for evaluating the larger sociopolitical context in which women generally live. Moreover, this study identified how an interaction between the social environment and a woman's decisions about drug use occurred at different phases in the women's lives. Similarly, practice and policy issues need to be considered for each phase of a woman's drug use.

This study, by describing the social context of women drug users in Winnipeg, provides an inductive approach to understanding the meaning as well

as the function of drug use for women. Future attention is needed to explore the extent of the women's barriers to finding the support and services they deserve. Greater collaboration is required between health and social services professionals and women who are using drugs themselves in order to assist service providers in developing more relevant and sensitive approaches.

References

Adrian, M., & Kellner, F. (1996). The Need for a Women-Centered Approach to Substance Abuse Issues. In M. Adrian & C. Lundy & M. Eliany (Eds.), Women's Use of Alcohol, Tobacco and Other Drugs In Canada. Toronto: Addictions Research Foundation.

Banonis, B. (1989). The lived experience of recovering from addiction: a phenomenoligical study. Nursing science Quarterly, 2(1), 15-34.

Binion, V. (1982). Sex Differences in Socialization and Family Dynamics of Female and Male Heroin Users. Journal of Social Issues, 38(2), 43-57.

Blackwell, J., Thurston, W. E., & Graham, K. (1996). Canadan Women and Substance Use: Overview and Policy Implications. In M. Adrian & C. Lundy & M. Eliany (Eds.), Women's Use of Acohol, Tobacco And Other drugs In Canada. Toronto: Addiction Research Foundation.

Blume, S. (1990). Chemical dependency in women: important issues. American Journal of Drug and Alcohol Abuse, 16(3&4), 297-307.

Brown, B. S., Gauvey, A. B., Meyers, M. B., & Stark, S. D. (1971). In Their Own Words: Addicts' Reasons for Initiating and Withdrawing Heroin. The International Journal of the Addictions, 6(4), 635-645.

Brown, V., Melchior, L., Reback, C., & Huba, G. (1994). Partner notification and HIV test results: Psychosocial and social issues for women. AIDS and Public Policy Journal, 6, *86-92.*

Brown, V., & Weissman, G. (1993). Women and men injection drug users: An updated look at gender differences and risk factors. In B. Brown & G. Beschner (Eds.), Handbook on Risk of AIDS: Injection Drug Users and Sexual Partners *(pp. 173-194). Westport: Greenwood Press.*

Bruneau, J., Lamothe, F., Soto, J., Lachance, N., Vincelette, J., Vassal, A., & Franco, E. (2001). Sex-specific determinants of HIV infection among injection drug users in Montreal. Canadian Medical Association Journal, 164*(6), 767-773.*

Campbell, C. (1995). Male gender roles and sexuality: Implications for women's AIDs risk and prevention. Social Science and Medicine, 41*(2), 197-210.*

Campbell, C. (1999). Women, Families, & HIV/AIDS. A Sociological Perspective on the Epidemic in America*. Cambridge: Cambridge University Press.*

Clarke, J. (1992). Feminist methods in health promotion research. Canadian Journal of Public Health, 83*(Suppl. 1), S54-57.*

Comfort, M., Shipley, T., White, K., Griffith, E., & Shandler, I. (1990). Family treatment for homeless alcohol/drug addicted women and their preschool children. Alcoholism Treatment Quarterly, 7*(Special Issue: Treatment alcoholism and drug abuse among homeless men and women: Nine community demonstration grants), 129-147.*

Creswell, J., W. (1994). Research Design: Qualitative and Quantitative Approaches*. London: Sage Publications.*

Crystal, S. (1992). Health-care barriers and utilization patterns among intravenous drug users with HIV disease. AIDS & Public Policy Journal, 7*(3), 187-197.*

De Zalduondo, B. O. (1991). Prostitution viewed cross-culturally: Toward recontextualizing sex work in AIDS intervention research. The Journal of Sex Research, 28*(2), 223-248.*

Dembo, R., Williams, L., Wish, E. D., Dertke, M., Berry, E., Getreu, A., Washburn, M., & Schmeidler, J. (1988). The Relationship between Physical and Sexual Abuse and Illicit Drug Use: A Replication among a New Sample of Youths entering a Juvenile Detention Center. The International Journal of the Addictions, 23*(11), 1101-1123.*

