

An ethnographic study of women who use intravenous drugs, their subculture and interpretation of health: Implications for nursing.

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Thesis submitted to the University of Ottawa
in partial Fulfillment of the requirements for the
Degree of Doctorate of Philosophy in Nursing

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Acknowledgements

I would like to thank my supervisor, Dr. Patrick O'Byrne, for the valued assistance and guiding wisdom which he has provided – from my application to the PhD Nursing program through to completion. His patient approach to developing my understanding and ability to do a critical ethnographic study, develop a critical focus, and express my words succinctly has been unendingly appreciated. Truly you have opened a world of knowledge to me.

To my committee, Dr. D. Holmes and Dr. M. Gagnon, an enormous thank you for ensuring the research and paper were on track by providing relevant and important comments while also being so warmly encouraging.

I would also like to thank my husband John and our son Dylan for the countless hours of time together that have been missed or rearranged so that I might work on my thesis writing, edits, and revisions. Thank you for your unwavering understanding and support.

Abstract

The following research was completed with an understanding that there is much to know about women who use intravenous drugs (WUID). The extant literature about the lives of people who use intravenous drugs (PWID) is mostly quantitative, highly androcentric, and primarily focused on HIV transmission. What is needed is information about the culture of WUID and the circumstances contributing to their poor health both from drug use and the conditions in which they live.

The ethnographic study involved (a) collecting artifacts, including photographs taken by the women, (b) observing participants during some of their daily activities and primary healthcare interactions, and (c) face-to-face interviews with WUID.

The results portray a life that closely resembles that which is known, but also the findings enable a lens into (a) the vicious circle associated with obtaining drugs and survival, (b) the violence, both systemic and personal, that homeless, urban-living WUID in Canada endure, and (c) the importance of “being clean” that directs much of their activities and presentation. From a theoretical perspective, the study enabled a deepened understanding of the importance of the continuum of cleanliness and how it interfaces with what the women believe. In summary, WUID have received unjust opportunities to care for themselves given the current laws and stigmatization that forces them to remain hidden, perform illegal activities, avoid discrimination, and fend for themselves in a world that perpetuates the hegemony of white middle-class Western peoples.

The results provide a direction for healthcare in terms of WUID. Primarily there is a need to engage WUID in establishing what would work for them and thus incorporating peers in the process of initiating and maintaining services. Clearly established is a need for drug use to be decriminalized to allow WUID to gain recognition, to avoid criminality, and to re-enter the world that belongs as much to them as any other.

Preface

It is the intention of this thesis to present what women who use intravenous drugs (WUID) think and say, that is, their perceptions and understanding of themselves, through their own personal experiences. This nuanced understanding of what it is to be a WUID will be examined and contrasted using a lens that rejects the dominant hegemonic standpoint that WUID are less than desirable and not deserving of fair and equal treatment. The thesis thus enables another perspective to be entertained, one that embraces WUID without prejudice as included members of society.

The binary conflict of what is known and what could be known about WUID has created a tension between the beliefs of those who fear, degrade, and dismiss WUID and those who approach them with humanity and empathy. Firstly, the study examines the literature for what is understood to be known about WUID. That the majority of this research employs predominantly quantitative methods highlights perceptions that WUID are little more than objects that can be enumerated and categorized, often without reference to their voice or agency. The literature review also demonstrates that research processes and the discussion of findings have often amalgamated findings from males and females who inject drugs into a single dataset. Thus, what becomes known is androcentric and dismisses the nuances of WUID. Identifying and articulating women's voices is important.

However, the methodology of the study presented herein, while qualitative and focusing exclusively on WUID, has also created conflict. Ethnographic studies employ several types of data collection: interviews, participant observation, and artifacts. To remain within the bounds of an ethnographic study, a researcher must report what participants say, what they do, and what they use. Here it was found that the women have internalized the idea that they are abject and marginalized within society. Using Kristeva's words to describe this concept, WUID feel they are "conjoined to another world, thrown up, driven out, forfeited" (1982, p. 6). From the words, actions, photographs, and other artifacts of the women who participated in this study, it is evident they

have internalized this identity which has been embedded within them by a society that sees WUID as “out of place.” The women described experiencing a vicious circle of life events that challenged their survival and exemplified the paradox of what they considered *living dirty and aspiring to be clean*. While the language of “dirty” and “clean” is notably stigmatizing, I have opted to retain these words to be consistent with the participants’ statements. This usage does not mean I believe in such concepts, and in fact, my collegial clinical practice with WUID demonstrates that I hold no such views. I use this language to ensure an unfiltered presentation of the data.

In the spirit of critical ethnography, it is nevertheless important to unravel the power structures and dynamics that enable these words – and thus the concepts, beliefs, and values that underpin them – to become known. And so, while the literature review and the findings may be viewed as presenting a negative image of WUID, it is these beliefs that are examined and reconstructed in my discussion of these findings. Certainly, I do not view WUID as deviant and disgusting; it is rather that they must be understood within the context of their lives, their challenges, and what is required for them to survive in a world that is hostile to them. The presentation here, including the language that is used (such as dirty and clean), is to understand these women as they see themselves and their lives. That they “do what they have to do” is a derivation of their experience, required and imposed by the structural violence of a society that rejects and abhors them. The assumption their identity has been “spoiled” (Ettorre, 1992, p. 77) rendering them as “not a normal woman” (Ettorre, 1992, p. 77) requires a re-exploration and resetting, and this thesis offers this possibility.

In my practice as a Nurse Practitioner to a population of homeless persons, including WUID, it is apparent that an acceptance of difference, an ability to come alongside the client, and an expression of respect illustrates some of the reasons that mainstream healthcare tactics fail. If one approaches healthcare with an attitude that requires compliance with “one size fits all” solutions and expectations of homogenous values and needs, it is inevitable that healthcare providers will miss the mark when they interact with and provide care for WUID.

In summary, the values and beliefs that underpin this research are those that aim to help WUID find a place in this world, to be esteemed and cared for in the context of their lives. In contrast, what is generally accepted about WUID and what WUID believe the world thinks of them, having internalized these expectations, formulates the basis for the thesis and provides grounds to reject and reconsider what is known. It is important to establish at the outset that what could be misconstrued as accepting WUID as dirty and deviant is a reflection of the world's general understanding of WUID and not the epistemology of this research. It is hoped that observation of the culture of WUID will enable a shift in the way healthcare is provided.

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Chapter One: Introduction

This dissertation details an ethnographic exploration of a subculture of homeless women who live in a Canadian urban centre and use intravenous drugs (henceforth “WUID”). The purpose of this research was to gain knowledge about the subculture of WUID to ultimately assist with the delivery of accessible and relevant healthcare, considering the structural context that condemns the existence of these women as dirty and dangerous (Ettorre, 2007; Lloyd, 2010; Murphy & Rosenbaum, 1999). A poststructuralist perspective was adopted to explore this subculture, on the premise that it can be used to consider how WUID end up being viewed – and viewing themselves – as stigmatized, abject bodies. It is important to note that while the research focuses on WUID, the study is not a feminist gender analysis. The focus here is on the norms of everyday life, the patterns of daily behaviour, and the activities inherent in the culture of an urban community of WUID. Because the extant literature is androcentric, and little has been done to explore and explain the subculture and ethos of WUID, the research will illustrate aspects of the culture of a part of the populace that was hitherto relatively overlooked. Women are thus the focus of the research, but this is not a study that employs feminist perspectives of analysis.

To this end, a description of the research is presented in sequential chapters. The first chapter outlines the need for the study and the research questions that drove the project. This chapter also includes the study’s ontological and epistemological stance. The second chapter reviews the available literature as it pertains, generally, to people who use intravenous drugs (PWID) and, specifically, to WUID. The third chapter expounds the theoretical framework that underpins data collection and data analysis. This framework is based on the work of several philosophers: Deleuze and Guattari, Foucault, Goffman and Kristeva. Their amalgamated work provides a framework that culminates synergistically to understand how the culture of WUID is situated within current society. Chapter four details the critical ethnographic methodology employed for this study, laying out how data were collected as artifacts and through observation

and interview, and subsequently analyzed independently and in combination to yield the study results. The fifth chapter presents said results. The sixth chapter is a discussion of the results, including an interpretation in light of the literature and theoretical framework, reflexivity to further the study's rigour, with the additional identification of the study's limitations and, lastly, recommendations. The seventh chapter summarizes the findings and concludes the thesis.

Research Problem

The impetus for this research is that poor health amongst WUID is well documented (Hayashi et al., 2016; Hser, Kagihara, Huang, Evans, & Messina, 2012; Popova, Rehm, Patra, Baliunas, & Taylor, 2007; Spittal et al., 2006). Spittal et al. (2006) estimated that mortality rates for WUID in British Columbia were 50% higher than for the general population in this province, and another Canadian study from 2016 found higher than average rates of mortality amongst WUID (Hayashi et al., 2016). Hayashi et al.'s (2016) study also found that, although treatment programs were heralded as the solution to drug use (thought to lead to decreased morbidity and mortality), treatment programs were protective for men only. Furthermore, Hser et al. (2012) found the average age of death for parenting or pregnant women (n=4447) who used substances and had entered treatment was 41.6 years of age, and their mortality rate was increased 8.4 times over that of similarly aged American women in the general population. Studies of homeless women (Cheung & Hwang, 2004), as well, have found that, in comparison to the general population, younger women under 45 years of age had a five- to thirty fold greater rate of mortality, while those who were older were two times as likely to die. In their review, Elzey, Barden, and Edwards (2016), found that women were more likely to be hospitalized for unintentional opioid overdoses than men. The studies point to the need for further research related to drug use and health, including overdoses which more often involve women.

In addition to issues related to drug use and overdose, some of the most common serious health issues WUID experience are blood borne infections (International Network of People Who

Use Drugs [INPWUD], 2014), including but not limited to septic joints, discitis, and endocarditis, all of which are difficult to treat and entail prolonged courses of intravenous antibiotics and hospital stays (Gordon & Lowy, 2005; Hecht & Berger, 1992; Ronan & Herzig, 2016). Studies have found blood borne viral infections (BBVIs) often accompany the use of illicit intravenous drug use and its associated lifestyle (El-Bassel, Shaw, Dasgupta, & Strathdee, 2014; Pinkham & Malinowska-Sempruch, 2008; The VANDU Women CARE Team [VANDU], 2009). Indeed, intravenous drug use is known to transmit HIV and hepatitis C (Ha, Totten, Pogany, Wu, & Gale-Rowe, 2016; Public Health Agency of Canada [PHAC], 2015, World Health Organization, 2012).

Moreover, treatment for these infections can be challenging because of difficulties accessing services, along with experiences of stigma and discrimination when utilizing the services (Flores, Leblanc, & Barroso, 2016; Kaposy et al., 2016; Kaposy et al., 2017; Wilton & Broeckaert, 2013). Those with HIV who inject drugs have also been found to have difficulty obtaining treatment (Torian, Wiewel, Liu, Sackoff, & Frieden, 2008).

In addition to the potential role in infection acquisition and transmission, sex work produces additional issues in the lives of WUID. Not only is drug use illicit, but the associated stigma increases when sex work is undertaken to obtain drugs (Ditmore, 2013; INPWUD, 2014; Lloyd, 2010; Pinkham & Malinowska-Sempruch, 2008). As Ettore explained, women “are viewed as having polluted their identities and their bodies” (2007, p. 39). WUID thus experience both the normative perspective of being less worthy as women, and the social consequences of having transgressed the line of being feminine by using their bodies as chattel and introducing illicit drugs through intravenous access.

Compounding this situation is that the role of WUID as mothers and caregivers can be in jeopardy as, socially, drug use and child rearing are seen as incongruent (Boyd, 2004; Boyd & Marcellus, 2007; Ettore, 2007; INPWUD, 2014; Murphy & Rosenbaum, 1999; Roberts, Mathers, & Degenhardt, 2010; Poole & Isaac, 2001). The result is that, during pregnancy, WUID may choose not to attend prenatal care due to fears their children will be taken away (Murphy &

Rosenbaum, 1999; Payne, 2007a, 2007b; Poole, 2007a; Salmon, 2007), and WUID are less likely to attend HIV treatment appointments, which increases the potential for vertical HIV transmission (Azim, Bontell, & Strathdee, 2015; El-Bassel, Terlikbaeva, & Pinkham, 2010; Pinkham & Malinowska-Sempruch, 2008). Unfortunately, as society views WUID poorly the ensuing lifestyle consequences of injecting drugs is enhanced because the stigma which occurs drives WUID further into hiding.

The health concerns WUID face are not directly related to drug use, but rather to the multiple factors that surround and create their subculture, for example, criminalization, violence, and stigmatization (Haritavorn, 2014; INPWUD, 2014; Roberts et al., 2010; VANDU, 2009). WUID are also more likely to die of homicide, reflecting the violence experienced in their lives (Hayashi et al., 2016). These women thus face an existence fraught with danger, disease, and rejection, and which produces pain, disease, and death. However, despite this context, WUID continue to endure their suffering with resilience and hope.

WUID are also subject to the general health conditions that may affect all women. These include liver failure, cancer, and heart disease (Cohen et al., 2002). However, as the focus of research and healthcare is often the sequelae of drug use, there is little done to address chronic conditions or preventative health measures. There is thus a need to view the health of WUID in its totality, not only as the known sequelae of drug use.

The complexity of the health needs of WUID is linked to social and structural issues, which culminate in these women being reluctant to seek care (Haritavorn, 2014; Neale, Sheard, and Tompkins, 2007; Neale, Tompkins, & Sheard, 2008; Palepu, Marshall, Lai, Wood, & Kerr, 2001). Studies have illustrated that WUID avoid healthcare for the following reasons: (a) attitudes of healthcare providers (Neale et al., 2007, 2008; VANDU, 2009; Wild et al., 2003) (b) poor care (VANDU, 2009), (c) feeling embarrassed (Neale et al., 2008; Haritavorn, 2014), (d) wait times (Neale et al., 2007; VANDU, 2009), (e) transportation issues (Neale et al., 2007), and (f) having their children taken by child and family services (Neale et al., 2008; Smith & Marshall, 2007). The

outcome is that, socially, WUID are seen as deviant, chaotic, and dirty (Ettorre, 2007; Rosenbaum, 1981; Taylor, 1993), while, individually, they face many physical and psychosocial health concerns.

WUID and nursing practice. These health concerns lead to many interactions between WUID and nurses. In hospitals, nurses provide services to WUID in emergency departments, as well as on in-patient units (Natan, Beyil, & Neta, 2009). In community settings, nurses administer services to WUID in primary and preventative care settings (Day et al., 2011), through outreach and harm reduction services (Anderson, Priest, Seymour, & the Street Nurse Program Project Team, 2007), and as part of drop-in and education services. In many such situations, nurses may be the first or only healthcare provider a WUID encounters, making this interaction an important linkage point for these women. Nurses must, therefore, provide excellent, relevant, and timely services in a safe and culturally appropriate manner to ensure both that WUID receive the care they need at the point of care, and that WUID feel comfortable and safe returning for care. Research highlights, however, that this is often not the case; nurses lack the education and expertise to provide care for WUID in ways that foster needed trust and respect (Abouyanni et al., 2000; Baldacchino, Gilchrist, Fleming, & Bannister, 2010; Chu & Galang, 2013; Deehan, Taylor, & Strang, 1997; Kelleher & Cotter, 2009; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). Research is thus needed about how to provide care for WUID, ideally to prevent serious and long-term sequelae (Gordon & Lowy, 2005; Kievlan, Gukasyan, Gesch, & Rodriguez, 2015; van Boekel et al., 2013).

Gaps in the current literature. Despite what is known about WUID and their health, there are many shortcomings in the literature. For one, while many studies addressed gender, they focused primarily on what men and women do differently, leaving little known about what women actually do. Anglin, Hser, and McGlothlin (1987) and Marsh and Simpson (1986), for example, reviewed differences in the drug use of men and women but revealed little of the lives of WUID and the factors that created the variances that were found for women. In the same vein, literature

has addressed the subcultural differences between men and women who use drugs regarding HIV acquisition. These studies identified that condomless sex and injection drug equipment sharing were more common amongst WUID, compared to men (Brown, 1998; Bruneau et al., 2001; Dwyer et al., 1994; Freeman, Rodriguez, & French, 1994; Gollub, Rey, Obadia, Moatti, & the Manif Group, 1998; Loxley, Bevan, & Carruthers, 1998). These studies did not, however, expound how and why these variances occurred, leaving subsequent explanations to be little more than conjecture and speculation.

Another knowledge gap in the literature relates to understandings about how WUID view health and how to meet the health needs with attention to their perspectives and life circumstances (Pinkham et al., 2012; VANDU, 2009). The health of WUID is poor for many reasons, including the practices and circumstances of intravenous drug use, poverty, homelessness, and social context (Fairburn, Small, Shannon, Wood, & Kerr, 2008; Roberts et al., 2010; Tompkins, Wright, Sheard, & Allgar, 2003; VANDU, 2009; Whynot, 1998). Without an understanding of what WUID experience and need, there is little likelihood of knowing what changes would assist a marginalized subculture that is stigmatized as dangerous, deviant, and dirty (Ettorre, 2004; Hunt & Derricott, 2001; Kirtadze et al., 2013; Lloyd, 2010; UNDOC, 2006). Additionally, despite what is known about barriers to seeking care, little is known about what encourages WUID to engage in healthcare (Pinkham, Stoicescu, & Myers, 2012; VANDU, 2009). When WUID do present for care, they often do so late in their illness, sometimes with life-threatening consequences (Palepu et al., 2001; Ronan & Herzig, 2016).

In summary, the literature includes an overabundance of studies that portray PWID as homogenous, while relying on androgenic observations to interpret what WUID do (Hankins, 2008; Roberts et al., 2010; United Nations Office on Drugs and Crime [UNODC], 2014b, 2016). Consequently, researchers need to better understand WUID – what they say and do, in short, their subculture – and to seek out suggestions for providing equitable healthcare. To this end, an ethnographic study was undertaken, providing a current and comprehensive understanding of

WUID, derived from the women as they described and enabled an understanding of their world and their lives.

