

HEALTH EXPERIENCES OF WOMEN WHO ARE STREET-INVOLVED AND USE  
CRACK COCAINE: INEQUITY, OPPRESSION, AND RELATIONS OF POWER IN  
VANCOUVER'S DOWNTOWN EASTSIDE

by

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## **ABSTRACT**

Women who live in Vancouver's Downtown Eastside experience some of the most devastating health problems among residents of British Columbia. While crack cocaine use has been associated with many of these problems, we lack an understanding of how women who use crack cocaine experience these health problems and what they do to manage them. Informed by tenets of intersectionality and social geography, a critical ethnographic approach was used to examine the scope of health concerns experienced by women who are street-involved and use crack cocaine, the strategies they used to manage their health, and the social, economic, political, personal, and historical contexts that influenced these experiences. Data were collected over a seventeen month period and included a cross sectional survey (n=126), participant observations, and interviews (n=53).

The women described experiencing poor physical and mental health throughout their lives; many of which were preventable. Respiratory problems, anxiety, sadness and insomnia were the most frequent concerns reported. They endured severe economic deprivation, unstable and unsanitary housing, and relentless violence and public scrutiny across a variety of contexts including their homes and on the street. These experiences were further influenced by structural and interpersonal relations of power operating within the health care, legal, and welfare systems. The women engaged in several strategies to mitigate the harmful effects of factors that influenced their health including: (a) managing limited financial resources; (b) negotiating the health care system; (c) managing substance use; and (d) managing on your own. These strategies were influenced by the types of concerns experienced, perceptions of their most pressing concern, the nature of interpersonal relations with health care providers, and the limited social and economic resources available.

Changes in the organizational policies and practices of the welfare, legal, and health care systems are needed to improve women's health. Possible strategies include increased access to welfare and safe, affordable housing, safer alternatives to income, and improved collaboration between illness prevention and law enforcement programming. New approaches are required that build on women's considerable strengths and are sensitive to ways in which gender, race, and class can disrupt opportunities to access services.

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## LIST OF ACRONYMS

Community Health and Safety Evaluation Project.....	CHASE
Downtown Eastside.....	DTES
Hepatitis C Virus.....	HCV
Human Immunodeficiency Virus.....	HIV
International Society for Equity in Health.....	ISEQH
Pivot Legal Society.....	PIVOT
Pre-Kit Distribution Survey.....	PKDS
Safer Crack Use Coalition.....	SCUC
Safer Crack Use, Outreach, Research and Education Project.....	SCORE
Safer Crack Use, Outreach, Research and Education Project Women’s Advisory Committee.....	SWAC
Sexually Transmitted Infections.....	STI
Vancouver Area Network of Drug Users.....	VANDU
Women’s Information Safe House Drop-In Centre.....	WISH
World Health Organization.....	WHO



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**In loving memory of my dad,  
Murray Augustus Bungay  
(1934-2004)**

**Because you taught me that everybody matters.**

# CHAPTER ONE: INTRODUCTION

## Situating the Problem

Women who live in Vancouver's inner-city neighbourhood known as the Downtown Eastside (DTES) experience serious inequities with regards to their health. They die at twice the provincial rate from potentially treatable illnesses including cervical cancer, bacterial infections, and pneumonia (BC Vital Statistics Agency, 2005).<sup>1</sup> Aboriginal women are significantly overrepresented and many live in poverty and unstable housing. Women in the DTES are at greater risk than men for trauma-related health issues and blood-borne infections and are more likely to be treated disrespectfully by health care providers (Community Health and Safety Evaluation Project [CHASE] Report, 2005). Additionally, despite the increase in health care clinics implemented by the regional health authority to serve the neighbourhood (Vancouver Coastal Health), women's access to health care remains a substantial problem which further exacerbates their likelihood of experiencing poor health (CHASE Report).

The DTES has gained international notoriety for its open drug scene. Crack cocaine is the most commonly used illegal substance and smoking is the most common method of consumption (Buxton, 2007; CHASE Report, 2005). Additionally, recent research indicates that women are more likely than men to use crack cocaine (CHASE Report). Crack cocaine use among women has been correlated with a myriad of health concerns that ultimately affect their health status including cardiac and respiratory health issues, acute psychosis, sexually transmitted infections (STI), unplanned pregnancies, HIV, hepatitis C (HCV), and increased violence against women (Butters & Erickson, 2003; Goodman, 2005). Research in the field of crack cocaine and women's health has focused almost exclusively on cocaine pharmacology, smoking practices, and women's sexual behaviours as factors influencing their health concerns. Conversely, research in the fields of sociology and criminology have emphasized the negative experiences of

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<sup>1</sup> It is of significance to note that men in the DTES also die at twice the provincial rate from preventable illnesses.

sexism, racism, and economic deprivation as factors influencing the day-to-day lives of women who use crack cocaine (Mahan, 1996; Maher, 1997; Murphy & Rosenbaum, 1992; Sterk, 1999). Many women who are street-involved experience severe economic and social deprivation including absolute and relative poverty, unstable housing, and increased arrest: experiences that often precede the use of crack cocaine (Maher; Sterk). Women have reported that they perceive biases and assumptions on the part of health care providers regarding crack use and poverty as the main causes of disrespectful and demeaning interactions with health service providers (Butters & Erickson, 2003; Goodman, 2005). In an attempt to avoid these experiences, women often try to manage health concerns independently, and do so with relative degrees of success (Ensign & Panke, 2002).

Despite evidence pertaining to the complexity of health experiences among women who use crack cocaine and knowledge related to the detrimental effects of poverty, sexism, and racism for women's health in general, few studies have specifically focused on women's experiences of health concerns in a manner that has served to expand our understanding of the influential factors that contribute to women's overall health. Substance use has remained the central factor in research almost treating the health experiences of women as a result of the substance itself rather than substance use as one of the contextual factors influencing women's lives. Women who use crack cocaine continue to experience severe health problems, are less likely to access health care, and are actively involved in managing their own health. How these experiences play out in women's lives is less well known. There are significant gaps in knowledge, for example, concerning the range of health concerns experienced by women who use crack cocaine that may or may not be related to their crack use. There are additional unknowns with regards to the influential factors that shape these experiences or how women make decisions with regards to managing their health. While not discounting the significance of the research that has preceded this project, it was timely to explore the health concerns and

health management strategies of women who use crack cocaine. It was also worthwhile to shift the emphasis from crack cocaine as the predominant factor influencing women's health to incorporate a broader perspective encompassing the social, economic, political, personal, and historical factors that may contribute to women's experiences of health and their health management strategies. This knowledge is essential for changes in research, education, policy, and practice aimed at reducing the influential inequities experienced by those who carry the greatest burden of illness (Frolich, Ross & Richmond, 2006).

### **Research Purpose and Objectives**

The overarching purpose of this study was to more fully understand the health experiences of women who are street-involved and use crack cocaine, the strategies these women use to manage their health, and the relations of power that influence their experiences. Situated specifically within DTES, I drew upon select aspects of intersectionality, social geography, feminist theory, and critical ethnography as a method of inquiry to critically examine the social, economic, political, personal, and historical aspects of women's day-to-day lives that both influenced and were influenced by their experiences of health. The specific research questions explored were:

1. What are the nature and the scope of day-to-day health concerns experienced by women who are street-involved and use crack cocaine?
2. What strategies do women use to manage their day-to-day experiences of health?
3. How are women's experiences of health and health management strategies influenced by relations of power, systems of oppression (e.g., sexism, racism, classism) and spatial relations?

The specific research objectives were to:

1. Critically examine women's experiences of health within the wider social, economic, political, spatial, personal, and historical contexts of their day-to-day lives.

2. Generate a broader understanding of the strategies that women who are street-involved and use crack cocaine use to manage their health including the influential power and spatial relations that contribute to these experiences.
3. Analyse the interrelationships between relations of power, systems of oppression, spatial relations, and women's health experiences and health management strategies to understand the implications of these interrelationships for women's experiences of health.
4. Generate recommendations in the areas of education, research, and practice to optimize women's opportunities for health.

### **Conceptual Issues and Definition of Terms**

Language and its inherent meanings are frequently problematic. To enhance clarity I provide a brief overview of key terms that were used in the design, implementation, and analysis of this project. The meanings that I ascribed were chosen in part from the language that the participants used to describe their experiences as well as from related literature.

The terms *woman* or *women* were not defined according to secondary sex characteristics but were conceptualized based on how the participants self-identified their gender. Participants who self-identified as female were descriptively categorized as women. Although a small number of participants self-identified as transgendered, they regularly accessed women-only services including housing and drop-in centres, and several had undergone surgical procedures to alter their appearance (e.g., breast implants or sex-reassignment surgery). Thus, the term woman was used to capture those who self-identified as female and transgender male-to-female.

*Street-involvement* was the term used to describe an inner-city context of housing, activity, and visibility among women who experience marginalization in housing and financial security. Women who are street-involved usually experience serious economic deprivation and may circulate between home and the street, have no connection to home, and/or have inadequate or insecure shelter (Caputo, Weiler & Anderson, 1997; Peressini & McDonald, 2000). They are

often highly visible within the public domain. Women who are street-involved may or may not have ties with mainstream society and may or may not be involved in criminal activity or substance use (Higgit, Wingert & Ristok, 2003). Street-involvement, as a descriptor, was not used to imply a homogenous population or experience among all women. Women were recognized as having individual characteristics, histories, skills, and resources.

**Health concern** was the term applied to describe women's experiences and perceptions of mental and physical health problems that contributed to their overall well-being, an experience that was described by the participants' perceptions of their health and my application of knowledge within the health sciences (e.g., pathophysiology). Mental and physical health concerns were not necessarily equated with medically diagnosed disorders (e.g., schizophrenia, osteoarthritis). Additionally, as recommended in the 2001 World Health Organization (WHO) Report on Mental Health, the category "mental health" incorporated a broad perspective including women's experiences of emotional and subjective well-being and a recognition that these experiences are influenced by biological, psychological and social factors (WHO, 2001).

Women's experiences of health concerns were also positioned within the realm of **inequities in health** (International Society for Equity in Health [ISEQH], 2005). As a concept, inequity implies injustice and unfairness (Frolich et al., 2006). Within the context of experiences of health concerns, inequities in health pertain to the "systematic and potentially remedial differences" (ISEQH, para. 2) in social, economic, political, and personal factors that negatively influenced women's experiences of health (Adelson, 2005; Frolich et al., 2006; Reimer Kirkham & Browne, 2006). Positioning women's experiences of health within the arena of inequities was important to highlight that women's experiences of health concerns were disproportionate in relation to other women within British Columbia and that an individualized notion of **equality**, or the state of being equal, was an insufficient conceptual tool to explore the injustices that influenced women's health concerns (Farmer, 2005; Reimer Kirkham & Browne, 2006).

Additionally, as noted by many who are concerned with inequities in health, rhetoric of equality has served to neutralize resistive discourses by rendering arguments against the racialized, class based, and sexist organization of social institutions as mere “complaints” and have diminished the aims of a social justice call to action that incorporates civil, social, and economic human rights (Collins, 2000; Crenshaw, 1991). Members of dominant groups have drawn upon assumptions of equality that are now integrated in many of our social institutions to argue that because equality is now “guaranteed,” individual’s experiences of poor health must represent individual failures, a tactic that effectively permits them to sidestep more meaningful social change within relations of power (Crenshaw; Farmer). Application of inequity as a conceptual tool was necessary to explore relations of power that justify and reinforce women’s experiences of poor health.

*Relations of power* is, necessarily, a significant concept in a project concerned with inequity in women’s experiences of health. Although described in greater detail in Chapter Three, briefly stated, relations of power refer to the social, spatial, economic, personal, and political processes, ideologies, and practices that sustain and resist domination and subordination, and advantage and disadvantage among members of society. Relations of power are historically situated and operate across multiple and intersecting racialized, gendered, and class-based systems of oppression.

*Health management strategies* referred to the actions, experiences, and decision-making processes employed by women as they sought to prevent and/or manage their experiences of specific health concerns. Women’s agency to actively engage in managing their health and the relations of power that influenced their options, and the interrelationships between relations of power and their decision making were integral ideas within the conceptualization of this term.

As a theoretical construct, *poverty* lacks cohesive conceptual clarity. Quite often it is expressed solely in terms of income in which a predetermined income level such as the Low



Income Cut Off (LICO) is viewed as an indicator for poverty (Reid, 2007). Within the context of this project, poverty was conceptualized as not merely a representation of income, but also as a deprivation of multiple dimensions of life including a long and healthy life, knowledge, and a decent standard of living (Krieger, 2001). Poverty was reflected through inadequate material possessions such as food, clothing, and shelter (absolute poverty) as well as social exclusion in terms of opportunity for employment, education, and full participation in community life (relative poverty) (Reid).

The language concerning *substance use* is inherently challenging. Few researchers within the health disciplines have historically differentiated between addiction and non-problematic use in relation to crack use (and other illegal substances). Drawing upon the voices of the participants, I recognized that not all use of substances could be considered *addiction*, an experience that was defined by the participants as the compulsive need to use to avoid serious experiences of withdrawal. I therefore chose to situate substance use within the context of the relationship between the person who is using, families, society overall, and the substance being used. Incorporated within this relationship were the route of use, contextual factors associated with use, and the pharmacological properties of the substance. When negative relationships were experienced with crack or other substances I applied the term *problematic substance use*. Problematic use was the use of any substance (e.g., legal or illegal) that contributed to individual and/or social harms which may have included but was not limited to dependence and addiction, crime, violence, employment difficulties, and other mental health issues (MacPherson, 2000; MacPherson, Mulla & Richardson, 2006).<sup>2</sup>

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<sup>2</sup> Note that the term illicit is intentionally not used to describe illegal substances or the use of illegal substances as this term is often value laden and implies a negative moral judgment concerning people's use of illegal substances.

## **Organization of the Thesis**

Having introduced the purpose and research questions addressed in this dissertation, the remainder of this work is organized around a central line of argument which illustrates how the experiences of health concerns and health management strategies of women who are street-involved and use crack cocaine are influenced by relations of power that operate across racialized, gendered, and class-based systems of oppression. In Chapter Two I review literature that was germane to the research. I begin with an overview of knowledge concerning crack cocaine and its physiologic properties and move forward to provide a brief historical perspective of critical and feminist work in the field of women, experiences of health, criminal justice practices, and crack cocaine use. In the final half of the chapter I emphasize the Canadian context and literature specific to health experiences to describe select aspects of the state of current knowledge about women's experiences of health and their health management strategies and include the identification of areas that require further investigation.

In Chapter Three I outline the theoretical foundations that underpin the research and explicate the research design that I employed. Positioned within the emerging body of nursing and related social science scholarship, I delineate the central tenets of intersectionality and social geography that influenced my understanding of relations of power, systems of oppression, and inequities in health. Drawing from these perspectives I explain my application of critical ethnography as a research approach and outline the methods and activities that were used to collect and analyse data. I specify the ethical considerations that were necessary within the scope of this project and provide rationale for choices that I made regarding the nature of research relationships with participants, participant codes, and my use of financial honorariums.

Chapter Four represents the first analytical chapter in relation to the data collected within the project. The overarching purpose of this chapter was to provide the backdrop against which women's experiences of health concerns and health management strategies could be better

understood. I provide an overview of the participants and highlight the day-to-day economic, personal, social, historical, and political context in which women live. Of particular relevance are the experiences of women living within the neighbourhood of the DTES, the continual threats to their personal safety, poverty, and the positive attributes they associated with the neighbourhood.

In the fifth chapter I present an analytical discussion of women's experienced health concerns and critically examine these experiences as inequities in health within the context of relations of power and systems of oppression. The discussion highlights the magnitude of chronic and acute physical and mental health concerns that occur throughout the course of women's lives and incorporates how women perceive of and experience these health concerns on a day-to-day basis.

In Chapter Six I describe the strategies that women employ to manage and/or prevent health concerns. Through the analysis, I illustrate the effects that perceived negative interactions with service providers have for women's health management strategies and also identify the positive and creative strategies that women employ on a regular basis. Within this chapter I draw upon the experiences of women to demonstrate the complexity of women's use of illegal substances and the wide range of experiences with crack and other substances used by individual women themselves and across women as a social group.

The final chapter is devoted to my discussion of the analysis, the broader meanings and the implications of this work for future research, policy making, education, and practice. Within the scope of this chapter I illustrate the damaging effects that ideologies of deviance housed within relations of power designed to advantage some social groups at the expense of others, have for women's overall health and their opportunities for more equitable experiences of health. In the final conclusions, I highlight some of the limitations of this work and methodological challenges along with recommendations for change.

## **CHAPTER TWO: REVIEW OF EXISTING KNOWLEDGE**

### **Introduction**

To situate this project within the realm of historical and current knowledge concerning the health experiences of women who are street-involved and use crack cocaine, I conducted a review of relevant health and social science literature. Given the breadth of research within this area, I reviewed literature published primarily between 1990 and 2007 with a specific emphasis on the Canadian context. For the most part, I limited the review to studies that had addressed health concerns and/or self-regulated health management strategies of women who use crack cocaine as their primary topics. In some instances, studies that focused more generally on women's issues within the context of illegal substance use and studies that involved both men and women were included as the study approaches, topics, and findings of this work were relevant within my overall project purpose. I have organized the results of the review into several themes within the realm of women who are street-involved and use crack cocaine: (a) the historical context of crack cocaine use and related discourse; (b) women's health concerns; (c) women's health management strategies; and (d) the spatial, economic, social, and political influences affecting women's health.

In reviewing this literature I was able to explore the state of current knowledge concerning study populations, methodological approaches, and general findings and identified topics that require further investigation. Because this project was also concerned with relations of power as influential factors for women's health, I also critically examined the mechanisms by which the arguments put forth in this literature challenged or resisted a homogenous, essentialized perspective of women who use crack cocaine.

## **Crack Cocaine: The Substance**

Cocaine is a powerful central nervous system stimulant and its effects include feelings of increased alertness and energy, inhibited appetite, and euphoria (Erickson, Adlaf, Smart, & Murray, 1994). The feelings of euphoria are directly related to the ability of cocaine to interfere with the re-absorption of dopamine, which is the chemical messenger in the brain that is associated with pleasure (Snyder, 1996). The physiological effects of cocaine include vasoconstriction (the constriction of blood vessels) which may contribute to increases in heart and respiratory rates and blood pressure and in some instances cause muscle spasm and vertigo (Volkow, 2004). Crack is a relatively inexpensive form of cocaine that is made by processing powder cocaine with baking soda or ammonia and crystallizing it into a salt (Goodman, 2005; Ratner, 1993). Few impurities are removed during this process and it is possible to add other substances at some point in the manufacturing process. Recent Canadian research indicates that the majority of crack bought “on the street” usually has small amounts of cocaine and is mixed with a variety of other substances (e.g., lidocaine, crystal methamphetamine) (Goodman).

Smoking is the predominant method of using crack cocaine although injection also occurs (Fischer, Rehm, Patra, Kalousek, Haydon, Tyndall, El-Guebaly, 2006; Leonard, DeRubeis, & Birkett, 2006). The crystallized cocaine, referred to as “rock,” is heated in a makeshift pipe made of glass or metal and the resulting vapours are inhaled (Goodman, 2005). Crack cocaine is quickly absorbed into the bloodstream which often results in a quick and intense “high” that is relatively short-lived (Porter, Bonilla, & Drucker, 1997; Ratner, 1993; Volkow, 2004). There is minimal empirical evidence to support reports within American and Canadian media that crack cocaine is immediately addictive (Erickson et al., 1994). Instead researchers have demonstrated that patterns of crack cocaine use vary considerably among people from occasional use (e.g., once per month) to a bingeing pattern of using large amounts in a relatively short period of time

and problematic use including addiction (Erickson et al., 1994; Decorte, 2000; Waldorf, Reinerman & Murphy, 1991).

The exact prevalence of crack cocaine use in Canada is unknown. In the 2004 Canadian Addiction Survey (CAS), which included a sample of Canadians over the age of 15 (n=13909) from the ‘general’<sup>3</sup> Canadian population, lifetime cocaine/crack use was recorded at 10.6% and use in the past year was 1.9% although rates in British Columbia were noticeably higher at 16.3% and 2.6% respectively (Adlaf, Begin, & Sawka, 2005). Recent Canadian data with people who were street-involved and lived in economic deprivation indicated higher rates of use. The data from a Canadian cohort of people who use illegal opioids in five Canadian cities for example, indicated that 54.6% of baseline participants had used crack in the past 30 days although there was some variation among prevalence according to sites ranging from 86.6% in Vancouver to 3.4% in Quebec City (Fischer et al., 2006). Data from recent work with 4000 people who were street-involved and had accessed community health services in the DTES illustrated that 55% reported using crack in the past six months and women were more likely than men to use crack (34% versus 27%) (CHASE Report, 2005), although the rationale underpinning this finding was unclear. Although people of all socioeconomic backgrounds use crack, as evidenced within the CAS results, researchers have suggested that the inexpensive cost of crack production and purchasing, has contributed to increased spread of use within city neighbourhoods characterized by severe economic deprivation (Mahan, 1997; Waldorf et al, 1991).

### **Locating Women and Crack Cocaine Use within a Historical Context**

The discourse concerning women’s use of illegal substances in general and crack cocaine in particular has a complex and at times conflicting history that has influenced how women have

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<sup>3</sup> To highlight that data was collected primarily with people who had a place of residence with phone access thereby limiting participation of those living without these resources, the term general is placed in single quotation marks.

been positioned within the health care and social science disciplines concerned with illegal substance use and addictions. Early medical and anthropological research focused on illegal substance use within the discourse of addiction which portrayed addiction as a disease entity that contributed to people's inability to control their actions (Keane, 2002). Moral claims about addiction and illegal drug use revealed a hierarchy within substances used in which illegal "drugs" such as heroin and cocaine were perceived as more socially deviant than legal substances such as alcohol or tobacco and were touted as contributing to the destruction of society (Brook & Stringer, 2005; Ettore, 1992). Proponents of prohibition argued that there was a direct link between criminal acts and the use of illegal substances, an ideology that remains prevalent today (Boyd, 2008). People who experienced addictions with illegal substances were portrayed as deviant, weak, and unable to act in their own best interest, and as such required that their actions be governed by others, particularly medicine and the criminal justice system (Boyd, 2004; Brook & Stringer; Cooper, 2004).

As noted by several feminist researchers, this ideology concerning addictions and illegal substance use has been significantly damaging for women. Women who use illegal substances historically have been positioned within health and social science discourse as a homogenous group incapable of self-control who have abdicated their nurturing and mothering roles within society and as individually weak and of poor moral character, particularly with regards to their sexuality (Boyd, 1999, 2004; N. Campbell, 2000; Ettore, 1992, 2004; Maher, 1997). This dominant ideology has served to legitimate an increased regulation of women by medicine and the state including the social service and criminal justice systems. For example, women who use illegal drugs, particularly those who experience economic deprivation and are Aboriginal (within Canada) or African-American (within the US) are more likely to be incarcerated for substance-related crimes and are also more likely to have their children apprehended into protective

custody than women within the “general” population (e.g., White women, women of greater economic resources) (Boyd, 1999).

Several researchers have highlighted that the dominant ideology is further influenced by intersections of race, class, and gender and that these relationships have had significant implications for women’s day-to-day lives (Boyd, 1999, 2004; Campbell, 2000; Cooper, 2004; Ettore, 1992; Maher, 1997). In her analysis of 297 health-related articles dated during the periods 1880-1920 and 1955-1975, Cooper demonstrated how oppressive assumptions of gender, race, and class played out within the realm of health research and theory development concerning the etiology of opiate addiction. She reported that health professionals attributed experiences of addiction to individual psychopathology such as immaturity, weakness, and regressive characteristics in relation to women from the working class or who were poor and/or men and women who were described as Latino, African-American, and indigenous. External factors such as the stressors associated with “living in the modern world” were cited as the primary cause of addiction experienced by affluent White males (Cooper, p. 441). Drawing upon theories of oppression and intersectionality, she further argued that *how* health professionals defined the root cause of addiction was not accidental, but instead reflected the inequitable social relations of these eras and was a deliberate attempt to “ratify this group’s supremacy over others” (p. 442).

Today the dominant ideology concerning women and illegal substance use permeates social science and health care research concerned with the lives of women who use crack cocaine. For example, several social science ethnographic studies have focused almost exclusively on issues of crack use and commercial sex work, exploring women’s experiences of sex-for-money or sex-for-crack exchanges with a specific emphasis on the location and types of sexual acts involved.<sup>4</sup> Researchers such as Inciardi, Lockwood, and Pottieger (1993) and Ratner

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<sup>4</sup> Commercial sex work involves work with the explicit purpose of exchanging sex activities for resources. Resources may include but are not limited to money, substances, food, protection, and shelter. Commercial sex work provides a more comprehensive approach to examining sex-for-resource exchanges than housed within traditional



(1993) studied the experiences of African-American women living in extreme economic deprivation within specific drug houses where sex-for-resource exchanges occurred. The researchers documented their observations of women's actions and experiences and presented their findings in a manner that decontextualized women from the rest of their lives. Women were described as "doing anything for the drug" and the economic or gendered forces influencing their lives were never discussed, despite the overwhelming literature that has demonstrated the link between survival commercial sex work, oppression of women, and severe economic deprivation (e.g., Kearney, Murphy & Rosenblum, 1994; Maher, 1997).

In more recent ethnographic projects within two separate economically deprived American inner-city neighbourhoods' researchers E. Anderson (1999) and Bourgois (2003) perpetuate the sexist stereotypical discourse of women who use crack cocaine as amoral, self-serving women who have abdicated their responsibility to the family. In his work that primarily targets African-American men and women, Anderson discusses crack cocaine use solely in the context of women's behaviours. He blames women's use for the destabilization of the family unit and draws upon stereotypes of Black matriarchal figures to reinforce his point.

One of the worst hazards is crack. Once a family member 'hits the pipe,' a process begins that destabilizes an already weak unit...it starts when the daughter gets in with the 'wrong crowd'...the grandmother often unintentionally aids and abets the daughter's fall into this life by babysitting for the children and helping out financially and in other ways, thus giving the daughter the freedom to pursue a good time (pp. 215-216).

Bourgois (2003) in his work with Latino men and women, describes men who engage in drug selling and violence as being victims of the economic circumstances within the United States and attributes their actions to a loss of masculine identity. Despite an acknowledgement of the difficulties women face in accessing social assistance programming, women's actions as dealers and people who use are described as "destroying the family." Drawing solely on his own

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ideas of prostitution and permits critical examination of the relations of power underlying the sex-for-resource exchanges.

experiences in the neighbourhood and interviews with only one woman he states, “she finally came to the realization that she was destroying herself and her family through her drug dealing” and that “her aggressive, street-wise single mother persona did not inspire credibility at the welfare office” (p. 245).

Over the past 25 years critical and feminist ethnographic and qualitative researchers have critiqued this dominant discourse as problematic.<sup>5</sup> While it is beyond the scope of this project to review all of these studies, a key number that reflect this resistive discourse should be highlighted. Beginning in the early 1980s, Rosenbaum (1981) acknowledged the lack of empirical work that accurately reflected the experiences of women and sought to critically examine aspects of women’s lives that pertained to illegal substance use from the standpoint of women themselves. Although her project focused upon women who used heroin, Rosenbaum was the first researcher that specifically identified the need to examine women’s experiences of their day-to-day lives and illegal substance use within the context of race, gender, and social class. Maher (1997) engaged in ethnographic work to examine the economic context of drug use and dealing among women within an impoverished inner-city setting and demonstrated the intricate relations between poverty, race, and gender as factors influencing the economic opportunities available to women who use crack cocaine. In their work with pregnant and parenting women, Murphy and Rosenbaum (1992, 1999) demonstrated that women were concerned for the welfare of their children and capable of enacting a variety of strategies to mitigate the harmful effects associated with substance use. In her qualitative work, Boyd (2004) demonstrated that women’s lives and actions related to mothering and substance use were significantly influenced by social, economic and criminal justice policies as powerful structural forces that shaped women’s experiences. As a result, significant advances were made in

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<sup>5</sup> Drawing from work of feminist sociologist Dorothy Smith (1987) the term problematic refers to inquiry that examines the social organization of experiences as they occur in the day-to-day lives of women and the discourse and knowledge that pertains to these experiences.

understanding the context of women's lives as they pertained to illegal drug use, poverty, race, motherhood, and violence. These researchers challenged assumptions regarding homogenous "woman's" experiences of initiation to drug use, patterns of drug use, resources and support needs, pregnancy and mothering, and women as both victims and perpetrators of violence (Boyd, 1999; DeCorte, 2000; Waldorf et al., 1991). These same researchers have brought to the fore the importance of examining the intersection of gender, race, and class in any study seeking to develop a better understanding of the experiences of women's lives and the social and structural forces shaping these experiences (Boyd, 1999; Mahan, 1996; Maher, 1997; Sterk, 1999). Some researchers (Boyd, 1999; Maher, 1997; Murphy & Rosenbaum, 1999; Taylor, 1993) expanded work in the area of women and illegal drug use to include a critical exploration of women's agency. Through their findings, they demonstrated that theoretical descriptions of women who used illegal drugs as "deviant" and "hypersexual" and "out of control" are inherently problematic. Instead, these researchers were able to demonstrate that many women who use crack cocaine and other illegal drugs are rational, active people making decisions based on the structural and personal factors influencing their lives (Taylor, 1993). In the remaining review of the extant literature, I draw upon more examples of this work as they pertain to the topics under review.

### **The Magnitude of Health Concerns**

Canadian research concerned with the health experiences of men and women who use crack cocaine has grown over the past 20 years.<sup>6</sup> Studies concerned with the typology and prevalence of health concerns predominated much of this work. In the early 1990s researchers explored health issues among people who reflected a socio-recreational pattern of use

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<sup>6</sup> Due to the breadth of research in Canada and the US and the overwhelming emphasis within US-based literature on the sexual practices of women who use crack cocaine and the resultant narrow scope with which women's health concerns are identified, I emphasize the Canadian literature as the focus of this discussion concerned with prevalence of health concerns. Comparisons with US and European-based research are made when deemed appropriate to the topic of discussion. More of the US-based literature is incorporated in the review of literature relevant to contextual factors influencing health.

characterized as infrequent use and use as a component of social activities (Erickson et al., 1994). More recently the focus has shifted to inner-city settings where high rates of unemployment, unstable housing, arrest for criminal activities, and more frequent use patterns predominate (Butters & Erickson, 2003; Fischer et al., 2006; Goodman, 2005; Leonard et al., 2006; Malchy, Bungay, & Johnson, 2007; Shannon, Ishida, Morgan, Bear, Oleson, Kerr, & Tyndall, 2006). Regardless of the setting or the social demographics all of the studies' findings reflected that people who used crack experienced a variety of health concerns. Poly-substance use defined as the use of substances in addition to crack was the most common pattern of use.

Erickson and her colleagues (1994) conducted one of the first Canadian studies that incorporated people's experiences with crack cocaine. As part of a larger study concerned with health concerns among people who used powder cocaine, they included items in their questionnaire that specifically targeted people's experiences with crack cocaine including crack use patterns, perceived risks, and negative and positive experiences associated with crack use. Of the 111 people who participated in the cross sectional survey, 78 reported having used crack at least once in the previous three years (59 men; primarily of Euro-White descent; all employed full time for at least six of previous 12 months). The researchers reported their findings about health concerns experienced during cocaine use within the context of the larger study and did not differentiate these findings according to the presence or absence of crack use. The most frequent concerns included increased heart rate, dry mouth and throat, nervousness, acute insomnia, paranoia, and hallucinations, most of which intensified with an increased frequency of use. Long-term negative reactions that participants associated with cocaine use included the inability to relax, chronic insomnia, physical and mental exhaustion, and weight loss. Those who reported crack use were also asked in an open-ended question to identify what they least liked about crack use. "Adverse physical effects" was the most common response (43.6%). "Adverse physical effects" was a generic category applied by the researchers to describe experiences of nausea,

sweating, painful breathing, and tachycardia (increased heart rate). These same participants responded “unlikely” when asked if they would seek health care attention for these concerns. The findings reported within this Canadian project were consistent with those of a US-based study concerned with general cocaine use among participants of similar demographics (e.g., primarily Euro-White men, who were employed full time). Insomnia, hallucinations, paranoia, frequent colds, sore throats, and nervousness were identified as the most common health concerns among participants who had also reported using crack (Waldorf et al., 1991).

More recent Canadian research has shifted the emphasis from powder cocaine use with people who are regularly employed to engage in study with people who are street-involved, experience poverty and unstable housing, and use crack cocaine. As with the earlier research, mental health concerns were frequently reported among the participants. For example, in a Toronto-based study with men and women who reported current crack use (n=108; 49% women, 44% men, 7% transgender; 50% Euro-White, 18% Aboriginal, 32% Other; 10% involved in paid work) “mental health issues” was rated at the most frequent health concern reported by the participants (41%) (Goodman, 2005). Unfortunately, what this term encompassed was not explained. Researchers from another Canadian study with people who were street-involved, unemployed, and used opioids noted that 54.6% of all participants (n=679) also reported crack use in the past 30 days (Fischer et al., 2005, 2006). Although fewer crack use participants scored significantly on the Composite International Diagnostic Interview (CIDI)-Short Form (Depression) Scale (43.7% versus 51.2%), it was apparent that depression was a common mental health concern for both groups (Fischer et al., 2006). Within a US-based study with 430 not-in-treatment people who used crack and shared similar demographics with this Canadian study, significant incidence of depression was reported with 55% of respondents scoring at a moderate-to-severe level (Falck, Wang, Siegal, & Carlson, 2003).

Unlike the research of the 1990s that emphasized the physiologic effects of cocaine (e.g., tachycardia), current research has highlighted a myriad of other physical health concerns among men and women who use crack. The differences in these findings may be due in part to the recent emphasis on health concerns that pertain to blood-borne infections (e.g., hepatitis C virus [HCV] and human immunodeficiency virus [HIV]), concerns attributed to the smoking practices associated with crack use (e.g., cuts and burns), and specific health concerns related to poverty and unstable housing (e.g., foot problems and malnutrition). For example, Goodman (2005) identified health concerns that were specific to infections, mental health, malnutrition, and diabetes in her survey with men and women who use crack; HCV, foot problems, diet/malnutrition, and chronic lung infections were the four dominant physical health concerns reported. In another Ontario-based study that targeted people who injected as a route of use and who identified crack cocaine as one of the substances used, researchers investigated prevalence of HIV, HCV, and smoking-related burns and/or cuts to the lips and mouth (n=112; 77% male, 9% Aboriginal identity, and 91% Other; 65% unstable housing in past six months) (Leonard et al., 2006). HCV (62.5%), HIV (12%) and cuts or burns (51.8%) were significant health issues experienced. Researchers have reported similar findings in their research with people who use crack in the DTES. In one cross-sectional survey pilot project, 74% of participants who reported current crack use experienced burns associated with smoking (n=97; men 51%; Euro-White 46%, Aboriginal 32%) (Malchy et al., 2007). Shannon and her colleagues (2006) reported high incidence of HIV (27%), HCV (69%), and burns (40%) among study participants in their project aimed at assessing potential public health impacts of medically supervised smoking facilities for people who smoke crack (n=437; 67% male; 45% Aboriginal; 43% homeless). Thirty-five percent of the participants did not inject as a route of use. Within the five-city Canadian study mentioned previously that focused primarily on people who were street-involved, unemployed, and used opioids, people who used crack were more likely than those who did not to report

physical health problems (78.2% versus 64.7%). HCV and pain were the most commonly reported concerns for both groups (Fischer et al., 2005, 2006). Testing of salivary antibodies illustrated that a greater number of those who used crack were HIV (17.7% versus 13%) and HCV (56.4% versus 46.6%) positive.

I could find only one Canadian study that specifically examined the health concerns of women living in poverty who regularly used crack cocaine (n=30; 17 Euro-White; 7 First Nations; 6 Black; 1 East Indian) (Butters & Erickson, 2003). In this qualitative study, researchers reported findings similar to those in other Canadian research. HCV, respiratory illness such as asthma and pneumonia, and mental health issues such as anxiety, depression and suicidal ideation were the common health concerns experienced by women. Women's reproductive and sexual health concerns were also significant. Sixteen women reported their health status as poor to fair, 15 had experienced an STI at least once in their lifetime and 14 of the women reported lifetime experience of miscarriage during at least one pregnancy.

While each of these studies have provided important information concerning the general health problems experienced by people who use crack cocaine, there are specific challenges in generalizing this research to women who are street-involved within the DTES. In several of the research projects for example, inclusion criteria was specifically targeted towards people who injected (Leonard et al., 2006) and/or used opioids (Fischer et al., 2005, 2006). Other studies predominantly targeted people who used cocaine powder (Erickson et al., 1994; Waldorf et al., 1991). People who used crack were often a sub-study of interest and not the primary target group. Although poly-substance use has been well documented among people who use crack cocaine (Goodman, 2005), it is reasonable to assume that some people who use crack may not use opioids or cocaine powder or inject as a route of use and therefore their concerns may be underrepresented within the findings of the current research concerned with the health experiences of those who use crack cocaine.

Men were frequently overrepresented in several of the Canadian projects (e.g., Erikson et al., 1994; Fischer et al., 2005; Leonard et al., 2006; Malchy et al., 2007). In some instances researchers reported that there were no statistically significant sex differences but the testing for differences was not consistently reported. Several studies overlooked the addition of women-specific health concerns in the construction of their instruments. Health concerns were not consistently defined or measured within the projects and only one project used a standardized instrument to assess depression among study participants (Fischer et al., 2005, 2006). The context of people's experiences of health concerns was often not fully explored. For example, only Goodman (2005) identified health concerns that have been associated with poverty and unstable housing as items to be measured (e.g., malnutrition and foot problems). While seeking to lessen the knowledge gaps concerning health concerns associated with crack use, it is apparent that current research has not yet fully explored these issues within the larger social, economic, political, and historical context of women's health and the full scope of health concerns experienced among women who are street-involved and use crack cocaine remains unknown.

### **The Contextual Factors Influencing Experiences of Health**

In more recent years, Canadian researchers have begun to examine a variety of social and economic factors as well as crack use practices that may contribute to the magnitude of health concerns experienced by women (and men) who use crack cocaine. This area of research is of particular importance in light of the growing empirical research that indicates that people who use crack cocaine and experience economic and social marginalization are more likely to experience poorer health and require more frequent medical attention when compared to people of similar life circumstances who use other forms of cocaine and/or other illegal substances (Ferri & Gossop, 1999; Fischer et al., 2006; Ottaway & Erickson, 1997). Within the literature previously discussed that targeted people within impoverished neighbourhoods, the vast majority of all participants who reported crack use were unemployed, relied on social income assistance,



and had experienced unstable housing over the past year (Butters & Erickson, 2003; Fischer et al., 2006; Goodman, 2005; Leonard et al., 2006). For example, 12 women in the Toronto-based study reported living in shelters at the time of the interview and none were regularly and/or legally employed (Butters & Erickson). Within the Canadian five-city project, people who used crack were significantly less likely to have stable housing or to have had paid work in the previous 30 days than those who used other illegal substances (Fischer et al.). Similar findings have been reported within a Brazil-based project with women (10%) and men (90%) that compared demographic characteristics based on route of cocaine administration – snorting powder (n=113) or smoking crack (n=95). Significantly more of the crack using respondents were unemployed and had lived on the street at some point throughout their lives (Ferri & Gossop, 1999). Although significant evidence exists demonstrating the increased likelihood of reduced opportunities for health among women and men who live in poverty and unstable housing (e.g., see Frankish, Hwang, & Quantz, 2005 for a review of the Canadian literature), the rationale for why women and men who use crack experience such high rates of unemployment and unstable housing and how these experiences may contribute to the health concerns within this population remains for the most part an under investigated area of research.

### **Smoking Practices**

The practices associated with smoking crack cocaine versus injection have also come under recent scrutiny as a contextual factor associated with health concerns. As noted previously smoking cocaine usually involves the use of a makeshift pipe made of glass or metal. There is growing evidence that the majority of these pipes contain splits or cracks which may contribute to cuts, particularly of the fingers and lips (Goodman, 2005; Leonard et al., 2006; Malchy et al., 2007). In recent project in Vancouver's DTES for example, 81% of respondents reported using pipes with splits or cracks (Malchy et al.). In addition, the heat required for crack vaporization and the inhalation of steel wool particles that break apart from the filter used to hold the crack in

place have also been associated with lip and mouth burns (Goodman, 2005; Moettus & Tandberg, 1997; Shannon et al., 2006). Determining the underlying cause of oral lesions however is complex. In a US-based study with youth who were street-involved (47.6% female; 77.9% Black), significantly more oral sores were present among those who smoked crack than those who did not although recently having syphilis and being HIV positive were also strongly correlated with the presence of oral lesions (Faruque et al., 1996).

Given the high incidence of HCV among people who use crack cocaine, many researchers have hypothesized that in the presence of oral lesions due to burns, the sharing of smoking equipment may be a route for possible infection (Tortu, McMahon, Pouget, & Hamid, 2004), particularly given the high incidence of pipe sharing documented within the literature (Leonard et al., 2006; Malchy et al., 2007). In light of the empirical evidence concerning increased likelihood of other activities associated with HCV infection (e.g., injection use, unprotected sex activities) that are prevalent among people who experience economic and social marginalization who use crack, other researchers have cautiously noted that it would be difficult to effectively demonstrate that pipe sharing would be the sole source of HCV transmission (Fischer et al., 2008). In a recent investigation that involved sampling of pipes for HVC-antibody, 2.0% of the pipes tested (i.e., one pipe out of 51) positive and in this instance, the pipe had been used by someone known to have HCV (Fischer et al.). The researchers caution that given the small sample size the results should be interpreted cautiously and further investigation is warranted.

## **Sex Practices**

The sexual practices of women who use crack cocaine, including numbers of sexual partners, condom use, and engagement in commercial sex work have also become topics of interest among researchers concerned with factors that influence women's opportunities for health. The interest in these topics has been due in part to the abundance of extant research that

indicates increased risk for STI, HCV and/or HIV infection among women who experience greater numbers of sex partners, are less likely to use condoms, and engage in commercial sex work (see Remple, 2007 for a review of this literature). Within the context of women's health, crack use has been correlated with increased numbers of sexual partners and less frequent condom use when compared to women who use opioids (Cohen, Navaline, & Metzger, 1994). In comparisons between men and women who use crack however, greater condom use by women has been reported (McCoy & Wasserman, 2001; Tortu et al., 1998). High rates of STI, particularly syphilis have also been documented although the correlation with crack use appears to be less well understood (Butters & Erickson, 2003; DeHovitz et al., 1994; Goodman, 2005; Logan & Leukefeld, 2000; Ward, Pallearos, Green, & Day, 2005).

Within Canada, researchers have reported that crack use is significantly associated with engagement in commercial sex work (Butters & Erickson, 2003; Fischer et al., 2006; Shannon et al., 2006; Spittal et al., 2003). In a two-city Canadian study with women who were street involved and used injection as a route of administration (n=591), crack cocaine smoking was independently associated with commercial sex work (adjusted OR = 3.3) although no significant differences among HIV rates were found in relation to the presence or absence of sex work (Spittal et al.).

Spittal and colleagues (2003) caution against drawing generalized conclusions concerning a causal relationship between sex work and crack use as the majority of participants involved in commercial sex work reportedly did so out of economic necessity due to limited options for income generation. These findings were consistent with two US-based qualitative projects with women who used crack cocaine and engaged in commercial sex work that demonstrated the presence of complex interrelationships between crack use, class, and gender (Kearney et al., 1994; Maher, 1997). The women in these projects, the majority of whom were African-American and living in economic deprivation, experienced less financial autonomy and

fewer options to generate legitimate paid income than men within the same neighbourhoods (Kearney et al.; Maher).

By contrast, many US-based research projects have examined commercial sex work as a health-influencing factor from the perspective of sex-for-crack exchanges and these studies appeared to be informed in part by ideologies and stereotypes concerning women's sexual behaviours in relation to crack use (e.g., Inciardi et al., 1993). Crack use was consistently portrayed as a negative behaviour and in most instances all crack use was equated with addiction despite the lack of evidence included in the reports to support such claims. Factors that may intersect with women's engagement in sex-for-crack exchanges were often overlooked. These assumptions underlying women's health research are inherently problematic as they portray an individualized, behavioural approach to complex issues such as condom negotiation, commercial sex work, economic deprivation, and crack cocaine use. Although the association between crack use and "riskier" sexual practices has been documented, the complex interrelationships between these factors and other economic and social circumstances (e.g., housing) as they pertain to women's experiences of health are not well understood. More sensitive and nuanced investigation is required.

## **Violence**

Much of the empirical literature has noted that women who are street-involved and use crack cocaine are often victimized by violence (Butters & Erickson, 2003; Erickson, Butters, McGillicuddy, & Hallgren, 2000; Falck, Wang, Carlson, & Siegal, 2001; Goodman, 2005; Liebschutz, Mulvey, & Samet, 1997; Mahan, 1996; Maher, 1997; Sterk, 1999). For example, in Goodman's (2005) Toronto based study, 64% (n=69) of participants cited violence as a significant concern and 44% reported sexual assault with women suffering significantly more sexual assaults than men (mean = 0.58 versus 0.19;  $p = 0.000$ ). Despite the high frequency however, few research projects have specifically explored the interrelationships between

violence, crack use, and women's experiences of health. This is somewhat surprising given the abundance of other health-related research indicating the serious mental and physical health implications that have been associated with violence including HIV (Gielen et al., 2000), traumatic injuries (J. Campbell, 2002), and mental health concerns (Morrow, 2002).

One US-based study was carried out in an attempt to address some of these gaps. One hundred seventy one women (57% Black, 43% Euro-White; impoverished urban neighbourhood) were interviewed about their experiences with physical assault and rape "since they had begun using crack cocaine" (Falck et al., 2001, p. 81). Data concerning women's arrest history for commercial sex work was also collected based on the researchers' stated assumption that commercial sex work increased the likelihood for violence, a finding that has been well supported elsewhere (see Lowman, 2000). Physical attacks were reported by 62% of the women since initiating crack use and 32% had been raped. Fifty-seven percent of the women who reported physical attacks stated they sought medical care to deal with injuries associated with the attack although the nature of the injuries was not included in the report. Although these statistics represent a very real concern regarding the violence experienced by women, there were serious flaws in the study design. First, the women were asked if they sought medical care because of the attack; they were not asked how badly they perceived themselves to be injured or if they perceived themselves as needing medical care. Therefore, the severity of the injuries suffered by the women may be under-represented. Also, the women were not asked about injuries associated with being raped or whether or not they required medical care due to injuries suffered from the rape. Although statistical analysis demonstrated increased odds of being raped if a woman had been arrested for sex work, being arrested is not an adequate measure of engaging in sex work nor the complexity of what constitutes sex work. Not all women who engage in sex work get arrested and the findings could under-represent the number of women engaging in commercial sex work within this study sample.

In addition to prevalence research, researchers in the field of violence against women have noted that it is important to examine violence as an influential health-related factor within the broader context of other socio-political and economic factors including race, gender, and poverty (Crenshaw, 1994; Razack, 2002a, 2002b; Smith, Varcoe, & Edwards, 2005). Within Canada for example, it has been well documented that Aboriginal women experience high incidence of violence (Razack, 2002b; Smith et al., 2005). Researchers have also demonstrated that the factors contributing to this violence are related to relations of power within society that have legitimated violence against Aboriginal women as reflected in the longstanding history of residential schooling (Smith et al.). Given the overrepresentation of Aboriginal women within the Canadian empirical literature concerned with crack cocaine use, the interrelationship between commercial sex work and violence, and the reported high incidence of commercial sex work among women who are street-involved and use crack cocaine, much more complex investigation is warranted to examine how race, class, and gender intersect with regards to violence as a factor influencing women's health.

## **Health Care**

It is generally accepted that health service access and utilization are significant factors that influence the health of all Canadians. Although a full review of the literature relevant to health care access and utilization are beyond the scope of this study, it is worthwhile to examine some of the literature particularly in light of the growing body of research that indicates barriers to adequate health care and/or social services may contribute to health inequities among men and women who use crack cocaine (Fischer et al., 2006; Shannon, Bright, Duddy, & Tyndall, 2005).

Researchers have recently begun to explore the dearth of harm reduction programming specific to people who are street-involved and smoke crack cocaine (Fischer et al., 2006). A meta-analysis of 33 US-based HIV intervention studies for people who are street-involved and use illegal drugs, for example, revealed that only 21% reported recruitment of people who

smoked crack while 94% focused on people who injected as a route of use of illegal drugs (Semaan et al., 2003), despite the previously noted increased prevalence of HIV among people who smoke crack cocaine (Fischer et al., 2005, 2005; Shannon et al., 2006). In Canada, harm reduction programming concerned with the health of people who use illegal substances has focused almost exclusively on “safer” injection including needle exchange programs and a safer injecting site, and opiate replacement therapy (e.g., methadone) all of which are connected to other essential health and social service programs. Strategies to enhance harm reduction programming for people who use crack cocaine (e.g., the distribution of less harmful smoking equipment, educational programming) have been met with significant socio-political resistance in many Canadian cities, so much so that such programming was recently cancelled within the city of Ottawa (Leonard et al., 2006). Law enforcement practices have further exacerbated problems with harm reduction programming. In all Canadian cities in which research has occurred, participants have consistently reported that their smoking equipment has been confiscated and/or smashed by police; a practice that one could reasonably assume may result in increased sharing of equipment and infectious disease transmission (Malchy et al., 2007; Shannon et al., 2006). In addition to the loss of supplies, enforcement strategies of increased arrest have contributed to less safe practices such as smoking in known areas of increased risk of violence in order to hide from police and smoking crack more quickly, a factor known to increase aspiration of the hot steel wool filter (Shannon et al.).

Experiences of discriminatory or disrespectful interactions with health service providers have also been identified as a potential barrier to health care (Butters & Erickson, 2003; Ensign & Panke, 2002; Goodman, 2005). Although Canadian-based research has not been explicit with regards to how discrimination was defined or measured, one study in particular noted that 50% of all survey respondents (all of whom use crack) reported discrimination due to poverty, substance use, and/or sex work as a barrier to receiving health care (Goodman). Within the

qualitative focus groups of the same study, participants described that they were denied service or made to wait specifically because they were people who used illegal substances and that the attitudes of health care professionals were often derogatory (Goodman). The experiences reported by these participants are consistent with those reported in a US-based study with adolescent and young women who were also street-involved and in some cases involved in illegal substance use (Ensign & Panke, 2002). Lack of respect and judgmental attitudes by service providers were reported among the women as significant barriers to health services, so much so that the women in Ensign and Panke's project reported that they avoided health care agencies and often attempted to manage a health concern without any health care intervention. In another US-based study situated within several inner-city areas in Miami involving 624 participants, women reported using health care services (defined as medical clinics, emergency rooms, family planning and STI clinics) more often than men overall but women who used crack cocaine were less likely to use services than those who did not (Metsch et al., 1999). The findings of this work must be interpreted cautiously however as the sampling strategies used in this work were problematic. First, the sample was predominantly of African-American ethnicity and the researchers did not report how this categorization was measured and whether any sampling strategies were used to represent greater variance in ethnicity within the study population. The researchers also chose to study HIV seropositive status and history of STI as factors influencing use of health care services. This choice of health concerns overlooks other research that has identified many other relevant health concerns experienced by women who use crack cocaine, specifically those associated with violence (Falck et al., 2001) and other general health concerns such as respiratory illness and burns or lacerations (Falck et al., 2003; Leonard et al., 2006; Malchy et al., 2007).



## **Women's Health Management Strategies**

The literature pertaining to the health management strategies of women who use crack cocaine is limited and much of this work has focused on pregnant or early parenting women (Kearney et al., 1994; Murphy & Rosenbaum, 1999). In the early 1990s a large-scale US-based mixed methods study was conducted with hundreds of predominantly African-American women who use crack cocaine, were not in drug treatment, and were either currently pregnant or had used crack at least weekly during their pregnancy. Several sub-studies have arisen from this work and researchers have reported findings associated with women's health management strategies (Kearney et al.; Murphy & Rosenbaum). These strategies included harm reduction practices such as using less crack, eating well, taking vitamins, avoiding stressful situations by distancing themselves from social situations known to be stressful, finding secure housing, and getting more sleep. Kearney and colleagues reported that many of these practices were also associated with reducing the amount of stigma (defined as social derision and rejection) women experienced and frequently included women choosing to have less contact with health services and a desire to manage their own and the fetus' health. While the findings reported by the researchers shed light on important strategies employed by women, in both instances the focus of the research was identifying women's practices with regards to the health of their fetus. How this information is related to women outside of the context of pregnancy or in the context of general health concerns remains largely under-investigated. This is increasingly important given the findings in other studies non-specific to crack cocaine use that demonstrated that women make conscious decisions regarding the substances they use (e.g., stimulant versus depressant) depending on the desired effect and a careful weighing of risks and problems associated with a specific substance (Boyd, 1999). Bungay and colleagues (2006) in their work with street-involved youth who use crystal methamphetamine demonstrated that the youth were knowledgeable about their drug use and recognized when they required time to take care of

themselves including taking a break from the drugs, sleeping, eating well, and avoiding people with whom they did drugs.