Doweiko, H. (1990). Concepts of Chemical Dependency*. Pacific Grove: Brooks and Cole.*

Dufour, M. H., & Nadeau, L. (2001). Sexual Abuse: A Comparison Between Resiliant Victims and Drug-Addicted Victims. Violence and Victims, 16*(6), 655-672.*

Dunn, L. (1991). Research alert! Qualitative research amy be dangerous to your health! Qualitative Health Research, 3*, 388-392.*

Ettore, B. (1989). Women and substance use/abuse: towards a feminist perspective or how to make dust fly. Women's Studies International Forum, 12*(6), 593-602.*

Ettorre, E. (1992). Women and Substance Use*. New Brunswick: Rutgers University Press.*

Fiks, K., Johnson, H., & Rosen, T. (1985). Methadone-maintained mothers: 3-year follow-up of parental functioning. International Journal of the Addictions, 20*, 651-660.*

Galaif, E. R., Nyamathi, A. M., & Stein, J. A. (1999). Pyshcosocial Predictors Of Current Drug Use, Drug Problems, And Physical Drug Dependence In Homeless Women. Addictive Behaviors, 24*(6), 801-814.*

Gollub, E., Rey, D., & al, e. (1998). Gender differences in risk behaviors among HIV+ persons with an IDU history: The link between partner characteristics and women's higher drug-sex risks. Sexually Transmitted Diseases, 25*(9), 483-488.*

Gregory, D., Russell, C. K., & Phillips, L. R. (1997). Beyond textual perfection: Transcribers as vulnerable persons. Qualitative Health Research, 7, *294-300.*

Groeneveld, J., & Shain, M. (1989). Drug use among victims of physical and sexual abuse: preliminary report. *Toronto: Toronto Addiction Research Foundation.*

Haverkos, H. W. (1990). Serious infections other than Human Immunodeficiency Virus amonh intravenous drug users. Journal of Infectious Diseases, 161, *894-902.*

HealthandWelfareCanada. (1990). Active health report on women. *Ottawa: Minister of Supplies and Services.*

Henderson, D. J., Boyd, C., & Mieczkowski, T. (1994). Gender, Relationships, and Crack Cocaine: A Content Analysis. Research in Nursing & Health, 17, *265-272.*

Henderson, S. (1999). Drugs and Culture: The Question of Gender. In N. South (Ed.), Cultures, Controls & Everyday Life. *London: Sage Publications.*

Hser, Y.-I., Anglin, M. D., & McGlothlin, W. (1987). Sex Differences in Addict Careers. Initiation of Use. American Journal of Drug and Alcohol Abuse, 13*(1&2), 33-57.*

Jackson, M. (2002). Mothering and Drugs: Four case studies. In H. Klee & M. Jackson & S. Lewis (Eds.), Drug Misuse and Motherhoog. London: Routledge.

James, J. (1976). Prostitution and addiction: An interdisciplinary approach. Addictive Diseases an International Journal, 2, 601-618.

Klee, H. (2002). Women, family and drugs. In H. Klee & M. Jackson & S. Lewis (Eds.), Drug Misuse and Motherhood. London: Routledge.

Kramarae, C., & Spender, D. (1992). The Knowledge Explosion: Generations of Feminist Scholarship. New York: Teacher's College Press.

Ladwig, G. B., & Andersen, M. D. (1989). Substance Abuse in Women: Relationship Between Chemical Dependency of Women and Past Reports of Physical and/or Sexual Abuse. The International Journal of the Addictions, 24(8), 739-754.

Lather, P. (1991). Getting Smart: Feminist Research And Pedagogy With/In The Postmodern. New York: Routledge.

Lewis, D., & Watters, J. (1991). Sexual risk behaviour among heterosexual intavenous drug users: ethnic and gender variations. AIDS, 5, 77-83.

Lex, B. W. (1991). Some Gender Differences in Alcohol and Polysubstance Users. Health Psychology, 10(2), 121-132.

