

ISSUES OF GENDER IN INJECTION DRUG USE: EXAMINING CONTEXTUAL
CIRCUMSTANCES OF WOMEN'S FIRST INJECTING EXPERIENCE AND FACTORS
ASSOCIATED WITH TREATMENT ENGAGEMENT

by

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ABSTRACT

Women who inject drugs (IDU) are at elevated risk for drug-related harms. While there has been growing interest in first injecting experiences of IDU, less attention has been given to broader socio-cultural, structural and environmental risk conditions in which marginalized women live and injection risk practices and addiction treatment engagement occur. For this thesis, I sought to build on previous research by using gender-based analysis (GBA) to describe the risk environment of IDU women and examine gender differences in circumstances surrounding first injecting experiences and addiction treatment engagement among IDU in Vancouver.

Between May 2005 and December 2007, cross-sectional data were drawn from a prospective cohort of 1,436 participants, including 496 women. GBA was used to identify gender differences in circumstances surrounding first injecting experiences and current addiction treatment enrolment. Risk environment, gendered violence and cultural safety conceptual lenses were used to inform the interpretation of findings.

Regarding first injection experiences, associations were found between female gender and Aboriginal ancestry, receiving assisted injection, and intimate partner injection drug use as a reason for first injection, whereas syringe borrowing, injecting in public, first taught to inject by self, and curiosity as a reason for first injection were negatively associated with female gender. Current addiction treatment enrolment was reported by 597 (41.6%) participants – 220 women (89 Aboriginal) – and 377 men (69 Aboriginal). Among women age at first injection and having an intimate partner were associated with treatment enrolment, whereas Aboriginal ancestry, homelessness, and frequent heroin injection were negatively associated. Among men, age at first injection was associated, whereas Aboriginal ancestry, homelessness, frequent alcohol and

frequent heroin were negatively associated. Methadone was the most common type of addiction treatment reported by both genders. Most common reasons for non-enrolment were ‘don’t feel a need to stop using drugs’ for women, and ‘don’t think treatment programs work for me’ for men.

Findings suggest intimate partner power relations are significant factors in mediating women’s drug using risk practices as well as the perceived degree of safety in accessing health services. These findings contribute to existing literature and provide significant implications for practice, policy and future research.

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DEDICATION

*For my loving partner, 'mon beau' Luc,
my sister Sharon, my mother Beverly,
my 'partners in crime', Judith and Thomas,
and my eternal friend and aspiring nurse, Michael.*

*Also, in loving memory of colleagues Lorie and Andrew,
and especially Gavin, my father – unrelenting advocate of social justice
and loyal and accomplished public servant and armed forces veteran to the
people of Canada.*

CO-AUTHORSHIP STATEMENT

This is to certify that the work presented in this thesis was conceived, instrumented, written and disseminated by the Masters student. The co-authors of the manuscripts that make up part of this thesis made contributions only as was commensurate with committee or collegial duties. The co-authors reviewed each manuscript prior to preparation for publication and offered critical evaluations; however, the student was responsible for overseeing and conducting data analyses and preparing the initial drafts of all manuscripts. In addition, the student was responsible for revising the manuscripts based on the suggestions of the co-authors and will be responsible for future submission of manuscripts for publication and subsequent preparation of final revisions based on the comments of the journal editors and external peer reviewers.

CHAPTER ONE:

Background, Objectives, Theoretical Perspectives and Research Design

Introduction

I have spent many years throughout my nursing career working with people who are disadvantaged and marginalized in Vancouver, in particular, people who use injection drugs and struggle with addiction, mental illness and other health and social issues such as inadequate housing and income. These experiences have profoundly shaped my nursing practice by helping me to reflect on what ethical practice is, and the role ethics has to play in health and social policy. As a nurse providing health promotion, HIV prevention and harm reduction services for people who use illicit injection drugs in Vancouver's Downtown East Side, I have long realized that assisting people – women in particular – to reduce high-risk injection drug related behaviours is much more complex than simply providing drug use related education and information (Wood, Zettel, & Stewart, 2003).

In part, some reasons for this complexity are to do with many of the shortcomings in the capacity of our social support systems and institutional structures to provide accessible multifaceted and integrated support services to those most vulnerable and at risk in our society. Several of these shortcomings are highlighted in the final report of the *Commission on the Future of Health Care in Canada* (2002) – commonly referred to as the 'Romanow Report' (in reference to the report's Commissioner, Roy Romanow). Some examples of support services alluded to in the Romanow Report as largely absent include: early intervention and addiction prevention services; integrated multi-modal addiction treatment and harm reduction services; mental health treatment and support services; stable housing; financial assistance; childcare support; and protection from various forms of social and interpersonal discrimination and gender-based

violence. The Romanow Report included specific recommendations regarding the importance of recognizing the differing gender-based health needs and points of access to the health care system for men compared with women. The shortcomings or structural limitations mentioned in the Romanow Report present challenges for health care providers and health policy makers in providing accessible and equitable services, and create conditions of *moral distress*¹, resulting in an accumulation of *moral residue*² (Doane, 2004; Varcoe, 2004; Bergum, 2004).

Myself and my colleagues recognized that we needed to deal with some of the moral distress we experienced in working with marginalized people who use drugs. In an article drawn from our previous work (Wood, Zettel et al., 2003) we asserted that:

The gap in nursing service provision between the drug user and his or her drug use had to be bridged. We needed to meet our clients where they were on the continuum of health, while acknowledging their expertise in directing their life (p. 22).

An illustration of how such action might look in practice is encapsulated in the following excerpt from that same work:

In December 2001, a nurse was approached by an injection drug user who asked for a 'rig' [syringe] ... [to inject] heroin. [The individual] ... planned just to shake up the drug with ... [self-]aspirated blood because ... [the person had no access to] ... water or facilities to 'cook' the mix. 'Yes, you do,' said the nurse, 'come with me.' And so began supervised injection practices ... (Wood, Zettel, et al., 2003, p 20).

The examples presented above from our previous work demonstrate how we came to realize that many of the complexities of our health care system and the limitations mentioned above lead to a

compounding of health and social issues for people who are street-entrenched and socially marginalized, especially women.

Women who are socially marginalized and use injection drugs bear a disproportionate burden of infectious disease and everyday violence compared to their male counterparts (Bourgois, Prince, & Moss, 2004; Spittal et al., 2002). Spittal et al. found HIV incidence rates among women in Vancouver's Downtown Eastside who use injection drugs to be forty percent higher compared to men, while Bourgois et al. found hepatitis C (HCV) incidence rates among a similar population of women in San Francisco to be fifty percent higher compared to men. Moreover, a recent qualitative study by Shannon et al. (2008) documents the pervasiveness of *structural violence*³ and unequal gender power relations among women in Vancouver who use drugs and engage in survival sex work. Such conditions of everyday violence constrain women's agency in negotiating drug and sex related risk reduction strategies. Further elaboration regarding forms of gender-based violence is presented later in this chapter.

Further exploration of how our understanding of women's injecting practices and factors associated with addiction treatment engagement has been shaped by broader socio-cultural, structural and environmental influences would serve to better inform ethical nursing practice and health policy-making. It is this kind of exploration that I am setting forth to undertake in this thesis.

Background and Purpose⁴

Injection drug use continues to be associated with severe harms throughout the world (Aceijas & Rhodes, 2007). Women who inject drugs have been found to be at elevated risk for drug-related harms, including HIV infection (Spittal et al., 2002). This has led to growing interest in women's early injecting experiences (Novelli, Sherman, Havens, Strathdee & Sapun,

2005). Although findings have been somewhat inconsistent, several studies in North America and Australia have described gender differences (for example, in age and social context) in the circumstances surrounding first-time injection experiences (Bryant & Treloar, 2007; Fuller et al., 2003; Kerr, et al., 2007). Gender differences in early childhood experiences of trauma (for example, sexual abuse) have also been implicated as possible influences in the context of injection drug initiation (Ompad et al., 2005). Novelli et al. (2005) contend that targeting prevention measures designed for young people who use drugs, but who have not yet transitioned into injection drug use, may serve to delay or prevent injection initiation. Moreover, for people who use illicit street drugs (either by injection or otherwise) a greater awareness of how broader socio-cultural, structural and environmental influences shape our understanding of women's injection practices would better inform gender-based health policy and strategies to improve access to environmentally, structurally and culturally safe, gender-sensitive addiction treatment programs and health services.

A recent study in Vancouver, Canada showed that adolescents who initiate injection drug use at an early age were at greater risk for subsequent high-risk injection drug use behaviour, including binge use, sex work, and criminalization (Miller, Strathdee, Kerr, Li & Wood, 2006). In general, women who inject drugs are more likely than their male counterparts to report having been injected by another individual (i.e., assisted injection) (Hankins, 2008; O'Connell et al., 2005; Wood, Spittal et al., 2003) – a practice associated with elevated risk for HIV infection (O'Connell et al.). Hankins suggests that women may have less autonomy in accessing drugs and injecting equipment and that such social dependency can increase their risk for HIV infection and overdose. As I have indicated above, greater elucidation of the environmental, social and structural dynamics involved in women's first injection experiences is needed. Drawing attention

to these dynamics would serve to better inform strategies and policies related to health promotion, addiction prevention, and health service provision and access. In particular, informed strategies and policies are needed to address barriers to accessing and providing addiction treatment and mental health services for vulnerable women who use drugs, including those who have not yet initiated injection drug use as well as those who have.

Despite a rapidly mounting body of literature on the individual and social harms associated with injection drug use in general, and related harm reduction efforts by nurses and other public health workers, there remains limited published work focused on how the gender-specific contextual interplay of multi-level (micro, meso and macro) influences plays a role in the particular vulnerabilities faced by socially marginalized women who use injection drugs. Several individual risk factors for HIV and other injection-related harms among women who use injection drugs have been identified (Spittal et al., 2002), however much less attention has been given to the broader socio-cultural, structural and environmental risk conditions in which marginalized women live and in which injection risk practices and addiction treatment engagement behaviours occur.

In light of this gap in the published literature, the overall objective of my thesis research is to describe the risk environment of marginalized women in Vancouver who use injection drugs and explore how our understanding of women's injecting practices has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions. I use these perspectives, while applying a lens of gender-based analysis to quantitatively examine the gender differences within the contextual circumstances of women's first injecting experience. Further, I use quantitative methods to explore gender differences in factors associated with being enrolled in addiction treatment services among people in Vancouver who use injection drugs. These

quantitative analyses, interpretations and discussions are presented in Chapters Three and Four and were conducted within the context of a larger program of research using secondary data drawn from the Vancouver Injection Drug User Study (VIDUS) – one of several large prospective cohort research programs operated under the Urban Health Research Initiative (UHRI) which is led by one of my thesis supervisors (Dr. Thomas Kerr). Lastly, I discuss the ethical implications of these findings for health policy and service delivery with respect to access to gender-sensitive and culturally safe addiction treatment services and environments for women who use drugs.

The Study Setting: Vancouver's Downtown Eastside

Since the 1980s, the illicit drug market in Vancouver's Downtown Eastside has become well-entrenched (MacPherson, 2001). Several social, economic, environmental and policy factors have helped to facilitate this development, including: increased poverty; substandard housing; high unemployment; increased availability of low cost heroin and cocaine; an exodus of legitimate businesses from the area; policy initiatives to de-institutionalize people living with mental health issues in the absence of adequate community health and social support structures; and displacement of street level drug dealers into the Downtown Eastside from other areas of the city as a result of enforcement policy initiatives in the 1970s and 1980s (MacPherson). The collective effect of these factors resulted in a dramatic increase in ghetto-like conditions in the Downtown Eastside community. Further, the response to these escalating problems by the addiction treatment system has been inadequate and slow (MacPherson).

In 1988, the City of Vancouver implemented policy to fund a needle exchange program – which has since become the largest in North America – and in 1989 the HIV/STD Prevention Street Nurse Program was implemented by the Provincial Health Authority (Gold, 2003).

Subsequently, the public health discourse regarding the notion of innovative harm reduction approaches was becoming louder, especially in Vancouver (Adlersberg, 2002; Elliott, Malkin & Gold, 2002; Gold, 2002; Kerr, 2000; Kerr, Wood, Palepu et al., 2003; Kerr, Wood, Small, Palepu & Tyndall, 2003; Marlatt, 1998; MacPherson, 2001; Wood, Zettel et al. 2003).

In many Canadian cities, including Vancouver, drugs such as heroin have been available throughout the past century and beyond. However, in about 1992, an increase in purity of street heroin was seen (MacPherson, 2001). This, along with the introduction of cheap cocaine and crack-cocaine to Vancouver in the early 1990s, resulted in a devastating effect on the health of individuals and communities, especially the Downtown Eastside (MacPherson). The total number of illicit drug related overdose deaths in British Columbia rose from 39 in 1988 to 331 in 1993 (Cain, 1994). Almost two thirds of these deaths occurred in Vancouver. In 1998, illicit injection drug overdose was the leading cause of death in British Columbia for males age 30–49 (Millar, 1998). Many of these deaths could have been prevented if appropriate resources and policies had been in place (Cain; MacPherson). Increases in rates of HIV, hepatitis C and overdose fatalities among persons injecting drugs became so severe that, in 1997, the local health authority declared a public health crisis (Palepu et al., 2001).

Inadequate engagement by primary health care providers and poor access to culturally safe services (although recently improved) continue to further compromise the health of people who inject drugs, resulting in costly and inappropriate emergency room visits, and hospital admissions (Palepu et al., 2001). In response to this public health crisis, in 2001 Vancouver City Council adopted *'A framework for action: A four-pillar approach to drug problems in Vancouver'* (MacPherson, 2001). This policy framework consists of four broad 'pillars': prevention; treatment; enforcement; and harm reduction. While a vastly disproportionate amount

of government funding is targeted at enforcement efforts (DeBeck, Wood, Montaner & Kerr, 2006), the predominant themes throughout this thesis foreground the other three pillars: those of prevention, treatment and harm reduction. As part of the contextual positioning of this thesis research, these themes are viewed in relation to gender differences in injecting practices, circumstances surrounding injection initiation, addiction treatment engagement, injection risk environments, and ethical issues related to equitable access to culturally safe and gender-sensitive health and social services.

Central Areas of Thesis Research

First Injection Experiences

While there has recently been a growing body of literature exploring first injecting experiences of people who are, or have been injection drug users (IDU) (Abelson et al., 2006; Doherty, Garfein, Monterroso & Latkin, 2000; Fuller et al., 2003; Kerr et al., 2007; Miller, Strathdee et al., 2006; Novelli et al., 2005; Roy et al., 2003), little attention has been given to in-depth gender-based analyses of the contextual socio-cultural, structural and environmental risk circumstances of women's initiation experiences. Novelli et al., in their Baltimore, Maryland study of the relationship between circumstances surrounding the first injection experiences of young people who inject drugs and future injection risk practices, found that age and self-injection (versus being injected by another individual) at initiation were independently associated with future injection risk behaviours. This finding suggests that young people who inject drugs may establish high-risk injecting practices during their injection initiation experience and may have been influenced prior to their first injection by certain socio-cultural, structural and environmental factors. Overall, findings from other studies imply that the intersections of social and demographic factors may place people who use drugs at heightened risk of harm. There have

been calls for more early intervention approaches (Novelli et al.) which also have implications for how various forms of addiction treatment services are provided and accessed by people who use street drugs, both by injection and otherwise.

Addiction Treatment Engagement

A study by Kerr, Marsh, Li, Montaner and Wood (2005) examining associations between methadone maintenance therapy (MMT) use and socio-demographic and drug-related variables found that female gender was positively associated with enrolment in MMT, whereas Aboriginal ancestry was negatively associated. Kerr et al. call for further study into associations between MMT engagement and the intersecting factors of Aboriginal ancestry and gender. With respect to a range of other addiction treatment options, however, Hankins (2008) argues that “since most addiction treatment programmes are designed with men drug users in mind as the predominant client, specific and sustained attention is urgently needed now to develop programmes which also serve the needs of the growing proportion of drug users worldwide who are women.” (p. 2).

In contrast, in a study by McCance-Katz, Carroll, and Rounsaville (1999) involving people seeking treatment for cocaine addiction in the United States (US), many women were found to be as severely ill as men but received less addiction treatment services. A later US study by Kim and Fendrich (2002) showed similar findings indicating that women who use drugs are less likely than their male counterparts to enrol in addiction treatment even though women often struggle with more severe drug-related and mental health issues compared to men and are more likely to identify their drug use as a problem (Kim & Fendrich). Inconsistencies between findings from Canadian studies compared to American studies related to women’s engagement in addiction treatment may be explained in part by the somewhat greater focus on interdiction as a major drug control strategy in the United States compared to Canada (Marlatt, 1998; Werb et al.,

2010). This central focus on enforcement of drug control laws (as opposed to a focus on health care) in the US, combined with a lack of gender-sensitive low-threshold access to addiction services, may influence women's lower level of engagement in American addiction treatment services compared to service engagement in Canada. Insight into how policy differences in drug control measures and in addiction prevention and treatment approaches have evolved between Canada, the US and elsewhere can be gained through an examination of historical social discourses.

Shaping Understanding Through Social Discourses

How current understandings of women's injecting practices, and of the risk environments in which such practices occur, have been shaped is elucidated through situating present discourses on gender roles related to street and drug using cultures within a historical context. It is from this historical landscape that reflective stances can be taken through applying a gender-based analysis approach to examining the multiple socio-cultural, political, environmental, and structural intersections upon which portrayals of injection drug users have been socially constructed. Further discussion in Chapter Two of these multiple intersecting factors begins to uncover the gender differences and complexities of how, why, where and when individuals initiate injection drug use, and subsequently (for many) access addiction treatment services. From this vantage point, drawing upon a number of relevant theoretical perspectives and social-political concepts is valuable in informing the meaningful interpretation of the quantitative analyses to be presented in Chapters Three and Four of this thesis.

Gender-Based Analysis

Used throughout all aspects of this research process, gender-based analysis is an evidence-based approach that takes into account how policies, programs, services and research

impact differently on the lives of women and men (Canadian Institutes of Health Research, 2007). Gender-based analysis offers great potential for valuable contributions to the addiction research literature, which can inform and direct further work into the appropriateness and effectiveness of gender-based policies and harm reduction strategies regarding prevention and treatment services for people who use injection drugs (Graham, Young, Valach & Wood, 2007). The relevance of gender-based analysis in this thesis is illustrated in several examples of how a variety of social, structural and environmental influences are used as means to shape social conceptions of drug users, which in turn produce deleterious consequences for people (especially women) who use drugs. Such consequences increase the level of vulnerability within heightened risk environments.

Theoretical Perspectives

Three main theoretical perspectives inform the present study: *the risk environment framework* (Rhodes, 2002); the concept of *intersections of gender and violence* (Bourgois et al., 2004, as cited in Fairbairn et al., 2008, pp. 817-818); and the lens of *cultural safety*, from a critical cultural perspective in keeping with the work of Smye and Browne (2002) and Browne and Varcoe (2006). These particular theoretical lenses have been selected because they fit well with a gender-based analysis and draw attention to the broader contextual features of women's lives that inform current understandings of injecting practices.

Risk Environment

Rhodes' *risk environment framework* is an articulation of the process of how various factors (for example, forms of gendered violence and *cultural risk*) function to produce poor health outcomes among marginalized women who use injection drugs (Rhodes, 2002). In the context of this framework, *risk environment* is defined as the social or physical space in which a

range of factors, exogenous to the individual, interact across the *micro* (individual/interpersonal), *meso* (local/social), and *macro* (structural/institutional, for example, political or economic) dimensions of the broader risk environment in which risk and harm are produced and reproduced (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005). Such factors operating within a specific local context can exert significant influence upon the course of disease outbreaks and other forms of harm among vulnerable groups, and can mediate the effectiveness of public health and prevention interventions (Galea, Ahern & Vlahov, 2003; Galea & Vlahov, 2002; Karpati, Galea, Awerbuch & Levins, 2002). Factors such as those mentioned above within the risk environment that contribute to initiation of injection drug use and to delayed or constrained access to appropriate addiction treatment services produce risk and harm, and are areas of central focus in this present thesis. Overlaying the risk environment is the concept of *intersections of gender and violence*.

Gendered Violence

This, the second conceptual perspective informing the present work, is comprised of three theoretical classifications of gendered violence: *everyday* (or interpersonal); *symbolic*; and *structural* (Bourgois et al., 2004; Fairbairn et al., 2008). These classifications, or layers, of gendered violence have been applied within public health contexts to elucidate the historical, political and cultural dimensions of gendered experiences of health and illness (Bourgois et al.; Shannon et al., 2008). Bourgois et al. assert that such a theoretical lens allows for a linking of individual risk behaviours, "... commonly associated [among mainstream society] with ignorance, psychopathology or immorality, to larger social power relations [such as addiction treatment service organizations] as well as to pragmatic constraints for survival as a street addict" (p. 254).

Everyday violence. Based on the term coined by Scheper-Hughes (1996) which was informed by the work of Kleinman (1988), Kleinman, Das and Lock (1997), and Bourgois, Lettiere and Quesada (1997), Shannon et al. use the description of everyday violence articulated by Bourgois et al. (2004) to refer to manifestations of violence “... that are normalized and rendered invisible because of their routine pervasiveness” (p. 254). In other words, everyday violence refers to those tacit interpersonal aspects of gendered violence which are invisible or unrecognized by those upon whom they are perpetrated – in particular, women (Bourgois et al., 2004). One example of a form of everyday violence can be illustrated through a common scenario where some women are unable to self-inject and are dependent on male partners for drug injection (assisted injection). Such a circumstance is often beneficial to the male partner who is entirely in control of the drug supply, injecting equipment and the drug administration process. This tacit and pervasive form of everyday violence that is commonly normalized within street culture involves the male partner preparing the drug for injection and then first injecting himself before using the same used syringe to inject the female partner. Because of the woman’s subordinate position of relational power, there is little choice available to her regarding imposing safer injecting practices on the male partner due to the threat that her drug injection will be withheld if she contests (Fairbairn et al., 2006). Within a micro-level risk environment context, such conditions of everyday violence constrain women’s agency in negotiating risk avoidance and risk reduction strategies. Consequently, socially marginalized women who use injection drugs bear a disproportionate burden of infectious disease and gendered violence – including everyday violence – compared to their male counterparts (Bourgois et al., 2004; Spittal et al., 2002).

Symbolic violence. Drawing on the work of Bourdieu (2001) and Epele (2002), Fairbairn et al. (2008) regard symbolic violence as rooted in a male-dominated street culture that situates women in subordinate positions with respect to control of resources and dependence on men for protection from harm by others through submission to a role that is akin to that of a man's 'property.' Symbolic violence is often systemic in nature and can be a means of excluding women from more senior levels of power within the hierarchy of street and drug culture. Thus, women's abilities to access health care services and harm reduction measures (such as supplies of condoms or clean syringes) are constrained. Further compounding difficulties in accessing health care and harm reduction services are various forms of structural violence.

Structural violence. Farmer (1997; 1999; 2000; 2004) regarded structural violence as the broader political and economic gendered power imbalances that, within the macro-level risk environment context, result in the social marginalization of women who use injection drugs, and that limit access to basic health and social services (Farmer, Nizeye, Stulac & Keshavjee, 2006).

Injection drug use initiation, practices and addiction treatment seeking generally occur within the complexity of intersecting social factors in a local risk environment context. As I have already indicated, in this thesis these intersecting social, environmental and structural factors are explored through a gender-based analysis approach which is informed by gendered violence and risk environment perspectives. These perspectives are discussed in depth in Chapter Two. Interpretation and discussion of the analyses that follow in Chapters Three and Four are presented in those chapters accordingly. The subsequent discussion in Chapter Five regarding health and social policies and interventions that reduce barriers to service access for women and people who are Aboriginal will comprise part of the closing work of this thesis. To appropriately and effectively inform these analyses, interpretations and discussions, applying an interpretive

lens of *cultural safety* positioned within critical post-colonial⁵ perspectives is an important (and possibly essential) consideration.

Cultural Safety

As the third key theoretical concept that informs this present work, cultural safety is used within critical theoretical views as a philosophical stance or interpretive lens. When situated within a critical post-colonial context, cultural safety assists us to understand how current colonial practices in health care have a tendency to cause *cultural risk* (Smye & Browne, 2002). This tendency in health care to cause cultural risk (further discussed in Chapter Two) is an important consideration in exploring the questions and objectives of this thesis. Critical post-colonial theories assist us in elucidating and uncovering vulnerabilities among individuals who use injection drugs, particularly women and people of Aboriginal ancestry, and who are socially marginalized and in need of access to appropriate health care and scarce culturally safe addiction treatment services.

A recent study by Wood et al. (2008) showed that about 32% of people who use injection drugs in Vancouver's Downtown Eastside are women. Aboriginal people comprise about 22% of this population. While non-Aboriginal people within this population include 26% women, Aboriginal people within the same population include 52% women. Such data illustrate the complex layering of minority status of women, especially Aboriginal women, within this already socially marginalized sub-culture population, and the relevance of cultural safety in the context of the dominant health care culture.

Intersections of Gender, Risk, Structural Influences and Cultural Safety

The substantial body of literature related to gendered aspects of injection drug use and street culture provides numerous illustrations of the intersections of gendered interpersonal,

environmental, structural and cultural variables, factors or influences. Some examples of how these factors intersect, and ways in which these intersections impact health, risk, and access to services are discussed further in Chapter Two. Cultural safety as an interpretive lens positioned within critical theoretical perspectives draws attention to the multiple intersecting contexts of risk environments and layered forms of gendered violence. This interpretive lens allows for examinations of gender differences in the social, structural and environmental circumstances of individuals' first injecting experiences, and in access to gender-sensitive addiction treatment services.

Rationale and Objectives

This thesis is situated within post-structural critiques of public health and drug policy that consider ways in which individuals are governed through messages of self-regulation and risk-avoidance as a form of neo-liberal governmentality (Moore, 2004; Petersen & Lupton, 1996). Shannon et al. (2008) argue that public health and harm reduction approaches in recent years have largely focused on individual-level, rather than collective/social/structural-level interventions. Such individual-level approaches fail to adequately consider the intersections of broader social and structural influences with micro-level risk environments which produce, reproduce, reduce and otherwise mediate risk in the everyday living conditions of women who use drugs (Shannon et al.). Shannon et al. further argue that there needs to be a re-thinking of future public health measures that affords moving beyond individual-level approaches.

The interwoven conceptual perspectives of risk environment, gendered violence and cultural safety begin to model a multifaceted contextual view of the social, structural and environmental factors associated with first injection experiences and with being enrolled in addiction treatment among people in Vancouver who use injection drugs. These interwoven

conceptual perspectives as applied in this thesis are used to examine gender differences in the risk environments of marginalized people in Vancouver who use injection drugs. Such contextual views are important in informing and guiding the overall objectives of my thesis research. Overall, the interwoven contextual perspectives serve as a preliminary model or framework that is most useful in guiding an exploration of how our understanding of women's injecting practices has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions.

As mentioned above, the overall objective of my thesis research is to describe the risk environment of marginalized women in Vancouver who use injection drugs and explore how our understanding of women's injecting practices has been shaped by socio-cultural, historical, political, environmental, structural and gendered dimensions. I apply a gender-based analysis approach, using quantitative methods, to examine gender differences within the contextual circumstances of women's first injecting experiences and among factors associated with being enrolled in addiction treatment services among people in Vancouver who use injection drugs. I also explore the ethical implications of the study findings for health policy and service delivery with respect to access to gender-sensitive and culturally safe addiction prevention, treatment, and harm reduction services.

Research Questions

Through this thesis research process, I address the following questions:

1. How has our understanding of injecting practices among marginalized women who use illicit injection drugs been shaped by socio-cultural, historical, political, environmental, structural and gendered dimensions?

2. Are there gender differences in social, environmental and structural circumstances surrounding initiation to injection drug use among a cohort of people in Vancouver who use illicit injection drugs?
3. Are there gender differences in factors associated with being enrolled in addiction treatment among a cohort of people in Vancouver who use illicit injection drugs?
4. What are the ethical implications for health policy and service delivery related to access to gender-specific and culturally safe addiction treatment services for women in Vancouver who use injection drugs?