Research Questions

This study sought to explain how the tacit knowledge of WUID informs their behaviour and actions. The aim was to develop a nuanced understanding of the subcultural norms of WUID, that is, the social and cultural attributes that make them vulnerable and susceptible to the acquisition of health issues, in the broadest sense. More specifically, the research questions were as follows:

What are the subcultural norms of WUID?

How do these subcultural norms relate to and influence health?

Study Paradigm, Ontology, and Epistemology

The paradigm of the current study is that of critical theory, with a more specific poststructuralist lens. In this section, a concise introduction and brief explanation of the ontological and epistemological assumptions guiding the research is provided.

Ontology. The ontology of this research, derived from critical theory and poststructuralism, will be contrasted with that of post-positivist paradigm to describe and demonstrate an alternate way of thinking about truth and the firmly ingrained lens of common culture. From a post-positivist perspective, the perceived truth is a developed reality; in other words, it is socially, politically, and historically created, ensuring a predictable manner of being, which is perpetuated, internalized, and lived as the values that are assumed by society to represent truth and the proper order of things. Knowledge is therefore not neutral, instead reflecting societal hegemony, which gained legitimacy and became considered as the best way of understanding the world (Angrosino, 2008; Giacomini, 2013; Strega, 2005). Other approaches to uncovering knowledge are regarded as producing quasi-truths versus verified truths, subjective knowledge versus objective, and further create difference and division.

The post-positivist paradigm can allow knowing, and accepting close approximations to accepted ways of being (Polit & Beck, 2012; Lincoln, Lynham, & Guba, 2011), but is not accepting of blatant deviance from firmly accepted knowledges and truth, which are evaluated against, and propagated by, the dominant discourses of science, law, medicine, and economics. In other words, such hegemonic discourses are reified as possessing absolute truth, created by a post-positivist lens. This position then discounts the reality of others, subjugating their perspectives as inferior. As Moosa-Mitha stated, “normative epistemological assumptions valorize sameness and view knowledge as a way to uncover events that follow universal laws in a predictable manner” (2005, p. 45). Such disregard can occur when the beliefs of science and scientists conflict with the perspective of others. Thus, the reality of marginalized people is often discredited and dismissed.

The ontological lens underpinning this study is thus one that promotes the discovery of the other, and which views marginalized people as oppressed by the dominant hegemony, for reasons that are historically developed and well entrenched. The voices of the marginalized may help uncover this alternate perspective of being, shedding the hierarchical perspective of gender, class, race, religion, and sexuality (Ladson-Billings, 2000; INPWUD, 2014), as well as social activity and economic freedom. Alternate perspectives can deconstruct the manner in which a reality is presented and distort the manner by which the status quo is maintained.

From a critical theory and poststructuralist perspective, one can challenge or deconstruct the dominant reality bringing to the fore alternate ways of thinking, that is, other discourses that can be considered as valid as the hegemony that dominates. Adams St. Pierre summarized this discussion when she said, “at this moment we are latched onto descriptions that are producing us and the world, descriptions that, over time, have become so transparent, natural, and real that we’ve forgotten they’re fictions. We accept them as truth” (2011, p. 623).

The singularity of a dominant hegemony will thus be rejected in this study, instead choosing the pluralism of considering difference. The current study breaks down some of the

constructed ways of knowing about the world, which appear to exclusively serve the interests of those who gain prestige and acumens bestowed by the dominant thinking and mainstream institutions. The resulting knowledge will be critical; in other words, it will assist with making emancipatory assertions with the goal of enabling a changed perspective of how one views the subculture of WUID in this society. As the study unfolds, an alternate truth, a way of being and pluralistic thinking will be demonstrated in the interest of the emancipation of a marginalized population (Thomas, 1993). From this perspective truth is neither stable nor universal; it is instead created, and those who do not follow the reigning hegemony continue to be admonished.

Epistemology. Researchers were traditionally regarded as objective, neutral observers, detached and in search of absolute truths, isolated from influencing research findings (Polit & Beck, 2012). From the poststructuralist epistemological lens, truth is relative. Within research, it is accepted that both the researcher and those participating may come from different paradigmatic perspectives, different worlds, truths, and knowing. What is observed and what is interpreted is determined through the lens of a socially situated self. However, also to consider is that “the knower and known interact and shape one another” (Denzin & Lincoln, 2011, p. 13). This dynamic is constantly shifting and evolving. The findings of this research will, therefore, be reflective of the intersection of the two worlds, not one or the other, but a composite. There is no one way to interpret the world, “no clear window into the inner life of an individual” (Denzin & Lincoln, 2011, p. 12). The current study recognizes the positionality of the researcher and the researched. The results are a product of a filtered lens.

The current study acknowledges the need for deconstruction and an awareness of a dominant hegemony inherent in critical theory, the pluralism of the ontological stance, and the epistemological influence of positionality. Sensitivity to these factors assists with the evolution and exposure of another way of interpreting and understanding perspectives of truth and what it conveys. The positionality of WUID—and also that of the researcher—is constructed by the

prevailing discourse that determines their subjectivity. It was with awareness that the evolving study's discourse informed the findings of this research.

The powers that pervade the world, determining and interpreting what is known, with an ability to marginalize and stigmatize that which is not regarded as part of the normative and accepted behaviours, needs to be illuminated. To know more about this oppression involved my intention to be with the women and to enable their voices to be heard over the clatter of what is accepted as truth. In short, the result of power/knowledge and discourse has been explored using a critical ethnographic methodology, exposing how WUID are shaped as abject and stigmatized and how they resist this marginalization.

Chapter Two: Literature Review

To appreciate what is known about WUID, this chapter reviews (a) the processes related to intravenous injection drug use, including the continuum from obtaining and injecting drugs through to quitting drug use and treatment options, (b) what is known generally about people who use intravenous drugs (PWID), (c) what is known more specifically about WUID, (d) evolving directions and influences on WUID culture, and (e) limitations of the extant literature.

The Process of Injecting Intravenous Drugs

This section details the literature about how PWID—with special attention to WUID where data are available—obtain (a) capital for drugs, (b) equipment to inject, and (c) drugs for injection. The action of injecting and important contextual drug use issues (i.e., overdose and withdrawal) are also discussed. Additionally, there is a review of what is known about abstaining from drug use in terms of oral opioid substitution and treatment programs. An understanding of the process of using drugs to inject is central to the culture of PWID, and thus to WUID.

Obtaining capital to disposing equipment. While the process of drug procurement has not been well studied, existing data identify that income from government cheques and regular work are often supplemented by stealing, sex work, collecting bottles and cans, panhandling, stipends for work completed for harm reduction agencies, incentive money for assisting with research, squeegee work, and trading leftover drug residue (Bourgois & Schonberg, 2009; Krebs et al., 2016; Miller & Neaigus, 2001; Neale, Nettleton, & Pickering, 2014; VANDU, 2009; Rosenbaum, 1981; Taylor, 1993). In combination, these sources of income are the “hustle” PWID refer to, and the busy chaos that has been observed. Obtaining capital can be dangerous, involves risks to personal and structural safety, and underpins some of the perilous vulnerability of those who use intravenous drugs. These means to obtain capital involve special skill sets and constant interactions and vigilance.

Rosenbaum (1981) stated that hustling (any means of obtaining capital to purchase drugs, as noted above), finding, obtaining, and using drugs are all inherently detrimental to health and involve possible legal consequences. These activities, which present potential obstacles to keeping oneself healthy and out of jail, are made more demanding when compounded by the symptoms of withdrawal, which can induce people to take desperate measures to obtain and use drugs.

Once capital is obtained, drug procurement is next, which Johnson and Williams (1993) identified as relying on economic reasoning and the estimated value or cost of using other people to assist them. Johnson and Williams (1993) identified that the person who does the most work during a drug interaction has the lower status. For example, a runner (someone who buys and delivers drugs) may receive some of the obtained drug as payment but does more work and takes more risks. The observed complexity of getting drugs described by Johnson and Williams (1993) is informative but leaves questions about WUID who sell drugs or act as intermediaries in obtaining drugs.

Finding a reliable dealer who has quality drugs, and sufficient quantities to sell, are other common issues. Moreover, the danger under which WUID live is twofold. As Taylor explains, WUID cannot employ the usual channels of informing the police about being “ripped off” (1993, p. 57). They would risk exposing themselves to arrest whether or not the issue was related to drugs or sex work. Thus, not only are they persecuted, but also the perpetrators are certain there will be no legal consequence, and the women are further removed from protection by the authorities.

Another component of obtaining drugs relates to which drugs are used, with many studies indicating that polysubstance use is prevalent (Bourgois & Schonberg, 2009; Firestone & Fischer, 2008; Gossop, Stewart, Treacy, & Marsden, J, 2002; Poole, 2007b; VANDU, 2009; Wild et al., 2003). Klee and Morris (1995) had participants in their study who injected up to nine different drugs, with an average of four. This variability can occur due to diminished supply or intentionally

(Bourgois & Schonberg, 2009; Taylor, 1993). An example of the latter is the use of opiates to address withdrawal symptoms, followed by cocaine to experience an energized high, later followed by another opiate to “come down” or to regain calmness (Firestone & Fischer, 2008).

When drugs are obtained, injection equipment is required. Needle exchange programs (NEPs) are a means to obtain such paraphernalia. Wild et al. (2003) showed that, despite these free services, drug equipment is still commonly reused, and concluded that NEPs should offer unlimited supplies to increase accessibility and reduce risks. Neale et al. (2007) suggested that NEPs should have predictably extended hours and should include token-run vending machines to increase access to equipment. In addition to these formalized mechanisms, Bourgois and Schonberg (2009) identified that some PWID sold syringes or traded new syringes for used ones. These authors (2009) also identified that PWID with drugs could access places for injection, provided they were willing to share their drugs with the persons already within these spaces.

With drugs and equipment available, the next step in the process of injecting drugs is the identification of a physical place to inject. Cruz et al. (2007), Taylor (1993), and Rosenbaum (1981) reported that PWID typically use drugs in their own or others' homes, and that those who inject in streets, parks, bathrooms, or vehicles are often homeless (Klee & Morris, 1995). Linas et al.'s (2014) study replicated these findings, highlighting that while most injection occurred at home, some was in less structured environments, such as abandoned spaces or while out walking.

Next, PWID must prepare their drugs for injection, with most of such research focusing on infectious disease transmission. For example, the act of licking needles prior to injection, which Binswanger et al. (2000) and Deutscher and Perlman (2008) estimated to occur amongst one third of PWID, has been associated with skin and heart infections due to the presence of oral bacteria (Mah & Shafran, 1990; Raucher et al., 1989). Bourgois and Schonberg (2009), Firestone, Goldman, and Fischer (2009), and Roy, Arruda, and Bourgois (2011) noted the following additional items regarding preparation for injection: (a) an acknowledgement of the potential

lethality of injecting drugs; (b) crushing pills (to then use for injection) with unclean cigarette lighters or other objects, or between pieces of cardboard; (c) re-inserting used needle tips into cookers to extract more fluid to re-inject; and (d) keeping the remaining contents of the cooker (known as a wash), including filter, for later use for another weaker high or to stave off withdrawal, or to use as a bargaining tool with others. Thus, the value of the wash overrides any apprehension that it may be a source of infection (Roy et al., 2011).

After preparation, PWID must select an injection site. Sheard and Tompkins (2008) found that PWID injected drugs into many veins on their bodies. Healthcare providers use some of these sites for medical purposes, while other sites (e.g., neck, axilla) are generally avoided due to an increased risk of adverse outcomes, such as endocarditis (Gordon & Lowy, 2005). Both Wild et al. (2003) and Bourgois and Schonberg (2009), however, identified that PWID inject into their necks. There is limited extant literature about how people make decisions regarding their preferred injection site.

The last step of injection drug use is equipment disposal. Although little is said about this topic, what is known shows that disposal often occurs in public spaces, making it a health concern due to the potential for infectious disease transmission (Green, Hankins, Palmer, Boivin, & Platt, 2003; Parkin & Coomber, 2011; Rhodes et al., 2007; Thompson, Boughton, & Dore, 2003). De Montigny, Vernez Moudon, Leigh, & Young (2010) found discarded needles not far from a site where injecting took place, and fewer discarded needles when injection equipment disposal, or biohazard, bins were placed close to a site where injecting occurred.

Another study cited the concerns of PWID about biohazard bin placement (Parkins & Coomber, 2011). Biohazard bins in open spaces decreased use because they could lead to identification as PWID, or could be known to police, which PWID felt could lead to arrest while disposing equipment (Parkins & Coomber, 2011). On this point, participants noted the irony of being encouraged to dispose used equipment for an act that was not sanctioned (Parkins &

Coomber, 2011). While inherently safe disposal is endorsed, the best means to provide this is yet to be determined.

Other considerations. Other important aspects of injection drug use relate to sharing, withdrawal, overdose, and initiating intravenous drug use in others. First, Davey-Rothwell and Latkin (2007) and Higgs et al. (2008) are amongst those that studied PWID and determined that social processes were involved in sharing injection equipment. Sheard and Tompkins (2008) demonstrated that WUID commonly shared injection equipment, and that deceit and deception were common with this practice. Wild et al. (2003) also found that while PWID valued NEPs, it was not enough to ensure they used clean equipment. There were social and individual circumstances – peer behaviour, convenience, trust, accidents, or not caring – which established one’s ability to voluntarily or involuntarily obtain NEP equipment and not reuse drug paraphernalia (Wild et al., 2003). How sterile equipment is supplied and distributed, including the particulars amongst women, requires further study.

Second, withdrawal, known as being “dope sick,” is associated with risk taking amongst PWID in attempts to procure and use drugs and, amongst WUID in particular, with engagement in sex work to obtain drugs (Bourgois & Schonberg, 2009; Connors, 1994; Johnson & Williams, 1993; Kerr, Small, Hyshka, Maher, & Shannon, 2013; Linas et al., 2014; Miller & Neaigus, 2002; Sheard & Tompkins, 2008; Taylor, 1993; Rosenbaum, 1981; Werb et al., 2008; Wright et al., 2007). These studies highlight an important aspect of intravenous drug use that needs to be addressed to move forward with efficacious harm reduction approaches: When the need for a drug is so strong that harm to one’s life is not a deterrent, yet-to-be-determined interventions are required.

Third, British Columbia reports (Ministry of Mental Health and Addictions, 2018) there were 1,422 illicit drug overdoses deaths in 2017. Similar statistics exist in the United Kingdom and elsewhere (European Monitoring Centre for Drugs and Drug Addiction [AMCDDA], 2018; Knopf, 2016; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2018; Seth, Scholl,

Rudd, & Bacon, 2018), leading to mass international roll-outs of interventions. Kerr et al. (2013) studied the effects of such interventions and warnings about identified potent drugs and found, as did Miller (2007), that messaging did not change injection practices. Participants sought out the potent drug to (a) avoid withdrawal, as they could purchase less than usual, and (b) get a better high; PWID also stated that their ongoing survival while using drugs provided confidence they could use the stronger drug without incident. These studies also highlighted that public health messaging was poorly constructed, as indicating that a drug is high potency is a selling tactic by dealers.

Sheard and Tompkins's (2008) study of WUID, some of whom had overdosed, identified that these women were often abandoned during the overdose due to others' concerns about legal repercussions if emergency services arrived, and that the overdose did not deter subsequent use. This information highlighted that current legal and health structures can worsen the outcome of overdose (related to being left alone), and that fear of overdosing does not prevent drug use.

Fourth, Tozer et al.'s (2015) study of street youth identified that PWID did not condone initiating youth into intravenous drug use. PWID would report youth using intravenous drugs to police, discourage them from injecting and follow a code of conduct prohibiting showing young people how to inject or injecting them (Tozer et al., 2015). One youth stated that if such assistance was given, it would be a sign of disrespect (Tozer et al., 2015). This code of conduct should be investigated for its universality and implications for young women wanting to initiate drug use. Bluthenthal et al. (2015) found WUID were more likely than men to be asked by others to initiate their drug use, although being white and having a sex partner who injected were also correlated. Based on their findings, Bluthenthal et al. (2015) proposed strengthening interventions to prevent people, and especially women, from initiating others into intravenous drug use.

Avoiding sequelae. Knowing the risks they are taking prompts some PWID to take steps to mitigate the various negative consequences of their lifestyle. These can be individually determined or can make use of institutions or organizations that seek to promote harm reducing activities and products. Safe injection sites (SISs) are being promoted by many advocates for overdose prevention, including PWID, as an important harm reduction strategy; however, they are not without their flaws and not all sequelae can be prevented.

McGowan, Harris, and Rhodes (2013) investigated how PWID prevent hepatitis C and identified the practices of not sharing equipment by marking syringes, using alone, preparing their drugs themselves, disposing in a biohazard, stocking up on equipment and drugs (to avoid the urgency produced by withdrawal), and using alternate consumption routes (McGowan et al., 2013). Nevertheless, McGowan et al. (2013) noted that these preventative practices were changed if other pressing priorities arose.

In addition to personal practices, systems strategies (NEPs and SISs) can reduce drug sequelae (Enns et al., 2015; Jozaghi, Reid, & Andresen, 2013; Pinkerton, 2011). In Germany, Zurhold, Degkwitz, Verthein, and Haasen (2003) found that 37% of those accessing SISs used clean equipment and 30% used less in public spaces. Kinnard, Howe, Kerr, Hass, and Marshall's (2014) Danish study of 41 people using an SIS similarly reported a reduction of 50% for outdoor injecting and of 43% for equipment sharing. Reduced injection in public and litter of used equipment were also noted after SIS implementation (Striker et al., 2013; Weekes, Percy, & Cumberland, 2005). Additionally, no fatal overdose has occurred in an SIS, contrasting with non-fatal overdose rates per injection quoted as being 1.11/1000 at Insite from 2003 through 2010 (Zlotorzynska et al., 2014). The latter number portrays a more accurate rate of overdose being experienced by PWID. A review of drug consumption sites in Europe by Dolan et al. (2000), plus a systematic review of the literature by Potier et al. (2014), also indicated low rates of reversed overdose by injection rate. As Weekes et al. (2005) pointed out, however, SISs do not eliminate

all risks; for example, the risks related to getting money or goods to trade for illicit drugs, and the trustworthiness of dealers, remain.