Lex, B. W., Teoh, S. K., Lagomasino, I., Mello, N. K., & Mendelson, J. H. (1990). Characteristics of women receiving mandated treatment for alcohol or polysubstance dependence in Massachusetts. Drug and Alcohol Dependence, 25, *13-20.*

Liebman, J., & al., e. (1992). Risk behaviour for HIV infection of intravenous drug users and their sexual partners recruited from street settings in Philadelphia. Journal of Drug Issues, 22, *867-884.*

Lyons, C., & Fahrner, R. (1990). HIV in women in the sex industry and/or injection drug users. NAACOG, 1*(1), 33-40.*

Mane, P. (1997). HIV prevention and gender. Focus, 12*(11), 7-8.*

ManitobaHealth. (1999). The Winnipeg Injection Drug Epidemiology (WIDE) Study: A Study of the Epidemiology of Injection Drug Use and HIV in Winnipeg, Manitoba. *Winnipeg.*

Marsh, J. C., Colten, M. E., & Tucker, M. B. (1982). Women's Use of Drugs and Alcohol: New Perpectives. Journal of Social Issues, 38*(2), 1-8.*

Marsh, K. L., & Simpson, D. D. (1986). Sex Differences in Opiod Addiction Careers. American Journal of Drug and Alcohol Abuse, 12*(4), 309-329.*

Merriam, S. B. (1988). Case study research in education: A qualitative approach. *San Francisco: Jossey-Bass.*

Morse, J., & Field, p. (1995). Qualitative Research Methods for Health Professionals (2nd edition ed.). London: Sage Publications.

Nelson-Zlupko, L., Kauffman, E., & Morrison Dore, M. (1995). Gender differences in drug addiction and treatment: implications for social work intervention with substance-abusing women. Social Work, 40(1), 45-54.

Nutbeam, D., Blakey, V., & Pates, R. (1991). The Prevention Of HIV Infection From Injecting Drugs - A Review Of Health Promoting Approaches. Social Science and Medicine, 33(9), 977-983.

Nyamathi, A., Bayley, L., Anderson, N., Keenan, C., & Leake, B. (1999). Perceived Factors Influencing the Initiation of Drug and Alcohol Use Among Homeless Women and Reported Consequences of Use. Women & Health, 29(2), 99-114.

Oakley, P. (1989). Community involvement in health development. An examination of the critical issues. Geneva: World Health Organization.

Paone, D., Chavkin, W., Willets, I., Friedmann, P., & Des Jarlais, D. (1992). The Impact of Sexual Abuse: Implications for Drug Treatment. The Journal of Women's Health, 1(2), 149-153.

Plumridge, E., & Chetwynd, J. (1999). Identity and the social construction of risk: injecting drug use. Sociology of Health and Illness, 21(3), 329-343.

Raine, P. (2001). Women's Perspectives on Drugs and Alcohol: The vicous circle. Aldershot: Ashgate.

Ramos, R., Aguilar, I., Anderson, M., & Caudillo, V. (1999). Tecatas: An ethnotheoretical look at Mexican American female injecting drug users. Substance Use and Misuse, 34(14), 2015-2055.

Reed, B. G. (1987). Developing Women-Sensitive Drug Dependece Treatment Services: Why So Difficult? Journal of Psychoactive Drugs, 19(2), 151-164.

Reed, R. (1985). Drug misuse and dependency in women. The meaning and implications of being considered a special population or minority group. International Journal of the Addictions, 20, 13-62.

Reinharz, S. (1992). The principles of feminist research: A matter of debate. In C. Kramarae & S. D (Eds.), The Knowledge Explosion: Generations of Feminist Scholarship (pp. 423-447). New York: Teacher's College Press.

Reutter, L., & Neufeld, A. (1995). Using critical feminist principles tp analyze programs for low-income urban women. Public Health Nursing, 12(6), 424-431.

Roberts, C. A. (1999). Drug Use Among Inner-City African American Women: The Process of Managing Loss. Qualitative Health Research, 9(5), 620-638.

Rohsenhow, D. J., Corbett, R., & Devine, D. (1988). Molested Children: A Hidden Contribution to Substance Abuse. Journal of Substance Abuse Treatment, 5, 13-18.

Rosenbaum, M. (1981). Women on Heroin. New Brunswick: Rutgers University Press.

Rosenbaum, M., & Murphy, S. (1999). Pregnant Women on Drugs: Combating Stereotypes and Stigma. New Brunswick: Rutgers University Press.