Other foci within the empirical literature have included women's efforts to reduce crack use or maintain abstinence (German & Sterk, 2002; Pursley-Crotteau & Stern, 1996; Roberts, 2001), social networks and relationships as a source of support in women's lives (Brown & Trujillo, 2003; Pottieger & Tressell, 2000), and condom use practices to prevent STIs and HIV (McCoy & Wasserman, 2001). Much of this work has occurred in the US and the participants in these studies have been predominantly African-American women living in inner-cities rife with high unemployment rates, poverty, single-parent households, unstable housing, and violence. The researchers of studies in the areas of support and crack use reduction or abstinence reported the importance of stable housing, family or friend support, and distance from people with whom they usually shared crack as strategies that reduced their crack use (Brown & Trujillo; German & Sterk; Pottieger & Tressell). None of the findings, however, were discussed in the context of managing one's health, addressing health problems, or women's health in general. While it seems reasonable to assume that factors such as housing, support, and reduced drug use would be significant for women's health, the nature of the interrelationships between these factors and what they mean for women's health experiences and health management strategies requires further investigation.

## **Summary**

Although there is a significant amount of empirical literature within a variety of disciplines that demonstrates a myriad of health concerns among women who are street-involved and use crack cocaine, less is known about the full breadth of concerns experienced, how these concerns play out within the realm of women's day-to-day lives, or how women manage these particular concerns. Research indicates a high prevalence of crack use in Canada among women who are street-involved and living in poverty, but few projects have examined use within the

context of women's health with an eye to a comprehensive exploration of how class, race, and gender intersect to influence women's experiences for health and the options available with regards to self-regulated health management. Given these gaps within the health-related literature, it was timely to undertake a project focused on the health concerns that women experienced and the strategies that women employ to mitigate inequities in health within the context of the socio-political and economic relations of power at play in their day-to-day lives.

## **CHAPTER THREE: RESEARCH DESIGN AND IMPLEMENTATION**

### **Introduction**

In order to address the research questions and overarching objectives I required a research design that could create an account of women's experiences of health concerns and health management strategies situated within the relations of power and systems of oppression that influence women's lives. To help orient me in designing a study concerned with relations of power and social justice, I drew from select theoretical perspectives located within the tradition of critical theory, specifically intersectionality, social geography, and feminist theory (e.g., Collins, 1998, 2000; Harding, 2004; Massey, 2005). I selected critical ethnography as the research approach as it best supported the use of methods that would lead to a rich description of women's experiences including the integration of information concerning relations of power as key factors influencing their experiences of health (Quantz, 1992). A critical ethnographic design enabled recognition of women as essential sources of knowledge, critical examination of my role as researcher within the research process, and when combined with the theoretical perspectives, supported me to implement an analytical approach congruent with making visible the interrelations between women's experiences of health, health management strategies, systems of oppression, and relations of power.

Before presenting a full discussion of the relevant theoretical perspectives, their integration into the research design and implementation, and the actual research process, several points of clarification are warranted. First, I recognize that there are many varying perspectives congruous with critical theoretical traditions including feminism, critical social theories, post-colonialism, and post-structuralism (among others) (Browne, 2003). My use of 'critical' refers to the shared position within all critical perspectives that relations of power influence the processes by which "...groups of people are differently placed in specific political, social, and historic

contexts characterized by injustice” (Collins, 2000, p. 298). I also adhere to the commitment to justice that is a part of critical traditions and as such have engaged in this work to make visible, and thereby create the potential to alter, the oppressive circumstances of people’s lives (Weber & Parra-Medina, 2003). This project follows in the tradition of many nursing scholars who have embraced critical perspectives within diverse substantive areas that have contributed to a greater understanding of the landscape of inequity that permeates women’s health across the globe (e.g., J. Anderson, 2004; Browne, Smye & Varcoe, 2007; Reimer Kirkham & Browne, 2006; Varcoe, Hankivsky & Morrow, 2007). Much of this work has also contributed to the development and implementation of effective strategies to reduce these inequities.

### **Intersectionality**

Intersectionality, as an analytical perspective, is a particular way of understanding social locations (e.g., the “groups” to which people belong) among multiple intersecting systems of oppression and inequity (McCall, 2005). Intersectionality refers to the perspective that “...systems of race, social class, gender, sexuality, ethnicity, nation, and age form mutually constructing features of social organization” (Collins, 2000, p. 299). Each of these systems of oppression are historically situated, socially constructed, and mutually interrelated in that they have the capacity to co-construct one another in a manner that further contributes to inequalities and inequities. Systems of oppression are not merely conceptual entities but represent social processes embedded within relations of power that translate directly into actual experiences (Crenshaw, 1991). These experiences are constructed in part in a manner that contributes to domination and subordination, and advantage and disadvantage among members of diverse social groups within society.

I used intersectionality as a heuristic device to provide me with direction concerning the identification of systems of oppression (e.g., race, gender, age, class, and sexuality) to be considered within the realm of women’s experiences of health. I applied it as a framework to

critically examine how inequities in health are created, sustained, and transformed by power relations operating within society. Although a singular unified theory of intersectionality does not exist, there were several key attributes of this scholarship that I used to inform this study. These attributes reflect the work of feminist sociologist Patricia Hill Collins (1993, 1995, 1998, 2000) particularly as it relates to Black feminist epistemology. I also drew from other scholars dedicated to developing a greater understanding of the social relations that contribute to women's experiences of health particularly among women who face multiple and intersecting barriers to better health (e.g., J. Anderson, 2002, 2004; Boyd, 2004; Browne, Smye & Varcoe, 2005, 2007; Crenshaw, 1991; Weber & Parra-Medina, 2003). The key tenets of intersectionality applied in this project are that:

- a) systems of oppression exist and are simultaneously socially constructed within specific social and historical contexts;
- b) power relations that contribute to domination and subordination among and within groups are situated within both macro (e.g., institutional) and micro (e.g., interpersonal) relations that sustain social hierarchies;
- c) social justice and social transformation are the underlying goals of intersectionality;
- d) the perspectives and experiences of those who suffer from inequities are a fundamental component of the transformative knowledge necessary for social justice;
- e) each individual will not necessarily have the same experiences or agree upon the significance of varying experiences;
- f) multiple systems of oppression are not inevitably equivalent or additive;
- g) systems of oppression translate into palpable experiences; and
- h) dichotomous binaries of oppressor/oppressed are problematic and therefore oppression needs to be explored within specific contexts.

## **Systems of Oppression and Inequity**

Systems of oppression and inequity refer to the unjust situations “where, systematically and over a long period of time, one group denies another group access to the resources of society” (Collins, 2000, p. 299). These systems, while mutually constructive, are neither additive nor equivalent (Collins, 1993, 2000). Conceptualizing oppressions as additive versus co-constructive and intersectional is problematic in that an additive approach contributes to a perspective of binaries in which systems of oppression such race, gender, and class are considered in terms of opposites (e.g., male/female; Black/White; rich/poor). When applied to theories of oppression, the creation of binaries results in everyone being classified as either oppressed or not oppressed and discounts the structural and interpersonal nuances of how oppression and human agency operate in the everyday (J. Anderson, 2004; Collins, 1993). Thus, an intersectional perspective directs us to examine specific oppressions within specific contexts.

Collins (1993) argued that although many systems of oppression exist, “race, class and gender are all present in any given setting, even if one appears more visible and salient than the others” (p. 29). In doing so, she draws particular attention to the significance of race, class, and gender as dimensions of analysis for an intersectional approach to understanding women’s experiences of health concerns and the contextual factors influencing their health. Race, class, and gender, however, do not necessarily play out in an equivalent manner among diverse social groups. It is not that one system is consistently and hierarchically more oppressive than another, but that the salience of a system is often situational and differences exist with regards to how systems of oppression actually play out among different social groups (Collins, 1995; 1998; 2000). As she eloquently points out, “treating race, class, and gender as if their intersection produces equivalent results for all oppressed groups obscures differences in how race, class and gender are organized, as well as the differential effects of intersecting systems of power on diverse groups of people” (Collins, 1998, p. 208).

At the outset of this project, it was infeasible for me to determine a priori which systems of oppression would be most salient for the various individuals and groups of women who participated. Being true to the tenets of intersectionality, my theoretical responsibilities were to approach this project in a manner that allowed for consideration of how each of these systems of oppression operated in the women's daily lives in a manner that co-contributed to their health status, health experiences, and opportunities for health. Based on previous empirical work highlighting the social and economic inequities experienced by women living in the DTES and the complex and dynamic mix of socially constructed racial and ethnic groups (e.g., Aboriginal, Latino, White, African American) within this location, I foresaw that, as noted by Collins (1993, 1998, 2000) gender, class, and race would require particular consideration and other systems of oppression, such as age, sexuality, and disability, would be considered as the project unfolded. For this reason, I briefly outline my understanding of these three concepts in the paragraphs that follow. Each of these descriptions is not intended to be exhaustive, but instead provides background regarding my theoretical positioning in relation to these constructs with regards to how these systems of oppression were considered in studying women's experiences of health.

## **Gender**

For the purposes of this project I conceptualized gender as a dynamic social process concerned with “the many and complex ways in which social differences between the sexes acquire meaning and become structural factors in the organization of social life” (Braidotti, 2003, p. 3). Thus, gender is relational and extends beyond the social properties of an individual person or interpersonal relations to include the broader structural relations of power of which we are part (Harding, 1987; D. Smith, 1999). Gender as a relational process required that I “direct attention to, and take up analytically, how what people are doing and experiencing in a given local site is hooked into sequences of action implicating and coordinating multiple local sites where others are active” (D. Smith, p. 7).



Gender relations are intricately connected to hierarchical power relations within multiple intersecting domains of power (discussed below) that influence norms, role expectations, and attitudes about men and women. These norms, role expectations, and attitudes further influence how men and women identify themselves as “man” and “woman”, act individually and in relation to one another, and how societal institutions such as health care clinics and hospitals respond to their health concerns (Krieger, 2003). The consideration of gender as a system of oppression required that I analyse norms, interpersonal relations, and institutional processes from the perspective of determining the impact that patriarchal ideologies and practices operating across intersecting systems of oppression had for women’s day-to-day lives and their experiences of health.<sup>7</sup>

In Canada, during the year 2000-2001, women represented over 63% (16,214 of 25,908) of all non-death related hospital visits where illegal substance use was the primary diagnosis and an additional 14,502 non-death hospital visits in which illegal substance use was identified as a contributing factor (Dell & Garabedian, 2003). A full appreciation of the factors influencing the inequities within experiences of substance use related illness requires a more nuanced analysis than an examination of biological sex differences would allow (Doyal, 1995, 2000; Weber & Parra-Medina, 2003). Writing specifically about the gendering of drug treatment, Ettore (2004) highlights the significance of gender relations as a factor contributing to women’s experiences of inequities in health:

While both women and men drug users will experience the damaging effects of gender whether as a social process or an institution, women are at a greater disadvantage because ‘masculinist’ (i.e., male privileging) more than gender-sensitive structures and paternalistic epistemologies predominate (p. 330).

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<sup>7</sup> Patriarchy has been defined as a relation of power between men and women in which men dominate women (Smith, 1987). As applied here, this notion of domination has been extended beyond the relationship between men and women to include male-centered ideologies that dichotomize male and female based on ideologies of domination and control that privilege the masculine as the dominant way of being and therefore relegate the feminine and women to the position of subordinate.

## Class

Traditionally, within the health literature, class has been conceptualized according to income status and other related factors such as access to education, housing, and community services and it has long been recognized that people with relatively low incomes tend to experience poorer health than those with higher incomes. It has also been argued that although the relationship between income and health exists, the tendency to describe this relationships in terms of narrowly defined constructs of class has led to an epidemiological focus on behavioural, environmental and psychological characteristics described as *risk factors*, and has contributed to notions of class as a fixed entity or something one possesses (Farmer, 2005; Krieger, Williams & Moss, 1997; Weber & Parra-Medina, 2003). Conceptualizing class within an intersectional perspective required that I understand class as a social relation influenced by hierarchical power relations and socially grouped concentrations of economic power (Collins, 1998; Krieger et al., 1997). Class as a social relation is expressed within unequal distributions of economic power that contribute to the construction of specific social groupings known as the upper, middle and ‘under’ classes (Collins 1998; 2000).<sup>8</sup> These groupings and inherent social processes are interdependent in that the maintenance of the economic power among those with greater concentrations of power is dependent in part on the economic deprivation of those with less (Krieger et al.).

Class, as system of oppression, operates in the day-to-day to produce experiences of segregation and exclusion often at the expense of the underclass. Those with less economic power experience less access to material resources necessary for health including access to income, food, shelter, and health care (Weber & Parra-Medina, 2003). In keeping with class as a

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<sup>8</sup> The notion of ‘underclass’ is a term coined by Black feminist theorist Patricia Hill Collins (1998). Underclass refers to people who are particularly economically disadvantaged such as those who have no source of income or receive public assistance and move between paid labour and no employment.

social relation, the access to these resources afforded to the upper and middle classes is dependent on the exclusion of those within the underclass.

I applied this conceptualization of class as a system of oppression embedded within economic inequities to explore the experiences of health among women in the DTES who use crack cocaine not only from the perspective of the distribution of resources necessary for health (e.g., food, shelter, health care sites) but also in relation to how the construction and maintenance of social groupings based on concentrations of economic power contributed to women's experiences of segregation and exclusion, and their health concerns (Weber & Parra-Medina, 2003). As noted by Krieger and colleagues (1997), "class understood as a social relation correspondingly helps explain the generation, distribution, and persistence of – as well as links between – myriad specific pathways leading to social inequities in income, wealth and health" (p. 346). Analysis of class relations also helped me to explore how class as a system of oppression intersected with other systems of oppression to maintain and protect the interests of those with greater economic power and how those with lesser economic power resisted these circumstances in an attempt to promote their health.

## **Race**

Within health research, race as an analytical construct has frequently been conceptualized as a fixed, biological entity and therefore used as an explanatory or predictive category with regards to understanding health and illness. It has been argued that assumptions of race as a fixed, biological entity are related to the process inherent in racialization whereby "race" is assumed as a natural and neutral means of physiological and behavioural categorization (Ahmad, 1993). Conceptualizing race within an intersectional perspective challenges these assumptions and requires an understanding of race as a social relation that is influenced by power relations that reinforce the construction of hierarchical racial social groupings (e.g., Asian, Aboriginal,

White, Hispanic) embedded within the oppressive practices of both racialization and colonization (J. Anderson, 2002, 2006; Browne, 2003; Collins, 2000; Harding, 2006).

Racialization as a social process “takes its power from everyday actions and attitudes and from institutionalized policies and practices that marginalize individuals and collectives on the basis of presumed biological, physical, or genetic differences” (Browne et al., 2005, p. 21). This ideology and resulting practices contribute to the construction of “Other,” which includes the projection of assumed differences and identities onto members of racialized groups that are founded on stereotypes and biased assumptions (Browne et al., 2005, 2007). The construction of the “Other” supports an uneven distribution of social, economic, and political resources on the basis of racialized groupings in a manner that supports the position of power for dominant social groups (J. Anderson, 2006; Browne, 2003; Collins, 2000).

Colonization, while not limited to the oppressive practices of racialization, has deep-seated historical connections with these practices (Jacobs, 1996). Maori scholar Linda Tuhiwai Smith (1999), for example, defines colonization as an imperialist process designed to conquer, exploit, and appropriate indigenous peoples and their lands for the purpose of not only economic gain but to establish the dominance of a Eurocentric political, cultural, and scientific way of being. Within Canada the social group identified as “Euro-White” has been historically linked to the colonization and resultant segregation, exclusion, and creation of the Other that has contributed to severe social, economic, and political inequities particularly among Aboriginal peoples (Razack, 2002a). Although gains have been made to reduce the impacts of colonization, many scholars have demonstrated that colonial practices continue but are often insidious and difficult to identify (J. Anderson, 2004; Browne, 2003; Browne et al., 2005). These insidious power relations, subsumed within what has been termed a neo-colonial ideology, are embedded within the relations of power to perpetuate the subjugation and domination of many racialized groups and support white middle-class privilege.

Understanding the interrelations between racialization and colonization bring to the fore the importance of understanding how history has influenced the experiences of the women who participated in this project as well as how current neo-colonialist and racialized ideologies and practices operate to contribute to social and economic inequities and inequalities that exist within the DTES. Conceptualizing race as a social relation enmeshed within the processes of racialization and colonization helped me to consider race as an intersecting system of oppression and to explore the processes by which race played out in the day-to-day lives of women in the DTES who use crack cocaine and how such processes influenced their experiences of health (J. Anderson, 2004).

### **The Domains of Power**

Intersectionality is founded on the premise that relations of power that support the processes involved in domination are significant factors in all social organization (Collins, 1993, 1995; Crenshaw, 1991, 1994; McCall, 2005). Relations of power operate across intersecting systems of oppression to exert “pressure” so that dominant group ideologies replace and/or restructure the ideologies of those groups considered less dominant. This pressure is exerted in such a way that justifies the practices of the dominant group to maintain a position of control (Collins, 2000). The specific social relations that reinforce this “pressure” are situated within a complex web of interrelated structural and interpersonal relations that operate across intersecting systems of oppression. Collins (2000) describes the interrelations between relations of power and intersecting systems of oppression as a *matrix of domination*. Within this matrix, she identifies four specific yet interrelated domains of power: structural, disciplinary, hegemonic, and interpersonal. These domains of power encompass both macro and micro relations and are historically and socially specific.

The *structural domain of power* encompasses social institutions such as law, politics, religion, the economy, and the health care system as well as how these institutions are organized

to reinforce systems of oppression over time (Collins, 2000). The organization of social institutions serves to exclude members of particular social groups who are constructed as Other from the full citizenship rights afforded to members of dominant groups (Collins). The structural domain of power operates to organize oppression and to ensure that the greater concentrations of wealth and privilege remain among the dominant. Structural institutions give rise to specific organizations and inform related policies and practices that serve to justify exclusion and segregation, advantage and disadvantage. These policies and practices are housed within the disciplinary domain of power.

The *disciplinary domain of power* includes many aspects of social organization including schools, hospitals, industries, and banks. This domain manages power relations primarily through the creation, maintenance, and operation of bureaucracies. According to Collins (2000), “bureaucracies, regardless of the policies they promote, remain dedicated to disciplining and controlling their work forces and clientele” (p. 281). Within bureaucracies, systems of oppression are hidden under the rubrics of efficiency, rationality, and equal treatment. Wilson (1992) provided an excellent example of the disciplinary domain and related domination inherent in the inner-city antenatal clinics that she studied. Although these clinics were established to prevent birth-related complications, most clinics did not have the appropriate resources to address these concerns and instead functioned to socially monitor women regarding their use of substances, parenting abilities, and their spending of money received on income assistance.

The *hegemonic domain of power* pertains to the construction of ideologies and the manipulation of ideas, images and symbols to justify the status quo in favour of the dominant groups. Ideologies symbolize bodies of ideas, assumptions, and beliefs that are historically situated, represent the interests of a particular social group, and are often used to depoliticize the inequities experienced by members of groups who are categorized as Other (Collins, 1998, 2000). Collins (2000) stated that, “by manipulating ideology and culture, the hegemonic domain

acts as a link between social institutions (structural domain), their organizational practices (disciplinary domain), and the level of everyday social interaction (interpersonal domain)” (p. 284). In earlier discussions concerning ideologies of deviance and substance use I noted that women involved in crack cocaine use are frequently labelled within the empirical literature and media as “addict”, “hypersexed, morally corrupt, disease carrying women” (Maher, 1997, p. 9) who lack any sense of agency or ability to act on their own behalf despite the growing body of empirical work that discounts this thinking. Hegemonic ideologies as they pertain to women who use illegal drugs, especially Aboriginal women and women who are poor have also been used to justify social practices of incarceration, increased surveillance by welfare services, and the domination over women’s bodies particularly during pregnancy (Boyd, 2004; Campbell, 2000).

The *interpersonal domain of power* comprises the regular, and routinized day-to-day social interactions and personal relationships that people encounter throughout their lives which may include relations with friends, colleagues, partners, strangers, and health service providers to name but a few. The interpersonal domain of power is concerned with how people treat one another and the impact of these interactions for the perpetuation of, or resistance to, oppressive social relations (Collins, 2000). Situating interpersonal relations within a matrix of domination directed me to recognize that as active agents, each individual can be engaged in interpersonal relations that may promote their own subordination, resist and challenge unequal distribution of resources or contribute to the subordination of others. Individuals are neither fully oppressed or an oppressor and the majority of people experience degrees of both (J. Anderson, 2004; Collins, 1998; Meyers, 2000).

Understanding the relational processes inherent within the domains of power that structure social organization supported me to explore in greater analytic detail the processes whereby structures, disciplines, ideologies, and interpersonal relations influenced women’s experiences of health across multiple and intersecting systems of oppression at both macro and

micro levels of society. In addition, application of an intersectional perspective required that I explore women's relationships with others to make visible not only the ways in which systems of oppression intersect to subordinate women, but also how women's own activities contribute to both their active resistance to, and the subordination of themselves and others.

## **Groups and Individuals**

Intersectionality emphasizes *group* versus *individual* as the unit of analysis (Collins, 1998; Weber & Parra-Medina, 2003). While each individual is recognized as having her own unique and evolving personal biography, intersectionality assisted me to explore the distinct social locations of groups within the context of power relations and systems of oppression (Collins, 2000). Groups are social entities constructed in part by ideas of difference that assign social categories to bodies such as Aboriginal, Black, White, male, female, poor and rich. The social construction of groups functions to create hierarchical categorizations and the Other. Individual "membership" is not necessarily based on individual choices and nor does a group automatically reflect collective decisions among members concerning what a group may constitute (Collins, 1998). Groups are shaped by relations of power and social practices that need to be understood within ethical (e.g., responsibility), political (e.g., power relations) and historical (over time) contexts (Collins, 1998). Groups are not fixed entities but are relational and as such, are malleable and fluid thereby creating the possibility for change. Many individuals are simultaneously associated with dominant and subordinate groups, the significance of which is influenced by their particular experiences within specific contexts (J. Anderson, 2004; Collins, 1993, 1998; Meyers, 2000).

The women who participated in this project were initially identified in relation to their past and current experiences with crack cocaine. They were assumed to occupy, to some extent, shared social, economic, political, and geographical locations informed in part by power relations and systems of oppression. As such they comprised the "group" that was the focus for



the study (Collins, 2000). As stated earlier, intersectionality as a heuristic device supports critical consideration of multiple and intersecting systems of oppression as they directly influence the different concentrations of economic, political, and social power among groups. All members of a group may not share the same experiences or even agree upon the significance of varying experiences (Collins, 2000). Instead, intersectionality supported critical examination of the shared and diverse challenges that people might experience based on their social location within relations of power (e.g., domination versus subordination) (McCall, 2003). It prompted me to analyse the complexities by which the intersecting systems of oppression situated within the matrix of domination influenced and shaped the women's experiences of health. Intersectionality facilitated an examination of the diversity of women's experiences of health while simultaneously permitting me to make some observations about the unjust power relations that contribute to the poor health experienced by women who use crack cocaine.

The emphasis upon shared and different experiences of the women who participated raised several important issues that I needed to consider concerning the individual women who participated in this project. Although the group, defined broadly as *women in the DTES who had a history with crack cocaine*, was the primary unit of analysis, it was the complexity of each individual woman's experiences and actions and the related influencing power relations that comprised much of the data for this project. The experiences, actions, feelings, hopes, and desires of each individual woman were valued as essential sources of knowledge (Harding, 2004; MacKenzie & Stoljar, 2000). I also recognized all of these experiences were situated within the specific historical, social, and political contexts of each woman's life. As such, I viewed each individual (e.g., the women who participated, myself as a researcher) as a relational being and therefore as a person who exists in relation to others and the social processes (e.g., power relations) of which she is part. This view did not preclude my recognition of each individual's autonomy to make choices and to act in particular ways, but incorporated a cognizance that

choices and actions are embedded within the broader interpersonal and social relations of the world which we inhabit (Boyd, 1999; MacKenzie & Stoljar, 2000; Maher, 1997; Sherwin, 1998).

The attributes of intersectionality concerned with the ‘group’ and the ‘individual’ as relational entities provided me with important analytical strategies including: (a) privileging women’s experiences and actions as data; (b) exploring their preferences, feelings and desires in relation to these experiences and actions in the present and for the future; (c) critical consideration of the interrelationship between intersecting systems of oppression, relations of power, and women’s actions and experiences as they pertained to their health concerns and strategies employed to manage their health; and (d) critical analysis of the shared and diverse challenges experienced by women including how these similarities and differences intersected among systems of oppression.

### **Social Geography: Place**

Until recently, social geography has been largely absent in investigations concerning women’s health (Dyck, Lewis & McLafferty, 2001). There is, however, a growing body of empirical evidence that demonstrates the importance of critically examining the mechanisms by which *where* women live, work, travel, seek health care, and carry out their day-to-day activities affects their health as well as how relations of power play out within specific geographical locales (for examples see Dyck et al.; Pratt, 2004). There is a diverse range of standpoints concerning what constitutes social geography and I chose to align myself with scholars who argue for a relational approach (Massey, 1994, 2005; McDowell, 1999). I drew specifically from the tenets that describe *place* as that which includes physical locations and recognizes place as spatial, temporal, dynamic, and relational and therefore of significance to an analysis of health concerns and related structural inequities organized across systems of oppression (Dyck et al.; Massey, 1994).

Conceptualizing place as physical, spatial, temporal, and relational requires some elaboration. First, because place is spatial and relational, it represents a constellation of processes that include human social relations and the natural (e.g., weather, landscapes, and water). As such, place is open and always in process due largely to the constant contestation and negotiation inherent within relations of power that contribute to the construction of place. As noted by Massey (2005), “place does – as many argue – change us, not through some visceral belonging but through *practising* of place, the negotiation of intersecting trajectories; place as an arena where negotiation is forced upon us” (p. 154).

Place as temporal refers to the existence of multiple and simultaneous trajectories or experiences that individuals and groups experience as they live their lives within a place. Trajectories are processes that occur over time and are therefore historical (Massey, 2005). Trajectories do not infer a singular history but allow for consideration of multiple and sometimes competing histories that occur within a specific locale. Because trajectories are relational, the trajectories experienced among those within the locale are interrelated. Recognition of place as the site and experience of multiple and intersecting trajectories highlights the complexity of social relations from a spatial perspective and is particularly relevant for an analysis designed to tease out relations of power as they influence women’s experiences of health. Thus, identification of specific geographical locations as a focus for study necessitated that I conceptualize place as “an integration of space and time; places are spatio-temporal events” (Massey, 2005, p. 130).

From either a global or local perspective, there are many relational, spatial, and temporal *places* that can be identified by a physical locale including countries, cities, institutions, home, the workplace, and a street corner to name but a few. Each of these places represents what social geographers refer to as a spatial *scale*. Scales are organizational tools to think about different kinds of places (McDowell, 1999). Scales are also representative of social relations within and

between places as the social and physical boundaries of scales are open and porous. As a result, the social relations inherent in one scale influence and are influenced by those in another (Massey, 1994, 2005).

The domains of power operating across intersecting systems of oppression contribute to geographical and social segregation and exclusion. As noted by feminist geographer Linda McDowell (1999), “places are made through power relations which construct the rules which define the boundaries. These boundaries are both social and spatial – they define who belongs to a place and who may be excluded, as well as the location or the site of the experience” (McDowell, p. 4).

I situated this project specifically within the place known as the DTES, which is an inner-city neighbourhood located within the City of Vancouver. Viewing women’s lives within the spatial context of the DTES required attending to the geography of this neighbourhood including how the boundaries of this place were produced, negotiated, and contested within the realm of women’s day-to-day lives. Combining place and intersectionality provided direction to explore how systems of oppression (e.g., race, class, and gender) and relations of power operated across the many scales (e.g., home, the street, the neighbourhood, the city and the province) to contribute to the health concerns experienced by women who use crack cocaine. Given the porous nature of boundaries and the complex interrelations across boundaries, place as an analytical perspective directed me to examine the relevant health and social policies that govern the types of resources available to women within this place, the degree of access these policies support, who is able to offer services to women, and other relevant forces that influence women’s experiences of health (Curtis, 2004; Gatrell, 2002). This does not suggest homogeneity of experiences of health across the spatial scales located within the DTES. Spatial relations are fluid and dynamic and people may have different experiences across different spatial settings or even with similar spatial settings (Conradson, 2003). Understanding these differences, and how

they play out in the context of women's health, was essential to a study whose objectives included understanding the complexity of health concerns experienced by women who use crack cocaine.

### **Critical Ethnography: The Research Approach**

Informed by a variety of critical and feminist perspectives, critical ethnography is a research approach that incorporates a specific orientation for the design, methods, and analysis of a research project that enables the researcher to empirically investigate women's day-to-day practices and experiences within the broader social, economic, political, and historical contexts of their lives (Carspecken, 1996; Madison, 2005; Quantz, 1992). Critical ethnography is predicated upon values that are congruent with compassion for human suffering and take up as the analytical purpose a commitment to social justice to alleviate this suffering (Carspecken; Madison; Quantz). The application of a critical ethnographic approach required that I employ the methods of observation, interviewing, and reflexivity to support the development of a rich description of people's day-to-day lives drawn from the experiences of women who were street-involved and had experience with crack cocaine. This research approach also incorporates a relational approach to knowledge in that knowledge is viewed as an ongoing contestation within asymmetrical relations of power. As a result, the women's experiences were analysed within the context of the historical, political, economic, and social relations of power that influence their lives.

Although there are some variations within the health and social science disciplines concerning what constitutes critical ethnography, I drew significantly from the work of Quantz (1992), Carspecken (1996), and Madison (2005) as key references that informed the types and sequence of research activities that I employed within the project (i.e., methods) and the ethical considerations underpinning these actions (i.e., reflexivity). I also drew from these researchers to identify several relevant theoretical tenets of critical ethnography. In the following discussion I

briefly review these tenets to demonstrate the relationships between critical ethnography as a strategy of inquiry and the theoretical perspectives of intersectionality, social geography, and feminism informing this work. In the upcoming discussions of the methods and the ethical considerations governing my actions, I elaborate more specifically to demonstrate how I used a critical ethnographic approach to carry out this work.

As noted previously, critical ethnography as a strategy of inquiry is predicated upon compassion for human suffering and a commitment to social justice to alleviate this suffering (Carspecken, 1996; Madison, 2005; Quartz, 1992). This requires an understanding of social justice that extends beyond the emphasis on distributive (e.g., access to resources) and individualistic (e.g., focus on the individual) perspectives of justice that are commonly found within nursing literature, to include a commitment to a collective perspective that situates individual experiences within the broader asymmetrical relations of power (Reimer Kirkham & Browne, 2006). A commitment to social justice as defined here is congruent with an intersectional framework in that it requires an exploration of the mechanisms by which gender, class, and race as systems of oppression intersect to give rise to injustices such as poverty and how these injustices are reinforced through relations of power to maintain a status quo of domination and subordination. Projects that incorporate critical ethnography as a strategy of inquiry must also work towards the ultimate aim of social change that alters the relations of power that contribute to the construction and experience of inequities (G. Anderson, 1989).

A second tenet of critical ethnography pertains to the purpose of this strategy of inquiry to support an empirical understanding of the *contexts* within which the women's experiences and practices were situated. Traditionally, ethnographic researchers (for an example see Roper and Shapira, 2000) have identified the broader context of people's lives as the "culture" or "cultural context" of experience. Cultural context was most frequently conceptualized within these traditions as an apolitical, pre-defined context comprising beliefs, practices, and values that were

often associated with particular ethnic groups (J. Anderson & Reimer Kirkham, 1999; Smye & Browne, 2004). Researchers concerned with social justice, colonialism, and racialization (e.g., J. Anderson & Reimer Kirkham; Hall, 1997; Quantz, 1992; Smye & Browne) have challenged the notion of “cultural context” as an apolitical entity and have argued that these depictions of “cultural context” are situated within relations of power that contribute to the creation and maintenance of Other. Within the realm of this project, I used the term cultural context to refer to the historical, social, economic, and political contexts of women’s lives as well as how these contexts influenced what women experienced and their perspectives of these experiences.

The third tenet of critical ethnography is concerned with the integration of reflexivity, positionality, and power into the research approach. This integration required that as a researcher, I critically examine and reflect upon my location (position) within relations of power as an influential factor in the research process (G. Anderson, 1989; MacBeth, 2001; Madison, 2005; Maher, 1997). The premise underlying this tenet includes an understanding that relations of power, personal history, and individual values are an integral component of all social life and therefore influence not only what I take up as a topic of interest but also the approaches and methods by which I engage in research. I engaged reflexively throughout the entire process to explore how my position as a Euro-Canadian, middle-class researcher who had chosen to situate myself within the field of women’s health with women who are street-involved and use crack cocaine influenced my actions and experiences within this project, the processes by which I developed relationships with the women who participated, the methods I employed, the analysis, and the presentation of the findings (Madison). I was challenged to examine how my values and experiences within various social groups and the historical context of my life (e.g., previous experiences as a nurse working with critically ill women who were street-involved and used illegal substances) played out in my role as an active participant throughout this project.

Consideration of positionality within a critical ethnographic project also required reflexive consideration of the knowledge associated with the research and necessitated that I critically question the relationship of the knowledge generated within this research to those who participated (Madison, 2005). I was aware of the long-standing history of research projects that have resulted, albeit at times unintentionally, in the exploitation of women and have contributed to an incorrect and essentialized notion of women who use crack cocaine as morally corrupt and deviant which has further contributed to their regulation by law, politics, and medicine (Boyd, 1999; Maher, 1997; Rosenbaum, 1981; Taylor, 1993). To adhere to the tenets of critical ethnography it was essential that I continue to pose questions concerning the relevance of this research not only to other researchers and health providers working in the field of women's health, but to the women who participated, and to the ultimate aims of social justice and social transformation.

Another tenet of critical ethnography that I addressed was in relation to the nature of the methods that I used to collect data. Field work in the form of observation is the hallmark of critical ethnographic work. However, it has also been noted that a researcher is obligated to employ methods that best facilitate a rich understanding of relations of power as influential factors within the topic of interest (Carspecken, 1996; Madison, 2005). Therefore, I integrated several data collection strategies including observations, a survey, interviews, document collection, and reflexive journaling, each of which is described in greater detail in the upcoming discussion.

### **Selecting the Place**

The application of critical ethnography informed by theoretical perspectives of social geography and intersectionality required that I position this research within a specific socio-spatial place in which women's activities, experiences of health, and their related contexts could be more fully explored (Carspecken, 1996). Given my experiential knowledge and related



research work in the area, I purposefully chose to carry out this project within the inner-city neighbourhood known as Vancouver's Downtown Eastside (DTES). Although the exact physical 'boundaries' of the DTES have been contested, the neighbourhood is most often identified by people who live and work in the area as a ten block radius that is bordered by historic Chinatown and Gastown to the south and west respectively, Railtown to the north, and Heatley Avenue to the east (Buxton, 2005) (see Appendix F). By contrast BC Stats (2005), the central statistical agency for the province of British Columbia, equates the DTES to Local Health Area 162 which extends significantly beyond these borders. Initially I chose to use the BC Stats description of the DTES to define the physical location, but as the project unfolded, it became apparent that the majority of research activities would occur within the ten block radius. The ten block radius was where the majority of the participants lived and engaged in their day-to-day activities, and opportunities for them to leave this area were limited. Construction sites with cranes and work crews dominate the landscape both surrounding and within the area as lofts, condominiums, retail centres, and office buildings are being erected, often at the expense of existing housing structures. Within the real estate industry, the area is positioned within the rubric of 'investment properties' whose value is projected to increase as the gentrification process continues. Local advertising encourages potential buyers to "get in early" and "watch your money grow."

The DTES is home to approximately 16,000 residents and is one of Canada's poorest neighbourhoods. The neighbourhood is characterized by a concentration of low-income single room occupancy (SRO) hotels that originally provided accommodations for seasonal, resource-based workers (Wood & Kerr, 2006). As resource-based economies began to slow over the past several decades, the DTES became the epicentre for illegal drug and sex-based economies. The neighbourhood and its residents have achieved international notoriety for the open drug scene, poverty, survival commercial sex industry, and violence that shape the day-to-day relations among many of those who live, work, and visit the area (Buxton, 2005; Boyd, 2006; City of

Vancouver, 2004). Aboriginal people, people who are homeless, and those with mental health issues are overrepresented (Morrow, Frischmuth, & Johnson, 2006). The overrepresentation of Aboriginal peoples is neither accidental nor coincidental (Robertson & Culhane, 2005). The outcomes of the racialization and colonization of BC's First Nations people that began in the eighteenth century continue to have devastating effects for many of their descendants including separation from families, poverty, violence, health disparities, and stigmatization (Browne, 2003). Furthermore, the recent fiscal cutbacks and decentralization within BC's mental health services have contributed to reduced access to mental health care. This reduction in services coupled with cuts to income assistance has left many people with mental health issues with few or no options for housing outside the boundaries of the DTES (Morrow et al.).

Inequities in health plague the people who live in the DTES and more people within this neighbourhood die of preventable and treatable illnesses than anywhere else in the province (BC Vital Statistics Agency, 2005). The residents of the DTES are among those who have been the hardest hit by recent provincial and federal government changes to social income assistance programming, resulting in reduced access to financial resources and ever-increasing numbers of people living below the LICO (Wallace, Klein, & Reitsma-Street, 2006). Gentrification and lack of housing resources have contributed to a steady decline in safe and affordable housing and emergency shelter services (PIVOT, 2006). The DTES is also home to law courts, churches, heritage buildings, parks, community health clinics, drop-in centres, social assistance offices, Canada's only supervised injection site, and the largest emergency shelter for people with mental health issues and/or addictions within the City of Vancouver.

Law enforcement has a long and contested history in this neighbourhood dating back to the 1950s. Early reports (e.g., Stevenson et al., as cited in Boyd, 2008) described people in the neighbourhood who used illegal drugs as "criminal addicts" (p. 217) which contributed to increased prison sentencing and police violence against those who used. Today large-scale

enforcement activities such as increased surveillance and arrests occur under the guise that these activities function to disrupt the open drug market and reduce some of the problems associated with illegal drug use (Small, Kerr, Charette, Schechter, & Spittal, 2006). However, there is a dearth of empirical evidence to support that these are effective strategies to reduce substance use related social and health problems. Instead research has indicated that these activities are more likely to reduce users' access to harm reduction and health related services, and as a result are more likely to contribute to harm (Cooper, Moore, Gruskin, & Krieger, 2005; Cooper, Wypij, & Krieger, 2005; Kerr, Small, & Wood, 2005; Small et al.; Wood et al., 2004). Research has also indicated that police violence against people who use is still of significant concern within the DTES (Csete & Cohen, 2003). Despite this evidence, law enforcement constitutes the bulk of resources directed towards addressing "problems" associated with illegal substance use (Small et al.).<sup>9</sup>

### **Negotiating Entry: Positionality and Relationships**

Negotiating entry to the "field" or place where the participants are located and live out their day-to-day lives is a common aspect of research and it requires an appropriate, effective, and ethical approach (Madison, 2005). At the time that this project was being designed I was working in the capacity of Project Director for The Safer Crack Use, Outreach, Research and Education Project (SCORE) funded through the Health Canada Drug Strategy Community Initiatives Fund. The main research aim for the SCORE project was to assess the effectiveness and feasibility of several harm reduction initiatives among the residents of the DTES who use crack cocaine. SCORE entailed a variety of research activities including cross sectional surveys, a "women-only" activity of constructing harm reduction kits to be distributed to people who use

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<sup>9</sup> Illegal drug use has been associated with negative consequences that impact individual lives, families, and communities with serious health and social welfare implications. In Canada the bulk of resources dedicated to addressing these negative consequences have been within the realm of criminal justice interventions as 94% of the \$454 million annual budget dedicated to addressing the negative implications associated with illegal use is spent on these criminal justice interventions (Brittain, 2001).

crack cocaine, and distribution of harm reduction kits as an outreach strategy to provide harm reduction education and equipment and to enhance access to health related services (Bungay et al., 2008). While simultaneously drafting the research questions for my dissertation it became apparent that the objectives of the SCORE project and funding for the project could not fully support a more critical examination of the complex interrelations between women's experiences of health and relations of power. I began to work with two members of the SCORE investigative team and another researcher in the field of women's health to draft a research proposal that would support an investigation congruent with my dissertation research objectives. I also worked with members of the Safer Crack Use Coalition (SCUC) of Vancouver, comprising community outreach workers, health service providers and men and women who used crack cocaine. It was largely through their input that the need to more fully explore women's experiences of health and influential factors shaping these experiences was identified. The SCORE project included an advisory group comprising four women who were selected by members of a women's drug user support group who were self-named as the SCORE Women's Advisory Committee (SWAC). The development of an advisory group was supported by the recommendations put forward in the document "*Nothing About Us without Us*", *Greater Meaningful Involvement of People who use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative* that highlighted a social justice imperative that people who use illegal drugs have the right to be involved in activities that affect their lives including research, policy development, and delivery of services (Jurgens, 2005). Members of SWAC worked closely with members of SCORE to design the women-only activities for that project including defining and describing meaningful involvement and research recruitment methods. As I worked closely with this team they also identified the gaps within the SCORE project concerning a more detailed study of women's experiences of health, and as a result I negotiated with them that they would also participate in my dissertation in an advisory capacity. Given the support of SCUC and SWAC and my role within SCORE, I

was already situated within the neighbourhood and had developed a respectful and trustful rapport with women who lived within the DTES. With the aid of members of SWAC, I developed a one page summary of the project purpose and activities and its relationship to the overall SCORE project that was shared with the larger women's support group and various community service providers (see Appendix B). The feedback to the project was overwhelmingly positive, an experience that was in some instances directly related to my identification as a nurse researcher. SCUC and SWAC members expressed that they believed that because of my experiences as a nurse who was involved in SCORE and had worked within the primary inner-city hospital where women were hospitalized, I would be able to understand the nature of the health concerns that women experienced as well as the context of their experiences of health. They also reported that my interest and commitment in learning more about these experiences from the perspectives of the women themselves would contribute to an interest in participation among women who lived and/or visited the DTES.

The members of SWAC provided input into the research design and participated in instrument development, recruitment, and data analysis. As the project unfolded, two of the members of SWAC left the group due to personal life situations. One left the DTES to enrol in treatment and the other was unable to commit to the time requirements due to her responsibilities as caretaker for an ill family member.

## **Participants**

As noted previously, the “group” of interest within this project were *women who were street-involved within the DTES who had a history with crack cocaine use*. Inclusion criteria for participation included: (a) self-identification of a history of crack use (current or past); (b) the ability to speak English; and (c) self-identification as street-involved within the DTES. The criteria were deliberately broad to support sampling and recruitment strategies to facilitate a sample of participants that varied according to age, ethnicity, experience with substance use, and

experiences of health. I employed a variety of data collection techniques that involved many different sampling strategies. For this reason, I have integrated a comprehensive discussion of the sampling strategies within the discussions pertaining to the various research activities involved in this project.

### **Data Collection: Methods and Process**

Data collection occurred over a 17-month period of time. During the initial five months I employed the methods of observation, reflexive journaling, document collection, and designed and implemented a cross sectional survey (in collaboration with SCORE). Once the survey was complete I added methods of participant observation, and formal and informal interviewing, all of which continued over the remaining 12 months. A timeline for the project is located in Appendix A. Each of the methods that I employed has been well substantiated within the empirical literature as rigorous methods for collecting rich, contextualized data (Spradley, 1979; Williams, 1996).

#### **The Cross Sectional Survey**

As noted in the previous chapter, only a few empirical projects have been undertaken that have specifically examined the general health experiences among women who use crack cocaine (Butters & Erickson, 2003). To further develop knowledge in this area and to better situate myself before I engaged with women to explore *how* they experienced these concerns on a day-to-day basis, I began data collection by conducting a brief cross sectional survey to empirically assess women's common health concerns, their self-reported health status, contextual information (e.g., place of residence, stability of housing, safety of housing, age, cultural or ethnic background, economic status), and substance use practices with a particular emphasis on crack cocaine (see Appendix D).

The cross sectional survey, referred to as the Pre-Kit Distribution Survey (PKDS), was a 52-item interviewer-administered survey that relied on self report. The survey was developed

within the scope of the SCORE project to gather information related to crack use practices, safer crack use knowledge, access to harm reduction services, health concerns, and harm reduction service needs among men and women using crack cocaine in the DTES. The items of the PKDS reflected measures of crack use practices, poly-substance use, safer crack use knowledge, health status, health concerns, service needs, support, and demographics.

Although the survey was designed within the scope of the SCORE project, several items of relevance to my dissertation project were added or expanded upon based on input from SWAC and SCUC and the state of existing knowledge concerning health concerns, contextual factors, and health management strategies with women who use crack cocaine. Once data collection was completed, a separate SPSS<sup>®</sup> database from that of the SCORE project containing only women's data was provided to me by the principle investigator for my use in analysis. The concepts of interest in my project included: crack use practices (items CU1-CU16), poly-substance use (items SU1-SU4), health status (item HP1), health concerns (item HP2), health management strategies (items HP3 and HP4), contextual factors such as safe places (items S3-S5) and demographic information including place of residence, stability of housing, safety of housing, age, cultural or ethnic background, and economic status (items D1-D8).

Several of these items, particularly those related to demographic information and crack use practices were also of relevance to the SCORE project. Ethical approval for the sharing of data between the two projects was obtained from The University of British Columbia Behavioural Research Ethics Board and participants were informed that the data would serve multiple purposes.

### **Sampling strategies**

Accessing a representative sample from the population of women who use crack cocaine was not feasible as it was impossible to identify the entire population of women who use crack cocaine within the DTES. Many people in the DTES are transient, lack a permanent address, or

are reluctant to identify themselves for the purpose of census taking or to participate in community-based surveys that would identify them as people who use illegal substances (Robertson & Culhane, 2005). As a result, the survey was conducted with a non-probability convenience sample of 126 women who could speak English and self-described as having used crack cocaine in the month prior to completing the survey.<sup>10</sup> Although the sample was defined as convenient, several strategies were employed in an attempt to draw a diverse sample of women that represented a variety of perspectives. Drawing upon my experiences within nursing practice and research and input from members of SCUC, the Vancouver Area Network of Drug Users (VANDU) Women's Group, SWAC, staff from women's resource facilities such as the Women's Information Safe House (WISH) Drop-in Centre, and street nurses, I strategically chose four different locations from which to access women. Initially I planned to work with peers<sup>11</sup> who were members of SWAC to recruit half of the participants "on the street" at locations at which women were known to spend time (e.g., a park, outside particular agencies). The plan was that peers would assess women's willingness to participate and if they agreed they would accompany them to a safe location (e.g., a private room in a drop-in centre) where a research assistant could explain the purpose and process for their participation and conduct the survey. The rationale underpinning street-based recruitment was that it would provide an opportunity to recruit a more diverse sample of women and their related experiences than if I relied solely on service agencies where women accessed health and social services (Shaver, 2005). This strategy has worked in previous research with youth who use crystal methamphetamine (e.g., see Bungay et al., 2006) and with women involved in the commercial sex industry (see Shaver). However, recruitment "on the street" was problematic. Members of

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<sup>10</sup> Convenience sample here refers to the selection of participants based on their availability to participate in the study (Henry, 1998).

<sup>11</sup> Peers in this instance refer to women who have life experience related to street-involvement and substance use and who are part of the social relation networks within the community.



SWAC noted that approaching women on the street was not always appropriate particularly if they were engaged in activities such as sex work and selling drugs. During attempts to recruit “on the street,” peers were threatened on two occasions by residents of the neighbourhood who insisted they be given an opportunity to participate. SWAC members also identified that if women were engaging in work to obtain money on behalf of another person (e.g., partner, dealer), disrupting a woman’s work potential to generate income may be put at risk. Due to these experiences, survey administration occurred in four different agencies. Two agencies were drop-in centres frequented by women, one was a women-only low-barrier housing facility, and the fourth was located at a local drug user group agency. In each agency I worked with a specific staff member to organize the recruitment and implementation of the surveys. Each staff member was given a copy of the project summary, and the survey process was reviewed including inclusion criteria, time commitments required for participation (i.e., 15-20 minutes), and an assurance of confidentiality for the participants. The staff member then recruited women on my behalf by explaining to women the purpose of the project, the activities involved, and the mechanisms used to guarantee confidentiality. Each staff member generated a list of participants with appointment times for them to participate. The staff members were actively involved in SCUC and VANDU and some were employed as research assistants with the SCORE project. Women who agreed to an appointment met with a trained research assistant at the time the survey was scheduled to ensure their eligibility, review the study purpose and survey activities, and to ensure that participants provided informed consent. Each participant received a verbal and written explanation of the study purpose as well as their right to refuse participation throughout the entire research process (Appendix C). Women were not asked to provide signed consent. As demonstrated in other studies with people experiencing severe marginalization and vulnerabilities, verbal consent was an appropriate method of consent as it respected the rights of women who wished to keep their identity private and enhanced confidentiality, safety, and

anonymity among study participants (Bungay et al., 2006; Ensign, 2003). All participants received ten dollars for completing the survey which served to acknowledge their input and expertise with the issues being examined (Shaver, 2005).

## **Observations**

In keeping with an ethnographic approach, direct and participant observations were significant data collection strategies that I employed throughout the course of the entire project. Direct observations included those with minimal or no verbal interaction between myself and potential participants or other people located within the neighbourhood (Roper & Shapira, 2000).<sup>12</sup> These observations began with my first visit to the DTES in the role as Project Director with the SCORE project and were documented in the form of field notes in order to inform a “thick record” or a detailed description of the physical structures such as buildings, vehicles, construction sites, retail and coffee shops, agencies that offered health and social services to name a few; the weather; the people, and the nature of the interactions that I observed (Carspecken, 1996). I paid particular attention to interactions that I observed between women and men, women and law enforcement officials including security guards, women and health service providers, for instance emergency medical technicians or street nurses, and each other. Contextual information such as the type and location of signs posted throughout the neighbourhood, hours of operation of agencies, and the general feelings I experienced as I moved within the neighbourhood were also recorded. The use of direct observations was particularly helpful for me during the first three months of the project as these observations served to provide

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<sup>12</sup> I intentionally chose to use a direct versus passive observational strategy. Carspecken (1996) articulated that passive observation usually discounts any interaction within the research setting and he recommends that during the initial phases of ethnographic work, any interaction between the researcher and potential participants should not occur. I found this an unrealistic expectation as it was almost impossible not to interact on some level as I moved through the various places within the DTES. I was part of the relations occurring within the place by the mere fact that I was present. It was not uncommon for me to interact with people in some manner such as smiling to people who smiled at me, responding to requests for directions or a greeting or saying “excuse me” as I worked my way through a busy entrance way to an agency. Instead of assuming a passive stance, I reflexively engaged with these experiences within my journal to critically examine my role in the research process.

a rich description of the neighbourhood and the general patterns of activities, structures, and related contextual circumstances that I observed. During this period I spent approximately two hours per week engaged in observational activities as I walked through the neighbourhood on my way to meetings, sat in coffee shops, or had lunch with SWAC members. While surveys were being conducted, my time spent in the neighbourhood averaged six to twelve hours per week during which time I also maintained a general observations record.

As the project unfolded, participant observation was employed as the primary observational method and continued for the remainder of the project. Participant observation involved more direct involvement between myself and the research participants as we engaged in shared activities (Roper & Shapira, 2000). These shared activities included travelling to agencies throughout the DTES to attend functions and meetings, and participation in the SCORE activity known as the kit making circle (Bungay et al., 2008).