Weekes et al. (2005) also stated there is little known about women using SISs. Fairburn et al. (2008) explored this and found that women described SISs as places they could be safe from violence, both personal (intimate partners) and structural (police, the public), and it freed them from some of the difficulties of interacting and negotiating with others (Fairburn et al., 2008). One participant reported that, due to instruction and education from SIS staff, she was able to inject herself and rely less on her boyfriend who was injecting her in a neck vein (Fairburn et al., 2008).

Others have reviewed this approach to assisting PWID who cannot self-inject (Fast, Small, Wood, & Kerr, 2008; Small et al., 2012; Wood et al., 2005; R. A. Wood, Wood et al., 2008). Fairburn et al. concluded that, while SISs prevent some harms, they do not address “various economic, legal, and social forces” (2008, p. 822) that compromise the lives of PWID. For example, SIS staff cannot physically assist with injection (McNeil, Small, et al., 2014), so those unable to inject themselves due to poor venous access or disability (e.g., immobility, tremor) – estimated to be 25% of PWID – may not receive help. In response, a peer-assisted injection site was established in Vancouver (McNeil, Small, et al., 2014), helping everyone, not just able-bodied injectors (McNeil, Small, et al., 2014). This service, however, closed July 2014 due to what authorities felt were possible risk to clients and poor practices (Damon & Neufeld, 2014).

Another identified issue includes the rule to not admit first-time users to the facility, which can lead to those most in need not being well served (Bayoumi & Strike, 2012; Weekes et al., 2005). There is much documented evidence that the first injection is fraught with complications including not knowing how to fix the drug (Wright et al., 2007), not having sterile equipment (Goldsamt, Harocopos, Kobrak, Jost, & Clatts, 2010), the risks of being injected by others (Goldsamt et al., 2010), and missing the intended vein and traumatizing tissue (Wright, et al.,

2007). Blood borne viral infection (BBVI) transmission is higher in the first injection and for the first few years thereafter (Goldsamt et al., 2010; Roberts et al., 2010).

This overview of intravenous drug use provides a background to understanding WUID. While their lives are affected by patterns of drug use, their personhood is more than that of a “drug user.” The following sections review the lives of PWID in general and then WUID more explicitly.

People Who Use Intravenous Drugs

This section summarizes what is known about PWID with the stated limitations that this literature is generally dated, specific to one geographic region, or limited by methodologies that restrict what can be known.

Health and healthcare utilization. PWID have complex health needs and are, at the same time, a unique subpopulation for healthcare delivery, both medically and socially (Day et al., 2011; Kemp, 2004; Larance et al., 2015; Mertz et al., 2008; Warner & Srinivasan, 2004). The range of health concerns for PWID includes BBVIs (e.g., HIV), soft tissue infections (e.g., abscesses), less superficial infections (e.g., endocarditis) proximal to an injection site, gynecological conditions (e.g., amenorrhea), trauma (e.g., childhood sexual abuse), and mental health (e.g., post-traumatic stress disorder). With early intervention, these health concerns may be prevented or more readily treated, limiting serious and sometimes life-threatening sequelae (French, McGeary, Chitwood, & McCoy, 2000; Morrison, Elliott, & Gruer, 1997).

Yet prevention is rare, and many PWID are admitted to hospital for lengthy stays (Glauser et al., 2016; Walley et al., 2012). Healthcare use and costs of caring for PWID can be elevated compared to for those not using drugs, because PWID often present for care at an advanced stage of illness (French et al., 2000; Morrison et al., 1997; Mertz et al., 2008; Ostertag, Wright, Broadhead, & Altice, 2006; Palepu et al., 2001; Popova et al., 2007). Their poor condition is, by this time, beyond community-based and preventative care services and requires tertiary

healthcare (French et al., 2000; Kerr et al., 2004; Morrison et al., 1997; O'Toole et al., 2007; Sterk, Dolan, & Hatch, 1999).

Studies identify that PWID avoid healthcare due to poor treatment and stigmatization by providers (Day et al., 2011; Kerr et al., 2004; Kirtadze et al., 2013). Participants in Wild et al.'s (2003) and Neale et al.'s (2008) studies found accessing healthcare in hospitals difficult for PWID, who felt they were more often judged in these settings. Ahern, Stuber, & Galea (2007) and others (Skinner, Feather, Freeman, & Roche, 2007; van Boekel et al., 2013) linked this stigma with a reluctance to seek healthcare.

Lloyd (2010), Seymour (2012), and Simpson and McNulty (2008) illustrated how ingrained negative and stigmatized terminology is. For example, their documents about PWID include phrases such as “drug misusers” and “problem drug users” (see Lloyd, 2010) despite their intention to moderate deprecating attitudes toward PWID.

These experiences of stigma may also lead to PWID “leave against medical advice” before being seen or before treatment concludes (Canadian Institute for Health Information [CIHI], 2013; Hwang, Li, Gupta, Chien, & Martin, 2003; Seaborn Moyse & Osmun, 2004; Smith & Telles, 1991). Studies have identified high rates of return to hospital and mortality for PWID who leave despite recommendations not to (Choi, Kim, Qian, & Palepu, 2011; Garland et al., 2013).

Inadequate pain management is one reason why PWID leave care. Haber et al. (2009) suggest that when experiencing pain, PWID need reassurance their pain will be controlled and, for people who regularly use opioids, analgesia and methadone should be started and dosed according to need (Chan et al., 2004). Longer-term management may require referral to a pain clinic, but discharge planning must maintain access to opioids as needed (Haber et al., 2009). Ti and Ti's (2015) review supported the need for in-hospital methadone and transitioning of care to the community when possible to help reduce PWID from leaving prematurely (Donroe et al., 2016; Ti & Ti, 2015).

Another aspect of healthcare avoidance relates to self-care. Although studies cite the lack of attendance of PWID at healthcare facilities (Leonard, DeRubeis, & Strike, 2008), Binswanger, Kral, Bluthenthal, Rybold, & Edlin, (2000) found, in their cohort, that many PWID engaged in self-care, including lancing their own abscesses or obtaining antibiotics from others. A study by Larance et al. (2015) similarly found that people with chronic pain often used their oral opioid medication by injection, and that diversion of these prescribed medications was also not uncommon. Thus, PWID may prefer self-treatment as it allows them to avoid accessing healthcare. Although helpful to know, the rationale for choosing self-care over that provided by a healthcare facility is not fully clarified in the foregoing studies.

Few studies examine what PWID think about, and how they use, healthcare. Of those that exist, many employ surveys and statistical analyses (e.g., Fischer et al., 2005, French, Fang, & Balsa, 2011; McCoy, Metsch, Chitwood, & Miles, 2001; McGeary & French, 2000), asking predetermined questions with little opportunity to expand an idea or offer commentary. Studies have acknowledged the barriers PWID experience accessing care and the lack of qualitative studies exploring PWID concerns and suggestions for healthcare (McLaughlin, McKenna, & Leslie, 2000; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002; Moore, 2009; Neale et al., 2007). Often, as well, the qualitative studies decontextualize experiences; interview guides and participants (e.g., those in treatment programs, no longer using drugs) limit data collection, so researchers collect data that align with predetermined areas of interest and cohorts chosen for their accessibility, rather than enabling the people actively using drugs to tell their stories.

Fortuitously, there are reports that use the words of PWID about health and healthcare and are insightful, empowering, and provide direction. Studies such as those completed by, for example, Bayoumi and Strike (2012); Sheard and Tompkins (2008); or Wild et al. (2003) provide much insight into the lives of PWID. Sheard and Tompkins' study (2008) demonstrated the benefits of employing a qualitative approach. They found it is not that the women do not have or use sterile equipment, but rather that WUID do not consider risks for BBVI to include any

equipment that is peripheral to the needle and syringe (Sheard & Tompkins, 2008). Furthermore, sharing equipment is closely tied to intimate relationships in the women's lives, demonstrating love and trust, and can undermine any intention to use clean injection equipment (Sheard & Tompkins, 2008). As another example, it was not the fear of BBVIs that motivated women to use clean equipment but, rather, the worry of marring their appearance with scars (Epele, 2002b; Sheard & Tompkins, 2008). Clearly studies with predetermined questions and areas of interest, based on surveys and statistics, focus on what researchers want to know and thus tend to develop a very superficial understanding of the lives of the participants. Additionally, these qualitative studies demonstrate how decisions made by those who are outside the culture, policy makers for example, may fail to adequately understand what motivates and underpins the practices of WUID, thereby missing the mark of their good intentions.

Despite these limitations, the literature highlights that PWID want a care provider who is consistent, respectful, and trustworthy, as well as who provides compassionate, competent care (Brown et al., 2005; Gelberg et al., 2004; Joyce, 2004; VANDU, 2009; Salvalaggio, McKim, Taylor, & Wild, 2013; Wild et al., 2003). PWID also appreciated when care providers explored presenting concerns and disliked having health problems automatically linked to drug use (VANDU, 2009; Salvalaggio et al., 2013). Overall, although many of these studies found that PWID appreciated their care (e.g., Fischer et al., 2005; Neale et al., 2007), this finding may have been related to PWID being unwilling to critique the services they were receiving.

Nonetheless, four themes emerged from the literature about what PWID appreciate in healthcare. These are (a) non-judgemental, non-punitive providers who employ harm reduction strategies and ensure WUID feel safe and welcome (Ditmore, 2013; Gelberg et al., 2004; Pinkham et al., 2012; VANDU, 2009; Salvalaggio et al., 2013), (b) comprehensive one-stop healthcare services (Brown et al., 2005; VANDU, 2009, p. 26) (e.g. crisis housing, counseling, employment and educational programming, and mobile or at minimum accessible drug treatment and NEPs [Pinkham et al., 2012], which are open extended hours with flexible appointments and little wait

time [Copeland, 1997; Ditmore, 2013; Neale et al., 2007]), (c) incorporating PWID in the planning stages of services (Homeless Healthcare, n.d.; Magee & Hurliaux, 2008; Pinkham et al., 2012), and (d) maintaining peers to work alongside the healthcare providers (Ditmore, 2013; Neale et al., 2007; VANDU, 2009). Canadian studies also suggest healthcare providers need to have more knowledge about health conditions relevant to those who use drugs (Ditmore, 2013; VANDU, 2009; Salvalaggio et al., 2007).

Zule et al. (2015) further illustrated the need to involve PWID in harm reduction proposals. In their study, advocating for low dead space syringes and needles, those that leave little to no residual blood, seemed an appropriate approach to reduce blood borne viral transmission. Participants, however, commented that the equipment was the wrong size for their needs (Zule et al., 2015). In this case, the newly introduced means of reducing blood borne viral transmission would not have been acceptable, and therefore not used by the PWID that this innovation was meant to serve. Not hearing what PWID have to say perpetuates health promotion strategies that are based on provider logic rather than a deep understanding of what propels and determines the behaviours and actions PWID take in their everyday lives.

Homelessness. Many PWID cycle through being housed and homeless, the latter ranging from “sleeping on the streets” to “couch surfing” (Dobson, 2011; Erickson, King, & Young Women In Transit, 2007; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Neale, 2001; Neale, 2008; Neale et al., 2014; Palepu et al., 2010). In both cases, living conditions can be unsafe and lead to negative health sequelae. Neale (2008) proposed that housing is public health issue because homelessness correlates with drug use, social exclusion, rape, and homicide. A global review (Pinkham et al., 2012) solidly correlates unstable housing with higher rates of HIV, possibly related to the risks of unregulated sex work (Corneil et al., 2006; Spittal et al., 2006). Indeed, Pinkham et al. (2012) identified that PWID make compromises for survival, meaning they take risks in the context of both injecting and sexual activities (Pinkham et al., 2012).

Gender differences. Of the literature regarding PWID, overwhelmingly, women – who represent about one third of PWID – are absent, or the study population is gender-homogenized, meaning that differences in findings between male and female participants were not explored (e.g., Day et al. 2011; Domingo-Salvany et al., 2010; Freeman et al., 1994; Hepburn, 2002; Hindler et al., 1996; McLaughlin et al., 2000; Neale et al., 2007; Salvalaggio et al., 2013; Whynot, 1998; Wright et al., 2007). Likewise, in studies about the attitudes of healthcare providers about PWID, conclusions address PWID as a single group and fail to elaborate on the differences, needs, and perceptions of WUID (e.g., Abouyanni et al., 2000; Chu & Galang, 2013; Howard & Chung, 2000; Jeffrey, 1979; McLaughlin, McKenna, Leslie, Moore, & Robinson, 2006; McLaughlin & Long 1996; Peckover & Chidlaw, 2007).

Other studies about PWID put some merit on gender demographics and the differences in the lives of men and women (e.g., Davey-Rothwell & Latkin, 2007; Doherty, Garfein, Monterroso, Latkin, & Vlahov, 2000; Domingo-Salvany et al., 2010; Frajzyngier, Neaigus, Gyarmathy, Miller, & Friedman, 2007; Freeman et al., 1994; Garcia de la Hera et al., 2001; Gollub et al., 1998; Loxley et al., 1998; Marsh & Simpson, 1986; McLaughlin et al., 2000; Merrill et al., 2002; Neale et al. 2007; Risser, Cates, Rehman, & Risser, 2010). Although some of these studies occurred two decades ago, these findings still form the basis of many assumptions about WUID.

More recent work, such as that by Cruz et al. (2007), found men commonly inject with friends or other PWID in public places and places where people gather to inject, whereas women were more likely to use drugs with intimate partners or close friends in their own or other's homes. The investigators postulated this difference occurred as a result of the women's need for safety, including the danger presented by the men they associated with (Cruz et al., 2007).

Other authors (Frajzyngier et al., 2007; Gerstein, Judd, & Roviner, 1979; Hser, Anglin, & McGlothlin, 1987; Powis, Griffiths, Gossop, & Strang, 1996) found differences in intravenous drug use initiation according to gender. Despite the literature that created the belief that men coerce women into such drug use, other studies suggest that men are not always instrumental in the

introduction to, nor continuance of, women injecting drugs (Doherty et al., 2000; Mayock, Cronly, & Clatts, 2015; Taylor, 1993; Powis et al., 1996). This point highlights that studies examining gender differences in PWID are needed. To further the knowledge of women-centred healthcare, it will be important to further study these nuances.

Coupled relationships. Although little is written about the relationships of WUID, what is known shows that couples who use drugs have loving, as well as dysfunctional, dependent, and violent, relationships (El-Bassel, Gilbert, Wu, Go., & Hill, 2005, 2011; Sheard & Tompkins, 2008; Simmons & Singer, 2006; Taylor, 1993). Studies have also concluded couples who inject drugs have differing needs from those of single members of this population (Cavacuiti, 2004; El-Bassel et al., 2010; Garcia de la Hera et al., 2001; Gay, Croce-Galis, & Hardee, 2016; Higgs et al., 2008; Jiwatram-Negron & El-Bassel, 2014; Pinkham et al., 2012; MacRae & Aalto, 2000; Rhodes & Quirk, 1998; Roberts et al., 2010; Simmons & Singer, 2006).

For one, in discordant drug use relationships, lying and deceit were common, and the relationship often ended when the drug use was discovered (Rhodes & Quirk, 1998). In some instances, however, non-using partners began using injection drugs as an evolution of the relationship. In contrast, the relationship of couples who both use drugs is often driven by a common drive to get and use drugs, and prevent withdrawal (Higgs et al., 2008; Rhodes & Quirk, 1998; Simmons & Singer, 2006). These couples demonstrated “care and collusion” (Simmons & Singer, 2006, p. 1), even though partnerships were difficult, and had rules for sharing drugs based on trust (Johnson & Williams, 1993; MacRae & Aalto, 2000). When one partner violated this agreement, such as when the needs of drug use superseded the relationship, arguments ensued (Rhodes & Quirk 1998; Rosenbaum, 1981; Simmons & Singer, 2006). Others have found the powerlessness of women in relationships of abuse impeded their attempts to safely use drugs (Haritavorn, 2014; Roberts et al., 2010; Wright et al., 2007). Rhodes and Quirk (1998) concluded that relationships involving drug use both “pragmatically and emotionally” (p.167) influenced the structure of the partnership. Lastly, Rosenbaum (1981) found that men and women were similar

in their drug use until children were conceived. At this time, women struggled with the needs for both drugs and child care. Men, in contrast, more often continued using drugs and did not have the same emotional turmoil surrounding their paternity (Rosenbaum, 1981; Taylor, 1993).

What Is Known About WUID

Childhood, family, and trauma. While some WUID have supportive family relationships, most are complex, strained, or severed (Bourgois & Schonberg, 2009; Murphy & Rosenbaum, 1999; Neale et al., 2007, 2014; Rosenbaum, 1981; Taylor, 1993). Contributing to the difficulties of familial relationships are the high rates of abuse suffered by WUID in childhood (Boyd, 1993; Neale et al., 2014; Roberts, 1999; Vaillancourt & Keith, 2007). Trauma has gained increasing attention, as the impact of such abuse is associated with substance use and physical health issues (Boyd, 1993; Boyd & Marcellus, 2007; Covington, 2008; Engstrom, El-Bassel, & Gilbert, 2012; Freeman, Collier, & Parillo, 2002; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Hadland et al., 2012; Mayock et al., 2015; Neale et al., 2014; Roberts, 1999; Roberts et al., 2010; Miller, 1999; Pinkham et al., 2012; Poole & Dell, 2005; The Jean Tweed Centre, 2013; Spittal & Schechter, 2001; Tyhurst, 2004; Wild et al., 2003). Spittal and Schechter's (2001) findings about women being brought into sex work and initiated into injection drug use at a young age attests to the initiation of drugs through force and violence. Additionally, Wild et al.'s (2003) participants described substance-using parents and leaving home at an early age or living in foster care homes.

Hadland et al. (2012) recommended addressing the issue of childhood abuse both through prevention strategies and early intervention. A review by Magee and Hurlaux (2008) concluded that amalgamating services operating on a harm reduction model, while providing trauma-sensitive programming and social services, assists women who are homeless or marginally housed.