Rosenshine, N., Sowder, B., Weissman, G., & Young, P. L. (1990). AIDS prevention model: Reaching women at risk. Bethseda, MD: NOVA Research.

Schilling, R. G., El-Bassel, N., Gilbert, L., & Schinke, S. P. (1991). Correlates of drug use, sexual behavior, and attitudes towards safer sex among African-American and Hispanic women in methadone maintenance. Journal of Drug Issues, 21(4), 685-698.

Shaw, N., & Paleo, L. (1986). Women and AIDS. Berkley: University of California Press.

Shedlin, M. G. (1990). An Ethnographic Approach to Understanding HIV High-Risk Behaviors: Prostitution and Drug Abuse. In C. G. Luekefeld & R. Battjes & Z. Amsel (Eds.), AIDS and Intravenous Drug Use (pp. 134-149). New York: Hemisphere Publishing Corporation.

Spittal, P. M., & Schechter, M. (2001). Injection drug use and despair through the lens of gender. Canadian Medical Association Journal, 164*(6), 802-803.*

Sterk-Elifson, C. (1995). Determining drug use patterns among women: the value of qualitaive research methods. In E. Lambert & R. Ashery & R. Needle (Eds.), Qualitative Methods in Drug abuse and HIV Research*. Rockville: National Institute on Drug Abuse Research Monograph 157.*

Stern, L. S. (1992). Self-injection education for street level sexworkers. In P. A. O'Hare & R. Newcombe & A. Matthews & E. C. Buning & E. Drucker (Eds.), The Reduction Of Drug-Related Harm*. New York: Routledge.*

Stevens, P. E., & Hall, J. M. (1998). Participatory action research for sustaining individual and community change. A model for HIV prevention. AIDS Education and Prevention, 10*(5), 387-402.*

Tait, C. (2000). A Study of the Service Needs of Pregnant Addicted Women in Manitoba*. Winnipeg: Manitoba Health.*

Taylor, A. (1993). Women Drug Users: An Ethnography of a Female Injecting Community*. Oxford: Clarendon Press.*

Teets, J. M. (1994). Sexuality Issues of Chemically Dependent Women. In R. R. Watson (Ed.), Addictive Behaviours in Women*. Totowa: Humana Press.*

Theidon, K. (1995). Taking a hit: pregnant drug users and violence. Contemporary Drug Problems, 22(Winter), 663-686.

Thompson Fullilove, M., Lown, E. A., & Fullilove, R. E. (1992). Crack 'Hos And Skeezers: Traumatic Experiences Of Women Crack Users. The Journal of Sex Research, 29(2), 275-287.

Van Den Bergh, N. (1991). Having Bitten the Apple: A Feminist Perspective on Addictions. In N. Van Den bergh (Ed.), Feminist Perspectives on Addictions. New York: Springer Publishing Company.

Wallace, B. C. (1990). Crack Cocaine Smokers as Adult Children of Alcoholics: The Dysfunctional Family Link. Journal of Substance Abuse Treatment, 7, 89-100.

Wang, C. (1999). Photovoice: A participatory action research strategy applied to women's health. Journal of Women's Health, 8(2), 185-192.

Wang, C., & Burris, M. A. (1994). Empowerment through photonovella: Portraits of participation. Health Education Quarterly, 21(2), 171-186.

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology and use for participatory needs assessment. Health Education and Behavior, 24(3), 369-387.

Wang, C., Cash, J., & Powers, L. (2000). Who knows the streets as well as the homeless? Promoting personal and community action through photovoice. Health Promotion Practice, 1*(1), 81-89.*

Wang, C., & Y, R.-J. (forthcoming). Photovoice ethics: Perspectives from Flint photovoice. Health Education and Behavior*.*

Wasson, D., & Anderson, M. A. (1995). Chemical dependency And Adolescent Self Esteem. Clinical Nursing Research, 4*(3), 274-290.*

Watters, J. K. (1989). Observations on the importance of social context in HIV transmission among intravenous drug users. Journal of Drug Issues, 19*(1), 9-26.*

Weissman, G., & Brown, V. (1995). Drug-Using Women and HIV: Risk-reduction and prevention issues*. New York: Plenum Press.*