Research Design and Methods

The Urban Health Research Initiative

Close collaboration with the Urban Health Research Initiative team (UHRI) was essential to achieve this objective within the context of a larger program of research from which data for secondary analysis in this thesis were drawn. UHRI, led by principal investigators Thomas Kerr and Evan Wood, was established in 2007 in Vancouver, Canada through the collaborative efforts and support of a number of stakeholders. These stakeholders include study participants and other community members, health care and social service providers, government agencies, and local, national and international research institutes and foundations. UHRI operates a number of research studies that help to identify and understand the impacts of various factors which affect the health of urban populations. Key areas of research focus include substance use, infectious diseases, the urban environment and homelessness. The stated mission of UHRI is “to improve the health of individuals and communities through research to inform policy” (UHRI, 2010). Research, knowledge translation and dissemination are carried out according to a set of guiding principles as presented on the UHRI website:

- *Protection and promotion of health and human rights:* UHRI is guided by the belief that community health is best achieved through efforts that prioritize human rights.
- *Respect:* Because UHRI carries out research activities within urban settings “at the intersection of complex health, legal, and political frontiers” (UHRI, 2010) involving marginalized groups who have experienced extreme forms of stigma and discrimination, controversy and interpersonal or political tensions are inherent in its work. Therefore, treating all stakeholders with respect is an important value of UHRI.
- *Collaboration:* The complexity of how a range of health determinants intersect in an urban inner-city setting to produce conditions of health and/or risk requires that all stakeholders actively collaborate and work effectively together within communities.
- *Adherence to the highest ethical and scientific standards:* Articulated on the UHRI website as a guiding principle, UHRI maintains an awareness and sensitivity to the fact that historically, unethical policies, interventions and research practices with marginalized populations have been commonplace, even if unintended. UHRI is committed to ensuring all research activities adhere to high ethical standards. All research conducted through UHRI is subject to ethics review and approval by the University of British Columbia–Providence Health Care Research Ethics Board. Consultation and input from an established community advisory board and community partners regarding research activities and ethical concerns is also essential. Moreover, the UHRI team believes there is an ethical obligation to ensure that policies and interventions employed in urban settings are informed and driven by the best scientific evidence available so that the impacts, whether positive or negative, can be properly evaluated, and policy-makers can be kept informed (UHRI, 2010).

The UHRI team (comprised of co-supervisors, principle investigators, statisticians, methodology and research design experts, administrative staff and other researchers, research assistants, students, and front-line survey and data support staff) operates under an umbrella agency, the British Columbia Centre for Excellence in HIV/AIDS (BCCfE). BCCfE is housed at St. Paul's Hospital in Vancouver and affiliated with the University of British Columbia (UBC) and Providence Health Care (a non-profit health care organization providing a large array of services to the public). One of the larger prospective cohort projects conducted by UHRI is the Vancouver Injection Drug Users Study (VIDUS) from which cross-sectional participant data was drawn for the present study.

The Vancouver Injection Drug User Study (VIDUS)

VIDUS is an open prospective cohort study of over 1,500 individuals who use injection drugs recruited since 1996 from Vancouver's Downtown Eastside. This cohort has been described in detail previously (Spittal et al., 2002; Strathdee et al., 1997; Tyndall et al., 2001). In brief, persons are eligible for inclusion in VIDUS if they report injecting illicit drugs at least once within the previous month, and are residents of Vancouver. Baseline and semi-annual interviewer-administered questionnaires are completed with all participants and blood samples are drawn for diagnostic screening. Through the questionnaire, demographic data as well as information regarding drug use patterns, HIV risk behaviour, and drug treatment engagement are obtained. Informed consent is obtained and a stipend (\$20 Cdn) is provided at each study visit to reimburse participants for time, transportation and other costs related to study participation. The study is approved annually by the Providence Health Care/University of British Columbia Research Ethics Board. VIDUS has been highly successful in terms of follow-up rates – more

than 85% of participants have been retained in follow-up since the study was initiated (Kerr et al., 2005). Approximately 40% of the cohort are women (Miller et al., 2005; Wood et al., 2005).

For this study, cross-sectional survey data were drawn from the VIDUS cohort to address the descriptive statistical analysis objectives (Questions 2 and 3) since random recruitment of study participants – a requirement for true controlled experimental designs – is not possible due to ethical considerations (for example, the requirement for voluntary participant consent and self-selection). Data derived from this prospective cohort study form the basis of the analyses in Chapter Three and Chapter Four. This design employs secondary analysis of prospective survey data to detect any significant gender differences in circumstances surrounding initiation to injection drug use, and in current enrolment in addiction treatment services among VIDUS participants.

Data Access and Research Ethics

As mentioned above, the VIDUS study is approved annually by the Providence Health Care–University of British Columbia Research Ethics Board. Because the present study is based exclusively on secondary analysis of data already collected, and because this study involves no direct contact with study participants, no additional ethics approval was required⁶.

Data Analysis Plan and Variables

The variables identified for consideration in this study (see Appendix) allow for a gender-based analysis approach using the risk environment framework, interwoven with the concepts of gendered violence and cultural safety. Application of these multifaceted conceptual lenses is critically relevant to informing and guiding the overall objectives of my thesis research – that of describing the risk environment of marginalized women in Vancouver who use injection drugs and exploring how our understanding of women's injecting practices has been shaped by socio-

cultural, historical, political, environmental, structural and gendered dimensions. These conceptual lenses inform the interpretation of quantitative analyses related to Research Question 2, presented in Chapter Three, and to Research Question 3, presented in Chapter Four.

Research Question 2: Are there gender differences in social, environmental and structural circumstances surrounding initiation to injection drug use among a cohort of people in Vancouver who use illicit injection drugs?

For question 2, the key dependent (outcome) variable of interest in the present study is *gender*. Socio-demographic variables among participants (see Appendix: Table 1) include: current age; age at first injection; and Aboriginal ancestry. Variables of interest related to reported first-injection drug-using risk behaviours among participants (see Appendix: Table 2) include: used syringe borrowing (yes versus no); receiving injection assistance from, or being injected by another individual (yes versus no); injecting in public (yes versus no); injecting alone (yes versus no); how injecting technique was first learned (taught by self versus taught by others); type of drug first injected (cocaine, heroin, speedball, Talwin/Ritalin, crystal methamphetamine, or methylenedioxyamphetamine – commonly known as MDA); state of intoxication at time of first injection (sober, consumed alcohol or consumed drugs); and reported reason for first injection (curiosity, pressured/injected by another individual without consent, to escape from problems/suicidal, or intimate partner using). To evaluate gender differences in circumstances surrounding initiation into injection drug use for this secondary analysis, the study sample was stratified into groups based on gender. Univariate and descriptive statistics were used to determine the relevant associations between the dependent and independent variables. Univariate categorical data were analyzed using Pearson's chi-square test. Tests of statistical significance were set *a priori* at $p \leq 0.05$ and all were two-sided.

Research Question 3: Are there gender differences in factors associated with being enrolled in addiction treatment among a cohort of people in Vancouver who use illicit injection drugs?

The behavioural variables of number of years injecting drugs, public injecting, borrowing syringes and frequency of service utilization at the supervised injection facility are essential in examining factors associated with gender differences in current enrolment in addiction treatment. Analysis and interpretation of the relationships between these variables within the context of the theoretical lenses previously described informs conclusions regarding ethical implications for health policy and service delivery related to access to gender-sensitive and culturally safe services for women in Vancouver who use injection drugs.

For Question 3, the key dependent (outcome) variable of interest is ‘current enrolment in addiction treatment’, defined as participation in any type of addiction treatment listed in Table 4 (see Appendix: Table 4), and is treated as a dichotomous variable (yes vs. no). Socio-demographic variables among participants (see Appendix: Table 3) include: current age; age at first injection; Aboriginal ancestry (First Nations/Inuit/Métis – yes versus no); housing (current homelessness⁷ – yes versus no); and current marital status (yes – legally married/common law or regular partner not living together, but together over 3 months, versus no – separated/divorced/widowed/no partner/single). Variables of interest related to drug-using risk behaviours among participants (see Appendix: Table 3) included: mental illness diagnosis (ever – yes versus no); history of sexual abuse (ever – yes versus no); degree of alcohol consumption (past six months – ≥ 4 drinks per day average – yes versus no), injection heroin and injection cocaine use (past six months – \geq daily versus $<$ daily); used syringe sharing (borrowing and/or lending: past six months – yes versus no); binge drug use (past six months – yes versus no);

history of overdose (ever – yes versus no); frequency of supervised injection facility (SIF) use (past six months, proportion of injections performed – $\geq 75\%$ versus $< 75\%$); history of incarceration (past six months – yes versus no); sex trade involvement (past six months – yes versus no); drug dealing (past six months – yes versus no); and HIV status (sero-positive – yes versus no).

To evaluate gender differences in factors associated with being enrolled in addiction treatment, the study sample was stratified into groups based on current enrolment in addiction treatment. Bivariate statistical analyses were conducted separately for women and for men to determine the relevant associations between independent variables. Pearson's chi-square was used to test for statistical significance of associations – set *a priori* at $p \leq 0.05$; all are two-sided. As a next step, we fit separate multivariate logistic regression models⁸ for women and for men to examine the adjusted odds of current enrolment in addiction treatment for each gender. The models described above were fit using the *a priori* defined model building protocol of adjusting for all variables that were statistically significant at the $p \leq 0.05$ level in bivariate analyses. The Wald test was used to determine statistical significance in multivariate analysis. In addition, we conducted simple univariate analyses (using descriptive statistical methods) to examine types of addiction treatment engagement among participants currently enrolled in addiction treatment, and reasons reported for non-enrolment in addiction treatment among participants not currently enrolled in addiction treatment. Both these additional analyses were stratified by gender.

Mental health data is collected through semi-annual follow-up surveys which include standardized measures for depression such as the Centre for Epidemiologic Studies Depression Scale (Radloff, 1977). Similarly, data on childhood trauma is collected using the Childhood Trauma Questionnaire (Bernstein et al., 2003; The Psychological Corporation, Harcourt, Brace,

& Co., 1998). As well, there are HIV knowledge scales (Carey & Schroder, 2002) and a non-standardized self-efficacy scale to evaluate self-efficacy to avoid injection drug use (Wood, Stoltz, Montaner, & Kerr, 2006).

Current enrolment in addiction treatment (the dependent variable of interest) is demonstrated through descriptive statistical analysis of participant self-reported longitudinal survey data. Gender-based analysis is used to identify differences in type of addiction treatment participants engage in (see Appendix: Table 4). Similarly, self-reported reasons for participants not being enrolled in addiction treatment are examined for gender differences (see Appendix: Table 5).

Strengths and Limitations of the Study Design

Strengths and limitations related to the design and methodology of the studies presented in this thesis are discussed in detail in Chapter Five. Chapters Three and Four also contain discussions of strengths and limitations specific to the particular analyses presented in those chapters.

Summary Layout of Thesis Chapters

It should be noted that this thesis is constructed in a manuscript-based thesis format in which individual chapters are written with the intention to be submitted as individual, independent ‘stand-alone’ manuscripts for external peer review and professional journal publication. Therefore, there is a significant amount of overlap and repetition of background, literature and theory among all chapters throughout this thesis. It is intended that Chapters Two, Three and Four will be submitted for professional peer review and journal publication. Readers should keep this intention in mind in appraising this work as a whole.

This thesis consists of five chapters, including this, the introductory chapter, which sets the stage for the remaining work. The second chapter consists of a comprehensive, gender-based review of relevant literature that informs the remaining work on this project by exploring how our understanding of injecting practices among marginalized women who use illicit injection drugs is shaped by socio-cultural, historical, political, environmental, structural and gendered dimensions. Chapter Three consists of a quantitative examination and discussion of the gender differences in socio-cultural, environmental and structural circumstances surrounding initiation to injection drug use among a cohort of people in Vancouver who use illicit injection drugs. A gender-based interpretive statistical analysis forms the foundation of Chapter Three. Similarly, Chapter Four focuses on a statistical analysis of factors mediating gender differences in the degree of engagement in addiction treatment services among a cohort of people in Vancouver who use illicit injection drugs. Finally, Chapter Five draws from the preceding thesis work to highlight the key points and conclusions put forth in this work and to examine related implications for health policy and service delivery related to access to gender-sensitive and culturally safe services for women in Vancouver who use injection drugs. Lessons learned and implications for ethical practice are reviewed and recommendations for policy, practice and further research are presented in that final chapter.

In closing this introductory chapter I would like to say that I am privileged to have the opportunity to work with such exceptional and inspiring faculty, mentors, clinicians and researchers at UBC and UHRI in the generation of research and knowledge, through my thesis work, that is likely to inform gender-sensitive and culturally safe health policies and practices. Moreover, I am humbled by the many life stories of the courageous people for whom I provide health care services. My years of work in this field have engendered considerable passion as a

nurse advocate to work toward improving the everyday conditions in which my clients live. Their resourcefulness and will to survive against monumental social barriers is truly awe-inspiring. It should not be difficult therefore to understand how my intuitive beliefs and values, which were mentioned during the opening to this chapter, are rooted in such rich, intense and fulfilling interactions with those whom I have worked with for so many years. The belief that people are ultimately the experts in leading their own lives and that it is nurses such as me and other health care providers and policy makers that need to re-think how health services can be delivered in ways which hold up to the standards of ethics, equity and social justice, which as nurses we are bound to honour, that fuels my passion and optimism for this work. The awareness of my own experience and history and the attention to reflecting on how it has influenced my current practice ensures that I will have the confidence to work through moral dilemmas (of which there is a multitude in this area of practice) and avoid moral distress in working with marginalized people who use drugs.

Endnotes

- ¹ *Moral distress* is “the negative feelings resulting from a situation in which moral choices cannot be translated into moral action” (Storch, 2004, p. 6).
- ² *Moral residue* is “what we carry with us when we knew how we should act but were unwilling and/or unable to do so” (Rodney, Browne & Liaschenko, 2004, p. 154).
- ³ “[S]tructural violence is one way of describing social arrangements that put individuals and populations in harm’s way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities).” (Farmer et al., 2006, p. 1686).
- ⁴ It should be noted that, due to the nature of this manuscript-based thesis format (in which individual chapters are written with the intention to be submitted as individual independent ‘stand-alone’ manuscripts for external peer review and professional journal publication), there is, of necessity, a significant amount of overlap and repetition of background, literature and theory among all chapters throughout this thesis.
- ⁵ Post-colonialism refers to a degree of heightened societal awareness of our historical locatedness, both past and present, regarding the consequences of colonial and neo-colonial attitudes and practices and the implications of social, political and structural policies for those more disadvantaged and marginalized in our society (Smye & Browne, 2002).
- ⁶ Joyce Tom, Associate Director, Policy and Procedures, Faculty of Graduate Studies, University of British Columbia verifies that, because data is being used for secondary analysis only, further research ethics approval is not required (email communication received on April 21, 2008 from jtom@interchange.ubc.ca).
- ⁷ Homelessness is defined as having no fixed address or living on the street, in a shelter or hostel, or ‘couch surfing’ – unstable, transitional short-term shelter arrangements with relatives, friends or acquaintances (Rachlis, Wood, Zhang, Montaner & Kerr, 2009).
- ⁸ Logistic regression is a statistical technique that makes use of the correlations between variables to determine which variables affect (or are likely to predict) the probability of a given event (Munro, 2005).

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CHAPTER TWO¹:

Gendered Dimensions in the Social Construction of Injection Drug Users:

Perspectives from the Literature

Injection drug use continues to be associated with severe harms throughout the world (Aceijas & Rhodes, 2007). Women who inject drugs have been found to be at elevated risk for drug-related harms, including HIV infection (Spittal et al., 2002). This has led to growing interest in women's early injecting experiences (Novelli, Sherman, Havens, Strathdee & Sapun, 2005). Although findings have been somewhat inconsistent, several studies in North America and Australia have described gender differences (for example, in age and social context) in the circumstances surrounding injection initiation (Bryant & Treloar, 2007; Fuller et al., 2003; Kerr, et al., 2007). Gender differences in early childhood experiences of trauma (for example, sexual abuse) have also been implicated as possible influences in the context of injection drug initiation (Ompad et al., 2005). Novelli et al. (2005) contend that targeting prevention measures designed for young people who use drugs, but have not yet transitioned into injection drug use, may serve to delay or prevent injection initiation. Moreover, for people who use illicit street drugs, either by injection or otherwise, a greater awareness of how broader socio-cultural, structural and environmental influences shape our understanding of their injection practices – women's in particular – would better inform gender-based health policy and strategies to improve access to environmentally, structurally and culturally safe, gender-responsive addiction treatment programs and health services.

¹ A version of this chapter will be submitted for publication. Wood, R.A., Rodney, P., Kerr, T. & Smye, V. (2010). Gendered Dimensions in the Social Construction of Injection Drug Users: Perspectives from the Literature.

Despite a rapidly mounting body of literature on the individual and social harms associated with injection drug use in general, and related harm reduction efforts by nurses and other public health workers, there remains limited published work focused on how the gender-specific contextual interplay of multi-level (micro, meso and macro) influences plays a role in the particular vulnerabilities faced by socially marginalized women who use injection drugs. Several individual risk factors for HIV and other injection-related harms among women who use injection drugs have been identified. These factors include frequent cocaine use, requiring assistance with injecting, unsafe sex with a regular partner, having an HIV positive partner, and being of Aboriginal ancestry (Spittal et al., 2002). However, much less attention has been given to the broader socio-cultural, structural and environmental risk conditions in which marginalized women live and in which injection risk practices and addiction treatment engagement behaviours occur.

In light of this gap in the published literature, the overall objective of my thesis research is to describe the risk environment of marginalized women in Vancouver who use injection drugs and explore how our understanding of women's injecting practices has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions. I use these perspectives, while applying a lens of gender-based analysis, to quantitatively examine the gender differences within the contextual circumstances of women's first injecting experience. Further, I use quantitative methods to explore gender differences in factors associated with being enrolled in addiction treatment services among people in Vancouver who use injection drugs. Lastly, I discuss the ethical implications of these findings for health policy and service delivery with respect to access to gender-sensitive and culturally safe addiction treatment services and environments for women who use drugs.

In this second Chapter of the thesis, I present a gender-based review of two inter-related areas of the literature: a) injection drug initiation experiences of street-entrenched people who use drugs; and b) addiction treatment service engagement among this same population. Chapter Two is intended to lay the groundwork for my overall objective (as articulated above) by informing the remaining work of this thesis through exploring how our understanding of injecting practices among marginalized women who use illicit injection drugs has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions. Starting with a brief history of the social construction of gender roles in the context of substance use, I provide some perspectives from medical anthropology. Following these historical and social perspectives is a discussion of neo-liberal views and the dynamics of social marginalization related to addicted persons and the social-structural mechanisms that produce stigma and social exclusion, which in turn increase risk. Perspectives are then presented which illustrate a basis for more humanistic and ethical approaches to dealing with the human suffering that often accompanies addiction.

The contrasting of different points of view in this Chapter helps to elucidate an understanding of how the cycles of oppression that result from neo-liberal approaches are perpetuated. Three key conceptual areas of theory are then described and illustrations are provided of how these concepts converge to form a relevant and helpful vantage point from which later analyses, interpretations and conclusions are viewed. These conceptual areas are drawn from the areas of risk environment, gendered violence and cultural safety. Finally, I offer a brief exploration of how critical feminist and post-colonial approaches can expose and address sources of oppression and stigma as possible solutions to mitigating these ethical concerns. I illustrate how such approaches to addressing ethical concerns can be effective in producing

conditions and environments that empower people who use drugs to avoid injection initiation, and in promoting gender-sensitive and culturally safe addiction treatment services. I begin with a brief background of issues related to people who use illicit street drugs in Vancouver.

Background

Assisting people, women in particular, to reduce high-risk injection drug-related behaviours is much more complex than simply providing drug use-related education and information (Wood, Zettel & Stewart, 2003). Women who are socially marginalized and use injection drugs bear a disproportionate burden of infectious disease and *everyday violence* compared to their male counterparts (Bourgois, Prince & Moss, 2004; Spittal et al., 2002). For example, Spittal et al. found HIV incidence rates among women in Vancouver's Downtown Eastside who use injection drugs to be forty percent higher compared to men, while Bourgois et al. found hepatitis C (HCV) incidence rates among a similar population of women in San Francisco to be fifty percent higher compared to men. In addition, in a recent qualitative study by Shannon et al. (2008) documents the pervasiveness of everyday violence and gendered power relations among women in Vancouver who use drugs and engage in survival sex work. Such conditions of gendered violence constrain women's agency in negotiating risk reduction strategies.

A recent study in Vancouver, Canada showed that adolescents who initiate injection drug use at an early age were at greater risk for subsequent high-risk injection drug use behaviour, including binge use, sex work, and criminalization (Miller, Strathdee, Kerr, Li & Wood, 2006). In general, women who inject drugs are more likely than their male counterparts to report having been injected by another individual (i.e., assisted injection) (Hankins, 2008; O'Connell et al., 2005; Wood, Spittal et al., 2003) – a practice associated with elevated risk for HIV infection

(O'Connell et al.). Hankins suggests that women may have less autonomy in accessing drugs and injecting equipment and that such social dependency can increase their risk for HIV infection and overdose. Greater elucidation of the environmental, social and structural dynamics involved in women's first injection experiences is needed. Drawing attention to these dynamics would serve to better inform strategies and policies related to health promotion, addiction prevention, and health service provision and access. In particular, informed strategies and policies are needed to address barriers to accessing and providing addiction treatment and mental health services for vulnerable women, including those who have not yet initiated injection drug use as well as those who have.

A Brief History of Women's Drug Use

In the latter part of the nineteenth century in North America, older, upper class women of European descent comprised about half of all reported drug addicts in the United States (Keire, 2001). According to Keire, an American social theorist and historian, gender differences were prominent in that women used drugs more for medical (or medicinal) reasons whereas men used drugs more for leisure and pleasure. This higher proportion of women over men in relation to drug use can also be explained by contemporary cultural norms at the time that frowned on women's consumption of alcohol, and by structural factors that constructed saloons and taverns (which served alcohol) as the exclusive domains of men. Women, not having the same access to alcohol, substituted medicinal products such as opiate and alcohol containing tonics, tinctures and compounds which were freely accessible for purchase in respectable shops that sold a broad range of proprietary medicinal remedies. Many of these products were promoted as treatments for a wide variety of (especially female) ailments and were referred to with such terms as 'health tonic' or 'women's friend' (Keire).

Another historical and cultural aspect of gender differences in drug use was the medicalization of common female ‘problems’ which was already taking a firm hold in the late nineteenth century. Women and physicians freely sought each other out for treatment of medical problems such as menstrual cramps, symptoms of menopause and ultimately, depression, anxiety, insomnia, and even unhappiness, loneliness, and boredom, all of which were viewed as pathologic – often referred to by the medical term melancholia (Gomberg, 1982). These psychic maladies were often treated by physicians using injections of morphine “... to numb the pain of ‘female troubles,’ or to turn the wilful hysteric into a manageable invalid” (Keire, 2001, p. 809).

Many of these female ailments were likely associated with socio-cultural factors rooted in oppressive patriarchal gender role expectations that viewed ‘respectable matrons,’ (with their intrinsic virtue, natural nurturing instincts and modesty) as the protectors of social morality (Gomberg, 1982). As such, they were expected to attend to caring for home and family. While some of these socio-cultural factors continued throughout most of the twentieth century – women remain more frequent users of health care services and use more prescription and over-the-counter medications than men (Gomberg) – social views of acceptable use of substances have changed drastically, as I will explore in this Chapter.

Legal History

The social history has been confounded by a number of legal responses. The evolution of public policy, laws and policing as forms of *structural violence* (Bourgois, 2000) (discussed further below) has significantly influenced – and been influenced by – societal views of drug use (Nolin et al., 2002) and in turn, has negatively impacted drug use risk environments (Rhodes, 2002). The Canadian *Opium Act* of 1908 and the subsequent *Opium and Narcotic Drug Act* of 1911, introduced by Mackenzie King (federal Minister of Labour at the time), were the first

domestic legislative measures in North America enacted to control the distribution and use of narcotics (Nolin et al.,). The United States-led *Hague International Opium Convention* of 1912 was the first international drug control treaty, requiring all signatory countries to enact domestic narcotic control laws (Musto, 1987). Shortly thereafter, in 1914, the United States followed suit with the passing of the *Harrison Narcotic Act* (Schuster, 2006). Increasingly more stringent and punitive international treaties and laws followed throughout the remainder of the twentieth century, including the *Single Convention on Narcotic Drugs* in 1961, and the *Convention on Psychotropic Substances* in 1974 (Nolin et al.). In Canada, the *Narcotic Control Act* of 1961 was the federal domestic legislative response to the international treaty requirements of the *Single Convention on Narcotic Drugs*. The *Narcotic Control Act* later evolved into the *Controlled Drugs and Substances Act* in 1996 which continues (with a variety of amendments) to be in force at present (Government of Canada, 1996). These increasingly punitive legislative approaches have been fundamental to the shaping of present day drug use risk environments.

Historical Social Shaping of Drug Use Risk Environments

The ways in which social phenomena and historic events shape (and have shaped) our understanding of socio-cultural gender roles associated with illicit drug use in Vancouver's Downtown Eastside become clearer when viewed through a wider national and international lens. An examination of the historical context of illicit drug use in Canada and elsewhere helps to set the stage for interpretation of the central analyses of this thesis which follow in the Chapters to come. The current state of injection drug use and street culture among participants in the present study, the risk environments in which these participants live, and factors associated with injection initiation and with addiction treatment engagement, can all be appreciated when viewed within historical, political, and structural contexts. Mechanisms used in the historical social

construction of drug users and of gender roles can be uncovered through critically reflective conceptual stances. A review of relevant anthropological perspectives is helpful in setting the stage for a discussion of some of these critical perspectives.

Perspectives from Medical Anthropology

From a medical anthropology perspective, Small (2004) contends that, similar to other ‘socially-alarming phenomena’ such as mental illness (and use – or non-use – of psychiatric facilities), drug addiction has historically been socially stigmatized and hidden from public view. Such attempts to ‘hide’ socially stigmatized people who use drugs from the public eye have included institutional means, such as drug detoxification and addiction treatment facilities (and more recently, supervised injection facilities), police enforcement of prohibition laws, and use of criminal justice measures (for example, jails, which have become a profitable industry in the United States [Levine, Muscheno & Palumbo, 1980] in large part, as a result of the pervasive US-led ‘war-on-drugs’). Another social-structural approach to limiting public visibility of people who use drugs is ghettoization into substandard living conditions through various means of social discrimination, as is the case currently in the Downtown Eastside of Vancouver. Small suggests that current dominant social values, influenced by the trends toward the medicalization of addiction and criminalization of drug use, regard marginalized people who use drugs as “unproductive (versus productive), irrational (versus rational), disordered (versus ordered), dangerous (versus safe), deceitful or manipulative (versus honest) [and] non-contributors (versus contributors)” (p. 38). Further, Small associates these current and socially dominant, value-laden and dichotomous portrayals of marginalized people with socio-cultural beliefs that marginalized people who use drugs:

... have made bad choices, choosing to use drugs and therefore are to blame for their condition; should simply choose not to use drugs or be forced to stop using drugs through detox, medical treatment, drug court or jail; [and] are fundamentally undeserving of government (taxpayer funded) programs such as [health care or] housing (most social housing will not take active addicts as tenants) (p. 38).

Social stigma. Within anthropology and social psychology circles, stigma has been described as a situational threat resulting from living in social situations that affect how one is treated by others (Yang et al., 2007). Stigma occurs when a given characteristic is used to negatively label individuals or groups as different, which leads to a socially constructed process of devaluation (Crocker, Major & Steele, 1998; Major & O'Brien, 2005). Negative emotions (prejudice) or negative behaviors (discrimination) of stigmatizers are seen to be rooted in the characteristics of social 'others,' leading to self-prejudice and self-discrimination by those who are stigmatized (Corrigan & Watson, 2002; Yang et al.).

In contrast to the dominant social values mentioned above, some anthropologists, such as Kleinman (1988), have adopted concepts of the broader social elements of illness (Kleinman, 1988), and violence and trauma (Das, Kleinman, Lock, Mamphela & Reynolds, 2001) through the lived social experience within a 'local world.' Yang et al. (2007) describe this local world as a place, social situation or domain where "something is at stake [– status, money, power, life chances, health, housing, employment, relationships, drugs or sex –] and daily life matters, often deeply" (p. 1528). This feature of having a 'stake in the local world' can be viewed as the 'moral mode' of lived experience (Kleinman, 1997; 1999; 2006). Views of stigma as a social,

interpretive, or cultural process, have long led anthropologists to the conception of stigma as a fundamentally moral issue (Erikson, 1966; Goffman, 1963; Scott, 1969):

... in which stigmatized conditions threaten what really matters for sufferers. In turn, responses arise out of what matters to those observing, giving care, or stigmatizing; here, what matters to these social interlocutors can allay or compound conditions. In addition to compounding the experience of illness, stigma can intensify the sense that life is uncertain, dangerous, and hazardous. ...