WUID and pregnancy. In Canada, few services specific to maternal child health exist for WUID (e.g., Canada FASD Research Network's Action Team on Prevention from a Women's

Health Determinants Perspective [Canada FASD], 2012; Hume & Bradley, 2007; Payne, 2007a, 2007b; Poole, 2000; Racine, Motz, Leslies, & Pepler, 2009; Island Health, n.d.). However, published reports on maternal and newborn services suggest a move toward a model of care that encourages working toward individualized goals and possibilities (Payne, 2007a, 2007b). The work in maintaining mother-baby relationships has been a positive step toward demonstrating the ability of WUID to retain custody of their babies (Abrahams et al., 2010; Payne, 2007a, 2007b; Poole, 2000).

Despite innovative programs and services, women face extensive social marginalization related to gender and child-bearing expectations (Boyd, 2004; Greaves & Poole, 2004; Mahan, 1996; Murphy & Rosenbaum, 1999; Rosenbaum, 1981; Seymour, 2012; Simpson & McNulty, 2008; Taylor, 1993; Wiechelt, 2008). The combined status as a woman and a person who uses drugs creates conflict with societal role expectations of wife and mother. Boyd (2004) and others (The Jean Tweed Centre, 2013; Sheard & Tompkins, 2008; Simpson & McNulty, 2008; Taylor, 1993; UNODC, 2016) highlight the social impression that WUID are incapable and unfit to care for children, based on the belief that they have not prioritized their children's care over their drug use, signaling that child care by another party or person is necessary. Other studies (Murphy & Rosenbaum, 1999; National Institute on Drug Abuse [NIDA], 1980; Rosenbaum, 1981; Taylor, 1993) argue that the children of WUID suffer due to lack of supports and stigmatization from those involved with the family, rather than from neglect.

Society of Obstetricians and Gynecologists of Canada (SOGC) guidelines for substance use in pregnancy inform care providers to employ a "flexible approach" to care and recommend methadone or, if not available, slow-released opioids (Wong et al., 2011, p. 368). Others concur with this approach (Haber et al., 2009). Although these guidelines recommend a non-judgemental approach, they do not address providers' attitudes that may undermine this strategy.

The literature also identified that it is difficult for WUID who become pregnant to decide about healthcare utilization. Although some WUID seek opioid substitution therapy, they are

reluctant to do so when pregnant for fear of ridicule or of losing their children or baby, due to concerns that providers will not treat them because they are pregnant, and because of perceptions of long wait times (Hepburn, 2002; Maddocks, 2008; Pinkham et al., 2012; Poole & Isaac, 2001; Smith & Marshall, 2007; Stengel, 2014). Some care providers, however, interpret seeking healthcare and treatment to mean a WUID wishes to quit drug use (Csete & Canadian HIV/AIDS Legal Network [CHLN], 2006; Whynot, 1998). For treatment, Roberts et al. (2010) encourage drug decriminalization to reduce pregnant women's fear of losing their children. There thus appears to be two approaches to mothering and drug use: that of denying a WUID her right to be pregnant and mother, and another that trusts and believes in WUID and their potential to mother. This is a multifaceted concern compounded by social attitudes regarding who should be entitled to mother and the supremacy of child welfare agencies.

Taylor's (1993), Roberts' (1999), and Rosenbaum's (1981) studies found that, despite an intent to mother, some WUID could not maintain custody, with the resulting loss of the child corresponding with increased drug use (Neale et al., 2014; Taylor, 1993). The women also spoke of wishing to strengthen their relationships with estranged children, but that they often delayed re-entering their children's lives for fear of further disrupting their families and children (Bourgois & Schonberg, 2009; Neale et al., 2014; Rosenbaum, 1981; Taylor, 1993, Whynot, 1998). Bourgois and Schonberg's (2009) study supports the finding that WUID care about, and are proud of, their children, and that they often hope to establish parent-child relationships. Overall, while the children of WUID may not always be physically with them, it seems they continue to be an important part of their lives.

A typical day. This section details what is known about the daily activities of WUID and highlights that WUID describe their lives as a "roller coaster" and "cycle" of drug use and prostitution (Smith & Marshall, 2007, pp. 167, 169). The most articulated recounts about this process are found in two studies: Rosenbaum (1981) described the daily life of WUID as chaotic – an ever-evolving daily search for effective ways to find drugs, and to use them – amongst the

ever-present scrutiny of police, other PWID, and the public. Taylor (1993) concluded, instead, that each activity is calculated and systematic, a matter of survival in which, like a chess game, movements cannot be fully known in advance. While the rotating evolution of “get money, get drugs” appears to be disorganized, Taylor (1993) showed it was structured and methodical within the context and awareness of undetermined danger and risk.

Selling drugs. Small et al. (2013) indicated that outcomes for PWID selling drugs included being stolen from and the consequences of not paying debts, which might occur if drug consumption exceeded what they could sell. Small et al. (2013) indicated that, for women, selling drugs can provide a brief reprieve from sex work and its inherent dangers; for men, by comparison, selling drugs can become a career, often interspersed with jail time and escalating drug use (Small et al., 2013). Small et al.’s (2013) participants noted a tendency of dealers to exploit women involved in selling drugs more than men, as women were seen as defenceless and less likely to use violence in disagreements. Wild et al. (2003) identified similar findings in their ethnographic study in Edmonton. In interactions with those who sell drugs, Taylor (1993) found that WUID who were new to buying drugs were more likely to get less quantity or quality than paid for. Interestingly, women often took “the fall” and “saved” the partner/dealer/boss from jail time for reasons that were not determined in the study (Sterk et al., 1999). Whether these actions were to protect the drug supply by keeping the dealers on the street or an unwritten expectation of WUID is not known.

Sex work. Roberts et al. (2010) found that, for women, initiating sex work was associated with drug purchasing. Jeal and Salisbury (2004), Pinkham et al. (2012), and Spittal et al. (2003), moreover, found that street sex work and drug use significantly overlapped and that the two posed danger for the women due to syringe sharing, working in isolation, and intermittent condom use. As part of this, drug withdrawal creates further risk taking to appease intolerable symptoms (Pinkham et al., 2012). As one participant in Sterk et al.’s study explained, “women hit the pipe as much as guys do but it’s different for them. They know that they have a pussy to sell, and the

guys know that she'll sell it for some rock" (1999, p. 2063). As the craving for drugs intensified, women became more likely to exchange sex for drugs without regard for, or ability to resist, risks.

Injecting practices. Anglin, Hser, McGlothlin, and Booth in different working groups (Anglin, Hser, & Booth, 1987; Anglin, Hser, & McGlothlin, 1987; Hser, Anglin, & Booth, 1987; Hser, Anglin, & McGlothlin, 1987), Rosenbaum (1981), and Taylor (1993) are some of the earliest researchers to focus on WUID and their injecting practices. Some of what continues to be accepted from these early studies is that women (a) are introduced to intravenous drug use by men (who are often sexual partners), (b) are more likely to share needles with partners (often after the partner injected with the same needle) (Tompkins, Sheard, Wright, Jones, & Howes, 2006; PHAC, 2014), (c) have others inject them (McNeil, Small, et al., 2014), and (d) become addicted more quickly and later in life than men (Anglin, Hser, & McGlothlin, 1987; Freeman et al., 1994).

Sheard and Tompkins (2008) and Tompkins et al. (2006, 2007) have added further understanding about the lives of WUID. These results and others illustrate that WUID are more likely to have others inject for them because of (a) difficulty injecting into smaller, less superficial veins (Sheard & Tompkins, 2008), (b) lack of skill injecting (McNeil, Small, et al., 2014; Tompkins et al., 2006; Wood, Spittal et al., 2003), (c) a fear that injecting incorrectly will leave visible marks, infections, and scars revealing drug use (Epele, 2002b; Sheard & Tompkins, 2008), (d) a fear of needles or injecting (Sheard & Tompkins, 2008; Tompkins et al., 2006, 2007), and (e) a desire to consolidate a relationship (Johnson & Williams, 1993; Roberts et al., 2010; Tompkins et al., 2006). The women also spoke of having "weaker veins" or "lack of skill," (Epele, 2002b, p. 48) and consequently asked others to assist with an injection, sometimes paying their assistant with drugs or money (Tompkins et al., 2006).

Of issue, these practices put control of injection with a partner, who may determine how, when, and in what quantity a drug will be injected (Sheard & Tompkins, 2008; Tompkins et al., 2006; Wright et al., 2007). Other deceitful practices occurred when asking others to help. WUID

had drugs stolen or syringes switched (Taylor, 1993; Tompkins et al., 2006). The women in Tompkins et al.'s study (2006) also worried about risks regarding others injecting them, such as infection. They related experiences of being physically harmed, for example with skin irritations and pain, due to the injector's technique when it was unsteady or completed while under the influence of a drug. Sheard and Tompkins's cohort described a combination of injecting self and having others inject "depend[ing] on context, choice and circumstance" (2008, p. 1541).

Sheard and Tompkins (2008) believed that a focus on injecting practices, particularly in women, could reduce some risks. They and others (Connors, 1994; Roberts, et al., 2010; VANDU, 2009) delved into the lives of WUID and found that pain (from injecting and withdrawal) and harm (e.g., overdose, damage to veins) were common. Others identified frequent cutaneous infections (Hope, Hickman, Parry, & Ncube, 2014). Jeal and Salisbury (2004), in their sample of sex workers, found that, despite knowing the risks of injecting and that these could be mitigated through NEPs, 25% endorsed needle sharing. Other studies have demonstrated women's functional practices in terms of procuring drug use, such as "flashblood" (a woman injects herself with a needle and then, without removing the needle, withdraws blood and drug from her vein and passes it to another woman, thus hoping to share the drug and perhaps assist the other woman with alleviating withdrawal symptoms) and having others inject them (Klee & Morris, 1995; Kral, Bluthenthal, Erringer, Lorvick, & Edlin, 1999; McCurdy, Williams, Ross, Kilonzo, & Leshabari, 2010; 2005; Sheard & Tompkins, 2008; Tompkins et al., 2006; Wright et al., 2007).

Experiencing violence. Studies have found violence and abuse are prevalent in populations of women who have a low income, as well as those who are not securely housed, have mental health issues or use substances, or are designated as criminals (The Jean Tweed Centre, 2013; Poole, 2007b). WUID are included in many of these populations and are thus at risk of violence, trauma, and their sequelae. Covington (2008) cited that more than half of women who use substances have been abused. A study from Vancouver (VANDU, 2009) revealed about 80% of their cohort of women who used substances had mental and physical health conditions

that were believed to be a result of violence. The report indicated that women presented at the interviews with physical injuries, and that two of the participants died of violence-related causes during the study period. Moreover, compared to those without addictions, women with addictions have been traumatized more often, for longer durations, and their incidence of incest and rape is markedly higher (Covington, 2008). Others concur that WUID have experienced violence in greater numbers than the general population (Des Jarlais, Feelemyer, Modi, Arasteh, & Hagan, 2012; Jeal & Salisbury, 2004).

Furthermore, a report on violence against women reinforced that WUID are acutely affected, and suffer multifocal origins for it, including drug laws and domestic partners (Harm Reduction International [HRI], 2013). Others supported this finding (Ditmore, 2013; The Jean Tweed Centre, 2013; Pinkham et al., 2012; Roberts et al., 2010; VANDU, 2009), indicating that nearly all WUID or women who sell sex have experienced physical, sexual, or psychological violence. The corollary is that many women also use drugs to cope with this violence (VANDU, 2009). There is thus a circular pattern perpetuated by the experience of violence, which can lead to drug use to cope by self-medicating, which can increase vulnerability to violence, leading to further drug use.

McNeil, Shannon, et al. (2014) studied violence in the context of PWID and place. Participants described avoiding areas of known, and often personal experiences of, violence, to the exclusion of harm reduction services, drop-ins, and housing targeted for PWID (which were seen as safe havens from the violence and turmoil of the streets but located in triggering areas). Thus, the women were repelled from areas with services that had as their intention to assist.

Although Rosenbaum (1981) found the WUID in her study thrived on the excitement of the danger their lives involved, this is a rare finding. Taylor's (1993) cohort neither associated danger with excitement nor thought of danger as a positive aspect of their lives. Instead, Taylor explained, for the women she studied, the danger and risks in their lives were likely normalized because of the frequent occurrence of undertaking and experiencing dangerous activities. A life using

addictive drugs involves “constantly looking for dealers to score from; the risks attached to their ways of making money, health problems arising from the adulterants in drugs; unhygienic injecting practices; and lack of nutritious food as money was kept for drugs” (Taylor, 1993, p. 153).

Interacting with police. Although the literature about WUID and the police is scant, there has been a recent focus on law enforcement in Eastern Europe due to the brutality and inhumane treatment WUID and sex workers receive; beatings, gang rapes, and required humiliating activities are listed amongst the offences (Merkinaitė, 2012). Fitzgerald (2005) questioned the lack of public health response to police practices that harm. Contemplating strategies to assist in profiling the absurdity of police presence in the day-to-day lives of PWID, he challenged researchers to convey this occurrence to the world and appealed to common sense.

Other studies (Pitpitan et al., 2016; Rhodes et al., 2007; Strathdee et al., 2011, Werb et al., 2008) illustrated that police, in attempts to decrease drug use, perpetuate risk because their presence creates the need to urgently hide drugs and equipment, leading to situations that increase risks for infection transmission, both for the person using drugs (Pollini et al., 2008; Philbin et al., 2008; Strathdee et al., 2011) and those inhabiting an area where used needles are discarded. Although Strathdee et al. (2011) conceded that cause and effect cannot be established, it is possible to surmise that the need to hide injection equipment may force drug use to go underground and unsafe practices arise, for example, as people share equipment instead of exposing themselves as PWID by attending NEPs. Shannon et al.’s (2008) social mapping research illustrated this point: WUID, who may or may not be involved in sex work, avoid areas that are policed. Unfortunately, these areas often included fixed-site harm reduction services, which speaks not only to police presence as a deterrent to NEPs and other services, but also to the need to maintain mobile and dynamic programs to meet needs.

WUID within the community of PWID. There is a paucity of literature addressing the social interactions specific to WUID, with the exception of Rosenbaum’s (1981) and Taylor’s (1993) work. In Taylor’s (1993) study, she indicated that WUID relied on each other for much of

the information and resources they needed to support their drug use. Additionally, the comradery amongst WUID provided a sense of support, as it was only within this community that these women felt they could frankly discuss their illicit behaviour (Taylor, 1993). The study concluded this was, in part, due to social exclusion and social intolerance, and stated that “the illegal nature of this lifestyle meant that much of their activities, pleasures and concerns had to remain hidden from the larger law-abiding community” (Taylor, 1993, p. 81). It was also found that as the networks of WUID within the community of PWID grew, relationships outside narrowed and were often eventually terminated (Taylor, 1993). However, Neale et al. (2014), Rosenbaum (1981), and Taylor (1993) found that participants did not consider drug using acquaintances friends. Instead, cautious vigilance underpinned interactions amongst WUID. WUID were united by invisible bonds created by social stigma and rejection, and thus became dependent on, and in conflict, with each other concurrently (Bourgois & Schonberg, 2009; Taylor, 1993). Bourgois and Schonberg described these social interactions as a “balance on a tightrope of mutual solidarity and betrayal” (2009, p.5).

In both Rosenbaum’s (1981) and Taylor’s (1993) studies, there was also an identified hierarchy amongst WUID. Those living in independent homes were held in higher esteem than those in shelters and on the streets, and those who became informants for the police, along with those who cheated or stole from others, were not well regarded, at least for a time, and sometimes ostracized (Taylor, 1993). Conversely, Taylor (1993) found WUID often accepted behaviour, such as “ripping off” others or being “ripped off” (p. 57) and the potential to be deceived, as a normal aspect in the ritual of buying and selling drugs. Taylor (1993) noted that WUID understood the desperation prompting these acts and often put them aside.

Overall, in a community of WUID, it seems there is mistrust and deceit, accompanied by a sense of responsibility to help others and a need to be helped. Mutual aid is common but does not always provide a positive health outcome. There are rules that guide behaviour, and these undoubtedly need to be learned to assist with survival, both socially and physically.

The importance of being clean. Within the literature, although little has been said directly about the idea of cleanliness, upon closer review, this concept is in fact interspersed throughout. Sheard and Tompkins noted, “scant attention has been paid to the cultural significance of ‘dirt’” (2008, p.1544). Sheard and Tompkins’s (2008) findings from interviews with WUID confirm participants’ preference to use clean syringes and needles. The authors describe a hierarchy of cleanliness regarding needles: The highest regard was given to unused sterile needles, next to their own already used needle, and next to another person’s used needle; WUID saw the latter as dirty (Sheard & Tompkins, 2008). Sheard and Tompkins (2008) also found the women placed high value on the cleanliness of those they were injecting with and would check other people’s hands for cleanliness before deciding if they would let the other help inject them. Taylor’s (1993) participants were also repelled if a person injected them with blood on their hands. Healthcare facilities, too, were required to be clean by homeless women in one study (Gelberg, Browner, Lejano, & Arangua, 2004).

The following quote depicts Rosenbaum’s participants’ thinking about cleanliness: “I’m a junkie, but yet I have a reputation for always keeping a very nice house. My children are always clean. My children are always bathed” (1981, p. 59). From Rosenbaum’s (1981) findings, it seems cleanliness is held as an example of good behaviour, or proof that one is worthy and able to maintain motherly and housekeeping roles, despite drug use. Taylor (1993) also observed this finding, noting a tendency amongst WUID toward “excessive and compulsive tidying and clearing away of anything lying around” (p.140). She related this behaviour to the ever-present threat of having children taken away. Although not stated directly, the WUID in these studies hoped the appearance of tidiness and order, or attention to a clean home and children, portrayed “good” mothering skills that overshadowed and compensated for drug use. Despite these findings, however, the concept of cleanliness is relatively unexplored in the literature.