The kit making circle was a research activity that adopted a feminist approach to bring groups of women together to construct harm reduction kits for people who smoke crack cocaine. These kits contained essential harm reduction equipment such as glass stems (pipes), rubber tubing (mouthpieces), brass screens (filters), chopsticks (push sticks), a lighter, condoms, alcohol swabs, and a harm reduction information card that provided “tips” for people who use to help reduce some of the harms associated with smoking crack. The aim of this activity was to achieve a philosophical goal of a holistic, women-centred approach to harm reduction. On average sessions were held 10-12 times per month and over the course of six months I attended 18 sessions. Each session was scheduled to be an hour long but the time spent engaged with participants often lasted 90 minutes as many women continued to dialogue once the activities were completed. Four women (one of whom was a peer-facilitator from SWAC) who lived and/or visited in the DTES, a non-peer outreach worker who was also a member of the SCORE investigative team (referred to as the team facilitator) and I took part in the sessions. For each of

the sessions we tried to set up the room in a manner that was inviting and non-threatening.

Usually there were six chairs around a table and each chair was treated as a work station. Each station was assigned a number as a means of recording the participants, and the numbers ranged from one through six in a counter-clockwise direction. Each person was assigned a station that involved specific kit making activities such as placing items into the harm reduction bag, cutting rubber tubing, and note taking. Two members of SWAC worked consistently with the project and alternated as peer facilitators within the sessions. My role within each session was as the note taker and I was responsible for maintaining field notes throughout the sessions. A small separate table in the room held information that the women could take with them including: a description of project activities; contact information for health care, advocacy, legal, housing, and income assistance services; and safety tips for women involved in sex work.

Once the women were seated around the table, the team facilitator welcomed the women to the session and thanked them for coming. She reviewed the purpose of the project, explaining that we were involved in a project aimed at reducing harms associated with crack cocaine use and that the kit making circle was an opportunity for women to come together and share their knowledge and expertise with regards to women's concerns and resource needs. She used statements such as, "we want to hear what women have to say so that we can ensure that your voices get heard" and "this is an opportunity for us to come together to talk about women's concerns." The peer facilitator explained the actual kit making process by walking the women through the task for each station and demonstrating how it worked. After welcoming the women I explained my shared roles with SCORE and as a doctoral nursing student and discussed with the participants how the information we gathered would be used for both projects.

Once the sessions began and women became involved in the tasks, the dialogue flowed naturally. There was no established script of questions. Generally, the women were very receptive to having someone take notes. In many instances the women would stop talking to

ensure that I had written down something they said. During these sessions I both observed and participated in the activities including the dialogue and the kit making activities such as assisting with the completion of the kits. I was judicious regarding what I observed as it was impossible to pay attention to everything that was occurring. I paid particular attention to women's general appearances, their clothing, and any data that pertained to their health and health management strategies as well as other contextual factors influencing their lives such as housing, income assistance, experiences within the health care system, food access, interactions with police, and relationships with other people in their lives.

General observations concerning the location of the kit making circles and social interactions occurring within these agencies distinct from the kit making activities (e.g., interactions between staff and the women) provided other relevant contextual information regarding how women negotiate their day-to-day lives within the context of using the resources in these facilities. Data concerning specific demographic information such as age, race/ethnicity, housing, and marital status was not specifically collected from each participant, but instead was noted as women shared aspects of their lives.

### **Sampling strategies and locations**

The kit-making sessions occurred at various locations throughout the DTES including drop-in centres, women's housing facilities, emergency shelters, and community health centres. The drop-in locations were chosen strategically to enhance women's access to services offered by these agencies. For example, one centre offered lunch, showers, and laundry and ran a "Grief and Loss" support group targeted towards women involved in commercial sex work. Another agency offered emergency mental health services including shelter. For half of the sessions, particularly those occurring at drop-in centres, women were recruited by peer facilitators who had been actively involved in establishing the inclusion criteria for the project. The peer facilitators underwent training concerning purposeful sampling techniques and actively

attempted to recruit women that could represent a diversity of experiences and life circumstances among women in the DTES. One peer was Aboriginal and the other was Euro-White and both had lived for extended periods of time in the DTES. Both were also well known in the neighbourhood and were involved in many community outreach activities.

The peers approached women in the DTES and asked them if they would like to participate in a project about women's health and harm reduction for people who use crack. Usually recruitment occurred prior to the session, often several days in advance, when the peers deemed it safe to approach women. These participants were often recruited from locations throughout the DTES where women spent their time socializing including a local park, on the street, or during social activities that were women-only. For the other half of the sessions women were recruited by staff members from the specific agencies where the sessions were scheduled to occur. These agencies included those designed to provide services to people living with AIDS and mental health and/or addictions health concerns, supportive housing, and drop-in centres. In these instances women received a "ticket" with their name on it and the time and location for their session. When women arrived at the session, a member of the investigative team explained the purpose of the project and why women were being asked to take part in kit making circles. If the women agreed to participate they were asked to take a seat at one of the stations at the table.

### **Recording Observational Data as Field Notes**

All observational data were recorded as field notes, which were essential to the development of detailed accounts of women's experiences of health and health management strategies and the contextual factors that influenced these experiences. Drawing from the work of Browne (1995, 2003) and Emerson and his colleagues (1995) I employed a series of strategies to organize the process of recording notes. Field notes were recorded as general observations that reflected what I observed during both direct and participant observation activities. Direct quotes from participants during kit making activities were included in these records although they were

noted as interview data. Methodological notes included notes that I made to myself concerning the research process and topics and questions for follow up in further observations and/or interviews. The third category of notes was contained within my reflexive journal. These notes represented my record of linking observational notes with existing theoretical and empirical literature as well as my self-reflexive notes in which I critically examined my role within the research process, my influence and some of the ethical challenges that I faced as I carried out this work.

Documenting key words and phrases during the process of conducting observations and/or interviews is a common ethnographic process (Emerson, Emerson, Fretz & Shaw, 1995), yet on many occasions I diverged from this practice. Although documentation was viewed as acceptable among the study participants during kit making sessions it was not always feasible or appropriate during direct observation periods or during the course of the interviews. Members of SWAC and other women from the neighbourhood informed me that the taking of notes during a one-on-one conversation may be misconstrued as disrespectful as it conveyed a sense of not listening. Note taking in public venues also carried the risk of potential misinterpretation of my activities. Members of SWAC explained to me that because women are often in a situation where their information is being documented by someone in a position of influence (e.g., health care provider, social worker) being able to “just listen” was a better strategy to support the development of respectful relationships. As a result, particularly during periods of direct observation or within the context of one-on-one conversations and more formal in-depth interviews, I learned to make mental notes and did my jottings immediately following an activity, usually at a local coffee shop or community centre. These jottings were then expanded upon in greater detail as soon as possible following each individual data collection session.

## **Formal and Informal Interviews**

Interviewing is a common technique used in ethnographic research and contributes to the collection of what Carspecken (1996) has described as “dialogic data” (p. 154). Within the context of this project, interviewing served multiple purposes including giving voice to participants, learning more about participants’ perspectives of the experiences that I observed, and supporting more in-depth exploration of topics and experiences than feasible through other data collection techniques. Both informal and formal approaches to interviewing were included. Informal interviews were often combined with participant observation activities and were spontaneous events that occurred most often within the context of kit making sessions in response to something that I observed or something one of the participants had stated. For example, it was common for me to spend time with a woman after a kit making session to explore in greater detail a topic that she had raised within the session in conversation with another woman and it was also common for participants to pose questions to me as an active participant in these sessions. These informal conversations constituted a significant portion of field note data.

Formal interviewing differed significantly from informal interviewing in that these were somewhat semi-structured, prescheduled, audiotaped, and later transcribed. As recommended within the ethnographic literature this research technique was not employed until I had spent a significant amount of time (i.e., eight months) collecting data in the DTES, had developed a richer understanding of the contextual factors influencing women’s experiences of health, and had established a respectful ongoing relationship with many of the participants in the project (Carspecken, 1996; Heyl, 2001). The interview guide was developed to allow for maximum flexibility and included several questions that were designed to generate dialogue concerning women’s experiences of health, their health management strategies and contextual factors influencing these experiences (Carspecken, 1996) (see Appendix D). The guide also included



several items of interest to remind me of areas that could be further explored if appropriate during the course of the interview. Key areas upon which I focused within these interviews included women's experiences of health such as their overall feelings about their health, the types of health concerns they experienced, their experiences with the health care system, and the factors that influenced their health. Each participant also completed a brief demographic questionnaire which in most cases served to build rapport and establish a respectful dialogue (see Appendix D).

In addition to the women who used or had a history with crack cocaine use, I engaged in formal semi-structured interviews with three service providers. Each of these providers worked consistently with the women who participated in this project and worked outside of the acute health care system. The decision to interview these providers was made as the project unfolded. Participants frequently identified the role that each of these providers played in contributing to women's experiences of health and they provided rich contextual data concerning the factors that contributed to health concerns that the women experienced.

Interviews were conducted in a variety of settings including women's homes, at community drop-in centres and at city parks. All formal interviews were recorded and later transcribed verbatim. Interviews with women who were street-involved and used crack cocaine lasted from 30-90 minutes while interviews with providers lasted one hour.

### **Sampling strategies**

Within the realm of both kit making and formal interviewing activities, I employed a purposive sampling approach. Maxwell (1998) defined purposeful sampling as "a strategy in which particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices" (p. 87). Of the ten women who participated in formal interviews, four were recruited directly from kit making sessions based on their varied experiences of health concerns, time spent living in the DTES,

ages, race/ethnicity, strategies employed to manage their health, and willingness to participate. The remaining six were recruited with the assistance of peer facilitators. These women were purposefully recruited as they represented the opportunity to engage with women who were not part of the kit making activities. These women tended to experience greater social isolation, and more complex health concerns when compared to many of the women who I had met thus far.

### **Supplementary Sources of Data**

In the design of this project I had proposed that supplementary data would be collected to support critical examination of the interrelations among women's experiences of health, their health management strategies, and relations of power. Supplementary sources of data included newspaper articles, press releases, health policies within sites where women accessed health care, other research protocols, signage at local agencies frequented by women, and reports concerning health-related vital statistics, Aboriginal health initiatives, enforcement activities, and critiques of current policies concerning cuts to income assistance and housing programs. These supplementary sources of data were essential to my understanding of contextual events that occurred over specific time periods to influence women's opportunities for health (Roper & Shapira, 2000).

### **Analysis**

Data collection and analysis occurred concurrently in an iterative manner and an interpretive thematic approach that incorporated strategies appropriate for ethnographic research was used (Sandelowski, 1995; Thorne, Reimer Kirkham, & O'Flynn-Magee, 1994). Analysis was complex and occurred in a non-linear fashion that integrated the following procedures.

Observational data from direct and participant observations were transcribed into text documents and checked for accuracy as the activities occurred. Interview transcription was conducted by an experienced transcriptionist and I checked each transcript against the original

recording for accuracy. A database was constructed using SPSS<sup>®</sup> (a statistical software package) by a trained database expert and all survey data were entered and checked for accuracy against the original surveys. The data were then analysed. Descriptive statistics constituted the bulk of the analysis of the survey data (Duffy & Jacobsen, 2001). These analyses included frequency distributions for each of the health problems, self-reported health status, health strategies, and demographics reported among the participants.

As data were continually gathered, whole interviews and observational field notes (including informal interviews) were read repeatedly to identify any recurring patterns (similarities) or unusual events (differences) (Carspecken, 1996). I also reread the data for possible linkages to theory and began to highlight illustrative examples from the data that depicted patterns and unusual events. As participant observation and interview data were collected I compared this data with the descriptive results from the survey, noting similarities and differences concerning women's experiences of health and contextual factors influencing these experiences and highlighted areas for further clarification in follow up interviews with participants. As more data were collected and reviewed I began to create codes based on the themes identified. Initially these codes were descriptive of the themes regarding women's experiences and activities. As analysis progressed, codes were further refined to reflect a more theoretical approach to the analysis that sought to analyse the data in a manner that would illustrate how relations of power operating across multiple and intersecting systems of oppression within the specific place of the DTES influenced women's experiences of health and their health management strategies. Once these codes were identified, the coded interview and observational data and my reflexive journaling entries were entered into NVivo<sup>®</sup>, a software program for organizing and grouping data into sets that can then be easily retrieved, compared and contrasted. As more data were coded, additional categories were added within the coding structure, some of which reflected the ethical challenges inherent in conducting this work. Other

categories were expanded or collapsed. The analysis also contributed to theoretical sampling to include four additional interviews; one with a woman who was street involved but had no experience with crack use and three with service providers who worked in outreach and support worker capacities. Each of these interviews contributed to additional angles for analysis.

While the dynamic coding and categorizations were underway I met with members of SWAC on three separate occasions to discuss the analysis and to seek clarification regarding some of my reflexive journaling notes regarding my interpretations of events that I observed during kit making activities. During each meeting, they challenged some of my interpretations and provided enhanced refinement for some of the coding. They also identified categories that warranted further elaboration and assisted in purposeful sampling to accomplish these tasks.

As the data collection period was drawing to an end, the analysis continued from a more theoretical position to generate broader theoretical constructs and propositions. The interpretive inductive approach required a level of abstraction that extended beyond the position of giving voice to participants (Browne, 2003; Thorne et al., 2004). The analysis continued until I achieved a synthesized account that represented the mechanisms by which relations of power operating across systems of oppression such as race, gender, and class influenced women's experiences of health, including an analysis of how these relations of power maintained the status quo and the resistive actions of the women to challenge these relations.

### **Ensuring Scientific Quality**

Research activities do not result in absolute truths and the knowledge generated through research is contextual to the specific historical, social, economic, and political circumstances associated with the research process and the lives of the participants (Angen, 2000; Collins, 2000; Harding, 2004; Hammersley, 1992; Thorne et al., 2004). Additionally, given that there are currently no absolute or finite rules or formulas to guarantee valid social knowledge, we are constantly challenged to ascertain the appropriateness of our strategies to ensure that we can

provide a credible, accurate, and confident (versus absolute) *representation* of participants' experiences and the contextual factors influencing these experiences (Angen; G. Anderson, 1989; Browne, 2003; Dyck, Lynam & J. Anderson, 1995; Hammersley). Throughout the course of this project I employed several strategies to enhance the scientific quality of the representation of women's experiences of health concerns, health management strategies, and relations of power influencing these experiences and many of these strategies for rigour were embedded within the critical and feminist perspectives informing the project.

The first strategy that I employed pertained to the actual research activities. As several researchers have noted, the processes used in the development of a 'representation' are crucial to ensuring scientific quality (Sandelowski & Barroso, 2003; Thorne et al., 2004). Multiple data collection techniques were used to capture "breadth" and "depth" concerning women's experiences of health including a survey, interviewing, and observation (Lather, 2007). The use of multiple data collection strategies provided me with an opportunity to compare study findings that diverged or complemented one another and contributed to a much richer understanding of the similarities and differences among women's experiences of health as well as the complexities of managing their health concerns. Additionally I continuously integrated these multiple sources of data with the theoretical perspectives informing the project (a process often referred to as triangulation), which supported an iterative data analysis and collection process that maintained an emphasis on relations of power influencing women's lives (Lather, 1991).

The research instruments I used were also important for scientific quality. The items of the cross sectional survey used within the context of the larger project and my dissertation were derived from a variety of sources including extant literature and existing research instruments related to crack use practices (Malchy et al., 2007), the VIDUS Study Follow-Up Questionnaire #9 (Kerr, Wood, Small, Palepu, & Tyndall, 2003), Short Form (SF-36) Health Survey (Falck, Wang, Carlson, & Siegal, 2000; Ware, 1993), and the input of experienced researchers in the

areas of substance use, determinants of health and health behaviour, sociology, and feminist theory. Two separate focus groups were conducted with men and women who use crack cocaine to review the draft questionnaire and ensure item relevance. Each item was reviewed in the focus group for clarity, relevance, appropriateness, and common understanding of the meaning of the item (Fowler, 1998). Revisions were made based on this feedback, including reframing some questions, deleting others and adding important questions pertaining to health concerns among people who smoke crack cocaine. No questions concerning HIV seroconversion status, Hepatitis (B or C), or STI were included as all participants in the focus groups expressed the concern that these health issues were too personal and private to be included in a short survey administered by a stranger or acquaintance and several large-scale studies were simultaneously underway within the neighbourhood by investigators from the BC Centre for Excellence of HIV/AIDS. The final survey was pilot tested with eight women and three men in the DTES who reported using crack. Several small revisions were made including appropriate language use and reframing questions pertaining to sharing practices so that participants did not perceive that they were being asked to identify who they were sharing with. The final version was administered by research assistants (RA's) and myself. A PKDS instruction guide was developed and all RA's underwent training prior to administration to enhance the likelihood of consistency in survey administration and to reduce the amount of variance obtained due to administration bias (Burns & Grove, 2001).

Although these strategies enhanced content validity there were several limitations that warrant comment. Several key health concerns were not included on the survey (e.g., HIV, HCV, and cervical cancer) or were inadequately articulated (e.g., skin infections or lesions). For example, skin infections was too generic an item to fully capture the frequency with which women experienced abscesses and lesions. Although each of these concerns was documented within the scope of the formal interviews and participant observation activities, these concerns may be significantly underrepresented within the data. Additionally, the context of housing was

inaccurately assessed as no questions were posed that reflected the instability of housing that women experienced. Instead, the data was limited to whether the women had housing at the time of the survey, which does not accurately reflect the housing crisis within the DTES or the instability of housing that has been reported elsewhere (PIVOT, 2006).

The amount of time I spent engaged in research within the DTES was another important factor in relation to developing a credible representation. Although there are no pre-established criteria regarding the amount of time an ethnographic researcher should spend in data collection, Carspecken (1996) noted that a sufficient time must allow for participants to become accustomed to the researcher and that she ought to remain in the field until she “finds herself recording the same basic routines over and over again” (p. 49). Over the course of 17 months with almost weekly visits to the neighbourhood, I became known to many of the participants and other people, therefore my presence was not an unknown or unexpected entity. As I went about my regular research activities I would often stop and chat with women I knew and on several occasions I accompanied women to various events such as memorial services, not all of which were activities that were specific to my research. In addition, while I recognize that there exist limitless possibilities for new ethnographic observations, in light of time commitments for project deadlines, the abundance of data collected with a diverse group of women, and the iterative data collection and analysis process used, I was comfortable exiting the field after 17 months as the analysis revealed sufficient breadth and depth to develop a credible representation of the women’s experiences of health concerns, health management strategies and the structural inequities that influenced these experiences.

Equally important to ensuring scientific quality within critical feminist research is the relational process of reflexivity as was previously discussed within the tenets of critical ethnography. In addition to reflexive journaling and methodological field notes, I was particularly concerned that an ethnographic approach might contribute to what Maher (1997) has

described as a “colonizing act” (p. 209). Historically research that has contributed to essentialized notions of Other has frequently occurred within an ethnographic context (L. Smith, 1999). Maher argues that projects that contribute to colonization are unethical and of little scientific merit within the critical and feminist research traditions. She goes further to note that further contributing to the colonization of people who are poor or indigenous is often unintended and critical self-reflection regarding our actions within the research process can limit these effects. During each aspect of the research I explored sampling methods that would support a wide range of experiences among women who use crack cocaine and in the writing of the report I repeatedly checked the exemplars I chose to represent the data to ensure that the wide range of women who participated could be represented. I strove to avoid becoming the “transformative intellectual” (Lather, 1991, p. 109) speaking on behalf of women who used crack cocaine and instead integrated verbatim quotes. I remained constantly embroiled in the challenges of writing about the “group” as the focus of analysis within an intersectional framework with an eye toward avoiding an essentialist perspective. I read and re-read my journal seeking to identify similarities and differences not only in women’s experiences but their perspectives of these experiences while simultaneously recognizing that they shared legacies of discrimination, violence, and poverty (Collins, 1998, 2000). Because I maintained to some extent the power of representation by being the primary author of the written reports, I documented my feelings in response to what I heard and observed and strove to be open in my learning and reactions so as not to distort the representation (Carspecken, 1996). When I was particularly challenged, I engaged with members of my dissertation committee to assist in this process.

I actively engaged with concerns regarding my position of influence as a Euro-Canadian middle class researcher and constantly re-examined my legitimacy as a researcher in this field. Adhering to the arguments put forth by Reimer Kirkham and Anderson (2002) I reflected on my legitimacy not as to whether or not I could be a researcher in the area of women’s health, but my



“...ability to explicate the ways in which marginalization and racialization operate” (p. 13). My issues was not to speak for women who are street-involved and use crack cocaine, but to make visible the interrelations between systems of oppression and relations of power that influence the health concerns they experienced.

### **Usefulness of the Research**

It has been argued that nurse researchers have a pragmatic obligation in that their research should be of relevance for the practice of nursing within the areas of research, education, clinical practice, or health policy (Thorne et al., 2004). This mandate is congruent with the critical and feminist aim of research to challenge the organization of dominant institutions (Harding, 2004) and transform current knowledge to better the lives of those experiencing marginalization (Carspecken, 1996; Collins, 1998; Madison, 2005). Evaluation of the utility is difficult to fully assess until the research is completed and the process of disseminating findings and developing plans are underway (Reimer Kirkham, 2000). In an attempt to begin this process however, the final discussion of this work highlights key recommendations for research, policy, education, and practice that are necessary to bring about social change to enhance women’s opportunities for health.

### **Ethical Considerations**

There were many significant ethical considerations involved in the design, implementation, and completion of this project. First, in accordance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (CIHR, NSERC & SSHRC, 1998), the research protocols for this project and SCORE including the sharing of data between the two projects were reviewed by the University of British Columbia Behavioural Research Ethics Board and a certificate of approval was obtained (see Appendix F). Research protocols, informed by feminist approaches to research ethics (e.g., McLeod & Sherwin, 2000; Patai, 1991), and the Tri-Council Policy Statement, included strategies to ensure confidentiality and informed consent,

data management and storage strategies, financial honorariums, and the establishment and maintenance of respectful research relationships.

### **Informed Consent**

Feminist ethicists have argued that the social processes involved in informed consent are often problematic, particularly for women who experience multiple and intersecting systems of oppression as the relations of power that operate across these systems may undermine women's autonomous decision making capacity by: (a) limiting options available; or (b) in some circumstances, limiting their opportunities to develop the autonomous decision-making skills (MacLeod & Sherwin, 2000; Sherwin, 1998). As noted previously many women who live within the DTES experience significant state regulation enacted through the criminal justice, social services (e.g., welfare), and health care delivery systems and as a result are often reliant on others to determine their fitness to receive services such as social income assistance, health service, or custody of their children (Boyd, 1999). This does not mean that women who experience oppression are incapable of autonomous acts but draws our attention to the need to "...examine how specific decisions are embedded within a complex set of relations and policies that constrain (or ideally promote) an individual's ability to exercise autonomy with respect to any particular choice" (Sherwin, 1998, p. 32). Drawing from critical and feminist perspectives, I employed a relational approach to informed consent. A one page summary outlining the project purpose, the research activities, rights of refusal and participation, approximate time commitments, and participation honorariums was provided to women for the survey, kit making sessions, and interviewing procedures (see Appendix C). The information was reviewed verbally with each woman and I encouraged them to ask questions. No written consents were obtained. Previous research has indicated that people who are street-involved and experience significant state regulation and stigma associated with their income and drug use status are often mistrustful

of activities that require their signature and that verbal consent is a more appropriate and respectful approach (Bungay et al., 2006; Ensign, 2002).

Research activities occurred in locations that were perceived as safe and comfortable for the participants including their homes, private rooms in drop-in centres, and for those concerned with potential retribution by partners and/or other people for participating, in community parks outside of the DTES. During kit making sessions I discussed with women that field note taking was a strategy that we could use to maintain a record of what they had to say. I also explained that I would be taking notes about the whole process of kit making. I reviewed that everything was confidential and that each woman had the right to request that a comment not be written down if she did not want it to be. At the end of each session women were reminded that they could request that their conversations be removed from the field notes but no women opted to do this throughout the course of the entire project. On several instances where women discussed painful life experiences including for example, rape, assault, and kidnapping, I often double-checked with women before they left to ensure that it was appropriate to record their comments. Women frequently thanked me for “checking” with them and on one occasion I was able to clarify with one woman aspects of her conversation that she wished to avoid being documented such as the location where the event had occurred and the other people involved. In some instances, I was able to support referral to counselling or outreach services that would assist women to address some of the concerns raised during our conversations.

### **Confidentiality**

To ensure confidentiality, all possible identifying information was removed from the recorded data, field notes, computer files, and written reports. Each participant was assigned an identification number that pertained to the related research activity. Survey participants were assigned a three digit number and formal and informal interview participants were assigned a three digit number prefaced by the initials “IP” to differentiate them from survey participants.

Within the body of written reports, verbatim quotes were identified using this notation to demonstrate the use of exemplars from the entire data set in the analysis of the data.

Additionally, descriptive data such as appearance, age, or self-identified ethnicity were only included in reports if they were deemed relevant to the underlying presentation of the findings.

This practice is contrary to many other research projects that have integrated a feminist approach to research ethics where women have chosen pseudonyms. The choice of numerical representation was intentional. Many women who participated already use pseudonyms in other aspects of their lives, particularly when engaged in illegal activities or when seeking to avoid men and women who posed a risk of violence. Women expressed that these pseudonyms provided a sense of distance between these activities and who they were as friends, partners, and mothers in the rest of their lives and they did not want to add another pseudonym to their lives. In keeping with the feminist aim of supporting women to enact choices that enhanced their own moral worth as human beings, women were given an option regarding how they wanted to be “identified” within this project (McLeod & Sherwin, 2000). The overwhelming majority stated they did not want a “fake name” nor did they wish to have one assigned. The rationale was that in their experience, “fake names” often reflected an aspect of the person and as such could still potentially be used to identify them within the context of this research. Women who were worried about negative repercussions for participating in this project such as violence from their significant others for talking to a researcher or feared repercussions by service providers who might recognize them if they read the final written reports, were particularly concerned about identification. After consultation with numerous women and members of SWAC, the decision was made to assign numbers. Women reported that they viewed this as a sign of respect for their privacy.

Confidentiality was also supported through data management strategies. All paper copies of data were stored in a secure location where I had the only key. Computer files were password

protected and again I was the only one with access to this password. Women were often asked if they wanted records of their transcripts, but all refused and reported that they would appreciate receiving a final report that summarized the key findings of the project.

### **Respectful Research Relationships**

There are few explicit guidelines or codes of conduct that provide direction regarding how one engages in a respectful research relationship. Yet as Maori scholar Linda T. Smith (2005) noted, “while indigenous communities and other marginalized groups may not understand the history of the ethical code of conduct...they do understand breaches of respect and negative impacts from research” (p. 101). In my attempts to negotiate respectful relationships I drew upon the ethical principles outlined in the *Guidelines for Ethical Research in Aboriginal and Strait Islander Health Research* (National Health and Medical Research Council, 2003 ), as well as the tenet of positionality (Madison, 2005) and integrated the processes of consultation, negotiation, recognition, and involvement throughout the research project.

Recognition involved recognizing my own strengths, limitations, and roles within the relationship. I was cognizant of the fact that I was a visitor in the lives of the participants and as such positioned myself largely in the role of “learner as researcher.” In developing relationships with women I acknowledged that through my experiences as a nurse in clinical practice and as a nurse researcher, I had learned a lot about women’s health, but that in reality, I had little experience regarding how women experienced their health on a daily basis or negotiated the multiple and intersecting systems of oppression. I also positioned myself as a nurse researcher concerned with supporting social, economic, and political change towards the improvement of the contextual factors influencing women’s experiences of health concerns. I was honest with women regarding the differences and similarities in our life experiences. Many women asked me throughout the course of the project, for example, if I had ever used crack cocaine and some questioned whether I could grasp what their lives were like if I had not experienced being street-

involved. I honestly answered that I had never used crack nor did I know what it was like to be street-involved, but I had, throughout my twenty-year career, worked with many women who shared similar life circumstances and that during this time I learned that women continued to suffer severe inequities in their health. I also expressed my belief that a concerted effort was needed on the part of all of us to initiate and maintain change to reduce social and economic inequities that influenced women's health. Women responded positively with my position of learner as researcher and expressed that they "felt respected" by my approach to learn from them about their experiences and actions as they attempted to manage their health. Women also expressed that they were "happy to talk" to me and contribute in any way to a project concerned with their experiences of health.

Involvement and consultation were negotiated in a variety of ways. SWAC was instrumental in providing advisory advice and support throughout the entire project, particularly regarding appropriate "rules of conduct" when working with women who are street-involved. They established recruitment strategies that were designed to support women's safety while at the same time providing the opportunity for participation to a diverse sample of women. As peer facilitators within the kit making sessions they negotiated with their peers general "rules" of conduct within the sessions. These including providing a fair opportunity for each woman to speak if she so desired, confidentiality within the group, and some boundaries concerning appropriate topics if and when other women became uncomfortable with a topic. Additionally, the use of kit making sessions supported a feminist approach to create a space where women could come together in a safe place to share their experiences and "take a break" from the constant vigilance that was required on the street to protect themselves and others. Our goal was to learn from women in their own words about their harm reduction programming needs including the contextual factors shaping these needs. It was a chance to participate in what feminist scholar bell hooks (1988) refers to as talking back: "Moving from silence into speech is

for the oppressed, the colonized, the exploited, and those who stand and struggle side by side a gesture of defiance that heals, that makes new life and new growth possible. It is the act of speech, of ‘talking back’ that is no mere gesture of empty words, that is the expression of our movement from object to subject – the liberated voice” (p. 9).

The key items addressed during interviews were reviewed with interview participants at the beginning of each interview. On some occasions I negotiated with women topics they considered “out of bounds” including any direct questioning on my behalf about their children. Women often raised the topic of children in the interview and they noted that this was acceptable but wanted to ensure that the interview in no way would be focused on their parenting abilities.

Although I specified that I was not acting as a nurse engaged in clinical practice but as a nurse researcher, there were many situations where women posed specific questions about their general health concerns. I listened to these concerns and in many instances supported women to access health resources such as community health clinics, outreach workers, and street nurses so that women could have their concerns be addressed by a health provider who could ensure continuity in the care they received.<sup>13</sup>

The final aspect of developing respectful relationships involved gleaning from the participants their input regarding how the results of the project would be shared back to their neighbourhood. Two strategies were decided upon. The first was that when I completed the project, I would give a presentation at a VANDU Women’s Support Group meeting that provided an overview of the findings. This would be scheduled for an hour and I was to ensure that women would have time to participate in a discussion about the work. Second, a brief

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<sup>13</sup> Throughout this research I recognized that both the women and I were emotionally invested in our relationships. How we experienced the emotional aspect of our relationships shared many similarities and differences. Within the scope of this dissertation I have not included of full discussion of the range of emotional experiences from my perspective or the emotional challenges of engaging in research with women who experience the magnitude of suffering that many of the participants experienced. A comprehensive discussion of the ethical issues and emotional challenges in engaging in this project is currently being addressed in a separate manuscript under development for publication.

newsletter outlining the study findings will be circulated to the agencies that women frequent such as women-only drop-in centres and other community programs. Members of SWAC will also help in the compilation and distribution of this newsletter.

### **Financial Honorariums**

Over the past several decades there has been ongoing debate, albeit largely within the realm of clinical trials for pharmaceutical products, concerning the moral appropriateness of the provision of financial honorariums to research participants (for examples see Anderson & Weijer, 2002; Grady, 2001; Macklin, 1981). Concerns have been raised that offers of payment may contribute to undue inducement or that the refusal to offer payment could be construed as disrespectful of the effort required for people to commit to these activities (for a more thorough discussion of these issues see Bungay, 2006). In this project, survey participants received ten dollars and kit making and interview participants received twenty dollars for their participation. SWAC members received additional fifteen dollar honoraria for their participation in advisory meetings.

The decision to offer honorariums was multifaceted. First, I recognized that women experienced severe economic deprivation. At the beginning of the project I was advised by members of SWAC and outreach workers that women spent a significant portion of their time trying to determine additional sources of income, a finding that was reinforced during this project. Therefore, it was appropriate to provide women with financial honorariums as their participation in research activities limited their options for alternative income during the time we spent together. Second, women considered it respectful to have financial acknowledgement for their participation. Honorariums contributed to a sense that I perceived them as experts in their own lives who had something meaningful to contribute to a project aimed ultimately at improving women's health. Finally, it has become common practice within the DTES for research projects to offer financial honoraria for participation. Spittal and her colleagues (2002),



for example, reported that “subjects were reimbursed CAN\$20 for each study visit” (p. 895) and anecdotal reports from participants identified that this is common practice. Within the context of this project I followed the trend for amounts of payment that were currently in practice to support consistency.

## **Summary**

Viewpoints drawn from intersectionality and social geography provided the interpretive perspectives through which I approached this research. Combined with critical ethnography as a strategy of inquiry, these theoretical perspectives were used to critically examine: (a) the nature of the health concerns experienced by women who use crack cocaine as articulated through the perspectives and experiences of women themselves; (b) the day-to-day circumstances that influenced women’s lives and opportunities for health; (c) the strategies employed by women to manage their health; and (d) the influential social, economic, political, and historical processes that shaped women’s experiences. I acknowledge that by applying these perspectives, there are some risks associated with focusing on aspects of the data and ignoring others. In reality, there are a multitude of analytical perspectives that could be used to examine the phenomena of interest within this project. My goal, however, was not to make the data fit the theory, but to critically engage in a reflexive manner regarding how these theoretical perspectives influenced the study and their strengths and limitations.

## **CHAPTER FOUR: “DOWN HERE” IN THE DTES: PLACE MATTERS**

### **Introduction**

In order to more fully understand the complexity of women’s experiences of health, the inequities that contributed to these experiences, and their related health managements strategies, I first analysed the actions and experiences of women as they occurred within the realm of living their day-to-day lives in the DTES. Within this chapter, I provide a comprehensive description of the women who took part in the various research activities, and highlight the similarities and differences among the women with regards to their age, income, places where they live, self-reported ethnicity, and substance use practices. In the remainder of the chapter I emphasize the meaning and attributes that women assign to the DTES as the place where they live (and in some instances visit) as well as how women’s experiences of racialized, gendered, and class-based systems of oppression operating within relations of power to influence what occurs within the context of their homes, shelters, and when outside in public places. Overall, I illustrate how the lives of the women are filled with relentless assaults on their personal safety, continuous public scrutiny, and an overwhelming sense of despair with regards to their perceived moral worth in society. In the midst of this they also incorporate creative and resistive strategies to circumvent oppressive life circumstances. In the next chapter I move from this ‘general’ description to more critically examine how the contextual factors and relations of power influencing women’s lives play out with regards to their experiences of health concerns.

Before I go further, it is important to note that my analysis of women’s experiences is not intended to imply that all women in the DTES experience their everyday worlds in exactly the same manner. There were multiple experiences and varying degrees of experience among the women. In keeping with the tenets of intersectionality, I present an analysis to critically represent the shared and diverse challenges experienced by women on a daily basis.

## **The Participants**

There were many similarities and differences among the women who took part in the various research activities. One hundred and twenty-six women completed the survey, 53 participated in kit making sessions and 13 women (three of whom were service providers) participated in lengthy, formal interviews. Many of the women represented the most marginalized women in the city as evidenced by their significant levels of poverty, homelessness, illness, violence, and reliance on illegal activities for income. Aboriginal women were overrepresented in all aspects of this project although only five percent of the Canadian population is of Aboriginal descent (Adelson, 2005).

### **Survey Participants**

One hundred and twenty-six participants who self-identified as “female” or “transgendered” participated in the cross sectional Pre-Kit Distribution Survey. Six participants who self-identified as transgendered were included in the findings as they completed the survey in “women-only” locations such as a women’s drop-in centre and a women’s low barrier housing facility.<sup>14</sup> All women reported having used crack cocaine at least once in the 30 days prior to the survey and many were daily crack smokers. A general demographic profile of these participants is provided in Table 1.

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<sup>14</sup> Low-barrier in the context of housing, shelter, and health care services refers to supportive housing, shelter, and health care agencies that do not require abstinence from illegal substances or alcohol or enrolment in treatment programs to be eligible for these services. Strictly supportive services are not low-barrier and frequently require abstinence and/or enrolment in treatment programs including mental health services. Low-barrier and supportive housing services also have 24 hour, onsite staff whose purpose is to assist women in accessing services (City of Vancouver, 2007).

**Table 1 Demographic Characteristics of the Survey Participants (N=126)<sup>15</sup>**

Characteristic	n	%
Living in DTES	126	
yes	117	92.9
no	9	7.1
Economic Status (LICO)	122	
above	14	11.5
below	108	88.5
Primary Income Source	124	
income assistance	83	66.9
other (e.g., family/friends; sex work; drug selling)	41	33.1
Age	121	
mean (SD)	38.5 (8.53)	
Self-Reported Ethnicity <sup>16</sup>	124	
Aboriginal-Canadian	58	46.8
Euro-Canadian	43	34.7
Other-Canadian	23	18.5

Within the survey findings I noted that 88.5% (n=124) of the women lived below the LICO. Of these women, 72.2% identified public assistance as their primary source of income while 27.8% (n=30) of the women identified “Other” as their main source of income. Of these 30 women, 22 listed sex work and/or dealing as their income source (both illegal activities), two reported no source of income, two refused to answer and six stated that they relied on family, friends, binning, and income assistance associated with continuing education. Of the fourteen women who reported living above the LICO, four reported “selling dope” as their primary source

<sup>15</sup> The total number of women who participated in the survey was 126. The response sample size for these particular items ranged from 124 – 126.

<sup>16</sup> Note: The ethnicity question in the original survey was open ended: *What would you say is your main cultural and ethnic background?* These responses were then collapsed into three categories based on participant’s responses. The Canadian suffix of each category reflects that the participant currently resides in Canada and is not a reflection of citizenship status.

of income, and six obtained income from commercial sex work activities such as street-based (working outside on the street) sex work and escort work (also known as “out-call”). None of the women reported having a “regular job.”

### **Kit Making and Interview Participants**

Throughout the 18 kit making sessions that I attended, I met 53 women, many of whom I met on more than one occasion as there were no limits on the number of kit making sessions that they could attend. As I noted previously in the discussion of data collection strategies, I did not employ a standardized approach to collecting demographic information among kit making participants. As we engaged in kit making I listened to their stories and took notes regarding how they described themselves in relation to the social and economic contexts of their day-to-day lives. I also made observations regarding their physical appearance, how they interacted with one another, and their worries and concerns about themselves and the people they cared about. The women represented a diverse group, ranging in age from early 20s to late 50s although the majority were between 35 and 45 years of age. Their housing situations were also diverse: ranging from low-barrier and supportive housing, emergency shelters or single room occupancy units (SRO’s).<sup>17</sup> Many were completely homeless (had no place to stay) and relied on friends to provide them with shelter. The economic circumstances of their lives was a common topic of discussion with the majority either receiving some form of social income assistance or having no formalized form of income.<sup>18</sup> Working within the commercial sex industry was common. Women were often involved in social and volunteer activities, for instance washing dishes at a drop-in centre, patrolling washrooms at a community clinic or doing peer-outreach in the alleys

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<sup>17</sup> SRO’s refer to single room occupancy units. Each unit typically consists of one room that measures about 10 by 10 feet. Residents share common bathrooms and sometimes cooking facilities. SRO’s are located in privately owned and managed buildings usually in the form of residential hotels or rooming houses (PIVOT Legal Society, 2006).

<sup>18</sup> Welfare refers to “income assistance (money and/or benefits) provided by the provincial government to people considered eligible under a strict set of rules. Welfare is a program of last resort – it is available only to individuals and families who do not have the resources to meet their basic needs, have no employment, have used up their savings, and have exhausted all other options” (Wallace et al., 2006, p. 9).

of the DTES. There were also many who were involved with the criminal justice system, who had spent time in prison or were currently involved in dealing with a criminal charge against them (e.g., possession, property crimes such as break and enter and theft). Some women were in educational programs including taking university courses attending community college. The majority of women who participated were Aboriginal and identified themselves as such throughout the discussions. Other women were Chinese, Filipino, African-American, and Euro-White. Everyone spoke English although for several women English was a second language. French, Chinese and Spanish were some of the other languages spoken.

Ten women, four of whom had also participated in kit making sessions, took part in lengthy, recorded, formal interviews. Each of these ten women completed a brief demographic information sheet similar to that included in the survey. Nine of them lived in the DTES and one lived in a supportive housing facility in a neighbourhood adjacent to the DTES. Eight of the women described themselves as single (two of these reported having been divorced), one reported having a common-law partner and one said that she was a widow. All of these women reported living below the LICO and income assistance was the primary source of income for nine of the women. While only one woman reported sex work as her primary source of income, six of the women reported having alternative incomes in addition to public assistance. These additional incomes included sex work, “selling dope,” and stipends associated with volunteer and research work. Three of the women lived in low-barrier housing, one was homeless and slept outside or “hung out” at agencies that were open throughout the day, evening and night (e.g., the Contact Centre and WISH), and the six other women lived in SRO’s. Two women expressed fear for their safety in their living arrangements due to threats of violence by men. Four women identified as Aboriginal, five as Euro-White and one as mixed Chinese and Hungarian. The women ranged in age from 38 to 59. Three women reported that their highest level of education

was between grades nine and eleven, two reported completion of high school, one had completed her GED, and four stated that they had some college or university.

Three outreach and support service providers were also interviewed. These women were purposefully chosen based on their consistent working relationships with many of the women who participated in the various data collection phases of this project. One was an outreach worker with experience working with women who were living with HIV. One participant managed an evening program at a local women's drop-in centre and the other coordinated a women's support group within a local drug user organization.

### **Patterns of Substance Use**

The patterns of substance use varied greatly among all participants who participated in the various data collection activities. It was common for women to be using more than one substance and many were receiving prescriptions for drugs such as Ativan, Valium and methadone from their physicians. Among the women who participated in the kit making sessions, some no longer used drugs other than those prescribed by a physician, some reported trying to quit using, others discussed using crack on a daily basis, while others talked about using different drugs depending on their mood: for example, crystal methamphetamine to feel energetic versus benzodiazepines to help them sleep. Among those who took part in the survey, they were asked to specifically identify substances that they commonly used, the results of which are outlined in Table 2.

**Table 2 Profile of Drug Use among Survey Participants**

Drug Use Characteristic	(n = 126)
Frequency of crack use	%
daily	63.4
weekly	27.0
less than once per week	9.6
Regular drug use	
tobacco	88.1
cocaine	77.6
alcohol	40.3
marijuana	38.7
methadone	37.1
pills	35.2
heroin	31.5
crystal methamphetamine	12.9
ecstasy	3.2
GHB	1.6
Route of drug use	
injection	42.9
smoke	98.4
snort	24.6
Change in drug use? (past year) (yes)	58.7

Of those who identified that their drug use had changed in the past year, 48.6% said they decreased the amount of drugs they used while 31.9% reported an increase in the amount of drugs used. Just under 10% reported a change in their dominant drug or route for administration, while 4.2% stated they had started a methadone program.

### **Down Here: Representations of the DTES**

The dynamic landscape of the DTES was where the women experienced much of their day-to-day lives and they described this neighbourhood as a specific place they called “down here”. “Down here” encompassed a physical scale as well as a socio-spatial place with open and porous boundaries. “Down here” represented a constellation of multiple meanings and experiences for women that reflected the often conflicting trajectories of their day-to-day lives



(Massey, 1994, 2005; McDowell, 1999; Razack, 2002a). Although “out there” was the term used by both service providers and residents to depict places outside of “down here,” it was apparent that “down here” and “out there” were not mutually exclusive or unrelated. “Out there” and “down here” represented a complex network of power relations that influenced many of the activities and experiences of the women that at times contributed to devastating consequences for their personal safety and health outcomes (Massey, 1994).

To more fully comprehend the significance of the interrelations among place, systems of oppression, and relations of power for women’s experiences of health, I first critically examined women’s experiences of being “down here” to identify the multiple representations that women described and/or experienced in relation to the DTES. These representations included the attributes and meanings that women associated with the DTES and mirrored the ongoing negotiations and conflicts between class-based, gendered, and racialized systems of oppression; the relations of power that influence these systems; and resistance to the status quo of domination that were evident in their day-to-day lives. Each representation reflects the women’s experiences of “being down here” and is related to the reasons women reported regarding *why* they lived “down here” and *how* people from “out there” behaved towards them. The DTES was dynamically constructed as a place tied to social relations of the past, present, and what was envisioned for the future by those living out there and down here. As noted by Massey (2005), “neither societies nor places are seen as having any timeless authenticity. They are, and always have been, interconnected and dynamic” (p. 67).

### **A Place of Escape**

In her work, *The Sphinx in the City*, Wilson (1992) documented the historical migration of women to cities beginning with the industrial era and argued that, for many women, their movement into a city represented a search for independence and freedom from oppressive social forces within their previous homes and neighbourhoods. This was the case for the vast majority

of women who shared their stories of how they had come to live within the DTES. Women reported running away, some as young as age 13, from violent home situations including childhood physical, emotional, and sexual abuse; intimate partner violence; and residential schooling. Many women had run away to other cities such as Edmonton and Winnipeg before moving to the DTES and there was sense of eventual migration to this particular neighbourhood. The movement to the DTES was a deliberate and intentional escape strategy and the city itself represented a place of freedom.

IP(004): When I was 17, I left for good, on bad terms. There was a lot of emotional abuse going on from my adopted family. I went to Edmonton and lived with my brother for a while. From there I moved to Prince George. I eventually came out here by myself to get out of an abusive relationship...I came here because I like big cities...I was here once before and I knew this is where I wanted to live.

The loss of loved ones, having little or no support, and the break-up of marriages also contributed to a sense of “needing to get away.” Getting away helped women distance themselves from familiar people and places and enabled them to take a break from the scrutiny and to deal with their losses using their own unique strategies. As noted by one woman who experienced the loss of her mother while simultaneously involved in a divorce and custody hearing for her children:

IP(002): I guess that’s what made me sort of end up moving down here. I needed to get away from being out there in that area because all the couples we knew and their kids were out there and they always said that they would be there if we ever broke up, but that’s bull, most of them sided with him.

### **No Place Else to Go**

Although it was apparent that the city represented a place to run *to*, for many women “down here” represented the only viable place to go within the City of Vancouver. Women were financially excluded from living elsewhere in the city as “down here” was the only neighbourhood where most could find “affordable” housing. Additionally, “out there” was perceived as problematic in that women believed that people “out there” did not want women

from “down here” living in their neighbourhoods. The comments of one of the service providers also illuminated the racialized underpinnings of the exclusionary relations of power, particularly for Aboriginal women, that maintained segregation within the city.

Provider(003): People can’t move from these 10 blocks because people will treat you like shit. And it’s not like you know with [name], she is now renting somewhere uptown. She’s white, she looks healthy and she looks clean. She’s not living down here anymore. She is using heroin and is using crack a lot. But she can survive; she is a very skilled white woman, so she can survive in a better neighbourhood.

Among the women with mental health concerns, “down here” was one of the few places where they could access supportive and low-barrier emergency mental health services. “Down here” was also considered an acceptable place to go as there was a sense of compassion and tolerance among members of the community that was not experienced elsewhere in the city for people living with mental health concerns. This sense of belonging was also related to not belonging anywhere else.

Provider(003): But people will look at you out there as if you are a leper, mainstream people the way they look at beggars. You see when people are taking the bus here, as high as the bus goes the population changes so you are left with one or two people who started this road, so you see how other people are, they won’t sit beside them. Yeah, I think the way people look at drug users it’s easier to be part of here, when everyone is a drug user and nobody will give you the evil eye. It must be a nightmare to be out there.

The DTES was a place where they could purchase substances at lower prices and in smaller quantities. As noted by one participant, “it took a while to get ‘down here.’ I just went where the drugs were and ended up down here. That’s the way it works when you are an addict” (IP007).

The disciplinary organization of services including food banks, drop-in centres and low-barrier health services that were not accessible in other parts of the city, also contributed to the sense of having no place else to go. In many situations the services in the neighbourhood not only responded to some of the needs experienced by the women who lived there but also created a situation in which women could not leave if they needed to receive these services. This was

particularly evident among women receiving prescription methadone. Women described being “down here” in relation to their appointments with their “methadone doctor” and although they acknowledged that other physicians “out there” prescribed methadone, the wait lists for physicians and the perceived lack of knowledge among physicians unfamiliar with people from “down here” contributed to a perception that accessing appropriate methadone maintenance treatment or other health services would be problematic in another neighbourhood.

### **A Place of Exploitation and Abuse**

In comparing the paradox of oppression and freedom for women within the city locale, Wilson (1992) noted that cities are increasingly becoming “playgrounds for the rich and dustbins for the poor” (p. 158). While the DTES was experienced paradoxically as a place of escape and an unavoidable place, it was also a place where women were violently abused and exploited. Men from “out there” and “down here” came to the DTES to buy and sell drugs and sex, and to engage in violent activities, frequently at the expense of women’s safety and dignity. The women’s stories reflected a recognition that violence and abuse existed “out there” beyond the DTES, but also demonstrated that women “down here” were considered more vulnerable and at greater risk for abuse than women elsewhere in the city.

IP(001): Down here it’s [violence] rampant, and I’m not saying it doesn’t happen in other places but its just people from down here seem to attract it because men come down here that want to do it to women because they know they can intimidate them, because a lot of the women already have issues, you know, its sad, but that kind of a man loves an easy target, you know, they don’t want to have to fucking fight with a girl. They want to be able to intimidate her easily to get what they want, you know, if they want her to go make some money, you know, go sleep with some guys to get them high they just want to have to say ‘go do it’ and they do it right, they don’t want to have to argue with her, you know. Yeah, they want to be in control and a lot of, most of the guys that come down here are that kind of a man.

In the DTES women faced relentless harassment, public scrutiny, and threats of violence. The women reported that local services such as restaurants and corner stores often refused to serve them and that they were repeatedly chased away or forcibly removed by security guards.

They were also at times, mistreated by those whose job it was to protect them and/or provide important health and social services. It was a place where women believed that their concerns and life experiences did not matter to people from “out there” particularly health care providers, law enforcement officials, and government representatives. Women’s reflections about the criminal trial of Canada’s largest alleged serial killer, dubbed the “pig farmer,” who targeted women from the DTES illustrated that they believed that women were considered of less value than other women in society by others “out there.”

IP(001): Do you know that the people that are there to help you are not even doing their jobs...a cop gets paid an awful lot of money but they do nothing to help you. Basically they’re worse, they’re the ones that we have to watch out for...when I was thirteen to sixteen I got raped by a cop...and you know what, until this fucking, oh sorry, till that guy got charged, the pig farmer, those cops they didn’t give two shits about us. They just thought, ‘ah, who cares, another hooker dead,’ I mean, you know, we’re not throw away people, we are human beings and we deserve to be protected, you know, not thrown away because some idiot thinks that its too much of a headache for him, you know? Who the hell are they to judge? It sounds like they’re the ones that are the criminals...they know what’s happening, they’re just as bad as that pig farmer.

### **A Place of Positive Possibilities**

As noted by Massey (2005), places represent the social processes of contestation and negotiation and it is through these processes that positive experiences and meanings can simultaneously endure in the presence of more oppressive relations. Women were not passive players within the realm of their day-to-day lives and “down here” did not always represent a negative place, even among women who acknowledged that they lived in the DTES because they could not afford to live anywhere else. There was a sense of belonging experienced among many of the women who lived “down here.” Belonging was attributed to having a sense of identity within a group; women described being able to be with people who shared similar experiences, or being with other “drug users,” “addicts,” or “crack heads.”

IP(010): People drive down here and you hear of them locking their doors and everything because they see us smoking. But we are the most harmless people you would ever meet...and when you’re on the skytrain or whatever going out to Surrey, you know you get these rude, ignorant people if you are dressed like this [points to her clothes] or

because of what it says on my shirt [Native]. But I am proud of who I am. And I'm a crack head. I don't care, think what you want.

People who lived in the DTES frequently “watched out for one another” and “took care of each other” especially when avoiding harassment from members of social groups that represented positions of authority, for instance the police. Code phrases that specifically alerted people to a police and media presence were common.

IP(010): But you know what, we have each other's back. We will say ‘they're filming, they're filming’ or like when the cops are doing their sweeps or whatever, you know we are like ‘six up’ we're not stupid, we help each other out.

The custom of helping each other out was also evidenced through the practices of sharing information and harm reduction supplies. Older women (e.g., between 40 and 60 years of age) shared strategies with younger women involved in sex work to help them try to be safer on the street. They told women to “trust their gut; don't get in a car if it feels bad” and “try to have a spotter [someone to note a description of a date and licence plate of car] when you are out there.” They carried extra condoms for the specific purpose of giving them to younger women who may have been more hidden from regular outreach service patrols.