For the stigmatized, stigma compounds suffering (Yang et al., p. 1528).

Structural determinants of stigma arise from economic, political, and historical power sources (Das et al., 2001; Yang et al., 2007). When policy makers (in positions of structural power) intentionally implement policies that impact opportunities for a given group (for example, legislative restrictions preventing people with mental illness from voting; prohibition of peer assisted injection at a supervised injection facility), it is referred to as ‘intentional institutional (or structural) discrimination’ (Link & Phelan, 2001; Yang et al.). Conversely, ‘unintentional structural discrimination’ occurs when policies limit the rights of people in unintended ways (Link & Phelan; Yang et al.). For example, social policies that limit or prohibit syringe distribution programs (an evidence-based HIV prevention measure) and that are driven by arguments that such programs cause harm by encouraging illicit drug use have been associated with increased HIV incidence rates among people who use injection drugs in Vancouver (Strathdee et al., 1997). Many of these existing oppressive and discriminatory social policies stem from western trends toward dominant neo-liberal views.

Neo-liberalism. Arising out of Western economic pressures during the 1970s and 1980s, neo-liberalism “asserts that free enterprise policies produce economic growth, which in turn is

the basis for all human well-being” (Coburn, 2006, p. 60). The neo-liberal intent is to create a culture which values individual responsibility for achieving living standards that include conditions such as stable housing and gainful employment. Attaining these living standards is generally assumed (and expected), within our increasingly neo-liberal political climate, to be seen by all individuals as more appealing than being on income assistance (welfare) (Ministry of Employment and Income Assistance, 2007). For example, welfare programs are aimed at converting ‘rational,’ unproductive non-contributors of society into self-sufficient taxpayers by using disincentive strategies such as fixed financial assistance rates at levels that are drastically below what is considered to be the ‘poverty line.’ However, a variety of measures are in place that exclude significant numbers of impoverished people – socially marginalized women in particular – from being eligible for such programs (for example, the requirement to have a residential address). Such simplistic and short-sighted policies have negative health and social impacts on some of the most vulnerable in our society, especially certain groups of women whose voices are marginalized by social and/or structural inequity (Browne, 2001). These negative health impacts, through the creation of conditions in which barriers to achieving adequate living standards exist, produce and increase risk.

The intent of these policies and the neo-liberal ideology upon which they are based continues to be under debate. One key structural mechanism that produces marginalization is the challenge of navigating the enormous complexity of our social services system; a challenge even for those more privileged in our society, but often virtually insurmountable for people living on the social margins where inequities in health status and service access result from intersecting forms of discrimination based on poverty, race, gender and age, among other factors (Anderson et al., 2003; Coumans, & Spreen, 2003; Vasas, 2005). Informed by neo-liberal values and

notions of what policy options are in the best interest of the public – primarily from a white, euro-centric and patriarchal perspective (Anderson et al.; Browne, 2001; Hall, 1999) – women’s (and aboriginal people’s) voices have historically been, and continue to be largely silenced in many areas of public policy decisions, thus reinforcing the marginalizing conditions in which these groups of people live (Hall; Vasas; Wood et al., 2005).

Overall, the intersecting challenges of undertreated mental illness, addiction, social and structural violence, abuse, trauma, and other health and social issues including gender and race inequities, present insurmountable obstacles for many women who lack the sophisticated skills required to negotiate a highly complex, bureaucratic and discriminatory social welfare system. Moreover, these intersecting challenges are the very constituents of the underlying conditions that foster drug use. Individuals are then held responsible for their ‘failures’ to negotiate these obstacles. This blaming results in a sense of powerlessness, hopelessness, lack of validation, and lack of meaning, leading to further isolation, inability to work, homelessness, and/or fear of the destruction of one’s personhood (Cassel, 1982). In order to address such problems, the central foundational stance for the purpose of this thesis is therefore that of *gender-based analysis*, which can help to address the challenges I have articulated above.

Reflective Stances

Gender-Based Analysis

Used throughout all aspects of this research process, gender-based analysis is an evidence-based approach that takes into account how policies, programs, services and research impact differently on the lives of women and men (Canadian Institutes of Health Research, 2007). Gender-based analysis offers great potential for valuable contributions to the addiction research literature which can inform and direct further work into the appropriateness and

effectiveness of gender-based policies and harm reduction strategies regarding prevention and treatment services for people who use injection drugs (Graham, Young, Valach & Wood, 2007). The relevance of gender-based analysis in this thesis is illustrated in several examples of how a variety of social, structural and environmental influences are used as means to shape social conceptions of drug users, which in turn produce deleterious consequences for people, especially women, who use drugs. Such consequences increase the level of vulnerability within heightened risk environments.

The Social Construction of Injection Drug Users: Intersections of Gender

As I have argued in this Chapter, current understandings of multidimensional mediators of injection risk behaviours among people who use injection drugs have been shaped both directly and indirectly by a variety of multi-level (micro, meso and macro) influences. The nature of these influences may be socio-cultural (for example, *post-colonialism*¹, social exclusion and male dominated street hierarchy), environmental (for example, street-level drug market activities and open public drug injection scenes), structural (for example, neo-liberal ‘war-on-drugs’ policies, laws and policing practices), historical (for example, trends toward increased prevalence of street-based female injection drug use over the past two decades), and gendered. The means by which socio-cultural, environmental, structural, historical, gendered and age related influences intersect, particularly at a macro level, are (unintentionally) well encapsulated in a quote by current Prime Minister Stephen Harper:

If you remain a drug addict, I don’t care how much harm you reduce, you are going to have a short and miserable life.... Police and others fighting the battle against drug abuse are up against a culture that since the 1960s has done little to discourage drug abuse and often romanticized it ... or made it cool, made it

acceptable.... As a father I don't say all these things blamelessly. My son is listening to my Beatles records and asking me what all these lyrics mean.

(Canadian Broadcasting Corporation, 2007)

The assertion that 'drug addicts' will "have a short and miserable life" may be characterized by many people as signifying a pledge. Although purely anecdotal, the Prime Minister's value-laden remarks can be interpreted as a moral stance, illustrating how social exclusion is achieved at the highest political and structural levels through the intersecting of neo-liberal ideology, historical events, and patriarchal power imbalances related to age and to gender inequality (reinforced through the conspicuous absence of feminine voice).

With respect to gendered influences, Ettorre (2004) adopts a *post-modernist*² lens, viewing gender as both an essential element in the process of human interaction, and as a socially structured institution which embeds inequality as a cultural norm. Moreover, experiences of gender differences are further compounded through the intersections with other forms of inequity such as race, culture, social class, poverty, unemployment, unstable housing and mental health status (Ettorre). Women and men 'do drugs' differently because they are playing out the differences in their culturally gendered roles (Graham et al., 2007; Measham, 2002). Although there is a growing volume of recent published research which highlights the need for gender sensitive addiction treatment and harm reduction services (Ettorre; Marshall, Fairbairn, Li, Wood & Kerr, 2008; Measham; Simpson & McNulty, 2008), such services are excruciatingly slow to materialize. For example, in a study of women enrolled in methadone maintenance therapy (MMT) in New York City, El-Bassel et al. (2004) found that almost half of the participants reported experiencing recent intimate partner violence. The authors called for

expansion of gender sensitive and gender specific treatment and harm reduction programs for women seeking such services. Moreover, in a recent study of women attending a supervised injection facility (SIF) in Vancouver, Fairbairn, Small, Shannon, Wood & Kerr (2008) found that many participants viewed the SIF as a refuge from street-based violence due to the gender-sensitive harm reduction approaches employed in the facility which create a safe environment for women.

Unfortunately, as implied by Prime Minister Harper's comments above, Canada's national drug strategy has shifted significantly since the SIF opened in 2003 and federal support for such services in Canada has been withdrawn. Furthermore, the federal government continues an ongoing legal battle to force the closure of the SIF (Hall, 2010). Government opposition to Vancouver's SIF illustrates structural barriers to accessing health care, based on social exclusion and worsening economic, age and gender inequities. Such barriers to health service access are examples of structural forces at play which hinder the expansion of gender-sensitive addiction treatment and harm reduction services, and which in turn, increase risk for people who use drugs, especially women.

As mentioned above, Wood, Zettel et al. (2003) contend that assisting people, particularly women, to reduce high-risk injection drug-related behaviours is much more complex than just providing risk-related education, especially given such structural barriers as described above. Hankins' (2008) contention that many women may have less autonomy in the ability to negotiate risk reduction strategies within the constraints of gender roles in the context of street culture adds an additional layer of complexity and challenge to the provision of, and access to, health services. However, the concept of *situated rationality* serves to provide some insight into the complexity of how and why women cope with this challenge.

Situated rationality. Receiving assisted injection among women during first injection experiences may imply an element of contextual or situated rationality. Specifically, situated rationality involves a rational weighing out of acceptable risk – situated within a specific local and interpersonal context – against a personal stake in meeting certain individual needs, such as for relative safety, shelter, food, a sense of interpersonal belonging within a social and cultural network, drugs, intimacy, or access to harm reduction and treatment services (Bloor, Robertson, McKeganey & Neale, 2008; Dietze, Jolley, Fry, Bammerd & Moore, 2006; Kleinman, 1997; 1999; 2006; Moore, 2008; Rhodes et al., 2006). For example, Bloor et al., in their prospective cohort study of people who use drugs in Scotland, found that, when considered from the perspective of a socially constructed situated rationality within a relational and interpersonal context, submitting to being injected by an intimate partner via the partner's previously used contaminated syringe was often viewed as a sign of trust and intimacy and therefore, an acceptable risk.

By exercising individual agency to resist the more immediate threat of interpersonal violence within the local context (for example, street-related or intimate partner violence), forms of treatment-related structural violence may be seen as more acceptable to some women who use injection drugs when viewed from the perspective of situated rationality (Kleinman, 1997; 1999; 2006; Moore, 2008; Rhodes, Stimson & Quirk, 1996). For example, in the United States, Brown and Meichior (2008) found that some women who use drugs and bear a high burden of intersecting health and social factors (such as homelessness, mental illness, pregnancy, child custody concerns, or histories of trauma) may experience certain residential addiction treatment programs, although lacking in gender sensitivity and capacity to effectively address co-morbid health and social concerns, to be safer (in relative terms) than the daily vulnerabilities faced on

the street. Treatment programs that are not trauma-informed or capable of addressing multiple intersecting health and social issues are more likely than gender-sensitive, integrated programs to foster environments of risk and structural violence for highly vulnerable women (for example, removal of child custody or lack of access to prenatal care due to an individual's inability to remain abstinent), despite the overall efficacy of addiction treatment interventions (Brown & Meichior). Fortunately, the needs of individuals struggling with multiple co-morbid health concerns has been better recognized over the past couple of decades, and services have generally improved in this regard. Nonetheless, barriers to access continue to be common (Brown & Meichior). In the absence of adequate screening and early intervention outreach services for youth at risk, needs for intimacy and social inclusion in peer networks often place young people who may be using non-injectable drugs at heightened vulnerability to initiate injection drug use (Moore; Novelli et al., 2005; Rhodes et al.).

First Injection Experiences

While there has recently been a growing body of literature exploring first injecting experiences of people who are, or have been injection drug users (IDU) (Abelson et al., 2006; Doherty, Garfein, Monterroso & Latkin, 2000; Fuller et al., 2003; Kerr et al., 2007; Miller, Strathdee et al., 2006; Novelli et al., 2005; Roy et al., 2003), little attention has been given to in-depth gender-based analyses of the contextual socio-cultural, structural and environmental risk circumstances of women's initiation experiences. Novelli et al., in their study of the relationship between circumstances surrounding the first injection experiences of young people who inject drugs in Baltimore, Maryland, and future injection risk practices, found that age and self-injection (versus being injected by another individual) at initiation were independently associated with future injection risk behaviours. For example, Novelli et al. found that individuals who had

used a previously used syringe for their first injection at a younger age were much more likely to report recent syringe sharing than were similar individuals who had used a new syringe for their first injection. This finding suggests that young people who inject drugs may establish high-risk injecting practices during their injection initiation experience and may have been influenced prior to their first injection by certain socio-cultural, structural and environmental factors.

Although findings have been somewhat inconsistent, other studies in North America and Australia have also described gender differences in factors such as age and social context in the circumstances surrounding injection initiation (Bryant & Treloar, 2007) as well as in the associations with early childhood experiences of trauma (for example, sexual abuse) as possible precursors to injection drug initiation (Ompad et al., 2005). Overall, findings from these other studies imply that the intersections of social (for example, previous childhood trauma or the cultural norm of sharing drug paraphernalia) and demographic (for example, gender or age) factors may place people who use drugs at heightened risk of harm. Novelli et al. (2005) contend that targeting prevention measures towards young people who use drugs but have not yet transitioned into injection drug use may serve to delay or prevent injection initiation. Early intervention approaches such as these also have implications for how various forms of addiction treatment services are provided and accessed by people who use street drugs, both by injection and otherwise.

Addiction Treatment Engagement

A study by Kerr, Marsh, Li, Montaner and Wood (2005) examining associations between MMT use and socio-demographic and drug-related variables found that female gender was positively associated with enrolment in MMT, whereas Aboriginal ancestry was negatively associated. Kerr et al. call for further study into associations between MMT engagement and the

intersecting factors of Aboriginal ancestry and gender. With respect to a range of other addiction treatment options however, Hankins (2008) argues that “since most addiction treatment programmes are designed with men drug users in mind as the predominant client, specific and sustained attention is urgently needed now to develop programmes which also serve the needs of the growing proportion of drug users worldwide who are women.” (p. 2). A greater awareness of how broader socio-cultural, structural and environmental influences have shaped our understanding of women’s injection practices would better inform gender-based health policy and strategies to improve access to gender-responsive addiction treatment programs.

In a study by McCance-Katz, Carroll, and Rounsaville (1999) involving people seeking treatment for cocaine addiction in the United States, many women were found to be as severely ill as men but received less addiction treatment services. In general, women report symptoms, seek help, and use health care services more than men (Kim & Fendrich, 2002; Tucker, Foushee & Simpson, 2009). Nonetheless, Kim & Fendrich, in their US study found that women who use drugs are less likely than their male counterparts to enrol in addiction treatment even though women often struggle with more severe drug-related and mental health issues compared to men and are more likely to identify their drug use as a problem (Kim & Fendrich). It may be that, compared to Canada, the somewhat greater focus on interdiction as a major drug control strategy in the United States, combined with a lack of gender-sensitive low-threshold access to addiction services, influences women’s level of engagement in addiction treatment services. While Grella and Joshi (1999) found that self-initiated treatment enrolment among men who use drugs in the United States seems to be facilitated through social structures, such as employment, the criminal justice system and their family, treatment enrolment among women in the same cohort was associated more with referrals from social support agencies. Grella and Joshi suggest that contact

with social service agencies may facilitate enrolment in addiction treatment more so among women compared with men. The success of such facilitation is likely influenced by the importance of child care responsibilities as a major factor affecting treatment enrolment for women (Kim & Fendrich; McCance-Katz et al.).

How current understandings of women's injecting practices and of the risk environments in which such practices occur have been shaped is elucidated through situating present discourses on gender roles related to street and drug using cultures within a historical context. It is from this historical landscape that reflective stances are taken through applying a gender-based analysis approach to examining the multiple socio-cultural, political, environmental, and structural intersections upon which portrayals of injection drug users have been socially constructed. This examination of multiple intersecting factors, while considering the conceptual perspectives of situated rationality, begins to uncover the gender differences and complexities of how, why, where and when individuals initiate injection drug use, and subsequently (for many) access addiction treatment services. From this vantage point, drawing upon a number of relevant theoretical perspectives and social-political concepts is valuable in informing the meaningful interpretation of the quantitative analyses in the Chapters to come.

Theoretical Perspectives

Three main theoretical perspectives inform the present study: *the risk environment framework* (Rhodes, 2002); the concept of *intersections of gender and violence* (Bourgois et al., 2004, as cited in Fairbairn et al., 2008, pp. 817-818); and the lens of *cultural safety*, from a critical cultural perspective in keeping with the work of Smye and Browne (2002) and Browne and Varcoe, (2006). These particular theoretical lenses have been selected because they fit well

with a gender-based analysis and draw attention to the broader contextual features of women's lives that inform current understandings of injecting practices.

Risk Environment

Rhodes' *risk environment framework* is an articulation of the process of how various factors (for example, forms of gendered violence and *cultural risk*) function to produce poor health outcomes among marginalized women who use injection drugs (Rhodes, 2002). In the context of this framework, *risk environment* is defined as the social or physical space in which a range of factors, exogenous to the individual, interact across the *micro* (individual/interpersonal), *meso* (local/social), and *macro* (structural/institutional, for example, political or economic) dimensions of the broader risk environment in which risk and harm are produced and reproduced (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005). This range of factors exogenous to the individual includes: peer groups and social networks; injecting environments; neighbourhood-level deprivation and disadvantage; social stigma and discrimination; policies (for example, addiction treatment models designed with men in mind that lack gender sensitivity and fail to consider needs from women's perspectives such as access to children or reproductive health services within treatment environments), laws, and policing; and *social capital*³. Such factors operating within a specific local context can exert significant influence upon the course of disease outbreaks and other forms of harm among vulnerable groups, and can mediate the effectiveness of public health and prevention interventions (Galea, Ahern & Vlahov, 2003; Galea & Vlahov, 2002; Karpati, Galea, Awerbuch & Levins, 2002). Factors such as those mentioned above within the risk environment that contribute to initiation of injection drug use and to delayed or constrained access to appropriate addiction treatment services produce risk and harm,

and are areas of central focus in this present thesis. Overlaying the risk environment is the concept of *intersections of gender and violence*.

Gendered Violence

Multi-layered forms of gendered violence have been described within a conceptual framework by Bourgois et al. (2004) in their ethnographic study of HIV risk among young people in San Francisco who are homeless and use heroin. More recently, the theoretical concepts described by Bourgois et al. were applied by Fairbairn et al. (2008) as a lens through which to examine the mediating influence of Vancouver's SIF on the impact of violence among street-involved women who use injection drugs. This, the second conceptual perspective informing the present work, is comprised of three theoretical classifications of gendered violence: *everyday* (or interpersonal); *symbolic*; and *structural*. These classifications or layers of gendered violence have been applied within public health contexts to elucidate the historical, political and cultural dimensions of gendered experiences of health and illness (Bourgois et al., 2004; Shannon et al., 2008). Bourgois et al. assert that such a theoretical lens allows for a linking of individual risk behaviours, "... commonly associated [among mainstream society] with ignorance, psychopathology or immorality, to larger social power relations [such as addiction treatment service organizations] as well as to pragmatic constraints for survival as a street addict" (p. 254).

Everyday violence. In their recent qualitative study, Shannon et al. (2008) document the pervasiveness of everyday violence and gender power relations among women in Vancouver who use drugs and engage in survival sex work. Based on the term coined by Scheper-Hughes (1996) which was informed by the work of Kleinman (1988), Kleinman, Das and Lock (1997), and Bourgois, Lettiere and Quesada (1997), Shannon et al. use the description of everyday

violence articulated by Bourgeois et al. (2004) to refer to manifestations of violence “... that are normalized and rendered invisible because of their routine pervasiveness” (p. 254). In other words, everyday violence refers to those tacit interpersonal aspects of gendered violence which are invisible or unrecognized by those upon whom (and often by whom) they are perpetrated – in particular, women (Bourgeois et al., 2004). For example, Shannon et al. describe themes among their study participants of women being regarded as sexual objects and sources of income whereby intimate male partners or pimps control the supply of condoms in an effort to ensure women engaged in sex trade work do not earn more money than can be accounted for by the number of condoms they are rationed. Within a micro-level risk environment context, such conditions of everyday violence constrain women’s agency in negotiating risk avoidance (for example, averting injection initiation experiences or accessing addiction treatment services) and risk reduction strategies (for example, avoiding used syringe borrowing or accessing safer injection assistance). Consequently, socially marginalized women who use injection drugs bear a disproportionate burden of infectious disease and gendered violence – including everyday violence – compared to their male counterparts (Bourgeois et al., 2004; Spittal et al., 2002).

Symbolic violence. Drawing on the work of Bourdieu (2001) and Epele (2002), Fairbairn et al. (2008) regard symbolic violence as rooted in a male-dominated street culture – a culture that can be regarded as a less subtle microcosmic reflection of larger social structures and institutions in general – that situates women in subordinate positions with respect to control of resources (for example, money/income, drugs, intimacy or access to harm reduction and other addiction treatment services, mental health support and health care services) and dependence on men for protection from harm by others through submission to a role that is akin to that of a man’s ‘property.’ As a form of a meso-level factor within a risk environment context, symbolic

violence, which is often systemic in nature, can be a means of excluding women from more elevated levels of power within the street hierarchy, limiting women's abilities to control resources derived through illicit drug trade, commercial sex trade work or other sources of income generation (Fairbairn et al.). Thus women's abilities to access health care services and harm reduction measures, such as supplies of condoms or clean syringes, are constrained. (Fairbairn et al.).

Structural violence. The concept of structural violence has been applied within public health literature to elucidate the historical and cultural dimensions of gendered experiences of health and illness (Bourgois et al., 2004). Farmer (1997; 1999; 2000; 2004) regarded structural violence as the broader political and economic gendered power imbalances that, within the macro-level risk environment context, result in the social marginalization of women who use injection drugs, and that limit access to basic services (for example, health care, addiction treatment and social services) (Farmer, Nizeye, Stulac & Keshavjee, 2006). Moreover, Shannon et al. (2008) viewed power through a broader post-structuralist lens that, against the dominant backdrop of more traditional discourses of power and powerlessness, draws on Foucaultian critical thought to foreground micro-level decision making processes and the exercising of individual agency (Foucault, 1981; Shannon et al.). Their view of power is similar to the discussion by Bourgois et al. of HIV risk among young people who use injection drugs in San Francisco. Foucault's term biopower refers to historically entrenched and institutionalized forms of social-structural power and control that serve to discipline human bodies and constrain individual agency (Foucault, 1982).

Methadone: A case example. An example of structural power and structural violence can be found in the form of certain external critiques of MMT programs – a longstanding pillar of

state and medically controlled harm reduction over the past half century which provide opiate substitution for people addicted to heroin (Keane, 2009). Bourgois (2000) argues that “[t]he definition of methadone maintenance as ‘drug treatment’ is a particularly concrete example of biopower at work.” (p. 167). Distinctions between methadone and heroin, defined by medical authorities as a proxy for the State, are primarily based on moral stances that are concerned with “controlling pleasure and productivity: legal versus illegal; medicine versus drug.” (Bourgois, p. 167). The methadone/heroin dichotomy is an illustration of how institutionalized social structures (i.e., the medical and criminal justice systems) control the use of pleasure by arbitrarily classifying certain drugs to be legal medicine while deeming others to be illegal poisons (Bourgois; Moore, 2004). Interestingly, this is similar to the earlier discussion in this chapter regarding the historical medicalization of common female problems and the medicinal use of morphine – an opiate derivative – used for treatment of women by physicians. “Ultimately, it can be argued that the most important pharmacological difference between the two drugs that might explain their diametrically opposed legal and medical statuses is that one (heroin) is more pleasurable than the other (methadone).” (Bourgois, p. 167).

Keane (2009), in her Foucaultian critical discourse analysis of four works related to MMT (Bourgois, 2000; Bull, 2008; Fraser & Valentine, 2008; Friedman & Alicea, 2001), found a common thematic view that MMT is a tightly regulated technology with the intent to turn people who use drugs into “productive and obedient subjects” (p. 450) by using structural power and violence to apply the very concepts and principles of biopower and discipline of human bodies described by Foucault (see also, Bourgois, 2000; Moore, 2004). Keane discusses how the Foucaultian concepts of disciplinary power, biopower and governmentality are depicted in the context of MMT throughout the four works included in her discourse analysis mentioned above.

In contrast to these views however, is the assertion that over the past couple of decades the degree to which disciplinary power, biopower and governmentality are manifested through MMT has lessened considerably through broad expansion of this harm reduction approach and a lowering of barriers to MMT access, particularly in British Columbia (Fischer, 2000). While increased access to MMT has been generally welcomed within the addiction treatment field, there remain inequities in access associated with certain socio-demographic variables such as ethnocultural background (for example, people of Aboriginal ancestry who are opiate dependent are substantially less likely to enrol in, or maintain enrolment in MMT) (Kerr, Wodak, Elliot, Montaner & Wood, 2004; Kerr et al., 2005).

Public health implications. The pervasiveness of gendered violence – everyday, symbolic and structural – throughout our society is accentuated within the risk environments of street and drug using cultures in Vancouver’s Downtown Eastside. Structural violence is of particular concern due to its significant influence on how health care is provided and what barriers to service access exist for people who use injection drugs, particularly vulnerable women and people who are Aboriginal. There continue to be calls for public health measures to further reduce barriers and increase access to health care and addiction treatment services (Kerr et al. 2004; Kerr et al. 2005). Such public health measures could include policies and interventions that better engage people of Aboriginal ancestry, and allow low threshold harm reduction approaches which are not conditional upon a requirement of abstinence (Fischer; 2000; Keane, 2009; Kerr et al., 2004; Kerr et al., 2005).

Injection drug use initiation, practices and addiction treatment seeking generally occur within the complexity of intersecting social factors in a local risk environment context. In this thesis these intersecting social, environmental and structural factors are explored through a

gender-based analysis approach which is informed by gendered violence and risk environment perspectives. In order to appropriately and effectively inform the interpretation of the analyses that follow, and, subsequently, policies and interventions that reduce barriers to service access for women and people who are Aboriginal, applying an interpretive lens of *cultural safety*, positioned within critical post-colonial perspectives, is an important (and possibly essential) consideration.

Cultural Safety

As the third key theoretical concept that informs this present work, cultural safety is used within critical theoretical views as a philosophical stance or interpretive lens. When situated within a critical post-colonial context, cultural safety assists us to understand how current colonial practices in health care have a tendency to cause *cultural risk* (Smye & Browne, 2002). This tendency in health care to cause cultural risk (further discussed below) is an important consideration in exploring the questions and objectives of this thesis. Post-colonial theories assist us in elucidating and uncovering vulnerabilities among individuals who use injection drugs, particularly women and people of Aboriginal ancestry, and who are socially marginalized and in need of access to appropriate health care and scarce culturally safe addiction treatment services.

Post-colonialism. While current feminist thinking is far from homogenous, encompassing a diverse range of views, the post-colonial perspective of ‘third wave’ feminism seeks to be more inclusive in its focus on gender, race and the power dynamics of oppression in general. Post-colonial feminism does this by giving voice to persons living in social marginalization and disenfranchisement (for example, women who use injection drugs), bringing them into the fray of the central discourse to better inform feminist thought (Anderson, 2004). Anderson contends that these forms of critical “...post-colonial theories are relevant to all [people] ...”,

acknowledging “...that suffering, health and well-being are woven into the fabric of the social-historical-political context, and as health professionals we have a moral responsibility to be mindful of this context” (p. 239). As Bourgeault (2006) notes, feminist medical sociology has sought to link the social-structural aspects of a patriarchal system to the lived experience of oppressed individuals and groups, such as socially marginalized women who use drugs. Examination of the intersections of addiction and the social determinants of health – especially in relation to historically-situated social, economic and environmental factors – allows for a broader understanding of the social situations, places, and structures where risk is produced in the lives of oppressed and socially excluded women who use injection drugs.

Another example of social-structural influence is the reproduction of gender inequity and vulnerability through social stigma and discrimination resulting from societal views (and policies) which regard women who use drugs as being “in breach of their feminine role, particularly in relation to motherhood [and child care] where drug using mothers are routinely cast as unfit” (Bryant & Treloar, 2007, p. 287). Women’s autonomous agency to negotiate risk in this context is severely constrained by a number of determinants. There needs to be a re-thinking of future public health measures that affords moving beyond individual-level approaches (Shannon et al., 2008). The limitations of a conventional ‘provider-client’ health service delivery model include the difficulty that service providers – such as nurses – have in reaching drug using women ‘on their own turf,’ difficult communication between nurses and clients, and fear among women who use drugs that use of services may alert police or child welfare authorities to their activities (Broadhead, Heckathorn, Grund, Stern & Anthony, 1995; Broadhead et al., 1998).