Discontinuing drug use. Quitting drug use is on the continuum of injecting drugs. Factors involved in, and influencing, the decision to quit drugs have been documented. The participants of Neale et al.'s (2007) and others' (Neale et al., 2014; Taylor, 1993) studies described being frustrated enough with the difficulties of injecting, such as missing or not being able to find the vein, that they feared serious health consequences and entertained stopping their drug use. Furthermore, the motivation of PWID to abstain can evolve from a desire to maintain or regain relationships with their children and others (Boyd & Marcellus, 2007; Neale et al., 2014; Pinkham et al., 2012; Taylor, 1993). Cessation and restarting injection drug use is common for WUID (Taylor, 1993).

Drug treatment programs have been hailed as an ideal method for drug discontinuation (Bean & Nemitz, 2004; MacPherson, 2001; NIDA, 2018). For such programs, a longer duration and scope have been recommended, but with concerns that, after treatment, participants could have few life skills and an inability to rebuild connections they had lost (Mahan, 1996; Neale et al., 2014). A strategy to assist with reintegrating could address these concerns. Other barriers include limited services and long waiting lists (Neale et al., 2007; Vaillancourt & Keith, 2007).

A more accessible outpatient method to quit opioids is prescribed substitutes, such as methadone or Suboxone. In terms of benefits, some people felt these medications were a reprieve from "the street," obtaining drugs, and dealers (Wild et al., 2003). However, some PWID avoid oral opioid substitution therapy, feeling it simply replaces one drug of addiction with another, and has unpleasant side effects and stringent routines and testing regimens (Boyd, 2004; Copeland, 1997; Neale et al., 2007; VANDU, 2009; Wild et al., 2003). Pinkham et al. (2012), moreover, identified that substitution therapies have better success for women than men, while detoxification centres favour men. Both the need to be urine drug tested (Sterk et al., 1999) combined with the idea of being drug free in treatment (Copeland, 1997) are other barriers to enrolment.

Some studies have consequently suggested non-abstinent treatment programs (Aston, Comeau, & Ross, 2007; Ditmore, 2013). This recommendation aligns with Wild et al.'s (2003) and

Neale et al.'s (2014) findings that the goal of PWID is often for less drug use, instead of abstinence, with drug use varying based on money, relationships, social context, health, overdoses, children, and negative life events that precipitated more frequent and intense drugs use (Wild et al., 2003). Some studies have also identified that participants prefer to engage in self-initiated strategies for quitting or reducing drug use, such as watching movies or reading (Taylor, 1993; Wild et al., 2003). Another means was to distance themselves from other people who use drugs, including not attending treatment and oral substitute programs (Neale et al., 2007; Taylor, 1993; Vaillancourt & Keith, 2007).

To conclude, thinking about quitting or quitting drug use, strategizing ways to decrease use, and going to treatment and restarting drug use are common cycles for those who use injection drugs.

Health concerns.

Blood borne viral infections. A main focus of the literature about WUID and health relates to their risks of acquiring BBVIs, such as HIV and hepatitis C. This literature details both the elevated incidence and prevalence of these infections amongst WUID, and the correlates of infection acquisition amongst WUID.

First, for infection rates, WUID are at risk of HIV. In 2000, Miller and Neaigus (2002) reviewed the life histories of a cohort of women who used drugs to know more about how they acquired drugs and whether there was an association with HIV, that is, how the context of their lives related to acquisition of this viral infection. Sexual relationships that enabled access to resources, such as drugs, had more probability of incurring situations leading to HIV infection than other occupations or activities that are undertaken to acquire drugs (Miller & Neaigus, 2002). Furthermore, fear of legal charges and being jailed was considered a worse fate than risking infection with HIV through profitable sexual encounters (Miller & Neaigus, 2002).

Women represent approximately one quarter of the number of people diagnosed with HIV (Bourgeois et al., 2017). Additionally, WUID represent approximately one-quarter of all women

with HIV, whereas men who inject drugs only account for 11%, rising to 16% if men having sex with men who also use intravenous are included (Bourgeois et al., 2017). Thus, proportionately, injection drug use is a stronger risk factor for acquiring HIV in women than in men. The most recent I-track study found that 70% of PWID are seropositive for Hepatitis C antibodies (PHAC, 2014). The prevalence of PWID who have HIV and are co-infected with hepatitis C ranges from 72% to 95% (Alter, 2006) with the potential sequela of more rapid liver deterioration, compared to those without HIV and hepatitis C co-infections (Graham et al., 2001; Rochstroh & Spengler, 2004).

Regarding the correlates of HIV and hepatitis C acquisition for WUID, studies have identified numerous attributes specific to the lives of these women that increase their risk of acquiring BBVIs. Davey-Rothwell and Latkin's (2007) study, for example, identified increased risks for these infections amongst WUID when they are "second on the needle," which refers to being injected with the same needle another person used; they are likely to contract any BBVI the other person has through the needle and syringe that have been contaminated by blood (Csete & CHLN, 2006; McCurdy, Ross, Williams, Kilonzo, & Leshabari, 2010; O'Connell et al., 2005; WHO, 2012; Wood, Spittal et al., 2003; Wright, Tompkins, & Sheard, 2007).

As well as being at risk for acquiring HIV through injection practices (Bruneau et al., 2001; Freeman et al., 1994; Garcia de la Hera et al., 2001; Gollub et al., 1998; Loxley et al., 1998), females are biologically more susceptible in terms of sexual acquisition, compared to males (Hankins, 2008; Miller & Neaigus, 2001; Spittal et al., 2002, 2003; Spittal & Schechter, 2001). This susceptibility relates to increased mucosal exposure during condomless vaginal or anal sex, and other inflammatory changes that can occur in the vagina. An example of the latter can be caused by bacterial vaginosis, a common imbalance of the normal vaginal flora, which indirectly increases the potential for sexual transmission of HIV from HIV-positive sexual partners (Martin et al., 1999; Myer, Kuhn, Stei, Wright, & Denny, 2005; Taha et al., 1998). Women with bacterial vaginosis

have also been found to transmit HIV infection to their male partners more readily (Cohen et al., 2012).

General health. The information on health conditions experienced by WUID, aside from that about BBVIs and injection-related infections, is sparse. Neale et al. (2014) found women were concerned about their appearance – and weight was one of these aspects. They mentioned that weight loss was associated with drug use and weight gain with reducing drug use and better health. Neale, Nettleton, Pickering, and Fischer (2012) studied the eating habits of people using heroin, and found that their cohort had erratic eating patterns, reduced appetites, a preference for sweets and foods of convenience, and that obtaining drugs took precedence over eating (Neale et al., 2012). Dental concerns, irritable bowel syndrome, and constipation (whether as a symptom of irritable bowel syndrome or a side effect of narcotic use), were compounding factors impacting nutritional status (Neale et al., 2012). These factors create a cumulative climate for malnutrition.

VANDU's (2009) study in Vancouver of 50 women who used drugs and their perspectives on healthcare indicated that almost 25% of participants had four or more chronic health conditions. VANDU (2009) and others (Jeal & Salisbury, 2004; Neale et al., 2014; Poole, 2007b) determined that some of the common health conditions, outside of injection-related infections, of WUID were dental issues, mental health conditions, lung conditions and infections, chronic pain, diabetes, thyroid disease, anemia, deep vein thrombosis, cancer, and skin and musculoskeletal issues. Buettner et al. (2014) uncovered that some of the “causes of death” in PWID noted as renal failure were in fact the secondary sequelae of cocaine use. Bourgois and Schonberg (2009) attributed hepatitis C, erratic and unhealthy eating, cigarettes, and alcohol to the many chronic conditions evident amongst the PWID they studied.

Neale et al. (2014) reported that women also noted issues with menstruation and pregnancy. Miller et al. (2005) found that women with HIV who used or were using substances and had a history of trauma had a greater incidence of experiencing menopause symptoms than those who were HIV negative. Whether the traumatic past, drug use, or HIV infection caused an

increase in menopausal symptomology was not specified, but it is possible further study would help determine causation or association, as well as the means to alleviate menopausal symptoms.

Olsen, Banwell, Dance, & Maher (2012) countered the discourse which indicated WUID neglect their health and found that WUID are actively interested in and do pursue their healthcare needs, signaling that it is, perhaps, healthcare providers who do not listen to the broader health concerns of WUID. This potential disregard for general health when caring for WUID may mean that diagnoses of common conditions may be missed. As WUID are identified as vectors of hepatitis C, HIV, and other infections, attention has been placed on these infectious conditions when examining their health. Studies about WUID and their health focus more on how drug use causes death and disease, rather than other concurrent health conditions. This focus may relate to a vested public health interest in ensuring the rest of the population is not infected by WUID.

Current Trends in Assisting PWID and WUID

Harm reduction. Due to the aforementioned increase in overdose deaths, a number of efforts are developing to diminish the untoward effects of illicit drug use. These include (a) increased distribution of naloxone, (b) use of opioid substitutes, (c) decriminalizing drug use, (d) improving hospitals for WUID, and (5) ideas for adapting treatment programs to the needs of women.

The first approach to the overdose crisis is that of supplying the opioid agonist naloxone to persons at risk of an overdose through harm reduction agencies and, more recently, in pharmacies as an over-the-counter antidote for opioid overdose. Research studies and reports indicate a positive response to access to naloxone use for PWID (Banjo et al., 2014; Clark, Wilder, & Winstanley, 2014; Davis, Carr, Southwell, & Beletsky, 2015; Kerr, Dietze, Kelly, & Jolley, 2008; McAuley et al., 2016; Rowe et al., 2015; Strang, Best, Man, Noble, & Gossop, 2000). Few have disputed naloxone's reputation as a lifesaving drug (Neale & Strang, 2015).

Some potential unexpected outcomes have arisen out of access to naloxone (Humphreys, 2015; Kirane et al., 2016; McAuley et al., 2016). Having naloxone available may incur a tendency toward using more drugs (Doe-Simkins et al., 2014). Moreover, some PWID have been reluctant to acquire required training and to call 911 when administering the drug. In the latter case both paramedics and police may attend the call (Banjo et al., 2014; Humphreys, 2015; McAuley et al., 2016), which may deter some from calling for assistance due to fear of arrest. In summary, the availability of naloxone to prevent opioid overdose deaths is a well-accepted and welcome addition to the harm reduction armamentarium. While there are some concerns, this drug successfully saves lives.

Second, opioid substitutes (methadone and suboxone- a trade name for the combination of buprenorphine and naloxone in a sublingual tablet) are used to treat opioid addiction. Although these medications help some in being drug free, others use the prescribed opioid substitute and continue to inject illicit drugs (Gjersing & Bretteville-Jensen, 2013). Those in the latter group, however, have demonstrated a reduction in the amount and frequency of street-based injecting and demonstrate less criminality (Gjersing & Bretteville-Jensen, 2013).

Some evidence suggests that alternate opioid substitutes, diacetylmorphine and hydromorphone, can be more effective than the above-noted agents in assisting PWID to discontinue intravenous drug use (Oviedo-Joekes et al., 2010, 2015, 2016). Oviedo-Joekes et al. (2010, 2015) also found that women with a long-term dependence on opioid drugs were better served by injectable diacetylmorphine than oral methadone. Heroin substitutes are also used in some European countries as an alternate treatment for those who are not assisted by methadone and buprenorphine (HRI, 2012; Strang, Groshkova, & Metrebian, 2012). Others continue to advocate for the use of such “medically assisted-treatments” (Schottenfeld & O’Malley, 2016, p. 438; Strang et al., 2012). Jozaghi (2014) completed a qualitative study of participants who used heroin-assisted treatment. Along with less criminal activity, drug use, and sex work, many of the participants were engaged in advocacy, and paid and volunteer work. Socially, they reported less

anger, and some had reconnected with family. Having a variety of medications to choose to assist with discontinuing opioid drugs holds potential to assist people attaining this goal. There has been less progress on substitutes for cocaine. Studies of the use of modafinil for people who are dependent on crack-cocaine (Nuijten, Blanken, van den Brink, & Hendricks, 2015) and dexamphetamine for those who continue to use cocaine while on an opioid substitute (Nuijten et al., 2016) have had some positive results. Dursteler and Vogel (2016) argue that while some progress has been made in the area of cocaine substitution, there remains a need to continue the pursuit to find an effective pharmacotherapeutic agent.

Third, decriminalizing personal drug use is another approach that some countries have considered and adopted. This approach has been noted to be successful in reducing crime without an accompanying increase in drug use. Both sides of the “resounding success or a disastrous failure” (Hughes & Stevens, 2012, p. 101) of Portugal’s move to decriminalize drug use have been studied (Coelho, 2015) and, while both hold some merit, positive outcomes are evident. The most apparent result of the move to decriminalization is a reduction in use of the legal system including policing, sentencing, and jail time (Laqueur, 2015). Moreover, Riddell (2012) believes the negative attitudes toward PWID by nurses may change should drug use be decriminalized and regarded as a public health rather than criminal issue.

Fourth, a recent article (Glauser, Petch, & Tierney, 2016) makes recommendations that support an alternate approach to initiating punitive consequences for drug use in hospitals. These include (a) SISs within the hospital, (b) the provision of clean injection supplies to those who are injecting drugs, and (c) teaching people who are going to inject into their peripherally inserted central line how to do it correctly. These measures would help ensure those working with PWID facilitate safety and health, rather than focusing on deterrence and punishment.

Other suggestions for care have included the provision of larger than normative doses of narcotics and methadone use for pain relief prior to individualized discharge planning (Haber, Demirkol, Lange, & Murnion, 2009; Miller et al., 2005; Wong, Ordean, & Kahan, 2011). When the

use of illicit injected drugs is accepted, then a change in attitudes may be possible for many, and a dialogue to create options can be further entertained.

Women-only treatment programs have also been initiated (Carr et al., 1996; Magee & Hurliaux, 2008), and Pinkham et al. (2012) cite several such programs that have been established internationally. Treatment programs are not always suited to the needs of WUID. The issues for women's treatment include (a) the fact that many programs were designed to serve men, (b) a lack of provision for treatment of couples, (c) disregard for the role trauma plays in the lives of WUID, and (d) a failure to incorporate reproductive issues into the curriculum (Copeland, 1997; The Jean Tweed Centre, 2013; Maddocks, 2008; Neale et al., 2014; Simmons & Singer, 2006). Furthermore, (e) programming hours may not accommodate the needs of WUID who are providing care for their children, or who may be relying on sex work or other work to support basic needs (Hume & Bradley, 2007; Roberts et al., 2010; Rosenbaum, 1981; Taylor, 1993; Westermeyer & Boedicker, 2000). It is evident that alternate means of addressing treatment approaches and assisting women with discontinuing drug use are needed.

Limitations of the Literature

The main limitation of the extant literature about WUID is an overuse of quantitative studies and poorly designed qualitative research, which have not differentiated findings based on sex or gender. This has resulted in findings being indiscriminately applied to all PWID, without distinctions made about when, how, and in what ways the experiences or practices of WUID are unique or different from those of their male counterparts.

The literature also illustrates that research commonly fails to understand the lives and social context of WUID, and this weakness can be linked to methods that rely on investigator-led questioning and observation. For example, suggestions to improve health, although well intentioned, fall short of fitting the lifestyle and context of PWID regarding drug use, social isolation, and so on (e.g., Bruneau et al., 1997; Kerr et al., 2004; Phillips & Stein, 2010). For

example, Kerr et al. (2004) recommended providing clients with better education about injection practices; Phillips and Stein (2010) reviewed the injection practices of PWID and concluded that cleaning the skin and hands with alcohol-based gel prior to injecting would reduce infection transmission; Bruneau et al. (1997) felt that increasing access to sterile injection equipment would reduce the incidence of HIV. Although these are sound and practical advisements, they fail in their understanding of the everyday life of PWID. Despite the provision of a strong harm reduction approach to care and safer drug use information in NEPs and, yet, blood borne virus transmission continues. More widely, illness prevention education is generally noted to fail when trying to motivate changing health practices. Examples that relate to substance use can be noted, for example, there have been attempts to have PWID use hand gel to clean their hands to prevent infection; however, these cleansers often contain alcohol and can be a source of oral intake for those with concurrent alcohol issues. Also, providing sterile injection equipment is laudable but how the equipment is used after receipt is in question. It would seem reasonable suggestions have been made, but they have limited feasibility given the day-to-day practicalities of WUID.

Global reports (Roberts et al., 2010), similarly, provide a review of what is known about WUID, which is helpful in its breadth, but may lack the detail required to understand WUID in local contexts. Reports (HRI, 2013; Odinkova, Rusakova, Urada, Silverman, & Raj, 2014; Simona, 2012) and studies (Haritavorn, 2014; Higgs, Owada, Hellard, Power, & Maher, 2008; Sarin & Selhore, 2008; Wechsberg et al., 2012) about WUID from many countries illustrate that although WUID have substantial concerns, they are not a homogenous population. Differing circumstances create variable need.

Page and Singer (2010) cite many ethnographic studies about WUID in their publication *Comprehending Drug Use: Ethnographic Research at the Social Margins*. While these studies are comprehensive, they are dated. For example, HIV was not of consequence in Rosenbaum's study (1981) and was predominantly considered a "gay man's disease" when Taylor (1993) completed her research. Moreover, the philosophy and practice of harm reduction, as they apply

to drug use and sexual activity, were little known (Cavalieri & Riley, 2012, Dolan et al., 2000, MacPherson, 2001; Potier, Laprevote, Dubois-Arber, Cottencin, & Rolland, 2014; Wodak & Owens, 1996). Although the ethnographies were interesting historical accounts and provided the background of what was believed to be known about WUID, the literature lacks relevance to today's evolving environment.

Among studies that did uniquely address HIV amongst WUID, methodological issues limit what can be known from these data. Bruneau et al. (2011), for example, showed little difference in HIV incidence between WUID who endorsed always obtaining syringes from a safe source and those who did not. Interestingly, Bruneau et al. (2011) asked participants about safe syringes but not about other equipment, and safe sources, but not NEPs. Notably, the study found the incidence rate for WUID was less than that of men (Bruneau et al., 2011), but provided no explanation. As 80% of participants were male, the results of the female portion may not be representative of WUID, and further investigation may be warranted.