“Down here” represented a place of familiarity and this contributed to a sense of feeling safer within the neighbourhood than elsewhere in the city. There were certain places that women could run to (e.g., a local store) if they ran into trouble and friends or outreach workers that would know if they went missing. This was particularly relevant for women who worked in street-based sex work.

R: So it sounds like it's important to know your space?

IP(001): Absolutely, your surroundings, yeah, absolutely, I mean, if I knew a certain area then I'd know that I could at least maybe run to someone's place or maybe to a store that I'm familiar with or something I'd know the neighbourhood.

Women drew upon their knowledge and experiences of living “down here” to justify their position as expert knowers concerning the injustices that women experienced and attributed their

experiences of being “down here” to providing them with a sense of purpose. Several women were politically active in fighting for improved access to better housing and health services as well as making it a “safer place for women.” Women served on local community committees, participated in community forums, worked as volunteers at local drop-in centres, and I spoke with several women who were considered community spokespersons.

IP(002): Yeah, I’m on a mission so now I have a reason to be down here. I ended up realising how big the issues were down here with social housing and I started to be quite an advocate. I got right into the politics of it all...I spent eight months on the street in the pouring rain in a one man tent...we were going to rallies...we had quite a strong voice...I want to make a difference, if I help only one other person, then it is worthwhile.

### **Women’s Day-to-Day Lives: Intersectionality and Place**

The relational processes inherent with women’s representations of “down here” intersected with race, gender, class, and damaging stereotypes concerning people who use illegal substances to significantly influence the day-to-day experiences and activities of the participants. Of particular relevance was the impact these intersections had for women’s experiences within their homes, of finding shelter when they did not have a home, and of “being out in the open” (e.g., walking on the street, being in an alley, going to appointments).

### **Home: A Complex Place**

Provider(001): Well, yeah, if you don’t have a home to go to, and so many of them if they have a hotel room, well they don’t turn the heat on all winter and it is like, ‘oh, somebody has been coming into my room’ and then you get the bugs, the bed bugs and the mice and the, whatever, and its like, you know, its not like us going home to our nice warm beds and feeling safe.

The preceding quote from one of the service providers eloquently illustrates the complex social relations embedded within women’s experiences regarding their homes. McDowell (1999) posits that *home* is one of the most complex words in the English language, particularly in relation to its many diverse symbolisms and meanings. Massey (1994, 2005) argues that beliefs about home as a private place of stability, security, nurturance, comfort, and permanence portray a romanticized version of home that discounts the power relations that shape home places and

the experiences of those within these locales.<sup>19</sup> She and several others (McDowell, 1999; Pratt, 2004) argue that this romanticized version of home is gendered in that home places have been equated with a version of “feminine” that has served to maintain an oppressive stance in which home represents the place where women belong and whose purpose is to provide for others. It has also been argued that home places, particularly among those who have been colonized, are places of disruption, transience and segregation and have served to reinforce sexist, racist, and class based dominant ideologies (Collins, 2000; Razack, 2002a). By contrast, hooks (1990) viewed home as a site of resistance where Black women constructed a locale in which “...all black people could strive to be subjects, not objects, where we could be affirmed in our minds and hearts despite poverty, hardship, and deprivation, where we could restore to ourselves the dignity denied us on the outside in the public world” (p. 42).

Within the realm of this project, home was used to refer to specific places where women lived and as such encompassed the physical structures and social relations that both produce and are produced within these places. There were multiple and varied home places and, “each of these home places [was] an equally complex product of the ever-shifting geography of social relations past and present” (Massey, 1994, p. 172). Home places reflected, to a large extent, the dynamic and complex sexist, racist, and class-based power relations inherent within the construction of the DTES and the experiences of the women who lived there. Home places were specific locations that afforded women little or no protection from harm. However, given the dynamic nature of place, home was occasionally a place of possibilities that contributed to a sense of comfort; be it through interactions with others, provision of food, or a place to escape from being out in the open.

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<sup>19</sup> The concept of locale includes a physical space that exists in relation to others (a location) as well as the relational attributes that make a place distinctive (Curtis, 2004).



## **Home: Structures and Locations**

The majority of women (73.8%) who participated in the survey reported having a “regular place to live” (see Table 3), which was interpreted as women having a place they considered home at that particular moment in time. As illustrated in the narratives of women who took part in the kit making and formal interview activities, SRO’s, usually referred to as “hotels,” were the most common living arrangements. SRO’s were buildings that consisted of varying numbers of single occupancy units (e.g., ranging between 40 and 100), shared washrooms and limited kitchen facilities. Rent ranged from 325 to 375 dollars per month. Many of these buildings were in a state of decay and infested with bed bugs and mice. Low-barrier, affordable (e.g., rent supplemented) housing within the DTES was home for a smaller number of women and encompassed a diverse range of services including emergency shelter, self-contained apartments, and support staff to assist women to enhance their independent living skills (City of Vancouver, 2007). Supportive housing, such as housing designed for women receiving mental health care, addictions treatment, or care associated with HIV and AIDS was home for very few women and the majority of these homes were outside and/or on the border of the 10 block radius of the DTES.

**Table 3 Shelter and Safety among Survey Participants**

Characteristic	n	%
Regular place to live	126	
yes	93	73.8
no	33	26.2
Feel safe where you are staying	125	
yes	92	73.6
no	33	26.4
Safe place to go in the day	125	
yes	100	86.4
no	25	13.6
Safe place to go in the evening	124	
yes	111	89.5
no	13	10.5
Safe place to go in the night	124	
yes	97	78.2
no	27	21.8

### **Home: A Temporary Place**

For the majority of women who took part in kit making and formal interviews, home was a temporary location. Women moved frequently from one SRO to another, in search of a safer, cleaner, and cheaper place to live. Eviction due to buildings being condemned or because women could not afford or neglected to pay their rent was common and violence, robbery, and exploitation among roommates also contributed to the need for relocation.

IP(003): We lived together for three weeks. So what happened, I had all my stuff in the [hotel], right, and I had given it to her for safe keeping, to put away. So I'm going, 'where is my big black hockey bag', and she says 'I will look for that stuff with ya when I get back from [name of city she was going to visit]', okay, fine, and the minute she is out the door I am up looking for my stuff and not one thing was left. She stole everything and she told me after I confronted her on it that it was my own fault for being a mark. She said 'If you are stupid enough to be a mark, you deserved it.' I had a chicken burger in my hand and I launched it against her face. So it was the end of our friendship and I had to move out. I still don't have a place to live.

Landlords' abusive and exploitive actions were also a source of conflict that caused women to move. Many landlords charged guest fees to residents of the SRO in the amounts of

\$10 to \$25 per visitor. There was recognition that these charges were illegal but fear of having to relocate, in light of the lack of available safe and affordable housing in the DTES, resulted in many women paying the fees. Other women who tried to address these concerns were often punished and left with no option but to relocate.

IP(101): I used to live in [name of SRO], but I made a complaint against the manager cause he was charging guest fees. He stopped accepting my mail and told people like my worker that I didn't live there anymore. I had no choice but to move. That's what happens if you are creating problems.

Women's explanations regarding exploitation by hotel management reflected the mechanisms by which intersections among gender, poverty, and problematic substance use operating through disciplinary and interpersonal relations of power limited the options available to women to resist this exploitation. The sense of futility was readily apparent within the women's narratives.

IP(007): You know, for the longest time nobody did nothing. I mean when you're a drug addict, I mean you don't have time to fucking, you know, you've got, you're too busy trying to make money for your next fix right so they take advantage of that kind of thing.

Gender, intimate partner relations, and the regulatory rules governing the policies of supportive housing also influenced women's experiences of having a home place. Women discussed giving up their home when they lived in a facility that did not permit their "boyfriend" to live with them. In some instances, women gave up their supportive or low-barrier home places and eventually ended up without any place to call home.

IP(123): I was the stupid one, I left Native Housing because of my boyfriend. They said he couldn't be there so we moved home [back to their hometown] and he just used way more. Now I am down here again, alone and I have nowhere to live.

Despite the many negative experiences that contributed to frequent relocation, humour was a consistent strategy employed by women to deal with the temporary nature of home.

Women joked and laughed about all of the different places they had lived and the events that occurred that contributed to their relocation. The story of a 59-year-old woman who had lived independently in the DTES since 14 years of age highlights this fact.

IP(008): Oh yeah, I lived in a lot of different places. I lived at, its not there no more, [hotel], I used to work downstairs in the bar and I worked upstairs too [laughs], I worked at the Sunrise, it's not the Sunrise anymore either... Where I live now, I like it. We've got free cable. I don't mind the ninth floor because it's pretty quiet, people there don't drink or do drugs... Yeah, I've lived in some places here, Main and Cordova... I was there when I first came to Vancouver, I only stayed there for about six months... The drunks knocked on my door and I said 'get away from my door, I don't want to see you.' I had a sign 'knock at your own at risk.' [Laughter]

### **Home: "It's Not Your Own Place"**

Massey (1994) argued that dichotomizing home as a private versus public locale is problematic as places produced through unequal power relations can rarely be reduced to either one or the other and in most cases reflect both of these attributes. This was the case for many of the women in relation to their home spaces. Most women reported that they lived alone and few had children or partners living with them on a permanent basis. Yet, a more complex analysis of the data revealed that living *alone* usually referred to a woman's experience of being the sole name on a lease and the person responsible for paying the rent. It was a rare occurrence that home was a place where other people did not live (albeit temporarily) or have expectations of access. Homes were private places in regards to housing women's belongings; they were also public places which other people could easily access and in some instances control what occurred. "Boyfriends" regularly moved in for periods of time and many women experienced a sense of having little control over this decision. Having a boyfriend was frequently equated with having protection from other men. This protection usually came at great expense including having boyfriends live in their homes, being forced to sell dope or engage in sex work to supply a boyfriend with money, being his sexual partner, and more often than not, being violently assaulted. The following two excerpts from interviews with kit making participants reflect these experiences.

IP(054): I just can't go home anymore. It's like nowhere is safe. My ex is trying to get me and [name of another man] has been staying in my place the last couple of nights and I don't want him there. I don't know how to get him out. Now he is telling everyone he is my boyfriend and saying to me I'm your boyfriend now. I don't want a boyfriend, I don't want to go through all of that [e.g., beating, forced sex work] again.

IP(033): He [previous boyfriend] can get into my place where I live. He is out to get me, so I can't go home. My new boyfriend doesn't get home until one in the morning, so I have to find somewhere safe until then...And I will have to save 10 of this 20 dollars I got today here doing this [kit making] for him so he can get smokes or something.

Home places were also the site of harassment and exploitation by police and municipal city officials, whose actions frequently negated the notion of home as a women's own place. Impromptu inspections by fire department officials were common and police frequently dropped by unannounced, particularly during the time period when welfare cheques had been issued. These practices demonstrated that women who were poor and labelled as drug users were not afforded the basic rights of notification prior to fire inspections or maintenance work and non-random visits by police. In essence, these practices reflected the dominant ideology concerning which members of which social groups are deserving of these basic rights.

IP(006): Yeah, I was constantly harassed, by the police. Which totally mystifies me because the only housing that I could get at the time, that was clean and I could afford was here [in the DTES] in the apartment building above Pigeon Park, um, a really small building... As soon as they [police] knew I lived down here, they came over so much that on welfare day I left my door open for them because I knew they were coming.

R: Why did they come?

P: Because I'm a recovering addict. So they just came, to the point where the social worker because, obviously when [my daughter] was first born we had a social worker until she was, I don't know six months and then they terminated it right, they didn't consider me a risk. She had to phone them and say 'if you do not stop coming to her place I will charge you with disruption, I will do it myself. I work with this family and if I don't consider it fit for me to be going over there then you do not need to be there, have you found any drugs, have you seen any drug use, have you seen any people there', 'um, no, no, no,' 'then why are you there?' 'Because she's an addict.' Yeah, a recovering addict which gives you a right to invade my space and they said 'we're just here to help you, support you', then can you do it open and honestly like ring my buzzer and not ring my neighbours and humiliate me by telling them you're coming to see me so I walk out my door and all my neighbours are staring at me like I'm a freak.

In situations where police presence in the home was seemingly an attempt to assist women, it was apparent that these circumstances still bespoke a sense of police being able to enter women's homes without their permission. Women could not necessarily expect that the

doors to their homes would not be opened unexpectedly or that they could experience a sense of privacy.

IP(010): The police come to my house like maybe every third or fourth day since he beat me...yeah, they actually literally got the manager to unlock my door to see if I'm ok, but I was sleeping. I woke up when they were coming in.

R: So does it feel good though that they are looking out for you?

P: Oh yeah, I give the police a big hand because they even stopped me in front of the [name of hotel] last week and it was just after he beat me up and the officer said 'you know [participant's name], we don't want to come over to your place and we have to identify you, ...you know?' Those are harsh words but coming from them...and this is funny, we were just talking about this at the women's group, I said to my friend 'I can't even enjoy a toke anymore because I'm scared the cops are going to come there and smell it.'[laughs].

In addition to the lack of privacy women experienced within their homes, maintenance crews routinely worked at night, disturbing women's sleep and removing their access to washroom facilities. There were limited options for women to fight against these disruptions for fear of retribution by landlords.

IP(093): I am tired because I didn't get much sleep. There were men in the building last night who were supposed to be fixing the bathroom. It was like midnight or early in the morning...They were supposed to be working, but you know, they are just in there doing dope. Yeah, this stuff happens in a lot of the hotels. The landlords don't care. And you can't call the police because then you will be a rat. And then you might not have anywhere to live or other stuff can happen.

The lack of privacy and the ongoing disruptions and harassment were experienced by all of the women, not just those living in SRO's. Women living in supposedly secure buildings such as supportive and low-barrier housing with around-the-clock staff also experienced a sense that their homes "were not your own".

IP(171): People come into your room because you have housing, you know, a regular place to live. People come to sniff the place out, you know, see what you have. Men are always looking for some girl to put them up. Guys are always checking your place out. This happens with men that you don't even really know, that they might just be there with someone else or they are some guy that you end up smoking with or something like that and then he won't leave.

In some circumstances women attempted to reassert with men that this was *their* home place.

More often than not, this resulted in violence.

IP(010): Yeah, like we were together every single day in the last month and everything was going good right? And I just wanted my space at that time but he was high and I was high and I said 'come on just go home. I can't smoke no more. I want to go to bed.' Right away he thought I was up to something. He just freaked out. That's when it happened [the beating that resulted in her current legal action against him]. The last time it was this bad he kept twisting my arm until he broke it.

Ultimately, the experience of not having a home be “your own” was constructed in part by gendered and class-based systems of oppression that were reinforced through women's interactions with men and people in positions of authority as well as the organizational practices of the disciplinary domain of power. Ideologies concerning women's roles in relation to men, particularly with regards to creating a home and having the explicit purpose of serving the needs of men were evident and often contributed to exploitation and abuse (McDowell, 1999). The practices of municipal workers (e.g., law enforcement, fire department) represented a disconnect between women's civil rights within municipal by-laws and what they actually experienced. The futility to resist these practices reflects the negative influence of domination for those constructed as Other.

### **Home: The Place Where “Police Don't Do Anything”**

As noted previously, violence within women's home places was common and took many forms including beatings, rape, and the constant threat of other people in the building “freaking out” and contributing to possible harm. The women's stories illustrated a sense of futility with regards to being protected by police in that police often did not respond to women's 911 calls for help, or when they did respond, their actions perpetuated the assaults experienced by women. This lack of protection and racialized violence at the hands of police was illustrated during discussions among a group of Aboriginal women with regards to the actions of police in their neighbourhood.

IP(032): I called the police because of my friend next door. I could hear her, and I knew that she was being raped. So I called the police. And when they came and interviewed her, I knew she was really scared and shook up. But they wouldn't let me be with her while they talked to her. I don't think this was very fair that she had to be alone. I waited out in the hallway until they were finished and then these two cops came out. One of them says, 'what are we doing here anyway? How the hell can you rape an Indian?' I know this is horrible, but it is not surprising given how Indian women get treated down here. That sort of stuff happens all the time. Prejudice still exists today but it is just more hidden, but it's still there. The cops are all racist and they [the police] just don't care.

The women perceived that the lack of police protection within the home and the exploitation the women experienced by men was influenced by their lack of worth within society; an experience that was attributed to their use of substances and involvement in commercial sex work. There was a belief that nobody cared what happened to them and a futility concerning the likelihood that these ideologies concerning women's value in society would ever change.

IP(113): That place is a bad hotel. I found it strange that the smoke detectors never worked. They were filming porno and women had no idea [she began to quietly cry]. I figured it out. It was weird you know, like what my boyfriend did and how he positioned me for sex. He would like, make me be a certain way. Like turning my head a certain way or how I was on the bed. And I talked to some of the other girls and they said the same thing. There is nothing you can do because if you said anything you could just end up in a dumpster if you did the wrong thing and that nobody would care. 'It is just another junkie whore' is what they'd say.

### **Home: A Place of Possibilities**

Given the dynamic nature of the social relations that produce and are produced by home places, it was not surprising that the experiences of women within their homes could not be dichotomized as simply "good" or "bad." There were many positive facets of women's home places. Home places, particularly when located within low-barrier and supportive housing facilities, provided a "roof over your head", a place to gather with friends, access to food, supportive staff that could intervene on a woman's behalf, and a "better place" where women could live with their children or partners. The processes by which these positive experiences played out varied among the women and were influenced by the location and structure of the



various home places. SRO's for example, were considered a more positive home place among many women who had been recently homeless and who had been living outdoors.

IP(104): I finally got a place to live. I have been on the street all summer but now I have somewhere to live. It's not that great a place, but man it was nice to sleep in a bed for the first time in three months.

SRO's and the low-barrier housing were also social places where women got together with their friends to "hang out." Hanging out often took the form of smoking crack with friends and was considered a safer alternative to smoking crack alone or in an alley.

Some low-barrier and supportive home places enabled women to have greater access to food. Women talked openly about being able to eat more regularly because they were living in particular housing facilities and that this contributed to their overall health.

IP(001): Living in Bridge Housing, I tell you, they make sure we have food which is good, because I probably wouldn't be so fat if I didn't have food [laughter]. Well I wouldn't be healthy if I didn't have all the food that I have. Mind you, the peanut butter and jam sandwiches aren't the most healthiest thing but the soups they give us, they are great.

Low-barrier and supportive housing also provided around-the-clock staff. The staff provided support services such as receiving prescribed medication from pharmacy deliveries, removing unwanted people from a woman's apartment and "looking out for women" when they were feeling unwell or in some instances concerned about harming themselves.

IP(172): My boyfriend is going to come and stay with me so I won't be alone. I have a friend who will check on me too. The staff here (women's housing) know I am scared of getting really sad and they will take care of me. I don't really want to hurt myself but I am scared that I'll be so sad on Christmas day that I might not think straight. I told them they had better put a trampoline outside my window on Christmas day. And they said they would make sure I was OK. That helps.

A few women with whom I spoke lived in supportive housing that was situated outside of the boundaries of the DTES. These home places were also places of positive possibilities in that provided women with more physical space within their apartments, which often permitted them to have separate bedrooms from their children. Being situated away from the DTES was

perceived as a positive experience that enabled women protect their children from the more violent aspects of living in the DTES.

IP(006): The only place that I could have got into quicker was down here and I refused to live down here with her right? It's not an appropriate place for her to be and I'm not going to shield her from the world but I certainly want don't want her to have to view it on a daily, twenty-four hour basis either. I mean luckily now like we're in subsidized housing so we have two bedrooms and so I can go have my own space in my own house and so can she.

### **Finding Places of Shelter: The Challenges**

As noted in Table 3, 26.2% of survey respondents reported having no regular place to live and 21.8% women noted a lack of safe places to stay between the hours of eleven at night and six in the morning. Because a lack of home places and safe locales exacerbated women's risk for violence, harassment, exploitation, and illness, those without home places often spent considerable time and energy trying to "find shelter." Women experienced significant challenges with regards to finding shelter that were influenced to a large extent by the high demand for shelter in a neighbourhood inhabited by people living in poverty who had no place else to find housing, and the unjust power relations that contributed to both gentrification and a dearth of low-barrier shelter facilities that provide services for women.

Over the past several years, gentrification in the DTES has contributed to the steady decline in the number of low-income units for singles (PIVOT, 2006). Between 2003 and 2005 there was a net loss of 415 low-income units and rent increases in SRO buildings continue to surpass the \$325 welfare allotment for rent. Although provincial and municipal strategies are being implemented to address these concerns, investigators reported that the number of facilities receiving government funding will not meet the demands of the residents of the DTES (PIVOT, 2006). It has been estimated that by 2010 the number of homeless people in the DTES will have doubled.

The participants recognized the declining state of affordable home places within the DTES and attributed these changes to the economic gains (e.g., increased rent) to be made by building owners and managers if they “renovated” an SRO. Renovations and rent increases were perceived as being related to the upcoming Olympic Games to be hosted by Vancouver in 2010. The women associated the declining housing with the Olympic games, based on their historical experiences of living in Vancouver during Expo in 1986 when they witnessed a considerable reduction in affordable housing.

IP(007): Oh yeah, that housing thing, that’s ridiculous like what are they going to do? I mean I keep going to Expo right, these Olympics right, what are they going to do, you know...they will rip everything fucking down here...they’re going to sweep it under the carpet, these people eh? I like to throw that out, what are you going to do when what do you call it [the Olympics] is over? You saw it with fucking Expo. I was here, yeah. Lucky I had places that I lived...that’s when you got like double beds in the hotels and stuff, you know, like places, for instance, the St. Helen’s and I used to live there. They got double beds and carpeting. Then one year later, jack the prices up you know. It’s going to be a big problem, they might be able to cover it up for the time being, for the Olympics, stupid man, they are just asking for trouble...after that, there will be a lot of crime and shit.

Economic barriers also contributed to the challenges of finding home places in that women could not always afford to pay their rent. As noted earlier, the majority of women lived well below the LICO and income assistance in the form of welfare payments was the dominant source of income. A single person considered employable in BC who passes the welfare eligibility criteria receives a total of \$510 per month, \$325 of which is allocated for shelter and \$185 for all other needs including food, clothing, and transit which averages to approximately six dollars per day (Wallace et al., 2006). The narratives of the service providers illustrated that while economic barriers were important, they needed to be understood within the scope of relations of power and systems of oppression that influenced the options available for women who are poor and use illegal drugs.

Provider(002): And when a women’s only, like the Vivian Transitional Housing gets put up and really fights to have a women-only low barrier housing, there’s protests and people trying to shut them down and it’s so sexist. There is this whole thing around ‘oh it’s a brothel in there and it’s this and it’s that.’ It’s amazing, like there is all these hotels

that are doing the most insane stuff and nobody questions it. Or there is tons of transitional housing that gets established and nothing is said. But then this women's one gets put up the community is like 'you should have asked us,' 'we want cameras,' 'they're hanging out outside.' You know it's totally crazy.

In addition to the challenges created by the reduction in the number of affordable home places to rent, accessing emergency shelters when without a home was tremendously problematic. "Down here" emergency shelters consistently operate at full capacity (PIVOT, 2006) and outreach staff and those working at women-only drop-in centres reported increasing challenges in assisting women to find shelter. Fewer beds were available for women within the gendered processes of shelter bed allocation in the neighbourhood and available places filled up quickly.

IP(073): We have nowhere to go in the night. Men have the [Union Gospel Mission] but women have nowhere to go and sleep when it was cold. We aren't allowed in there. We need a place to go get warm too. I was out the night before last and it was freezing. It is worse now that the weather is getting worse. And you know [name of residence] has 45 slots for men but only 12 slots for women. Why is that? Other places have no beds for women at all. Women are left out in the rain. There just isn't enough housing for women. There are way more women down here than men but people think it is the other way around. There are lots of women with nowhere to go.

Too few of these available beds were low-barrier which prevented women who were using substances from being able to access these facilities. Women who were "using" were increasingly segregated from safe places to spend the night an experience that illustrates the oppressive ideological assumptions about women who are poor and use illegal substances that underpin the practices of shelter organizations. "And you see those, the ones that will take people who are using and are in the most fucked up state, are usually the ones that are fuller and faster" (Provider001).

Rules limiting the length of time that one could remain at a shelter also contributed to women's challenges in locating temporary shelters. Some shelters regulated their beds by requiring people to leave at 6:30 in the morning while others locked their doors at a specific time of night. If a woman arrived after lock-out time there was no option but to stay on the street. One

shelter limited the amount of time women could spend in the facility. After 30 days they were forced to leave regardless of whether or not they had a home place to go to. The following excerpt from one provider who was attempting to find shelter for a woman at her agency reflects these experiences.

Provider(001): So, they'll [shelter staff] be like 'she can't come back for thirty days' because if you stay there for a certain amount of time then you have to wait thirty days before you're allowed to come back. So one of the girls right now is sleeping in a garage because she used up all her time at one of the places and can't go back so she has to wait out the thirty days and then try to get a bed again. She loved the place, it was great but now she can't get in anywhere so she's sleeping in a garage downtown somewhere. She's like 'I've got a headache from all the fumes of the cars' and I'm going 'oh dear, do you know how dangerous that is' and she say, 'yeah, but its warm right there.' Like warm and waking up dead, you know, like you've got headaches from the fumes, you need to move so, so every day that she doesn't come in or comes in late I'm just waiting for her to show up because I just have visions of, you know, her not waking up.

The fear associated with “other people” staying in a shelter and the actions of the shelter staff also contributed to barriers in finding shelter. Women expressed concerns for their own safety when housed with people considered violent or “seriously mentally ill.” In addition, reports of aggressive actions by staff were not uncommon.

### **Out in the Open**

IP(160): The woman at the second station said that her biggest fear was being found dead in an alley naked, by the cops. She asked the others to promise to cover her if they found her.

Intersections between race, class, and gender embedded within relations of power also influenced women's experiences outside of their homes in the places they commonly described as “out in the open.” “Out in the open” included the multiple and dynamic places within and outside their neighbourhood where women went about their regular day-to-day lives. These activities included but were not limited to attending appointments related to health care, income assistance, housing, and legal issues; visits to local drop-in centres; work related activities such as peer-outreach, sex work and drug selling; shopping; educational activities; attempts to find shelter by those who did not have a home place; buying and using crack (or other substances);

and obtaining drug using equipment. “Out in the open” inferred a certain degree of unavoidable visibility beyond what they experienced within their home places particularly in relation to the general public, the media, men from “out there” and the police. Being “out in the open” increased the accessibility of women to those who could harass, exploit and physically endanger them. Conversely, “out in the open” was also a place of escape to take a break from home places and violent partners, a place to socialize, and a place where a woman could find protection. These contradictory yet simultaneous processes associated with being out in the open were not surprising given the non-static nature of socio-spatial places.

### **“Always a Target”**

Cities as places of violence against women have been of increasing concern to social and feminist geographers over the past several decades. The majority of this work has focused on the “safeness” of city structures (e.g., location of buildings, lighting, and bus stops) as women move between places within a city locale. More recently, Listerborne (2002) has called for a more critical examination of the relations of power that construct city structures to more fully appreciate women’s experiences of fear and violence within the city. While little work has been done to examine violence within a geographical context among women who use crack cocaine, analysis of the experiences of the participants illustrated that violence and anxiety related to the constant threats of violence, were legitimate concerns for women when “out in the open.” The violence was associated with the specific activities in which women were engaged including moving between places, seeking shelter, working, and using out in the open. Although these activities are separated here for discussion purposes, overlap among these activities was common.

### **Moving between places**

Women's mobility and visibility on the city streets contributed to their likelihood of being harassed. Women rarely walked from one place to another without being approached for sex, the offer of drugs, or for people to demand that they give up personal items such as cigarettes or food. On one occasion, for example, while a group of us were leaving an agency, one woman who was carrying a tray with two muffins was approached by a tall, heavy-set man. He called out to her and she smiled but kept moving and he simply stepped in front of her and asked for her food. She responded, "I need this. Look how skinny I am." He kept walking in front of her and saying "come on." The facilitator and I positioned ourselves on either side of her and walked out of the building. He followed us to the outside, but did not approach her again. Later when I asked her about the incident she commented, "oh yeah, that happens all the time. People are always trying to get something you have."

Women were also targeted by film crews from local television news stations and independent film makers. There was a sense of frustration related to "always being filmed" or "always having to watch out for a camera" and women were rarely asked for permission to be filmed. Film crews were often on the street and in alleys, and were usually accompanied by police. On one occasion I noted that there was a television news crew accompanied by police and talking to a woman who was standing on the street. She was an older woman, probably in her 60's and she was swaying from side to side. I wondered if maybe she was starting to experience withdrawal. The light from the camera was almost blinding and they had a huge microphone directly in her face. There were two police officers standing off to the side in uniform.

Policing practices were also a source of concern for women when they were out in the open. Women were frequently approached by police and detained for questioning while they attempted to go about their everyday business. Women described the harassment as "relentless"

and “unfair” and the data also reflected that harassment was at times targeted, purposeful, and racialized.

IP(006): My daughter was three weeks old, she [my partner] walked from the apartment to the store which is like a half a block and they [POLICE] already nailed her and were hauling her back, ‘what are you doing with this kid’, ‘its my daughter’, ‘no it’s not’, ‘yes, it is my daughter.’ Yeah, and you know what she was told, ‘you don’t look like your child.’ ‘What because I’m fucking Native, like excuse me, you go do this in the west end and see what happens to you, right?’ So what about all these kids that are adopted, and stuff like that, I mean inter-racial marriages or whatever, I mean not everybody looks like their frigging kid. Yeah, and the thing is that it’s not just me it happens to so it makes it even fucking worse right? And I mean what happens when you can’t afford to live anywhere else, it’s a shitty area.

Targeting and harassment also took the form of men waiting for women outside their homes, drop-in centres, and community clinics. Men waited for women to bring food from women-only locales serving food and threatened women with violence if they did not give up their food. It was not uncommon during kit making sessions for men to interrupt a session to let a participant know he would be waiting for her when she was finished and this was most frequently associated with sharing a woman’s financial honorarium or her harm reduction supplies (e.g., pipe) obtained during the session. There was an ever-present concern for their safety particularly when women knew that “someone was out to get them”. Ex-boyfriends were the most common people identified as trying to find women and women expressed tremendous fear for their safety in relation to being found while out in the open.

IP(054): I hate going outside because I know he is always looking for me and now he has his friends looking for me too. There is always one of his boys around saying things like ‘guess who I saw today’ or ‘he would love to see you’. It’s like people are always trying to get at me. I worry what he might do to the other girls [women who lived in her housing complex]. I don’t want anyone hurt because of me.

Later when the facilitator and I were alone and talking about our concerns for her, the facilitator sighed and said, “And the worst part is that we can try and do all these things to keep her safe, but eventually she is going to be out there on her own and he will probably get to her.”



### **Working out in the open**

Street-based commercial sex work was the primary activity associated with working out in the open. This type of sex work usually involved women “out in the open” on particular city streets with the intent of engaging in sex for money exchanges with men who solicited these services. These streets were, more often than not, areas of somewhat less traffic than other busy streets. Women usually worked throughout the hours of the evening and well into the night. The action of participating in commercial sex work reflected intersections of gender, poverty, and substance use. As noted previously, street-based sex work was one of the few options available for women to obtain income or to supplement their \$510 monthly income from welfare, and in some instances was an activity that was forced upon them by boyfriends. The need for money was also intimately connected to substance use.

IP(004): I've been like working the streets for like five years since I have been down here. And, you know, for the most part its been okay, I mean I had one potentially bad date but, you know, its just that, you know, I am a drug addict so, you know, I have to do it, you know, and the hours are like you go out all night and I came in around five and sleeping like till two or three and it just screws up my whole day, you know?

The nature of sex work required that women regularly get into cars with unknown men or perform the activities in secluded alleys with little or no protection. Women suffered severe beatings, were raped, kidnapped and dumped out of town, robbed, not paid for services, and were victims of motor vehicle hit-and-runs. Bad date sheets that described women's experiences of assaults and physical descriptions of the man (or men) and the vehicle were circulated weekly to local agencies frequented by women. These bad date sheets, which have been in place in the DTES for several years, were viewed as a tool to help women recognize these men with the hope that they could avoid doing a date with them. It was also apparent, however, that these sheets did not truly reflect women's experiences.

Provider(001): I mean there's all kinds of different criteria what they consider a bad date or what they, whatever I mean there's, what they go through on a daily basis, I mean where is your norm? It changes all the time depending on if you've been using or if you

need to be using or if you're going to get beaten if you don't do the date or maybe the date is not as bad as what you're gonna get at home, there's so many variables...but generally speaking, if they get their money, they have to be pretty bad to be a bad date.

Many women expressed feelings of constant anxiety due to fear for their personal safety, never knowing what might happen, and the possibility of being killed. The current trial of the "pig farmer" and the frequency with which women "go missing" from the DTES were regular topics of discussion in relation to risks associated with working out in the open.

Provider(003): It's a bit cliché now with the Pickton trial, but it's like every day when I think whenever a woman gets into a car, she doesn't know what will happen next, or whenever she gets some drugs, you have the hope that nothing will happen but you cannot really tell.

Within women's stories, it was apparent that substance use, lack of money, and domination by men all contributed to the violence they experienced. These intersections were perceived as different from "everyday women" or other women in society who were not from "down here" and not visible on the street.

IP(002): I think down here especially because there are a lot more, uh, I guess easier targets in the sense you're a lot more vulnerable because there's drug addiction, there's a lot of sex trade workers. I think that any potential criminal activity happens a lot of time down here because you are such an easy target. I mean look at the pig farmer, for instance, he targeted women that were addicted street workers because he knew that they were vulnerable and he knew exactly what they needed in order to get through their day and used that to his advantage and that's sick in itself. But I think that because of that, yeah, there's some issues that might not be *everyday women* kind of issues like the working girls.

The changing drug market economy and related oppressive circumstances of women's lives were also contributing factors that increased the risk for violence among women who worked out in the open in the sex industry. The relationship between declining drug costs, reduced costs for sexual activities, and the related temporal factors were of particular significance, as effectively demonstrated in the following quote:

IP(134): Have you thought about the link between the sex work costs and the drug market. It used to be that it used to cost 40 dollars for a blow job and a rock costs that much. Now a rock is 10 dollars and so is a blow job. The cost for sex is going down and

that means women have to work more and are more at risk because they have to be out there longer and do more dates.

As in other places, women were not provided with protection from police when “out in the open.” Police failed to respond to their reports of violent dates, and instead, targeted women for arrest and harassment.

IP(183): I went to the police when I had a bad date. He robbed me and beat me. You know I told the police this and they said to me ‘well, you shouldn’t be working.’ Like this guy just beat me up and it is all my fault because I am working?

IP(121): I’m on probation. Yeah, a john approached me and I said OK that I would do the date and we went to a bank machine so he could get money. I was out in Surrey. And then these cops came up and arrested me for working, but nothing happened to the john. I think it was a set up. I don’t know why they did that. The police set up women all the time who are doing dates.

R: What usually happens to the johns when women get busted?

IP(121): Nothing ever happens to them. They really only target the women.

Women had very few safe locations that they could access to escape or to simply “take a break.” The only drop-in centre that was specifically for women working in the sex industry closed at 11pm despite a three-year effort to open a 24-hour facility. Any other locations such as the Health Contact Centre or the Supervised Injection Site are open to both men and women. While some women felt safe in these locations, others reported not wanting to be there due to being hassled by men or not wanting to be at a site where people were “fixing”. Women were left with a sense of feeling exposed and vulnerable to assault, robbery, and potentially death.

### **Dealing**

“Selling dope” or “dealing” was also a means of working out in the open for a small number of the participants. Dealing usually occurred on busy city streets, in parks, alleys, hotels and local bars. Customers included both people from “out there” and “down here.” Lawyers, medical professionals, and police officers for example, were reported to be regular customers.

IP(010): It’s just not downtown east side. My lawyer does it, I swear to God, my lawyer. When I used to deal at the hotel down the street he’d come there and score off of me. I’ve

known people, another lady she worked in a critical unit at Children's Hospital and she did it."

IP(003): Remember I was a dealer. My best customers were cops and their wives...you know, my middle-class customers. I had a lot of people that were real estate agents too.

Dealing, like sex work, was considered one of the few options available to women to generate income. Among some women, dealing was an activity forced upon them by boyfriends. Women who sold for their boyfriends were rarely permitted to keep any of the money they obtained and compliance with these rules was ensured by violence. Dealing out in the open also contributed to women being targeted during periods of intensified police activities (e.g., increased surveillance and arrests), commonly referred to as crackdowns, aimed at reducing drug availability, consumption, and related crime. Crackdowns occurred regularly and tended to exacerbate the violence inflicted upon women working out in the open.

Provider(001): Yeah and its always the women, I mean how often do they pick up the guy, its always the women and then the guys are there waiting for them when they get out of jail and it just puts them that much further in danger really, yeah, its frustrating as hell...and then you have the police crack down so they don't feel safe from that either because if somebody is forcing them to go out and deal and then they get picked up and then the police take the drugs and they owe that person the money because they've lost the drugs. That's one of the things that's happening right now is a lot of the cops are picking the girls up and then it makes life way worse for them because they do lose the drugs but they still owe the people and so they get beaten for that and then they're out there and they're having to work [sex work and dealing] more and it's a vicious circle so that, that's something that's been escalating for the last little while for sure.

Not all women who sold drugs did so because of coercion by their boyfriends. The few women that I met who were "dealing" and were willing to discuss their activity, viewed "selling dope" as a means to achieve better financial stability. These women were perceived among other participants as "more dangerous than men" and someone who would "rip you off" or "beat the shit out of you if you fucked with them" (IP053). The aggression on the part of women who were dealing was portrayed as necessary to survive as a dealer. "Yeah, I have my own corner where I deal. Women are very aggressive dealers, they have to be" (IP162).

## Using out in the open

Smoking crack (and other substance use) out in the open was a common occurrence among participants. There were many specific places where women smoked crack including (but not limited to) doorways on city streets, alleys, parks, parking lots, and public washrooms.

Smoking crack out in the open was associated with specific risks for women including being targets for rape, violence, and robbery; forced sharing of crack and crack smoking equipment; and harassment, humiliation, and arrest by the police. During the survey, for example, women were asked in an open-ended question to list some of the problems experienced by women who smoked crack. Representative responses included: “boyfriends - because they want half and if women don’t give it, they get beat up”; “at risk for rape or violence if they get too high”; and “being a target for men; guys hit on girls that are high.”

Smoking out in the open increased women’s visibility and contributed to others, particularly men, harassing women to share smoking equipment and crack. Women reported that threats of violence were common when they expressed their preference not to share. Women were concerned about sharing equipment due to the possibility of contracting infectious diseases and wanted to be able to “use their own dope without hassle.” The desire to smoke without hassles or violence occasionally played a part in reducing women’s mobility out in the open so much so that they rarely left their home places.

IP(171): You know, I have been an addict for over 40 years and that I don’t want to share anymore. This guy wanted to share but he had a sore on his mouth and I told him no way, I wasn’t sharing with somebody with a sore. I barely go outside anymore. Smoking in my room is more safe than outside. Then I don’t need to worry about sharing.

Certain locations were more problematic than others. Smoking in alleys was especially dangerous for women due to the lack of visibility within these particular locales.

IP(001): Yeah, because guys are preying on girls in the alleys...this girlfriend of mine, she was in the alley, she was smoking and two black guys came up and tried to rape her right in the open, in the doorway. She said that if a car hadn’t driven by and got them to turn around and she bolted that they would have raped her.

Despite these risks, it was apparent that more women were smoking in alleys than in other outdoor locations and this was chiefly due to the increased crackdowns by the police. Police actions contributed to women not carrying their own smoking equipment which increased the likelihood of having to share thereby exposing them to risks associated with smoking with men. Police frequently smashed women's smoking equipment or forced them to smash their pipes. Within the context of the survey data, 55 (43.7%) of women reported not carrying their own pipe or mouthpiece due to fear of being "jacked up" by police, 27% of women reported having their pipes smashed by police and 18.3% (23) women reported that the police made them smash their pipes. Women described these experiences with police as humiliating and degrading.

IP(072): It is really humiliating because they hassle you in front of other people and they humiliate you with what they say and do...they take your stuff, smash your pipe and then you have to go and work [sex work] and make some money so you can buy your stuff, cause they just smashed yours. That's hard."

The actions of the police contributed to a reduction in the number of safe locations out in the open for women to smoke and also influenced women's experience of the DTES as a place where people could "help each other out." Using in less visible locations meant that women were unable to assist each other, and this was considered particularly problematic for women who were described as "too high and not knowing what was going on."

IP(123): Police are charging for possession if you are using outside now. It used to be that they would just 'smash our pipes'. This is driving people way less out in the open and you won't be able to keep an eye on people or check in and see how they are doing.

### **Place of Possibilities**

Women's experiences of being out in the open were not always negative. When out in the open, women were able to assist other women to be safer or to give care such as identifying and acting on behalf of someone who needed to go to the Emergency Room. Women who engaged in peer outreach activities, which represented the majority of women who participated in the kit making sessions (and possibly the surveys, although there was no way to determine this), were

especially involved in providing assistance. Participation in peer outreach work included being on the street, in alleys and in areas where women worked. This work provided women with a sense of accomplishment in that felt they could be of some value to other people. It also provided a way to generate some additional income.

IP(002): Some people say what's outreach, I say 'well turn around reach out', outreach, its literally what it means, you're reaching out, I think anybody that can benefit from something I've gone through and not have to go through it is a good thing...so to me its beneficial in so many ways like I believe that everybody has a mission in life and I think part of mine is to be here and to be doing what I'm doing and doing the outreach and touching people's lives and realizing that I'm just a small, small spec in the big picture but I myself can have a huge influence on other people and that is like people say 'what can one person do', one person can do a whole lot.

In their everyday activities of moving between places, "out in the open" was also a place where women could accompany one another especially when a woman felt unsafe or worried. Women recognized the importance of "safety in numbers" and perceived being out in the open together as a means by which to build "a community of sisterhood."

IP(034): I was on the bus and a woman who got off the bus at the same time looked really nervous and asked where I was going and it turned out we were going the same way. I walked with her, because it's important that women not be alone.

Out in the open was a place where women socialized with each other and shared information about upcoming events or resources, for instance upcoming self-defence classes and a change in hours at a local drop-in centre. Seeing friends "on the street" that they had not seen for a period of time was one of the most positive aspects of being out in the open. Due to the lack of mechanisms such as phone or e-mail to maintain contact with each other, and the infrequency of women visiting each other in their home places, women often experienced a sense of loss and fear if another woman was perceived to be "missing." A woman was deemed missing if she was not seen for several days going about her usual activities of moving between places. Being missing was frequently due to admission to hospital, being ill at home, or in worse case

scenarios, being kidnapped or murdered. Being able to see a woman who had been missing was experienced as a sense of relief among other women who knew and cared about her.

There were also positive and supportive relations that occurred with men who lived in the neighbourhood. Many of the women reported having a “street brother” who helped to provide protection when they were out in the open. Street brothers were not necessarily blood relations, but men from the neighbourhood who volunteered their time and energy to enhance women’s safety in the DTES.

IP(008): Street brother is, well I met him when I was about fourteen, its just like having a brother but he’s not your real brother and I always call him my street brother, say when he went to jail, he got, uh, his friends to keep an eye on me when I was down here so I was, if I had any problems, they were there...yeah, in case somebody jumped me or something.

“Out in the open” was experienced as a complex series of processes, both positive and negative. These processes were intricately connected to the relational attributes of the place known as the DTES and the systems of oppression operating within women’s lives.

## **Summary**

In this chapter, I presented a comprehensive analysis of the everyday circumstances of the lives of women in the DTES who use and/or have experience with crack cocaine. Although there was diversity among participants, the majority of women experienced relentless harassment and violence across a variety of spatial scales and in relation to diverse groups of people including other women, men who visited the DTES, boyfriends, landlords, and police. Women lived in both absolute (low-income) and relative (lack of opportunity for income) poverty (Krieger et al., 1997; Reid, 2007) that contributed to poor housing and homelessness, engagement in sex work, and reduced opportunities for alternative living arrangements or sources of income. By contrast women’s day-to-day lives were influenced by the positive possibilities that being situated within the DTES were perceived to offer including a sense of belonging and a sense of understanding among other women who shared similar life experiences.



Each of these circumstances of women's lives were significantly interrelated and influenced by intersecting systems of oppression such as race, class and gender as well as women's individual strengths and capacities to deal with these circumstances on a daily basis.

## CHAPTER FIVE: WOMEN'S EXPERIENCES OF HEALTH

### Introduction

In this chapter I build upon the previous analysis to critically examine *how* the interrelationships among the women's day-to-day life circumstances and relations of power contributed to the myriad of complex and at times devastating negative health experiences. To begin, I present the main health concerns reported by women who participated in the Pre-Kit Distribution Survey. I then draw on other data sources to more critically examine how women experienced these concerns and include an analysis of the relations of power that influenced these experiences. For ease of discussion I have divided women's health experiences into the broad categories of *mental* and *physical* health concerns. This division functioned solely as a heuristic device for analysis. Mental and physical health were significantly interrelated, a fact that is apparent in the upcoming discussion.

As I organized the analysis for presentation, it became readily apparent that it was unfeasible to address every possible interrelationship between life circumstances, relations of power and each health concern. As a result, I focused upon select exemplars that were highlighted in the data that best reflect not only the dominant health concerns experienced by the participants but also make explicit the processes by which the systems of oppression and relations of power influenced women's opportunities for health.

### Experiences of Health: A Beginning Snapshot

The women who participated in this project experienced a myriad of complex and interrelated mental and physical health problems that were both chronic (e.g., arthritis, asthma, depression) and acute (e.g., pneumonia, oral lesions, psychosis, withdrawal) in nature. Many women experienced their health as a continuous worsening of conditions that, as they aged, contributed to chronic physical and emotional pain, disability and eventual death. The cross-

section of women who were currently using crack cocaine and who had participated in the Pre-Kit Distribution Survey provided data that serves to increase understanding of the nature of the general health concerns that the women had experienced over the course of the previous year. Their responses provided a snapshot of women's general health experiences and their self-reported health status, the results of which are presented within Tables 4 and 5 respectively. Both physical and mental health problems were identified within the top ten health concerns. Respiratory problems dominated the physical concerns while anxiety, feeling sad and sleep disturbances were the most frequently reported issues for mental health.

Throughout the entire project it was apparent that there were similarities and differences in how women perceived and experienced their health concerns. These similarities and differences were influenced by dynamic relations of power operating across class-based, racialized, and gendered systems of oppression, and were reflected in women's personal beliefs and assumptions regarding the meaning they attributed to their experiences of health concerns, the degree of access to material resources and health services necessary for health, pre-existing health issues, and the social interactions that they experienced with health service providers. The remainder of this chapter is devoted to these issues.

**Table 4 Prevalence of General Health Concerns Over Past Year (n = 126)<sup>20</sup>**

Health Problem	n	Valid %
Coughing up phlegm	99	79.8
Dry cough	93	75.0
Feeling nervous/anxious	92	74.2
Feeling sad/blue	83	66.4
Insomnia/trouble sleeping	82	65.6
Teeth/gum problems	81	64.8
Trembling hands/the shakes	74	59.2
Sore throat	73	58.4
Pains in your chest	64	51.2
Feeling paranoid	63	50.4
Burns on lips/mouth	59	47.2
Heart palpitations	55	44.4
Brillo <sup>®</sup> in mouth, throat, lungs	51	41.1
Skin infections/abscesses	47	37.6
Lung infections	45	36.6
Psychosis	38	30.6
Oral lesions (cracked lips/sores)	36	29.0
Broken bones/joint pain	18	14.4
Seizures	18	14.5
Other <sup>21</sup>	44	35.5

<sup>20</sup> The number of participants ranged from 124-126 and therefore the reported percentage varies to reflect the differences within the number of participants in each item. The range of 124-126 is due to missing data based on participants' non-response in some items.

**Table 5 Self-reported Health Status (n = 119; non-response to item n=7)**

Health Status	n	Valid %
Poor/Fair	63	52.9
Good/Excellent	56	47.1

### **Women’s Experiences of Physical Health**

Women experienced a diverse range of physical health concerns. Some concerns were acute or short lived, while others were experienced as conditions that worsened as they aged and as a result contributed to chronic pain, disability and eventual death. The level of complexity among the women’s experiences of health posed many challenges in presenting a systematic yet comprehensive analysis. To enhance clarity I have organized the key exemplars of women’s physical health concerns according to the relevant body “system” including the respiratory, musculoskeletal, immune function and reproductive systems. Each system is discussed in relation to the actual health concerns that women experienced and the influential factors that contribute to these concern.

#### **Respiratory Health Concerns**

Respiratory health concerns were those that involved a woman’s mouth, throat, nose, and/or upper and lower airways including her lungs (Porth, 2005). Women experienced a multitude of respiratory concerns including burns to the throat, mouth, and lungs; infections; and coughs and colds. Within the kit making sessions, women often described chronic respiratory concerns as “breathing or lung problems” which referred to experiences of asthma, emphysema, and bronchitis. In some instances women were unaware of the diagnosis associated with their

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<sup>21</sup> Examples of other health problems included asthma, pneumonia, musculoskeletal problems (e.g., sore back; neck pain, arthritis), diabetes, endocarditis, HIV, HCV, weight loss, swelling in hands and feet, PTSD, and traumatic injuries (e.g., head injury, stabbing).

respiratory problems, and understood them solely in terms of the symptoms they experienced. As one woman noted, “My lungs – there is all this stuff in there. I take medication for it” (IP153).

Recurring coughs, colds, and flu-like symptoms were common experiences for women involved in all aspects of this project. Statements such as: “I have had four colds in the last month” or “I’ve been sick for days with this cold” were common. Women complained of colds and flu-like symptoms in nine of the 18 kit making sessions, and six of the women who participated in the lengthy interviews had a cold at the time the interview was conducted. Women often became sufficiently ill that they were unable to leave their homes for several days to weeks at a time, which then contributed to them missing other essential health care appointments such as picking up prescriptions or following up with a physician to address another health concern. In most of these instances, the respiratory problem was more severe than a common cold, but women equated any new onset of “breathing problems” or sore throat with having a “cold.” Women described many scenarios in which they were at home “with a cold” only to have their health deteriorate to the point that required hospital admission, predominantly due to experiencing pneumonia.

Although lung infections were among the lowest occurring respiratory problems noted in the survey data (36.6%), during the interview and kit construction portions of this study there was an outbreak of pneumonia in the City of Vancouver that primarily affected residents of the DTES. As noted in a memorandum from the Vice President of Medical Affairs for Vancouver to physicians working within the local health authority, many of the people infected “...presented in septic shock and nearly a third required intubation and admission directly to ICU. Lengths of stay in ICU are averaging two to four weeks” (Providence Health Care, 2006, p. 1). Many women had either been hospitalized or knew of a friend who was hospitalized during this outbreak. The impact of pneumonia for women’s health was articulated clearly in the description

of the experiences of a 45-year-old woman living with HIV, HCV, asthma, depression, and arthritis who had been hospitalized due to pneumonia.

IP(005): My whole body was sick. Yeah, I didn't even know what it was. I was out of breath, walking to the clinic to pick up my script [methadone], having to stop all the time. This whole side here, [pointing to the front of her chest on one side] was like on fire and really hurt...And it was both sides. I was like 'check me out,' and she [her doctor] said '[name] you are going to the hospital right away.' She called the ambulance right away. I thought I would be there for four or five days [instead of three weeks]... Yeah and I didn't even know that I was that sick. It came up slowly, I figured it was just a cough, you know getting worse. But it really hurt.

Among women who experienced colds, many also experienced rhinitis that contributed to excoriation around their noses. During our conversations, women described these experiences as "very painful" and attributed this problem to "blowing my nose so much." It was not uncommon for me to observe severe chafing and dried blood around women's noses and women described a sensation of their "skin ripping apart" when they had to blow their nose. Access to tissues often meant taking toilet paper from a public washroom or requesting tissues from a drop-in centre. Due to their limited economic resources, women could not afford to buy tissue paper that was softer or had moisturizers within. They reported instead that they had to buy the "cheap stuff" and that these tissues and the toilet paper were "harsh" on their faces. Women also could not afford to buy creams or moisturizers that would help to alleviate the pain around their nostrils or prevent the chafing from occurring.