Thorough consideration of social-historical perspectives and social-structural mechanisms that cause social marginalization of addicted persons, the approaches used to

achieve stigmatization and social exclusion, and how such approaches produce risk and risk environments will help to provide insight into how our understanding of women's injecting practices has been shaped. Such insight will inform ethical practice, policy and further research with respect to the extent to which gender differences mitigate or produce risk within the social, environmental and structural circumstances surrounding initiation to injection drug use, as well as in the process of engagement in addiction treatment services. Exploration of the discourse and intent of cultural safety helps to shed light on how cultural influences contribute to shaping understandings of injection practices among women who use drugs.

Conceptualizations of cultural safety. The concept of cultural safety as a philosophical stance evolved in response to a recognition by Maori nurse leaders and other health practitioners and educators in New Zealand that the health needs of indigenous peoples were not being adequately met, either by traditional (i.e., colonialist) health care approaches or by newer strategies (such as nursing education in cultural sensitivity and cultural competence) to address culturally-based gaps in care provision (Ramsden & Spoonley, 1994). Cultural safety was created within a post-colonial context as an educational process for health care providers whereby a heightened awareness is developed of how one's own cultural influences impact the effective provision of health care for people of different ethnocultural backgrounds (Polashek, 1998; Ramsden, 1993). As a philosophical and conceptual approach to health education whereby opportunities are provided for ethnocultural minority groups to have input and influence into the way health care providers are educated, cultural safety "involves the recognition of the social, economic and political position" (Smye & Browne, 2002, p. 46) of ethnocultural minority groups.

Although the concept of cultural safety was developed in response to concerns about the health and health care of the Maori people in New Zealand, Smye and Brown (2002) explored the exportability of the concept of cultural safety to a Canadian – and more specifically, a British Columbian – context. For the purpose of this thesis, it is valuable to understand how historical underpinnings shape the context of health and health care in the present (Anderson et al. 2003), particularly related to addiction treatment access and more specifically, among people who are Aboriginal. While there are no formal strategies in Canada for health education and practice to be inclusive of concepts related to cultural safety (Brown & Varcoe, 2006), “[n]ursing as a discipline must consider how committed we are to unravelling the intricacies of racism and to engaging in the political activity of social transformation.” (Brown & Varcoe, p. 165).

In keeping with the work of Smye and Browne (2002), I use cultural safety within a reflective critical process as an interpretive lens through which we can examine and question dominant discourses in health and social policies, practices and attitudes that recreate or perpetuate historic inequities within social and political relationships (Polashek, 1998; Ramsden, 1993; Smye & Browne) with women who use injection drugs. This interpretive lens helps to inform how dominant social policy discourses influence rates of enrolment in addiction treatment services among people of Aboriginal ancestry compared with persons who are non-Aboriginal. Cultural safety, particularly as it relates to addiction treatment access among people who are Aboriginal, will be explored further in Chapter Four during the discussion of the analysis on treatment enrolment. Through the lens of cultural safety, we can examine “how dominant organizational, institutional, and structural contexts shape health and social relations and practices” within a post-colonial and/or neo-colonial framework (Varcoe, 2004, p. 425). Cultural safety:

... is concerned with fostering an understanding of the relationship between minority status as a way of changing nurses' [and other health care providers' and policy makers'] attitudes from those which continue to support current dominant practices and systems of health care to those which are more supportive of the health of minority groups (Smye & Browne, p. 47).

Cultural risk. As briefly asserted above, the concept of cultural safety stems from the need to address tendencies in health care (Smye & Browne, 2002) to cause cultural risk – conditions that come about when people of a particular ethnocultural group perceive that they are “demeaned, diminished or disempowered by the actions and the delivery systems of people from another culture” (Ramsden & Spoonley, 1994, p. 164). The intent of cultural safety is to shift attention away from stereotypical aspects attributed to Aboriginal people or people of different ethnocultural and social backgrounds toward greater scrutiny of the culture of health care, and highlighting how practices and policies can unintentionally produce marginalizing conditions and inequities (Anderson et al., 2003; Browne, Smye & Varcoe, 2005). In other words, the lens of cultural safety has the potential to focus attention on how social and structural aspects of health care in British Columbia contribute to, or even cause structural violence and further aggravation of the risk environments in which marginalized women who use injection drugs live. In relation to the scope of work in this thesis, some examples of how social and structural health policies produce structural violence and aggravate risk environments include: prohibition of assisted injection at a supervised injection facility, leaving women who are dependent on others to inject them, vulnerable to predatory men and other forms of everyday violence on the street; and the predominantly male orientation of addiction treatment programs which can recreate past traumas for women.

Since critical feminist perspectives (including post-colonialist views) advance the objectives of identifying and addressing sources of oppression and power inequities (Rodney, Pauly & Burgess, 2004), the lens of cultural safety when positioned within these critical theoretical perspectives assists us in drawing attention toward addressing social and structural inequities that shape health and health care, particularly for those persons historically marginalized by inequity (Smye & Browne, 2002). From a risk environment perspective, the intersections between socio-demographic or cultural variables (Constantine, 2002) such as gender, Aboriginal ancestry and age, as well as stigma and social marginalization, may have significant implications related to cultural risk. In other words, cultural risk can result from policies and/or practices that negatively impact the lives of people vulnerable to social exclusion from health care and addiction treatment services.

A recent study by Wood et al. (2008) showed that about 32% of people who use injection drugs in Vancouver's Downtown Eastside are women. Aboriginal people comprise about 22% of this population. While non-Aboriginal people within this population include 26% women, Aboriginal people within the same population include 52% women. Such data illustrate the complex layering of minority status of women, especially Aboriginal women, within this already socially marginalized sub-culture population, and the relevance of cultural safety in the context of the dominant health care culture.

Cultural risk is of particular relevance in contributing to the vulnerability among those who are, or are becoming, entrenched in various aspects of street culture (Novelli et al., 2005). An increased likelihood of subsequent high risk injection-related behaviours, such as binge use, syringe sharing, injection by other individuals, sex work, and criminalization – all of which are known to increase the risk of infection, disease transmission and overdose (Miller, Kerr et al.,

2006; Miller, Strathdee et al., 2006; Novelli et al.) – render street entrenched individuals more vulnerable to cultural risk. Many of these individuals, particularly those of Aboriginal ancestry, report experiences of feeling demeaned or disempowered by health care providers who are perceived as regarding the health concerns of street entrenched persons as primarily self-inflicted (Anderson, Reimer Kirkham, Browne, & Lynam, 2007; Wood et al. 2005; Wood et al. 2008). Structural and institutional discriminatory practices both result in and produce cultural risk, as manifested by barriers to accessing health care, social services, housing or employment. Further, risk of sustaining various forms of gendered violence may be perpetuated as a consequence of inadequate opportunities and/or constrained access to culturally safe addiction treatment services and health care, particularly for women (Bourgois et al., 1997; Bourgois et al., 2004; Fairbairn et al., 2008; Farmer et al., 2006; Shannon et al., 2008).

Intersections of Gender, Risk, Structural Influences and Cultural Safety

The substantial body of literature related to gendered aspects of injection drug use and street culture mentioned above provides numerous illustrations of the intersections of gendered interpersonal, environmental, structural and cultural variables, factors or influences (see also Anderson et al., 2003; Bourgois et al., 2004; Bryant & Treloar, 2007; Epele, 2002; Fairbairn et al., 2008; Fuller et al., 2003; Kerr et al., 2007; Kral, Bluthenthal, Erringer, Lorvick & Edlin, 1999; Major & O'Brien, 2005; Marshall et al., 2008; Measham, 2002; Miller, Strathdee et al., 2006; Novelli et al., 2005; O'Connell et al., 2005; Ompad et al., 2005; Pederson & Raphael, 2006; Rhodes et al., 2005; Scheper-Hughes, 1996; Shannon et al., 2008; Smye & Browne, 2002; Spittal et al., 2002; Varcoe, 2004; Yang et al., 2007). Some examples of high risk injection-related behaviours discussed above illustrate how various intersecting forms of oppression (based on gender, age, ethnicity, culture, history, poverty, stigma, social marginalization, and

entrenchment in street culture and its associated cultural norms) are manifested, and highlight the importance of cultural safety – and cultural risk – in the context of the dominant health care culture (Browne et al., 2005; Varcoe; Wood et al., 2008). As argued earlier, cultural safety as an interpretive lens positioned within critical theoretical perspectives, draws attention to the multiple intersecting contexts of risk environments and layered forms of gendered violence. This interpretive lens allows for examinations of gender differences in the social, structural and environmental circumstances of individuals' first injecting experiences, and in access to gender-sensitive addiction treatment services.

This thesis is situated within post-structural critiques of public health and drug policy that consider ways in which individuals are governed through messages of self-regulation and risk-avoidance as a form of neo-liberal governmentality (Moore, 2004; Petersen & Lupton, 1996). Shannon et al. (2008) argue that public health and harm reduction approaches in recent years have largely focused on individual-level, rather than collective/social/structural-level interventions. Such individual-level approaches fail to adequately consider the intersections of broader social and structural influences with micro-level risk environments which produce, reproduce, reduce and otherwise mediate risk in the everyday living conditions of women who use drugs (Shannon et al.). These broader social and structural influences are reflected in social processes such as the perpetuation of social and economic gender inequities through male domination of commercial sex work and the illicit drug trade (Shannon et al.). The interwoven conceptual perspectives of risk environment, gendered violence and cultural safety begin to model a multifaceted contextual view of the social, structural and environmental factors associated with first injection experiences and with being enrolled in addiction treatment among people in Vancouver who use injection drugs. These interwoven conceptual perspectives as

applied in this thesis are used to examine gender differences in the risk environments of marginalized people in Vancouver who use injection drugs. Such contextual views are important in informing and guiding the overall objectives of my thesis research. This preliminary model or framework is most useful in guiding an exploration of how our understanding of women's injecting practices has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions.

Summary

The risk environment of marginalized, street entrenched people – women in particular – who use injection drugs is a central source of mediating factors which produce and reproduce risk. It is a physical and social space where complex intersections of a range of historic, social, structural, economic, cultural and gendered factors or variables create conditions of vulnerability among people who use injection drugs. However, the risk environment can also create conditions that are empowering if social discourses are dominated by themes of gender equality, social inclusion and equitable distribution of resources, including social services, housing, health care and addiction treatment services. The historical social and cultural structures and mechanisms that perpetuate marginalization, stigma and discrimination all impact the shaping of our understanding of the conditions in which people who use injection drugs live, why people initiate injection drug use, why certain high risk injecting practices continue, and what influences contribute, positively or negatively, to access to, and engagement in addiction treatment services.

Chapter Two has laid the foundation of theory and knowledge that informs the interpretation and integration of the quantitative analyses in Chapters Three and Four. Using a gender-based analysis approach, I have provided a variety of critical perspectives and viewpoints from which a basis for more humanistic and ethical approaches to providing gender-sensitive and

culturally safe addiction treatment services and to viewing injection drug use and people who use injection drugs can be considered. The lenses of the risk environment, gendered violence and cultural safety, when positioned within a critical theoretical context, can be used to examine the multiple intersections of social, cultural, structural, historical and gendered factors and how they impact on the daily lives of street-entrenched people on the social margins who use injection drugs in Vancouver. Precisely how these lenses are applied will be illustrated in Chapter Three in relation to examining gender differences in circumstances surrounding individuals' first injecting experiences, and in Chapter Four in relation to gender differences in engagement in addiction treatment services.

Endnotes

- ¹ *Post-colonialism* refers to a degree of heightened societal awareness of our historical locatedness, both past and present, regarding the consequences of colonial and neo-colonial attitudes and practices and the implications of social and structural policies for those more disadvantaged and marginalized in our society (Smye & Browne, 2002).
- ² *Post-modernism* emphasizes "... the importance of subjectivism and microsociological analysis and ... stress[s] cultural relativism and a plurality of viewpoints" (Bourgeault, 2006, p. 49).
- ³ "*Social capital* is usually measured in terms of the social, collective, economic and cultural resources available to a network, neighbourhood or community" (Rhodes et al., 2005, p. 1032). Social capital thus provides an ecological evaluation of differences in risk or health within communities or social networks, and of how well these communities and social networks respond to increased risk.

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CHAPTER THREE²:

Gender Differences in Circumstances Surrounding First Injecting Experiences

Injection drug use continues to be associated with severe harms throughout the world (Aceijas & Rhodes, 2007). Women who inject drugs have been found to be at elevated risk for drug-related harms, including HIV infection (Spittal et al., 2002). This has led to growing interest in women's early injecting experiences (Novelli, Sherman, Havens, Strathdee & Sapun, 2005). Although findings have been somewhat inconsistent, several studies in North America and Australia have described gender differences (for example, in age and social context) in the circumstances surrounding injection initiation (Bryant & Treloar, 2007; Fuller et al., 2003; Kerr, Tyndall et al., 2007). Gender differences in early childhood experiences of trauma (for example, sexual abuse) have also been implicated as possible influences in the context of injection drug initiation (Ompad et al., 2005). Novelli et al. (2005) contend that targeting prevention measures designed for young people who use drugs, but have not yet transitioned into injection drug use, may serve to delay or prevent injection initiation. A recent study in Vancouver, Canada showed that adolescents who initiate injection drug use at an early age were at greater risk for subsequent high-risk injection drug use behaviour, including binge use, sex work, and criminalization (Miller, Strathdee, Kerr, Li & Wood, 2006). In general, women who inject drugs are more likely than their male counterparts to report having been injected by another individual (i.e., assisted injection) (Hankins, 2008; O'Connell et al., 2005; Wood et al., 2003). Hankins suggests that women may have less autonomy in accessing drugs and injecting equipment and that such social dependency can increase their risk for HIV infection and overdose. Greater elucidation of the

² A version of this chapter will be submitted for publication. Wood, R.A., Kerr, T., Lai, C., Montaner, J. & Wood, E. (2010). Gender Differences in Circumstances Surrounding First Injecting Experiences.

environmental, social and structural dynamics involved in women's first injection experiences is needed to better inform strategies and policies related to health promotion, addiction prevention, and health service provision and access for vulnerable women; strategies and policies which should address women who have not yet initiated injection drug use as well as those who have.

Background

While there has recently been a growing body of literature exploring first injecting experiences of people who are, or have been injection drug users (IDU) (Abelson et al., 2006; Doherty, Garfein, Monterroso & Latkin, 2000; Fuller et al., 2003; Kerr, Tyndall et al., 2007; Miller, Strathdee et al., 2006; Novelli et al., 2005; Roy et al., 2003), little attention has been given to in-depth gender-based analyses of the contextual socio-cultural, structural and environmental risk circumstances of women's initiation experiences. Novelli et al., in their study of the relationship between circumstances surrounding the first injection experiences of young people who use injection drugs in Baltimore, Maryland, and future injection risk practices, found that age and self-injection (versus being injected by another individual) at initiation were independently associated with future injection risk behaviours. For example, Novelli et al. found that individuals who had used a previously used syringe for their first injection at a younger age were much more likely to report recent syringe sharing than similar individuals who had used a new syringe for their first injection. This finding suggests that young people who inject street drugs may establish high-risk injecting practices during their initiation experience and may have been influenced prior to their first injection by certain socio-cultural, structural and environmental factors that may have shaped the establishment of future injecting risk behaviours.

Purpose and Research Question

The purpose of this study is to build on previous findings using gender-based analysis – an evidence-based approach that takes into account how policies, programs, services and research impact differently on the lives of women and men (Canadian Institutes of Health Research, 2007) – to quantitatively examine the gender differences within the contextual circumstances of first injecting experiences. Specifically, I sought to address the question of whether there are gender differences in social, environmental and structural circumstances surrounding initiation to injection drug use among a cohort of people in Vancouver who use illicit injection drugs. To achieve this objective, data for secondary analysis were drawn from a larger program of research through close collaboration with co-supervisors, principle investigators, statisticians, methodologists, other researchers, research assistants, students, administrative staff, and front-line survey and data support staff, all of whom comprise the Urban Health Research Initiative team (UHRI – further described in detail in the previous Chapters).

Theoretical Perspectives

Two main theoretical perspectives inform the current study: the *risk environment framework* (Rhodes, 2002) and the concept of *intersections of gender and violence* (Bourgois, Prince & Moss, 2004, as cited in Fairbairn, Small, Shannon, Wood & Kerr, 2008, pp. 817-818).

Risk Environment

Rhodes' *risk environment framework* is an articulation of the process of how various factors (for example, forms of gendered violence) function to produce poor health outcomes among marginalized women who use injection drugs (Rhodes, 2002). In the context of this framework, *risk environment* is defined as the social or physical space in which a range of factors exogenous to the individual interact across the broader risk environment in which risk

and harm (for example, initiation of injection drug use) are produced and reproduced (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005). These exogenous factors include peer groups and social networks; injecting environments; social stigma and discrimination; policies, laws, and policing; and *social capital*¹, which interact across the *micro* (individual or interpersonal), *meso* (social), and *macro* (structural/institutional, for example, political or economic) dimensions of the broader risk environment. Overlaying the risk environment is the concept of *intersections of gender and violence*.

Gendered Violence

Multi-layered forms of gendered violence have been described within a conceptual framework by Bourgois et al. (2004) in their ethnographic study of HIV risk among young people in San Francisco who are homeless and use heroin. More recently, the theoretical concepts described by Bourgois et al. were applied by Fairbairn et al. (2008) as a lens through which to examine the mediating influence of Vancouver's supervised injection facility (SIF) on the impact of violence among street-involved women who use injection drugs. This, the second conceptual perspective informing the present study, is comprised of three theoretical classifications of gendered violence: *everyday*; *symbolic*; and *structural*. These classifications, or *layers* of gendered violence have been applied within public health contexts to elucidate the historical, political and cultural dimensions of gendered experiences of health and illness (Bourgois et al., 2004; Shannon et al., 2008). Bourgois et al. assert that such a theoretical classification can be used as a tool or lens that allows for a linking of individual risk behaviours, "... commonly associated [among mainstream society] with ignorance, psychopathology or immorality, to larger social power relations as well as to pragmatic constraints for survival as a street addict" (p. 254).

Everyday violence. In their recent qualitative study, Shannon et al. (2008) document the pervasiveness of everyday violence and gender power relations among women in Vancouver who use drugs and engage in survival sex work. Everyday violence – a term coined by Scheper-Hughes (1996) – was informed by the work of Kleinman (1988), Kleinman, Das and Lock (1997), and Bourgois, Lettiere and Quesada (1997) on social suffering². Shannon et al. use the description of everyday violence articulated by Bourgois et al. (2004) to refer to manifestations of violence “... that are normalized and rendered invisible because of their routine pervasiveness” (p. 254). In other words, everyday violence refers to those tacit interpersonal aspects of gendered violence which are invisible or unrecognized by those upon whom (and often by whom) they are perpetrated – in particular, women (Bourgois et al., 2004). Within a micro-level risk environment context, such conditions of everyday violence constrain women’s agency in negotiating risk avoidance (for example, averting injection initiation experiences) and risk reduction strategies (for example, avoiding used syringe borrowing). Consequently, socially marginalized women who use injection drugs bear a disproportionate burden of infectious disease and gendered violence – including everyday violence – compared to their male counterparts (Bourgois et al., 2004; Spittal et al., 2002).

Symbolic violence. Drawing on the work of Bourdieu (2001) and Epele (2002), Fairbairn et al. (2008) regard symbolic violence as rooted in a male-dominated street culture – a culture that can be regarded as a less subtle microcosmic reflection of larger social structures and institutions in general – that situates women in subordinate positions with respect to control of resources (for example, money/income, drugs, or intimacy) and dependence on men for protection from harm by others through submission to a role that is akin to that of a man’s ‘property.’ As an example of a meso-level factor within a risk environment context, symbolic

violence – often systemic in nature – can be a means of excluding women from more senior levels of power within the hierarchy of street and drug culture, limiting women’s abilities to control resources derived through illicit drug trade, commercial sex trade work or other sources of income generation (Fairbairn et al.). A case illustration of symbolic violence is well presented by Fairbairn et al. through depictions by female participants in their study who describe how street entrenched women who use drugs are “routinely hassled and exploited ... by men for drugs or money due to their perceived ability to access resources and generate income, such as through survival sex work.” (p. 820). This kind of aggressive treatment of vulnerable women by men within the meso-level risk environment of street culture poses a real or implied threat of physical harm to women through the potential for robbery and physical injury. Such a threat, real or implied, constitutes symbolic violence (Fairbairn et al.).

Structural violence. Farmer (1997; 1999; 2000; 2004) regarded structural violence as the broader political and economic gendered power imbalances that, within the macro-level risk environment context, result in the social marginalization of women who use injection drugs, and that limit access to basic services (for example, health care, addiction treatment and social services) (Farmer, Nizeye, Stulac & Keshavjee, 2006). Moreover, Shannon et al. (2008) viewed power through a broader post-structuralist lens that, against the dominant backdrop of more traditional discourses of power and powerlessness, draws on Foucaultian critical thought (similar to the discussion by Bourgois et al. (2004) of HIV risk among young people who use injection drugs in San Francisco) to foreground micro-level decision making and the exercising of individual agency (Foucault, 1981; Shannon et al.). Shannon et al. provide an example of structural violence in a discussion of their study participants’ portrayal of the risks inherent in the lack of safe locations to take commercial sex partners. Current laws related to prostitution were

described by female participants as “direct structural barrier[s] to HIV prevention by limiting their control with dates, increasing the risk of violence and reducing their ability to negotiate condom use. ... [O]nce women enter a [customer’s] car, their ability to control their situation [is] severely compromised.” (p. 916).

Intersections of Gender, Violence, Risk Environments, and Structural Influences

The substantial body of literature related to gendered aspects of injection drug use and street culture provides numerous illustrations of the intersections of gendered interpersonal, environmental, and structural influences that manifest in various forms of oppression based on such factors as age, ethnicity, history, poverty, stigma, social marginalization, and entrenchment in street culture and its associated cultural norms (Anderson et al., 2003; Bourgois et al., 2004; Bryant & Treloar, 2007; Epele, 2002; Fairbairn et al., 2008; Fuller et al., 2005; Kerr, Kimber & Rhodes, 2007; Major & O’Brien, 2005; Marshall, Fairbairn, Li, Wood & Kerr, 2008; Measham, 2002; Pederson & Raphael, 2006; Rhodes et al., 2005; Scheper-Hughes, 1996; Shannon et al., 2008; Spittal et al., 2002; Varcoe, 2004; Wood et al., 2008; Yang et al., 2007). As previously discussed, examples of intersections between gender, violence and risk include such themes as male aggression toward street entrenched women due to the perception of women as sources of income and drugs (based on the likelihood of women’s involvement in survival sex trade work), and compromised ability to exercise individual agency in negotiating risk due to the need for sex trade produced income to mitigate the consequences of extreme poverty. The lenses of the risk environment and layered forms of gendered violence are used to begin to lay a foundation for a conceptual framework within which attention can be drawn to the multiple intersecting contexts that inform the present analysis. These lenses assist in guiding the integration and interpretation

of quantitative examinations of gender differences in the social, structural and environmental circumstances of individuals' first injecting experiences.

Methods

The Vancouver Injection Drug User Study

A cross-sectional survey approach was used to identify gender differences in circumstances surrounding initiation to injection drug use among participants of the Vancouver Injection Drug User Study (VIDUS) cohort. VIDUS is an open prospective cohort study of over 1,500 individuals who use injection drugs, recruited since 1996 from Vancouver's Downtown Eastside. This cohort has been described in detail previously (Spittal et al., 2002; Strathdee et al., 1997; Tyndall et al., 2001). In brief, persons were eligible for inclusion in VIDUS if they reported injecting illicit drugs at least once within the previous month, and are residents of Vancouver. Baseline and semi-annual interviewer-administered questionnaires are completed with all participants and blood samples are drawn for diagnostic testing. Through the questionnaire, demographic data as well as information regarding drug use, HIV risk behaviour, first exposure to injection drug use and drug treatment are obtained. Informed consent is obtained and a stipend (\$20 Cdn) is provided at each study visit to reimburse participants for time, transportation and other costs related to study participation. The study is approved annually by the Providence Health Care/University of British Columbia Research Ethics Board. VIDUS has been highly successful in terms of follow-up rates – more than 85% of participants have been retained in follow-up since the study was initiated (Kerr, Marsh, Li, Montaner & Wood, 2005). Approximately 40% of the cohort are women (Kerr et al., 2005; Miller et al., 2005).

Analysis

The key dependent (outcome) variable of interest in the present study is *gender*. Socio-demographic variables among participants include: current age; age at first injection; and Aboriginal ancestry. Variables of interest related to reported first-injection drug-using risk behaviours among participants include: used syringe borrowing (yes versus no); receiving injection assistance from, or being injected by another individual (yes versus no); injecting in public (yes versus no); injecting alone (yes versus no); how injecting technique was first learned (taught by self versus taught by others); type of drug first injected (cocaine, heroin, speedball, Talwin/Ritalin, methylenedioxyamphetamine – commonly known as MDA, or crystal methamphetamine); state of intoxication at time of first injection (sober, consumed alcohol or consumed drugs); and reported reason for first injection (curiosity, pressured/injected by another individual without consent, to escape from problems/suicidal, or intimate partner using). To evaluate gender differences in circumstances surrounding initiation into injection drug use for this secondary analysis, the study sample was stratified into groups based on gender. Univariate and descriptive statistics were used to determine the relevant associations between the dependent and independent variables. Univariate categorical data were analyzed using Pearson's chi-square test. Tests of statistical significance were set *a priori* at $p \leq 0.05$ and all were two-sided.

Results

Between May 2005 to December 2007, 1,436 participants were surveyed, including 496 (34.5%) women, of whom 239 (48%) reported being of Aboriginal ancestry, and 940 (65.5%) men, of whom 222 (24%) reported being of Aboriginal ancestry. The median current age at the time of survey was 39.0 years for women (IQR: 31.5 – 45.0), and 43.2 years for men (IQR: 36.5 – 48.8) – indicating that female participants are on average approximately four years younger

than their male counterparts. The median reported age at first injection was 18.0 years (IQR: 15.0 – 24.0) for women and 19 years (IQR: 15.0 – 25.0) for men.

As indicated in Table 1, demographic and environmental risk factors positively associated with female gender included: Aboriginal ancestry (OR = 3.01; 95% CI: 2.39 – 3.79; $p < 0.001$); and receiving assisted injection (OR = 1.64; 95% CI: 1.26 – 2.12; $p < 0.001$).

Behavioural, social and environmental risk factors negatively associated with female gender included: syringe borrowing (OR = 0.72; 95% CI: 0.54 – 0.95; $p = 0.023$); injecting in public (OR = 0.70; 95% CI: 0.50 – 0.97; $p = 0.032$); and first taught to inject by self (OR = 0.75; 95% CI: 0.57 – 0.99; $p = 0.040$). Injecting alone was not found to be statistically significant at the $p \leq 0.05$ level.

TABLE 1: Factors associated with first injection episodes among female and male injection drug users ($n = 1436$)

Characteristic	Female <i>n</i> = 496 (34.5%)	Male <i>n</i> = 940 (65.5%)	Odds Ratio (95% CI)	<i>p</i> - value
Median current age (per year older) (IQR)	39.0 (31.5 – 45.0)	43.2 (36.5 – 48.8)	—	< 0.001
Median age at first injection (IQR)	18.0 (15.0 – 24.0)	19.0 (15.0 – 25.0)	—	0.027
Aboriginal				
yes	239 (48%)	222 (24%)	3.01 (2.39 – 3.79)	< 0.001
no	257 (52%)	718 (76%)		
Borrowed syringe*				
yes	82 (17%)	203 (22%)	0.72 (0.54 – 0.95)	0.023
no	414 (83%)	737 (78%)		
Assisted injection*				
yes	396 (80%)	665 (71%)	1.64 (1.26 – 2.12)	< 0.001
no	100 (20%)	275 (29%)		
Public injection*				
yes	55 (11%)	143 (15%)	0.70 (0.50 – 0.97)	0.032
no	441 (89%)	797 (85%)		
Injected Alone*				
yes	23 (5%)	63 (7%)	0.68 (0.41 – 1.11)	0.119
no	473 (95%)	877 (93%)		
First taught by[†]				
Self	95 (24%)	226 (29%)	0.75 (0.57 – 0.99)	0.040
Others	307 (76%)	546 (71%)		

* These variables are specific to first injection episodes

[†] $n = 1174$

Table 2 shows gender differences in the type of drug used the state of intoxication just prior to injection, and the reason given for the first injection. Intimate partner injection drug use as a reported reason for first injection was positively associated with female gender (OR = 2.73; 95% CI: 1.58 – 4.71; $p < 0.001$), whereas curiosity as a reported reason for first injection was negatively associated with female gender (OR = 0.68; 95% CI: 0.54 – 0.86; $p = 0.002$). No other reported reasons for first injection were found to be statistically significant at the $p \leq 0.05$ level.