As noted previously, studies and programs examining sex and gender differences in the activities of PWID have been completed. They have found that the everyday lives of WUID involve norms of behaviour, lifestyle experiences, and societal expectations that are at variance with those of their male counterparts. Unfortunately, although informative, these study recommendations provide, at best, suggestions derived from numbers and not directly from the wisdom of those concerned. However, the studies make it apparent that differences of gender should be considered in the population of PWID if a better understanding of their challenges and needs are to be gained.

In summary, many studies have identified issues for WUID but have not asked WUID what they think could help. Jeal and Salisbury's study (2004) is an example of findings that identify important demographic and circumstantial commonalities: WUID take greater risks with their health than women in sex work who do not inject drugs, and yet, the study did not illuminate what women felt could change their situation. Instead, the researchers introduced the idea that

alternate, empathetic, and holistic stances were needed to provide relevant and effective healthcare, illustrating an approach that is applicable universally to healthcare, and not specific to WUID. Several articles have, at least indirectly, addressed the restraints of “one size fits all” approach to care, and recommended more tailored and targeted services for WUID (e.g. Chu & Galang, 2013; Donroe, Holt, & Tetrault, 2016; French et al., 2000; Glauser et al., 2016; Henderson, Stacey, & Dohan, 2008; Rivers, 1998; Wasylenki, 2001).

More specific attempts to engage WUID in healthcare have been challenging. Employing a harm reduction approach (Bowman, Eiserman, Beletsky, Stancliff, & Bruce, 2013; Pinkham & Malinowska-Sempruch, 2008), flexibility of appointment times, such as drop-in service delivery (Azim et al., 2015; Pinkham & Malinowska-Sempruch, 2008; Whynot, 1998), and unique care settings, such as mobile or outreach settings have been suggested (Azim et al., 2015; Pinkham et al., 2012, United Nations Programme on HIV/AIDS [UNAIDS], 2014; UNODC, 2014) or initiated (Magee & Hurlaux, 2008). Nonetheless, issues surrounding healthcare continue for WUID (Tomas, Dhami, Houston, Ogunnaike-Cooke, & Rank, 2015), suggesting that what theoretically should work to provide healthcare for WUID does not always have the intended outcome.

Part of the issue may be that the decisions to, and how to, provide care are determined from the top down. Service users may not be asked how they would like healthcare delivered, and instead are expected to conform to services designed to optimize efficiencies and budget constraints (Kuluski, Peckham, Williams, & Upshur, 2016). Complicating this issue is that studies of healthcare for PWID have identified increased costs associated with tailored services (French et al., 2000).

Another limitation of the extant literature is that the primary focus for much of it is the acquisition of BBVIs. This perspective reduces WUID to vectors or susceptible vessels of illness and disease, and effaces the complexities, intricacies, and relationships in their lives. Reports such as *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs* have stated, “There is considerable discussion on the risks of HIV faced by women who inject drugs found

throughout this report” (Roberts et al., 2010, p. 72). Indeed, this report, while promising to look broadly at women, was written for the Reference Group to the United Nations on HIV and Injecting Drug Use and primarily focused on the risks of acquiring HIV. Funding then may be in part responsible for the study and focus on WUID in the context of HIV.

Summary

In conclusion, there is paucity of recent qualitative knowledge about WUID, and a lacuna of understanding related to their lifestyles and concerns. Indeed, most extant research misses important nuances about WUID, as it is taken out of context or asks the questions researchers are invested in, thus narrowing what WUID are asked to speak about. In other words, WUID have been less than involved in developing what researchers know about them.

While the topic of blood borne infections is important, and the literature illustrates there is an interest in prevention amongst WUID, available research mostly lacks focus on the social contexts surrounding the risks of WUID acquiring these infections. Despite promising titles, such as Pinkham et al.’s (2012) “Developing Effective Health Interventions for Women Who Inject Drugs,” the discussion focuses on the practices of WUID that put them at risk for HIV. This subject narrows the scope and breadth of what is known, and leaves little to no examination of other life or health issues. Excellent ethnographic studies completed by Rosenbaum (1981) and Taylor (1993) are too old to be relevant now. The first and second decade of the millennium have seen the growth of harm reduction philosophy, NEPs, and SISs. Some of the research (El-Bassel et al., 2010; El-Bassel, Gilbert, Witte, Wu, & Chang, 2011; Epele, 2002a, 2002b; Ettore, 2004; Sheard & Tompkins, 2008; Wright et al., 2007) and reports (HRI, 2013; Roberts et al., 2010) about WUID add to the understanding of the complexities of the lives of WUID. However, current knowledge around their contextual decision making underpins a need to further understand what initiates and sustains decisions around health. It seems that the practice of injecting drugs overshadows all aspects of a woman’s identity.

What then becomes of healthcare in a more general sense? How do we serve a population of women who have others risks and barriers, in a way that respects their world and needs, and allows for reachable moments that may enhance health, prevent a treatable disease, or remedy an episodic condition? It is anticipated that some of these insights could be provided by WUID.

Chapter Three: Theoretical Framework

The following chapter explains the theory that underpins the research. The discussion includes Deleuze and Guattari's work on rhizomes, assemblages, space (smooth, striated), and war machines; Foucault's writings on power, knowledge and discourse, the body, and resistance; Goffman's ideas around stigma; and Kristeva's conceptualization of abjection. The theoretical framework provides a lens through which the findings are viewed (see Appendix A).

Deleuze and Guattari

A discussion of Deleuze and Guattari's concepts is not linear. As such, several of their concepts are described, starting with the ideas of rhizomes and assemblages. These two concepts are presented first to match how these two authors started their book *Capitalism and Schizophrenia*.

Rhizomes and assemblages. Deleuze and Guattari (2000) posited that the physical and non-physical world is a dense network of connections. They called this the rhizome, which is a biologic term describing a densely interconnected root system without start or finish, or top or bottom, and which spreads out without centre or periphery; as an example, potatoes grow rhizomatically. A rhizome "has neither beginning nor end, but always a middle (milieu) from which it grows and which it overflows" (Deleuze & Guattari, 2000, p. 21). In Deleuzian terms a rhizome relates to interconnectivity within a "non-hierarchical nature" (Young, Genosko, & Watson, 2013, p. 263), connecting "any point to another point, and its traits are not necessarily linked to traits of the same nature" (Deleuze & Guattari, 2000, p. 21).

These two authors contrast the rhizome against what they feel is an arborescent view of the world, which includes hierarchies, established and linear linkages, and acceptable and unacceptable connections. Continuing this analogy, the tree has a top and bottom, a root and leaf

system, a perceived inside and outside, and is discrete from other trees. This contrasts with the rhizomatic view of interconnection.

Deleuze and Guattari (2000) did not, however, reject the arborescent view outright, instead positing that the allegedly discrete structures that are foundational to this perspective are what they called assemblages. Assemblages are artificial constructs given a discrete shape and content based on human perception, but which have been arbitrarily labeled as such at the expense of disregarding other connections which break the discreteness of these structures. In other words, connections outside the assemblage are ignored to maintain perceptions that assemblages are discrete, stable, and separate.

An assemblage, however, is never static. Further connections and outcomes continue to evolve. Not only the type, but also the degree or strength of the connection alters and transforms how the assemblage evolves. The assemblage will be stratified by place and circumstance. It will also be stratified in a society based on mores and norms, determined by the governing bodies and institutions (Holland, 2013). However, it is important to note that these are created, not intrinsic, stratifications.

As such, an assemblage is determined by its context, that is, “biological, social, historical, or political circumstances” (Young et al., 2013, p. 36), or “exterior forces” (Young et al., 2013, p. 307). Given that circumstances change, the assemblage can change its composition. This transformation is a reaching out, which Deleuze and Guattari call a “line of flight” (2000, p. 89), more precisely “translated” by some as a “line of escape” (Young et al., 2013, p. 183). However, Young et al. further explain that this escape is not future goal orientated but is more about “the process of becoming” (2013, p. 183), a term that refers to a transition, or reconstitution that is perpetual and incessant.

The assemblage, to state it succinctly, is thus a set of connections that are deemed discrete and are labeled and named as an identifiable object or item within what Deleuze and Guattari perceived was a multitude of connections within an otherwise indefinite space.

Space. According to Deleuze and Guattari (2000), space can be smooth or striated, or may exist in some form of in-between state. Smooth and striated spaces are thus not dichotomous, but can be combined, depending on the ease by which people and items produce or inhibit lines of flight within these spaces, that is, enable or restrict movement between various assemblages. As such, space may be nomadic, that which is changing or pursuing change, or sedentary, that which is situated and set. Linking to the previous concept, the production of assemblages is the striation of smooth space.

To explain further, smooth spaces are those that are less defined and more malleable. They are the uninterrupted and unconstrained rhizome. One example of smooth space could be that of an open field, with its endless sources of connection and limitless potential; this space could be used for parking cars, having a picnic, taking nature photographs, meeting with others to talk or walk, or partying. This space has no rigid limitations. It is a canvas to be painted, the proverbial blank slate, waiting for interpretation. With the uptake of the space for a certain task, it becomes, at least temporarily, striated, always remaining capable of re-creation. Smooth space is transformable and unpredictable, rhizomatic, and evolutionary, allowing creativity.

The second type of space is striated – that is, rigid – and, through the manner in which it is perceived, more directive. Malins (2007) gives the example of a grocery store to explain striated space. Initially, the space maybe without an obvious specific purpose; it only has the potential of intention. Subsequently, the space is given, or developed to have, a purpose as a stratified or designated space, in this case, useful for obtaining food and other goods. At this point, items are separated (e.g., the fruit section, and the canned goods section), thereby a more rigidly stratifying the space. This striated space – specific in purpose and designed to efficiently enable the task of, in this case, obtaining groceries – is ordered. It should be noted the rigidity of striation is not value laden, bad or good; it merely serves to perform a specific task or purpose. As Malins (2007) explained, the striations add order and structure; that is, they help bodies know how to relate with

each other. The rigidity is also, necessarily, limiting, as the possible connections within the space are defined and designated.

One might compare striated space to Deleuze and Guattari's royal science, that is, post-positivist approaches to knowledge development, and arborescent thought, which is linear and unidirectional (2000). Smooth space, conversely, is likened to nomadic science, qualitative research could be one example, and rhizomatic thought aligns with ideas that develop unpatterned, reaching further and changing because of encounters that shape what is to evolve (Deleuze & Guattari, 2000). The former is quantitative linear thinking and understanding while the latter is unconventional thinking, which "emerges and grows in simultaneous, multiple ways" (Holmes & Gastaldo, 2004, p. 263).

Striated spaces, although comforting in the ability to produce routine and normalize expectations, can also repel (Malins, 2007). If one were to enter the grocery store and skate down the aisles, or use the canned goods to build castles, the structure and purpose of a grocery store would be destratified. The "matter out of place" (Douglas, 1985, p. 40) or as Kristeva states "the jettisoned object" (1982, p. 2) disturbs and disrupts order (Kristeva, 1982). However, these destratifications can be important to the ongoing evolution of assemblages as a means of reorganizing structure and beginning anew. The cans placed in the shape of a castle can be, for example, a new way of advertising a product, bringing it to the consumer's eye. This deconstruction and restratification can enable further thinking and opportunity for differing perspectives to emerge. As Malins stated, "bodies need these moments of destratification in order for life itself – as a continual production of difference – to continue" (2007, p. 153). Destratification enables the process of becoming, that is, of evolving as a body and an assemblage.

Yet, Deleuze and Guattari (2000) believed that destratification was not outright beneficial and should be approached with caution. In the process of an assemblage "swinging between the surfaces that stratify it and the plane that sets it free" (Deleuze & Guattari, 2000, p. 161), there is a potential for negative outcomes. This process can be too fast and too violent. Alternately, it can

produce unwanted and uninvited outcomes. In contrast, destratification can occur at a pace that creates opportunity to engage in growth and change productively, remaining relatively stable but permitting movement. Should a body set itself free and destratify to the extreme, it is possible it will be “dragged toward catastrophe” (Deleuze & Guattari, 2000, p. 161). Deleuze and Guattari (2000) suggested, instead, exploring and engaging the stratum with caution. They stated,

Staying stratified – organized, signified, subjected – is not the worst that can happen... Lodge yourself on a stratum, experiment with [the] opportunities it offers, find an advantageous place on it ... see how it is stratified for us and in us and at the place where we are. (2000, p. 161)

Although Deleuze and Guattari (2000) describe the rhizome (smooth space) and its stratification into striated space (through the production of assemblages), they do not inherently critique any such process; they simply provide the theoretical tools to envision what is and what can be. They do, however, warn against the harms of reifying such assemblages, stratifications, and striated space, describing how these structures can become problematic and need to be destratified (through the war machines).

Fold. The fold, in Deleuze’s description (2013), is a phenomenon that develops out of subjectivity. It is a force that works in multiple ways but is essentially the outside assemblages and connections folding into the interior of oneself. The different assemblages include the body embedded in space and how space creates bodies (Deleuze, 2013; Malins, Fitzgerald & Threadgold, 2006). The first manner in which the fold can operate is in connection with the force of a space one occupies. The force of the space might fold inwardly and alter how we think, act and feel. For example, entering a space that has meaning might evolve our presentation from one of confidence to shyness. We have folded the force of intimidation into our interior.

Folding by force is not always passive, but also can be a choice which spurs us to action, to construct oneself to act and produce (Deleuze, 2013; Malins et al., 2006, p. 511-2). This is the second type of fold. Malins, Fitzgerald and Threadgood (2006) suggest this is the force that can create resistance. O’Sullivan writes this fold may “produce dissenting, politically radical subjects...

commodified and alienated subjectivities- or even deadly military assemblages” (2005, p. 105). The third fold is the way knowledge and discourse folds into the body, thus it is a means of interacting with the world and having the world interact with oneself. This force allows one to internalize the outside and enables us to conform, to meet expectations. It makes us a docile body. Lastly, there is the fold of the line outside, that produces the ability to become. Malins et al. (2006) describe this as creative potential. For Deleuze (2013, p.86), this fold creates “hope for immortality, eternity, salvation, freedom or death or detachment”. Malins et al. (2006) stated this fourth force can form “an inherently risky practice, for it unravels those stable knowledges of self and identity that allows us to move about the world, and to speak, with certainty. Yet it is also a practice that opens up space for bodies to create and fold themselves anew” (Malins, 2006, p.512). Together the operation of these four ways in which the fold performs provides one with an understanding of how bodies act on and are acted upon within their context. These assemblages are forces: “folding – unfolding... enveloping - developing, involution – evolution” (Deleuze, 1993, p. 9).

War machines. As noted above, space can be stratified and have purpose, or be open to change and alteration. When arborescent thinking predominates, rigidity exists, and there is less possibility for change. Truths are accepted and taken for granted as delivered from the prevailing hegemony. Against such situations, war machines are needed – in other words, the “metaphorical initiation and performance of resistance” (Holmes & O’Byrne, 2012, p. 54). The war machine perpetuates change and rethinking by deconstructing existing assumptions; it is neither a negative force nor an object that acts offensively, taking over and replacing existing values and assumptions with a new form of predominant insistence. Once this process is completed, the war machine assumes a new target and resumes its ambition to defy the prevailing hegemony and governance. It is a perpetual act of critique, reflection, and destabilization. Indeed, it is the very ability of the war machine to employ rhizomatic actions and confront how society views accepted

norms, thus falsifying them as accepted truths, that allows one to question what is known of a striated space and creates possibilities for change. Enabling the war machine opens reconsideration about an evolution in the way of thinking about assumed certainties.

Foucault

Power. To understand the concept of power, this study has adopted a Foucauldian (1975/1995) perspective, meaning that power is seen as pervasive, not owned, not imposed from the top down, and not something one can possess (Cameron, Willis, & Crack, 1995; Foucault, 1976/1990; Perron, Fluet, & Holmes, 2005; Smart, 2002). Smart explained, "Power is not a commodity or a possession of an individual, a group or a class; rather it circulates through the social body, 'functions in the form of a chain,' and is exercised through a net-like organization in which we are all caught" (2002, p. 79). According to Foucault, power is not a form of repressive control determining what can and cannot be done; instead, it is "a productive network which runs through the whole social body" (1972/1980, p. 119). As Foucault stated, "what makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (1972/1980, p. 119). In a Foucauldian sense, power emulates a presence that courses through society, not having a repressive or authoritarian role, but the function of gentle persuasion, and one that is taken up, accepted, and followed freely by those it encompasses.

Foucault's (1975/1995) conceptualization of power thus contrasts with historical viewpoints, which position power as a concrete and visible force that a sovereign could impose onto the people. Foucault (1975/1995) reflected on the past use of public torture and punishment as means of coercing behaviour. Foucault (1975/1995) noted the evolution from public punishment was required as people began to object to the cruelty and horror of the torture that was inflicted. Power-over-behaviour had to be made less visible, less able to be resisted. Power became a form of permeating influence – so imperceptible that resistance was less likely (Perron

et al., 2005). Holmes, Roy, and Perron clarified how this pervasive power enacts its influence when they stated, “This approach bears some resemblance to a regime that does not *prohibit* one to speak, but *forces* one to speak in a specific way” (2008, p. 49). Thus, the evolution of power, as it is embedded in and creates discourse, has the ability to persuade and to control what is accepted.

Biopower. In his writings, Foucault (1976/1990) described the idea of biopower, which is the power over, and of, life (Georges, 2008; Holmes & O’Byrne, 2006; Perron et al., 2005). It is a pervasive power that focuses on how we act, think, and believe, and how we talk and interact to produce who we are as individuals (Gagnon, Jacob, & Guta, 2013; Holmes & Gastaldo, 2002). Following norms and expectations gains a person acceptance and belonging, and in this way social processes occur in two ways: The first is anatomo-politics, which relates to normalizing and regulating individual bodies, and the second, biopolitics, involves managing populations (Georges, 2008; Holmes & O’Byrne, 2006; Perron et al., 2005). These two aspects are not separate ways of governing, but two interrelated items.