My field observations and interviews with women supported the survey findings that sore throats and laryngitis were frequently experienced. Many women's voices were raspy and on some occasions it was obviously painful for them to talk. Women reported getting a sore throat as frequently as once per month. While in many instances a sore throat was related to getting a "cold" or the "flu," in some instances the experience of a sore throat was associated with immunocompromise such as occurs with HIV: "I've had tonsillitis for a few weeks. My count [CD4] is low and I get sick really easy" (IP143). Additionally, many of the women joked

amongst themselves that sore throats were due to smoking crack as reflected in the following dialogue between two of the participants.

IP(092): I think I need some Halls or something, my throat really hurts.

IP(093): [Laughs and playfully taps the other woman on the arm] You smoke too much...that's what is going on.

IP(092): It's not smoking this time. I am coming down with something. My throat has been sore for a couple of days and it is really raw.

The experience of a sore throat associated with crack smoking was related to the drying of women's mouths and throats, due in part to the pharmacology of cocaine (e.g., drying effect) as well as burns that resulted from the inhalation of hot particles such as steel wool or glass. As one participant noted:

IP(104): Man, I swallowed my brillo and I just kept hacking and horking until I coughed it out, and that really hurt. I had this huge burn in my throat right here [she pointed to the side of her throat just below her chin]. It hurt really bad for about three weeks.

The inhalation of particles also contributed to the production of phlegm, the coughing up of which only further exacerbated throat soreness. Women expressed concern that the impurities associated with crack cocaine, a phenomenon referred to as "bad dope," also contributed to respiratory problems.

IP(010): My partner he deals with the Iranian guys out there, he works for them every day. When he comes home he has enough for us to get high. When I smoke that dope I'll get this really nasty cough and it feels like I can't breathe. It's a dry cough. But when I score off of other people I don't have that.

As women's health deteriorated over the course of their lives, respiratory concerns were identified as one of the most significant indicators for worsening health and women often associated these concerns with the experience of dying. This was particularly relevant for women living with HIV as evidenced by the following quote from a woman who had been living with HIV for 21 years and who was quite ill at the time of our meeting.

IP(171): I know that I am getting sicker all the time. I have been sick now for a while with my lungs. I know I might be dying and I don't want to die. I don't want to go



through that. [My doctor] said that if I don't get better soon I am going to have to go into the hospital. I don't want to do that. I don't want to die there. She said something about PCP. What's PCP?

## **Musculoskeletal Health Concerns**

The majority of women experienced a myriad of concerns associated with their musculoskeletal health including bone infections, reduced bone density, arthritis, impaired mobility, fine hand tremors or “the shakes,” and traumatic fractures, sprains, and soft tissue injuries. Women's general appearances illustrated that their bodies exemplified the realities of these health concerns. Many women walked with visible limps and several women over the age of 50 had noticeable facial drooping associated with having a stroke. Some women had mobility aids such as walkers, canes, or crutches, while other women reported needing such devices. Arthritis was prevalent among women over the age of 35 and was cited by women as the most significant factor contributing to their impaired mobility and chronic pain. Many women took frequent breaks during kit making to exercise “stiff joints” or to relieve pain particularly in their shoulders and lower back. There was significant frustration associated with impaired mobility, especially in terms of the impact on women's abilities to engage in regular daily activities.

IP(008): When I walk downstairs it takes me half an hour. If I go shopping I have to bring a, a cart for shopping or I ask my son to come with me...Arthritis is really hard.

Scarring was another physical attribute that exemplified women's musculoskeletal health concerns. The majority of women had a wide range of visible scars including surgical scars of the shoulders, neck, legs, arms, hands, and feet; jagged scars on the inner aspects of their forearms and wrists; and circular scarring patterns on the backs of their hands. Health issues such as reduced bone density, bone infections, depression, and fractures were frequently associated with scarring as exemplified in the following excerpt from an interview with a 38-year-old woman who, at the time of our first interview, had recently recovered from osteomyelitis (a bone infection) that required multiple surgeries and six months of halo traction.

IP(002): So, they tried to do a bone graft and it wouldn't take which makes sense because after having been a heavy user for so many years and my bones and teeth being compromised, why would it, uh, you know, why would my bones that are already weak and not the greatest to begin with? It makes sense that it wouldn't hold a heavy head and do the job that it needed to keep my neck stable, so they ended up doing a second surgery and putting a little piece of metal in there.

In addition to scarring, many women had casts or ace bandages on their wrists and arms as well as visible bruising and swelling all over their bodies, particularly their faces and necks. The women talked openly about their experiences of violence and accidents that contributed to numerous broken bones (e.g., noses, arms, legs), and soft tissue and head injuries. The majority of these injuries were a direct result of accidental falls or cuts and experiences of being battered by boyfriends, dates, or other women.

IP(143): I even wanted to have my nose fixed, but I can't have surgery either because of my count...My boyfriend broke it when he hit me with a pipe.

IP(010): Yeah, this scar [lifts her arm to show a surgical scar approximately 6 inches long] on my arm here, that's where he just kept twisting and twisting behind my back until it finally broke.

I was surprised by women's narratives that indicated a high incidence of being hit by a motor vehicle among women in the DTES. In most instances, women described these experiences as "hit and runs" in which the driver of the vehicle fled the scene. Women reported that, to their knowledge, the offending driver was rarely located by the police. The injuries associated with being struck by a motor vehicle were extensive and in some cases contributed to severe life-altering head injuries.

IP(094): I am on all kinds of meds now. Sometimes I don't know if I am coming or going. It's all because of being hit by a drunk driver...It was 10 years ago, and I was in a coma for two months. It was the best sleep of my life [laughs]. I woke up bald, drooling out of the side of my mouth, with a needle in my arm. I didn't want my kids to see their mother like that. I had to learn to walk again. The nurses were trying to help, you know, wanted me to walk on this little step or something. I got really mad at them. I told them I wasn't an idiot and I use to walk before and I was going to walk again. I have this scar [she pulled up her pant leg to reveal a surgical scar that ran from her thigh to her ankle] and seven rods in my leg and another bunch in my shoulder. It really fucked me up. And now I am on all kinds of meds and I don't know, sometimes they fuck up my head.

## Immune Function and Health Concerns

Immune function health concerns were those that could be directly attributed to infections. I have already addressed several of these concerns within the realm of respiratory (e.g., pneumonia, colds) and musculoskeletal (e.g., osteomyelitis) health concerns. In what follows, I emphasize abscesses and sores and blood-borne infections (e.g., HCV and HIV) as additional significant immune function health consequences.

Although 37.6% (n = 47) of survey participants reported experiencing abscesses or skin infections in the previous year, it was apparent through field observations and interviews that the majority of women responded affirmatively to this item *only* if they had sought medical or nursing treatment for an infection. The vast majority of women had multiple sores on their hands, faces, forearms, and feet. Some women covered the sores with bandages which they explained helped them not to scratch and “make them worse.” The sores varied in size from one millimeter to several centimeters. Some were reddened and oozing purulent drainage. Others were healing over. Pain was a significant side effect of these sores, especially those on the face.

Abscesses were common and almost every woman had experienced an abscess at some point in her life, with the majority having abscesses on a recurring basis. Abscesses were associated with oral infections, particularly in relation to women’s teeth and gums. Blackened teeth and gums, broken teeth, and ill-fitting dentures were common. Phrases such as “unbearable” and “excruciating” were used to describe the pain associated with oral infections and exposed nerve endings due to dental decay. Oral thrush was common among women living with HIV. The implications of oral infections and damaged teeth and gums were not limited to immune function health. In many situations, women were unable to eat due to the pain associated with these concerns.

Provider(001): We’ve got one gal, who for a month now we’ve been giving her pudding and Jell-O like whenever we have anything, its almost all she can eat, she can’t even eat the mashed potatoes half the time, its too painful because her teeth are broken off and she

has to wait six months or a year or something just to get a tooth pulled, you know, and that's all it would take, is to get it pulled and let it heal over.

Women experienced abscesses at other locations including injection sites, backs, arms and torsos. Bed bug bites on arms, legs, feet, and backs frequently became infected and many women's hands were reddened and cracked due to washing with bleach in an attempt to rid their homes of the bugs. These bites occurred in part due to the overwhelming bed bug epidemic that occurred in the DTES during the course of this project. In many instances women showed me their sores to ensure that I could adequately describe their physical bodies and simultaneously understand the emotional impact of having these sores.

IP(003): You're a nurse right, take a look at this. [pulls up her shirt to show me open sores about the size of a penny on her upper abdomen] Now look at my back [turned and lifted her shirt so that I could see her back]. She had multiple sores on her back that were open and appeared yellowish in the centre and very red around the edges. She also had them on her neck and I noticed one on her left cheek. She pulled her shirt down and when she turned to face me she had tears on her cheeks. She looked at me and said, 'how the hell have I got here? What the fuck has happened to me?'

Women expressed the belief that "abscesses seem to be on the rise down here" as those who were no longer injecting reported increased incidence of skin abscesses. There was an uncertainty regarding the factors contributing to these abscesses but many women cited the impurities of "bad dope" as a possible factor.

IP(001): I don't know what it is that's in the drugs down here but people are getting abscesses that don't even shoot up. I mean I haven't shot a needle in quite awhile and I got an abscess in the back of my bloody arm, I mean I didn't even use to muscle my heroine there for Christ's sake. I'm thinking 'what the fuck? It's really sore. It was in a spot where you can't quite see it, I could see a little bit of redness so I got the mirror and I looked and it was a big huge abscess there, it was the size of about ... three silver dollars. It was pretty big, you know, and I thought 'holy Christ, what the hell?' I didn't know what it was at first because I mean like I've been an addict for thirty years, I've never seen abscesses like that ever; like I always thought you had to, in order to get an abscess you had to use injection drugs or something like that.

In addition to skin infections and abscesses, blood-borne infections such as HCV and HIV were prevalent. Although not specifically identified among the items listed in the survey, several women who answered yes to experiencing "other" health problems cited HCV (n=9) and

HIV (n=8) as health concerns.<sup>22</sup> Nine of the ten women who participated in the more detailed interviews described themselves as “having hep C;” and two of the women reported being “HIV positive.” This level of prevalence was due in part to the fact that several kit making sessions occurred in collaboration with services that specifically targeted women living with HIV.

The length of time since HIV diagnosis was described as an important aspect of health for all of the women who were living with HIV. Women compared their “years positive” (ranging from 10 to 20 years) with one another as well as the various consequences for their own health and those of others who were HIV positive. Living with HIV meant living with the constant threat of immunocompromise and the development of opportunistic infections. As noted previously, sore throats, oral thrush, and pneumocystitis carinii (PCP) were particular concerns among women living with HIV.

HIV also contributed to women’s experiences of grief and loss due to the high incidence of death among their friends and family during the HIV/AIDS epidemic of the previous decades (Kerr et al., 2005). Women who had been living in the DTES for over twenty years described the neighbourhood as a “ghost town” in comparison to twenty years previously, and commonly made statements such as, “AIDS killed everyone.”

Women expressed concerns about their own mortality, especially those who had been living with HIV for over 15 years. In some instances these concerns were associated with assumptions regarding the association between AIDS and HIV and the perception that injection drug use in and of itself could shorten one’s life expectancy.

IP(081): But I only have two years to live. I have HIV, Hep C, asthma and depression. Life expectancy for HIV is 19-20 years so I only have 2 years. When the an outreach worker for women living with HIV stated that she knew people who lived much longer than 20 years with HIV and other women in the group agreed with her, the young woman

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<sup>22</sup> These numbers likely under-represent the number of women experiencing HCV and HIV due to the request by women who participated in instrument development and piloting that these issues not be included in an itemized list of health concerns. According to BC Centre for Disease Control First Nations women accounted for 28.4% of all new cases of HIV among women in 2004 (total of 15 new cases among women in BC). HCV rates are decreasing but were very high in mid-to-late-90s when many of the women were still injecting.

shook her head and responded. ‘Yeah, but I have been doing a lot of stuff to shorten my life, like fixing [injecting] and other stuff.’

There were many differences among the participants with regards to how they experienced living with HCV. Women aged 40 through 59 experienced a worsening of symptoms, and fatigue was the most common concern. Among some women however, the reality of being extremely ill and facing their own mortality was the more prevalent health concern.

IP(132): You know, it is weird, I have been [HIV] positive the least amount of time but I am the sickest of us all. I am really sick because my Hep C is active, not from HIV. My count is great, no problem there, but the reality is that I am dying with Hepatitis C.

Several women did not experience any symptoms associated with HCV and their concerns focused instead on monitoring their bodies for symptoms, and engaging in behaviours to help reduce their likelihood of developing symptoms such as getting adequate sleep, hydration, and proper nutrition.

### **Reproductive Health Concerns**

Although identified less frequently than other health concerns, it was apparent that women experienced significant reproductive health concerns. The majority of women over the age of 30 reported amenorrhea and/or irregular menstrual cycles and those in their late thirties and early forties often stated that they were “in the change of life” or “having menopause.” Analysis of their discourse revealed that amenorrhea since the age of 30 was considered “normal.” Women between the ages of 45 and 60 described multiple health issues associated with “having menopause.” Some expressed an extreme sadness at no longer being able to get pregnant while others reported frequent “hot flashes” and periods of feeling intensely cold or warm. There were significant gaps in women’s knowledge concerning the meaning of menopause from a physiological perspective (e.g., how it occurs, why it occurs) and women expressed reluctance to address their questions and concerns with their primary care physicians. The reasons underlying this reluctance were varied. Several women, particularly those over the

age of 40, expressed discomfort in discussing what they described as “women’s hygiene stuff” with their often younger and male physicians. Other women expressed a sense that physicians would “not care” or not respond appropriately to these concerns.

In addition to “having menopause,” three women reported that they had been diagnosed with cervical or ovarian cancer, and it was apparent within field observations that women recognized that these types of cancer were prevalent among women in the DTES. The women’s narratives were reinforced by recent data released through the Vital Statistics Agency of British Columbia (2005) that women living in the DTES are significantly more likely to die of preventable cervical cancer than anywhere else in the province. Breast health was rarely discussed among women, although one 59-year-old woman was waiting for follow-up after having a mammogram where “they found little lumps.” Her sister had died several years earlier due to breast cancer and she expressed fear that she would also die.

For some women, infertility was a pressing health concern, and women frequently associated infertility with “doing dope.” The severe malnutrition and low body weight that women experienced or tobacco smoking were not acknowledged as contributing factors. Women who were actively attempting to get pregnant expressed tremendous sadness at their inability to have children as well as a sense of responsibility that they had let their “partner down.”

### **Women’s Experiences of Mental Health**

Women experienced a variety of interrelated mental health concerns including feelings of anxiety, sadness, paranoia, and difficulty sleeping, most of which were influenced by their experiences of chronic abuse and exploitation that occurred throughout their lives. As I engaged with women regarding their experiences of mental health, I reaffirmed my position that mental health was not limited to specific medically diagnosed disorders (e.g., schizophrenia) but also reflected women’s experiences of emotional and subjective well-being (WHO, 2001).

## Feeling Nervous and Anxious

Within the survey findings, the majority of women reported that *feeling nervous or anxious* was a dominant health concern (see Table 4). As I worked with women during kit making and the interviews, it became apparent that anxiety was experienced primarily as a persistent state of worry and fear associated with the complex interrelationships among systems of oppression and relations of power. The women described “always being on edge,” “waiting for something to happen,” “never being able to relax,” “never knowing who was going to come through the door,” and “always having to worry about food or getting indoors” which contributed to difficulty sleeping and a limited sense of being in control of their daily lives. As one young woman noted during our discussions after completing the survey, “I am scared to sleep. I am scared I will wake up with someone’s hand over my mouth. And then it [sexual assault] will happen all over again.”

Women constantly worried that they would experience “triggers” (events or emotional sensations) that would remind them of previous violence; an experience that, for many women, contributed to devastating emotional sensations of feeling as if they were “there all over again.” Triggers were perceived as causing women to become “messed up” which was experienced as feeling sad, a loss of vigilance of your surroundings, being more easily taken advantage of because “you just don’t care what happens to you,” “hurting yourself” (e.g., attempting suicide), and “using dope” more frequently. The concern about triggers was exemplified in the following narrative of one Aboriginal woman in relation to her experiences in residential schooling.

IP(103): There are so many triggers out there, like just sitting around joking with your girlfriends - that can be a trigger. Because that’s what we did in those schools, you know, just being girls joking around together. That’s how you dealt. Triggers are really hard. You don’t always know when they will happen.

Worry about exposure to triggers, potentially violent situations, and harassment contributed to women’s isolation. Women went to great lengths to avoid these situations, which



most often resulted in staying at home alone for long periods of time. It was not uncommon during kit making sessions that occurred within specific housing agencies to hear comments such as “I barely go outside anymore,” “I will only go out if I have to,” or “the nurse comes to see me now since I won’t go out anymore.”

The worry experienced by the participants extended to concern for the welfare and safety of their friends and family members. Many women provided supportive assistance to others in the form of providing a safe locale during psychosis, monitoring activities for early recognition and intervention in the presence of crisis, coordinating health care, and giving money and food when needed. These care-giving activities were described as “responsibilities” that helped prevent their loved one from dying, being incarcerated, or having to go to an emergency room at a local hospital. It was apparent that women experienced tremendous anxiety about the suffering of loved ones, and as a result they often put their own needs second to providing help to another.

IP(005): My son comes to my place, he was on crystal meth right. I would just talk to him. And he would yell at me, but I don’t take it personally. I would just say to him ‘everything is OK, just relax.’ I would just let him be there....and my sister, I try and track her down so I can help her and I got my doctor to look into it too...and I worry a lot...worry, worry, worry...and my HIV and those seizures make me tired...but I have to help her.

### **Feeling Sad and Blue**

The experiences associated with *feeling sad and blue* shared many commonalities with feeling nervous or anxious particularly in relation to feelings of fatigue and social isolation. The women’s narratives revealed that most women experienced irregular sleep-wake cycles (see Table 4) and the majority cited that fatigue was a constant feature of their day-to-day lives. As women talked about their fatigue, I learned that these experiences were related to their emotional experiences of a deep sense of sadness. Many women cried as they spoke about fatigue in combination with their perceptions of “not belonging,” feeling powerless to change the circumstances of their lives, or having someone in their life that truly cared about them.

IP(002): I always knew I was adopted as a baby so I never felt completely connected even I just didn't feel complete inside and I still sort of feel like there's little piece of me missing because I haven't got those roots to really trace back to my family.

Feelings of sadness about the chronic abuse and exploitation women experienced throughout their lives were prevalent. For many, violence began with childhood experiences of abuse and neglect, and continued with harassment, battering, exploitation, and sexual assault throughout their adult lives. Although there are debates within the mental health literature concerning the appropriateness of diagnoses associated with abuse, it is generally accepted that feelings of powerlessness, depression, and symptoms of dissociation such as amnesia and anxiety are common among women who have experienced abuse, particularly at an early age (Morrow, 2002).

In addition, sadness was regularly accompanied by grief over the loss of a loved one or for many women, their ongoing grief of having their children apprehended into foster care many years before. Women cried as they talked about their children's lives of growing up in foster care and the sadness they felt knowing that their children likely had experienced similar violence and exploitation that they themselves had experienced when they were children. This was particularly prominent among conversations with Aboriginal women who had been removed from their homes as children.

IP(005): I am just a tired, tired woman. Yeah, I have a lot of personal stuff, like in my childhood and stuff. Part of it I can't even remember, I was in so many different foster homes, and I was moved around all the time. It reminds me of my kids right [grimaces and shakes her head and quietly begins to cry]. Especially my son eh. He comes to see me every day, and you know, 'what part do you remember about foster care?' Well it's being victims.

Feeling sad and blue also contributed to many women experiencing difficulty concentrating and completing tasks. Women talked openly about wanting to join groups or seek assistance to deal with other health and housing concerns but experienced a sense of apathy and decreased energy to engage in these activities. Other women reported feeling "sad" or

“depressed” due to the progression of illnesses such as HIV and arthritis that limited their mobility and resulted in isolation from their social networks. Women also experienced sadness in relation to their desire for their intimate partners to be more loving and less violent or grieved the loss of relationships due to the arrest of their partner as evidenced in the following excerpt of the narrative of a woman awaiting the trial of her boyfriend due to his most recent assault:

IP(010): I fell in love with him when he was clean and I’m still in love with him and hoping that person will come back...I had to charge him. We’ve been apart now for two weeks and I miss him. My self esteem is down. I don’t care what my apartment looks like anymore...I wish it was different. I know what jail is like. I don’t want that for him but in there he might get help.

### **Problematic Substance Use and Mental Health Concerns**

Over half of the women who participated suffered specific mental health concerns that were influenced by their experiences of problematic use (e.g., use that contributes to individual and social harm) (MacPherson, 2000; MacPherson et al., 2006) as well as other illness determinants including poverty, violence and discrimination. Two of the most common mental health consequences were paranoia and psychosis (see Table 4). Service providers and women with a history with crack use noted the difference between chronic and persistent psychosis and paranoia associated with a “diagnosed mental illness” (e.g., schizophrenia) and psychosis and paranoia they was attributed specifically to substance use especially smoking crack. This form of paranoia and psychosis was the predominant experience among the participants, and thus is where I chose to focus this discussion.

Although the survey results identified that paranoia occurred more frequently than psychosis, women’s discussions of their experiences illustrated that they often experienced these concerns simultaneously or used the terms interchangeably. Paranoia associated with substance use was experienced as “a horrendous sensation of not knowing who you can trust” and “the feeling of having to be hypervigilant of your surroundings” even if this was not really the case. Women reported experiences of “thinking everyone is a cop and out to get you,” thinking there

was somebody lurking outside of their home places when there was nobody there, and a belief that they were always being lied to, even by best friends. In some instances the paranoia was coupled with auditory and visual hallucinations (usually referred to as psychosis) that left them feeling afraid and created the potential for harm. For many women, these experiences were reported to be directly related to their use of “bad dope.”

IP(010): It's [crack] making people go crazy, I've seen people like when they are straight, and I've seen people when they're high, a friend of mine, I just saw her today and when we get high together she thinks the building is falling on her...and last night [after using crack] like I think he has it out for me because I charged him with assault. I thought 'okay, he did something in my place, he knows that I'm scared of snakes, maybe he put some snakes in my place. And I started digging through my clothes. I ripped off this shirt because I thought there were snakes in it. I thought I could feel them crawling on me. I was messed... Yeah, like sometimes there is like mice crawling up my pant legs. I'll tuck in my pant legs sometimes, or take off my pants and wear shorts.

It is important to highlight that the experiences that I am describing here are different from those that the women described with regards to the “hypervigilance” that was required for them to maintain their safety on a day-to-day basis. Women made a clear distinction between the regular “paranoia” they experienced regarding who they could “trust” or their legitimate experiences of feeling constantly monitored by other people in the neighbourhood, police, and television crews and their experiences of paranoia and psychosis that they attributed to substance use. On the one hand, the regular paranoia was perceived as a positive coping strategy associated with the realities of their lives while paranoia associated with substance use was experienced as something that was not “real.”

In addition to paranoia and psychosis, women also experienced what they described as “being addicted” or an “addict.” Addiction referred primarily to a pattern of using large amounts of substances, especially opiates, cocaine and alcohol, at high frequencies and an accompanying sensation of “having to use,” “jonesing,” and “being hooked.” Although the sensation of being addicted was non-static, women associated the experience with a belief that they were at risk for many health consequences as well as increased violence. They frequently experienced a sense of

futility and remorse that they were unable to alter these circumstances. Women made comments such as “you’re jonesing so bad you just don’t care” and “I am a drug addict, I have to do it.”

The following excerpt represents one woman’s reflections about her experiences when she was “addicted.”

IP(002): When I was using I couldn’t see anything but what my little world, how am I going to get it, where am I going to get it, you know what I mean and it’s a sick way of thinking but...it sure drives you. I mean your every moment is living to get your next fix and its just craziness. That’s not living.

Women experienced great loss associated with “being addicted” including a sense of a loss of self-esteem and self-respect. Women reported losing supportive family members because of their “drug problems.” These experiences were often accompanied by a sense of anger and resentment towards the “older adults” who introduced them to illegal drugs when they were young, in some cases teenagers.

IP(123): I get so mad now. I was young and a little lost and she introduced me to it and I got hooked. And once you get hooked then just think of the things you thought you wouldn’t sell...your home, your car, your soul.

Closely associated with the experience of addiction were women’s varying experiences of withdrawal associated with not using when they felt they needed to. Women who experienced addiction with opiates described severe physical and mental health effects such as not being able walk without swaying, nausea and vomiting, agitation, insomnia, irritability, and a sense of loss of control. These combined experiences were referred to as “being dope sick.” Women who experienced addiction with crack and other forms of cocaine emphasized an “emotional withdrawal” including a deep sense of sadness, nightmares, reoccurring memories from previous traumatic violence and abuse, and a willingness to do anything to avoid these feelings. The lack of money to purchase substances to prevent withdrawal was the most common contributing factor to the experience of withdrawal. The following two excerpts from women describing their experiences with crack and heroin addiction, respectively, exemplify these points.

IP(131): Doing rock is hard. It makes you do things, cause you have to do it. Before you even light your lighter you are thinking about the next one.

IP(007): I was half an eight ball of heroin, half an eight ball of coke a day, I was way, way out of my mind. When they dropped the price of heroin then it escalated, you know, I was doing like a ¼ gram just to get to the first dealer. I had to, because if I didn't I'd be too shaky. Just to get off my ass I'd have a quarter gram ten minutes later just to get kind of a buzz, there's half a gram right there. That's 80 bucks. You got to get the money somewhere.

### **“Why” Women Get Sick: An Overview**

Margaret Lock (1998) argued that individuals' experiences of health and illness are inherently political phenomena that are both historically situated and socially mediated within relations of power. Analysis of the factors influencing women's experiences of the health concerns discussed thus far illustrated that these experiences indeed were influenced by the complex interplay between domains of power, systems of oppression, and place. To further illustrate these complex interrelations, I chose two exemplars from the data that highlight the processes by which the social organization of relations of power that contribute to domination and subordination within society operated across class-based, racialized and gendered systems of oppression to contribute to health concerns and inequities in health that women experienced. These exemplars are not intended to be all inclusive but instead provide insight into the subtle nuances of oppression as it pertains to women's health.

#### **Exemplar One: “Underclass,” Gender, and Relations of Power**

The vast majority of the participants in this project lived their day-to-day lives firmly entrenched within the social grouping Collins (1998) categorized as the “underclass” which from a social and economic context, was experienced largely as poverty, segregation, and exclusion (see Table 1). Women's experiences as members of the underclass were reflected by their meagre incomes and the lack of safe and feasible opportunities to generate income that usually left women with only unsafe and challenging options including sex work and dealing. Additionally, women's so-called “membership” within the underclass contributed to their

exclusion from sufficient material resources that could positively influence their health (Krieger, 2001; Weber & Parra-Medina, 2003). An exemplar of this exclusion was the material and personal deprivation that contributed to women's experiences of inadequate shelter and clothing and their exposure to the harsh weather conditions.

Over the course of this project, record cold temperatures and rainfalls and numerous windstorms resulted in frequent power outages, damage to the public water supply, and extensive "boil" water advisories. It was not uncommon to see water running down the streets during downpours and snow and sleet were prevalent. Women often arrived at kit making sessions with their jeans soaked to their knees, their shoes saturated and wearing jackets that were not waterproof. Umbrellas were rare and many women did not own socks. Some women wore garbage bags over their clothes and carried their personal belongings in plastic bags or in shopping carts covered with tarps in an attempt to keep them dry. Many women wore open-toed shoes regardless of the weather conditions and I noted that their feet were discoloured, had open sores, and dry, cracked skin. Women relied on clothing donations or when feasible, bought used clothes at thrift shops. As one woman noted, "I get all my clothes at the church. I only get one hundred dollars per month on welfare so I can't afford to buy clothes" (IP101).

The gendered nature of work options within the commercial sex industry also increased women's likelihood of exposure to the harsh weather conditions due to the clothing associated with the work and the prolonged periods of time they would be standing outside within the segregated areas commonly referred to as the "strolls." Leaving the street during their work hours (usually late at night and early in the morning hours) posed the risk of losing a possible date and the associated income. While working, women frequently wore "mini skirts" and "short coats" and they described these clothes as "working girl clothes" that were required to obtain dates. Women recognized that getting wet and being cold increased their risk of experiencing

illnesses such as pneumonia, colds, and influenza, yet also acknowledged there was little they could do to stay dry.

IP(007): You need to be indoors more now though like its getting colder and its wet, that's what happens in Vancouver, its starts raining. Yeah, you can't get wet here; once you get wet you'll catch pneumonia or something. But what can you do?

The experience of being cold and wet and the lack of adequate clothing also contributed to women seeking shelter during the night in the few segregated places available for shelter during the late night and early morning hours, including alleys and one of the few drop-in centres that were open past midnight. As I noted earlier, these places were sites of potential violence and harassment and women's exclusion from material resources often contributed to options that forced them to weigh the risks of assault or harassment against the need for warmth and a reprieve from the elements.

IP(074): It is so cold. I don't have a warm coat and I need one and I am not sure where I am going to get a new coat. It is freezing out there and I have nowhere to go. It was so windy last night I had to go into the alley to get out of the wind, and that's just not safe.

Living within the underclass also contributed to exclusion from resources essential for personal hygiene, a factor that has been repeatedly linked to the spread of infectious diseases (Porth, 2005). Women were frequently dependent upon drop-in centres to access showers, washrooms, facilities to wash their hands, and the supplies needed during menses. This was especially problematic among those who were without a home or adequate hygiene facilities within their SRO. The bureaucratic policies and practices of drop-in centres often required that women line up at the front desk in the entrance of an agency to request soap, shampoo, and tampons. In my conversations with women, it quickly became apparent that accessing these hygiene supplies was embarrassing and they often felt demeaned by having to discuss their bathing needs in front of others, particularly men. In an attempt to reduce this assault on their dignity, women frequently waited at a front desk until one of the women who worked there became available, which sometimes resulted in missing an opportunity to shower altogether. The



washrooms often had little space to wait in line for the shower and women often had other appointments like meetings with their “welfare worker” or “methadone doctor,” and would have to give up their place in line and their opportunity for a shower so that they would not miss an appointment. At one particular drop-in agency, people had to request toilet paper from the information desk located in the main entrance if they wanted to use the washroom and the soap dispenser was frequently empty.

During kit making sessions we visited a wide array of agencies and while many offered shower facilities, it was apparent that several of the facilities were struggling to maintain a clean environment. On numerous occasions I observed women shaving their legs at a sink instead of in the shower. The choice of sink was to avoid taking up too much time in the shower and thereby “holding up the line” of women waiting. Women sometimes cut themselves while shaving leaving blood on the floor and surrounding the sink. Garbage cans were overflowing and people who worked at this site talked about how difficult it was to keep the washrooms cleaned. Few had regular “cleaning” staff and instead relied on volunteers. Many of these agencies closed before five o’clock in the afternoon, leaving people to seek other sites for access to showers and washroom facilities.

Hand washing was also problematic for many of the women and was identified by the participants as problematic for all of the residents of the DTES who were “poor.” Throughout my field work I noted that many, but not all, of the women’s hands had broken dirty nails, blackened fingertips, embedded dirt, and numerous sores that were either bleeding or in the form of pustules. Women were aware of the association between hand washing and the spread of infections as demonstrated in the excerpt from one participant:

IP(003): But think about it...you’ve got dirty hands, you’ve got an abscess, you scratch with dirty hands and your abscess is going to get bad. I think its back to the basics of hygiene. You’ve got to wash your hands. It might stop some of the bad abscesses right?

The meagre access to places that enabled women to wash their hands often combined with women's experiences of hunger, homelessness, and/or inadequate shelter to contribute to the likelihood that women would need to access drop-in centres which then brought them into close proximity with other people who were ill with potentially infectious illnesses including pneumonia, colds, and flu's. As noted by one participant with regards to accessing food:

IP(002): Down here you just get people hacking in your face, right, so, its so hard to get rid of them when you're eating because...when you go out for a free meal or something, you've got to eat with everybody else, people don't put their hands over their mouths, [makes coughing sounds] you know...so I mean you're eating contaminated food, right and I mean you're not going to go throw it back because you're starving, you know, a hungry person will just say, 'oh well, I'll put up with the cold, I'm hungry, you know, I want my food'.

During several kit making sessions women talked about the realities of living in poverty and how this influenced what people opted to focus upon as a priority for survival. Several women explained to me that for many women and men living in the DTES, being hungry and homeless contributed to an experience that made hygiene much less of a priority. As one woman noted, "you just don't think about washing your hands and stuff when you have been on the street for so long, had nowhere to live and are always hungry" (IP001).

Lack of sanitation or clean living conditions was also apparent within many of the SRO's where women lived and was identified among the participants as another influential factor for women's health. Heavy rainfalls contributed to leakage resulting in mould and rotting walls, which were rarely repaired despite women's complaints. Washrooms were poorly cleaned and it was apparent that within many of the SRO's, water faucets and toilets did not work properly. Women described living in situations in which toilets overflowed regularly. For many women living in SRO's, personal hygiene was not feasible within their home. The circumstances were different however, among women who lived in low-barrier and supportive housing facilities. In these situations women described having regular access to a shower and working washroom facilities. In some agencies that offered independent living apartments women had their own

washrooms and attributed their improved health outcomes to the better sanitation afforded within these agencies.

IP(174): I was in and out of hospital with pneumonia over and over again. I was always getting sick when I lived in hotels. They are unhealthy and dirty and you have to share bathrooms. They just make you sick. I am so much better now that I am living here. I don't get sick like that anymore.

Living within the underclass also severely affected women's exclusion from adequate nutrition. Most women were dependent upon drop-in centres and shelters for their meals, the outcomes of which were significantly influenced by the bureaucratic policies of these agencies as well as women's relationships with men in the neighbourhood. The amount of food that a woman could consume was strictly regulated in some agencies. Portions of food at one of the most frequented women-only drop-in centres were described as "very small" and each woman was permitted only "one serving." While I recognize the challenges of funding for these programs in relation to meeting the nutritional needs of women in the DTES, it was also apparent that these services were influenced by an underlying individualist ideology that held women accountable for their experiences of poverty. The women perceived that they were viewed within these agencies as less deserving of the access to basic necessities in life such as food when compared to the middle and upper classes (Collins, 2000). For example, when I explored these experiences with women, it became obvious that there were expectations within the agencies regarding women's responses to these services. Women experienced a sense that they had little voice with regards to how food services were delivered and perceived that there was an expectation within the agencies that they should "feel grateful" to receive any food.

IP(008): Yeah, they've got a cook there who does healthy foods, some of the food like they have chicken, they have a chicken about this big [makes a small circle with her fingers], I think they should give two instead of one...my granddaughter can eat one [she is three years old]. But I can't complain; it's free. That's what they say.

Eating in drop-in centres enhanced the likelihood that women would be targeted by men. Women were often harassed or pushed from their place while waiting in line outside a local

drop-in centre and were regularly approached and hassled to give up their food if it was visible to others. In some instances, even in their own home places, women had no choice but to give food away for fear of retribution if they did not comply.

IP(010): But I noticed people are walking over me because I'm very vulnerable right now, because they know I'm alone, but when my old man, my partner was there nobody would come over. But now they know that I'm alone they come over, they get me high, they take advantage, they eat my food, they drink my juice, and here's me backed in the corner because I'm high and I won't say nothing.

Within some agencies, there were specific "rules" that women were not permitted to remove food from the premises, even if they were under duress to do so from their boyfriends. When women disobeyed this rule, which they usually did in order to prevent a violent retaliation, they were at risk of being "banned" from accessing these agencies. As one service provider noted:

Provider(002): Men wait for the women to come out, they'll wait out by the doors or if it's like a closed thing like WISH - women get it in so much trouble for bringing their food out, like they've got their old man out there 'saying bring me food' and they're getting in trouble by the staff and she's not even eating in the process.

Women also reported that in some situations their social interactions with service providers, for instance "welfare workers" affected their ability to maintain adequate nutrition. In the following excerpt one woman explained her experience of negative social interactions after requesting assistance to obtain additional funding to deal with replacing clothing for her daughter and furniture, both of which were ruined due to an infestation of bed bugs.

IP(006): You know what my worker told me? I am on disability so I get the extra money to buy vitamins, water, stuff like that, he said 'well you get extra money, use that,' and it's like 'that's for me, for my health buddy, uh, okay, I'm going to use that for my rent' like people just don't think.

Living within the underclass coupled with experiences of chronic illnesses further reduced women's opportunities for adequate nutrition. Among women living with HIV infections, for example, the experience of oral thrush interfered with their ability to eat. Among women with mobility problems due to arthritis and general fatigue associated with other illness

such as AIDS, HCV, and depression, shopping for food, carrying food home, or walking to a drop-in centre to get “free food” was a challenge. As one woman dying with AIDS expressed, “I can’t be bionic woman and carry all the groceries home” (IP005).

Women could not afford to pay a taxi to help transport them either to or from a grocery store or a drop-in centre. They often had to rely on others such as their children or friends in the community, which often contributed to a sense that they were being a “burden” to others and therefore limited the requests they would make for help.

There were notable exceptions with regards to access to food, and as was the case with improved clothing and sanitary living conditions, these exceptions occurred more often among women who lived in low-barrier or supportive housing. Although there was some discussion that the food supply was limited in these agencies and that it was not necessarily of good quality, it was apparent that having access to food in these settings was helpful to women’s ability to maintain some nutritional intake. The benefits are exemplified in the following statement from a woman living in a low barrier agency for people living with HIV: “I was 86 pounds when I got here and now I weigh 102” (IP141).

### **Exemplar Two: Crack Use and Relations of Power**

As I noted previously within the literature review, there has been a tendency within the health literature to examine the interrelationship between health and substance use with a specific emphasis on the nature of the substance being used rather than or inclusive of the social, economic, and political contextual factors associated with use (Brook & Stringer, 2005; Keane, 2002). Although the pharmacology of crack cocaine was important in understanding the relationship between crack use and women’s experiences of health, it was also apparent that legal, economic, and interpersonal factors, and the dominant ideologies associated with crack cocaine were also influential.

One of the most important factors that influenced the relationship between women's experiences of health and crack cocaine use was the presence of impurities in crack, a phenomenon that women described as "bad dope." Impurities included substances that would not normally be added during the manufacturing process; the most common impurities included heroin, crystal methamphetamine, kerosene, lidocaine, and speed. The addition of other "drugs" was perceived by the women as a strategy employed by dealers to try and "get us addicted" to other substances, thereby increasing the diversity and amount of substances sold. Kerosene or lidocaine-based products were added to reduce the amount of cocaine in the crack, which in turn would require people to buy more crack if they wanted to get the "right high."

The illegal nature of crack and the ability to purchase it in small, inexpensive quantities (e.g., five or ten dollars per "rock") were perceived as contributing to the increased likelihood that a woman would buy "bad dope." There were few options available to women to determine prior to use whether the crack was "bad" and there were no means of recourse once they purchased the crack. Women recognized the challenges they faced in trying to ensure that they did not buy bad dope and expressed a desire for effective methods to determine the purity of crack including "drug testing kits" and decriminalization. As one woman noted, "I want to buy my crack in a store. Then they have to tell me what's in it. That would help" (IP113).

The smoking practices involved in crack use were also problematic. In order to smoke crack women required a pipe, filter, push stick, source of flame, rock of cocaine, and ideally a piece of rubber tubing to use as a mouthpiece. To facilitate my understanding of the relationship between smoking practices and women's health concerns, several women described the smoking process in great detail. A filter was placed in the pipe with the aid of a "push stick" and then a "rock" was placed on the filter. The pipe was then heated slowly and the crack was inhaled once it began to vaporize. Women frequently "made do" with materials at hand (e.g., broken umbrella pieces as a push stick) or used the cheapest materials they could purchase due in part to the

expense of supplies and the lack of options to purchase the “least harmful” equipment. This was particularly prevalent during the day on which welfare payments were received. The cost of supplies purchased through illegal means often doubled or tripled in price, leaving people with the option of paying more or finding the cheapest alternative during this period of intense “mark up.” Because there were no regulated rules regarding the economy of equipment, women were left with few options other than to purchase equipment at the mark-up cost.

Pyrex<sup>®</sup> pipes, made of heat-resistant glass, were reported by women to be the “best pipes to use” as they were less likely to crack and lasted longer than other pipes. Although the majority of women reported using Pyrex<sup>®</sup> pipes (see Table 6), women also used glass pipes on a regular basis (see Table 5). Glass pipes were made of thin, less heat resistant glass and prone to breaking and exploding once heated. Women frequently used pipes until they were little more than a couple of centimetres in length due largely to the presence of resin (small amounts of crack) within the pipe and the challenges inherent in accessing a new pipe. Women recognized that using pipes of this size contributed to the likelihood of burning their fingers or lips, but reported that there were few alternatives available.

Steel wool known as Brillo<sup>®</sup> was the primary filter used by participants as it was effective in holding a rock in place and was relatively inexpensive and easily accessed. For example, local convenience store owners would open a box of Brillo<sup>®</sup> and sell small quantities from the package to people who knew the appropriate language to request the item. Women described that the wool they used was coated with cleaning chemicals that got “burned off” when they were heating their pipes and inhaled with the vaporized crack. The wool often broke apart when heated and the inhalation of hot steel wool particles was particularly problematic for burns to the mouth and throat. Push sticks, particularly metal items such as broken car antennas and sharp-edged, bicycle tire spokes were used to pack the pipe tightly and to scrape the remaining crack residue (resin) off the side of the pipes. The metal often scratched the glass thus weakening the

thin glass pipes and women reported cutting themselves on the sharp edges of these sticks as an event that “happened all the time.”

Smoking crack with other people was a common practice for many women and the rationale underlying this practice varied including lack of available equipment, forced sharing of drugs with men, and the desire to engage in social activities with friends. Many women preferred to use a piece of rubber tubing, referred to as a “mouthpiece” when smoking crack with others (see Table 7). Mouthpieces were attached to the end of the pipe and described as helpful to prevent burning of the lips as well as the spread of infectious diseases associated with sharing of pipes. It was apparent that women recognized the possibility of disease transmission when people shared equipment and they attributed this risk to the presence of open sores on lips and in people’s mouths, as well as the risk of viruses that contributed to colds and pneumonia that could spread in saliva. Women’s concerns were realized during the recent pneumonia outbreak in which the sharing of smoking equipment was identified by local medical health officers as a significant contributing factor (Buxton, 2007).

Despite the possibility of the spread of infectious diseases and the desire to use a mouthpiece, women were often unable to find a mouthpiece when needed (see Table 6). Women attributed the local health authority’s withdrawal of a publicly funded “mouthpiece program” several months prior to the study as a significant contributor to the challenge of using mouthpieces. There was a sense of confusion and anger expressed among the participants regarding the withdrawal of these harm reduction services. Several women noted that the cancellation of these programs was due in part to the perception among health service providers and society at large that people who used crack were “less important than other people who like inject and stuff. Everything is all about AIDS and stuff. We don’t matter” (IP132). These comments reflect a hierarchy within the allocation of health services, a topic which I explore in more detail in the final discussion chapter.



**Table 6 Crack Smoking Practices (n = 126)<sup>23\*</sup>**

Smoking Practice	Frequent n (%)	Infrequent n (%)
Use Brillo <sup>®</sup>	124 (98.4)	2 (1.6)
Share pipe	59 (46.8)	67 (53.2)
Share mouthpiece	37 (29.6)	88 (70.4)
Use pipe with splits/cracks	55 (43.7)	71 (56.3)
Use Pyrex <sup>®</sup> pipe	75 (59.5)	51 (40.5)
Use mouthpiece	74 (58.7)	52 (41.3)
Can find pipe when needed	96 (76.8)	29 (23.2)
Can find mouthpiece when needed	62 (50.4)	61 (49.6)
Smoke with other people	58 (46.0)	67 (53.2)

**Table 7 Other Smoking Practices (n=126)**

Smoking Practice	n	%
Prefer to use mouthpiece		
yes	86	68.3
no	40	31.7
Use pipes other than Pyrex <sup>®</sup>		
yes	89	29.4
no	37	70.6
Types of pipes other than Pyrex <sup>®</sup>		
glass only	73	82
metal only	4	4.5
other (combination)	12	13.5
Push stick		
metal	86	73.5
wood	4	3.4
plastic	4	3.4
other (combination)	23	19.7

<sup>23</sup> The number in each cell ranged from 123-126 due to missing data and percentages reflect these differences.

## Summary

Throughout this chapter, I illustrated that women experienced a wide range of physical and mental health issues that were both acute and chronic in nature. These findings may not reflect all health concerns that women experienced and some essential concerns may not have been identified or adequately explored, particularly when the analysis is compared to the leading causes of death within the DTES as identified through Vital Statistics (2005) such as cervical cancer and infectious illness. What these findings do indicate however, is that women experienced grave health consequences that were significantly influenced by their life circumstances including severe economic deprivation, abuse and exploitation, and substance use. Many of the women who lived in low-barrier and supportive housing reported increased access to resources essential for health including sanitation, food, safety, and support. Despite access to increased resources, they too shared a legacy of violence that most often began in childhood and progressed throughout their lives.

## **CHAPTER SIX: TAKING CARE OF YOUR HEALTH: MANAGING THE DAY-TO-DAY**

### **Introduction**

One of the most astounding analytical discoveries of this project was the complexity of the strategies and activities in which women actively engaged to prevent and/or mitigate the serious health consequences associated with relations of power and systems of oppression operating in their day-to-day lives. This was not entirely surprising as “women are rarely best viewed as ‘victims’, but should be seen as women exploring and using active strategies in managing health and illness and accessing both formal and informal health care systems” (p. Dyck et al., 2001, p. 2-3).

The strategies employed by women were multifaceted and for the purpose of clarity, I thematically organized them according to four specific categories: (a) managing limited financial resources; (b) negotiating the health care system; (c) managing substance use; and (d) managing on your own. Despite the goal towards improving their health, not all strategies were effective, particularly in situations where these activities were influenced by a lack of resources, discriminatory practices of health service providers, and a dearth of knowledge concerning the severity of health concerns. The degree to which individual women engaged in these strategies was varied and these differences were significantly influenced by the options available, knowledge concerning effective strategies, and women’s self-perceptions regarding their capacities to positively influence their health.

### **Managing Limited Financial Resources**

As I noted previously, exclusion from material resources necessary for health associated with experiences of relative and absolute poverty reduced women’s opportunities to secure shelter, food, clothing, sanitation, and freedom from violence: factors that have been deemed as essential for health and well-being (Farmer, 2005; Krieger, 1999; 2001). Despite the experience

of economic deprivation, women actively engaged in a diverse range of activities to manage their limited financial resources. These strategies were specifically designed to reduce the amount of exclusion from health resources that they experienced and represented their attempts to achieve a higher quality of health.

### **Managing the Money you Have**

Women recognized that they did not have sufficient money to secure all of the material resources necessary to manage their health, and as a result were forced to make difficult decisions based on what they perceived to be the most pressing concerns that required attention. These competing concerns frequently included but were not limited to securing a home place, purchasing food, managing chronic pain, and seeking a reprieve from the daily challenges they faced within the DTES. Their decisions were further influenced by the organization and practices inherent within the welfare and health care systems as well as their interpersonal relations with boyfriends, friends, and family.

Many of the women's activities to manage their finances were organized around "cheque day," which was the one day per month that welfare payments were issued, most often in the amount of \$510. In discussion with women during kit making and interview activities, I learned that for many women, it was vital to ensure that they were able to secure their home places. One tactic by which this was accomplished was to work with an advocate (a person who worked for the provincial government to assist with welfare applications) to ensure that their financial account with income assistance was set up to pay their rent and damage deposit payments via direct deposit from welfare payments to the SRO or housing agency. This strategy assisted women to avoid eviction for not paying rent.

IP(104): That's what happened to me. I used to have them give me all my money and I didn't use it for rent. And then I ended up homeless. Now I make sure they pay the rent. But there isn't anything left. I owe welfare a bunch of money and they take twenty dollars a cheque, another twenty for a damage deposit and another twenty for stuff.

Women also made certain that they bought food that they could store such as canned soup or packages of pre-dried noodles as well as other essential items such as soap or tampons. Many women set financial limits on their purchase of drugs and alcohol and some women gave money to a family member for safekeeping so that they would have “a few dollars left” later in the month.

Not all women employed these strategies and everyone recognized the unlikelihood that they could afford to pay rent, obtain food, and avoid withdrawal simultaneously. In some situations a small number of women opted not to secure housing that required rent payments. These women preferred living out in the open and had many strategies to manage their personal safety and health.

IP(007): Yeah, you know, I could get a room down here but I'm not, from bed bugs and I can't believe like the infestation, you know, I'd rather live on the street than that. You are fucking right man...and those fucking landlords...but I'm pretty well indoors most of the time right now in this weather. Because I've got like the Contact Centre and that's open 'til six in the morning. And WISH is open from six at night 'til ten, in the day time. In the summertime it's easier, I would go to Burnaby and live at the library there. There's flowers and everything, we stash our blankets and stuff during the summer.

Several women who were underweight and suffering from malnutrition often did without resources such as clothing or personal hygiene items so that they could purchase expensive fortified protein food supplements. In these cases, women had either been denied eligibility or were awaiting approval to receive these supplements as part of their welfare benefits. The following excerpt from the narrative of an emaciated 38-year-old woman recovering from surgery illustrates this point.

IP(002): I am trying to keep my weight up. It costs two dollars per can and I have no food subsidy with welfare cause I'm not on disability. I get \$510 and then there is rent and damage deposit. But I am trying to get healthy.

Women also often managed their money so that they could purchase illegal substances such as morphine and Tylenol 3<sup>®</sup> (acetaminophen with 30mg of codeine); an activity that supported them to deal with concerns of chronic pain related to arthritis and traumatic injuries.

The non-narcotic prescribing policies and practices of many of the clinics located within the DTES were perceived by women as a significant contributor to inadequate pain management. Women described scenarios in which they had been discharged from hospital without a prescription for pain medication, despite the fact that they had been receiving this medication throughout the course of their hospital stay up to and including just prior to discharge.

IP(032): I was in the hospital for six months and I was really sick and I was getting morphine for pain everyday. And then I got out and I had nothing for pain. They didn't give me anything. My pain just didn't go away. Then you just end up buying drugs to help with the pain and then you have to do things to get the money to buy the drugs.

The economic circumstances of women's lives and the options available to them with regards to managing their finances to address their experiences of pain were further influenced by the hegemonic, biomedical ideologies concerning "drug-seeking behaviour" patterns among people who experience problematic substance use (Alford, Compton & Samet, 2006). Both the women who used crack cocaine and the provider participants perceived that, for the majority of women who use illegal drugs, experiences of pain were considered illegitimate by health care providers. In many instances women lived this experience in ways that discounted them as "people just like everyone else" and instead were reduced to being "an addict."

IP(031): It's like if you are an addict, you don't have real pain. That's what they [physicians] think.

IP(003): It says right there on the sign [referring to a local CHC], 'we do not give out Tylenol 3's here.' But you go there and they know you are a chipper and you have a dirty piss test and they won't give you any painkillers. That's unconscionable. They've got to go sell their body because they are on welfare, so they won't get medication. People can still be in pain even though they are an addict.

As a result, women were often left with no choice but to use their scarce economic resources to deal with issues of pain.

Managing finances to accommodate travel was an additional factor that influenced women's activities regarding their economic situations. Traveling from the DTES to visit family or to simply "get away" or "to take a break" was a costly yet important strategy among many

women to manage the fatigue, despair, and isolation they experienced in their lives. Women who did not qualify for a “bus pass” often had to “sneak” onto local transit if they wanted to simply “get out of the DTES” for a day or even a few hours. If caught, they were sometimes humiliated in front of other passengers and forced to leave the transit vehicle, regardless of how far they might be from the DTES. Many women reported that they incurred significant expense when they wanted to travel to their home communities within and outside of the province to “pay their respects” to a family member who had passed away. In some situations, women who were traveling to a First Nations’ community received a small travel assistance stipend and reported that this was extremely important for their “peace of mind.”

Women who lived with and/or had boyfriends frequently assumed primary financial responsibilities (e.g., paying rent, buying groceries, buying dope) and as a result engaged in creative and resistive strategies to secure money for their personal needs. Women sometimes withheld additional money that they had received from research participation or volunteer work and carefully weighed the benefits of these decisions against the potential consequences of being caught withholding money, particularly the threat of violence. Their decision-making processes were based on their knowledge and experience with their boyfriends in that they had learned “what you could get away with,” a process that has been described elsewhere as “edgework” (Lyng, 2005; Rajah, 2007).