WHO. (1986). The Ottawa Charter for Health Promotion*. Copenhagen: The World Health Organization.*

Whynot, E. (1998). Women who use injection drugs: the social context of risk. CMAJ, 159*(4), 355-358.*

Williams, A. (1991). Women at risk: an AIDS Educational needs assessment. IMAGE: Journal of Nursing Scholarship, 23*(4), 208-213.*

Wojcicki, J., & Malala, J. (2001). Condom Use, Power and HIV/AIDS Risk: Sex-Workers Bargain Survival in Hillbrow/Joubert Park/Berea. Social Science and Medicine, 53*(1), 99-121.*

Wolitski, R., Fishbein, M., & al, e. (1996). Sources of HIV information among injection drug users: association with gender, ethnicity, and risk behaviour. AIDS Care, 8*(5), 541-555.*

Worth, D. (1989). Sexual decision making and AIDS: Why condom promoting among vulnerable women is likely to fail. Studies in Family Planning, 20*(6), 297-307.*

Worth, D. (1990). Minority Women ands AIDS: Culture, Race, and Gender. In D. A. Feldman (Ed.), Culture and AIDS*. new York: Praeger.*

Wright, S. (2002). Women's use of drugs: gender specific factors. In H. Klee & M. Jackson & S. Lewis (Eds.), Drug Misuse and Motherhood*.*

Young, A. M., PBoyd, C., & Hubbell, A. (2002). Self Perceived Effects of Sexual Trauma Among Women Who Smoke Crack. Journal of Psychosocial Nursing, 40*(10), 46-53.*

Appendix A

Project Information Sheet

Carla Pindera is conducting a study "A Qualitative Needs Assessment of Inner-City Women Injection Drug Users." The purpose of this project is to describe the strengths and concerns of inner-city women injection drug users from their own point of view, and to bring forward the knowledge and experiences of their everyday lives. The objective is to identify the issues of importance, especially the health needs of women injection drug users. The information provided will be used to inform policymakers about issues of concern to women drug-users.

Carla is a University of Manitoba graduate student in the Department of Community Health Sciences and her advisors are Dr. Joe Kaufert and Dr. Lawrence Elliott. Carla has many years experience as a Public Health Nurse working in inner-city Winnipeg, and has a sincere interest in talking to women drug users. She believes that by talking with women injection drug users, a better understanding of their concerns can be gained. Discussing their strengths, problems and solutions is a way of promoting their own and their community's wellbeing.

Participants in this study will be invited to take photographic images of the issues of importance and the concerns in their lives. The photographs will be used as a way to think about and discuss issues of importance for themselves and their community. The discussions around their photographs will be in private between the participant and principal investigator. The participants will also be invited to be part of a focus group to explore the images and themes that emerge from their photographs and interviews. In this focus group they will be asked to identify

priority issues for the community and potential solutions and strategies to deal with these issues. The group will be asked to identify a target audience of policymakers and/or programme planners to serve as an audience for the participants' images, stories and recommendations

All information collected through interviews and the focus group will be kept confidential. Photographs will not be released for publication or use in public forums without the written consent of the participant. Information included in any written report will not include the participant's name, and will be shown to the woman providing the information for her approval before the final report is released. Women may withdraw from the study at any time.

If you are interested and willing to participate, please give your name, phone number, and address, or other method that you would like to be contacted to the person who has given you this letter, or call Carla at (cellular phone number will be given) Carla will contact you to arrange an interview. Thank you for your interest and your time.

If you have any questions, please do not hesitate to contact Carla Pindera at 952 9276.

Principle Investigator:
Carla Pindera
Address:
Department of Community Health Sciences
Faculty of Medicine
University of Manitoba
750 Bannatyne Avenue
Winnipeg, Manitoba R3E 0W3
Ph: 952-9276

Appendix B

Photovoice Ethics: *Minimum* Best Practices

- Provide and review with participants a consent form, regardless of whether required by facilitator's sponsoring institution.
- Provide an "acknowledgement and release" consent form on which participants obtain signatures of the people they photograph, regardless of whether required by facilitator's sponsoring institution.
- Frame an interview around a discussion about the use of camera, power, and ethics, emphasizing safety and the authority and responsibility that come with using a camera.
- Provide written material that participants can give subjects or interested community members.
- Provide participants with prints to give back to people they have photographed.
- Provide and review with participants a consent form indicating permission to publish any, or only specified photographs, to promote project goals, regardless of whether required by facilitator's sponsoring institution.
- Mentor project participants on the ethical principles and actions underlying photovoice