To explain further, first, anatomo-politics aims to have all people act as required (Perron et al., 2005). This process is complex and begins early in life as one internalizes what is expected behaviour through inculcation and training within what Foucault called disciplinary institutions, such as healthcare, school, and home (Perron et al., 2005). In these environments, people are evaluated, categorized, and corrected through partitioning, determined by such structures as function, meting, and language (Holmes & O’Byrne, 2012; Perron et al., 2005). When applied to nursing, for example, caring is interacting as an agent of the prevailing hegemony, while performing the role of a professional discipline (Gagnon et al., 2013). The healthcare professionals/bodies are a blend of “docility and usefulness” (Perron et al., 2005, p. 539; Gagnon et al., 2013) – enabling efficient and purposeful behaviours in caring for others in the context of a healthcare setting to ensure desired behaviours are exacted.

Discipline of the body and regulation of the population constitute the two facets through which “power over life” is achieved (Foucault, 1976/1990, p. 139; Hoffman, 2011). Foucault (1976/1990) described that this occurs through a three-part sequence of hierarchical observation, examination, and normalizing judgement. That is, discipline is achieved through observation by those deemed capable of judging others, and the subsequent distribution of rewards and punishments based on the findings of these observations.

To explain further, the first component of this sequence – hierarchical observation – flows from Bentham’s panopticon prison model (Driver, 1999; Foucault, 1972/1980), wherein there was a central tower overlooking the prison (Foucault, 1975/1995; McHoul & Grace, 1993). In this structure, prison guards in the tower observed from above and did not have to physically punish prisoners to have them comply with expectations. Rather, the central structure permitted constant surveillance of the prison yard, with the belief that prisoners would control and manage their behaviour because they were aware they were being observed (Foucault, 1975/1995; Perron et al., 2005). Foucault (1975/1995) posited, as a parallel, that this process occurs socially, with people acting in socially expected ways when they think they are being observed. Appropriate responses and actions are known and given.

Normalizing judgement is the second aspect of anatamo-politics. It occurs through rewards and punishments, shaping and channeling what is desired and what is not, helping to encourage conformity and discourage non-conformity (Foucault, 1975/1995; Hoffman, 2011; McHoul & Grace, 1993). Using Foucault’s description, “what is specific to the disciplinary penalty is non-observance, that which does not measure up to the rule, that departs from it. The whole indefinite domain of the non-conforming is punishable” (1975/1995, pp. 178–179). By observing the subject and measuring behaviour or findings against expected norms, one is informed as to whether there is a “need” to intervene. The desired state is the outcome one would want to achieve. This process aims to ensure outcomes are within an accepted range (Foucault, 1975/1995). Foucault stated,

In the regime of disciplinary power ... it refers individual actions to the whole that is at once a field of comparison, a space of differentiation and the principle rule to be followed. It differentiates individuals from one another, on terms of the following overall rule: that the rule be made to function as a minimal threshold, as an average to be respected or as an optimum towards which one must move ... The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions it compares, differentiates, hierarchizes, homogenizes, excludes. In short, it normalizes. (1975/1995, pp. 182–183)

Lastly, examination comprises an evaluation, plus discouragement of undesired behaviour and reward for performance that meets expectations (Foucault, 1975/1995; Hoffman, 2011). In this way, examination combines both observation and normalizing. As Foucault explained, examination links a body of knowledge to the “exercise of power” (1975/1995, p. 187). He concluded that the way disciplines enact their knowledge ensures their endowed power and identifies observed individual differences as acceptable or deviant (Foucault, 1975/1995). It is the normalizing gaze, spoken in terms of healthcare as the medical gaze. Foucault described this further as being able to enable a “confession” under “recodified” guise of “therapeutic operations” (1976/1990, p. 67).

The evolution of shaping individuals within a range of acceptability into that of larger populations demonstrates the succession of anatomo-politics and biopolitics. The resulting ability to manage and survey larger populations and regulate life from a more distant, yet more intent, focus is the achievement of normalization (Perron et al., 2005). Foucault stated that this process of normalization has four elements: (a) spatial distribution, (b) activities, (c) segments or stages of training, and (d) coordination of these elements (Foucault, 1975/1995; McHoul & Grace, 1993). First, spatial distribution can be accomplished by physical barriers, walls and buildings, so that one belongs to or is identified by a place or space. Second, activities are those that involve the distribution of time and labour; bodies are trained to perform at regulated times and schedules. Third, training proceeds from simple to complex, developing skills and abilities that are scrutinized and observed, and progressively corrected and refined. Lastly, the whole process requires coordination and purpose (Foucault, 1975/1995).

These elements are collectively known as disciplines and promote norms of expected behaviour by developing “‘practiced’ bodies” (McHoul & Grace, 1993, p. 71) – which occur when people internalize the training, and then execute and comply with this training irrespective of observation; in short, “discipline ‘makes’ individuals” (Foucault, 1975/1995, p. 170). The institution of a discipline involves a knowledge which is integral to power and, as such, in which opposing forces must be anticipated and contained. Those who are different are more outstanding because of their dissimilarity. Indeed, individual qualities are not suppressed but brought to the fore. As Foucault explained, “The prime effects of power [is] that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals” (1972/1980, p. 98).

The discipline of medicine is an example of power that is prevalent, accepted, and impalpable. The knowledge of healthcare professionals contributes to the concept of hierarchical observation. That is, knowledge which is legitimized, legislated, and regulated (Gastaldo, 1998; Holmes & O’Byrne, 2006) permits surveillance and enables discipline through interactions that lay patients’ concerns bare, and allow the healthcare professional to solve the issue by prescribing a course of action that the patient is expected to follow (Lupton, 1998; Turner, 1998). As Foucault stated,

The exercise of discipline presupposes a mechanism that coerces by means of observation; an apparatus in which the techniques that make it possible to see induce effects of power, and in which, conversely, the means of coercion make those on whom they are applied clearly visible. (1975/1995, pp. 170–171)

Flowing from this, in healthcare, patients accept and allow nurses to question, investigate, monitor, and examine their bodies because these activities are sanctioned and seen as normative (Armstrong, 1983; Lupton, 2012). Turner described the ability of healthcare practitioners to “exercise a hegemonic authority” (1998, p. xiv), one that demonstrates the coercion possible through normalization of an activity. This is not a top-down authoritarian regime, but a subtle and pervasive example of anatomo- to biopolitical power. Whereas once an activity maintained and

enacted by the individual, health is now a medical phenomenon – stemming from the productive use of power by a sanctioned discipline.

What power involves is a pervasive and subtle maneuvering of individuals and populations in a manner that fits the contemporary social order. Foucault insisted,

We must cease once and for all to describe the effects of power in negative terms: it “excludes,” it “represses,” it “censors,” it “abstracts,” it “masks,” it “conceals.” In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. (1975/1995, p. 194)

Healthcare professionals are not exercising dominant power; they are part of an apparatus through which power flows – the other part being the patient and, another still, being the healthcare environment (Foucault, 1972/1980; Lupton, 1998). The patient is no less than a vehicle of power, and the interaction the locus of data collection, analysis, and correction of a population to conform to assumed health goals by adapting endorsed behaviours.

As Holmes and Gastaldo (2002) pointed out, Foucault’s work assists with an understanding that nursing is more than a caring interaction and more than a benign provision of services. Gastaldo and Holmes (1999) agreed with Henderson, who wrote, “Foucault provides for insightful analysis of unacknowledged assumptions and metaphors in healthcare” (1994, p. 935), which can encourage reflection on the practices and dynamics that exist between patients and nurses. For marginalized populations, the end effect of power is, at least in part, that this dynamic comprises an intent to control. Given their desire and ability to resist, the lives of marginalized persons – for example, WUID – remain stigmatized until the discourse that envelops them evolves. It is not until the accepted knowledge of a society is able to alter content and direction that change is possible. The concept of knowledge is thus important in understanding the women of this study.

Knowledge. Holmes and O’Byrne’s (2012) work will be used to focus on the component of Foucault’s work known as the *episteme*, which, from Greek, translates as worldview (Holmes & O’Byrne, 2012). As Holmes and O’Byrne (2012) stated, an episteme is the predominant way in

which people understand their world and interpret their context because of the acceptance of what is right and wrong; in other words, it is the prevailing knowledge. Holmes, Murray, Perron, and McCabe concurred in earlier work when they stated, “an ‘episteme’ is the implicit ground of our knowledge, the condition of possibility for something to appear to us as true or false, good or bad” (2008, p. 396). This episteme – in other words, a hegemonic manner of thinking – is then conveyed widely through the cultural institutions that form the structure of a society. These would include government, education, law, and healthcare. The beliefs and principles that underpin these institutions and their accompanying professionals are not perceptible; instead, they are invisible in their influence and persuasion. The existence of, and how we come to accept, conventions and established truths is thus what is captured in the term episteme.

To explain further, the manner by which knowledge is gained by through rituals of research and perpetuated in education is ingrained and camouflaged as assumptions of certainty. Reflecting on Foucault’s work, Holmes and O’Byrne asserted that “the pervasiveness of *epistemes* ... function to maintain specific constructions of reality” (2012, p. 46). Thus, new knowledge is judged on how well it aligns with what is known, preserving dominant knowledge. Furthermore, Holmes and O’Byrne, citing Holmes, Murray, Perron, and Rail (2006a, 2006b), concluded that “it [the episteme] is the system within which thought and behaviour make sense and become knowable” (2012, p. 47), and because of this knowledge and the accompanying power, discourse is enabled. From this perspective, much of what people think and believe, and how we think and believe, is formulated according to what is already known and is internalized and reproduced.

As its outcome, the current worldview, or episteme, stratifies and stigmatizes objects, people, and events through accepted values and beliefs (Holmes & O’Byrne, 2012; Malins, 2011). Those stratified to the bottom are those who do not exhibit or follow the dominant hegemony and discourse (Malins, 2011). A report prepared by Seymour (2012) supports the idea of media as influential communicators of what social opinion is thought, or ought, to be. The episteme then

“structures social interactions, guides interpersonal connection and organizes both individual and group behaviour” (Holmes & O’Byrne, 2012, p. 46). The encompassing episteme influences institutions to function in certain ways, without questioning what is perceived and enforced as the truth and what is right (Gastaldo & Holmes, 1999; Holmes & O’Byrne, 2012; Perron et al., 2005). What is not right is considered out of order and is a violation of hegemonic discourse. Therefore, people’s perceptions of correct and incorrect ways of being determine our very selves.

Adapted from Foucault and described by Holmes & O’Byrne (2012), there are ways of behaviour, some considered good and others bad, or right and wrong, accepted and problematic. Behaviour not in line with mainstream thinking, the pervading episteme, is marginalized. This form of discourse requires further exploration.

Discourse. Stemming from the episteme is the concept of discourse, which Francis stated is “socially and culturally produced patterns of language, which constitute power by constructing objects in particular ways” (2000, p. 21). Discourse enables one to know what is acceptable, and what must be constrained (Foucault, 1969 & 1971/2010a). Carolan (2005) posited that what one is and becomes is based on cultural and social discourse. Foucault (1975/1995) further argued that the body is constructed through discourse. As Smart summarized, “the individual is both an effect of power and the element of its articulation” (2002, p. 79). This description of the individual extends to the physical body and its interpretations.

Discourse, however, is not fixed in time or situation; it changes alongside the evolution of institutions, as striated spaces, in the society from which discourse emanates (Francis, 2000). Discourse mutates, as McHoul and Grace identified when they stated, “What the discourse does, whom it acts upon, how it is distributed, and the forms of resistance it meets ... are all open to transformation” (2002, p. 46).

The person or self becomes, through the immersion in social practice, not as a result, an ever-evolving identity formed and reformed through participation in discourse (Foucault, 1972/1980). As McHoul and Grace clarified, “In any given historical period we can write, speak

or think about a given social object or practice ... only in certain specific ways and not others” (2002, p. 31) because of what we know, and how this constrains and enables us to speak. In short, discourse is a product of knowledge and power (Cheek & Porter, 1997; Foucault, 1972/1980; Francis, 2000).

Resistance. In Foucault’s later work (1986/1988, 1976/1990), he became interested in resistance, specifically relating to how power is enacted in everyday life and how persons avoid what is expected of them and contravene social standards (Hartman, 2003; Lupton, 1998). Before his death, Foucault was beginning to look at “knowledges that tended to be buried and disguised beneath more dominant, often more ‘scientific’ or ‘expert’ knowledges” (Lupton, 1998, p.104). Several authors (Armstrong, 1983; Gastaldo, 1998; Hutton, Rudge, & Barnes, 2009; Lazarus, 1988; Lupton, 1996; Osborne, 1999) have considered the experiences and responses that arise from what Foucault (1975/1995, p.184) called the “normalizing gaze.” This work bolstered what Foucault suspected: Subjectivity is contextually based and, moreover, there is always resistance where there is power (Foucault, 1976/1990). Like the push and pull of energies, resistance is always present because power does not belong to an entity; it is everywhere. It is not unidirectional, but a net woven throughout society (Foucault, 1976/1990, Foucault,1972/1980). Cameron et al. stated, rather simplistically, that people are “either adopting resistant positions or accepting dominant positions in every aspect of our lives” (1995, p. 338). Resistance to the pervasive power in a society is of interest to this thesis, as the research explores the lives and thoughts of a population as they negotiate a stance and coexist within a societal context that attempts to persuade and normalize their being.

Such resistance can arise from bodies that neither fit norms nor behave in expected and accepted ways and, as such, these bodies are considered disgusting, dangerous, disruptive, and diseased (Holmes, Lauzon, & Gagnon, 2010; Holmes, Perron, & O’Byrne, 2006; Rudge, 2009, 2010; Rudge & Holmes, 2010) by those whom Goffman terms “*normals*” (1963/1986, p. 5). When the body defies expectations, stigma is created. Moreover, through disciplinary knowledge,

nurses interact with, examine, and instruct people on their behaviour (Gagnon et al., 2013; Holmes & O'Byrne, 2006). Gastaldo and Holmes (1999) observed that little notice has been taken of the power that nurses espouse, and the resistance that occurs in healthcare interactions. There have been few questions asked about whom is being better served by nurses who follow the dominant discourse of healthcare: the institution that defines knowledge and assumptions of truth, nurses, or patients (Gastaldo & Holmes, 1999; Holmes & Gastaldo, 2002).

Goffman

Goffman (1963/1986) discussed the term stigma in the traditional Greek sense of a perceivable body sign that indicates there is something abnormal or immoral about the signifier. Goffman also succinctly described stigma in the preface of his book as “the situation of the individual who is disqualified from full social acceptance” (1963/1986, preface) and who, consequently, is considered different, even less than human. Being inhuman, even to a degree, evokes certain discriminatory actions, such as name calling and being categorized as having non-human traits. Members of discredited populations, in Goffman's (1963/1986) terms, due to physical markings or so-called character flaws, may seek to be identified in the credible group, but live in fear of being discovered or revealed as other. Their very appearance can belie the conditions of living. In the setting of healthcare, the marks left on the skin surface will be exposed on physical examination and the trained eye of the healthcare provider will identify the marks and know their meaning. In Goffman's words, the “know-about-ness” (1963/1986, p. 50) of the marks on the skin, termed stigmata, are signs that will be interpreted in all that it signifies. Stigma thus formulates a position for people in the bottom layers of stratification in society – for example, those who do not follow the dominant discourse of health (Gagnon et al., 2013). Deviance and the resulting resistance further formulates their subjectivity and identity as difficult, or as a bad patient or bad citizen (Holmes & Gastaldo, 2002).

Kristeva

Adding to the concept of stigma is that of abjection, which Kristeva (1982) defined as the repulsion that is evoked when an object, person, or event defies social expectation. As Kristeva stated, “It is thus not the lack of cleanliness or health that causes abjection, but what disturbs identity, system, order. What does not respect borders, positions, rules (1982, p. 4). A body that is abject is one “that is socially ambivalent – sanctified and reviled – and that exceeds bodily boundaries and borders” (Cregan, 2006, p. 7). It is not the crime that is abject, but that which does not follow the accepted and expected:

He who denies morality is not abject; there can be grandeur in amorality and even in crime that flaunts its disrespect of the law. ... Abjection ... is immoral, sinister, scheming, and shady: a terror that disassembles, a hatred that smiles ... a friend who stabs you. (Kristeva, 1982, p. 4)

Abject beings disrupt, upset governance, threaten control, and endanger what is accepted as truth and power (Rudge & Holmes, 2010). Malins (2011), in her discussion of the body, revealed how images of drug use are portrayed in advertising (heroin chic) and in contemporary art, particularly that of Francis Bacon. She commented on Bacon’s work as representing “bodies which are leaking out in all directions, moving fast toward their limit-points: toward schizophrenia, overdose, unconsciousness, death” (2011, p. 175). She also noted advertising’s use of the “drug-using body, a body abjected, [and] stratified in everyday life” (2011, p. 166), which appeals in a perverse manner to becoming other. These reflections are in line with Kristeva’s (1982) work indicating that fluids that transgress bodies, being rapidly out of control, are abject and thus both repelling and intriguing.

Holmes, Perron, et al. (2006), in discussing nursing and abjection, stated that the existence of marginalized groups creates social anxiety and hostility amongst those who feel they belong to the hegemonic mainstream. As Kristeva wrote, “The abject is perverse because it neither gives up nor assumes a prohibition, a rule, or a law; but turns them aside, misleads, corrupts; uses them, takes advantage of them, the better to deny them” (1982, p. 15).

Marginalized populations contravene expected norms of common discourse, disrupt the expected order and, consequently, become a relegated other. This relegation occurs because there is a tendency to “homogenise the subject as ‘not me’ and thus a certain safety or distancing [sic] can occur between the reader/watcher and the subject” (Fitzgerald, 2002, p. 374). We deal with our abjection by distancing through othering – that is, by means of rejection, derogatory statements and beliefs, separation and isolation, and attempting to protect ourselves from the perceived toxicity and danger (Jaworski, 2010).

Such othering occurs because of norms formulated by the pervasive powers of discourse, which shape what is accepted and what is expected. Othering is a form of the “us and them” phenomenon. Others are those who are not like ourselves, different from and different than, are capable of producing disgust and repulsion.