IP(033): I will have to tell him that I got some money for being here today. He knew I was coming. But I’ll just share like ten of the twenty dollars with him so he can get some smokes or something. I am having a lot of pain because I have cancer and a hoot helps with that. I’ll just give him the ten bucks. He won’t know that I did that cause he is at work.

### **Seeking Opportunities for Income**

During informal and formal interviews, I realised that the majority of the participants recognized that it was not possible to manage complex health concerns such as exposure, malnutrition, chronic pain, and withdrawal, or to fulfill their financial responsibilities with their

intimate partners with their limited incomes. As a result, they expended a significant amount of time and energy to seek opportunities for additional money although the options available were severely limited. Many of the women had, at some point in their lives, worked in low-skilled and short-term employment settings such as factories, fish processing plants, and lumber mills, but at the time of this project, most were not involved in the “formal” employment sector (e.g., jobs that paid at least minimum wage and adhered to Canadian labour laws) and none had a consistent regular job on either a full-time or part-time basis. Having spent time in prison was considered among participants as a significant detriment to finding employment. This was due in part to the hiring practices of organizations that refused to hire people with a criminal record. Many women experienced physical and mental health disabilities that rendered physical labour or other regular employment infeasible. Women reported that “straight jobs” such as those in the formal employment sector simply “did not exist.” Many women were unaware of services that would assist them with training and employment opportunities, although I observed that some of these resources were offered in the DTES. In some situations, women acknowledged that substance use hampered their ability to obtain employment and expressed a sense of frustration concerning the lack of resources to help address their issues with problematic use. As one participant noted:

IP(101): My worker told me that I could go on disability instead of welfare and that I would be better off. I told her that I didn’t want to go on disability. I could work, but what’s stopping me from work is the drugs and alcohol. If you give me more money, I’m just going to do more drugs.

The majority of opportunities for additional income existed within the “informal” economic sector which included activities that generated financial or material (e.g., food, shelter, and clothing) goods in a manner that was outside of the formal employment sector (Maher, 1997). Much of this work posed significant risk for women and contributed to further exploitation in their daily lives. Some income-generating strategies such as sex work and selling “dope,” for example, were illegal, posed the risk of arrest, and were often associated with abuse



and exploitation. Commercial sex work, the most common means of additional income, was not a desired strategy. Women expressed a sense of feeling “degraded” by this work, but described that it was “forced” upon them due to their financial circumstances or for some, the need to fulfill the financial needs of men.

IP(072): You know men go around saying things like ‘women have it all’ cause we have the women’s centre and stuff like that. Yeah, we’re a gold mine. Guys get to lie on the sofa at home all day and we have to go out and work [sex work]. We are on the corner because we are supporting our men’s habits.

Engaging in “volunteer work” was an important activity for women to obtain additional income. This work was regulated predominantly by health and social service agencies and research programs within the DTES. Women spent a significant amount of time and effort trying to secure what they described as “shifts.” Shifts for volunteer work were usually four hours in length and paid a cash honorarium of seven dollars per hour. Some agencies limited the number of shifts a person could work to one or two per week. Women reported that men were hired more frequently than women by the agency that coordinated the majority of shifts available within the DTES. My field observations concerning the hiring practices of this agency corroborated women’s experiences. Other agencies, such as a woman’s drop-in centre had “women-only” hiring policies. The types of volunteer work varied and included street-based needle exchange program activities and peer outreach, which usually occurred throughout the night and early morning hours, dishwashing and other cleaning activities, and monitoring washrooms in drop-in centres for crowd control. Often, the women’s participation in volunteer work provided essential services to hard-to-reach people. They dealt with conflict among residents of the DTES who were accessing agencies, sometimes at personal risk to themselves. Yet they did not receive the benefits that many people receive who are formally employed, including the eight dollar per hour wage that is the legislated minimum wage in BC, sick leave, or health care benefits.

Additionally, the bureaucratic policies that regulated peer outreach volunteer work mandated that

women worked in teams of two and if one woman was unavailable, the other was sent home without pay and was denied the opportunity to work her scheduled shift.

IP(172): On outreach we are buddied and she didn't show up. It's like, I was there, but we can't go out alone so there is nothing you can do if your buddy doesn't show up. And then you are out the money and you depend on that you know.

Research participation as “participants” or “research assistants” was another common source of additional income. Several research programs occurring within the DTES hired women as research assistants and paid an honorarium ranging from seven to twenty dollars an hour. Research projects frequently paid cash honorariums to participants as a recruitment strategy and to acknowledge the time commitments of people who took part in these studies. Opportunities for research participation were limited by “eligibility criteria,” “sample sizes,” and the short-term time restraints of research projects. Competition for these opportunities often created conflict among women. Women developed creative strategies to ensure their participation in these activities including sharing information with each other. Women would tell other women about upcoming opportunities that offered honorariums and repayment for receiving this information was an informal rule of conduct. Failure to repay the “favour” carried specific consequences including being excluded from the information-sharing “loop” and a loss of opportunities for income. During one kit-making session, for example, after one woman thanked another for facilitating her participation in the honorarium-supported activity the other woman noted:

IP(043): No problem. Now it would be nice if you can keep me in mind when something comes up next time, right?

### **Negotiating the Health Care System**

Although many women preferred to avoid involvement with the health care system whenever possible, the complexity of their health concerns frequently necessitated accessing health care services in order to manage their health. Among the survey participants, almost half (46.8%) responded that they preferred to manage a health problem on their own and when they

did access services, physicians (77%) and street nurses (46.8%) were the primary service providers accessed. Community health clinics (57.1%) were the most common locales and less than one quarter of the women (24.6%) reported regularly accessing hospital services (e.g., emergency room) to address a health concern.

Throughout my observations and interviews, it was apparent that accessing health care was a complex relational process that required significant knowledge and skill on the part of the participants to ensure that a concern was appropriately addressed. This knowledge and skill was usually learned over the course of the women's lives due to their frequent and repeated interactions with the health care system. The women's activities were directed towards minimizing the effects of discriminatory and sometimes abusive practices of health service providers, dealing with their most pressing health concern, and minimizing exposure to the system in terms of the amount of time spent in the system and the number of people involved.

### **Negotiating the Place and the People**

Although exercising a choice about *where* they accessed health care was not always a realistic option, the narratives among the women who participated in kit making and interview activities illustrated that they expended significant amounts of time and energy in an attempt to access specific health care agencies and people, and avoid others. Women actively attempted to access places where they perceived the health care providers to be “genuinely wanting to help,” “non-judgemental,” and able to “see me as a person.” Vancouver General Hospital, for example, was the preferred Emergency Room (ER) for many participants even though St. Paul's Hospital was much closer and did not present the same transportation challenges. Women went to extreme lengths in order to avoid St. Paul's including negotiating with the EMT who responded to their 911 call, taking several buses despite being acutely ill, finding transportation through family,

friends, or an outreach worker, calling Safe Ride, and in some instances being driven by a “date” while they were working.<sup>24</sup>

IP(001): I had this abscess and it just got to the point where it was really bad...my arm is going [waving arm and making buzzing and pulsation type sounds]...so I went to VGH, and I couldn't believe how good they looked after me, it was fabulous... I had one of my regulars take me. I mean what could I do, sometimes you can wait four hours for Safe Ride...and I was in a lot of fucking pain...and I am thinking that's [the treatment by providers] so unusual...and now if I get into an ambulance or a friend of mine is getting in an ambulance, I tell them right straight 'do not go to St. Paul's with my friend.'

Agencies that offered comprehensive services such as primary care, pharmacy, and nutritional and social work support were also places of preference as the organization of these services prevented women from having to access multiple agencies at different sites to address their varying health concerns. Oak Tree Clinic, an agency designed to provide comprehensive care to women and children living with HIV, and She-Way and Fir Square, a combination of programs providing care to pregnant and early parenting women experiencing problematic substance use, were viewed positively by women. In these agencies women could make appointments and therefore could avoid the lengthy wait times that were common among the clinics in the DTES all of which have a “no appointment” policy. Agencies that were primarily “women-only” were also preferred as they enabled women to avoid waiting in areas shared with men, thereby reducing their fears concerning harassment and violence during that time.

Women were more likely to attend agencies where they interacted with staff who were non-judgmental and who were less likely to act in the capacity of surveillance regarding women's involvement in illegal activities (Wilson, 1992). Women often felt supported in their interactions with providers in these agencies and experienced a sense of having greater input into their health care and a feeling that they “mattered as a person not just an addict.”

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<sup>24</sup> Safe Ride is a transportation service designed specifically to transport people within the DTES who have been assessed by 911 or by police as requiring transportation to their home or another agency (e.g., detox). In some circumstances Safe Ride will accept a referral from an agency but do not accept self-referrals. Although designed specifically for people who are considered “intoxicated,” Safe Ride often transports people who have no other resources and require safe transportation.

IP(006): I just found like they were so supportive and, you know, when you did fuck up it wasn't like they would beat you over the head till you're blue, its, 'okay, what do we need to get you not to do it again,' its not like 'oh you're a fuck up', but 'what help do you need right?' and I don't know they just, it was really supportive and I think like knowing that they were on my side when I went in there instead of like 'am I going to get my kid when I leave here?' Like do I lie? I mean what have I got to do right, but I was able to be honest and upfront which made a really big difference.

Similar to VGH, Oak Tree Clinic was located a significant distance (e.g., across the city) from the DTES. Women who qualified for services at this agency (women living with HIV) most frequently accessed them through the aid of non-peer outreach workers who provided transportation and in some instances advocacy to assist women to have their health concerns addressed.

The organizational policies and practices of the Oak Tree, Fir-Square, and She-Way programs, while beneficial, were not necessarily accessible to a significant number of women living in the DTES. Those who were not living with HIV, were not pregnant or early parenting, did not know about the opportunity to access these services, received HIV-related care elsewhere, or those who experienced a sense of mistrust with outreach workers did not or could not access these services. In particular, women over the age of 40 who were not living with HIV were afforded few opportunities to use facilities that provided a comprehensive approach to addressing the multiple health concerns they experienced in their day-to-day lives.

One of the few exceptions to the emphasis with pregnant women or those living with HIV was the Native Health Medical Clinic located within the DTES. This clinic offered both daytime and evening hours and included services that ranged from primary medical and nursing care to diabetes teaching, dental services, and alcohol and drug counselling (Vancouver Native Health Society [VNHS], 2005). Some of the women reported that they accessed this clinic regularly while others reported avoiding it due to their experiences of discomfort with the other people there as evidenced by the following statement from one Aboriginal woman, "I won't go there. It's not my sort of people" (IP005). This sense of discomfort may help to explain why, in

2005, women represented only 34% of all patient visits (VNHS), although census data illustrates that approximately 46% of DTES residents are women (Buxton, 2007).

Street nurses were often perceived by those aware of their services as a positive starting point for accessing health care. Once a street nurse assessed a specific health concern, women relied on them to make recommendations about “who” (e.g., which physician, which hospital) they should visit to address the concern as well as what type of questions they should ask and what kind of treatment to expect.

IP(001): Well the street nurses are great because they’ve got a head up on whose the best and who give the people down here the best treatment...they know that the women down here get treated like garbage.

Street nurses were most frequently accessed through women’s drop-in centres that provided shelter, showers, food, and advocacy resources to women as they visited these agencies on designated days and times throughout the week. Women learned about street nurses’ schedules by reading posters at drop-in centres and by word-of-mouth from other women and service providers.

Street nurses were also accessed on the street and in SRO’s. Women reported “catching one of them” if they “saw one” and then asking them to assist with a specific health concern. Women also reported that at times other providers such as nurses or physicians from a clinic or an outreach worker would make a referral to the street nurse program and this contributed to women’s experiences of being located by a street nurse to assist in the provision of primary care. The delivery of street nurses’ services were not always consistent; a factor that frequently contributed to women’s delay in seeking health care. Women reported leaving their health concerns unattended, sometimes for days while waiting for a street nurse to be available.

Provider(001): We do have nursing care a couple of times per week, assuming of course that they show up. We can go a week or two without even seeing any nurses and we don’t always know whether or not they are going to show up.

In addition to attempting to access specific places and people, women actively developed strategies to avoid others. Many women for example, attempted to avoid what they described as any “formal” health care agency and instead relied on health services offered through various research programs situated within the DTES. Many of these research programs were designed specifically around health issues associated with injection as a route of substance use. Women would enrol in studies so that they could get tested for HIV, STI, and HCV. For some women, this was their only link to primary care.

IP(004): No, I don't like seeing a doctor for anything, well I go to this ESIS [a research study underway in the DTES], so I go every six months for blood work and they do a survey and that is really the only time I see a doctor, well not doctors but they have a nurse there and so the only thing I have is hep C, but I have never been sick from that, and I don't have any other health issues other than that, so I don't go see a doctor...and at ESIS they can line me up for women's stuff...they're nice there. I mean like the doctors, you don't even want to be in the same room as them, you know, its aggravating, it kind of pisses you off but these people [at ESIS] they talk to you like you're a human being, you know what I mean, its not 'I'm better than you' which is that attitude that you're not there, you know, they're there to help you, you know what I mean? They treat you as a human being, you know like you don't want to be thinking of your first exit out of there, with him, you know you feel like punching him upside the head, then leaving, you know, let me out of there, you know?

The majority of women considered some agencies such as the ER of St. Paul's Hospital, Triage Emergency Service (an emergency mental health service agency), and many recovery “homes” as places to be avoided “at all costs” and “if at all possible.” Phrases such as “you wouldn't want your dog to go there,” “they are sick bastards at that place,” “they don't care anything about you,” and “they treat you like you are something less than human” were commonly used by women as descriptors of the health care delivery and the people who worked at these particular agencies.

IP(002): It's [Triage] like the Gestapo of places to go. If you are even a little high or act out just a little bit the staff get really physical with you. There is never any warning. They treat you like children, not adults. I wouldn't go there no matter what I had going on. I am better off on the street.

Service providers who accompanied women to these agencies also engaged in strategies to mitigate the insults to women's dignity. One outreach worker described a scenario in which she spent several hours arguing with nurses in a psychiatric unit to allow a woman to have a bible so that she could pray as this was her primary strategy for dealing with anxiety. In another scenario, a provider reported lying to the admission clerk of a particular agency so that a woman could receive primary care.

During my discussions with women it was obvious that they were reflective about the attitudes and practices of people working at these sites as they attempted to try and understand the rationale for the providers' behaviours. Several women acknowledged that it could be challenging to consistently work with people living with mental health and addictions.

IP(133): Lots of hospital treat people like shit. I guess people do that because they get tired of seeing addicts all the time. You know, in the system, seeing the same people over and over again. I think people get burnt out working with addicts and not seeing anyone get any better.

Women also questioned the motivation and professional ethics of nurses and physicians in an attempt to understand the behaviours. Among the women reflecting on providers' behaviours there was a general perception that if they understood what motivated people they could then figure out the best way to approach them, a fuller discussion of which is included in the upcoming section.

### **Working within the System**

Once women accessed health services, they engaged in a variety of activities to manage their health concerns and to lessen their exposure to discriminatory and abusive social interactions with providers. One of the most significant strategies was to determine how they could "make the health care providers more accepting" of them. These activities were reported as crucial to creating a social interaction in which the health concern that contributed to a woman's need to access services was the focus for the provider, rather than a woman's substance use



practices. Upon presentation at the triage desk of an ER, for example, women frequently provided a false address so that they would not be identified as being from the DTES or what was referred to as a “total downtown east-sider” (Provider002); a label that inferred “drug user” or “addict” status to an individual. Women experimented with this strategy to test its effectiveness and once proven useful, adopted it in other ER encounters or at clinics where they were not known by the health care staff.

IP(002): A friend of mine was going in, we were both very sick, well we had different things going on but we both went in the Safe Ride at the same time to the Emergency, and I said ‘let’s put this to the test.’ She used a different address out in Burnaby and said she was just visiting somebody when she came down with these symptoms and I gave my address downtown. Well they treated her like a queen compared to me; they had her into the Fast-Track like within half an hour and I was waiting there two and a half hours in the waiting room before I even got to see a doctor, that speaks huge volumes...The only reason I was still there was because it was my legal right as a person, that was the only reason why they were even giving me a second thought, I was just like a headache to them more than anything...so whenever I do have any issues I just give them a bogus address, anywhere but downtown.

In addition to falsifying their addresses, women went to great lengths to avoid sharing other information that would highlight their substance use. Women withheld that they were receiving prescription methadone and denied using any substances when asked during the admission process at a clinic or an ER. When feasible, many women adopted a completely different persona during interactions with health care providers. It was obvious that women were aware that by not sharing information about their substance use, some health concerns (e.g., withdrawal, burns, and seizures) might not be addressed. They perceived, however, that denying substance use was essential to being treated with respect and to avoid feeling “less than human in their [health care providers’] eyes.”

IP(006): They [nurses] talk to you, all condescending, like the only health issue that you have or ever will have has to be an addiction-related thing, I mean I actually went in and refused to say that I did drugs and hid it because I felt like they were looking at nothing else in my health except something that was addiction related...I mean if you are lying, I mean you’re obviously not going to receive the services and support that you need right? And unfortunately most of the health care I’ve accessed I’ve felt like I have to lie, I had

to make up a different person so I would access services or just to be treated not like a piece of shit right?

It was apparent in my discussions with the women who reported “lying” about addresses and substance use that the “need to lie” was a demoralizing experience. Women often expressed a sense of despair that they would need to lie to health care providers “for the rest of our lives” if they wanted to have a health concern addressed or to be treated with a modicum of respect during an interaction. The need to lie also contributed to feelings of “not being honest” and “never really being known or understood as the person you are.” Women also recognized that lying was only useful in certain situations such as when they accessed a clinic or ER infrequently. The transfer of medical charts between physicians and the accessibility by providers to previous medical records in clinics and hospitals were noted as a key source of information about women’s previous addresses, substance use, and “drug-related problems.” Among women who were no longer experiencing problematic substance use, this was viewed as a key detriment to developing a positive sense of self-identity; and I would add, a significant aspect in the construction of women in the DTES as Other.

IP(006): It doesn’t matter if you go to a new doctor, your health care record follows you and it is one of the first things they see in it...and especially now, like I really, really take things to heart even more than I ever did because I’m trying so hard to take myself out of the place I was. And I feel like I keep getting kicked right so its, no matter how much you show how good you’re doing, somebody gives you a kick in the ass because you were a drug addict, past tense...And then you wonder how people relapse. It’s like I mean you’re constantly told, and maybe not in so many words, it’s like actions and gestures that, you know, that you’re a fuck up. It just hits you in your soul right?

Some women, although not the majority, reported that it was crucial to be assertive with providers in order to have their health concerns addressed. Being assertive included activities such as “reminding” a primary care physician of what they perceived as physicians’ ethical responsibilities in providing care (e.g., “it’s your job to help me”) and stating to a physician that it was “not their job” to judge how a woman lived her life. This was viewed as an effective strategy when a woman was unable to be seen by her regular physician and as a result was in a

situation with a physician that she believed “did not understand” her or was unaware of her particular health care needs. As one young woman stated, “When my doctor is not available, I go in and see any of the doctors there. I just tell them ‘you don’t want to do this, you want me to die, fine’ and that makes them pay attention” (IP081). In an ER or other hospital unit, assertiveness was often enacted through continuous repetition of their symptoms particularly when they were “accused” by a provider of seeking drugs. Women referred to this strategy of repetition as “not buying into their shit.” Other strategies included asking for the full names of providers who they believed treated them unethically in an attempt to let providers know that they might pursue a formal complaint; and observing the behaviours of physicians and nurses to determine who would be the most likely to listen to their concerns.

IP(005): They wouldn’t give me some of the drugs, they would just say ‘she is just drug seeking.’ And I was like ‘no I ain’t. I ain’t, I ain’t, I ain’t.’ And another doctor came in, and I knew he was different, and I said ‘I ain’t’ and he said ‘she is not drug seeking. It is time to get her what she needs.’ And he was a young doctor too.

Perseverance was also a significant assertiveness strategy. Women described the need to seek health care on a frequent basis until their health concern was addressed. In many circumstances this perseverance required accessing multiple sites and different providers throughout the entire city, sometimes over the course of several months.

Being assertive was not a predominant strategy employed by most of these participants, however, which may be due in part to the severe consequences that women experienced when they pushed the boundaries of the disciplinary domain of power within the health care system. Women frequently reported feelings of “being punished” for advocating on their own behalf or for challenging the normative practices and policies of clinics and providers, the outcomes of which usually negatively impacted their health.

IP(004): I had to go on his [physician] schedule every week, he only came in like four hours out of the week. I could have come once per month. So it was a money thing for him right and I was late and because I was late I stayed at the same level [of methadone]. He didn’t know me like my counselor knew me, and just the way he talked to me its like

he had something against me and for no reason. It's like that the respect was not there...you know and I was like I don't have to put up with this. But I was on 65 and I was supposed to go up to 70 but he kept the prescription of 65, and he goes 'you were supposed to go up to 70. That was planned today.' But I was late so it was sixty-five, you know, so that had nothing to do with my health at all, it had nothing to do with getting me better...It had to do with, you know, if I pissed him off or if I pleased him. So like I learned how, you know, doctors treat you, you know drug addicts when you try and do it right.

The desire to avoid potential negative consequences contributed to a variety of other activities in which women engaged to "work within the system." Many women reported that at some point in their lives they had engaged in the strategy of "not getting too involved in your own health care." This included tolerating or ignoring the attitudes and behaviours of providers. In some instances women simply sat quietly while they were lectured by a physician or did not speak up when treated "roughly" (e.g., ignored while asking a question or physical roughness during an examination) as evidenced in the following exemplars from the data.

IP(004): Yeah, I'm not going to lose out again. I'm not going to focus in on how they talk to someone; I am just going to focus on what I need from them. You know, they think they [physicians] are God or something. So if that is the way they are, well, I'm not going to lose that because of an asshole doctor, you know. I'll just take the way he talks and get what I need.

IP(006): I mean I had to go to the extremes so that they would do the tests they think needed to be done but I find they're very dismissive like if you try to get involved in your health care its like 'you do this, do that, and be quiet, right, like don't ask questions', they don't want to answer you, um, or if they do answer you they talk to you like you're a fool so I just knew to avoid the whole process right because health care to me is something that I need.

Many women opted to only address the health concern that they perceived that the provider thought was important, and in doing so were reluctant to raise any other health issues during the interaction. This strategy was particularly prominent among women who were receiving prescription methadone. Opiate use and methadone maintenance therapy (MMT) were often the only issues discussed with their primary care physician as the women perceived that most of the physicians were focused on this issue.

IP(083): All my physician gives a fuck about is methadone. Nobody talks about women getting older. And you can't switch doctors and that's hard cause you can only see them when they are available not when you necessarily need a doctor.

This strategy of focusing on “what the doctor thinks is the problem” was influenced by a number of factors, most of which were influenced by structural and disciplinary relations of power designed to justify and sustain physician dominance within the health care system. During the course of this project many of the clinics in the DTES stopped accepting new patients. In addition, only a limited number of BC physicians have prescribing privileges for methadone and patients receiving MMT are not usually permitted to switch prescribing physicians as long as that physician is available within the city. These physicians are usually only available within a four-hour time-block on a weekly basis. As a result, women were reluctant to challenge physicians for fear of being without a primary care provider or access to MMT. Without MMT, women experienced an increase likelihood for severe “dope sickness” which only enhanced the probability that they would resume the use of illegal opiates (e.g., heroin). In contrast physicians had explicit rights regarding the termination of the doctor-patient relationship as outlined within the *Methadone Maintenance Handbook* prepared by the College of Physicians and Surgeons of BC (2004):

If patients are verbally abusive or threaten staff with violence, the taper schedule should be at the discretion of the prescriber. If any prescriber feels unsafe...he or she may offer a rapidly witnessed ingestion methadone taper and discontinue the doctor-patient relationship (p. 40).

Women also reported that agreeing with their physician's opinion about a health concern even though in reality, they did not perceive that they experienced that particular concern was another common strategy to work within the system. The women talked about accepting prescriptions for medications that they felt were unnecessary so as not to undermine the physician or make the physician “feel like they are wrong.” This strategy was important to ensure that physicians “felt like they were in control” so they “would listen” in the future. Many

Aboriginal women reported that they believed physicians over-prescribed certain medications (e.g., benzodiazepines) or required them to have more frequent visits based on the health care coverage benefits that people who have Registered First Nations Status receive. These beliefs were related to their assumptions concerning the economic aims underpinning physicians' practices, as reflected in an excerpt from a conversation I had with four Aboriginal women during a kit making session.

IP(104): I don't need Valium but my doctor gives it to me anyway. I don't take that stuff ... They know you are Status and that it is all paid for so, they just overdo it.

These experiences were certainly not the case for all women, nor did women engage in each of these activities during all interactions with providers. Several women reported positive interactions with their primary care physician in which they could bring any health concern to the fore and experienced a sense of "being respected" or "being listened to."

IP(002): Yeah, he's a great doctor...he's very good in the addictions experience too like he's really great for counselling and whatnot. I don't feel comfortable with just anybody especially when you're sharing on a real personal level and a lot of the times women have a lot of issues in the abuse factor, whatever, and it's not always going to be comfortable saying stuff to a man, I wouldn't think twice about that. But for some reason even when I first started going to see him I felt comfortable and relaxed and I didn't feel, I don't know for some reason he has a quality about him that you just feel comfortable and safe and you just know that he's not going to judge you or think any different of me and I don't know, it's really unusual for me to think like that about any doctor so, for sure, issues that are personal and that kind of, it's huge, it's pretty major especially with a man and a lot of my issues, they're based around not trusting men.

In some situations, once women developed a rapport with a physician they trusted, they went to great lengths to maintain this relationship. Traveling and relocation to access a physician who provided "good care" was an important action. This was particularly relevant for women who were taking prescription methadone and had been doing so for several years.

IP(007): I used to go to my doctor on Commercial but now I have to see him down here. I am being punished [laughs]. He [doctor] is an OK guy. But his hours sucked cause they were like 10-12 and it was hard to get there on time or sometimes to get there at all. Now I have to see him down here if I want my script. I live down here now so I can get my script.

## Managing On Your Own

Women engaged in a variety of activities to manage and prevent their mental and physical health concerns that excluded accessing the health care system, which from an analytical perspective, represented a particular health management strategy that I characterized as “managing on your own.” The activities associated with “managing on your own” were influenced by a variety of interrelated factors including the desire to avoid negative interactions with providers, feelings of sadness and fatigue, knowledge deficits concerning the severity of a concern and/or the resources available, and gaps in health care service delivery. Although in some circumstances managing on your own was perceived as the “only option,” most women viewed this strategy as a reflection of personal strength and courage that supported a positive sense of self-worth and value “as a human being.”

### Dealing with the Basics

“Managing on your own” included engaging in activities to secure shelter, food, and freedom from violence, factors that represented some of the basic necessities for living (Farmer, 2005). In an attempt to lessen negative consequences such as environmental exposure and violence that were associated with being out in the open women without a home place often strove to secure temporary shelter. Occasionally, women stayed with friends who were willing to let them sleep on their floor. This was often time-limited and “not overstaying your welcome” was an essential component of being able to access this place in the future. In other instances a woman could stay with a man if she was willing to barter sex in exchange for a roof over her head for the night.

IP(121): I stayed with Howard at the old folks’ home last night...there is this place where the old folks live down around the corner. Sometimes I stay with this guy Howard, he lets me sleep there. You know, I had nowhere to sleep so I *visit* him [raises her eyebrows up and down], so I got to sleep there.

“Squatting” or living in a condemned building was another approach to securing shelter. Living in condemned buildings usually excluded women’s access to running water, functioning toilets, or heat. These buildings usually had crumbling walls and ceilings, and there were no locks on any of the doors. Women frequently squatted with friends and stayed in these living arrangements for as long as possible. Often, women had been living in the building prior to it being condemned.

IP(007): Like the city came in and said ‘we’re going to shut this place down’... so they boarded it up and they shut off like the water, my friend he’d go out and turn it back on somehow, you know. Well we stayed there longer, right, and, you know, so we were squatting in the place, maybe two months, they didn’t know what to do with us right, yeah, and they turned the electricity off, they, you know, oh yeah, then they had to have the emergency people come, that was the last night we were there... they finally boarded it up.

Women also actively sought out opportunities to establish temporary housing in local shelters and more permanent housing within low-barrier and supportive housing agencies.

“Patience,” “perseverance,” and “luck” were all words women used to describe the attributes required to secure temporary or permanent shelter. It was not uncommon for women to wait for hours in line-ups in hopes of gaining access to a shelter for a night and wait-lists of up to three years to gain access to low-barrier and supportive housing were the norm.

Women were cognizant of the barriers they faced in securing shelter. When they perceived that they had exhausted their personal capacities and began to experience a sense of despair or felt more desperate about the need to find some form of shelter, they often initiated relationships with “professionals”<sup>25</sup> in hopes of accelerating the process of gaining access to shelter. Women described the need to “keep hassling” advocates to ensure that their name remained on wait-lists for permanent low-barrier or supportive housing. Women also worked to “keep track” of when a room might become available due to such circumstances as eviction or

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<sup>25</sup> Professionals usually took the form of outreach and/or drop-in centre service providers as well as advocates. Advocates were people hired by the City of Vancouver to assist people in applying for social service care benefits including housing and welfare, and extended health services (PIVOT, 2006).



the death of the current tenant. Informal networks with friends helped to keep women up-to-date of the state of residency within many of the housing facilities and once women learned of a possible vacancy, they would “hassle the advocate” in hopes of gaining entry. Within the context of temporary shelter it was apparent that a woman’s entry into a shelter could be facilitated by having a professional “vouch” for a woman’s ability to “behave,” an experience that was reinforced in the narratives of the providers.

Provider(001): I’ll call for them you know...well then they’ll say ‘are they using?’, I’m like ‘well, you know, they’re sort of, you know, it doesn’t appear so’ but we can’t send them if they’re really obviously totally fucked up because they’ll send them away so what’s the point right? So if they can sort of pull it off we’ll say, you know, we’ll do the non-committal sort of, ‘she seems fine’ and we’ll send them off and with any luck they’ll get in.

Finding a place to live or to sleep were not the only aspects of securing shelter. Women sought out opportunities to seek temporary shelter for short periods of time ranging from one to several hours. These types of shelter were usually drop-in centres and were often associated with accessing food and/or clothing and taking a break from being out in the open. These agencies were also important places where women could come together to socialize. Women recognized the need to reduce their isolation which assisted them to experience a momentary freedom from feelings of sadness or anxiety concerning other events occurring in their lives. Several of these sites were “women-only” and provided women with a reprieve from what many of the participants described as “dealing with men.” As noted by one woman during a kit making session at a local drop-in centre, “it was good to get out today and do this by myself, without him” (IP073). Common agencies accessed by women were the Downtown Eastside Women’s Centre (DTEWC) and VANDU. In some of these agencies, women participated in support groups such as a MMT group and a women-only harm reduction group.

As I noted previously, the threat of abuse and exploitation was ever-present in women’s lives and they experienced limited options concerning whether they participated in activities that

placed them in potentially violent social situations. Over the course of their lives, however, the majority of women had developed a wide range of tactics they could employ in an attempt to prevent or lessen the amount of abuse they experienced. When engaged in “sex work” women attempted to avoid doing dates with men that were perceived as being more likely to be violent. Several of the women in their 40s and 50s for example, discussed the importance of avoiding “younger” dates. As one participant stated,

IP(008): I’ve work the street and had bad johns and good johns. I always got the older guys cause I trust them more than the younger ones.

Women also attempted to have a “spotter” or “someone to watch out for you” whenever possible, but recognized this was not always feasible. “Having a spotter” was not necessarily perceived as preventing abuse but was considered important in the event that a woman went missing.

IP(002): Have a spotter, you know, somebody spotting, to watch out, to take down a licence number, you know, what the person [date] looked like. Even if you do have something happen, you might not know until a certain time and then it might be too late. But at least you have something to sort of connect you. People think that’s morbid but it would be foolish not to think like that. You’ve got to assume that everybody is sick and if they’re not, great, bonus. But you’ve got to assume the worst and hope for the best down here.

Keeping abreast of “bad date sheets” as an abuse prevention strategy was a topic of debate among the participants. Bad date sheets were notices that were circulated as flyers within the DTES that described women’s experiences with an abusive date. The flyer usually included such information as a physical description of the man (or men), the vehicle, the location, and details of the assault. The goal was to provide women with current information about “bad dates” with the intent of assisting women to avoid this date in the future. While not discounting the importance of sharing this information among each other, the women and service providers recognized that there were many limitations associated with this strategy. Of particular concern was that because of the severe economic deprivation experienced by women and the threat of

violence from boyfriends, women were not always in a position to be able to refuse a date. Additionally, there was considerable variation among women regarding what constituted a “bad date” and as a result many assaults went unreported. There was also a sense of fatigue about reporting “bad dates” as these experiences occurred at high frequencies and law enforcement provided minimal protection or support in the event of an assault.

Distinct from the context of sex work, women also attempted to avoid assault by actively seeking to remain “hidden” when out in the open. It was particularly important to avoid “speaking out” about any injustices they witnessed or experienced. Phrases such as “keep your head down” and “keep your mouth shut” were used to describe how to avoid being targeted by other people in the neighbourhood such as other women, boyfriends, police, and dealers. Wearing a hood to cover your head was perceived as a potential strategy to reduce the likelihood of being recognized and targeted.

In circumstances in which women needed to voice their concerns for the purpose of maintaining their safety, it was critical that they knew *where* and with *whom* they could speak. In low-barrier and supportive housing, for example, “boyfriends” frequently moved into women’s places uninvited. When this occurred, women could confidentially request that the staff ensured that the man vacated the place based on “house rules” and as a result they were not held accountable for these actions.

Safe places were also relevant for women while “out working.” Many women had a regular location where they worked with built-in safety structures such as a local convenience store or friends’ places where they could run to escape potentially violent situations and people. This strategy has become problematic for many women as the gentrification of the DTES continues. New residents to the neighbourhood who are not involved in sex work have begun engaging in programs such as John Watch to remove women from their regular locations for work. As one woman noted,

IP(001): Like this sign I saw the other night, I was doing outreach and it was called John Watch and I found out that they're not good for any of the girls. They take down licenses and names and then they print them in local newspapers and the cops backed them right up because, yeah, it's one less person for them on the street as far as they're concerned...It discourages them so they've got to go to other areas, other neighbourhoods that they might not be as familiar with or that they don't know anybody so they can't go to someone's place if they have a problem or if they had some guy trying to do something to them where are they going to run to? They don't know the neighbourhood, they don't know people around there, I mean just it sucks in every which way...I had, uh, those John people follow me up Fraser one day and surrounded me and would not let me out of it, I said 'you guys I'm going to call the cops on you.' I said 'this is called unlawful confinement.' It was awful.

"Not stealing" was identified as another violence prevention strategy among some of the participants. Stealing from dates, boyfriends, or peers, particularly personal belongings and money, was considered to dramatically increase the potential for assault. Many women expressed the belief that "it was their own fault" if a woman who stole got beaten and described this scenario as an important learning experience of being in the DTES.

IP(003): Like this one little girl, you know, she's worrying because she's ripped off her John and he's found her and beating on her eh. I said 'honey look at you', I was a little hard on her, I said 'you're fucking well ripping the guy off, you're fucking like a dirty little skank you're stealing his shit and you don't expect to get beaten? Look at yourself, get it together man.'

Some women were compassionate towards women were "forced to steal" to secure health essentials such as food and clothing. However, this sense of compassion was related to scenarios in which "stealing" referred to theft from department stores or the buying or selling of stolen goods at a much discounted price and not from individuals per se.

Maintaining personal safety while "using" involved other unique violence prevention activities. Smoking crack inside of your home place or that of a friend was a strategy that enabled women to avoid smoking in known abusive locations such as alleys or strangers homes. Women recognized that "being indoors" was not always possible, but described that if the option existed, they would avoid alleys "at all costs." "Who" a woman smoked with was significant. Some of the women smoked alone in their home places with the door locked while others

reported smoking with friends so that they could look out for one another. Smoking with friends was considered important not only to help prevent violence but to also ensure that someone could respond or get help if one person experienced a negative experience related to use including, for instance, overdose, psychosis, an anxiety attack, or difficulty breathing.

Being able to defend oneself in the event of an assault was considered crucial to survival. Many of the participants described in vivid detail the processes by which they had learned to fight as well as how they taught other women to be able to defend themselves. As one woman noted:

IP(001): I know for a fact in two different occasions if I hadn't been as strong and known how to fight as good as I do, I would be dead right now...But I thank my brothers for it, even though I didn't thank them at the time [laughing] because they were beating the shit out of me, but as kids, you know, there's not really any gender.

Several women had taken a self-defence training class offered at a local drop-in centre and they shared with other women how they could gain access to such programs. Women discussed the pros and cons of carrying a weapon such as a knife, and several of the women reported “never leaving home without it.” The fear of having their own weapon used against them was acknowledged, but it was also apparent that women recognized that if they were in a violent situation that warranted the use of a weapon, the threat of being killed outweighed this fear and that “just surviving” became the most prevalent concern.

### **Substance Use to Manage Health**

Although women experienced particular health concerns associated with substance use, it was also a strategy they employed to manage and/or prevent physical and mental health concerns. In many situations, this strategy was a direct result of discrepancies between the organization and delivery of health services and women's experiences of health concerns.

Of particular relevance was substance use as a strategy for women to manage their experiences of acute and chronic physical pain. As I noted in the previous chapter, the

experience of pain was a predominant health concern that was for the most part inadequately managed during their interactions with health care professionals.<sup>26</sup> Many of the local community health clinics had signs posted that stated it was against “clinic policy” to prescribe Tylenol 3<sup>®</sup> or any other opiates and women reported consistently being discharged from hospital without pain medication. Crack, alcohol, and opiates such as heroin and illegally purchased Tylenol 3<sup>®</sup> were some of the substances women used for the purpose of pain management.

IP(172): I have had lots of trouble with my teeth but now I have dentures. I had 24 teeth taken out and lots of trouble with dry sockets afterwards. I drank a lot of rye when that happened. I had these dry sockets and they hurt so much and they would only give me aspirin.

Women worked within the system to engage with providers in any manner that would support their eventual ability to address their pain. Women’s deliberate passivity with physicians for the purpose of ensuring that physicians “felt like they were in control,” as discussed earlier, exemplifies this point. In some interactions where women received perceived unnecessary prescriptions, the medications provided a resource that they used to barter within the informal drug economy to receive more effective pain medication. Women expressed that they believed that many physicians perceived women as “less than a person” or “a way to make money” and therefore they experienced little remorse about playing such a passive or in some instances, deceitful, role within the interaction.

Occasionally women did receive prescriptions to receive opiate analgesics outside of the hospital setting, particularly if they had experienced a traumatic injury such as a fracture. Physicians who acknowledged and treated pain that was sufficient to warrant opiate analgesics were described as being “humane” and “compassionate” individuals capable of seeing women as

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<sup>26</sup> There is a substantial body of literature that empirically supports that people who use cocaine and heroin are chronically under-treated concerning pain management despite evidence that demonstrates lower pain thresholds among those who use these substances regularly (Compton, 1994). Misconceptions regarding the physiology of pain in the presence of these substances, the ability of methadone for those receiving MMT to act as an analgesic, the risk of addiction relapse, and misconceptions that reports of pain by people who use always constitutes drug-seeking behaviour, have contributed to such practices (Alford, Compton, & Samet, 2006).

“real people.” In these instances, women usually obtained a prescription for a one-day amount and would revisit their physician or pharmacist on almost a daily basis in order to receive their pain medication. Many women acknowledged that physician’s prescribing practices were inconsistent and reported that the most significant contributing factor was the fear of reprisal that physicians faced concerning their prescription practices.

IP(031): Some physicians are really good and they know that you aren’t just looking for drugs but have real pain and they try and treat that pain. But they just get into trouble with the college or whatever. They watch what doctors are doing and they think they are giving out too many drugs. They never bother asking us why we have those drugs though.

On several occasions I noted that some women appeared to have misinformation regarding whether opiate analgesics could be taken if they were receiving MMT and experiencing pain that warranted opiate analgesics. I discovered that this knowledge was based on information that they reported receiving from their physician and was associated with a fear of experiencing an opiate overdose or a relapse of addiction. In these instances, women expressed that pain was something they “had to live with if ibuprofen didn’t work” and were therefore unable to advocate on their own behalf for adequate pain management. These findings are somewhat disturbing given that the concern that MMT combined with opiate analgesics may contribute to overdose or “addiction relapse” has never been clinically substantiated (Alford et al., 2006, p. 129). In addition, methadone is limited to a four hour duration as an analgesic and given that most people receiving MMT only receive a dose once every 24 hours, it is unlikely that MMT would function appropriately as an adequate analgesic in conditions that warrant opiate analgesic treatment (Alford et al.)

Substance use was also significant factor within the realm of women managing mental health concerns. Despite the high incidence of mental health concerns experienced by women, over half (50.8%) of the women who participated in the survey reported “never” when asked about the frequency of seeing a counselor and the lack of “counselors” to address mental health

concerns was raised as an important issue among survey and interview participants. Over the past several years, BC has experienced severe cuts in community mental health programming and welfare benefits, leaving many people who are most at-risk for mental health concerns without adequate resources to address these concerns (Morrow et al., 2006). I was not surprised then that women's substance use was considered an effective self-management strategy to address their mental health concerns. Women reported experiencing a sense of "relief" when they used crack and other substances such as "pot" and "sleeping pills" particularly in relation to their experiences of sadness, despair, and fatigue. As one survey participant eloquently summarized when asked to identify problems for women who use crack: "women experience lots of inner stuff; personal issues they are trying to bandage with crack." Crack use was also associated with feeling a sense of calm that enabled women to escape from worries about life and experiences of loss and despair, particularly concerning their relationships with abusive partners.

IP(010): I only just smoke so I don't have to think about him and I can just totally drift off to a different place. I don't think about nothing... my mind is just blank. I don't have anything to worry about...I smoke to forget.

Among women who did receive counseling, crack use was described as an effective strategy to assist them to deal with issues raised during this activity. During a conversation among several Aboriginal women about their experiences in residential schools, for example, one woman discussed her use of crack in relation to being in counseling.

IP(101): I was in a residential school for six years. When I started dealing with all that stuff, well that's when I started using crack. I used it because I was dealing with that.

Each of the three service providers reinforced the women's narratives concerning the role that substance use played in how women "dealt" with their life circumstances. They spoke openly about the impact of life-long trauma for women's health and commented that "if that was my life I would use too." When elaborating on the meaning of "if that was my life" it became apparent that they referred not only to the daily abuse and exploitation women experienced in their homes



or while out in the open, but also the discriminatory and derogatory care that women received when they interacted with the health care system.

Provider(002): Why would you go to the hospital to wait for hours and hours and get treated like shit, not get your pain medication because you are a drug user. You have to sit there by yourself while people are poking and prodding you and treating you like shit. I don't know, but for me, I'd go back out on the street and do a whack of heroin. It heals the pain, it numbs the mind and you are around the people that are at least your people, whether they are treating you like shit or not. They are not standing there in white jackets looking down on you.

Substance use was also associated with managing mental health concerns associated with feelings of hyperactivity or manic behaviours. In many of these situations, women had experimented with a diverse range of substances, with the hope of finding something that would assist them to have greater focus when engaged in tasks and contribute to reduced feelings of "being jittery" or unable to "sit still."

IP(002): I guess chemically that [ADD] would explain why I started the crystal meth route the first few times because it sort of levelled me out and I couldn't understand like everybody else is like, you know, got all weird and they were hyper and for me it sort of did the opposite because I was already hyper it sort of mellowed me out and, like I could do things a little better and I would complete my little projects and stuff and it was just bizarre, I could go to sleep like that [snaps her fingers] at night, no problem and wake up in the morning bright and bushy-tailed.

Substance use to manage insomnia or "difficulty sleeping" was common. Women acknowledged that physicians often prescribed sleeping aids but that these were usually insufficient to assist with this concern.

IP(010): I can't stay up for days and days. I put myself to sleep. I always make sure I have Valium or something and I take a hot bath when I know it's time to get like calm down, have something to eat and go to bed.

R: Does your doctor give you Valium or do you have to get it?

P: I have to get it. But I get Tylenol 3<sup>®</sup> like every second day [for pain associated with a spiral fracture of her arm] and they also put me to sleep and so does the seroquel. Yeah, my doctor put me on 100mg of seroquel and plus I take Valium and Tylenol 3<sup>®</sup> and I'm out.

Crack use was specifically employed as a pragmatic solution for dealing with fatigue and low energy. As I have previously noted, women involved in commercial sex work often worked throughout the night and until the early hours in the morning. Women expressed that they needed “something” to help them have energy during the day. “I need my morning hoot. It livens me up” and “I have no energy until I have my toké” were typical of comments made with regards to the energy-boosting benefits of crack use.

For other women, crack use was a purely social activity that they engaged in with their friends as a way to reduce their social isolation, and to experience a sense of pleasure and release from the day-to-day activities of their lives. Throughout their conversations, women often discussed the social benefits of crack use and joked about the fun they had when they used as evident in the following excerpts from kit making participants.

IP(054): I don’t smoke like I used to. I smoke for fun now. I like the high. I don’t do it every day anymore.

IP(053): I know, I don’t do it much anymore, like once per month, to get a break from my kids.

The pleasure and sense of escape that women experienced was a strong motivator for use, and the women’s narratives illustrated that they controlled their use. Many women expressed that they would continue to use crack throughout their lives so that they could experience the “positive” outcomes associated with its use. This desire to use “forever” was reflected in the following dialogue with two women in their early 50s who had been friends for an extended period of time and had spent most of their lives street-involved and living in poverty in the DTES.

IP(022): I am never going to stop. When I’m on my deathbed just bring me my pipe, brillo and a nice ten dollar rock. That’s what I want. [laughing]

IP(023): Yeah, I could be dying with fucking cancer and in bed and I’ll figure out a way to smoke it. There’s no way I am going to stop it.

## **“Doing Nothing”**

In addition to the women’s many creative activities and actions to “manage on their own,” women sometimes did not engage in any activities to address a specific health concern or to attempt to prevent issues from occurring. This phenomenon of “doing nothing” was intricately related to the social, political, personal, and economic contexts of their day-to-day lives. For example, women were often so accustomed to experiencing chronic health concerns that these issues became normalized as the “day-to-day” and were not perceived as something that could benefit from activities to address the concern. As noted by one service provider, “many women don’t do anything until it’s like they can’t breathe anymore; they are just so used to feeling bad” (Provider002). Women frequently simply “waited” for deep cuts due from stepping on broken glass to “heal over” although they acknowledged that in retrospect they might have benefited from having it sutured. Many of these cuts became infected and did not heal properly leaving women with chronic tenderness at the site of injury. Women reported that they “stayed in bed” for periods up to several weeks because they were feeling unwell or run-down, even in the presence of productive coughs, vomiting, and diarrhea. During a discussion with the advisory group in which I attempted to seek clarification concerning the practice of “doing nothing” in relation to experiencing these health concerns, the women responded that “there’s nothing that they can do...I think a lot of them suffer through it.”

Of particular concern related to the practice of “doing nothing” were women’s misconceptions and misinformation concerning what constituted a health issue, when to access health services to assist in addressing a concern, and the lack of information regarding what services were available. This was particularly apparent in conversations that focused upon their experiences of menopause, infertility, and joint pain. Amenorrhea among women under the age of 50 was perceived as a “normal” experience. As one 38-year-old woman noted, “I haven’t had a period in eight years. Like a lot of the women down here, it’s just an early change I guess”

(IP002). Women rarely reported seeking health care attention to prevent or lessen the potentially harmful consequences associated with amenorrhea. Most were unaware of the association between amenorrhea and osteoporosis or the relationship between bone density loss, arthritis and painful mobility (Porth, 2005) or that they were effective interventions to mitigate some of the harmful consequences associated with these concerns. In some instances, women reported that they had received misinformation from their physicians, although they were unaware at the time that the information was not fully accurate. When I explored these issues in greater detail during interviews, it was apparent that physicians frequently interacted with women in a manner that conveyed substance use, isolated from the detrimental effects of malnutrition, exposure, and violence, was *the* cause of their health concerns. As a result, women often believed that there was “nothing that could be done” to improve their health.

IP(044): I have a fiancé and we want to have babies, but because I put all that stuff in my system, that’s why I can’t get pregnant. My doctor was the one that told me that I couldn’t get pregnant because of all the drugs I used. I feel really bad that we can’t have babies because of the stuff I did.

Women were often unaware of their eligibility for services or simply did not know about services that were available within their neighbourhood. Many women who suffered from pain related to dental cavities and broken teeth for example, were unaware of their eligibility for services to address these concerns if they qualified for and/or were receiving second-level of disability income assistance and health care benefits. In addition, several women were completely unaware that health services were covered by extended health benefits for people with registered First Nations Status. Isolation and fear of judgment by service providers contributed to this dearth of knowledge.

IP(006): When I was first diagnosed [with HIV] I didn’t access any services, like for one thing I didn’t know about most of them, because I kind of stuck to myself and so I didn’t know that I could access all these different places, people, things and stuff. And the few things I did know, like the downtown clinic, I despised the clinic. I didn’t want to go. My partner finally got me going to things.

Eligibility or receiving extended health benefits did not guarantee, however, that women would access these services. Discriminatory and derogatory social interactions and the gaps in services that were actually available were also significant factors that contributed to women's practices of "doing nothing."

The fatigue and sadness associated with living with chronic illnesses and the work of surviving their day-to-day lives (e.g., seeking additional income, attempting to avoid violence and the police, and searching for food) also contributed to "doing nothing." It was not uncommon for women who experienced a sense of fatigue to express interest in dealing with their health concerns, but they acknowledged that their feelings of fatigue and malaise often prevented them from taking any initiative. Even in circumstances where outreach workers and advocates had helped to set up appointments, the energy required to travel and attend the appointment was often perceived as an insurmountable effort, an experience which further contributed to increased isolation and general feelings of "being unwell."

IP(005): I want to do something different. I want to get into counseling...I am just tired of this day after day. I need to get out there and do other things...I have trouble keeping appointments...I am just a tired, tired woman, don't know what I want to do. I get frustrated with myself and I am depressed a lot lately.

A small number of women expressed a sense of despair concerning violence, illness and death as the inevitable outcomes of their lives. When asked in an open-ended question "what do you do to keep yourself safe" during the survey, some women responded with phrases such as "there is nothing you can do" and "nothing, what happens – happens." Several also reported that "you can't do nothing" to stay healthy when you are smoking crack. In such circumstances, women often stated that "it was only a matter of time before something happened." When I explored these issues further I learned that this sense of impending death frequently referred to the likelihood of being kidnapped, beaten to death or dying from an illness such as AIDS or HCV.

Women's options to not address a health concern were also associated with the overwhelming desire to avoid interacting with health care providers. Women expressed that in many instances health care providers did not "understand" the nature of the health concerns that women faced on a regular basis. Women described multiple scenarios of seeking health care assistance only to be "misdiagnosed" or misunderstood, a scenario that contributed to simply living with the concern until an emergency admission to hospital was warranted.

IP(002): [The doctor] had not worked down here at all so he wasn't really up with a lot of the issues that are common down here like infections, abscesses, any of those kinds of things...he just kind of made a diagnosis like a lot of other doctors. They just sort of took what the symptoms I was telling them and figured it must have been a pulled muscle, but it got progressively worse and worse until my head was stuck [bends head down to her shoulder]. I woke up one morning paralyzed in pain. I had to yell at the top of my lung for like an hour for somebody to come to my room. I'm screaming 'call 911, it's a medical emergency, please help me in room blah, blah...it was horrible, getting told 'it's just a pinched nerve' and I just lived with it. And I ended up in the hospital for six months.

In other circumstances, women either chose not to access services or delayed access due mainly to their assumption that health care providers' would not assist them to address their health concerns. This assumption was based on their experiences of social interactions within the health care system and as one service provider who regularly accompanied women to health service agencies stated:

Provider(003): I think especially from health care providers, because they [women who use illegal drugs] have to use them, they cannot just avoid it. At St. Paul's Emergency, like the staff will say anything, like if you fall asleep but you feel so shitty, so the nurse will say 'oh well if you can sleep it means you feel better.' Or yeah, if you're standing and saying 'I've been here for three hours,' 'oh you can stand so you feel better.' Whatever they do, it works against them so they get kicked out and I think many people do believe it's like drug users are not like real people so maybe they will die sooner and the street will be cleaner. I think subconsciously that is the hope of the people who work there, and they think 'keep them as far away from us as possible' is better. 'Let them take care of themselves, kill each other.'