(Adapted from Wong and Redwood-Jones, 2001)

Appendix C

THE UNIVERSITY OF MANITOBA

FACULTY OF MEDICINE
Department of Community Health Sciences

750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3

Fax: (204) 789-3905

A Qualitative Needs Assessment of Inner City Women Injection Drug Users

Participant Information and Interview Consent Form

Principal Investigator:
Carla Pindera
Address:
Department of Community Health Sciences
Faculty of Medicine'
University of Manitoba
750 Bannatyne Avenue,
Winnipeg, Manitoba R3E 0W3
Ph: 952-9276

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may wish to discuss it with your friends or family. This consent may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of the Study

The purpose of this project is to describe the strengths and concerns of inner-city women injection drug users from their own point of view, and to bring forward the knowledge and experiences of their everyday lives. The objective of these interviews is to identify the issues of importance, especially the health needs of women injection drug users. The information provided will be used to inform policymakers about issues of concern to women drug-users.

Study Procedures

If you take part in this project, you will be asked to take photographs of issues of importance or concern in your life. You will be asked to take to take part in three interviews, each lasting approximately one to two hours. The first interview will be to explain the purpose of project, and to discuss the use of photographs to tell your life stories and to identify your concerns. The second interview will be to give you a camera, and to talk about what themes you can focus on to photograph that will represent and enhance your life. The final interview will be to discuss your photographs and the stories and concerns that are identified from them. You are the owner of your photographs and negatives and you will choose the images you wish to share in the interview. With your permission I will tape-record the interviews. Although I will try and write down your responses as well, the results from the interviews will be more accurate and

better represent your actual words if they are tape-recorded. All of the tapes will be erased at the end of the study. This project will take place over a 1-year period.

Risks and Discomforts

The use of cameras to photograph your life stories and issues of concern may have potential risks, such as physical harm and loss of privacy to yourself and/or your community. It is important that others privacy and rights are respected. You will be asked to get written consent from all subjects you photograph in order to take their photograph and to use these photographs for the project. Due to the illegal nature of drug possession, no photographs possibly depicting any illegal behavior will be accepted for discussion in the research project. No picture is worth taking if it leads to harm or ill will to you the photographer.

Benefits

Participation in this project may not benefit you directly. However, information from this study may be used to identify important issues and concerns to inner city women injection drug users, and this information can be used to help plan appropriate support services.

Costs

The interviews will be conducted at no cost to you. The cameras, film, and development of the film will all be provided for you. You are being invited to act as a research associate to this project, for this you will receive an honorarium payment of $100 at the completion of the data collection.

Confidentiality

All information you provide in the interviews will be kept strictly confidential. Your name and consent form will be kept separate from the photographs and interview data to ensure that you cannot be identified. Access to this personal information will be restricted to project staff and secured physically from public access in a locked cabinet. Interviews will be tape-recorded and all tapes will be erased upon completion of the study.

Information gathered in this research project may be published or presented at public forums, however none of your photographic images will be released without your written consent, and your name will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information will be disclosed if required by law. Organizations, such as the University of Manitoba Health Research Ethics Board, may inspect and/or copy your research records for quality assurance purposes.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is strictly voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision to not participate or to withdraw from the study will not effect the health care you receive. You will be told any new information that may affect your health, welfare, or willingness to stay in this research project.

Participant/Research Associate

I, the undersigned, have fully explained the relevant details of this study to the photograph subject named above and believed that the participant has understood and has knowingly given their consent.