TABLE 2: Drug Type, Pre-Injection State and Injecting Reason during first injection episodes among female and male injection drug users ($n = 1436$)

Characteristic	Total (%) ($N = 1436$)	Gender		Odds Ratio (95% CI)	p – value
		Female (%) $n = 496$ (34.5%)	Male (%) $n = 940$ (65.5%)		
First drug injected*					0.101 [‡]
Cocaine	564 (39%)	199 (40%)	365 (39%)	—	—
Heroin	473 (33%)	169 (34%)	304 (32%)	—	—
Speedball [†]	76 (5%)	21 (4%)	55 (6%)	—	—
Talwin/Ritalin	95 (7%)	42 (8%)	53 (6%)	—	—
MDA	54 (4%)	14 (3%)	40 (4%)	—	—
Crystal Meth	40 (3%)	10 (2%)	30 (3%)	—	—
Pre-injection state**					0.752 [‡]
Sober	837 (58%)	298 (60%)	539 (57%)	—	—
Consumed alcohol	379 (26%)	124 (25%)	255 (27%)	—	—
Consumed drugs	239 (17%)	79 (16%)	160 (17%)	—	—
Other	26 (2%)	9 (2%)	17 (2%)	—	—
Injecting reason***					< 0.001 [‡]
Curiosity	1030 (72%)	330 (67%)	700 (75%)	0.68 (0.54 – 0.86)	0.002
Pressured/non-consensual injection	94 (6%)	34 (7%)	60 (6%)	1.08 (0.70 – 1.67)	0.731
Escape problems/suicidal	42 (3%)	18 (4%)	24 (3%)	1.44 (0.77 – 2.67)	0.252
Intimate partner using	55 (4%)	32 (6%)	23 (2%)	2.73 (1.58 – 4.71)	< 0.001

* $N = 1302$ (91% response)

** 71 (5%) participants reported either more than one response, no response, or ‘other’.

*** 9 (1%) participants reported ‘other’ and 206 participants (14%) reported no response.

[†] Heroin and cocaine mixed together.

[‡] Overall p -value; pairwise comparisons were only conducted with overall p -values of ≤ 0.05 level of significance achieved.

Discussion

The findings herein indicate that women were more likely than men to have initiated injecting within the context of an intimate relationship with a partner who used injection drugs, and were less likely than men to report curiosity as a reason for injection initiation. In fact, the present findings indicate that injection drug use by an intimate partner was reported about three times more often by women compared to men as the reason for initiation, whereas the primary reason for initiation reported among male participants was curiosity. Moreover, women were about one and a half times more likely than men to be injected the first time by another individual (i.e., assisted injection) and were less likely than men to be self-taught in self-injection skills. It is also worthy of note that, in contrast to previous work by Novelli et al. (2005), results from the present study suggest that some risk behaviours, such as syringe borrowing and injecting in public, were negatively associated with female gender.

Assisted Injection

The practice of assisted injection has previously been shown to be associated with high risk syringe borrowing (Novelli et al., 2005), HIV incidence (O'Connell et al., 2005), as well as non-fatal overdose among persons who use injection drugs (Kerr, Fairbairn et al., 2007), and therefore the high rate of received assisted injecting reported by women in this study is concerning. Receiving injection assistance has previously been found to be more common among women than among men (Wood et al., 2003), with women and men reporting different reasons for engaging in this practice. Specifically, in comparison to men, women have been found to be more likely to report a lack of knowledge of how to self-inject as a reason for engaging in assisted injection (Wood et al.). This link between lack of self-injection knowledge

and receiving assisted injection is consistent with the findings of the present study which suggest that women were less likely than men to teach themselves how to inject.

The finding concerning higher rates of receiving assisted injection among women during first injection experiences may imply an element of contextual or *situated rationality*. Specifically, situated rationality involves a rational weighing out of acceptable risk – situated within a specific local and interpersonal context – against a personal stake in meeting certain individual needs, such as for relative safety, shelter, food, a sense of interpersonal belonging within a social and cultural network, drugs, or intimacy (Bloor, Robertson, McKeganey & Neale, 2008; Dietze, Jolley, Fry, Bammerd & Moore, 2006; Rhodes et al., 2006). For example, Bloor et al., in their prospective cohort study of people who use drugs in Scotland, found that, when considered from the perspective of a socially constructed situated rationality within a relational and interpersonal context, submitting to being injected by an intimate partner via the partner's previously used contaminated syringe was often viewed as a sign of trust and intimacy and therefore, an acceptable risk.

Furthermore, the pervasiveness of assisted injection during women's first injecting experiences may reflect a form of everyday violence, within a micro-level risk environment context, whereby the male control over women's drug use – and over the injection process itself – have become commonplace, despite the many risks associated with assisted injection (Bourgois et al., 2004; Shannon et al., 2008). As already pointed out, the findings in the present study indicate that women participants were three times more likely than men to report intimate partner injection drug use as a *reason* for their first injection. In light of these current (and previous) findings regarding higher rates among women of both receiving assisted injection and reporting intimate partner injection drug use as a reason for initiation, the potential implications

of micro and meso-level socially constructed gender power dynamics – producing conditions of male domination and female subordination – (for example, manifested forms of situated rationality and everyday violence) ought not to be overlooked. These implications of gender power dynamics require further and ongoing attention from researchers and policy makers.

Intimate Partner Injection Drug Use

The significant association shown between injection initiation and intimate partner injection drug use is consistent with previous work in this area (Bourgois et al., 2004; Fairbairn et al., 2008; Shannon et al., 2008; Spittal et al., 2002). When viewed through the lens of the risk environment framework, interpersonal, social and peer group *risk norms* may be seen as factors within street culture that serve to construct or precipitate certain manifestations of situated rationality at the micro-environmental level among young women who are willing to take ‘acceptable’ risks to meet their needs for intimacy (Bloor et al., 2008; Dietze et al., 2006; Rhodes et al., 2006). For example, Rhodes et al. discuss how using a situated rationality model of risk can elucidate the social mechanisms by which the micro-level risk environment shapes injection practices over time to construct a cultural normalization of risk behaviours such as groin (femoral vein) and jugular vein injections – both particularly high risk practices (Irish et al., 2007) – as acceptable risks and preferred routes of injection for recipients and providers of assisted injection due to the greater ease of venous access (Hoda, Kerr, Li, Montaner & Wood, 2008; Lloyd-Smith et al., 2005; O’Connell et al., 2005; Wood et al., 2003; Wright & Tompkins, 2004).

Power Relations

Structural gender inequalities and gendered risk at the macro-environmental level support and perpetuate the gendered nature of power relations in drug using relationships, exhibited

through various dynamics including everyday and symbolic violence in the local context (Bourgois et al., 2004; Fairbairn et al., 2008; Rhodes, 2009; Shannon et al., 2008). The dynamics of gendered power differentials within the context of injection initiation produce disproportionate risk for young women (compared to men) (Kerr et al., 2005; Novelli et al., 2005; Spittal et al., 2002). Male control of injecting also serves to reinforce male-domination within drug using culture, since men often maintain control of injecting equipment, the drugs and their administration (Shannon et al., 2008; Spittal et al., 2002). There is considerable evidence in the literature indicating that male control over resources within drug using cultures, including drugs and drug administration, is associated with elevated risks for women (Abelson et al., 2006; Bourgois et al., 2004; Bryant & Treloar, 2007; Fairbairn et al., 2006; Fuller et al., 2003; Kerr et al., 2006; Novelli et al., 2005; O'Connell et al., 2005; Rhodes & Cusick, 2000; Rhodes et al., 2005; Shannon et al., 2008; Spittal et al., 2002; Strathdee et al., 2001; Wood et al., 2003). These risks include HIV and Hepatitis C infection and other sexually transmitted infections, as well as bacterial infections, overdose, opiate withdrawal ('dope sickness'), and various forms of gendered violence.

A recent study by Shannon et al. (2008) demonstrated the culturally accepted practice of male partners controlling the supply of drug equipment and the administration of drugs, including the time and frequency of the women's use, while the women work to generate the income required to sustain the drug needs of both themselves and their partners. Shannon et al. also uncovered examples of intimate male partners' attempts to control women's working environment, thereby constraining women's agency, autonomy and ability to negotiate prevention strategies for HIV and other harms associated with injection drug use and street culture. For example, one participant in the study by Shannon et al. discussed how her male

partner would control the number of condoms she was allowed to carry during periods of commercial street-based sex work so that the male partner could ensure the woman was not taking in more money than the number of condoms provided would account for (Shannon et al., 2008).

Critical Perspectives on Power and Risk

As previously discussed, Shannon et al. (2008) and Fairbairn et al. (2008) view power through a broad critical post-structuralist lens. In actively resisting the dominant discourses of power and powerlessness, Shannon et al. and Bourgois et al. (2004) both apply a Foucaultian analysis (Foucault, 1981) and interpretation of micro-level decision making and the exercising of individual agency among women in the context of structural violence at the macro-level of the risk environment.

Since critical feminist approaches advance the objectives of identifying and addressing sources of oppression and power inequities (Rodney, Pauly & Burgess, 2004), the post-colonialist lens of *cultural safety* – an important and relevant critical stance in relation to the present work, and one which will be discussed in further depth in Chapter Four – assists us to draw our gaze toward inequities within social and political relationships among disenfranchised and historically oppressed people (Smye & Browne, 2002). From a risk environment perspective, the intersections between the cultural phenomena of young women's vulnerabilities to first time experiences with injecting drug use – via assisted injection by an intimate male partner in the context of gendered power inequalities – may have significant implications over time. For example, within the risk environment, interpersonal, cultural and structural conditions are produced which generate risk as women become more deeply entrenched in injection drug and street culture, and thus further stigmatized, socially marginalized and *othered*³ (Canales, 2000)

by dominant health and social structures and institutions (Bourgois et al., 1997; Bourgois et al., 2004; Rhodes et al., 2005; Vlahov, Fuller, Ompad, Galea & Des Jarlais, 2004). Consequently, access to services that are more likely to become increasingly important over time may be significantly constrained (Miller, Kerr et al., 2006; Miller, Strathdee et al., 2006; Novelli et al., 2005). Moreover, as argued earlier, risk of sustaining various forms of gendered violence, especially structural violence, may be increased as a consequence of initiating injection drug use (Fairbairn et al., 2008; Farmer et al., 2006; Shannon et al., 2008).

As Bourgeault (2006) notes, feminist medical sociology has sought to link the social structural aspects of a patriarchal system to the lived experience of oppressed individuals and groups, such as socially marginalized people who use drugs. The intersections of addiction and the social determinants of health – especially in relation to the historically situated social, economic and environmental factors described by MacPherson (2001) – requires a broader understanding of the health and health care experiences of oppressed and socially excluded persons who use injection drugs (Bourgeault).

Implications for Practice, Policy and Research

Women who use injection drugs tend to fall at the lower end of power distribution within the socially marginalized context of street culture (Shannon et al., 2008; Spittal et al., 2002). Since individual autonomy can only be viewed within the context of one's vulnerabilities within complex social relationships (Sherwin et al., 1998), it is through the interactiveness of relationships with others that the capacity or skill to exercise relational autonomy is either fostered or inhibited (Sherwin et al.). Disenfranchised people, such as individuals who use injection drugs, have been shown to have a high likelihood of underdeveloped capacity to negotiate individual autonomy within social relationships (Kral, Bluthenthal, Erringer, Lorvick

& Edlin, 1999; Spittal et al., 2002). This limited capacity to negotiate individual autonomy is likely to render people who are socially marginalized – especially women – more vulnerable to harms associated with environmental and structural risk as well as various forms of gendered violence. Therefore, in the present context, ‘curiosity’ as a motivation for injection initiation – more likely among men – can be seen as a more direct form of micro-level decision making and the exercising of individual self-agency (i.e., injection drug use in itself as an ‘end’). Conversely, the need for intimacy – more likely among women – can be seen as a more indirect motivation which involves a lesser degree of self-agency vis-à-vis injection initiation in and of itself (i.e., injection drug use as a ‘means to an end’ rather than a specific and deliberate objective). Greater understanding by health care and other service providers of factors that serve to constrain relational autonomy – for example, male control of women’s resources (i.e., income, drugs, condoms) and female dependence on men for protection from harm – would potentially help to create enabling environments for risk reduction and reduce barriers to service access. The lenses of risk environment and gendered violence assist us to better appreciate how women’s autonomy is constrained.

While men tend to be culturally stereotyped as *risk takers* (Charles & Walters, 2008) – a notion consistent with the present and previous findings of a greater propensity of men than of women to initiate injection drug use because of curiosity – the significantly greater driving influence of intimate relationships for women (compared to men) as a reason to initiate injection drug use, in spite of the associated environmental risks and vulnerabilities to gender power inequalities and gendered violence, is an area that demands further exploration and elucidation. A greater understanding among researchers, policy makers and service providers of factors and precursors that lead women into such relationships could provide insight into strategies for early

prevention and other public health measures. The concept of situated rationality is helpful in gaining appreciation for some of the complex relational dynamics that need to be considered. Further, it has been suggested that a discourse of illicit drug addiction as a health issue may serve to provide more accessible and factual information for young people, and demystify the associated underground sub-culture that tends to promote risky drug use (Kerr, Tyndall et al., 2007). Such an approach would have the potential to address issues of curiosity and reduce overall incidence rates of initiation, particularly among men.

Limitations

There are a number of limitations associated with this study. First, similar to other prospective cohort studies of persons who use injection drugs, VIDUS is not a random sample. However, previous studies have indicated that VIDUS is highly representative of persons who use injection drugs in the Downtown Eastside (Wood et al., 2000). Second, it should be noted that the drug-using population and socio-political climate in Vancouver are seen to be somewhat unique to those of other jurisdictions for a variety of reasons (Small, Palepu & Tyndall, 2006), which are not explored in depth here. For example, the political and social history that led to the opening of Vancouver's SIF – the first in North America – was shaped by a sequence of complex and interrelated events produced by a multitude of activities carried out by social justice advocates, drug user organizations, community service providers, policy makers, popular media, scholars and many other key actors to create conditions for social change and cultural transformation (Small et al.; MacPherson, 2001). This uniqueness would need to be considered in any future research conducted elsewhere. Third, data derived from the VIDUS cohort is based on self-report and, therefore, may be susceptible to a degree of socially desirable responding. Although some previous studies suggest that individuals who use injection drugs may

underreport undesirable behaviours (e.g., Ball, 1967), other studies conclude that self-reporting among people who use injection drugs generally has a high degree of validity and reliability (Darke, 1998). Furthermore, participants were blinded to this eventual use of the data. Thus, there is little reason to believe that these findings are biased. Fourth, the retrospective nature of the survey methods concerning first injection experiences may have been influenced by contextual and temporal factors, limiting the accuracy of participant recall of historical events. However, the present findings are supported by previous studies of youth from the same population (Miller, Strathdee et al., 2006), and therefore this is not a significant concern here.

Finally, because the scope of the present study is to examine gender differences, intimate partnerships were assumed to be heterosexual rather than same-sex relationships. While intimate partner violence and relational power related control are not exclusive to heterosexual partnerships, such interpersonal and relational power dynamics among VIDUS participants in same-sex partnerships have not been previously reported. Although there is no reason to believe that data from same-sex partnerships included in this study would be enough to result in significant over-reporting of gender differences, this is clearly an area for further examination.

Conclusion

The present study indicates that during first injection experiences, women were more likely than men to be injected by another individual – often an intimate partner. Further, women were less likely than men to identify curiosity as a reason for initiating injecting, but were more likely to report that they initiated injecting because they had an intimate partner who injected drugs. It may be that initiation is often a manifestation of situated rationality where the risks associated with injection drug use among women are essentially traded off as a way of meeting personal needs such as intimacy. Women were also less likely than men to be self-taught in self-

injection skills, and the high rate of received assisted injecting – a significant risk behaviour – reported by women in this study is concerning. The potential implications of micro and meso-level socially constructed gender power dynamics producing conditions of male domination and female subordination may constrain access to services that are likely to become increasingly important. Moreover, risk of sustaining various forms of gendered violence, especially structural violence, may be increased as a consequence of initiating injection drug use. Further exploration of factors that mediate women's ability to negotiate risk within intimate partner relationships is needed to better inform strategies that create enabling environments which foster greater cultural safety and relational autonomy, while reducing barriers to service access. Finally, addressing issues of curiosity through continuing to further shape the discourse of illicit drug addiction as a health issue, which may serve to demystify the associated underground drug sub-culture, has a potential to have an impact on overall incidence rates of injection drug use initiation among young people, especially among men. Finally, a greater understanding among researchers, policy makers and service providers of factors and precursors that lead women into such relationships could provide insight into strategies for early prevention and other public health measures.

Endnotes

¹ *Social capital*: "... is usually measured in terms of the social, collective, economic and cultural resources available to a network, neighbourhood or community" (Rhodes et al., 2005, p. 1032).

Social capital thus provides an ecological evaluation of differences in risk or health within communities or social networks, and of how well these communities and social networks respond to increased risk.

² *Social suffering* is a socially constructed concept that focuses:

on lived or social experience, which refers to the felt flow of engagements in a local world.... within which daily life takes place.... What defines all local worlds is the fact that something is at stake. Daily life matters, often deeply. People have something to gain or lose, such as status, money, life chances, health, good fortune, a job, or relationships. (Yang et al., 2007, p. 1528).

³ *Othering*: According to Canales (2000):

The self is only known through Others, and how Others are "marked" and "named" depends on the role taking of the self. How the Other is perceived, and how this role taking is enacted, has consequences for how the Other is defined" (p. 18). Othering is conceptualized in two categories of complex processes (although not strictly dichotomous or mutually exclusive): exclusionary and inclusionary. "[B]oth processes exist within the context of power and power relationships Exclusionary othering ... uses the power within relationships for domination and subordination.... [resulting in] alienation, marginalization, decreased opportunities, internalized oppression, and exclusion.... [whereas] Inclusionary othering ... attempts to utilize power within relationships for

transformation and coalition building.... [resulting in] consciousness raising, sense of community, shared power, and inclusion. (Canales, 2000, pp. 19-20).

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CHAPTER FOUR³:

Gender Differences in Factors Associated with Addiction Treatment Use:

A Gender Based Analysis of Risk Environment

Despite a rapidly mounting body of literature on the individual and social harms associated with injection drug use in general, and related harm reduction efforts by nurses and other public health workers, there remains limited published work focused on how the gender-specific contextual interplay of multi-level (micro, meso and macro) influences plays a role in the particular vulnerabilities faced by socially marginalized women who use injection drugs. Several individual risk factors for HIV and other injection related harms among women who use injection drugs have been identified, such as frequent cocaine use, requiring assistance with injecting, unsafe sex with a regular partner, having an HIV-positive partner, and being of Aboriginal ancestry, (Spittal et al., 2002). However, much less attention has been given to the broader socio-cultural, structural and environmental risk conditions in which marginalized women live and in which injection risk practices and treatment engagement behaviours occur.

Background

A study by Kerr, Marsh, Li, Montaner and Wood (2005) examining associations between methadone maintenance therapy (MMT) use and socio-demographic and drug-related variables found that female gender was positively associated with enrolment in MMT, whereas Aboriginal ancestry was negatively associated. However, with respect to a range of other addiction treatment options, Hankins (2008) argues that “since most addiction treatment programmes are designed with men drug users in mind as the predominant client, specific and sustained attention

³ A version of this chapter will be submitted for publication. Wood, R.A., Kerr, T., Lai, C., Montaner, J., & Wood, E. (2010). Gender Differences in Factors Associated with Addiction Treatment Use: A Gender Based Analysis of Risk Environment.

is urgently needed now to develop programmes which also serve the needs of the growing proportion of drug users worldwide who are women.” (p. 2). A greater awareness of how broader socio-cultural, structural and environmental influences shape our understanding of women’s injection practices would better inform gender-based health policy and strategies to improve access to gender-responsive addiction treatment programs.

In a study by McCance-Katz, Carroll, and Rounsaville (1999) involving people seeking treatment for cocaine addiction in the United States, many women were found to be as severely ill as men but received less addiction treatment services. In general, women report symptoms, seek help, and use health care services more than men (Kim & Fendrich, 2002; Tucker, Foushee & Simpson, 2009). Women often struggle with more severe drug-related and mental health issues compared to men and are more likely to identify their drug use as a problem (Kim & Fendrich). While Grella and Joshi (1999) found that self-initiated treatment enrolment among men who use drugs in the United States seems to be facilitated through social structures, such as employment, the criminal justice system and one’s family, treatment enrolment among women in the same cohort was associated more with referrals from social support agencies. Grella and Joshi suggest that contact with social service agencies may facilitate enrolment in addiction treatment more so among women compared with men. Success of such facilitation is likely influenced by the importance of child care responsibilities as a major factor affecting treatment enrolment for women (Kim & Fendrich; McCance-Katz et al.).

Purpose and Research Question

The purpose of this study is to build on previous findings using gender-based analysis – an evidence-based approach that takes into account how policies, programs, services and research impact differently on the lives of women and men (Canadian Institutes of Health

Research, 2007). Specifically, I sought to quantitatively examine gender differences in social, environmental and structural factors associated with being enrolled in addiction treatment among a cohort of people in Vancouver who use illicit injection drugs. Further, I explored these findings with respect to ethical implications for health policy and service delivery related to access to gender-sensitive and culturally safe addiction treatment services for people who use injection drugs in Vancouver.

Close collaboration with the Urban Health Research Initiative team (UHRI – previously described in detail in Chapter One) was essential to achieve my objectives within the context of a larger program of research from which data for secondary analysis were drawn. The UHRI team (comprised of co-supervisors, principle investigators, statisticians, methodology and research design experts, administrative staff and other researchers, research assistants, students, and front-line survey and data support staff) runs a number of cohort projects under an umbrella agency, the British Columbia Centre for Excellence in HIV/AIDS. One of the cohort projects is the Vancouver Injection Drug Users Study (VIDUS – also described in more detail in Chapter One and briefly described again below) from which cross-sectional participant data for the present study was drawn.

Theoretical Perspectives

Three main theoretical perspectives inform the present study: *the risk environment framework* (Rhodes, 2002); the concept of *intersections of gender and violence* (Bourgois et al., 2004, as cited in Fairbairn et al., 2008, pp. 817-818); and the lens of *cultural safety*, from a critical cultural perspective in keeping with the work of Smye and Browne (2002) and Browne & Varcoe, (2006). These particular theoretical lenses have been selected because they fit well with

a gender-based analysis and draw attention to the broader social, environmental and structural contextual features of women's lives that inform current understandings of injecting practices.

Risk Environment

Rhodes' *risk environment framework* is an articulation of the process of how various factors (for example, forms of gendered violence and *cultural risk*) function to produce poor health outcomes among marginalized women who use injection drugs (Rhodes, 2002). In the context of this framework, *risk environment* is defined as the social or physical space in which a range of factors, exogenous to the individual, interact across the *micro* (individual/interpersonal), *meso* (local/social), and *macro* (structural/institutional, for example, political or economic) dimensions of the broader risk environment in which risk and harm are produced and reproduced (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005). This range of factors exogenous to the individual includes: peer groups and social networks; injecting environments; neighbourhood-level deprivation and disadvantage; social stigma and discrimination; policies (for example, archaic addiction treatment models, designed with men in mind, that lack gender sensitivity and fail to consider needs from women's perspectives – such as access to children or reproductive health services – within treatment environments), laws, and policing; and *social capital*³. Such factors operating within a specific local context can exert significant influence upon the course of disease outbreaks and other forms of harm among vulnerable groups, and can mediate the effectiveness of public health and prevention interventions (Galea, Ahern & Vlahov, 2003; Galea & Vlahov, 2002; Karpati, Galea, Awerbuch & Levins, 2002). Factors, such as those mentioned above, within the risk environment that contribute to delayed or constrained access to appropriate addiction treatment services produce risk and harm, and are areas of central focus in this present study. Overlaying the risk environment is the concept of *intersections of gender and violence*.

Gendered Violence

Multi-layered forms of gendered violence have been described within a conceptual framework by Bourgois et al. (2004) in their ethnographic study of HIV risk among young people in San Francisco who are homeless and use heroin. More recently, the conceptual framework described by Bourgois et al. was employed by Fairbairn et al. (2008) in their examination of the mediating influence of Vancouver's supervised injection facility (SIF) on the impact of violence among street-involved women who use injection drugs. This, the second conceptual perspective informing the present study, is comprised of three theoretical classifications of gendered violence: *everyday* (or interpersonal); *symbolic*; and *structural*. These classifications, or *layers* of gendered violence have been applied within public health contexts to elucidate the historical, political, economic and cultural dimensions of gendered experiences of health and illness (Bourgois et al.; Shannon et al., 2008). Bourgois et al. assert that such a theoretical lens allows for a linking of individual risk behaviours, "... commonly associated [among mainstream society] with ignorance, psychopathology or immorality, to larger social power relations [such as addiction treatment service organizations] as well as to pragmatic constraints for survival as a street addict" (p. 254).

Everyday violence. In their recent qualitative study, Shannon et al. (2008) document the pervasiveness of everyday violence and gender power relations among women in Vancouver who use drugs and engage in survival sex work. Based on the term coined by Scheper-Hughes (1996), and informed by the work of Kleinman (1988), Kleinman, Das and Lock (1997), and Bourgois, Lettiere and Quesada (1997) on social suffering², Shannon et al. use everyday violence to refer to the "...normalization of violence that renders it invisible due to its routine pervasiveness" (p. 914). In other words, everyday violence refers to those tacit interpersonal

aspects of gendered violence which are invisible or unrecognized by those upon whom they are perpetrated – in particular, women (Bourgois et al., 2004). Within a micro-level risk environment context, such conditions of everyday violence constrain women's agency in negotiating risk avoidance (for example, accessing addiction treatment services) and risk reduction strategies (for example, accessing safer injection assistance). Consequently, socially marginalized women who use injection drugs bear a disproportionate burden of infectious disease and gendered violence, including everyday violence, compared to their male counterparts (Bourgois et al.; Spittal et al., 2002). Because everyday violence is normalized and embedded within the daily lives of street-entrenched women, it is easily reinforced by means of symbolic violence.

Symbolic violence. Drawing on the work of Bourdieu (2001) and Epele (2002), Fairbairn et al. (2008) regard symbolic violence as rooted in a male-dominated street culture – a culture that can be regarded as a less subtle microcosmic reflection of larger social structures and institutions in general – that situates women in subordinate positions with respect to control of resources (for example, money/income, drugs, intimacy or access to harm reduction and other addiction treatment services, mental health support and health care services) and dependence on men for protection from harm by others through submission to a role that is akin to that of a man's 'property'. Symbolic violence is often systemic in nature and can be a means of excluding women from more senior levels of power within the hierarchy of street and drug culture. To a large extent, this means of exclusion operates within the meso-level of local social and group interactions by influencing perceptions of group 'norms' regarding what constitutes acceptable female roles and injecting practices (Rhodes, 2005). These social group norms are often determined along gender lines and limit women's abilities to control resources derived through illicit drug trade, commercial sex trade work or other sources of income generation (Fairbairn et

al., 2008). Thus, women's abilities to access health care services and harm reduction measures, such as supplies of condoms or clean syringes, are constrained. Further compounding difficulties in accessing health care and harm reduction services are various forms of structural violence.