## **Managing Substance Use**

The participants engaged in a diverse range of activities in their attempts to lessen some of the harmful health consequences associated with substance use in general, and crack cocaine

use in particular. These activities varied throughout the course of the women's lives and were influenced by their personal experiences and histories, individual hopes and desires, the availability of resources, the types of substances used, the legal status of substances, and the degree to which their substance use was experienced as problematic. Among women who described themselves as an "addict," for example, avoiding the negative consequences associated with withdrawal was of primary concern. Women went to great lengths to ensure that they had an adequate supply of the appropriate substance at crucial times throughout the day. Using when they first woke up often enabled women to avoid withdrawal and the related negative health consequences and supported them to go about their other daily activities. During a discussion about crack use, one woman noted, "It gives me a start to my day. I can then get up and shower, and do other things I need to do" (IP084).

Women who had required admission to hospital for a specific illness (e.g., pneumonia, sepsis) often left the hospital prematurely or "against medical advice" in order to self-manage withdrawal. In such cases, women reported that their "addiction" was not appropriately managed during the hospital stay and they explained that they were left with no option but to leave. Leaving the hospital prematurely was particularly common among women who experienced problematic use with heroin and other opiates, as reflected in the following excerpt from a conversation with a woman about her experiences of working with women during her peer-outreach activities.

IP(003): And there is this one young girl, she's never better because she's always outside right? So she doesn't stay [in hospital] long enough because she's a heroine addict, and they don't manage it. I don't understand that, I wouldn't run a hospital like that.

Often, it was a challenge for most women to have an adequate supply of substances in order to prevent withdrawal. This was due primarily to women's experiences of poverty and the costs associated with the substances they used. Women frequently experienced withdrawal until they could purchase or barter for access to a substance that would alleviate some of their

symptoms. Women relied on friends, boyfriends, and dates; sold personal belongings (e.g., crack using equipment or food); and engaged in sex work for money to obtain substances. Buying small amounts of crack or heroin to “take the edge off” provided a reprieve from withdrawal and afforded women the opportunity to strategize how to purchase more of a substance before they began to experience withdrawal again.

For women who could not afford to purchase smoking equipment, borrowing from others was a regular occurrence. Borrowing contributed to sharing the crack and the equipment, often in situations that placed women at risk for abuse. The person who owned the pipe received the benefit of the resin (remaining crack residue) when they next used the pipe, making it lucrative for people to share their equipment while simultaneously reducing the amount of crack available to the women who purchased it.

There were few options available to women to manage the paranoia and psychosis that they experienced in relation to their substance use. Women described these mental health concerns as something that they “just have to get through.” Women often “waited” for symptoms to pass and hoped that the negative consequences of self-injury or violence inflicted by others did not occur. Avoiding police and Emergency Medical Services (EMS) providers was crucial in how they managed paranoia and psychosis. The involvement of these individuals was usually experienced as exacerbating the suffering that a woman would endure due to the increased likelihood that they would be physically restrained and “treated roughly.” The majority of women had a great deal of compassion for a person experiencing paranoia and psychosis and were actively involved in supporting one another through these episodic events.

IP(113): I feel so sorry when I see someone being so paranoid. Because you know, you have been there and you know what it is like. If I can, it is good to just be there with them, you know just to be there...make sure they don't get hurt.

Some of the participants actively engaged in activities to avoid experiencing paranoia and psychosis including cessation of the substance that they perceived as the most significant



contributor, an activity that often resulted in the initiation of a new substance. The rationale for changing the type of substances used was not limited to experiences of paranoia and psychosis. In some situations, changes were related to pre-existing health concerns and to limit the “work” associated with obtaining substances. Many women reported that over the past several years their use of illegal substances had decreased while their consumption of alcohol had increased. Alcohol was perceived as being “easier” to obtain and did not carry some of the social, economic, and health consequences associated with illegal drugs (e.g., arrest; exposure to bad dope).

IP(024): I drink more now. It is easier and way less work. With crack you have to get the money, get the dope, get the supplies. It’s a lot of work being an addict...and drinking is cheaper.

Several women living with HCV reported no longer drinking alcohol for fear that they would experience liver dysfunction and identified an increase in the use of other substances such as marijuana and crack. It was apparent that women actively weighed the risks and benefits of individual substances in deciding what substances they would continue to use on a regular or occasional basis.

IP(008): Like I was using the needle... I don’t use drugs anymore just social...I just use crack once in a while, I don’t use much drugs, I do maybe once a month... so my health is better.

To lessen the possibility of some negative health consequences women also tried to develop effective strategies to limit their exposure to “bad dope.” During kit making sessions women talked about “dealers to avoid” and frequently shared their knowledge with one another concerning how to identify bad dope. In the following excerpt, one woman shared the monitoring strategies she used when purchasing crack.

IP(054): You have to be careful that you don’t get crack with heroin in it. You can recognize this crack because it usually has a silver wrap around it. I use heroin too so its okay, but the girls who don’t know can get really messed up.

Purchasing from a consistent dealer known to supply “good dope” was beneficial but not always feasible. The women experienced significant challenges in locating their dealer which often resulted in purchasing from someone they did not know. Dealers were frequently arrested and imprisoned, and in some instances they simply vanished or died.

IP(024): I was having trouble finding rock. I like to get it from my same dealer and then I found out he was dead. I had been looking for him all over and here he’s dead.

Although used by very few women, the strategy of holding a dealer accountable for the quality of the cocaine was occasionally successful. Women who appeared to more able to regulate their use and those who were less likely to experience withdrawal were more likely to apply this strategy. As one woman noted:

IP(113): I just tell them when they say ‘hey it’s freebase’... ‘it’s supposed to be freebase you idiot. Like it’s only supposed to be cocaine. There isn’t supposed to be all this other shit in it.’ I tell them that they are supposed to give me what I want cause I’m the client. I don’t take any shit from them.

Only one other women in the project articulated that she solely purchased freebase as a strategy of avoiding impure crack cocaine. Other women addressed their concerns about purchasing “bad dope” by re-cooking the crack themselves with either ammonia or water, in an attempt to remove the impurities prior to smoking.<sup>27</sup>

Patterns of using substances varied over the course of women’s lives and defied an obvious trajectory. Women often switched among their patterns of use depending on other circumstances occurring in their lives and most recognized that their own patterns of use were dynamic and ever-changing. Not using any illegal substances temporarily or permanently, an experience women referred to as “being clean,” was an important activity to address some of the negative health consequences associated with use.

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<sup>27</sup> The powder form of cocaine is sold as a hydrochloride. Freebase cocaine has had the hydrochloric acid removed by mixing it with a liquid base such as ammonia or baking soda and then dissolving the product in ether. This is a highly purified form of smokeable cocaine. Crack cocaine is processed from the powder with baking soda as a base and then crystallized. Few impurities are removed, part of the baking soda remains as a salt and many impurities such as oragel (e.g., lidocaine) or other substances may be added (Ratner, 1993).

“Being clean” on a permanent basis was experienced by a very small number of women, many of whom were also receiving MMT. It was apparent among this small group that this change was often associated with having experienced a health crisis, the fatigue associated with the chronic health concerns they related to use (e.g., abscesses), and fatigue due to the “work” that was required to be able to maintain an adequate supply of substances.

IP(141): I’ve been clean for seven years now. I had it. The last time I used I got a collapsed lung and I got so sick. It just wasn’t worth it any more. I just got too tired. I got so tired of how much work it is to do drugs, work [sex work] for the money, work to find the drugs. I like having money in my pocket now.

Several women that I met in the course of the interviews and kit making sessions were actively engaged in the process of “trying to get clean.” Deliberate exposure to triggers to practice resisting use and acknowledging “slip ups” (e.g., using when trying not to) as realistic and sometimes unavoidable experiences were important strategies that women identified as assisting them to continue in their attempts to “get clean.”

IP(063): I am not going to kid you. I am going to slip tonight. Thanks for the offer [to store her smoking equipment], but no, this is just something that I have to go through. I will be OK.

It was also readily apparent that peer support and encouragement were essential to this process. Women congratulated each other on their successes of engaging in periods of not using and offered encouragement and support for those who talked openly about having a “slip up.” Phrases such as “you are only human” and “pat yourself on the back for getting this far” were common.

Throughout the processes of “trying to get clean,” the women varied significantly with regards to accessing formalized systems such as detoxification and/or treatment programs. Although several had accessed these programs on several different occasions, many women worked at eliminating substances without accessing these services. Several women, for example,

engaged in specific strategies of eliminating one substance at a time and perceived it as under their own control to regulate their use.

IP(010): I don't do needles. I've been clean off of needles for 18 years now and yeah I quit cold turkey. Yeah, it was hard. I did Talwin and Ritalin out in Winnipeg and that was like abscess city and misses... Yeah, I did it on my own, and I'm going to slowly quit that [crack] because it's starting to get expensive. It will be no problem to quit that, it's mind over matter.

A temporary and episodic approach to “not using” was the most common experience of “being clean.” Time periods for “being clean” ranged from days to months, and most often there existed no underlying goal of permanently not using. Episodic periods of “being clean” were described as “taking a break” or “trying not to use” particularly if they perceived that a period of “being clean” would help them to address a specific health problem that was occurring in their lives.

IP(132): I have been clean for 47 days because of my count. I want to be healthier and not make myself sicker than I am right now.

For some women, the opportunity to have a period of time without use correlated with being able to leave the boundaries of the DTES to travel to visit friends or family members elsewhere in the city or province and ranged in time from a few hours to several days. As I noted previously, leaving the DTES was not only beneficial as a strategy to support not using, but also provided an emotional break from the constant fear, anxiety, work, and violence that constituted much of their day-to-day lives.

Among women who used regularly, but did not perceive or experience their use as problematic in terms of being addicted or interfering with other aspects of their lives, their substance use was carefully regulated with regards to when, where, and amount used. This was especially common among women who used crack cocaine as their primary substance for “getting high.” Women made deliberate decisions regarding when and in what quantities they

used crack and these decisions were often influenced by other events occurring in their lives such as work or school. As one participant noted:

IP(001): I only do it [crack] when I don't have other obligations. Like, if I have a shift. I mean I've had drugs sitting right on the table and my shift is like half an hour down the road, I'll just put the drugs away and go and do my shift and I'll come back later after my shift, right, but a lot of people can't do that, I mean I've been an addict for thirty years so its like I'm basically what I call myself is a functional addict.

To support a pattern of use that was less frequent and in smaller amounts women also regulated their spending for use. They set financial limits (e.g., \$60) for themselves and were able to ensure that they did not extend beyond this amount when they actively used. Some women would ensure that they did not have more money in their pocket than their allotted amount for use while others were able to control their use to guarantee that they did not go beyond their limit. The amount allocated for use was for the most part significantly less than what they had usually spent when they were using at much higher frequencies and quantities.

The women learned the strategies that they shared with me throughout the course of their lives. Trial and error was the most dominant learning method as they strove to regulate their use. Significantly, the women developed the ability to recognize when substance use interfered with other aspects of their lives that they viewed as positive, for example, working towards their future goals. Many women expressed a sense of control over their use and were able to recognize if their use became problematic.

IP(009): I smoke crack now and again but I don't use heroin. I've smoked jib once in a while. I did drink and I don't do any of that stuff except for smoke crack, but if I thought my crack smoking was going to interfere with my schooling and whatnot, I tell you right now, I would never go back into a recovery house, I'd go into a treatment and deal with it.

## **Summary**

Women's strategies to manage their health were multifaceted and reflected their creative and resistive capacities to respond to inequities in the distribution of social, economic and health care resources. Many of these strategies were learned by trial and error, and often came at great

personal cost to the women. Substance use was non-static and was experienced both as problematic use and as a self-regulated strategy to address health concerns. Despite women's strength and creativity, their health management strategies also illustrated the significant barriers that exist and limit women's opportunities for less inequitable experiences of health. Limited knowledge concerning the services available and the implications of health concerns experienced combined with institutional policies and discriminatory social interactions with health service providers to negatively affect women's likelihood of receiving appropriate health care. In the face of all of these issues, women continue to share what they know and learn with each other and strive to self-manage their pain, their health, and their substance use.

## **CHAPTER SEVEN: CONCLUSIONS, DISCUSSIONS, AND SOME FINAL THOUGHTS ON INTERSECTIONALITY**

### **Introduction**

In this final chapter I examine the contributions of this project to our understanding of women's health in general and the health experiences of women who are street-involved and use crack cocaine. I begin with a brief overview of the key findings, particularly as they pertain to women's experiences of health concerns and related health management strategies and then discuss the dominant themes that were reflected in the findings within the broader arena of relations of power. Within this discussion, I shift the focus from women's experiences as individual members of a social group, to more critically reflect upon the dominant ideologies at play within the findings and how these ideologies contributed to structural, disciplinary, and interpersonal relations of power that served to influence, justify, and reinforce social, economic, and political inequities that contribute to women's negative health experiences. In doing so, I identify similarities and differences between these findings and those reported in the empirical work that has preceded this project.

I then present my conclusions regarding the significant implications of this project and recommendations for the future. I discuss the research process, and incorporate my critical reflections on the research methodology, the strategies I employed, ethical issues, and study limitations. I also comment on strategies for research, education, and practice that include strengthening women's resistive capacities and argue that such approaches are necessary if we are to truly strive towards equity and equality among women who are street-involved and use crack cocaine. Finally, I conclude with a discussion of the contributions that the project has made to the fields of nursing research, education, and practice.

## Overview of Key Findings

The DTES is a place of dynamic contestation and negotiation that reflected the complex trajectories of women's lives. The women experienced the DTES as a place characterized by racialized, gendered, and class-based systems of oppression where they endured relentless violence, public scrutiny, and targeted enforcement activities across a variety of spatial scales including their homes, on the street, and in various health and social service agencies. Relocation was unrealistic due to the lack of affordable housing, emergency shelters, and drop-in centres that provided essential health-related services (e.g., food and personal hygiene facilities) elsewhere in the city. The DTES was also experienced as a place where women sought escape from oppressive and often violent situations. It was also where women expressed a sense of belonging. In the DTES, women cared for one another and their family members and took pride in their involvement in community activist activities including membership on neighbourhood committees and participation in rallies. These experiences reinforced that this neighbourhood was in fact their home.

The DTES was constructed through relations of power as a place of deviance where people who lived there were perceived as “abnormal” and “amoral” by members of dominant groups in society, and in some instances, by those who lived there (Razack, 2002b). Within the women's descriptions of their interactions with health care providers, law enforcement officials, and other members of dominant groups, it often appeared that they were viewed by some, not as individuals with personal histories, strengths, and courage but as “addicts, junkies, and whores.” Women described that these labels and their inherent meanings were often attributed to them simply because they were situated within the DTES. Women perceived that they were viewed by members of society who did not live in the DTES as being of less moral worth than other women in society overall. The experience of being of less moral worth contributed to the lack of recourse available to women with regards to the mistreatment they experienced by some people



or for criminal acts committed against them. Women experienced a sense of despair and futility that they would ever be treated as individuals in their own right. Instead they reported that they were regarded solely as people who used substances or who worked in the commercial sex industry and this affected not only how they felt about themselves, but the strategies that they employed to manage their health concerns and the mitigating factors.

The women experienced a myriad of acute and chronic physical and mental health concerns, many of which were often interrelated and served to exacerbate one another. Their physical health concerns involved almost every body system particularly within the respiratory, musculoskeletal, immune, and reproductive systems. For example, sore throats, productive and unproductive coughs, musculoskeletal injuries, arthritis, and premature menopause were common. Women's experiences of mental health concerns were multifaceted. Feelings of sadness and anxiety and experiences of chronic insomnia were regular occurrences. Paranoia and psychosis also occurred and these concerns were most often attributed to experiences with poor quality crack cocaine. Women lived their day-to-day lives in chronic pain, most of which was not adequately managed within the health care system.

There was no single factor that I was able to identify as the major determinant or influential factor that shaped women's experiences of their health concerns. Unlike the preceding research that has emphasized the interrelations between women's use of crack or experiences in commercial sex work as singular determinants of health concerns (e.g., Inciardi et al., 1993; Tortu et al., 1998), it was apparent that poverty, violence, exploitation, discrimination, substance use, and ongoing trauma all intersected in a variety of ways and in matters of degrees to influence the various health concerns experienced by the women. Additionally, these influential factors were reflected in significant inequities in women's health in that many of these factors were potentially remediable and represented injustices within relations of power.

The women engaged in a variety of strategies in their attempts to lessen the harmful effects of poverty, violence, substance use, and discrimination as factors influencing their health. These strategies included: (a) managing limited financial resources; (b) negotiating the health care system; (c) managing on your own without accessing the health care system; and (d) managing substance use. How women enacted these strategies was dependent in part on the types of concerns they experienced and what they perceived to be the most pressing concern that required their attention. For example, ensuring that rent was paid was a prevailing strategy among most women who received income assistance to prevent sleeping on the street or relying on shelters or friends for accommodation. Negotiating the health care system often involved learning through trial and error where to go and who to see with regards to accessing services. Women regularly withheld information about their health concerns and accepted a provider's authority to identify the concern as a strategy to protect their own dignity and to ensure that some of their concerns would be addressed in the future. Women often preferred to avoid interacting with the health care system which at times only contributed to worsening of their health concerns.

Women were not always knowledgeable regarding the severity or underlying causes of their health concerns. Nor were women always aware when a health concern warranted attention by a health care provider. Women often expressed misinformation regarding why they experienced a health concern or the appropriate strategies to manage their health. For example, many women were unaware that methadone maintenance therapy was not sufficient cause to negate the prescription of opiate analgesic for pain management or that premature menopause carried significant risk for other health concerns. Physicians were often attributed with providing misinformation as well as "blaming" women for their experience of health concerns. Many of the women accepted that their health concerns were an unavoidable part of life, and also blamed themselves for these concerns, especially in relation to their substance use practices.

Substance use, both legal and illegal, was a complex facet of the women's lives that could not be simply reduced to experiences of addictions or problematic use. The use of multiple substances was the most common pattern of use. Patterns of use and the degree to which use was experienced as problematic also varied over the course of their lives. Many women reported having experienced addiction to one or more substances at some point in time and although most were currently using substances, not all of the women experienced their current use as "addiction." To add to this complexity, women simultaneously reported using substances to self-manage health concerns; a strategy that appeared to be related to policies and practices within the health care system. Due to the experienced lack of availability of analgesics or mental health services for example, many women reported that they used crack to manage acute and chronic physical pain or to manage emotional pain associated with current and past physical, sexual, and emotional trauma. Whether or not a woman's use was experienced as an addiction was described by women as irrelevant to this practice.

To date, most research concerned specifically with the health concerns experienced by women who are street-involved and use crack cocaine has emphasized a narrow approach to explore concerns and related influential factors. Crack use, addiction, sex work, access to health care, and homelessness have been studied almost exclusively as potential influencing factors for health; often in ways that have suggested that health concerns were determined by single, isolated variables that could be attributed to women's actions and activities. These approaches have frequently overlooked the interrelationships among relations of power, systems of oppression, crack use, sex work, homelessness, and access to care as health determinants as well as other influential factors (e.g., poverty, violence, and discrimination) for women's health. Although many of these studies have been beneficial to a growing body of knowledge concerned with women's health, these works have also, at times, contributed to essentialized depictions of

women who use crack cocaine as “drug users,” “addicts,” “homeless,” or “sex workers” and have also exacerbated the racialized discourse concerning women and crack cocaine use.

My approach to research was different. Informed by tenets of intersectionality and social geography and the previous work of critical and feminist researchers who challenged an essentialized notion of women who use crack cocaine (Boyd, 1999; Maher, 1997; Murphy & Rosenbaum, 1999; Taylor, 1993), I employed a critical ethnographic approach that allowed me to explore women’s experiences of health within the context of their day-to-day lives and the relations of power that influenced their lives. I sought to avoid studying a specific health concern or a single influencing factor and as a result I was able to draw from women’s experiences to develop a greater understanding of the complexity of their health concerns, the strategies they employed to manage their health, and the obstacles and barriers they faced with regards to achieving more equitable health experiences.

## **Discussion**

It is indisputable that the women experienced complex and multifaceted health concerns that significantly influenced their overall health and well-being on a day-to-day basis. Equally important was that these health concerns could be considered preventable or at the very least, the severity with which they were experienced could be reduced. Access to adequate clothing, housing, nutrition, health care, hygiene, sanitation, and freedom from violence, have all been internationally lauded as essential to preventing illness and death (Farmer, 2005). Yet, as evidenced throughout the previous analytical chapters, these influential factors were significantly limited, and in some instances, absent within the women’s lives. Understanding the complexities of the health concerns experienced by the women, as members of the underclass, cannot be fully appreciated solely within the context of resource allocation or distribution. Instead, women’s experiences of health must be situated within a discussion of relations of power and systems of oppression (Weber, 1998; Weber & Parra-Medina, 2003).

The women's experiences of health were influenced by relational processes associated with dominant ideologies concerning women who are street-involved and use crack cocaine; particularly ideologies of deviance, difference, and individualism. These ideologies further influenced the structural, disciplinary, and interpersonal domains of power that also shaped women's experiences of health. The women's experiences of health reflected the inequitable concentrations of social, economic, political, and personal power at play within our society that serve to reinforce and justify the social location of dominant groups. I concur with other critical and feminist researchers (e.g., Collins, 2000; Varcoe et al., 2007) that it is only by critically examining and exposing these relations of power that we can truly move towards sustainable social change that supports women's abilities to exercise their full citizenship rights of equitable opportunities for health. I am not suggesting that women's individual actions were not contributory to their experiences of health, but that women's actions and experiences need to be positioned within the realm of relations of power that influence and shape their day-to-day lives.

### **Dominant Ideologies and Women's Health**

Ideologies of deviance and difference are class-based, racialized, and gendered and operate to depoliticize inequities and sustain a status quo of Eurocentric domination (Collins, 1998, 2000; Cooper, 2004; Razack, 2002b). The construction of ideologies of deviance and difference by dominant groups has, as noted earlier, historically contributed to the imaging and assumptions about women who are street-involved and use crack cocaine as abnormal and amoral women whose actions are controlled by the "desire" to use crack and who, when left unregulated by the state, pose a threat to the good of society (Boyd, 2004; Brook & Stringer, 2005; N. Campbell, 2000; Keane, 2002; Maher, 1997). Throughout this project, the women's experiences reflected the pervasiveness of ideologies of deviance and difference at play in their day-to-day lives. As was the case in research by Maher (1997) and Goodman (2005), women described that they had experienced being "labelled" by members of dominant groups as "users,"

“crack heads,” “Indians,” and “whores.” Each label was experienced by women in ways that served to rob them of their personhood and limited their identity to an activity or a member of a racialized or gendered group.<sup>28</sup> These labels were also occasionally used by women to portray negative stereotypes and meanings in relation to themselves and other women in the neighbourhood, a finding that reflects the pervasiveness of these ideologies.

One of the most significant findings regarding the relationship between ideologies of deviance and difference and women’s experiences of health concerns was women’s perceptions of how these ideologies contributed to their interpersonal relations with health service providers. As has been reflected in other research (Butters & Erickson, 2003; Goodman, 2005), it appeared that during interactions with health service providers, the emphasis within the interaction was often women’s crack and other substance use practices, frequently at the expense of having another health concern addressed. Although I cannot comment on the actual practices of health service providers, I argue that, given the frequency with which women discussed this issue, it is likely that these ideologies were at play within these interactions. This was best illustrated with women’s reported experiences concerning pain management. As I noted previously, pain was a critical health concern experienced by women, yet they consistently reported a disparity with regards to experiencing this concern and having it addressed in interactions with their health care providers. Women also perceived that providers negated their experiences of pain or need for analgesic because they were engaged in illegal substance use. Women expressed that, in their opinion, providers viewed them as attempting to access analgesics solely for the purpose of “using” thereby raising the question of whether or not providers’ associated women’s actions with assumptions regarding their being “controlled” by the desire to use. Some were also concerned that providers did not think that they could actually experience pain. It was not clear

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<sup>28</sup> Personhood as applied in the context of this work refers to women’s day-to-day life experiences that are integral to them as people including but not limited to personal histories, family and love relationships, strength and courage, and moral worth as human beings (Razack, 2002).

why women felt that their concerns regarding pain were not addressed. Given the evidence that illustrates the reduced pain tolerance by people who use illegal substances (e.g., Alford et al., 2006; Compton, 1994), I am left to question the rationale that might underpin the women's experiences with the health care system. "Drug-seeking" has remained a consistent theme in health discourse with people who use illegal substances and the women's experiences reflected their belief that this assumption on part of providers dominated approaches to pain management. Given that the majority of women in this project and in other research concerned with women who are street-involved did almost anything to avoid interactions with the health care system (Boyd, 1999; Ensign & Panke, 2005; Metsche, Pereyra, & Brewer, 2001) and the abundance of other strategies they employ to obtain substances, it seems unlikely that women accessed services for the sole purpose of obtaining substances related to problematic use.

It is obvious that more effective strategies for pain management are required to address this pressing health concern. Several researchers have put forth the importance of education with health care providers to debunk myths concerning the relationship between experiences of pain, drug seeking, and substance use (Alford et al., 2006; McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005; Morgan, 2006). Unfortunately, most of this work has been specifically related to men who use opiates, and as such a dearth exists in our understanding of pain and substance use for women in general and for those who use crack cocaine. Education, while important, is insufficient to address the complexity of these issues. As was the case in my analysis, the providers' perspectives are frequently absent in this discourse. More research that helps us to understand the health providers' decision-making processes, the historical context of non-prescribing policies, and the influential ideologies informing practices and interpersonal relationships is essential and it is also important that this research be positioned within an analysis of relations of power. It is worthwhile to note that although I have highlighted pain to discuss the potential interrelationships between ideologies and interpersonal relations between

women and providers, these problems are not limited to issues of pain management, but are relevant within the broader scope of how women's experiences of health concerns are addressed more generally.

### **Domination and Subordination: Economy, Health Care, and the Law**

Dominant ideologies of deviance and difference were not limited to influencing women's health at the micro-level of interpersonal relations between women and health service providers. They also influenced specific aspects of macro-level relations of power, particularly in relation to the organization of the economic, health care, and legal systems that were relevant for women's health. These macro-level relations of power are important to consider within the context of the analytical findings for a number of reasons. First, they were influential in shaping women's experiences of health concerns and their health management strategies. Second, macro relations of power as reflected in structural and disciplinary domains of power, served to reinforce and justify the domination and positions of power of dominant groups within society. Relations of power serve to ensure that social institutions and disciplinary practices are structured in such a way as to directly benefit members of dominant groups (Collins, 2000; Weber, 1998). As such, it is worthwhile for me to discuss some of the analytical findings concerning how relations of power played out to benefit the dominant groups while simultaneously contributing to the overwhelming and complex nature of the health concerns experienced by the participants.

#### **Economic resources: The costs, benefits and women's health**

The women experienced appalling economic deprivation that had significant implications for their experiences of health. Although the association between poverty, inadequate access to material resources, and illness has been well documented in the literature, when I examined these associations and women's experiences within the realm of relations of power it was obvious that both the experiences of economic deprivation and the relational processes by which women were excluded from access to resources contributed to the magnitude of their health concerns (Collins,



2000; Farmer, 2005; Krieger et al., 1997; Krieger, 2001; Weber & Para-Medina, 2003). Similar to empirical work noted earlier, Canada's income assistance program known as "welfare" was an important component of women's access to economic resources (Butters & Erickson, 2003; Goodman, 2005; Leonard et al., 2006; Mahan, 1996; Maher, 1997; Sterk, 1999). Yet, the actual amounts allotted were insufficient for women to access basic resources such as food, shelter, sanitation, and clothing. As a result, women were often inadequately clothed to deal with the environmental conditions of Vancouver, lived in unsanitary and often temporary places that contributed to their risk for violence, and regularly experienced malnutrition.

The relationship between economic deprivation and negative health experiences was additionally complex when intertwined with problematic substance use and addiction. Economic deprivation played a role in women's experiences of withdrawal in that they could not afford to purchase crack and/or other illegal substances to ward off these experiences. Experiences of withdrawal and the strategies they used in an attempt to avoid this concern (e.g., sex work, dealing, and agreeing to have a "boyfriend") often left them vulnerable to violence, theft and exploitation, all of which further exacerbated their health concerns. Women were forced to make difficult choices regarding the use of their scarce economic resources in order to purchase substances, although as I noted earlier, these "choices" concerning using money for substances were not isolated to the experience of withdrawal. Management of pain, insomnia, and feeling sad or anxious were also relevant to how women managed their money and the purchase of substances was particularly relevant for women if they perceived that these concerns were not fully addressed within the context of their relations with health service providers. Despite the growing body of evidence that highlights women's use of illegal substances to address health concerns (e.g., see Boyd, 1999), a significant dearth exists within this substantive field regarding the complexity of the relationships among women's experiences of economic deprivation, the use of illegal substances, management of economic resources, and interactions with the health

care system. Critical questions remain concerning the factors that contribute to limited options for women regarding the use of their scarce resources to best address their most pressing health concerns and the role that illegal substances play within the realm of managing withdrawal or other health concerns.

The stark economic circumstances of women's lives and their attempts to secure material resources for health were illuminating and of relevance to understanding the complex interplay between women's actions and experiences of health. Women went to great lengths to secure economic resources in order to mitigate the harmful effects of influential factors such as unstable housing or malnutrition including engagement in illegal activities which conversely often contributed to the overwhelming violence and the related mental and physical health concerns that they experienced. Although other research has emphasized women's illegal activities in regards to income generation (e.g., Jeffrey & MacDonald, 2006; Maher, 1997; Sterk, 1999), the findings of this study illustrated that women also sought legal opportunities including "volunteer work" and research participation. Regardless of the illegal or legal nature of their work, much of women's daily lives were organized around securing resources; so much so that, at times, other important strategies for managing health were unattainable. As economic opportunities arose, women had to make difficult choices regarding how they spent their time, and this often contributed to missed health care appointments or opportunities to access a drop-in centre that offered food, or they went without sleep after being up throughout the night while working within the commercial sex industry or engaging in outreach volunteer activities. The inconsistencies in opportunities for income and the need to secure additional income were obviously relevant for women's health.

Approximately one third of the women in this study received no form of income assistance and this was a particularly disturbing finding in light of the fact that none of the women had regular employment. To better understand the contextual factors that contributed to

this finding, I chose to discuss it in light of the organization and practices of the welfare system. Over the past several years we have witnessed extensive cuts within Canada's social programming and the provincial and federal governments have justified these cuts as a strategy necessary to enhance Canada's growth within the global economic structure (see Morrow, Hankivsky, & Varcoe, 2004 for a critical analysis of this argument). Policy analysts have illustrated that people who experience the most severe marginalization with regards to economic resources have been most harmed by these cuts. As was the case for women in this project for example, Aboriginal people, and women who live in poverty and experience other forms of social marginalization including homelessness and mental and/or physical disabilities have been most negatively affected (Morrow et al.; Wallace et al., 2006). Recent bureaucratic changes in the application process and determination of eligibility criteria are based on an assumption that all applicants are immediately employable and each applicant must demonstrate an active work search in the formal economic sector for a period of three weeks prior to the application (Wallace et al.). As was the case in the work of Wallace and colleagues, many of the women could not realistically be considered employable due to their experiences of mental and/or physical disabilities and problematic substance use. Furthermore, the application process has become so complex that it requires working with an advocate to ensure that the application is completed correctly (Wallace et al.). Throughout the analysis, I discovered several additional factors that contributed to the women's exclusion from these economic resources. Women's lives reflected a complex interplay between time commitments due to frequent appointments with advocates or health care providers, the chronic fatigue associated with their underlying mental and physical health concerns, and the need to spend time securing material resources through other means. It is perhaps the complex interplay between these factors and barriers to access of income assistance that may account for the number of women in this project who received no form of income assistance and lived well below the LICO.

A factor that has been considered less frequently in relation to access to welfare, but was identified by the women, was the influence of having been incarcerated. Women's criminal records not only contributed to reduced likelihood of employment within the formal sector, but the cessation of income assistance during incarceration meant that they had to re-apply once discharged from a corrections facility. Women who had been deemed "unemployable" previously due to disability were now faced with the onerous task of re-establishing their status as unemployable, during which time they received no income assistance.

The problems associated with bureaucratic and obstructive practices also contributed to women's economic interdependence with men, even when these men were extremely violent. As was the case in the participants in the work of other researchers (Morrow et al, 2004; Wallace et al., 2006), changes in social income assistance programming contributed to reduced access to economic resources and fewer options for women who were seeking to leave violent home situations; a factor that can only serve to increase their experiences of violence.

In keeping with the premise that relations of power often serve to benefit dominant groups (Collins, 1998; 2000), it is also important to discuss women's economic deprivation within the broader arena of how these experiences benefited members of dominant groups. Members of dominant groups (men and women) who lived and worked "out there" had the financial resources and freedom of mobility to travel to the DTES. When in the DTES they could purchase sex and in some instances drugs from women and engage in often degrading and violent social interactions that posed few risks of recourse for their actions. Razack (2002b) noted that the freedom of men to travel to places of deviance to engage in degrading activities with women must be considered within the context of Canada's history as a white settler society that has served to normalize violent social interactions between members of dominant groups and those constructed as Other. Commenting on violence against Aboriginal women who work in the commercial sex industry she notes, "what a spatial analysis reveals is that bodies in

degenerate space lost their entitlement to personhood through a complex process in which the violence that is enacted is normalized” (Razack, p. 155). Thus the benefits afforded to men who travel to the DTES often come at the expense of the mental and physical health of women who are poor and street-involved within this neighbourhood.

To more fully appreciate the complexity of the benefits achieved by women’s exclusion from economic resources, I also considered how these benefits extend beyond the individual men and women who may travel to the DTES to the larger arena of dominant groups more generally. The cuts in welfare programming that occurred in BC in 2002 were unprecedented in Canada with regards to the extent of the cuts and the changes in eligibility criteria (Klein & Long, 2003). These cuts however, directly translated into tax breaks for those who belong to the upper and middle classes. It has also been argued that these cuts have reinforced an individualist ideology, where individuals’ experiences of economic deprivation are viewed within society as personal failures, thereby removing poverty as a social justice issue that requires a macro-level approach to resolve (Morrow et al., 2004). As I highlighter earlier, women were paid honorariums versus formal salaries with benefits for work within the realm of outreach, custodial, and security services. The payment of honorariums was also utilized in the research processes. I cannot help but question the economic reasoning behind this payment structure. It is feasible to assume that these informal economic structures serve to reinforce the benefits of those within the formal economic enterprise. Controlling the options for employment and spending less money in salaries may help to guarantee that material resources are withheld from those who are considered as Other, thereby ensuring that the unequal concentrations of economic power remain intact.

Drawing from the preceding discussion, I put forward several recommendations that could assist in mitigating the harmful effects of economic deprivation; most of which have been well documented over the past several years and are specific to welfare program delivery. These

include (a) the discontinuation of the three-week employment search and onerous reassessments of persons with disabilities; (b) increased funding; and (c) the redesign of program delivery to enhance the ease of the application process, particularly for women in crisis (Klein & Long, 2003; Wallace et al., 2006). Coupled with these recommendations are those for improved access to safe, low-barrier, and supportive housing and adequate food (City of Vancouver, 2007; PIVOT, 2006).

It is also important to note that women need safer alternatives to income that reduce their risk for violence, and I believe that the processes by which this may occur is an issue that requires more careful consideration. It is timely for researchers, service providers, and policy makers to critically re-examine our engagement with the women with regards to their volunteer work, the related payment structures, and the lack of formal employment opportunities. Although it may be beneficial to increase the hourly pay rates to at least equal the minimum wage in this province, the issues are more complicated than an alteration of the payment structure. Women's work in outreach capacities and informal networks of support were essential service in the delivery of health care, often to those who were at greatest risk for illness and injury. It is important that we examine these relationships to determine how we may be either perpetuating discriminatory policies or working towards the aims of social justice. We need to determine the most effective means by which women's work is recognized, supported, and integrated as an important service in the delivery of health care.

Research that highlights relations of power as influential in shaping women's health is also required to examine the long term implications of policy and service delivery changes. Of particular relevance, is research that exposes the oppressive circumstances of women's lives and challenges the status quo of domination. It is important that we continue to critically examine the processes by which ideologies that negate women's moral worth in society and hold individuals accountable for social problems influence the structural inequities that construct the oppressive

barriers to income. As noted by Massey (2005), we need to explore how these processes are justified as relevant to the overall economic benefit of Canada by government and industry while they simultaneously overlook an analysis of which Canadians benefit from these approaches or how these processes influence structural inequities that contribute to significant health concerns among women who are street-involved and use crack cocaine.

### **Health services and health concerns**

Given that almost every woman had experienced numerous health concerns over the course of her life, I was not surprised that the majority reported frequent interactions with the health care system. It was also important to note that these interactions occurred in many different sites including primary care clinics, emergency rooms, street outreach services, and occasionally in their homes. Both the frequency and location of the interactions depended largely on interrelationships between women's underlying health concerns, their active strategies in managing their health, the nature of their relationships with health service providers, and the availability of services.

Access and utilization of health services have long since been considered important to the health of women who are street-involved and use crack cocaine (Fischer et al., 2005, 2006; Kidder, Elifson, & Sterk, 2001; Metsch et al., 1999; Ottaway & Erickson, 1997; Shannon et al., 2005). Although I would agree with this premise, the findings of this project have illustrated that the interrelationships between access, utilization, and women's health may not be as simplistic as we have been lead to believe. One of the most significant findings was the women's reports of the discrepancy that they perceived concerning the health concerns they experienced and those concerns that were addressed during interactions with health service providers. Among many participants, accessing services did not necessarily equate with having their health concerns addressed. Women often felt forced to manipulate an interaction in order to have a pressing concern addressed while foregoing bringing attention to other important health concerns. Despite

their knowledge of their bodies, they perceived that it was vital to maintain a relationship of physician authority. I cannot help but wonder at the magnitude of concerns that were untreated and the long term implications that these concerns will have for women's health throughout the course of their lives.

The women's experiences of health concerns were also influenced by a chasm between the scope of health services available and the nature of the concerns they experienced. While not discounting the benefits of the available holistic prenatal care programs or harm reduction services associated with problematic opiate use and injection as a route of use, it was obvious that these services were insufficient to respond to the complexity of women's health concerns. If we examine mental health for example, it was apparent that fatigue, depression, anxiety, and insomnia were experienced at disturbing rates; a finding which has been supported in many other research settings (Butters & Erickson, 2003; Falck et al., 2003; Fischer et al., 2005; Goodman, 2005). Yet few women were connected to any mental health services and mental health funding has been drastically altered over the past several years resulting in reduced community-based services and increased workloads among mental health service providers within British Columbia (Morrow et al., 2006). These findings mirror international health service organizational practices in that although, "mental and behavioural disorders are estimated to account for 12% of the global burden of disease, the mental health budgets of the majority of countries constitute less than 1% of their total health expenditures" (WHO, 2001, p. 3). Given the high incidence of mental health concerns, it is important to reflect on why this particular service area has been so critically under-funded.

Researchers have reported that relations of power and oppressive organizational structures that adhere to an ideology of deviance with regards to mental health overlook the complex interrelationships between physiological, psychological, and social factors that contribute to mental illness and that these ideologies have been reinforced by inaccurate media



portrayals of people with mental health concerns as “out of control” and “violent” people who need to be segregated in order to protect the rest of society (WHO, 2001). The shortage of mental health services is also racialized, class-based, and gendered. Members of social groups who often experience marginalization experience an overburden of mental health concerns, largely associated with the damaging effects of racism, sexism, and poverty (WHO). As noted in the World Health Report on Mental Health (2001) and supported within this study, women’s increased responsibilities within the home and the labour market, combined with discriminatory economic, political and social policies and practices, and violence, increase women’s likelihood of experiencing mental health concerns.

Harm reduction health service programming was also relevant to women’s experiences of health. As is the case in many Canadian cities, few harm reduction programs specifically address the harms associated with crack cocaine smoking practices (Goodman, 2005; Leonard et al., 2006). The gap in services contributed to women using less safe equipment, sharing their equipment with potentially violent men, and increased isolation when women attempted to avoid sharing. Each of these factors further contributed to their experiences of mental and physical health concerns. Currently, research in harm reduction and crack cocaine use emphasizes the need for safer equipment to reduce the potential for transmission of infections, burns and cuts (e.g., Haydon & Fischer, 2005; Leonard et al.). While not discounting the significance of reducing these harms, I argue that an emphasis on infections, burns and cuts is limiting as a harm reduction strategy. The study and practice of drug-related harm within the realm of women’s health needs to include other mental and physical health concerns that may be associated with crack cocaine use. It is also essential that we explore harms that pertain to the broader context of factors influencing women’s health that may be related but are not limited to substance use including women’s relations with men and the social nature of crack use in general.

In light of the analytic findings and the issues I have brought forward, I put forth the following recommendations for health care programming and research in order to enhance the interrelationships between the organization and delivery of health services and women's experiences of health. First, it is important that the chasm between services needed and services available be addressed and that these changes incorporate the scope of women's health concerns that occur across their lifespan (Hankivsky, 2007). The women's ranges of health experiences shifted throughout the course of their lives and were influenced temporally by the detrimental effects of poverty, exclusion, segregation, racialization, and degradation that occurred over time. Research is needed to more critically examine the impact of relations of power operating across intersecting systems of oppression at various stages in women's lives to fully comprehend the immediate and cumulative affects. Re-allocation of mental health services is also vital in order to address the magnitude of mental health concerns experienced by the participants. Principles of equity, such as fairness and justice are required to inform these transformations as an emphasis on equity justifies health as a human right and positions women's experiences of health as an issue of justice (Farmer, 2005; Reimer Kirkham & Browne, 2006).

Several questions remain with regards to how we can realistically create and sustain these transformations in health care delivery, particularly in light of the increasing cuts to health service programming. An evaluation of the costs associated with women's health concerns that often went untreated, particularly their dental concerns, the long term effects of violence, and the mental health costs associated with chronic trauma may be useful. The strategy of estimating potential cost savings that can arise from preventing the incidence or worsening of health as outlined by Hankivsky and Friesen (2007) may assist us to conduct more comprehensive financial evaluations of health care programming. By illustrating the potential cost savings with prevention strategies, we may be better able to inform decisions for health service programming.

Many of the policies and practices within health service agencies were paternalistic and punitive. It is important that we reconsider these issues and develop more equitable practices that enhance women's opportunities for health. Women who wish to make health care appointments to accommodate their other life demands need to be able to do so, and greater emphasis on women-only health care sites to enhance safety and freedom from violence is required.

Derogatory and degrading interactions with health service providers are unacceptable as they negate women's personhood and contribute to the perpetuation of violence against women in the DTES. These approaches to social interactions must stop, but given that they occur in venues where women have little recourse against these actions, it is challenging to make recommendations for sustainable change. It seems surprising that I have to state that during interactions between women and providers, women's strategies to enhance their opportunities for health require acknowledgement and women have a right to have active participation in managing their experiences of health. It is equally difficult that I must bring to the fore a reminder that organizational practices and social interactions that fall short of protecting women's dignity are unacceptable. Although researchers working in the arena of provider-client interactions have highlighted the underpinning ideologies regarding race, gender and violence against women that inform service providers' perspectives (for example see Browne, 2007; Varcoe, 1997) further research concerning the most appropriate approaches to change these practices is necessary.

### **The illegal context: Costs, benefits, and women's health**

It was apparent that the illegal context of women's substance use activities was significantly influential for their experiences of health concerns and their health management strategies. One area of particular relevance was the influential practices of law enforcement. This finding was not particularly unexpected given the growing body of evidence that has highlighted the negative association between policing policies and practices (e.g., increased police presence

and arrests) and factors that have been demonstrated to promote the health experiences among people who are street-involved and use illegal substances. Researchers, for example, have illustrated that police “crackdowns” have directly reduced people’s access to harm reduction programming and outreach health services and contributed to harmful use practices including more rapid injections and smoking and injecting and smoking in less safe places (Cooper, Moore, et al., 2005; Kerr et al., 2005; Shannon et al., 2006; Wood et al., 2004). The women’s experiences illustrated several other issues that were particularly relevant that have not yet been fully explored within this discourse. Policing contributed to women’s loss of income and/or substances and these actions appeared to contribute to the increased likelihood that women would experience withdrawal, be unable to obtain material resources necessary for health, and/or be at risk for violence by boyfriends who were influential in shaping women’s actions of obtaining money and/or crack. It was also apparent that enforcement practices contributed to the loss of privacy within their homes, loss of personal dignity, and the loss of places that women considered to be safe; all of which were influential in their experiences of mental and physical health concerns. Additionally, criminalization and enforcement practices influenced the unregulated production of crack and therefore the quality of substances being purchased. Crack mixed with often toxic impurities contributed to significant health concerns experienced by the women and there was no recourse for women when this occurred.

Due in part to the negative health consequences that the women described in relation to their experiences with police, I concur with Cooper and her colleagues (2005), that it is timely to consider these practices and their oppositional position to health service programming directed toward health promotion and illness prevention (e.g., harm reduction programming). A macro-level perspective of relations of power offers us some insight. The criminal laws associated with crack cocaine and other substances have reportedly afforded law enforcement agencies increased freedom under the guise of protecting the public good (Boyd, 2004; Cooper, Moore, et al., 2005).

Assuming, as noted by Collins (2000), that law enforcement is often organized in a manner that serves to justify the social location of dominant groups, it is worthwhile to reflect upon *who* actually benefits from such enforcement tactics and how these benefits are organized within relations of power. Throughout my analysis of women's descriptions of their experiences with police, it appeared that many of the enforcement tactics mirrored the spatialized, class-based and racialized law enforcement practices reported in other impoverished inner-cities. For example, although the use of illegal substances occurs in affluent neighbourhoods and is not limited to members of the under-class, members of dominant groups have not experienced the same degree of targeted law enforcement practices (Boyd, 2004). Instead, these strategies have occurred primarily within impoverished inner-cities where Aboriginal peoples (Small et al., 2006), and African-Americans (Cooper, Moore, et al., 2005; Cooper, Wypij, et al., 2005) are overrepresented. The increased police presence, the allocation of police resources to the DTES, and the increased arrest rates that are currently being reported (Small et al., 2006), may also serve to reinforce the ideology that the DTES and the women who live in this neighbourhood are deviant, and therefore "require" the intense policing that the women described. By publicly regulating the women's actions and behaviours through the law, the dominant groups may continue to be positioned as morally superior, thereby reaffirming their location within relations of power.

Additionally, the contradictions between health care service delivery aimed at harm reduction and the magnitude of enforcement strategies employed are also representative of unequal concentrations of social, economic, and political power between dominant and subordinate groups. The current conservative federal government has embraced a "war on drugs" approach with regards to regulating illegal substances in Canada, which is reflected in the recent national anti-drug strategy (see <https://www.nationaldrugstrategy.gc.ca>). Significant cuts to harm reduction programming have occurred and increased enforcement strategies are being devised.

These approaches reinforce a criminal perspective of problematic substance use and addiction as legal problems in a manner that dims the significance of the social, economic, and health contexts associated with use. Thus it is unavoidable that contradictions exist between the aims of health promotion programming to reduce potential harms and the organization of law enforcement. It is most unfortunate however, that the women and their peers who took part in this project will likely continue to experience significant health concerns associated with these contradictions.

The legal context of women's activities as influential for their experiences of health was not limited to crack cocaine. Intersections between the illegal activities associated with commercial sex work and law enforcement practices were also significant. Unlike the laws associated with crack cocaine, Canadian laws that pertain to commercial sex work are inherently paradoxical. For example, although the sale of sexual services among adults is legal, current communicating, procuring and bawdy-house laws make it difficult for women to engage in sex work without breaking a law which often contributes to their increased likelihood of criminal consequences.<sup>29</sup> The gendered enforcement practices reported here demonstrated that the women perceived an increased likelihood that they were more likely than their male clients to be targeted by police; an experience that has been well substantiated in the literature (Benoit & Millar, 2001; Jeffrey & MacDonald, 2006; Lowman, 2000; Pivot, 2004, 2006). As a result women were often displaced to less safe locations as they attempted to avoid arrest, thereby reducing their safety nets of familiar locations and people and increasing their risk of violence.

Additionally, the policing practice of "non-response" was particularly problematic for women's health. Non-response included the limited enforcement practices on behalf of the women in the DTES when they experienced criminal acts (e.g., violence, robbery, and rape)

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<sup>29</sup> The communicating law makes it illegal to communicate in a public place for the purpose of buying or selling sexual services; the bawdy house laws makes it illegal to operate, work within, or live off the income of sexual activities within a building and procuring or living of the avails are illegal (Lowman, 1998, 2000).

against them. Women reported that they were not afforded protection by the police from violence; a practice that contributed to a myriad of health concerns. This lack of protection on behalf of police has been implicated in the increased violence against women in the DTES, the increasing homicide rate of women engaged in sex work in Canada, and the accompanying low arrest rates for those who commit these crimes (Lowman, 2000).

Many reasons have been put forth in an attempt to explain this gap in policing services. Lowman (1998, 2000), for example, argued that sex work laws create an adversarial relationship between those engaged in sex work and police; a factor that reduces the likelihood that women will report violent assaults to the police. He also argued that ideologies of deviance have contributed to assumptions, beliefs, and policing practices that hold women involved in sex work accountable for the crimes committed against them and as a result normalize these experiences as unavoidable and perhaps acceptable. Unlike the participants in Lowman's work, however, many of the women in this project did attempt to seek protection from police. Their actions challenge current knowledge regarding the underlying rationale for the lack of social interactions between police and women engaged in sex work or police protection. I argue that it was not fear of admitting to criminal activity that eventually contributed to women not reporting criminal acts against them, but the assumption, based on their experiences, that the police would do nothing on their behalf. This argument has been well substantiated in research concerned with policing responses to violence against women more generally (J. Campbell, 2002).

It is not my intent to imply that all men who purchase sex from women intended to engage in violence. As reflected in other research, the lack of police support to solve disputes among those involved in criminal activities often gives rise to the likelihood that violence will be used as the most common strategy to settle disputes between women and their dates (Lowman & Atchison, 2006; Maher, 1997) and the women's experiences supported this fact. While research may indicate the inevitability of violence, this inevitability is unacceptable particularly when

considered in light of the magnitude of suffering that women experienced as a result of this violence. The women reported that in most altercations they were overpowered by men.

Violence against women has been a longstanding practice in our society to regulate and control women. The experiences of the women illustrate that this disturbing reality continues, and there seems to be little recourse for women when it occurs and fewer options regarding support from police to prevent violence or to hold those who commit this crime accountable.

As with economic deprivation and the illegal context of crack use, I considered it worthwhile to examine *who* benefits from the women's engagement in sex work beyond the level of individual. The City of Vancouver is world renowned for its sex industry and select venues for advertisement under the guise of tourism highlight that the sex industry, its locations, and easy access to women are positive attributes of the city (for an example see <http://perb.com>). The locations of street-based sex work are well known and a flourishing brothel industry operates under the pretext of licensed massage parlours and escort agencies. Within Vancouver, municipal bylaws licence these parlours and recoup revenue from the licensing of the venues and the women who work there (Remple, 2007). What these benefits mean in relation to law enforcement and women's health requires greater exploration.

Several recommendations have been made in earlier research to address many of the problems that arise that are associated with the illegal context of both substance use and commercial sex work including: (a) decriminalization of crack and other substances; (b) the decriminalization of commercial sex work activities; (c) the cessation of searching of women's bodies and removal of harm reducing smoking equipment; and (d) the creation of alternative means of income for women who wish to leave the commercial sex industry (Csete & Cohen, 2003; Lowman, 2000; PIVOT, 2004). Many of these arguments have been positioned within human rights imperatives and have been made for the explicit purpose of reducing the violence and other health-related harms that women experience in relation to these activities. While I



concur with the intent of these recommendations and view these strategies as valuable, I believe that they are insufficient in and of themselves to alter the oppressive circumstances of women's lives. As has been highlighted elsewhere, changes in laws or charters do not guarantee that these changes will translate into the organizational and interpersonal practices of those who are directly associated with ensuring their implementation (Collins 1998, 2000; Massey, 2005; Reimer Kirkham & Browne, 2006; Youngblood Henderson, 2000). As noted by Youngblood Henderson, "although the *Charter of Human Rights and Freedoms* affirms and protects Aboriginal rights as fundamental...the dominant response of Canadian politicians, judges, lawyers, and scholars, has been to unreflectively assert colonial privileges" (p. 167). Therefore, these changes must be accompanied by simultaneous ideological shifts that inform the structural, disciplinary and interpersonal domains of power influencing women's health. I do not have a simple recommendation as to how this may occur, but agree with Collins (2000) that the ongoing production of counter knowledge can assist this process. Counter-knowledge is knowledge that resists the dominant ideologies that construct relations of power that serve to justify a status quo of oppression and is of relevance within the aims of social change. Counter-knowledge can be used to challenge the consciousness of individuals and groups concerning the values, beliefs, and assumptions regarding women who use crack, Aboriginal women, and women living in poverty. As noted by Collins, "reversing this process whereby intersecting oppressions harness various dimensions of individual subjectivity for their own ends becomes a central purpose of resistance" (p. 285).