Printed name: _____ Date: _____

Signature: _____

Role in the Study: _____

Appendix D

THE UNIVERSITY OF MANITOBA

FACULTY OF MEDICINE
Department of Community Health Sciences

750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3

Fax: (204) 789-3905

A Qualitative Needs Assessment of Inner City Women Injection Drug Users

Acknowledgement and Release to be Photographed Consent Form

Principal Investigator:
Carla Pindera
Address:
Department of Community Health Sciences
Faculty of Medicine
University of Manitoba
750 Bannatyne Avenue,
Winnipeg, Manitoba R3E 0W3
Ph: 952-9276

You are being asked to have your photograph taken for use in the research project: A Qualitative Needs Assessment of Inner City Women Injection Drug Users. Please take your time to review this consent form and discuss any questions you may have with the study participant. If you have further questions, please contact the principal investigator, Carla Pindera at 952-9276 before signing this consent.

Purpose of the Study

The purpose of this project is to describe the strengths and concerns of inner-city women injection drug users from their own point of view, and to bring forward the knowledge and experiences of their everyday lives. The objectives of this project are to identify the issues of importance, especially health needs of women injection drug users, and to develop ideas for action to address the issues and concerns. The information provided will be used to inform policymakers about issues of concern to women drug-users.

This project will take place over a 1-year period.

Procedure

If you agree to be participate, you will be asked to sign this consent agreeing to be photographed and have the photographs used for discussion. The photographs will be developed and used during interviews between the study participant and investigator to talk about issues of importance and concerns in their lives. The ideas and stories that come out of these discussions will be brought to a focus group with other study participants to develop ideas for actions to address the issues and concerns of inner city women injection drug users. These photographs, stories, and ideas for actions will be presented to policymakers and programme planners. Information and photographs gathered in this research project may be published or presented at public forums.

Risks and Discomforts

The use of cameras to photograph your life stories and issues of concern may have potential risks, such as physical harm and loss of privacy to yourself and/or your community. No photographs of you will be taken without your written consent.

Benefits

Participation in this project may not benefit you directly. I hope, however, that the information from this project may be used to identify important issues and concerns to inner city women injection drug users, and this information can be used to help plan appropriate support services. You will not receive any payment to have your photograph taken. If you wish, a copy of the photographs of you will be given to you at the completion of the study.

Confidentiality

Your name and consent form will be kept separate from the photographs and interview data to ensure that you cannot be identified. Access to this personal information will be restricted to project staff and secured physically from public access in a locked cabinet.

Information and photographs gathered in this research project may be published or presented at public forums, however your name will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information will be disclosed if required by law. Organizations, such as the University of Manitoba Health Research Ethics Board, may inspect and/or copy your research records for quality assurance purposes.

Voluntary Participation/Withdrawal from the Study

Your decision to be photographed for this study is strictly voluntary and you may refuse to participate.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research project with the photographer. I have had my questions answered in a language I understand. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my participation to be photographed for this project is voluntary. I freely agree to be photographed for this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed.

Photograph subject's signature: _____ Date: _____

Photograph subject's printed name: _____

Participant/Research Associate

I, the undersigned, have fully explained the relevant details of this study to the photograph subject named above and believed that the participant has understood and has knowingly given their consent.

Printed name: _____ Date: _____

Signature: _____

Role in the Study: _____

Appendix E

THE UNIVERSITY OF MANITOBA

FACULTY OF MEDICINE
Department of Community Health Sciences

750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3

Fax: (204) 789-3905

A Qualitative Needs Assessment of Inner City Women Injection Drug Users

Photograph Release Consent Form

Principle Investigator:
Carla Pindera
Address:
Department of Community Health Sciences
Faculty of Medicine
University of Manitoba
750 Bannatyne Avenue,
Winnipeg, Manitoba R3E 0W3
Ph: 952-9276

You are being asked to allow any of your photographs, or only certain specific photograph, to be published or used as part of this project. Please take your time to review this consent form and discuss any questions you may have with the study staff. This consent may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of the Study

The purpose of this project is to describe the strengths and concerns of inner-city women injection drug users from their own point of view, and to bring forward the knowledge and experiences of their everyday lives. The objectives of this project are to identify the issues of importance, especially health needs of women injection drug users, and to develop ideas for action to address the issues and concerns. The information provided will be used to inform policymakers about issues of concern to women drug-users.

Study Procedures

This project is hoping with your permission, to use any photographs or only certain specified photographs taken by you to enhance the life stories and ideas for actions that will be presented to policymakers and programme planners. Information and photographs gathered in this research project may also be published or presented at public forums.