Structural violence. Farmer (1997; 1999; 2000; 2004) regarded structural violence as the broader political and economic gendered power imbalances that, within the macro-level risk environment context, result in the social marginalization of women who use injection drugs, and that limit access to basic services (for example, health care, addiction treatment and social services) (Farmer, Nizeye, Stulac & Keshavjee, 2006). Moreover, Shannon et al. (2008) viewed power through a broader post-structuralist lens that, against the dominant backdrop of more traditional discourses of power and powerlessness, draws on Foucaultian critical thought to foreground micro-level decision making processes and the exercising of individual agency (Foucault, 1981; Shannon et al.). Also related to the discussion by Bourgois et al. of HIV risk among young people who use injection drugs in San Francisco, Foucault's term biopower refers to historically entrenched and institutionalized forms of social-structural power and control that serve to discipline human bodies and constrain individual agency (Foucault, 1982). Foucault, a prominent French philosopher and historian during the last half of the 20th century, saw the western medicalization of human conditions (for example, areas of women's reproductive health) as forms of biopower and disciplinary tools for state control of persons who did not conform to the dominant views of the powerful social elite (Foucault, 1981). Foucaultian critical thought was popular with many feminist groups and, while not a direct precursor, reflected several similarities with the concept of cultural safety.

Cultural Safety

The third theoretical perspective that informs the current study is *cultural safety*. Since critical feminist approaches (including post-colonialist views) advance the objectives of identifying and addressing sources of oppression and power inequities (Rodney, Pauly & Burgess, 2004), the lens of *cultural safety* assists us to draw attention toward addressing social and structural inequities that shape health and health care (Smye & Browne, 2002). Cultural safety is an important and relevant critical stance in relation to this present work, particularly for those persons historically marginalized by inequity. In the context of the present analysis, cultural safety refers to an interpretive lens, informed by critical perspectives, through which I critically examine, reflect upon, and question dominant discourses in health and social policies, practices and attitudes that recreate or perpetuate inequities within social and political relationships with women who use injection drugs (Polashek, 1998; Ramsden, 1993; Smye & Browne). This interpretive lens helps to elucidate how dominant social policy discourses are associated with significantly lower rates of enrolment in addiction treatment services among people of Aboriginal ancestry compared with persons who are non-Aboriginal. From a risk environment perspective, the intersections between socio-demographic, or *cultural* variables (Constantine, 2002) such as gender, ethnicity and age, as well as stigma and social marginalization, may have significant implications related to a lack of cultural safety. For example, policies and/or practices within health care and addiction treatment services that negatively impact people's perceptions of cultural safety can lead to *cultural risk*.

Cultural risk – a sense of being “... demeaned, diminished or disempowered by the actions and the delivery systems ...” (Ramsden & Spoonley, 1993, p. 164), - is of particular relevance in contributing to the vulnerability among those who are, or are becoming entrenched

in various aspects of street culture (Novelli, Sherman, Havens, Strathdee & Sapun, 2005). An increased likelihood of subsequent high risk injection related behaviours, such as binge use, syringe sharing, injection by other individuals, sex work, and criminalization – all of which are known to increase the risk of infection, disease transmission and overdose (Miller, Kerr et al., 2006; Miller, Strathdee, Kerr, Li & Wood, 2006; Novelli et al.) – render street entrenched individuals more vulnerable to cultural risk. Structural and institutional discriminatory practices both result in, and produce cultural risk as manifested by barriers to accessing health care, social services, housing or employment. Further, risk of sustaining various forms of gendered violence may be perpetuated as a consequence of inadequate opportunities and/or constrained access to culturally safe addiction treatment services and health care, particularly for women (Bourgois et al., 1997; Bourgois et al., 2004; Fairbairn et al., 2008; Farmer et al., 2006; Shannon et al., 2008). It is not surprising then that perceptions of cultural risk may form a basis upon which the lack of culturally safe addiction treatment programs that could meet participants' needs is commonly given by many individuals who use injection drugs as a reason for not being enrolled in addiction treatment (Kim & Fendrich, 2002).

Intersections of Cultural Variables

The substantial body of literature related to gendered aspects of injection drug use and street culture provides numerous illustrations of the intersections of gendered interpersonal, environmental, structural, and cultural variables, factors or influences. For example, a recent study by Wood et al. (2008) found that, among a cohort of persons who use injection drugs in Vancouver's Downtown Eastside, 26% of non-Aboriginal individuals are women, whereas 52% of Aboriginal individuals are women. Findings such as these and others (see also Anderson et al., 2003; Bourgois et al., 2004; Bryant & Treloar, 2007; Epele, 2002; Fairbairn et al., 2008; Fuller et

al., 2003; Kerr et al., 2007; Kral, Bluthenthal, Erringer, Lorvick & Edlin, 1999; Major & O'Brien, 2005; Marshall, Fairbairn, Li, Wood & Kerr, 2008; Measham, 2002; Miller, Strathdee et al., 2006; Novelli et al., 2005; O'Connell et al., 2005; Ompad et al., 2005; Pederson & Raphael, 2006; Rhodes et al., 2005; Scheper-Hughes, 1996; Shannon et al., 2008; Smye & Browne, 2002; Spittal et al., 2002; Varcoe, 2004; Wood et al., 2003; Yang et al., 2007) illustrate the intersecting forms of oppression (such as gender, age, ethnicity, history, poverty, stigma, social marginalization, and entrenchment in street culture and its associated cultural norms) and the relevance of cultural safety – and cultural risk – in the context of the dominant health care culture (Browne, Smye & Varcoe, 2005; Varcoe; Wood et al., 2008). Cultural safety as an interpretive lens positioned within critical theoretical perspectives, draws attention to the multiple intersecting contexts of risk environments and layered forms of gendered violence.

An example of structural violence can be found in the form of certain views of methadone maintenance therapy (MMT) programs – a longstanding pillar of state and medically controlled harm reduction over the past half century which provide opiate substitution for people addicted to heroin. Keane (2009), in her Foucaultian critical discourse analysis of four works related to MMT (Bourgois, 2000; Bull, 2008; Fraser & Valentine, 2008; Friedman & Alicea, 2001), found a common thematic view that MMT is a tightly regulated technology with the intent to turn people who use drugs into “productive and obedient subjects” (p. 450). Keane discusses how the Foucaultian concepts of disciplinary power, biopower and governmentality are depicted throughout these four works in the context of MMT.

In contrast to these views however, is the assertion that over the past couple of decades, the degree to which disciplinary power, biopower and governmentality are manifested through MMT has lessened considerably through broad expansion of this harm reduction approach and a

lowering of barriers to MMT access, particularly in British Columbia (Fischer, 2000). While increased access to MMT has been generally welcomed within the addiction treatment field, there remain inequities in access associated with certain socio-demographic variables such as race (for example, people of aboriginal ancestry who are opiate dependent are substantially less likely to enrol in, or maintain enrolment in MMT) (Kerr et al., 2005; Kerr, Wodak, Elliot, Montaner & Wood, 2004), and there continue to be calls for public health measures to further reduce barriers and increase access (Fischer; Keane, 2009; Kerr et al., 2004; Kerr et al., 2005).

The present analysis is well situated within post-structural critiques of public health and drug policy that consider ways in which individuals are governed through messages of self-regulation and risk-avoidance as a form of neoliberal governmentality (Moore, 2004; Petersen & Lupton, 1996). These interwoven conceptual perspectives of risk environment, gendered violence and cultural safety begin to provide a multifaceted contextual view of the social, structural and environmental factors associated with being enrolled in addiction treatment among people in Vancouver who use injection drugs. This multifaceted view serves to inform and guide the present analysis, integration and interpretation of quantitative examinations of gender differences in perceptions among marginalized people who use injection drugs regarding access, safety and risk related to enrolment in addiction treatment services.

Methods

The Vancouver Injection Drug User Study

A cross-sectional survey approach was used to identify gender differences in factors associated with being enrolled in addiction treatment among participants of the Vancouver Injection Drug User Study (VIDUS) cohort. VIDUS is an open prospective cohort study of over 1,500 individuals who use injection drugs, recruited since 1996 from Vancouver's Downtown

Eastside. This cohort has been described in detail previously (Spittal et al., 2002; Strathdee et al., 1997; Tyndall et al., 2001). In brief, persons were eligible for inclusion in VIDUS if they reported injecting illicit drugs at least once within the previous month, and were residents of Vancouver. Baseline and semi-annual interviewer-administered questionnaires are completed with all participants and blood samples are drawn for diagnostic screening. Through the questionnaire, demographic data as well as information regarding drug use patterns, HIV risk behaviour, and drug treatment engagement are obtained. Informed consent is obtained and a stipend (\$20 Cdn) is provided at each study visit to reimburse participants for time, transportation and other costs related to study participation. The study is approved annually by the Providence Health Care/University of British Columbia Research Ethics Board. VIDUS has been highly successful in terms of follow-up rates – more than 85% of participants have been retained in follow-up since the study was initiated (Kerr et al., 2005). Approximately 40% of the cohort are women (Miller et al., 2005; Wood et al., 2005).

Analysis

The key dependent (outcome) variable of interest is *current enrolment in addiction treatment*, defined as participation in any type of addiction treatment listed in Table 6 below. Socio-demographic variables among participants included: current age; age at first injection; Aboriginal ancestry (First Nations/Inuit/Métis – yes versus no); housing (i.e.: current homelessness, defined by Rachlis, Wood, Zhang, Montaner & Kerr (2009) as having no fixed address or living on the street, in a shelter or hostel, or ‘couch surfing’ – unstable, transitional short-term shelter arrangements with relatives, friends or acquaintances – yes versus no); and current marital status (yes – legally married/common law or regular partner not living together, but together over 3 months versus no – separated/divorced/widowed/no partner/single).

Variables of interest related to drug-using risk behaviours among participants included: mental illness diagnosis (ever – yes versus no); history of sexual abuse (ever – yes versus no); degree of alcohol (past six months – ≥ 4 drinks per day average – yes versus no), injection heroin and injection cocaine use (past six months – \geq daily versus $<$ daily); syringe sharing (past six months – yes versus no); binge drug use (past six months – yes versus no); history of overdose (ever – yes versus no); frequency of supervised injection facility (SIF) use (past six months, proportion of injections performed – ‘most’ or ‘all’: $\geq 75\%$ versus ‘none’, ‘few’ or ‘some’: $< 75\%$); history of incarceration (past six months – yes versus no); sex trade involvement (past six months – yes versus no); drug dealing (past six months – yes versus no); and HIV status (sero-positive – yes versus no). To evaluate gender differences in factors associated with being enrolled in addiction treatment, the study sample was stratified into groups based on current enrolment in addiction treatment. Bivariate statistical analyses were conducted separately for women and for men to determine the relevant associations between independent variables. Pearson’s chi-square was used to test for statistical significance of associations – set *a priori* at $p \leq 0.05$; all are two-sided.

As a next step, we fit separate multivariate logistic regression models for women and for men to examine the adjusted odds of current enrolment in addiction treatment for each gender. The models described above were fit using the *a priori* defined model building protocol of adjusting for all variables that were statistically significant at the $p \leq 0.05$ level in bivariate analyses. The Wald test was used to determine statistical significance in multivariate analysis.

In addition, we also conducted simple univariate analyses, using descriptive statistical methods, to examine types of addiction treatment engagement among participants currently enrolled in addiction treatment, and reasons reported for non-enrolment in addiction treatment

among participants not currently enrolled in addiction treatment. Both these additional analyses were stratified by gender.

Results

Between May 2005 to December 2007, 1,436 participants were surveyed, including 496 (34.5%) women, of whom 239 (48.2%) reported being of Aboriginal ancestry, and 940 (65.5%) men, of whom 222 (23.6%) reported being of Aboriginal ancestry. The median current age at the time of survey was 39.5 years for women (IQR: 31.5 – 44.9), and 43.2 years for men (IQR: 37.6 – 48.8). Among all participants surveyed, 597 (41.6%) reported current enrolment in addiction treatment (Table 1), including 220 (44.4%) women, of whom 89 (40.5%) were of Aboriginal ancestry, and 377 (40.1%) men, of whom 69 (18.3%) were of Aboriginal ancestry.

Table 1: Current addiction treatment enrolment by gender

Gender	Enrolled in Treatment		<i>N</i>
	Yes (%)	No (%)	
Women	220 (44.4%)	276 (55.6%)	(<i>n</i> = 496)
Men	377 (40.1%)	563 (59.9%)	(<i>n</i> = 940)
Total (%)	597 (41.6%)	839 (58.4%)	(<i>N</i> = 1436)

As indicated in Table 2, the median age among female participants enrolled in addiction treatment was 40.2 years (IQR: 32.9 – 45.7) compared to 38.7 years (IQR: 30.1 – 44.1) among female participants not enrolled. The median number of years since first injection among female participants enrolled in addiction treatment was 22.2 years compared to 19.7 years among female participants not enrolled – a difference of 2.5 years longer among women enrolled in addiction treatment compared to women not enrolled.

Table 2: Factors associated with current addiction treatment use among women who use injection drugs

Characteristic	Enrolled in Treatment		Odds Ratio (95% CI)	<i>p</i> - value
	Yes	No		
Median current age	40.2	38.7	—	
(per year older) (IQR*)	(32.9 – 45.7)	(30.1 – 44.1)	—	0.003
Median Age at first injection	18.0	19.0	—	
(IQR*)	(15.0 – 24.0)	(15.0 – 25.0)	—	0.027
Aboriginal ancestry				
Yes	89 (40%)	150 (54%)	0.57 (0.40 – 0.82)	0.002
No	131 (60%)	126 (46%)		
Homelessness - current				
Yes	29 (13%)	70 (25%)	0.45 (0.28 – 0.72)	0.001
No	191 (87%)	206 (75%)		
Married - current				
Yes	104 (47%)	100 (36%)	1.58 (1.10 – 2.26)	0.013
No	116 (53%)	176 (64%)		
Mental illness diagnosis [†]				
Yes	121 (55%)	141 (51%)	1.17 (0.82 – 1.67)	0.386
No	99 (45%)	135 (49%)		
Sexually abused [†]				
Yes	92 (42%)	110 (40%)	1.08 (0.76 – 1.56)	0.658
No	128 (58%)	166 (60%)		
Daily alcohol use [‡]				
Yes	54 (25%)	76 (28%)	0.86 (0.57 – 1.28)	0.452
No	166 (75%)	200 (72%)		
Daily heroin injection [‡]				
Yes	46 (21%)	117 (42%)	0.36 (0.24 – 0.54)	< 0.001
No	174 (79%)	159 (58%)		
Daily cocaine injection [‡]				
Yes	23 (10%)	43 (16%)	0.63 (0.37 – 1.09)	0.097
No	197 (90%)	233 (84%)		
Syringe Borrowing [‡]				
Yes	10 (5%)	23 (8%)	0.52 (0.24 – 1.13)	0.097
No	210 (95%)	253 (92%)		
Syringe Lending [‡]				
Yes	9 (4%)	16 (6%)	0.69 (0.30 – 1.60)	0.390
No	211 (96%)	260 (94%)		
Binge drug use [‡]				
Yes	43 (20%)	54 (20%)	1.00 (0.64 – 1.56)	0.996
No	177 (80%)	222 (80%)		

(Continued ...)

Characteristic	Enrolled in Treatment		Odds Ratio (95% CI)	<i>p</i> - value
	Yes	No		
Overdose [†]				
Yes	14 (6%)	26 (9%)	0.65 (0.33 – 1.28)	0.217
No	206 (94%)	250 (91%)		
SIF Frequency ^{‡§}				
Yes	28 (13%)	32 (12%)	1.11 (0.65 – 1.91)	0.701
No	192 (87%)	244 (88%)		
Incarceration [‡]				
Yes	28 (13%)	48 (17%)	0.69 (0.42 – 1.15)	0.153
No	192 (87%)	228 (83%)		
Sex trade involvement [‡]				
Yes	79 (36%)	100 (36%)	0.99 (0.68 – 1.43)	0.941
No	141 (64%)	176 (64%)		
Drug dealing [‡]				
Yes	54 (25%)	85 (31%)	0.73 (0.49 – 1.09)	0.124
No	166 (75%)	191 (69%)		
HIV-positive				
Yes	73 (33%)	85 (31%)	1.12 (0.76 – 1.63)	0.571
No	147 (67%)	191 (69%)		
* Interquartile Range				
† Refers to lifetime occurrence				
‡ Refers to activities during the past six months				
§ ≥ 75% of injections performed at the SIF				

Being married or having an intimate partner was the only statistically significant factor positively associated with being enrolled in addiction treatment among women (OR = 1.58; 95% CI: 1.10 – 2.26). Factors negatively associated with being enrolled in addiction treatment among women included: Aboriginal ancestry (OR = 0.57; 95% CI: 0.40 – 0.82); homelessness (OR = 0.45; 95% CI: 0.28 – 0.72); and frequent heroin injection during the past six months (OR = 0.36; 95% CI: 0.24 – 0.54). None of the other variables considered in this study were significant at the $p \leq 0.05$ level in relation to female gender.

Table 3 shows multivariate logistic regression analyses of variables found to be statistically significant among women in bivariate examination (Table 2 above). Factors positively associated with being enrolled in addiction treatment among women included age at

first injection (AOR = 1.03; 95% CI: 1.01 – 1.06) and being married or having an intimate partner (AOR = 1.59; 95% CI: 1.08 – 2.34). Factors negatively associated with being enrolled in addiction treatment among women included Aboriginal ancestry (AOR = 0.55; 95% CI: 0.37 – 0.80), homelessness (AOR = 0.54; 95% CI: 0.33 – 0.90), and frequent heroin injection during the past six months (AOR = 0.37; 95% CI: 0.24 – 0.57).

Table 3: Logistic regression analysis of factors associated with current addiction treatment use among women who use injection drugs

Variable	Adjusted Odds Ratio (AOR)	95% Confidence Interval (95% CI)	<i>p</i> - value
Current age (median)	0.99	0.96 – 1.01	0.23
Age at first injection	1.03	1.01 – 1.06	0.02
Aboriginal (yes vs. no)	0.55	0.37 – 0.80	< 0.01
Homeless – current (yes vs. no)	0.54	0.33 – 0.90	0.02
Married/Intimate partner – current (yes vs. no)	1.59	1.08 – 2.34	0.02
Daily heroin injection [‡] (yes vs. no)	0.37	0.24 – 0.57	< 0.01
[‡] Refers to activities during the past six months			

Table 4 shows the bivariate results for the same variables as in Table 2 above in relation to men. The median age among male participants enrolled in addiction treatment was 43.9 years (IQR: 36.9 – 49.8) compared to 42.5 years (IQR: 38.3 – 47.9) among male participants not enrolled. The median number of years since first injection among male participants enrolled in addiction treatment was 25.9 years compared to 22.5 years among male participants not enrolled – a difference of 3.4 years longer among men enrolled in addiction treatment compared to men not enrolled.

Table 4: Factors associated with current addiction treatment use among men who use injection drugs

Characteristic	Enrolled in Treatment		Odds Ratio (95% CI)	p- value
	Yes	No		
Median current age	43.9	42.5	—	
(per year older) (IQR*)	(36.9 – 49.8)	(38.3 – 47.9)	—	0.001
Median Age at first injection	18.0	20.0	—	
(IQR*)	(15.0 – 23.0)	(16.0 – 28.0)	—	< 0.001
Aboriginal				
Yes	69 (18%)	153 (27%)	0.60 (0.44 – 0.83)	0.002
No	308 (82%)	410 (73%)		
Homelessness - current				
Yes	55 (15%)	164 (29%)	0.42 (0.30 – 0.58)	< 0.001
No	322 (85%)	399 (71%)		
Married - current				
Yes	103 (27%)	136 (24%)	1.18 (0.88 – 1.59)	0.275
No	274 (73%)	427 (76%)		
Mental illness diagnosis [†]				
Yes	166 (44%)	208 (37%)	1.34 (1.03 – 1.75)	0.030
No	211 (56%)	355 (63%)		
Sexually abused [†]				
Yes	281 (75%)	414 (74%)	1.05 (0.78 – 1.42)	0.732
No	96 (25%)	149 (26%)		
Daily alcohol use [‡]				
Yes	93 (25%)	183 (33%)	0.68 (0.51 – 0.91)	0.010
No	284 (75%)	380 (67%)		
Daily heroin injection [‡]				
Yes	65 (17%)	181 (32%)	0.44 (0.32 – 0.61)	< 0.001
No	312 (83%)	382 (68%)		
Daily cocaine injection [‡]				
Yes	38 (10%)	63 (11%)	0.89 (0.58 – 1.36)	0.590
No	339 (90%)	500 (89%)		
Syringe Borrowing [‡]				
Yes	22 (6%)	37 (7%)	0.88 (0.51 – 1.52)	0.648
No	355 (94%)	526 (93%)		
Syringe Lending [‡]				
Yes	16 (4%)	26 (5%)	0.92 (0.48 – 1.73)	0.786
No	361 (96%)	537 (95%)		
Binge drug use [‡]				
Yes	72 (19%)	120 (21%)	0.87 (0.63 – 1.21)	0.409
No	305 (81%)	443 (79%)		

(Continued ...)

Characteristic	Enrolled in Treatment		Odds Ratio (95% CI)	<i>p</i> - value
	Yes	No		
Overdose [†]				
Yes	22 (6%)	40 (7%)	0.81 (0.47 – 1.39)	0.443
No	355 (94%)	523 (93%)		
SIF Frequency ^{‡§}				
Yes	41 (11%)	90 (16%)	0.64 (0.43 – 0.95)	0.027
No	336 (89%)	473 (84%)		
Incarceration [‡]				
Yes	70 (19%)	104 (18%)	1.01 (0.72 – 1.41)	0.971
No	307 (81%)	459 (82%)		
Sex trade involvement [‡]				
Yes	6 (2%)	13 (2%)	0.68 (0.26 – 1.82)	0.446
No	371 (98%)	550 (98%)		
Drug dealing [‡]				
Yes	129 (34%)	181 (32%)	1.10 (0.83 – 1.45)	0.509
No	248 (66%)	382 (68%)		
HIV-positive				
Yes	103 (27%)	143 (25%)	1.10 (0.82 – 1.48)	0.511
No	274 (73%)	420 (75%)		
* Interquartile Range				
† Refers to lifetime occurrence				
‡ Refers to activities during the past six months				
§ ≥ 75% of injections performed at the SIF				

Being diagnosed with a mental illness was the only statistically significant factor positively associated with being enrolled in addiction treatment among men (OR = 1.34; 95% CI: 1.03 – 1.75). Factors negatively associated with being enrolled in addiction treatment among men included: Aboriginal ancestry (OR = 0.60; 95% CI: 0.44 – 0.83); homelessness (OR = 0.42; 95% CI: 0.30 – 0.58); frequent alcohol use during the past six months (OR = 0.68; 95% CI: 0.51 – 0.91); frequent heroin injection during the past six months (OR = 0.36; 95% CI: 0.24 – 0.54); and frequent use of SIF services (OR = 0.64; 95% CI: 0.43 – 0.95). None of the other variables considered in this study were found to be statistically significant in bivariate analysis at the $p \leq 0.05$ level in relation to male gender.

In multivariate logistic regression analysis, identical to that for women as described above (Table 3), Table 5 shows factors associated with current addiction treatment use among men. Age at first injection was the only factor positively associated with being enrolled in addiction treatment among men (AOR = 1.05; 95% CI: 1.03 – 1.06) at the $p \leq 0.05$ level of significance. Factors negatively associated with being enrolled in addiction treatment among men included: Aboriginal ancestry (AOR = 0.59; 95% CI: 0.42 – 0.83); homelessness (AOR = 0.47; 95% CI: 0.32 – 0.67); frequent alcohol use during the past six months (AOR = 0.60; 95% CI: 0.44 – 0.82); and frequent heroin injection during the past six months (AOR = 0.48; 95% CI: 0.34 – 0.69). Multivariate analyses showed no statistical significance at the $p \leq 0.05$ level for current age among either women or men, nor did it show mental illness diagnosis and frequency of SIF service use to be statistically significant at the $p \leq 0.05$ level among men.

Table 5: Logistic regression analysis of factors associated with current addiction treatment use among men who use injection drugs

Variable	Adjusted Odds Ratio (AOR)	95% Confidence Interval (95% CI)	<i>p</i> - value
Current age (median)	0.99	0.97 – 1.00	0.12
Age at first injection	1.05	1.03 – 1.06	0.02
Aboriginal (yes vs. no)	0.59	0.42 – 0.83	< 0.01
Homeless – current (yes vs. no)	0.47	0.32 – 0.67	< 0.01
Mental illness diagnosis [†]	1.19	0.90 – 1.58	0.23
Daily alcohol use [‡] (yes vs. no)	0.60	0.44 – 0.82	< 0.01
Daily heroin injection [‡] (yes vs. no)	0.48	0.34 – 0.69	< 0.01
SIF Frequency ^{‡§} (yes vs. no)	0.84	0.55 – 1.28	0.41

[†] Refers to lifetime occurrence
[‡] Refers to activities during the past six months
[§] $\geq 75\%$ of injections performed at the SIF

Table 6 shows simple descriptive statistical analysis of types of current addiction treatment use for women and men. The most common type of addiction treatment reported among both women and men by far was methadone maintenance therapy (MMT – 90.5% and 84.1% respectively). Reported engagement with an addiction counsellor was the second most common type of addiction treatment reported and was approximately the same for both women and men (11.8% and 11.1% respectively). Self help groups were the third most commonly reported type of addiction treatment for both genders. However, women reported participation in groups such as Narcotics Anonymous (NA), Cocaine Anonymous (CA), or Alcoholics Anonymous (AA) less often than men (5.9% and 12.2% respectively).

Table 6: Type of current addiction treatment enrolment by gender

Type of Treatment	Women (%) (n = 220)*	Men (%) (n = 377)*	Total (%) (N = 597)*
Detox/Youth Detox	2 (0.9%)	12 (3.2%)	14 (2.3%)
Daytox	0 (0.0%)	1 (0.3%)	1 (0.2%)
Recovery House	6 (2.7%)	20 (5.3%)	26 (4.4%)
Treatment Centre	1 (0.5%)	3 (0.8%)	4 (0.7%)
Counselor	26 (11.8%)	42 (11.1%)	68 (11.4%)
NA/CA/AA	13 (5.9%)	46 (12.2%)	59 (9.9%)
Methadone Program	199 (90.5%)	317 (84.1%)	516 (86.4%)
Cocaine Treatment Program	0 (0.0%)	1 (0.3%)	1 (0.2%)
Residential, Therapeutic Community	0 (0.0%)	4 (1.1%)	4 (0.7%)
Other Out-Patient Treatment Program	1 (0.5%)	2 (0.5%)	3 (0.5%)
* Total numbers of participants and percentages for all types of addiction treatments listed exceeds the actual numbers of participants in the samples (number of participants reported for all types of treatment > n; > 100%) due to some participants reporting more than one concurrent type of addiction treatment.			

Table 7 indicates the frequency of a number of reasons reported for non-enrolment in addiction treatment during the past six months for women and men. Women most commonly reported previous temporary or intermittent enrolment in addiction treatment at some time during the past six months (25.0% versus 8.5% for men). The most commonly reported reason given by women who had not participated in treatment during the past six months was ‘don’t feel a need

to stop using drugs' (20.7% compared to 22.4% among men). The most commonly reported reason given by men who had not participated in treatment during the past six months was 'don't think treatment programs work for me' (25.2% compared to 19.9% for women). Women reported 'can handle it on my own' as a reason for non-enrolment less often than men (12.3% versus 18.6% respectively) and women also denied having 'a problem with drugs' less often than men (11.2% versus 15.1% respectively).

Table 7: Reasons reported for non-enrolment in addiction treatment during prior 6 months by gender

Reported Reason[†]	Women (%) (n = 276)	Men (%) (n = 563)	Total (%) (N = 839)
Waiting List	6 (2.2%)	20 (3.6%)	26 (3.1%)
Don't know of any programs	0 (0.0%)	3 (0.5%)	3 (0.4%)
Turned down by program	2 (0.7%)	4 (0.7%)	6 (0.7%)
No treatment program nearby	2 (0.7%)	1 (0.2%)	3 (0.4%)
Don't have type of program I need/want	5 (1.8%)	1 (0.2%)	6 (0.7%)
Can't afford the fees	2 (0.7%)	1 (0.2%)	3 (0.4%)
Behavioural problems	3 (1.1%)	5 (0.9%)	8 (0.9%)
Failed too many times	6 (2.2%)	2 (0.4%)	8 (0.9%)
Habit is affordable	3 (1.1%)	16 (2.8%)	19 (2.3%)
Don't feel a need to stop using drugs	57 (20.7%)	126 (22.4%)	183 (21.8%)
Can handle it on my own	34 (12.3%)	105 (18.6%)	139 (16.6%)
Treatment is for weak people	0 (0.0%)	3 (0.5%)	3 (0.4%)
Don't think treatment programs work for me	55 (19.9%)	142 (25.2%)	197 (23.5%)
Concerned about family (losing kids/spouse)	1 (0.4%)	1 (0.2%)	2 (0.2%)
Don't have a problem with drugs	31 (11.2%)	85 (15.1%)	116 (13.8%)
N/A – was in treatment intermittently in past 6 months [‡]	69 (25.0%)	48 (8.5%)	117 (13.9%)

[†] Refers to non-participation in addiction treatment during the previous six months.
[‡] Several participants reported prior temporary addiction treatment enrolment during the previous six months.