### **Health Management and Women's Resistance to Oppression**

The creative strategies that women actively employed to manage and deal with the intersecting systems of oppression and relations of power that influenced their health was a significant finding that reflected women's agency in managing their own health. The knowledge that women used in the formulation of these strategies was also particularly illuminating.

Women's perspectives as members of subordinate groups reflected that they were often aware of the positions of power held by dominant groups in relation to their own social locations as well as the influence that ideologies of deviance and difference had for their interactions with service providers. As I illustrated earlier, women regularly used their knowledge of the relations of power at play in these interactions to manipulate the situation in order to achieve a specific health-related goal, for instance, to ensure that a pressing health concern was addressed; that the relationship with the provider would continue in the future; or to secure substances that could be bartered for other resources. More specifically, many women reported that they *intentionally* enacted a subordinate role that appeared to be in deference to the position of authority held by health service providers in order to achieve these aims. Women also perceived that the providers were unaware of their pretence.

Feminist and intersectional researchers have long since identified that members of subordinate groups experience a sense of "living two lives" (Collins, 2000, p. 97) in that they have knowledge regarding the affects of systems of oppression directly associated with their membership within a subordinate group and knowledge about the experiences of members of dominant groups that arise largely from their observations of, and experiences with, members of these groups (Collins, 1998, 2000; Harding, 2006; hooks, 1990; D. Smith, 1987, 1999; Weber, 1998; Weber & Parra-Medina, 2003). They have also noted that these experiences of "two lives" have been used to inform women's activism in altering the oppressive circumstances of their lives. Drawing from the analytic findings, I believe that women's knowledge of subordination and domination, and how it played out within their health management strategies was a two-edged sword. On the one hand, the application of this knowledge in interactions with health service providers contributed to women's sense that they were actively involved in managing their health. Throughout their narratives the women expressed feelings of confidence, intelligence and the capacity to survive that were positively associated with their abilities to

obtain the services necessary to manage their health concerns. Conversely, women simultaneously expressed a sense of sadness and despair regarding the need to “pretend” and this sense of despair was associated with a perception that the pretence discounted the likelihood that health care providers would ever know or appreciate them within the realm of their full personhood.

Although earlier research with women who were street-involved and used heroin and/or crack cocaine has highlighted that women have significant capacities to actively manage their health (Boyd, 1999; Kearney et al., 1994; Murphy & Rosenbaum, 1999), it appears that the meaning that women attributed to these experiences and the related contextual factors contributed to much more multifaceted health managements strategies and personal experiences than previously reported. In her work with Aboriginal women regarding their experiences in acute care agencies, Browne (2003, 2007) has reinforced this finding. She highlighted that women’s “behaviours” associated with deference with service providers were intricately related to the broader historical context of oppression engendered by patterns of paternalism and authority within the health care system and society more generally. She also noted that investigation of this level of complexity is required if we are to develop a better understanding of such behaviours. I concur with Browne, and also recommend that that a more nuanced exploration of the complex interplay between systems of oppression, women’s actions and active resistance to oppression, and their experiences of assaults to their dignity is necessary to more fully understand the affects these interrelationships have for women’s health. As noted here and in related research (Ensign & Panke, 2002), many women who are street-involved have demonstrated a preference to manage their health concerns without accessing health services primarily due their expressed wish to avoid potentially degrading interactions with health service providers or to avoid assuming a different persona. A more complex understanding of women experiences may illuminate both the positive and negative affects that their strategies to

manipulate interactions with providers have for their health concerns, as well as their sense of self-worth and well-being.

### **The Strengths and Challenges of Intersectional Research**

The theoretical perspectives that informed this project and the research approach that I employed afforded me the opportunity to study the complexity of relations of power and intersecting systems of oppression and how these intersections played out in the realm of women's experiences of health and their health management strategies among those who were street-involved and used crack cocaine. I experienced both the strengths and challenges in engaging in this type of research and believe it is worthwhile to review these experiences in light of the contributions of intersectional research to the field as well as some of the struggles within this approach that require further consideration for the ongoing development of intersectional research.

### **Multiple Locations and Multiple Systems of Oppression**

One of the greatest strengths that I attribute to intersectionality is that by applying this perspective, I was able to explore women's multiple locations within social groups not as individualized attributes of the women, but as relational processes that had significant influence for their experiences of health (Weber & Para-Medina, 2003). Women's membership within the underclass for example, permeated their life circumstances and played out through structural and interpersonal relations of power to contribute to and exacerbate the myriad of health concerns they experienced. In fact, this was a shared social position held by the vast majority of the women; a finding that reinforces recent arguments by many researchers of the need to further incorporate experiences of class in research concerned with women's health (McCall, 2005; Weber & Parra-Medina). Additionally, because the women occupied membership in multiple other groups that have been socially positioned according to race, age, and disability, critical examination of women's experiences that acknowledged each of these intersecting systems of

oppression highlighted how these systems mutually intersected in ways that further influenced their health. This is not to say that all systems were equivalent in their influence. White women for example, were perceived as being able to access housing outside of the DTES more so than Aboriginal women and older women reported fewer health services specific to their concerns as they aged. I was able to illustrate however, that each of these intersections were relevant in a study concerned with exposing how oppression contributed to the multiple social and economic inequities that influenced women's health. If I had engaged in research that acknowledged only one system of oppression, this level of complexity would likely have been missed (Collins, 1998, 2000; Weber, 1998; Varcoe et al., 2007).

In addition to the complexity associated with intersecting systems of oppression, adherence to the tenets of intersectionality enabled me to position women's experiences within ideological, structural, bureaucratic, and interpersonal relations of power. This permitted exploration of dominant macro-level ideologies that negatively influenced women's health and justified their social location in subordinate groups. I was able to identify important issues for consideration regarding how these factors may operate to the benefit of dominant groups within society and illustrated how these benefits obstructed equity in women's opportunities for better health experiences.

Despite these strengths, I experienced several challenges that were directly related to my attempts to study women's locations within social groups and relations of power as influential for their experiences of health. First, because women occupy multiple social locations simultaneously, I had to make choices with regards to whether or not I needed to study all possible combinations of groups to fully understand the complexity of their experiences of oppression (McCall, 2005). I determined that this was not only infeasible but unnecessary. As noted by several scholars concerned with the identification of social groups in intersectional research (Weber, 1998; Weber & Parra-Medina, 2003), an emphasis on specific groups, such as

women who are street-involved and use crack cocaine, is acceptable as the point of this research was not to generalize from one place and time to another, but to understand experiences and oppressions that operate at specific locales with a specific group. This was particularly relevant within the scope of my project as women who are street-involved and use crack cocaine as a particular group have often been overlooked within studies concerned with women's health, inequity, and social justice. The approach to studying a specific group does not imply however that the study of multiple combinations of groups is not beneficial or justified. Instead, it reinforces the importance of identifying the underlying purpose of a project and how this purpose can guide the identification of groups for study.

I also experienced challenges related to how I examined the various social locations while simultaneously attempting to study their intersections. This was an incredibly complex process that required foundational knowledge in multiple theories of oppression including capitalism, patriarchy, and colonialism, to name a few. I also found it necessary to concurrently explore ideologies and theories concerned with the organization of social structures and interpersonal relations. This contributed to a wealth of data not only enmeshed in women's experiences, but in policies and the organizational practices of the health care, legal, and welfare systems. Therefore, while the level of complexity in understanding women's experiences of health within relations of power was a significant strength of an intersectional perspective, this complexity was simultaneously challenging; particularly in relation to the feasibility and complexity of incorporating multiple theoretical positions and structures. This was especially evident in my attempts to identify pragmatic and realistic recommendations for social change.

In face of these challenges, I employed some useful strategies to manage this complexity. First, I recognized that this project served to inform and build on research in the area of women's health and could not be considered as the final truth with regards to the reforms necessary in the organizations that influenced their experiences. As such, it reinforced the recommendations by

many other researchers that an integrated approach to health care, welfare, and housing reform is necessary to address the complex interrelations between inequities and women's health (Boyd, 1999; Morrow et al., 2004; PIVOT, 2006; Shannon et al., 2006; Wallace et al., 2006). Second, I recognized that it was infeasible to study every health concern or every health management strategy. I balanced the choices that I made against the current knowledge concerning the health experiences of women who use crack cocaine and sought to contribute to this knowledge in a meaningful way. I acknowledged the limitations of having only minimal input from service providers' and re-state my perspective that it is apparent that more nuanced research studies to examine the organizations, the people who work there, and interpersonal dynamics are needed if we are to more fully comprehend relations of power that influence women's health.

### **The Nature of Knowledge**

Research as a process is best judged by its ability to generate new knowledge and insights. The contributions that this project has made to the generation of counter-knowledge are significant. Counter-knowledge is essential to developing substantiated arguments that expose injustice within relations of power and challenge dominant ideologies that reinforce the social location of subordinate groups (Collins, 2000). Of particular relevance was the counter-knowledge that illustrated the complexity of crack cocaine use and the desire and capacities among the women to manage their health concerns. For example, crack cocaine use historically has been situated within the realm of addictions. In studying women's experiences, I illustrated that the complexity of crack use must be situated within the realm of structural, personal, economic, and social inequities. Crack cocaine use was more than a health concern. It also represented an outcome of these inequities that influenced women's lives. Additionally, most health management research has emphasized women's actions of reducing the amounts of substances used or strategies they employed in the care of their unborn child (e.g., Murphy & Rosenbaum, 1999). The women in this project were active in managing all aspects of their health

and expressed a wish to experience better experiences of health overall. The ongoing construction of counter-knowledge is essential so that we can challenge and alter ideologies of deviance and difference that inform relations of power that contribute to inequities in health.

I recognize that the approaches that we use in the construction of counter-knowledge are also important. Approaches that integrate intersectionality and challenge bio-medical hegemony, notions of an essentialized woman's experience, or ideologies that always equate the use of illegal substances with problematic use, created new possibilities for understanding the complexity of women's health. By shifting the focus away from individualized behaviours and substance use to undertake studies of poverty, discrimination, racialization, and other factors that influence women's experiences of health, a more comprehensive approach to research, policy and practice aimed at improving women's health experiences may unfold.

The experiences of women who suffer inequities in health and complex health concerns, and their perspectives of how and why these inequities occur were also essential to the construction of counter-knowledge. As noted earlier, women have insights into the factors that influence their opportunities for health which contribute to knowledge development that more accurately reflects the lived realities of their day-to-day lives (Harding, 2006; D. Smith, 1987; Weber, 1998). The necessity of incorporating women's perspectives concerning how issues of inequities are problematized within the research questions and investigated in research methods was a significant strength of this research. As several scholars have noted, intersectional research aims to generate counter-knowledge in ways that ensure that the women and their related social groups are not problematized in and of themselves. Instead the factors contributing to social, economic, and political inequities are to be the emphasis of research (Lather, 2007; L. Smith, 1999).

I experienced many challenges as I sought to meet the requirements for generation of counter-knowledge and meaningful involvement of the women in the project. One of the greatest



challenges I faced was in relation to the conflict between my position as researcher and my personal relations with women. As I noted in the discussion of methodology, the women and I both recognized that we did not share a similar social locations with regards to poverty, experiences of health, unstable housing, violence, or substance use. I did however, have years of experience working in the realm of clinical practice with women who shared similar locations. Upon reflection, my social positions as a nurse, woman, and someone who did not live “down here” was viewed positively by the participants and most women expressed a sense of trust and relief in sharing the details of their lives with me. They also perceived me as someone with authority that could take their stories forward to those in positions of authority that organize policies and practices within the health care system. While these experiences contributed to the wealth and quality of the data I collected, I struggled ethically with the potential ramifications that could arise if aspects of this knowledge were shared with other members of dominant groups. As women shared their resistive strategies to manage their health in light of challenging experiences within the health care system, I grappled with the implications of presenting this knowledge within the health care literature for fear that this knowledge could be used against them. Women also disclosed horrendously painful experiences in their lives and I was challenged to present these experienced in a respectful and compassionate yet pragmatic manner.

These issues have not been fully addressed within the realm of discussions concerning intersectional research, which is not surprising given their complex nature. As noted in Chapter Three, I did find it particularly helpful to draw from scholars who have provided direction in avoiding the trap of essentialism (Lather, 2007; Manias & Street, 2001; L. Smith, 1999) and avoiding research approaches that perpetuated acts of colonization (Browne et al., 2005, 2007; Maher, 1997). Overall, I realised that the ethical challenge in reporting knowledge concerning women’s health management strategies was intricately connected to how I articulated women’s agency and autonomy in relation to their actions and the contextual factors that influenced their

available options (MacKenzie & Stoljar, 2000; Sherwin, 1998). It is vital as researchers concerned with the structural inequities that influence women's health that we articulate findings that neither identify women as passive victims in their lives, nor represent their actions in isolation of the factors that influence these actions. This requires a continuous reflexive approach throughout the project that will need to continue in my ongoing work in this field.

### **Combining Intersectionality and Social Geography**

As a final point of discussion in relation to the research approach, I considered the relevance and implications of combining intersectionality and social geography for research within the field of women's health. The central tenets of intersectionality underpin that segregation and exclusion are outcomes of relations of power that operate across intersecting systems of oppression. This segregation and exclusion has most often been addressed within the empirical literature in terms of material resources, educational and employment opportunities, and geographical segregation particularly as it pertains to impoverished inner-city neighbourhoods (Collins, 2000) and reserves (Razack, 2002a). However, the addition of a spatial analytical perspective brought to the fore more than the physical boundaries of DTES. It required that I consider the DTES as a socio-spatial place that was experienced in particular ways that exacerbated or reduced the structural inequities that influenced women's overall experiences of health. Drawing upon place as a matter of significance enabled me to more critically examine intersections between the environmental conditions experienced by women and access to material resources as factors that contributed to health concerns. I was also able to identify, through critical analysis of the intersections between relations of power and place, the mechanisms by which women's segregation within the DTES benefited members of the dominant groups in general, and in particular, those who travel to the DTES for the purpose of exploiting the women who live there.

Combining intersectionality and social geography was also useful for thinking about women's health in general, and in assessing the relevance of this approach for women who may not be located within the DTES. Studies in women's health need to consider where women live, work, travel, and access health care services and include the meanings that women attribute to these places and the means by which spatial segregation is reinforced and justified by relations of power to exclude women spatially from resources necessary for health.

### **Thinking about Nursing**

Most of the recommendations that I have put forth within the realm of research and the nature of respectful interpersonal relations that protect women's dignity thus far are fully applicable to nursing research, education, and practice. However, there are several other points that I believe require more thorough consideration.

Nursing research has a long history within the arena of social justice and it is essential that we continue in these traditions. Within our research among women who use crack cocaine or any other number of substances, it is important that we incorporate the wide range of experiences among women and avoid the construction of reference groups based solely on one social group's experiences, or the experiences of women within a single geographical locale. Counter-knowledge drawn from the experiences of women of similar and different social groups and related relations of power within urban, rural, and remote settings is critical to the broader mandate of improving the circumstances of all women's lives that detrimentally affect their health. It is also important to acknowledge that no single study or discipline can address all of the complexity associated with the topics that I have illustrated within the scope of this project. Comprehensive study of the health care, legal, and economic policies and organizational practices that are relevant for women's health require the collaboration of multiple disciplines as well as multiple methods of data collection and analysis.

Within nursing education, it is important that curricula incorporate counter-knowledge regarding how we think about substance use and addiction. Perspectives that challenge ideologies of deviance and addiction and make visible the racialized, sexist, and class-based underpinnings of these ideologies are crucial. This may foster critical reflection by nurses and others who will work with women who are street-involved and use crack cocaine, challenge the ideologies that influence our own consciousness, and may enhance the growth in numbers of those engaged in a social justice agenda. Of equal concern is the approach that we use in education to explore and discuss the social, economic, and political factors that influence health. Supporting students to critically think about the difference it makes with regards to how we provide care or organize the health care system when we consider these factors as relational processes instead of individual attributes would be beneficial.

Nurses working in clinical practice work directly with the women who took part in this project and as a result are in a unique position to contribute to women's experiences of health. It is important that we recognize that women are often capable of creating realistic and sustainable solutions to the problems they face. Nurses working with women who are constructed within relations of power as deviant or different require strategies that support women to both articulate solutions as well as opportunities to put these solutions into practice. Listening to women's perspectives of their health concerns is important as is recognizing that women may have a viable solution to address their health concern. It is also significant that we are aware of women's health management strategies in which they perceive a need to lie or adopt a different persona. We can ask ourselves if our practices acknowledge and appreciate their personhood or rob them of their sense of self.

Thus far these strategies are aimed at outcomes that specifically address women's health concerns. Nurses however, also run the risk of moral distress as they are witness to the magnitude of suffering that women experience and may have few options available to do

anything to relieve this suffering. Coupled with education to address issues of social justice and the complexity of women's experiences of health, we must also incorporate realistic strategies that nurses may employ to prevent this distress. Acknowledging the emotional impact of witnessing suffering is important, as is teaching skills to facilitate change in order to alleviate factors that influence this suffering. Nurses in practice need available and practical information that they can use to decide when they need assistance in managing the distress they may experience. They also need working knowledge of the range of services available to women to which they may be referred and how to negotiate the system themselves so that women are able to receive these services. There are no simple answers to the moral distress that any of us may experience in working with the degree of suffering that many of these women experienced. Further research in all areas of clinical practice (e.g., acute care, public health, crisis intervention) is needed to determine the most effective strategies to lessen the harmful effects of moral distress that we may experience.

## **Conclusion**

Although this study was limited to a particular social group in a specific geographical locale and did not incorporate the perspectives and experiences of many of the social groups that the women deemed instrumental in affecting their experiences of health, there are several significant conclusions from this project that merit comment. As I have noted on several occasions, the magnitude and complexity of women's experiences of health was overwhelming and I continue to wrestle with understanding how these inequities can exist in a city that possesses so much affluence. I have little doubt that, among many people in our society, albeit perhaps unintentionally, the women who took part in this project are rarely considered as individuals capable of incredible caring and compassion, who have hopes and dreams, and who face significant challenges to their survival on a day-to-day basis.

I was also troubled by the degree to which many of the health concerns they experienced were actually preventable. Given the inequitable distribution of resources within our society however, these concerns were more likely unavoidable. I am left to question why our health care, criminal justice systems, and economic safety net programs perpetuate racialized, gendered, and class-based discrimination. And I am at a complete loss to understand the rationale underpinning the degrading social interactions with health service providers, case workers, police officers, and dates that women described.

I do hold out significant hope that sustainable social change is feasible. Many researchers, activists, and policy analysts are working toward an agenda for social justice. My hope is that this project contributes to this work in some meaningful way to continue to push the exclusionary boundaries of dominant relations of power towards not only equitable distribution of resources, but for changing ideologies that inform our beliefs, values, and assumptions concerning the lives of women who are street-involved and use crack cocaine.

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## APPENDIX A: SCHEDULE AND SEQUENCE OF DATA COLLECTION ACTIVITIES

Proposed Date of Activities	Activities
December 2005 – May 2006	<ul style="list-style-type: none"> <li>• Pilot and revise PKDS</li> <li>• Preliminary fieldwork</li> <li>• Complete PKDS</li> <li>• Preliminary analysis of direct observation and PKDS</li> <li>• Meetings with SWAC</li> </ul>
June 2006 – September 2006	<ul style="list-style-type: none"> <li>• Continue meetings with SWAC</li> <li>• Informal interviews</li> <li>• Begin participant observation with kit making circle</li> <li>• Begin interviews with women who use crack cocaine</li> <li>• Preliminary analysis including integration with PKDS</li> </ul>
September 2006 – April 2007	<ul style="list-style-type: none"> <li>• Participant observation with kit making circle</li> <li>• In-depth interviews</li> <li>• Informal interviews</li> <li>• Preliminary coding</li> <li>• Identification of providers for interviews</li> <li>• Interview providers</li> <li>• Follow-up interviews when feasible</li> <li>• Integration with PKDS data</li> <li>• Feedback for coding with committee members</li> </ul>

## **APPENDIX B: PROJECT DESCRIPTIONS**

## Project Summary for Kit Making and Interview Participants



**Project Title:** Health Concerns among Women who are Street-Involved and use Crack Cocaine: Inequities, Oppression, and Relations of Power in Vancouver's Downtown Eastside

Crack cocaine is the most commonly used drug in the DTES and it has been associated with health problems such as HIV, AIDS, tuberculosis, Hepatitis C, teeth and gum infections, and malnutrition. This study came about due to the reports from women in the DTES that there are very few services specific to the health needs of women who use crack cocaine. There have been only a few research studies done that examine the health concerns or issues of health care access among women who use crack cocaine. More work is needed to make sure that better services can be provided for women. The information learned in this work will be used to make recommendations to the people who make decisions about health care services that women use. By working with women to learn about their experiences, this information will come from the voices of women themselves.

This research is being conducted by Vicky Bungay as part of her graduate thesis at UBC in the School of Nursing. She is also the Project Coordinator for the Safer Crack Use, Outreach, Research and Education (SCORE) Project. The SCORE project is aimed at evaluating the effectiveness of the construction and distribution of safer crack kits as a harm reduction and outreach initiative. Vicky's research of health problems and health care access extends the work of the S.C.O.R.E. project, and takes an in-depth look at women's health issues in the DTES.

**This research project has four key objectives:**

- To develop an understanding of the general physical and mental health issues women experience.
- To develop an understanding of the processes women use to manage their health issues.
- To develop an understanding of the factors that contribute to women's health including what helps or hinders women being healthy.
- To make recommendations that are informed by women who use crack to change those circumstances that contribute to women getting sick.

This study will take place over a 12 - 18 month period. The first part of the study has already been completed. It included surveys with 126 women who use crack cocaine. This survey provided a descriptive overview of the general patterns of crack use among women, the mental and physical health problems they experience and the usual strategies they use to manage their health problems.

The next phase of the study involves more detailed interviews with women on a one-to-one basis and during some of the kit making sessions, to hear their stories about how they manage their health concerns and their experiences with the health care system. Women who participate in the interviews will be interviewed by Vicky at a convenient and safe location and will receive reimbursement for their time. Women may be asked to participate in more than one interview.

Vicky may also interview health service providers to learn about their thoughts and ideas about women's health problems and health care access.

If you would like information about this project you can reach Vicky at xxx-xxx-xxxx or email her at xxxxxxxx.

The University of British Columbia, School of Nursing, 302-6190 Agronomy Rd, Vancouver, BC



## Project Summary for SCORE Project Participants

**Project Title:** Safer Crack Use in an Urban Crack Using Population – A Health Canada Drug Strategy Community Initiative Project

This project is ultimately directed at understanding ways to help reduce the harmful effects of crack use and provide outreach services to marginalized populations. Crack use has been associated with increased risk of HIV/AIDS, tuberculosis, Hepatitis C, sexually transmitted infections, and esophageal and lung damage. Individuals who use crack cocaine have been shown to be more isolated than other substance users and have more unmet health care needs than some other populations. Reports from the Vancouver site for the Canadian Community Epidemiology Network on Drug Use (CCENDU) note that the majority of substance users in the inner city population smoke crack and that crack use is on the rise. Despite this information, there are very few services and programs within British Columbia that are directed at reducing the harms associated with crack use and improving the health of crack users.

This project represents a collaborative effort between *The University of British Columbia (UBC) Nursing and Health Behaviour Research Unit, the Centre for Addictions Research of British Columbia and the Safer Crack Use Coalition of Vancouver*. It is a two-phase project that is geared towards providing outreach services and harm reduction and health promotion initiatives among a community of drug users in Vancouver Downtown Eastside.

Phase I of the project involves working with street-involved women who access a women-only drop-in centre in the DTES to create the safer crack kits. The women will receive twenty dollars per session. Kit construction will occur in a safe environment and other services will be available to the women including meals, shower facilities, and health and social service workers to address concerns such as housing information, personal safety, STI screening and treatment and referrals to appropriate agencies. During kit construction women will be asked to share their ideas about “safer” crack use including thoughts about how to best distribute the kits.

Phase II will involve distribution of 10,000 safer crack kits to men and women who are using crack in the DTES. This initiative is an outreach strategy aimed at reducing some of these drug related harms associated with crack use particularly those associated with drug paraphernalia, infectious diseases, isolation and reduced health care access. The kits will be distributed by outreach workers and members of the project team. Detailed information will be collected about the kit distribution including the number of kits distributed, who the kits get distributed to (e.g., men, women, people accessing other services), the nature of the interaction between the outreach workers and people receiving the kits, and how the kits are being used among the crack using population. Baseline data will be collected about the crack use practices of users before the kits are distributed. After kits have been distributed crack practices will be assessed to determine if practices related to crack use are changing as a result of the wide distribution of the kits. The kits will include: Pyrex<sup>®</sup> pipes, mouthpieces, condoms, lighters, lip balm, alcohol swabs, vitamins, safer crack information pamphlets, bandages, pipe screens, bamboo pushers, and WET lube. **For more information call xxx-xxx-xxxx or email xxxxxxxx.**

**Nursing and Health Behaviour Research Unit**  
School of Nursing, 302-6190 Agronomy Rd, Vancouver, B.C., Canada V6T 1Z3  
**Centre for Addictions Research of British Columbia**  
University of Victoria, PO Box 1700 STN CSC Victoria BC V8W 2Y2  
**Safer Crack Use Coalition**  
Vancouver, BC

## **APPENDIX C: CONSENT FORMS**



# Health Provider Consent Form

## THE UNIVERSITY OF BRITISH COLUMBIA

June 2006

Nursing and Health Behaviour Research Unit  
School of Nursing  
302-6190 Agronomy Rd  
Vancouver, BC, Canada V6T 1Z3  
Tel: (604) 822-7435 Fax: (604) 822-7869  
www.nursing.ubc.ca



### **Project Title: Health Concerns among Women who are Street-Involved and use Crack Cocaine: Inequities, Oppression and Relations of Power in Vancouver's Downtown Eastside**

#### **Health Provider Consent**

Principal Investigator: Joy L. Johnson, PhD, RN  
The University of British Columbia (UBC) School of Nursing  
xxx-xxx-xxxx

Co-Investigator: Vicky Bungay, PhD(C), MN, RN  
Doctoral student, UBC School of Nursing  
xxx-xxx-xxxx

#### **Purpose**

The purpose of this research project is to explore health concerns, women's health care strategies and issues of health care access for women who use crack cocaine. This research is being carried out by Vicky Bungay to meet the requirements of her PhD in Nursing in the School of Nursing at The University of British Columbia.

#### **Study Procedures**

**Observations:** Vicky Bungay will observe staff and clients at relevant health care agencies participating in the study during admissions and in general interactions with one another. During observations Vicky will make brief notes to help her recall what she has later observed.

**Interviews:** Study participants will be interviewed at least once. Most interviews will be very brief (e.g., 10 minutes) to discuss an aspect of an observed event. Some participants may be asked to participate in a longer interview lasting 30 to 60 minutes. With permission, these longer interviews will be tape recorded and then later transcribed. Identifying information will be removed. Interviews will be conducted at a time and place that is mutually convenient.

Participants have the right to refuse to answer any questions or to stop the interview at any time.

A summary of research findings will be available to participants upon request, at the conclusion of the study. Participants may also contact the co-investigator at any time during or following the study to clarify questions or concerns about the study.

#### **Confidentiality**

Any information resulting from this research study will be kept strictly confidential. All documents pertaining to interviews or observations will be identified only by a coded identifying

number known only to Vicky and will be kept in a secure place. Research materials will be kept for possible use in future studies, with the understanding that additional research projects that use this information will be approved by appropriate University committees.

**Contact**

This research is being carried out by Vicky Bungay to meet the requirements of a graduate degree. If you have any questions or require further information with respect to this study, you may contact Dr. Joy Johnson.

If you have any concerns about your rights, or how you are treated as a research subject you may phone The Research Subject Information Line at the University of British Columbia at 604 822 8598.

**Consent**

I understand that my participation in this study is completely voluntary and that I may refuse to participate or withdraw from the study at any time. Withdrawal from the study or refusal to participate will not jeopardize my employment or professional standing.

---

Signature

Date

# Interview Participant Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

October 2006

Nursing and Health Behaviour Research Unit  
School of Nursing  
302-6190 Agronomy Rd  
Vancouver, BC, Canada V6T 1Z3  
Tel: (604) 822-7435 Fax: (604) 822-7869  
www.nursing.ubc.ca



## Interview Participant Consent

### **Project Title: Health Concerns among Women who are Street-Involved and use Crack Cocaine: Inequities, Oppression and Relations of Power in Vancouver's Downtown Eastside**

Dear Study Participant:

I am a doctoral student in the School of Nursing at the University of British Columbia. As part of my graduate thesis, I am conducting a study to learn more about the health problems experienced by women who use crack cocaine and the supports and barriers to health services for women to deal with these problems. This study came about due to the reports from women in the DTES that there were very few services specific to women who use crack cocaine. I am hoping to learn more about what health issues are important to women and the types of services women need. This information can be used to help people making decisions about health resources to plan in a way that better meets women's needs.

I will be conducting interviews with approximately 30 women who have used crack cocaine. In these interviews I will be asking women to tell me about their health concerns, how they manage their health and their experiences with the health care system. If you agree to participate, we can find a time and location that works best for you. If it is OK with you, the interview will be taped and will take about 30-45 minutes. Your responses will be kept totally anonymous and no identifying information will be recorded. When the tapes are made into text, your name or the names of anyone you mention will not appear anywhere in the text version. You will receive twenty dollars for your time. You may be asked to take part in a second interview at a later time. This interview will occur just like the first one and you will receive an additional twenty dollars for your time. Your payment for the first interview will not be influenced by your decision to participate in a second interview.

You have the right to choose if you want to participate in the study and you are free to stop at any point in the interview. If you have any questions about this project please contact me at xxx-xxx-xxxx. If you have any concerns about your rights, or how you are treated as a research subject you may phone The Research Subject Information Line at the University of British Columbia at 604 822 8598. Dr. Joy Johnson is my Supervisor for this project. You can speak with her directly at xxx-xxx-xxxx.

Thank you for your assistance. Please keep this information in case you have questions later and want to contact me.

Vicky Bungay

*Women's Interview Information Sheet, Version 3, October 2006*

## Kit Construction Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

December 2006

Nursing and Health Behaviour Research Unit  
School of Nursing  
302-6190 Agronomy Rd  
Vancouver, BC, Canada V6T 1Z3  
Tel: (604) 822-7435 Fax: (604) 822-7869  
www.nursing.ubc.ca



### **Project Title: Safer Crack Use in an Urban Crack Using Population**

Dear Study Participant:

Dr. Joy Johnson, Dr. Jane Buxton, Dr. Susan Boyd, Ms. Jodi Loudfoot, Ms. Leslie Malchy, and Ms. Vicky Bungay are conducting a study to learn more about the harmful effects of crack use and whether distributing safer crack kits reduces these harmful effects. We also hope to connect with crack users in the DTES. We hope that by doing this study, we can provide solid evidence to the Health Authorities of BC of the health problems of crack users and the effectiveness of having safer crack kits to give out to reduce harm and create outreach initiatives.

The study is funded by Health Canada Drug Strategy Community Initiative Fund. This Fund aims to assist communities in addressing the factors that underlie problematic substance use.

As part of this study we are asking for help from women who have had exposure to crack cocaine to create the kits. Each kit making session will be about one hour in length and you will be given details about how to make the kit from the research assistant. As you are making the kit, the research assistant will be taking notes about things like how many kits are made and other issues that get talked about concerning safer crack use among women. The assistant may ask you questions about what you think about how useful the kit will be, and how the kits should be distributed in your community. During the kit making sessions in which Ms. Bungay is present, some of that data may also be used in her thesis that focuses on women's health problems and self-care. You will be given twenty dollars for your participation in a kit making session and you are able to participate in more than one session if you want to. Your responses to any questions asked by the research participant and your interactions with the other women participating in the session are completely anonymous and confidential; no identifying information will be recorded. If you do not want to participate you will still be given a safer crack kit.

You have the right to choose if you want to participate in the study and you are free to stop at any point in the kit making process. If you have any questions about this project please contact Vicky Bungay at xxx-xxx-xxxx. If you have any concerns about your rights, or how you are treated as a research subject you may phone The Research Subject Information Line at the University of British Columbia at 604 822 8598.

Thank you for your assistance. Please keep this information in case you have questions later and want to contact me.

Vicky Bungay

*Kit Construction Participant Info Sheet, Version 3, December 2006*

# Survey Participant Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

November 2005

Nursing and Health Behaviour Research Unit  
School of Nursing  
302-6190 Agronomy Rd  
Vancouver, BC, Canada V6T 1Z3  
Tel: (604) 822-7435 Fax: (604) 822-7869  
www.nursing.ubc.ca



## Project Title: Safer Crack Use in an Urban Crack Using Population

Dear Study Participant:

Dr. Joy Johnson, Dr. Jane Buxton and Dr. Susan Boyd, Ms. Jodi Loudfoot, Ms. Syd Malchy and Ms. Vicky Bungay are conducting a study to better understand the harmful effects of crack use and the effectiveness of distributing safer crack kits as a harm reduction and outreach initiative among crack users in the DTES. We hope that by doing this study, we can provide solid evidence to the Health Authorities of BC of the health concerns experienced by crack users and the effectiveness of safer crack kit construction and distribution as a harm reduction and outreach initiative.

If you have any questions please contact the Project Director Vicky Bungay at xxx-xxx-xxxx. If you have any concerns regarding your treatment or rights as a research subject you may phone The Research Subject Information Line at the University of British Columbia at 604 822 8598.

The study is funded by Health Canada Drug Strategy Community Initiative Fund whose aim is to assist communities to address the underlying factors associated with problematic substance use.

We are conducting interviewer administered surveys with 150 crack users prior to distributing the kits and 150 crack users who have received a kit. The interviewer will review with you which survey you are eligible to participate in. The interviews will take about 10-15 minutes of your time and you will be ten dollars for your time. If you participate in a more in-depth interview, you will receive a ten dollar gift certificate and this interview may be tape recorded. Your responses to either the survey or in-depth interview are totally anonymous; and no identifying information will be recorded. Your refusal to participate does not exclude you from receiving a safer crack kit.

You have the right to decline to participate in the study or may withdraw at any stage of the interview without consequence.

Thank you for your assistance. Please keep this information in case you have questions in the future and wish to contact me.

Vicky Bungay

**APPENDIX D: RESEARCH INSTRUMENTS: SURVEY AND INTERVIEW  
GUIDES**

## Pre-Kit Distribution Survey

ID # \_\_\_\_\_

ID LOCATION: \_\_\_\_\_

DATE: \_\_\_\_\_

RA'S INITIALS: \_\_\_\_\_

### Part 1: Crack Use

CU1. How often do you *usually* smoke crack?

**PROMPT FOR PEOPLE THAT ASK WHAT YOU MEAN: for example, every day, every week**

**PROMPT FOR PEOPLE WHO SAY AS MUCH AS I CAN: When you have enough money, how much would you usually smoke?**

**DO NOT READ RESPONSES: TICK BEST RESPONSE. *If they say daily ask how many times per day.***

- Less than once a week
- Once a week
- 2-3 times a week
- Daily: If daily how many times a day do you usually smoke? \_\_\_\_\_

**GIVE THEM THE CARD TO LOOK AT, REVIEW WHAT EACH NUMBER MEANS AND THEN READ EACH QUESTION AND CIRCLE THEIR RESPONSE**

When you smoke crack:	Never	Almost Never	Sometimes	Usually	Always
CU2. How often do you use Brillo?	1	2	3	4	5
CU3. How often do you use Pyrex pipes?	1	2	3	4	5
CU4. How often do you use pipes with splits or cracks?	1	2	3	4	5
CU5. How often do you use a mouthpiece?	1	2	3	4	5
CU6. How often do you use a mouthpiece that has already been used by someone else?	1	2	3	4	5
CU7. How often do you use a pipe that has already been used by someone else?	1	2	3	4	5
CU8. How often have you had a pipe explode or break apart? ( <b>prompt: overheat and break</b> )	1	2	3	4	5
CU9. How often do you get your crack yourself?	1	2	3	4	5

CU10. How often can you find a pipe when you need one?	1	2	3	4	5
CU11. How often can you find a mouthpiece when you need one?	1	2	3	4	5
CU12. How often do you prepare your pipe yourself?	1	2	3	4	5
CU13. How often do you smoke with other people?	1	2	3	4	5

CU14. If you smoke crack with others, do you smoke with?

**READ OUT “PEOPLE YOU KNOW” OR “PEOPLE YOU DON’T KNOW”**

- |  |  |
|--|--|
| <input type="checkbox"/> People you know       | <input type="checkbox"/> You don’t smoke crack with others (N/A) |
| <input type="checkbox"/> People you don’t know | <input type="checkbox"/> Refuse to answer                        |

CU15. Who have you shared a mouthpiece with?

**READ OUT “PEOPLE YOU KNOW” OR “PEOPLE YOU DON’T KNOW”**

- |  |  |
|--|--|
| <input type="checkbox"/> People you know       | <input type="checkbox"/> You don’t smoke crack with others (N/A) |
| <input type="checkbox"/> People you don’t know | <input type="checkbox"/> Refuse to answer                        |

CU16. Who have you shared a pipe with?

**READ OUT “PEOPLE YOU KNOW” OR “PEOPLE YOU DON’T KNOW”**

- |  |  |
|--|--|
| <input type="checkbox"/> People you know       | <input type="checkbox"/> You don’t smoke crack with others (N/A) |
| <input type="checkbox"/> People you don’t know | <input type="checkbox"/> Refuse to answer                        |

CU17. Do you prefer to use a mouthpiece?

- Yes
- No: Why not? \_\_\_\_\_
- Refuse to answer

CU18. In the last month, if you wanted to smoke crack and you didn’t have your own mouthpiece, what did you do?

---

CU19. What is the range you pay for pipes? (*Note: If they report other things than money, include these items when you write down their response*)

---



CU20. Do you use pipes other than Pyrex? (**PROMPT: GLASS FOR EXAMPLE**)

- Yes (What kind?): \_\_\_\_\_
- No
- Refuse to answer

CU21. What do you use to scrape the resin? (**PROMPT: IF THEY SAY A PUSHER ASK WHAT KIND**)

---

CU22. In the last month, have you not carried your pipe or mouthpiece because of the police?

- Yes
- No
- Refuse to answer

CU23. In the last month, have police ever taken away or smashed your gear, or made you smash it?

- Yes: Did they take it away, smash it or make you smash it? \_\_\_\_\_
- No
- Refuse to answer

CU24. Have police or security guards ever stopped you or tried to stop you getting help or supplies? (**PROMPT: you can say “for example, a drop-in centre, the hospital, outreach workers, entering INSITE**)

- Yes
- No
- Refuse to answer

## **Part 2: Substance Use**

SU1. What other drugs do you use on a regular basis?

**READ THE LIST OUT OR SHOW IT TO THEM AND CHECK ALL THAT APPLY**

<b>DRUG</b>	<b>YES</b>	<b>NO</b>	<b>REFUSE TO ANSWER</b>
a. Pot			
b. Alcohol			
c. Methadone			
d. Crystal meth			
e Heroin			

f. Cocaine			
g. Ecstasy			
h. GHB			
j. Pills (what kind?)			
k. Other (what else?)			

SU2. Do you currently?

**READ EACH ONE AND CHECK ALL THAT APPLY**

- Inject (Shoot up)
- Smoke
- Snort
- Anything else? What is it? \_\_\_\_\_
- Refuse to answer

SU3. Has your drug use changed at all in the past year?

- Yes: How? \_\_\_\_\_
- No
- Refuse to answer

SU4. Do you smoke cigarettes?

- Yes:
- No
- Refuse to answer

**Part 3: Safer Crack Use Knowledge/Practice**

K1. How do you stay safe *when you are using crack*? (PROMPT: What do you do so that you don't get harmed when smoking?)

K2. What do you do to keep yourself healthy *when you are using crack*?

K3. Have you heard about or seen any information about safer crack use?

Yes: Where at or who told you?

---

No

Don't know

Refuse to answer

#### **Part 4: Health Experiences and Services**

HP1. How would you rate your overall health?

**SHOW THEM THE CARD AND READ OUT EACH ITEM**

Poor

Fair

Good

Excellent

Don't have an opinion about my health

Refuse to answer

HP2. Have you had any of the following health problems in the past year?

**GIVE THEM THE CARD IF THEY NEED IT AND TICK THEIR RESPONSE TO EACH QUESTION**

	Yes	No	Don't Know	Refuse to Answer
a. Burns on your lips or mouth from smoking				
b. Lesions such as cracked lips or sores on your lips or mouth from smoking				
c. Problems with your teeth or gums (e.g., cavities or bleeding gums)				
d. Seizures				
e. Lung infections				
f. Sore throats				
g. Dry cough				
h. Coughing up phlegm				
i. Brillo in your mouth, throat or lungs				
j. Skin infections or abscesses				
k. Broken bones or joint sprains				
l. Heart palpitations (Prompt: feels like your heart is racing or pounding out of your chest)				
m. Pains in your chest				
n. Trembling hands or the shakes				
o. Insomnia or trouble sleeping				
p. Feeling paranoid				
q. Feeling sad or blue				
r. Feeling nervous or anxious				
s. Psychosis				
t. Any other health problems you can think of. What are they? <b>Write their answers here</b>				

HP3. What do you usually do if you have a health problem?

**READ: TICK ALL THAT APPLY**

- I prefer to manage it on my own if I can
- I get help from friends
- I go to the hospital
- I go to a community health clinic
- I tell an outreach worker and they help me figure out what to do
- I see one of the Street Nurses
- I visit my doctor
- Home care such as a visit by a nurse or doctor
- I never have any health problems
- Other (Specify): \_\_\_\_\_
- I do nothing
- Refuse to answer

HP4. How often do you usually have contact with the following people?

**GIVE THEM THE CARD AND THEN READ OUT EACH PERSON IN THE LIST AND ASK THEM TO TELL YOU HOW OFTEN THEY USUALLY HAVE CONTACT WITH THAT PERSON**

	Daily	Weekly	2-3 times/ week	Monthly	Only a Few Times	Never
<b>a. Nurse</b>						
<b>b. Outreach Worker</b>						
<b>c. Volunteer</b>						
<b>d. Counsellor</b>						

HP5. Do you know of any services for crack users?

- Yes (What are they?): \_\_\_\_\_
- No
- Don't know
- Refuse to answer

HP6. What types of supports or services do you need?

**Part 5: Support**

S1. Who provides you with support? I am not looking for names, just the people like friends, workers, that sort of thing. **(Prompt: Ask “anyone else?” twice)**

**DO NOT READ: TICK ALL THAT APPLY**

- Partners/ex-partners
- Friends
- Co-workers
- Street Nurses
- Volunteers
- Counsellors
- Refuse to answer
- Family members or relatives
- Neighbours
- Community workers/outreach workers
- Other health care professionals
- Religious or spiritual groups
- Others (Who is it?): \_\_\_\_\_
- Nobody

S2. Has anyone ever reached out to you to offer you support or help? I don't need names.

Yes: Who was it? (e.g., a friend or an outreach person, or someone like that)

\_\_\_\_\_

No

Don't know

Refuse to answer

---

***IF PARTICIPANT IS A MAN GO TO PART 6***

***For Women Only***

S3. Do you have somewhere that you can go during the **DAY** if you need to be safe or be protected? By day I mean between 6 in the morning and 4 in the afternoon.

Yes: Describe

\_\_\_\_\_

No

Don't know

Refuse to answer

S4. Do you have somewhere that you can go during the **EVENING** if you need to be safe or be protected? By evening I mean between 4 in the afternoon and midnight.

Yes: Describe

\_\_\_\_\_

No

Don't know

Refuse to answer

S5. Do you have somewhere that you can go during the **NIGHT** if you need to be safe or be protected? By night I mean between midnight and about 6 in the morning.

Yes: Describe

\_\_\_\_\_

No

Don't know

Refuse to answer

S6. What are some problems for women who smoke crack?

S7. What kind of help or support do you think women *who smoke crack* need?

**Part 6: General Information**

In this last section I am going to ask you some general questions about yourself such as where you live and your age and that type of thing. Once we finish this section we will be finished the survey.

D1. Do you live in the DTES?

- Yes
- No
- Refuse to answer

D2. Are your living arrangements stable? (**PROMPT: do you have a regular place to live that you don't have to leave for a while?**)

---

D3. Do you feel safe where you are staying?

- Yes
- No
- Refuse to answer

D4. What is your age? \_\_\_\_\_

D5. What would you say is your main cultural or ethnic background? \_\_\_\_\_

D6. Do you identify as.....

**READ LIST AND TICK THEIR RESPONSE**

- Female
- Male
- Transgender
- Other
- Refuse to answer





## **Interview Guide: Women's Version**

### **Introduce Myself**

1. I am a nurse who has gone back to school and am now doing research in the area of women's health, particularly for women who use drugs.
2. I worked for a long time in intensive care and have seen a lot of women who are really sick and have cared for a lot of women who are from the DTES and who have died and I am interested in trying to stop this from happening so much.
3. I am hoping that by learning what women have to say I can help to make better health policy that are what women really need and want so that they can be as healthy as possible.

### **Introduction to the Research**

So as I said, I am really interested in women's health. I am hoping to learn more about how women take care of themselves, how they stay healthy, or what happens if they have a health problems such as who helps; where do they go; and whether or not the people and places actually help them get healthier.

I am focusing on women who use crack cocaine because not a lot of people have done this and I want to learn if there are special things that women need and if these things are different for women if they use crack.

I am really thankful that you agreed to talk to me. I don't have a whole long list of questions prepared. I was just hoping we could take some time and talk about what is going on in your life and that we could get to know each other better.

### **Questions**

1. I am interested to get to know you a little bit more, to hear about who you are and what your experiences have been. So if it is OK with you, let's begin with you telling me a little bit about yourself (e.g., tell me a bit about how you got to be here today).
2. Within the kit making sessions a lot of women have talked about their experiences in health care.

Option A if participant raised an issue during participant observation: I remember that during one session you talked me about (scenario within the context of interacting with a health care provider(s). Can you tell me in as much detail what happened? Try starting with why you went there and then talk about each thing that happened.

Option B if participant did not raise an issue during participant observation: Can you describe for me some of your experiences such as visiting a clinic or going to the hospital? It may be helpful to just pick one situation and describe for me in as much detail what happened. Start with why you went and then talk about each thing that happened.

3. Can you tell me about the things you do to take care of yourself? For example, what do you usually do when you are not feeling well? When might you decide to go to one of the clinics or the emergency room?
4. Can you tell me in your own words why you think so many women get sick in the DTES?

**Topics to pay attention to throughout the interview:**

- a. health concerns
- b. safety
- c. violence
- d. agency (the things women do to take care of themselves)
- e. race
- f. gender
- g. poverty
- h. strategies to manage health concerns
- i. experiences with health care providers
- j. substance use (e.g., amount of crack, context of crack use)

**Interview Guide: Provider's Version**

As you know, I am interested in experiences of health among women who use crack cocaine. I have asked you to take part in an interview so that I could learn more about your experiences and perspectives regarding the health issues of women who use crack cocaine.

To begin, can you tell me a little bit about the work that you do such as where you work, the activities you do, that sort of thing?

Can you describe in your own words, your perspectives of women's health in the DTES including what you think are some of the major health challenges that women face?

Can you describe for me in your own words, why it is that women in the DTES experience so many health problems?

Can you tell me, what you think would help to improve women's health?

## Demographic Data for In-depth Interviews

D1. Do you live in the DTES?

- Yes
- No

ID: \_\_\_\_\_

Date: \_\_\_\_\_

D2. Are your living arrangements stable? (**PROMPT: do you have a regular place to live that you don't have to leave for a while?**)

- Yes
- No

D3. Do you feel safe where you are staying?

- Yes
- No

If no, why not? \_\_\_\_\_

D4. What is your age? \_\_\_\_\_

D5. What would you say is your main cultural or ethnic background?

- Aboriginal (e.g., First Nation, Métis, Inuit)
- Euro/White
- Chinese
- South-Asian (e.g. Indian, Pakistani)
- Other Asian (e.g. Vietnamese, Japanese)
- Latin American
- Middle Eastern
- Black
- Other, specify \_\_\_\_\_
- Unsure/don't know
- Declined

D6. Marital Status

- Single
- Married/Common Law
- Widowed
- Declined

D7. What is your highest level of education?

- Grades 9-11
- Grades 12-13
- Some college/university
- University Degree
- Graduate Degree
- Declined
- GED



## APPENDIX E: CERTIFICATES OF ETHICAL APPROVAL



The University of British Columbia  
Office of Research Services  
**Behavioural Research Ethics Board**  
Suite 102, 6190 Agronomy Road, Vancouver,  
B.C. V6T 1Z3

### CERTIFICATE OF APPROVAL - MINIMAL RISK AMENDMENT

<b>PRINCIPAL INVESTIGATOR:</b> Joy L. Johnson	<b>DEPARTMENT:</b> UBC/Applied Science/Nursing	<b>UBC BREB NUMBER:</b> H06-80437
<b>INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:</b>		
<b>Institution</b>	<b>Site</b>	
UBC Other locations where the research will be conducted: N/A	Point Grey Site	
<b>CO-INVESTIGATOR(S):</b> Susan Boyd Colleen Varcoe Victoria Bungay		
<b>SPONSORING AGENCIES:</b> N/A		
<b>PROJECT TITLE:</b> Health Challenges, Agency, and Health Care Access among Women Who Use Crack Cocaine		

**Expiry Date - Approval of an amendment does not change the expiry date on the current UBC BREB approval of this study. An application for renewal is required on or before: July 6, 2007**

<b>AMENDMENT(S):</b>	<b>AMENDMENT APPROVAL DATE:</b> January 24, 2007	
<b>Document Name</b>	<b>Version</b>	<b>Date</b>
<b>Consent Forms:</b>		
Women's Interview Consent	3	October 1, 2006
<b>Questionnaire, Questionnaire Cover Letter, Tests:</b>		
Demographic Information	1	October 1, 2006
<b>Other Documents:</b>		
Clarification of Secondary Use of Data	N/A	January 15, 2007
The amendment(s) and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.		
<i>Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:</i>		
<hr/> Dr. Peter Suedfeld, Chair Dr. Jim Rupert, Associate Chair Dr. Arminee Kazanjian, Associate Chair Dr. M. Judith Lynam, Associate Chair		



The University of British Columbia  
 Office of Research Services  
**Behavioural Research Ethics Board**  
 Suite 102, 6190 Agronomy Road, Vancouver,  
 B.C. V6T 1Z3

## CERTIFICATE OF APPROVAL- MINIMAL RISK RENEWAL

<b>PRINCIPAL INVESTIGATOR:</b> Joy L. Johnson	<b>DEPARTMENT:</b> UBC/Applied Science/Nursing	<b>UBC BREB NUMBER:</b> H06-80437
<b>INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:</b>		
<small>Institution</small>	<small>Site</small>	
UBC	Point Grey Site	
Other locations where the research will be conducted: N/A		
<b>CO-INVESTIGATOR(S):</b> Susan Boyd Colleen Varcoe Victoria Bungay		
<b>SPONSORING AGENCIES:</b> N/A		
<b>PROJECT TITLE:</b> Health Challenges, Agency, and Health Care Access among Women Who Use Crack Cocaine		

**EXPIRY DATE OF THIS APPROVAL: July 13, 2008**

**APPROVAL DATE: July 13, 2007**

The Annual Renewal for Study have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

*Approval is issued on behalf of the Behavioural Research Ethics Board*

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# APPENDIX F: FIGURE 1. MAP OF DTES NEIGHBOURHOOD