Risks and Discomforts

The use of cameras to photograph your life stories and issues of concern may have potential risks, such as physical harm and loss of privacy to yourself and/or your community. It is important that others privacy and rights are respected. Due to the illegal nature of drug

possession, no photographs possibly depicting any illegal behavior will be accepted for discussion in the research project.

Benefits

Participation in this project may not benefit you directly. However, information from this study may be used to identify important issues and concerns to inner city women injection drug users, and this information can be used to help plan appropriate support services.

Confidentiality

Your name and consent form will be kept separate from the photographs and interview data. Information gathered in this research project may be published or presented at public forums, however none of your photographic images will be released without your written consent, and your name will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information will be disclosed if required by law. Organizations, such as the University of Manitoba Health Research Ethics Board, may inspect and/or copy your research records for quality assurance purposes.

Voluntary Participation to Release Photographs

Your decision to release your photographs for publication or use in public forums is completely voluntary. You may refuse to release your photographs for any secondary uses in this project. Your decision to not participate or to withdraw from the study will not effect the health care you receive. You will be told any new information that may affect your health, welfare, or willingness to stay in this research project.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research project with the research staff. I have had my questions answered in a language I understand. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my decision to release my photographs for publication or use in public forums is voluntary and that I may choose to withdraw my permission at any time. I freely agree to release my photographs or only certain specified photographs for use in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of my records that relate to this study by the University of Manitoba Health Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any legal rights that I have as a participant in a research study.

Participant signature: _____ Date: _____

Participant printed name: _____

Research Staff

I, the undersigned, have fully explained the relevant details of this study to the participant named above and believed that the participant has understood and has knowingly given their consent.

Printed name: _____ Date: _____

Signature: _____

Role in the Study: _____

Appendix F

Guidelines for Obtaining Consent

"The Acknowledgement and Release to be Photographed Consent Form" has two purposes: to explain about the project; and to get written proof that the person being photographed has been told about the purpose of the project, consents to being photographed, understands any risks involved, and knows that having their picture taken is completely voluntary.

The procedure for obtaining consent from anyone you photograph is as follows:

1. Talk to the person you want to include in your photograph. Explain the project briefly. Explain the purpose of the study, how the photographs will be used, the potential risks of being photographed, that their decision to be photographed is completely voluntary, and that their names will not be included with their photograph.

2. Explain to the person being photographed that you must get written consent before you can take any pictures.

3. You are responsible for answering any questions that the person may have before taking any photographs. If you cannot answer their questions or the person is not clear about the use of the photographs, you can have them call the Principal Investigator (Carla Pindera) before taking any photographs.

4. Once you have explained the study and the consent form, give the person a chance to read the consent form. If they are willing to participate you must ask them to sign 2 copies of the consent form on the line called "Photograph subject's signature." If they do not want to participate, do not take their picture.

5. Once the person you are photographing has signed the consent forms, you will also sign the section called "Participant/Research Associate."

6. You will keep one copy of the consent and you will give the second copy to the person being photographed.

Appendix G

Unstructured Interview Guide I

I. Socio-demographic

A. Date _____

B. Location _____

C. Self –Described Ethnicity _____

D. Age _____

E. Educational Experience _____

F. Relationship Status _____

G. Number of Children_____

H. Employed _____

I. Treatment- # times _____

II. Brainstorm around issues of importance/ concern as content for photographs

A. What makes you happiest about your life?

B. What makes you angry about your life?

C. Who or What provides you with support in your life?

What is helpful?

What is not helpful?

What would be helpful?

III. Factors which facilitate prevention or function as barriers to treatment or risk reduction.

A. If any agency or individual helped you, who was it?

B. What was not helpful?

C. What makes it possible for you to keep using drugs?

D. Or, what keeps you from stopping your drug use?

People? Things? Situations?

Appendix H

Unstructured Interview Guide II

Participants will be invited to do "freewrites" around the photos that they feel are the most important or that they like the best. These questions will be set around the mnemonic "SHOWeD":

- What do you **S**ee here?
- What is really **H**appening?
- How does this relate to **O**ur lives?
- **W**hy does the problem or strength exist?
- What can we **D**o about it?

Discussion will be around the participants' photographs and their free-writes.

(Adapted from Wong and Redwood-Jones, 2001