Discussion

The present study found that 44.4% of female participants and 40.1% of male participants reported being in some form of addiction treatment. The vast majority of both female and male participants in treatment reported MMT as the primary type of addiction treatment, although a higher proportion of women reported being enrolled in this type of treatment. Methadone is a

long-acting opiate agonist, allowing for once daily oral administration for blocking the effects of opiate withdrawal symptoms (Greenstein, Fudala & O'Brien, 1997). Although some methadone treatment programs are somewhat restrictive, MMT remains one of the longest standing and accepted methods of evidence-based harm reduction and addiction treatment for opioid addiction (Keane, 2009; Kerr et al., 2005). Indeed, there have been ongoing calls to for further expansion of 'low-threshold' methadone programs which reduce barriers – such as structural medical and state control – to MMT in a variety of settings (Keane; Kerr et al.).

The positive associations between female gender and being enrolled in treatment are strongest among those enrolled in MMT, for which the largest gender difference (6.4%) was observed. However, findings from the present study also indicate that participants who self-identified as Aboriginal were just over half as likely as non-aboriginal participants to be enrolled in any type of addiction treatment. Moreover, among treatment enrolled participants of Aboriginal ancestry, men were enrolled at less than half the rate of their female counterparts. These findings related to associations between treatment enrolment and the variables of gender and race are consistent with those observed previously by Kerr et al. (2005) as part of a larger body of research which draws on the cross-sectional and longitudinal nature of the VIDUS cohort data.

The finding that people who identified as Aboriginal, particularly men, were significantly less likely to be enrolled in treatment than non-aboriginal individuals demonstrates how the intersections of gender and Aboriginal ancestry further compound existing economic and political power differentials (Browne et al., 2008) and leads to reductions in social capital – the degree to which social, economic and cultural resources can be used to respond to increased risk within a group or community (Rhodes et al., 2005). While the disproportionately high

representation of socially marginalized women who use injection drugs and are of Aboriginal background compared to their male counterparts is consistent with previous findings from the VIDUS cohort (Kerr et al., 2005; Wood et al., 2008) and may in part be a result of sampling methods within the cohort (i.e.: inability to recruit a random sample), it nonetheless draws attention to potential shortcomings of the health care system to regard the importance of cultural safety in providing access to addiction treatment services (Smye & Browne, 2002; Wood et al.). For example, what meanings – historical, socio-cultural, economic, or political – do persons of Aboriginal background ascribe to health, illness, mental health, suffering and healing? What social role does gender play in the context of health and drug use within Aboriginal cultures? Does the dominant health care delivery system in Vancouver (and Canada) provide a safe space for Aboriginal people, particularly women, or does it create structural inequities that place Aboriginal people at greater cultural risk (for instance, inadequate access to culturally safe addiction treatment)? With respect to this last question, our current findings imply the latter. With these considerations in mind, the overrepresentation of people of Aboriginal ancestry among VIDUS participants (32% – double the 16% reported by Statistics Canada (2006) for the corresponding population census tract, and dramatically higher than that of the Greater Vancouver Metropolitan Area proportional Aboriginal population of 2%) is not unexpected given the social and structural inequities influencing and shaping the health and health care of Aboriginal people in British Columbia.

Foucaultian Perspectives and Risk Environment

From a risk environment perspective, Keane (2009) applies a Foucaultian analysis, using the concepts of biopower, disciplinary power and governmentality, to MMT. Foucault, a French theorist and philosopher, became a central – and controversial – figure in the critique of social

structures and institutions and is often cited in some areas of post-modern feminist literature (Bourdieu, 2001; Bourgeault, 2006; Friedman & Alicea, 2001; Keane; Sherwin et al., 1998). A major focus of his work highlighted the medicalization of human conditions (for example, addiction), through the use of ‘bio-power’, as a form of structural oppression. “Bio-power refers to the ways historically entrenched institutionalized forms of social control discipline [human] bodies” (Bourgois et al., 1997, p. 156). Keane, in her recent review of previous work by Bourgois (2000) and Friedman and Alicea, characterizes MMT, in the context of the lived experiences of individuals who are, or have been engaged in this type of addiction treatment, as a form of structural biopower where street life represents freedom, choice and personal agency, while enrolment in MMT represents disciplinary power and social control. Rhodes (2009) regards limitations in addiction management choices as contributing to structural local environments that produce risk at both the individual, or micro-environment level resulting from economic factors (i.e.: conforming to treatment regulations and considerable scrutiny at a relatively low financial cost versus relative freedom on the street at a higher financial cost – often addressed through income generating activities such as drug dealing and sex trade work)(Shannon et al., 2008), and at the macro-environment level through political and policy factors that govern drug use and addiction treatment.

Also drawing on the work of Foucault, Rhodes (2009) refers to a “risk governmentality” (p. 197) as the everyday interplay and tension between physical, social, economic and political risk factors (or enabling factors) at the micro- (individual), meso- and macro-environmental levels within a local context. This tension is produced by dynamics such as individual agency and acts of resistance to influences that produce risk. Some MMT programs may be examples of biopower, discipline and social control at work, producing the political-economic aspects of

structural violence (Bourgois et al., 2004) perpetrated more so against women (and in particular, women of Aboriginal ancestry) than men.

Intimate Relationships, Gendered Violence and Situated Rationality

The positive association among female participants between being married or having an intimate partner and being enrolled in addiction treatment allows for speculation that some forms of addiction treatment – such as MMT within which there may be inherent degrees of structural violence – may play a protective (enabling) role in avoiding certain forms of risk (for example, everyday or intimate partner violence) (McCloskey et al., 2007). By exercising individual agency to resist the more immediate threat of interpersonal violence within the local context, forms of treatment related structural violence may be seen as more acceptable to some women who use injection drugs when viewed from the perspective of *situated rationality* (Kleinman, 1997; 1999; 2006; Moore, 2008; Rhodes, Stimson & Quirk, 1996). Situated rationality involves a rational weighing out of acceptable risk – situated within a specific local and interpersonal context – against a personal stake in meeting certain individual needs such as pleasure and intimacy (Kleinman, 1997; 1999; 2006; Moore; Rhodes et al.). However, there are other possible explanations for this finding (for example, intimate partner support), and this question would need to be examined in more depth in future research.

Being married or having an intimate partner was associated with a greater than 50% higher likelihood of being enrolled in treatment among women, whereas there was no significant association in this regard among men. The negative association between daily heroin injection and being enrolled in treatment among participants may be due in part to *high-threshold* barriers to treatment access resulting from the high level of scrutiny and monitoring that is inherent in the state regulated mandate of MMT (for example, daily clinic or pharmacy-based witnessed

administration and regular urine drug screening). This finding may also imply an element of contextual or situated rationality. While MMT prevents symptoms of opiate withdrawal, it lacks the degree of euphoria, intimacy and pleasure derived from heroin use when situated within intimate relationships (Rhodes & Cusick, 2000). However, as described in the previous chapter, there was a high proportion among women in this cohort who reported having an intimate partner who used injection drugs as the reason for initiating injection drug use (Wood, 2010, p. 12), yet the findings in the present study indicate that having an intimate partner is also strongly associated with being enrolled in addiction treatment. One possible explanation for this apparent contrast is that there is a potential for a process of situated rationality to lead to a compromise among some women whereby the structural violence associated with MMT is seen as less risky than the interpersonal or everyday violence experienced within some intimate partner relationships. Further qualitative examination of this phenomenon would be helpful in providing greater insight into the contextual dynamics of individuals' access to addiction treatment while being involved in intimate relationships with others who use injection drugs.

Cultural Safety

The perspectives of cultural safety (or cultural risk) provide a meaningful lens through which to consider the negative association in the present study between Aboriginal ancestry and treatment enrolment, particularly among men. In the current study, women not enrolled in treatment (55.6%) were more likely to report reasons such as 'don't have the type of program I need or want' and less likely to report 'don't think treatment programs work for me' than their male counterparts. Moreover, women not enrolled were significantly more likely than men to report being 'in treatment intermittently in the past six months' and 'failed too many times' as reasons for current non-enrolment. These findings are indicative of significant rates of

participant reporting, especially among women, regarding a lack of access to suitable treatment programs that could meet their addiction treatment needs. Such findings are consistent with earlier work by Kim and Fendrich (2002) showing that women are more likely than men to identify their drug use as a problem. The present findings also imply that, despite reported inadequate access to types of addiction treatment programs in demand by women who use injection drugs, the higher rate of reported repeated attempts at addiction treatment by women may indicate a higher level of perseverance and commitment compared with men. Such implications would also need to be supported through more in-depth examination in future research.

Other gender differences in factors negatively associated with addiction treatment enrolment found in the present study include: frequent alcohol use among men, however no significant association with alcohol use among women; daily heroin injection among both genders, although somewhat stronger among women; and homelessness among both genders, however more pronounced for men. While culturally safe, gender sensitive and lower-threshold programs are evolving (Krusi, Small, Wood & Kerr, 2009), historic social stigma and structural discrimination related to substance use and marginalization, as well as racism, often undermine efforts to promote cultural safety by perpetuating higher-threshold barriers to addiction treatment service access (for example: zero tolerance abstinence policies of many treatment programs; inability of individuals to pay fees often charged for MMT, due in part to requirements such as having a residential address to be eligible for social financial assistance; and culturally unsafe treatment approaches and policies – designed primarily for Caucasian males who are able to remain abstinent from the point of treatment entry – that disregard the cultural needs of people of different ethnic origins or Aboriginal people).

In addition, consistent with previous research by Kerr et al. (2005), the present study found positive associations among both genders between median years of injecting experience (calculated as median current age minus median age at first injection) and treatment enrolment. While further insight is needed to better understand the association between length of injecting career and treatment enrolment, one possible explanation for this association may be that increased time and exposure to the health care and addiction treatment systems (particularly among those – such as women who use injection drugs – who have made repeated attempts to access services) may result in improved familiarity, knowledge, skills and agency in navigating these structural systems.

Implications for Practice, Policy and Research

Further exploration of how our understanding of women's injecting practices and factors associated with treatment engagement has been shaped by broader socio-cultural, structural and environmental influences would serve to better inform ethical nursing practice and health policy making. Although there is a growing volume of recent research which highlights the need for gender sensitive and culturally safe addiction treatment and harm reduction services (Ettorre 2004; Krusi et al., 2009; Marshall et al., 2008; Measham, 2002; Simpson & McNulty, 2008), such services are excruciatingly slow to materialize. Further examination is also needed with respect to the influences that female gender role identification and intimate partner relationships have on addiction treatment enrolment.

Limitations

There are some limitations associated with this study. Firstly, although random sampling was not possible, previous studies suggest the probability that VIDUS participants are representative of the population of people who use injection drugs in Vancouver's Downtown

Eastside (Tyndall et al., 2001). Nonetheless, it should be noted that the drug-using population and socio-political climate in Vancouver are seen to be somewhat unique to those of other jurisdictions for a variety of reasons, which have not been explored in depth here (Tyndall et al., 2001). This uniqueness would need to be considered in any future research conducted elsewhere. Secondly, data derived from the VIDUS cohort is based on self-report and therefore, may be susceptible to a degree of socially desirable responding resulting in a potential for over-reporting of past or present treatment engagement, or under-reporting of drug use risk behaviours. However, although some studies support the reliability of self-reporting among people who use injection drugs (De Irala, Bigelow, McCusker, Hindin & Zheng, 1996) while others suggest that people who use injection drugs may underreport undesirable behaviours (Darke, 1998), participants were blinded to this eventual use of the data and therefore, I have no reason to believe that these findings are biased.

Conclusion

Although the majority of participants in this study reported not being currently enrolled in addiction treatment programs, women were more likely than men to be among those who did report being enrolled. Methadone maintenance therapy is a predominant type of addiction treatment among both genders, but particularly among women. However, people who use injection drugs and are of Aboriginal ancestry were found to be just over half as likely as non-aboriginal participants to be enrolled in any type of addiction treatment. Moreover, among people who use injection drugs who are of Aboriginal origin, men were approximately half as likely as women to report being enrolled in treatment. Among women involved in an intimate relationship, there was more than a 50% higher likelihood of being enrolled in treatment, whereas intimate partnerships showed no significant influence in this regard among men. Among

participants not enrolled in addiction treatment, lack of suitable treatment programs that could meet their needs was seen as a significant barrier, particularly for women. However women also reported previously attempting addiction treatment more often than men. These findings suggest that structural and institutional racial and gender related barriers to addiction treatment access continue to exist, perpetuating risk environments among Aboriginal individuals and women who use injection drugs. Programs and policies which support enabling, empowering and equitable environments for people who use injection drugs and seek access to safe, appropriate and effective addiction treatment are required.

The lenses of risk environment, gendered interpersonal, symbolic and structural violence, and cultural safety are tools that draw our attention to the negative impacts of gender inequities embedded in micro-, meso- and macro-level social, political and economic institutions and structures. Further research is needed to examine the gender differences in rates of addiction treatment enrolment, the effectiveness of various types of gender sensitive and culturally safe treatment, and the gender differences in reasons for non-enrolment. The questions posed herein regarding the historical, socio-cultural, economic and political meanings ascribed to health and illness by people of Aboriginal ancestry, and whether our health care system provides a safe space for those individuals or places them at greater risk, are beyond the scope of the present study. Nonetheless, they are relevant to a developing body of literature, which requires ongoing attention – particularly in Canada – from researchers, health care providers and policy makers.

Endnotes

¹ *Social capital*: "... is usually measured in terms of the social, collective, economic and cultural resources available to a network, neighbourhood or community" (Rhodes et al., 2005, p. 1032).

Social capital thus provides an ecological evaluation of differences in risk or health within communities or social networks, and of how well these communities and social networks respond to increased risk.

² *Social suffering* is a socially constructed concept that focuses "on lived or social experience, which refers to the felt flow of engagements in a local world.... within which daily life takes place.... What defines all local worlds is the fact that something is at stake. Daily life matters, often deeply. People have something to gain or lose, such as status, money, life chances, health, good fortune, a job, or relationships." (Yang et al., 2007, p. 1528).

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CHAPTER FIVE:

Summary, Conclusions, Limitations, and Recommendations

Review of Thesis Objectives

As a nurse providing health promotion, HIV prevention and harm reduction services for people who use illicit injection drugs in Vancouver's Downtown East Side, I realize – and related research confirms – that people in Vancouver's Downtown East Side who are street-entrenched and use non-injection illicit street drugs via other routes of administration (for example, oral consumption, sniffing, smoking, etc.) are at high risk of initiating injection drug use (Novelli, Sherman, Havens, Strathdee & Sapun, 2005; Ompad et al., 2005). Findings from the present study reported in this thesis support previous calls for early intervention efforts aimed at the prevention of transition to injection drug use among non-injection drug users (Novelli et al., 2005; Ompad et al., 2005) and also reinforce my own experiential perspectives related to the importance of such early intervention efforts. Further, based on work previously published by myself and my colleagues (Wood, Wood et al., 2008; Wood, Zettel & Stewart, 2003), it has been apparent to me for some time that improved and expanded access to a range of low threshold, integrated addiction treatment and harm reduction services that provide culturally safe and gender-sensitive environments are needed for people who use injection drugs.

Inspired by my practice experiences, the purpose of my thesis research has been to portray the risk environment of marginalized women in Vancouver who use injection drugs and explore how our understanding of women's injecting practices has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions. While applying a lens of gender-based analysis, I sought to draw on my experiences and delve further into evidence from existing literature related to the shaping of understandings of injection practices in order to

quantitatively examine gender differences within the contextual circumstances of first injecting experiences. Drawing on research led by Dr Thomas Kerr, I further sought to use quantitative methods to explore gender differences in factors associated with being enrolled in addiction treatment services among people in Vancouver who use injection drugs. In this chapter (Five), I draw from the preceding chapters of this thesis work to highlight the key points and conclusions put forth and to examine related implications for health policy and service delivery pertaining to access to gender-sensitive and culturally safe services for women in Vancouver who use injection drugs. Lessons learned and implications for ethical practice are reviewed and recommendations for policy, practice and further research are presented. The key points, conclusions, lessons learned and implications comprise what I hope will be significant contributions to the current growing body of literature related to issues of gender among street-entrenched people who use illicit injection drugs.

Contributions to the Current Literature

This thesis began with a review of relevant literature to identify gaps in published work related to exploring how our understanding of women's injecting practices has been shaped by socio-cultural, historical, environmental, structural and gendered dimensions. Starting within the context of my own experiential perspectives (positioned within a risk environment framework) I identified the need for contributions to this growing area of literature that takes a gender-based analysis approach. Specifically, my intent was to: a) describe the risk environments of women who use illicit street drugs in Vancouver; b) examine gender differences in first injecting experiences among people in Vancouver who use injection drugs; and c) examine gender differences in factors associated with addiction treatment engagement among people in Vancouver who use, or have used, injection drugs.

In Chapter Two, I provided a gender-based review of relevant literature, exploring how our understanding of injecting practices among marginalized women who use illicit injection drugs has been shaped by socio-cultural, historical, political, environmental, structural and gendered dimensions. In Chapter Three, a quantitative analysis was presented which examined gender differences in circumstances surrounding first injecting experiences. In Chapter Four, I provided a quantitative analysis and discussion of gender differences in factors associated with treatment enrolment. The quantitative analyses, interpretations and discussions presented in Chapters Three and Four were conducted, as I have indicated above, within a larger program of research using secondary data drawn from the Vancouver Injection Drug User Study (VIDUS) – one of several large prospective cohort research programs operated under the Urban Health Research Initiative (UHRI) which was led by one of my thesis supervisors (Dr. Thomas Kerr) and has been described in detail in Chapter One.

The conceptual lenses of risk environment, gendered violence and cultural safety fit well with a gender-based analysis approach and have provided insightful interpretive and critical perspectives related to the objectives of this project as stated above. Collectively, this thesis research contributes to filling gaps in published work focused on how the gender-specific contextual interplay among a variety of influences plays a role in the particular vulnerabilities faced by socially marginalized women who use injection drugs.

In this, the closing chapter of my thesis, I proceed with drawing conclusions from the main body of this work through summarizing key findings related to the analyses and discussions of gender differences in circumstances surrounding first injecting experiences (presented in detail in Chapter Three) and in addiction treatment use (presented in detail in Chapter Four) among participants of VIDUS. Various themes and perspectives drawn from the analyses and

discussions presented in those earlier chapters are touched on as they are viewed through the conceptual contexts of the risk environment framework, the intersections of gender and violence, and the interpretive lens of cultural safety. These same contextual contexts are then used as a backdrop to highlight implications of this work for practice, policy, and research. Ethical considerations are also discussed as they relate to implications for practice and policy, and some attention is given to related views of social justice and public health. Following this discussion of implications, strengths and limitations of the overall study design are presented. Finally, this chapter (and thesis) concludes with a number of recommendations for practice, policy and research which are drawn from the conclusions and implications discussed. I end this work with some of my own brief closing remarks.

Summary of Findings

First Injecting Experiences

Findings from the analyses presented in Chapter Three indicate that, among VIDUS participants, women were more likely than men to have initiated injecting within the context of an intimate relationship with a partner who was already using injection drugs, and were less likely than men to report curiosity as a reason for injection initiation. Moreover, women were about one and a half times more likely than men to be injected the first time by another individual (i.e., assisted injection) and were less likely than men to be self-taught in self-injection skills.

Intimate Partner Injection Drug Use. The significant association shown between injection initiation and intimate partner injection drug use found in the study informing this thesis is consistent with previous work in the area (Bourgois, Prince & Moss, 2004; Fairbairn et al., 2008; Shannon et al., 2008; Spittal et al., 2002). When viewed through the lens of the risk

environment framework, interpersonal, social and peer group risk norms may be seen as factors within street culture that serve to construct or precipitate certain manifestations of situated rationality¹ at the micro-environmental level among young women who are willing to take ‘acceptable’ risks to meet their needs for intimacy (Bloor, Robertson, McKeganey & Neale, 2008; Dietze, Jolley, Fry, Bammerd & Moore, 2006; Rhodes et al., 2006). Rhodes et al. discuss how situated rationality within the local micro-level risk environment shapes drug use practices over time to construct a cultural normalization of risk behaviours. Transitioning to injection drug use from other non-injection routes of drug consumption is regarded in the present study as an example of such normalized risk behaviours, particularly when the transition occurs within the influence of an intimate relationship where the intimate partner is already using drugs via injection.

Assisted Injection. The practice of assisted injection has previously been shown to be associated with high risk syringe borrowing (Novelli et al., 2005), HIV incidence (O’Connell et al., 2005), as well as non-fatal overdose among persons who use injection drugs (Kerr, Fairbairn et al., 2007). The high rate of received assisted injecting reported by women in this study is therefore concerning. Receiving injection assistance has previously been found to be more common among women than among men (Wood et al., 2003), with women and men reporting different reasons for engaging in this practice. Specifically, in comparison to men, women have been found to be more likely to report a lack of knowledge of how to self-inject as a reason for engaging in assisted injection (Wood et al.). This link between lack of self-injection knowledge and receiving assisted injection is consistent with the findings of the present study which suggest that, among VIDUS participants, women were less likely than men to teach themselves how to inject.

The finding concerning higher rates of receiving assisted injection among women during first injection experiences (similar to the dynamics of intimate partner injection drug use described above) also suggests an element of situated rationality (Bloor et al., 2008; Dietze et al., 2006; Rhodes et al., 2006). More importantly, Bloor et al. found that submitting to being injected by an intimate partner via the partner's previously used contaminated syringe was often viewed as a sign of trust and intimacy and therefore, an acceptable risk. Furthermore, the pervasiveness of assisted injection during women's first injecting experiences may reflect a form of everyday violence within a micro-level risk environment context, whereby the male control over women's drug use – and over the injection process itself – have become commonplace, despite the many risks associated with assisted injection (Bourgois et al., 2004; Shannon et al., 2008). In light of these current (and previous) findings regarding higher rates among women of both receiving assisted injection and reporting intimate partner injection drug use as a reason for injection initiation, the potential implications of micro and meso-level socially constructed gender power dynamics – producing conditions of male domination and female subordination – (for example, manifested forms of situated rationality and everyday violence) ought not to be overlooked.

Power relations. Structural gender inequalities and gendered risk at the macro-environmental level support and perpetuate the gendered nature of power relations in drug using relationships, and are exhibited through various dynamics including everyday and symbolic violence in the local context (Bourgois et al., 2004; Fairbairn et al., 2008; Rhodes, 2009; Shannon et al., 2008). The dynamics of gendered power differentials within the context of injection initiation produce disproportionate risk for young women compared to men (Kerr et al., 2005; Novelli et al., 2005; Spittal et al., 2002). Male control of injecting also serves to reinforce male-domination within drug using culture, since men often maintain control of injecting

equipment, the drugs and their administration (Shannon et al., 2008; Spittal et al., 2002). There is considerable evidence in the literature indicating that male control over resources within drug using cultures, including drugs and drug administration, is associated with elevated risks for women (Abelson et al., 2006; Bourgois et al., 2004; Bryant & Treloar, 2007; Fairbairn et al., 2006; Fuller et al., 2003; Kerr et al., 2006; Novelli et al., 2005; O'Connell et al., 2005; Rhodes & Cusick, 2000; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; Shannon et al., 2008; Spittal et al., 2002; Strathdee et al., 2001; Wood et al., 2003). These risks include HIV and Hepatitis C infection and other sexually transmitted infections, as well as bacterial infections, overdose, opiate withdrawal ('dope sickness'), and various forms of gendered violence.

A recent study by Shannon et al. (2008) demonstrated the culturally accepted practice of male partners controlling the supply of drug equipment and the administration of drugs, including the time and frequency of the women's use, thereby constraining women's agency, autonomy and ability to negotiate prevention strategies for HIV and other harms associated with injection drug use and street culture. The potential implications of micro and meso-level socially constructed gender power dynamics producing conditions of male domination and female subordination may constrain access to services that are likely to become increasingly important after initiation of injection drug use (Miller, Kerr et al., 2006; Miller, Strathdee et al., 2006; Novelli et al., 2005).

Critical perspectives on power and risk. From a risk environment perspective, the intersections between the cultural phenomena of young women's vulnerabilities to first time experiences with injecting drug use via assisted injection by an intimate male partner in the context of gendered power inequalities may have significant implications over time. For example, within the risk environment, interpersonal, cultural and structural conditions are

produced which generate risk as women become more deeply entrenched in injection drug and street culture, and thus further stigmatized, socially marginalized and othered ² (Canales, 2000) by dominant health and social structures and institutions (Bourgois et al., 1997; Bourgois et al., 2004; Rhodes et al., 2005; Vlahov, Fuller, Ompad, Galea & Des Jarlais, 2004). The risk of sustaining various forms of gendered violence, especially structural violence, may be increased as a consequence of initiating injection drug use (Fairbairn et al., 2008; Farmer, Nizeye, Stulac, & Keshavjee 2006; Shannon et al., 2008).

Addiction Treatment Use

Findings from the analyses presented in Chapter Four demonstrated that, although the majority of VIDUS participants in this study reported not being currently enrolled in addiction treatment programs, women were more likely than men to be among those who did report being enrolled. Methadone maintenance therapy (MMT) was the predominant type of addiction treatment reported among both genders, but particularly among women. However, people who use injection drugs and are of Aboriginal ancestry were found to be about half as likely as non-aboriginal participants to be enrolled in any type of addiction treatment. Moreover, among people who use injection drugs and are of Aboriginal origin, men were approximately half as likely as women to report being enrolled in treatment.

These findings suggest that structural and institutional racial and gender related barriers to addiction treatment access continue to exist, perpetuating risk environments among Aboriginal individuals and women who use injection drugs. Programs and policies which support enabling, empowering and equitable environments for people who use injection drugs and seek access to safe, appropriate and effective addiction treatment are required. There continue to be ongoing calls to for further expansion of 'low-threshold' methadone programs which reduce barriers

(such as structural medical and state control) to MMT in a variety of settings (Keane, 2009; Kerr et al., 2005).

Cultural safety. While the disproportionately high representation of socially marginalized women who use injection drugs and are of Aboriginal background compared to their male counterparts is consistent with previous findings from the VIDUS cohort (Kerr et al., 2005; Wood et al., 2008) and may in part be a result of sampling methods within the cohort (i.e.: inability to recruit a random sample), it nonetheless draws attention to potential shortcomings of the health care system to regard the importance of cultural safety in providing access to addiction treatment services (Smye & Browne, 2002; Wood et al.). The perspectives of cultural safety (or cultural risk) provide a meaningful lens through which to consider the negative association in the present study between Aboriginal ancestry and treatment enrolment, particularly among men. In the current study, findings are indicative of significant rates of participant reporting, especially among women, regarding a lack of access to suitable treatment programs that could meet their addiction treatment needs. Such findings are consistent with earlier work by Kim and Fendrich (2002) showing that women are more likely than men to identify their drug use as a problem. The present findings also imply that, despite reported inadequate access to types of addiction treatment programs in demand by women who use injection drugs, the higher rate of reported repeated attempts at addiction treatment by women may indicate a higher level of perseverance and commitment compared with men.

Power and Intimate Relationships. The positive association among female participants between being married or having an intimate partner and being enrolled in addiction treatment allows for speculation that some forms of addiction treatment (such as MMT within which there may be inherent degrees of structural violence) may play a protective or enabling role in

avoiding certain forms of risk (for example, everyday or intimate partner violence) (McCloskey et al., 2007). By exercising individual agency to resist the more immediate threat of interpersonal violence within the local context of intimate relationships, forms of treatment related structural violence may be seen as more acceptable to some women who use injection drugs when viewed from the perspective of situated rationality (Kleinman, 1997; 1999; 2006; Moore, 2008; Rhodes, Stimson & Quirk, 1996). However, there are other possible explanations for this finding (for example, intimate partner support), and this question would need to be examined in more depth in future research.

Being married or having an intimate partner was associated with a greater than 50% higher likelihood of being enrolled in treatment among women, whereas there was no significant association in this regard among men. The negative association between daily heroin injection and being enrolled in treatment among participants may be due in part to *high-threshold* barriers to treatment access resulting from the high level of scrutiny and monitoring that is inherent in the state regulated mandate of MMT (for example, daily clinic or pharmacy-based witnessed administration and regular urine drug screening). Further qualitative examination of this phenomenon would be helpful in providing greater insight into the contextual dynamics of individuals' access to addiction treatment while being involved in intimate relationships with others who use injection drugs.

Implications for Practice, Policy and Research

Consideration of social-historical perspectives and social-structural mechanisms that cause social marginalization of addicted persons and the approaches used to achieve stigmatization and social exclusion – and how such approaches produce risk and risk environments – helps to provide insight into how our understanding of women's injecting

practices has been shaped. In Chapter Two, I presented an in-depth discussion of various socio-cultural, historical, political, environmental structural aspects of gender and drug use which have contributed to the shaping and social construction of marginalized injection drug users.

The Risk Environment

Rhodes' (2002) risk environment framework was incorporated within this thesis project in order to counter individual-level views of drug-related risk that are prevalent in the current body of public health literature (Rhodes et al., 2006; Shannon et al. 2008). Public health and harm reduction approaches in recent years have largely focused on individual-level, rather than collective/social/structural-level interventions (Shannon et al.). Such individual-level approaches fail to adequately consider the intersections of broader social and structural influences with micro-level risk environments which produce, reproduce, reduce and otherwise mediate risk in the everyday living conditions of women who use drugs (Shannon et al.).

The risk environment of marginalized, street entrenched people (women in particular) who use injection drugs is a central source of mediating factors which produce and reproduce risk. It is a physical and social space where complex intersections of a range of historic, social, structural, economic, cultural and gendered factors create conditions of vulnerability among people who use injection drugs. The historical social and cultural structures and mechanisms that perpetuate marginalization, stigma and discrimination all impact the shaping of our understanding of the conditions in which people who use injection drugs live, why people initiate injection drug use, why certain high risk injecting practices continue, and what influences contribute (positively or negatively) to access to, and engagement in, addiction treatment services.

A greater understanding among researchers, policy makers and service providers of factors and precursors that lead women into such relationships would inform strategies for early prevention and other public health measures. Further, it has been suggested that a discourse of illicit drug addiction as a health issue may serve to provide more accessible and factual information for young people, and demystify the associated underground sub-culture that tends to promote risky drug use (Kerr, Tyndall et al., 2007).

Gendered Violence

Further informing the present work has been the concept of intersections of gender and violence (Bourgois et al., 2004, as cited in Fairbairn et al., 2008, pp. 817-818). As a conceptual framework in which multi-layered forms of gendered violence can be viewed and interpreted, this concept was previously applied by Fairbairn et al. (2008) as a lens through which to examine the mediating influence of Vancouver's supervised injection facility (SIF) on the impact of violence among street-involved women who use injection drugs. This conceptual perspective, interwoven with the risk environment framework, is comprised of three theoretical classifications of gendered violence: everyday; symbolic; and structural. These classifications or layers of gendered violence have been applied within public health contexts to elucidate the historical, political and cultural dimensions of gendered experiences of health and illness (Bourgois et al., 2004; Shannon et al., 2008). For the purpose of this thesis, the intersectionality of gender and violence has been contextualized within the socio-cultural and structural dimensions of the risk environment while applying an interpretive lens of cultural safety, positioned within critical post-colonial perspectives.

The lenses of risk environment and gendered violence assist us to better appreciate how women's autonomy is constrained with respect to access to services that are likely to become

increasingly important after initiation of injection drug use. The limited capacity to exercise individual autonomy in negotiating risk reduction within street culture and within the health care system is likely to render people who are socially marginalized – especially women – more vulnerable to harms associated with environmental and structural risk as well as various forms of gendered violence. Greater understanding by health care and other service providers of factors that serve to constrain relational autonomy (for example, male control of women’s resources such as income, drugs, condoms, etc.) and female dependence on men for protection from harm would inform approaches to creating enabling environments for risk reduction and reduce barriers to service access.

Cultural Safety

For the purpose of this thesis, cultural safety has been used within critical theoretical views as a philosophical stance or interpretive lens. When situated within a critical post-colonial context, cultural safety assists us to understand how current colonial practices in health care have a tendency to cause cultural risk (Smye & Browne, 2002). Post-colonial theories assist us to elucidate and uncover vulnerabilities among individuals who are socially marginalized and use injection drugs, particularly women and people of Aboriginal ancestry. These vulnerabilities often place such individuals in need of access to appropriate health care and scarce culturally safe addiction treatment services. Exploration of the discourse and intent of cultural safety helps to shed light on how cultural influences contribute to shaping understandings of injection practices among women who use drugs.

Access to Addiction Treatment Services

These findings suggest that structural and institutional racial and gender related barriers to addiction treatment access continue to exist, perpetuating risk environments among Aboriginal

individuals and women who use injection drugs. Women's autonomous agency to negotiate risk in this context is severely constrained by a number of determinants. There needs to be a re-thinking of future public health measures that move beyond individual-level approaches (Shannon et al., 2008; Broadhead, Heckathorn, Grund, Stern & Anthony, 1995; Broadhead et al., 1998). However, the risk environment can also create conditions that are empowering if social discourses were to become dominated by a commitment to gender equality, social inclusion and equitable distribution of resources; including social services, housing, health care and addiction treatment services. Informed strategies and policies are needed to address barriers to accessing and providing addiction treatment and mental health services for vulnerable women who use drugs, including those who have not yet initiated injection drug use as well as those who have. Such insight informs ethical practice, policy and further research with respect to the extent to which gender differences mitigate or produce risk within the social, environmental and structural circumstances surrounding initiation to injection drug use. As well, such insight informs the process of engagement in addiction treatment services.

Implications for Ethical Practice and policy

I have spent many years throughout my nursing career working with people who are disadvantaged and marginalized in Vancouver – in particular, people who use injection drugs and struggle with addiction, mental illness and other health and social issues such as inadequate housing and income. These experiences have profoundly shaped my nursing practice by helping me to reflect on what ethical practice is, and the role ethics has to play in health and social policy.

Ethics as a values-based lens that can help us to move from what *is* taking place to what *ought* to be happening (Yeo, 1994) has a vital role to play in the health and social policy

implications for people who are disadvantaged and marginalized in Vancouver and other regions. In particular, people who use injection drugs and struggle with addiction, mental illness and other health and social issues such as inadequate housing and income are at high risk for a variety of health concerns, yet, due to social and structural inequities, are often least able to access health care services that meet their needs (Anderson et al., 2009). Yet discourses on ethics have been under-represented – often replaced by ideological ‘moralizing’ positions, at times inaccurately portrayed as ethical arguments – resulting in a profound mis-shaping of socially constructed views of people who use injection drugs, especially women and people of Aboriginal ancestry. For example, as discussed previously in Chapter Two, Small (2004) contends that dominant social portrayals of people who use drugs are characterized by notions that such individuals have made bad choices and are to blame for their own health problems; thus, they are undeserving of taxpayer-funded health care services. Further exploration of how our understanding of women’s injecting practices and factors associated with treatment engagement has been shaped by broader socio-cultural, structural and environmental influences serves to better inform ethical nursing practice by nurses and other health care providers and ethical health policy development, implementation, and evaluation. Nursing in particular has an ethical obligation to advocate on behalf of vulnerable groups in our society for social justice in the equitable access to culturally safe, gender-sensitive health services (Canadian Nurses Association, 2008).

Social justice. As central values within critical feminist perspectives of health care, gender and racial power equality and equitable opportunity and access to services, through engagement of and with health care providers in the context of complex relational networks and social institutions, are fundamental to the cause of social justice (Anderson et al., 2009; Rodney,

Pauly & Burgess, 2004). Identifying and addressing sources of oppression and power inequities are essential objectives in feminist health care approaches. Disenfranchised people (such as women who use injection drugs) have been shown to have a high likelihood of underdeveloped capacity to negotiate individual autonomy within social relationships (Kral et al., 1999; Spittal et al., 2002). Given the prevalence of intersecting factors such as structural violence, trauma and mental illness among people who use drugs, particularly women (Kral et al.; Morrow, Hankivsky & Varcoe, 2004; Sherwin et al., 1998; Spittal et al.), this reduced capacity for social and relational negotiation should not be surprising. Such individuals tend to fall at the lower end of power distribution within these social contexts (Spittal et al.). Therefore, feminist approaches to social justice would place optimal relational autonomy, reduced dependence and individual empowerment as paramount goals for socially marginalized women struggling with addiction. Further, as is illustrated in Chapters Two and Four of this thesis, approaches to addressing dynamics of oppression can be further elucidated through the critical lens of post-colonial thought and have significant implications for informing public health strategies.

Public health implications. The pervasiveness of gendered violence – everyday, symbolic and structural – throughout our society is accentuated within the risk environments of street and drug using cultures in Vancouver’s Downtown Eastside and likely in other communities with similar challenges across Canada. Structural violence is of particular concern due to its significant influence on how health care is provided and what barriers to service access exist for people who use injection drugs, particularly vulnerable women and people who are Aboriginal. There continue to be calls for public health measures to further reduce barriers and increase access to health care and addiction treatment services (Kerr et al. 2004; Kerr et al. 2005). Such public health measures could include policies and interventions that better engage people of

Aboriginal ancestry, and allow low threshold harm reduction approaches which are not conditional upon a requirement of abstinence (Fischer, 2000; Keane, 2009; Kerr et al., 2004; Kerr et al., 2005).

The gender-based analyses of differences in circumstances of first injecting experiences and in addiction treatment enrolment presented in this thesis indicate that significant social and structural barriers remain, particularly for women and people of Aboriginal ancestry. Power imbalances in intimate partner relationships place women in harms way by means of high risk activities such as assisted injection and gendered violence. Moreover, through an interpretive lens of cultural safety, findings regarding enrolment in addiction treatment services suggest that barriers to access continue to exist, especially for Aboriginal people attempting to negotiate a complex, highly medicalized system which perpetuates colonializing practices.

Recommendations for further related research that is beyond the scope of this present thesis project, along with an exploration of practice and policy implications, are offered following a discussion of study strengths and limitations.

Strengths and Limitations of the Study Design³

Generally, while the objectives of most research designs are to generate findings that are generalizable and applicable to a given population, achieving these objectives is dependent on the main assumptions that the sample being measured is representative of the population from which it is drawn; the methods and instruments used actually measure what they are intended to measure; and there is no significant chance that observed effects are the result of factors extraneous to the independent variable being manipulated (Polit & Beck, 2008). Although VIDUS does not employ random sampling methods, an open cohort community recruitment approach has produced a large sample (over 1500 participants) over a period of almost twelve

years. The sample size – the largest cohort of people who use injection drugs in Canada – combined with the longitudinal nature of the study enhance its capacity to be robust to the assumption of representativeness. A consistent semi-annual participant follow-up rate of > 85% using a multi-dimensional, structured, trained interviewer-administered questionnaire has generated research demonstrating persistent levels of self-reported injection risk behaviours (O’Connell et al., 2005; Wood et al., 2006; Wood et al., 2003), thus indicating a high level of internal validity and specificity of measurement instruments. Such a large and well established cohort study with a solid and longstanding track record of generating high calibre research provides confidence that the data used for this study are reliable in accurately describing circumstances and factors surrounding first injection experiences of participants and their current patterns of engagement with addiction treatment services.

Standardized measurement protocols over a broad range of socio-demographic, drug use, and risk behaviour characteristics allow for control of several potentially confounding variables during data analysis, while enhancing statistical power so as to minimize the chance of Type I error (i.e., erroneously concluding that a relationship exists between variables). Several of these measurements (such as those concerned with physical, social, economic and environmental influences) also allow for a risk environment framework perspective to be applied during analysis and interpretation of findings (Rhodes, 2002). Further, the data fit well with the theoretical concepts of structural violence (as described by Bourgois et al., 2004) and cultural safety (as described by Anderson et al., 2003; Browne, Smye & Varcoe, 2005; Smye & Browne, 2002), and complement the risk environment framework during interpretation of findings. This interwoven framework provides a contextual perspective allowing appropriate analysis, integration and interpretation of quantitative examinations of gender differences in the social,

structural and environmental circumstances of individuals' first injecting experiences, and of their current engagement with addiction treatment services. Employing the theoretical perspectives described above serves to strengthen construct validity in the study.

Although I believe the research design and methods described here to be the best balance between scientific rigor and practicality, and a number of measures are proposed throughout to further strengthen the basic quasi-experimental design, certain limitations to this overall approach remain and need to be considered. Threats to internal validity include self-selection bias (VIDUS employs convenience sampling methods), testing bias (for example, due to multiple administrations of follow-up questionnaires) and socially desirable response bias (due to power differentials between participants and researchers by whom participants may want to be regarded as conforming to perceived mainstream social norms). Further, recent work by Browne et al. (2008) within Aboriginal populations highlights the need for data on ethnocultural background to be “analyzed as [an] intersecting variable ... in combination with ... [other socio-demographic variables such as] ... gender, income level, primary language spoken, educational level, postal code ... and age” in order to derive any meaningful interpretation (p. 3). While some of these variables are considered within the larger program of research, not all are included. The omission of data on certain variables (such as income level, primary language and educational level) presents challenges to meaningful analysis and interpretation of the intersectionality of social, structural and environmental factors among people of Aboriginal ethno-cultural backgrounds (Browne et al., 2008). In this study there may be similar implications for research among marginalized women who use injection drugs, which could lead to the potential for a degree of mis-representation of findings. However, several of these areas of bias are also ongoing concerns

within the VIDUS cohort itself and I am not aware of any particular reasons that would cause substantially greater concern with respect to the particular study proposed here.

Recommendations for Practice, Policy and Research

As I have indicated already in this Chapter, the findings and conclusions of this thesis research raise a number of issues that require further attention from front-line decision makers in the provision of health care and social services for vulnerable and socially marginalized populations such as people in Vancouver's Downtown East Side who use drugs. Furthermore, ongoing attention to these issues is also required from and health policy makers and researchers. Although some important recommendations are provided here, these do not comprise an exhaustive list. Ongoing consideration and reflection of the implications discussed in what follows are important in continuing ongoing dialogue and debate which can exert meaningful influence on dominant discourses of health in the context of illicit street drug use, especially injection drug use.

Practice

There continue to be calls for further expansion of 'low-threshold' methadone programs which reduce barriers – such as structural medical and state control – to MMT in a variety of settings (Keane, 2009; Kerr et al., 2005). However, MMT or other forms of pharmacotherapy need to be provided in conjunction with other forms of regular therapeutic group and/or individual therapy as well as social, mental health and economic support such as stable housing for those individuals in unstable living conditions. Overall, public health measures need to include policies and interventions that better engage people of Aboriginal ancestry, and allow low threshold harm reduction approaches and other culturally safe health services and social supports which are not conditional upon a requirement of abstinence.

Addressing issues of curiosity in an open, honest and factual manner, through continuing to further shape the discourse of illicit drug addiction as a health issue would serve to demystify the associated underground drug sub-culture. Such an approach to addiction prevention has the potential to have an impact on overall incidence rates of injection drug use initiation among young people, especially among men. Consequently, a decrease in incidence rates of injection initiation among young men would reduce the number of drug using intimate male partners with whom young women might also be vulnerable to injection initiation.

Policy

There needs to be a re-thinking of future public health measures that affords moving beyond conventional individual-level approaches. A greater understanding among researchers, policy makers and service providers of factors and precursors that lead women into intimate relationships with injection drug using partners would provide valuable insight into the needs and motivations of young women at risk of injection initiation. Such insight would inform strategies for early intervention, education, social support, prevention and other public health measures aimed at reducing the incidence of injection drug use initiation among young people, particularly women. For example, further research into the association of early childhood abuse as a potential precursor to injection initiation within the context of relationships with intimate male partners who use injection drugs may be helpful in identifying young women who are at highest risk for initiating injection drug use. Such identification of specific risk factors could inform early intervention strategies such as targeted street outreach services.

The implications of gender power dynamics require further and ongoing attention from researchers and policy makers in order to better appreciate the complexities of the practice of assisted injection for both the recipient and the provider. Further efforts are needed to better

address women's propensity for assisted injection and to develop evidence-based strategies that serve to empower street-entrenched women who use drugs. For example, allowing supervised assisted injection at the supervised injection facility in Vancouver would offer increased safety and potential opportunities for greater engagement with health care providers who may be able to provide education in self injection techniques (Wood, Wood et al., 2008). Also, programs and policies which support enabling, empowering and equitable environments for people who use injection drugs and seek access to safe, appropriate and effective addiction treatment regimens are required.

Research

Ongoing research aimed at developing a broader understanding of the health and health care experiences of oppressed and socially excluded persons who use injection drugs is required.. Such research should include further exploration of gender-based factors that mediate women's ability to negotiate risk within intimate partner relationships so as to better inform strategies that create enabling environments – environments which foster greater cultural safety and relational autonomy, while reducing barriers to service access. Research such as this would ultimately help our health care system to promote social justice for a particularly marginalized group.

More specifically, further examination is needed with respect to the influences that female gender role identification and intimate partner relationships have on addiction treatment enrolment. Qualitative methods would be valuable in providing greater insight into the contextual dynamics of individuals' access to addiction treatment while being involved in intimate relationships with others who use injection drugs.

In addition, ongoing evaluation is needed to examine the gender differences in rates of addiction treatment enrolment, the effectiveness of various types of gender sensitive and

culturally safe treatment, and the gender differences in reasons for non-enrolment. For example, implications related to the higher rate of reported repeated attempts at addiction treatment by women may indicate a higher level of perseverance and commitment compared with men but such a hypothesis would need to be supported through more in-depth examinations in future research.

Regarding the individual and population needs of people who are aboriginal, there are valuable insights to be gained regarding the meanings – historical, sociocultural, economic, or political – persons of Aboriginal background ascribe to health, illness, mental health, suffering and healing (Browne, Smye & Varcoe, 2005). Moreover, broad understanding of the social role that gender plays in the context of health and drug use within Aboriginal cultures is vital to ensuring evidence-based, gender sensitive and culturally safe health and addiction treatment services are equitable and accessible. For example, an important area for future research is the examination of the degree to which structural inequities of the dominant health care delivery system in Vancouver (and Canada) fail to provide a safe space for Aboriginal people (particularly women) and, in fact, produce cultural risk.

Concluding Remarks

In closing, I would like to offer some reflections. This thesis project has been part of a longstanding and ongoing journey of discovery in which I have had many privileged opportunities to be an active participant. This work has been inspired by my own experiential, intuitive and historical practice in providing health care services to marginalized people in Vancouver who use injection drugs. My commitment – both professionally and personally – to advocating for social justice and ethical practice in the provision of health care services as well as in health policy making is driven by a belief in the importance of fostering truly equitable

access to appropriate, respectful and safe services for all Canadians. Those who are most vulnerable in our society require and deserve extra effort on the part of health care providers and policy makers, all of whom comprise the health care 'system' as an institutional social structure. Health care providers and policy makers ought to work at all levels (individual, organizational, and societal) to ensure services are fully accessible and all individuals are treated with dignity regardless of social class, race, ethnocultural background, health status, gender or any other characteristics that may be considered distinct.

While I have gained new insights through this project, my ultimate hope, shared by the leaders of the research project I have drawn upon, is that this thesis work will contribute unique and meaningful knowledge to the existing literature and will reinforce the base of evidence upon which positive social change can be advanced. The conclusions drawn from this work are pertinent to all who work with people who are socially marginalized and use illicit street drugs.

Endnotes

¹ Previously discussed in detail in Chapter Two, situated rationality involves a rational weighing out of acceptable risk – situated within a specific local and interpersonal context – against a personal stake in meeting certain individual needs, such as for relative safety, shelter, food, a sense of interpersonal belonging within a social and cultural network, drugs, intimacy, or access to harm reduction and treatment services (Bloor, Robertson, McKeganey & Neale, 2008; Dietze, Jolley, Fry, Bammerd & Moore, 2006; Kleinman, 1997; 1999; 2006; Moore, 2008; Rhodes et al., 2006).

² According to Canales (2000),

The self is only known through Others, and how Others are ‘marked’ and ‘named’ depends on the role taking of the self. How the Other is perceived, and how this role taking is enacted, has consequences for how the Other is defined (p. 18).

Othring is conceptualized by Canales in two categories of complex processes (although not strictly dichotomous or mutually exclusive): exclusionary and inclusionary:

[B]oth processes exist within the context of power and power relationships

Exclusionary othring ... uses the power within relationships for domination and subordination.... [resulting in] alienation, marginalization, decreased opportunities, internalized oppression, and exclusion.... [whereas] Inclusionary othring ... attempts to utilize power within relationships for transformation and coalition building.... [resulting in] consciousness raising, sense of community, shared power, and inclusion (p. 19-20).

³ Limitations of study findings were further discussed in Chapters Three and Four as they apply more specifically to the particular quantitative analyses described in those chapters.

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APPENDIX

Table 1: ANALYSIS #1:

First Injection – Description of Demographic/Environmental Variables for Question 2*

Variable	Description	Type of Measure	Questionnaire Item
Median Age at first injection (IQR)	Median Age in years (IQR)	Continuous	F1. The first time you fixed how old were you?
Aboriginal ethnocultural background	Yes vs. No (other)	Dichotomous	A4. What ethnic group or family background do you identify with? (Aboriginal includes First Nations, Inuit & Métis.)
Borrowed Syringe	Sharing (borrowing) of syringe (Yes vs. No).	Dichotomous	F9. The first time you fixed, did you use a needle that someone else had used?
Assisted Injection	Yes vs. No	Dichotomous	F11. Did someone fix you?
Setting	<ul style="list-style-type: none"> Indoor private/semi-private place (includes shooting gallery/crack house & jail) or indoor public place Outdoor public place 	Dichotomous	F3. The first time you fixed, what type of setting were you in?
Number of People	<ul style="list-style-type: none"> None (alone) vs. \geq one 	Dichotomous	F7. How many people were with you?
First Taught by	<ul style="list-style-type: none"> Self taught Friend/Relative/Boyfriend/girlfriend/partner Pimp/client/sex trade worker/acquaintance/stranger. 	Categorical	F76. Who first taught you how to inject?

Table 2: SUB-ANALYSIS #1(a):

First Injection – Description of Injection Risk Behaviour Variables for Question 2*

Variable	Description	Type of Measure	Questionnaire Item
Drug Type	<ul style="list-style-type: none"> Crack (Yes) Cocaine (Yes) Heroin (Yes) Crystal Meth (Yes) Other (Yes) 	Categorical	F4. What drug did you inject the first time?
Prior Condition	<ul style="list-style-type: none"> Sober/Straight Drinking alcohol/ High on drugs Sick from withdrawal Other 	Categorical	F5. What was your condition before you shot-up the very first time?
Injecting Reason	<ul style="list-style-type: none"> Others introduced it/Curious/ experiment To forget/escape problems Pressured into it Make sex better Best friend/lover doing it Other 	Categorical	F10. Why did you inject that first time? (i.e. instead of smoking or snorting)

* SOURCE: V 05/05 – The VIDUS Baseline Questionnaire

Table 3: ANALYSIS #2:
Treatment Enrolment – Description of Variables for Question 3*

Variable	Description	Type of Measure	Questionnaire Item
Median Years injecting (IQR)	per year older than median age at first injection (IQR)	Continuous	F1. The first time you fixed how old were you?
Aboriginal ethnocultural background	Yes vs. No (other)	Dichotomous	A4. What ethnic group or family background do you identify with? (Aboriginal includes First Nations, Inuit & Métis.)
Homelessness ^{††}	Yes (NFA/Street/ Shelter/Hostel) vs. No (Apartment/Room in Hotel/House/Treatment/ Recovery House/Jail/ Other)	Dichotomous	A21. What type of place are you living in now?
Married	Yes (Legally married/ common law/ Regular partner – not living together, but together over 3 months) vs. No (Separated, divorced/ widowed/no partner/ single)	Dichotomous	A24. What kind of relationship are you in right now?
Mental illness [†]	(yes vs. no)	Dichotomous	NQ-23. ('ever') Have you been diagnosed with one of the following mental illnesses in the last 6 months? <ul style="list-style-type: none"> • Depression • Anxiety • Obsessive compulsive disorder • Schizophrenia • Post-traumatic stress disorder • Personality disorder (e.g., borderline, sociopath) • Bipolar • Attention deficit disorder • Oppositional defiance disorder • Other hyperactive disorder • Other Instrument: <i>Childhood Trauma Questionnaire, The Psychological Corporation, Harcourt Brace & Company</i>
Sexual abuse [‡]	(yes vs. no)	Dichotomous	K1. Have you ever been sexually abused?
Alcohol use [†]	(yes vs. no)	Dichotomous	D2. In the past 6 months, which of the following alcohols did you use and how often? D2a. Beer/Cider/Coolers/ Wine D2b. Liquor D2c. Cooking Wine/ rubbing alcohol/mouthwash D2d. Other

Variable	Description	Type of Measure	Questionnaire Item
Frequent heroin injection [†]	(> daily vs. < daily)	Dichotomous	F12. In the last 6 months, when you were using, which of the following drugs did you inject and how often? F12a. Heroin F12b. Cocaine F12c. Heroin and Cocaine
Frequent cocaine injection [†]	(> daily vs. < daily)	Dichotomous	
Syringe Borrowing [†]	(yes vs. no)	Dichotomous	F46. In the last 6 months, have you fixed with a rig that had already been used by someone else?
Syringe Lending [†]	(yes vs. no)	Dichotomous	F56. In the last 6 months, have you lent your used rig to someone else?
Binge drug use [†]	(yes vs. no)	Dichotomous	F20. In the past six months, did you go on runs or binges (that is, when you injected drugs more than usual)?
Overdose [†]	(yes vs. no)	Dichotomous	G1. Have you ever overdosed by accident (i.e., where you had a negative reaction from using too much drugs)?
Frequency of service utilization at the supervised injection facility [†]	All or Most ($\geq 75\%$ to 100% of the time) vs. Some, Few, or None ($< 75\%$)	Dichotomous	F81. In the last six months, what proportion of your injections did you do in InSite?
Incarceration [†]	(yes vs. no)	Dichotomous	J9. Have you been in detention, prison, or jail in the last 6 months?
Sex trade involvement [†]	(yes vs. no)	Dichotomous	M6. In the last six months, have you received [money, gifts, food, shelter, clothes, or drugs] in exchange for sex? OR M7. In the last 6 months, how many different people have you had sexual activities with where you received money, gifts, drugs or something else?
Drug dealing [†]	(yes vs. no)	Dichotomous	C4. During the last 6 months, did you receive any money from [selling drugs]?
HIV-positive	(yes vs. no)	Dichotomous	Confirmed by HIV antibody blood test.
[†] Denotes activities in the previous 6 months; ^{††} Denotes current activities; [‡] Denotes lifetime history.			

Table 4: SUB-ANALYSIS #2a:

Treatment Enrolment by Type and Gender – Description of Variables for Question 3*

Current Enrollment in Addiction Treatment by Treatment Type and Gender				
Enrolled in:	Female	Male	R3. Are you currently in any kind of alcohol or drug treatment?	
Detox	X	X	(Yes vs. No)	If yes, what kind?
Daytox	X	X		
Recovery house	X	X		
Treatment centre	X	X		
Counselor	X	X		
NA/CA/AA	X	X		
Methadone program	X	X		
Cocaine treatment	X	X		
Residential, Therapeutic community	X	X		
Other out-patient treatment program	X	X		
Other	X	X		

Table 5: SUB-ANALYSIS #2b:

Reasons for Treatment Non-Enrolment – Description of Variables for Question 3*

Characteristic	Female (n = x)	Male (n = x)	p - value
Reasons:			
Wait list	X	X	X
Turned down by program	X	X	X
Don't know any programs	X	X	X
No programs nearby	X	X	X
Not type I want/need	X	X	X
Can't afford	X	X	X
Behaviour problems	X	X	X
Failed too many times	X	X	X
Habit is affordable	X	X	X
Don't need to stop	X	X	X
Can handle it myself	X	X	X
"It's for weak people"	X	X	X
Doesn't work for me	X	X	X
Worried about losing side-sponsor	X	X	X
Don't have a problem	X	X	X
Other	X	X	X

* SOURCE: V 05/05 – The VIDUS Baseline Questionnaire