It is also possible to see oneself as other. Those who have bodies that are abscessed, marred, and marked (Sheard & Tompkins, 2008) may see their own bodies as a testimony to who they are and what they have become, much like the changes to the body that can occur with HIV, such as lipodystrophy. Gagnon (2010) discussed what it is to have one’s body transformed in such an identifiable way, creating both an interpretation of self and by others as diseased and “abjectionable.”

Abjection, then, is created and sustained by the prevailing discourses about what is good, and what constitutes accepted behaviour and appearance. It divides and places all of what is available in the realm of accepted truths, in rank order, and formulates the stratification that determines interactions and reactions between people, objects, and events. For Foucault (1976/1990), stratification is what creates the resistance that occurs against biopower, the force of life, resisting and rejecting the normative shaping of what is expected.

Integration of Theoretical Framework

The preceding discussion has presented the theoretical background that informs this thesis. To summarize, Deleuze and Guattari provided an understanding that although “there is no lesser, no higher or lower” (2000, p. 69), neither a better than, nor a hierarchy of importance, the opinion of the majority creates strata, which are more and less desired, within an otherwise endlessly connected rhizome. The space associated with strata can be rigid and defined – in other words, arborescent space – that helps encourage order. Alternately, space can be open and flexible in its intention and use. The rhizomatic nature of some spaces allows fluidity and evolution of interpretation, which makes them, thus, open and not yet defined.

It is within these strata that institutions and people co-exist. The strata are determined by the evasive power that provides direction and guides behaviours. Thus, although there is no fundamental good or bad, there are accepted values and assumptions that make some actions, lifestyles, and attitudes more and less favourable. Change, however, is constant, and the forces that drive change constantly overturn what is considered true and good, false and evil. This is the work of the war machines, without a singular intent other than to change what is to what could and might be.

The manner, in other words, the power over, by which these determinations are made about what is acknowledged as normal, ensures specific social outcomes. It includes the ability to influence how one thinks and speaks, that is biopower, as an individual (anatomo-politics) and en masse (biopolitics). The ability to survey large numbers of people, for example through statistical analysis and observation, assists with shaping idealized behaviour so that performance is guided by venerated outcomes. The episteme that is offered constructs a reality based on accepted knowledge and ways of being, further developed and supported by the institutions, discourse, and forces that reinforce this lens as true. Thus, how we present ourselves, live our lives, and behave is gently, but persuasively, guided.

When these behavioural expectations are rejected, they draw attention. Those whose behaviour or appearance is outside what is considered acceptable may be seen as resistant. Consequently, they can be discredited, considered deviant, and ridiculed. That is, they can be stigmatized, and seen as repulsive, objectionable, and “abjectionable” – in other words, viewed as a threat to expectations and to what is desired and correct.

In conclusion, the knowledge, power, and discourse spheres of the framework surround, encompass, and produce the resulting perspective of the body and stratification, which in turn produces what is considered abject. Poststructuralist ideas encompass the dynamic and diverse ways in which subjectivity is expressed, based on a context inclusive of interactions with others and perceptions of self as developed by the truth created by a pervading hegemony. This theoretical framework provides a lens which focuses a perspective with which to explore the lives and culture of WUID.

Chapter Four: Methodology

“How do we know the world or gain knowledge of it?” (Denzin & Lincoln, 2013, p. 26)

This chapter explains critical ethnography as the methodology chosen for the thesis, specifically focusing on how the components of ethnography (participant observation, artifact collection, interviews, and field notes) were planned and executed. The concept of *braiding the data* is described to illustrate how the foregoing components of the study were interwoven to describe this cohort of WUID. Lastly, rigour, reflexivity and positionality and ethical considerations, are also discussed in concluding the chapter content.

Study Design: Critical Ethnography

Ethnography is an anthropological endeavour which studies cultures during a period of prolonged field work by striving to know what a particular group of people say, make and use, and do (Creswell, 2013; Polit & Beck, 2012; Robinson Wolf, 2012; Sluka & Robben, 2012; Thomas, 1993). This intimate window into an emic understanding of tacit knowledge is then portrayed by the ethnographer to describe and explain a people's traditions and norms. The gathering of data occurs through observing and speaking to participants, and by collecting artifacts that are important to the group under study (Creswell, 2013). Hammersley and Atkinson (2007) believe ethnography is similar to the processes of making sense of everyday life, but when undertaken as research, the process must be “deliberate and systematic” (p. 4). They stated,

Ethnography ... involves the researcher participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or questions through informal and formal interviews, collecting documents and artefacts. (Hammersley & Atkinson, 2007, p. 3)

Although ethnography was traditionally seen as an objective means for researchers (often from dominant cultures) to observe others (often from non-dominant, marginalized cultures), the methodology has changed. There are now many variants of this research, such as performance, institutional, and autoethnography (Marshall & Rossman, 2016; Polit & Beck, 2012). Another type,

critical ethnography, is most often employed to study marginalized populations when there is intent to raise consciousness, or an aim to illustrate the need for emancipatory action (Marshall & Rossman, 2016; Polit & Beck, 2012). While the approach to data collection is similar in all types of ethnography, it is the underpinning theoretical framework, ontology, and epistemology that lead to an interpretation that is different in intention than traditional ethnography. Therefore, beyond the purpose of describing a culture, critical ethnography seeks to explore social injustice and facilitate change (Carspecken, 1996; Madison, 2012).

Moreover, critical or poststructuralist ethnography, also labeled disruptive ethnography, was described by Robinson Wolf as a process that still relies on “participant observation, key informants, and interview,” but goes beyond “conventional ethnography with political purpose, power relations and disempowerment, interpretation, critical historical analysis, reflexive presence of author, [and] promotes cultural change” (2012, p. 289). Additionally, Thomas (1993) defined the method of critical ethnography as one that studies the relationships of knowledge, society/culture, and political action. Thomas further detailed that “critical ethnographers describe, analyze, and open to scrutiny otherwise hidden agendas, power centers, and assumptions that inhibit, repress, and constrain” (1993, pp. 2–3). As Madison concurred, critical ethnography “takes us beneath the surface appearances, disrupts the *status quo*, and unsettles both neutrality and taken-for-granted assumptions by bringing to light underlying and obscure operations of power and control” (2012, p. 5). The critical ethnographer is thus driven by a tenet to delve into the unjust and inhumane in an effort to “penetrate the borders” (Madison, 2012, p. 6) of a population with little political voice, to thereby produce “emancipatory knowledge and discourses of social justice” (Madison, 2012, p. 6).

Employing elements of Foucault’s thinking, Madison (2012) delineated several items she believed were important for critical ethnography. These included, first, deconstructing current thinking and values which illuminate what constitutes accepted knowledge and truths, and which leads to questioning and rethinking what might be and should be. Second, researchers who

interpret data that represent the people being studied must understand their position and effect on the work. Thomas supported this point, stating that ethnographers are “active creators” (1993, p. 46) who, through involvement with participants, must engage in self-reflection and determination of how this interaction influences data collection, analysis, and interpretation. Third, whereas in traditional ethnography, the researcher would observe, interpret, write, and proclaim truth, the critical ethnographer engages in a discourse that conjoins researcher and participant and transforms both. Madison concluded that the “conversation with others [is] ... no longer an artifact captured in the ethnographer’s monologue, immobile and forever stagnant” (2012, p. 11). The researcher, then, is not an objective conveyor of knowledge, who documents and lays out truth (Rudge, 2002); rather, the researcher influences and is influenced by the process. Additionally, Madison (2012) commented on the ability of critical ethnography to bring theory to life through its very execution. The methodological process becomes the “doing” of critical theory (Madison, 2012). Each piece of the research process is important, but it is the way the study is accomplished, in other words, the methodology, that sets the focus and completes the work at hand.

In line with a poststructuralist epistemological stance, founded in critical theory, the methodology of the present research is, as stated, critical, which proposes to “call into question the social and cultural conditioning of human activity and the prevailing sociopolitical structures” (Kincheloe & McLaren, 2011, p. 172). It is with this understanding that the subculture of WUID within a local geographic and social circumstance was sought. It was also understood that the research was an interpretation of situated discourse and prevailing power/knowledge about a population who shared their lives, experiences, and thoughts (Kincheloe, McLaren, & Steinberg, 2011).

Study Protocol

Despite varying ethnographic approaches, Hammersley and Atkins (2007, p. 3) described five principles for such research. These are the following: (a) Participant behaviour should be observed in everyday environments; (b) data should be obtained from a variety of sources; (c) data collection should be mostly “unstructured”; (d) the sample is inclusive of a small number of cases; and (e) analysis evolves from an interpretation of the data to build an interpretation of participant behaviour.

As such, to understand the WUID subculture, the study included participant observation, artifact collection, and semi-structured interviews and unscheduled, unstructured conversations. Field notes, audiotapes, and personal records documented the research (see Diagram 4.1).

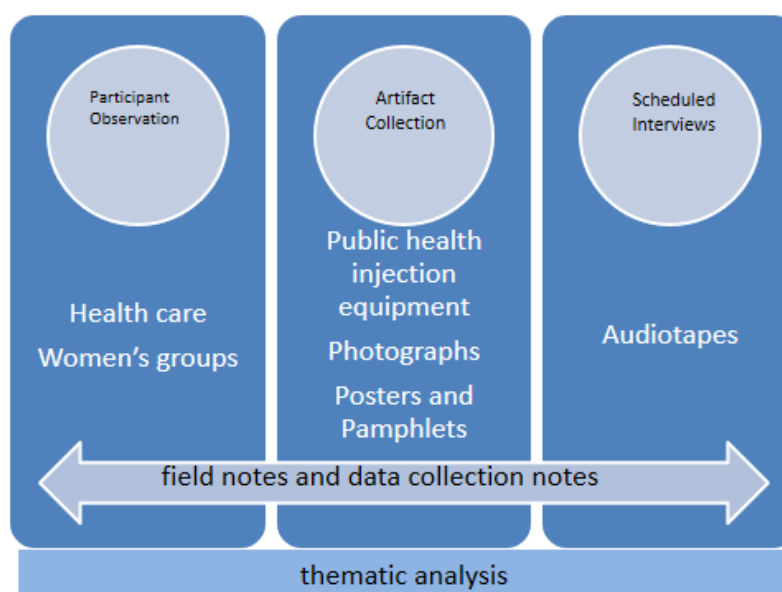


Diagram 4.1 Ethnographic research process

To fulfil the principles of ethnography (as detailed by Hammersley & Atkinson, 2007), the current study ensured WUID were observed in healthcare settings and in a women's only social program. Artifacts were gathered, including posters and flyers, along with drug use equipment.

Additionally, WUID took photographs of things they felt were health related. Face-to-face audio-recorded interviews also occurred with WUID, who spoke about their lives and their ideas about health and healthcare. Lastly, field notes were compiled and included in the research analysis, which was structured using thematic analysis (Guest, MacQueen, & Namey, 2012).

It was recognized that some study participants might contribute to more than one aspect of the study; for example, a woman might be interviewed and also agree to take photographs (see Diagram 4.2). This potential overlap enhances the description, by allowing data collection from the same WUID in different contexts. Congruencies and discrepancies of such content can identify commonalities and unique attributes of cultural norms. Therefore, the subculture of a small cohort of homeless WUID in a Canadian urban environment were studied in a multifaceted and in-depth manner.

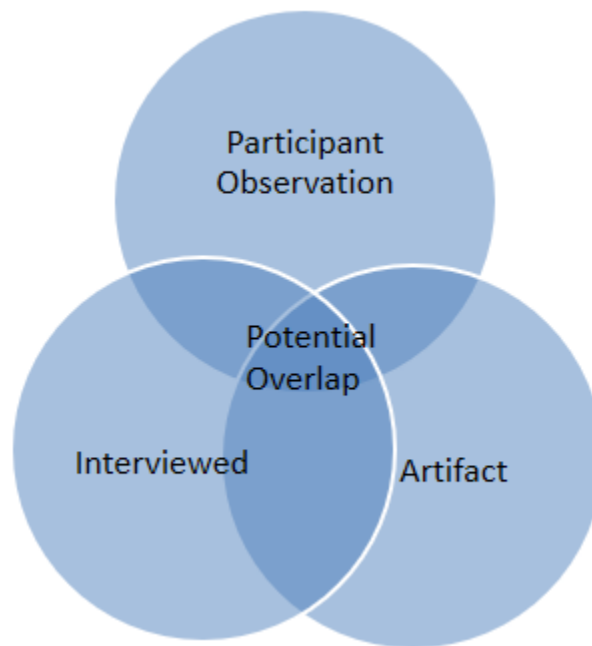


Diagram 4.2 Potential overlap of participation by WUID

Study Procedures

This section details the data collection and analysis procedures. It progresses through observation, artifact review, and semi-structured interview. The process repeats for analysis in the same order, explaining how each was uniquely analyzed, then combined into a whole.

Participant observation – Data collection. Congruent with ethnography (Angrosino & Rosenberg, 2013; Hammersley & Atkinson, 2007; Polit & Beck, 2012), participant observation was integral to the study. Participant observation enhanced understandings about reported subcultural norms, thus increasing appreciation and insights about the unwritten rules that shape when and how the women act. The naturalistic setting of these observations, moreover, provided an unstructured environment in which to collect data about the subjective experience of WUID accessing care. There were various methods of participant observation, including healthcare appointments, receiving care in a women’s shelter program, a women’s drop-in program, and chance meetings (see Diagram 4.3).

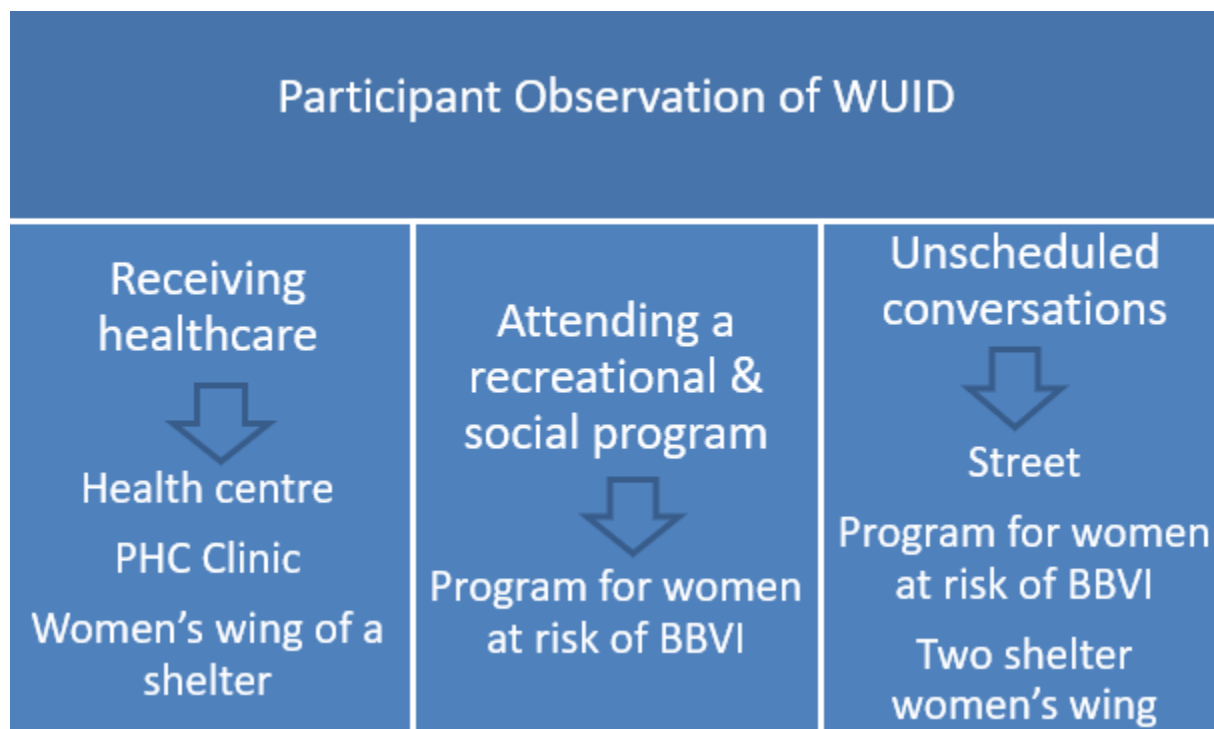


Diagram 4.3 Types of participant observation

First, WUID were observed accessing and engaging in interactions in downtown healthcare services. Specifically, women were observed at a health centre, an inner-city clinic, and in shelter programs. Additionally, women were observed in a social/recreational program for women at risk of BBVI. These locations were selected as environments that WUID are attracted to attend and receive services. Key stakeholders provided verbal and written agreement (see Appendix B for Written agreement with stakeholders) prior to observation.

Formal written consent was provided by specific healthcare providers at the first observation period (Byrne, 2000). Participant observation proceeded with the healthcare provider asking the client privately – in the absence of the researcher – if the researcher could be present during the appointment. When permission was given, and prior to the start of the healthcare appointment, an overview of the research and the participant role was provided for the client by reviewing the consent form. If the women agreed to participate, the form was signed using a designated code format. This coding system was employed to ensure anonymity of the data. (See Appendix C for participant observation consent.)

The researcher remained as unobtrusive as possible while observations took place in the waiting area, office, and clinical examination rooms (Byrne, 2000; Hammersley & Atkinson, 2007; Jorgensen, 1989; Robinson Wolf, 2012). Questions that arose about the researcher's role were answered frankly (Madison, 2012; Robinson Wolf, 2012). No questions arose in the waiting areas. The examination room questions were mostly addressed when written consent was obtained.

The waiting area or examination rooms were described with written words, and a rough map was drawn to assist analysis. This concentration helped focus the observations, rather than noting the totality of the environment and interactions. Indeed, Hammersley and Atkinson (2007) noted that an emphasis on details relevant to the study will take precedence over a broader range of observation; as such, the study aims, and questions structured all observations. Appendix D (Study Questions and Participant Observation Notes) outlines how the study questions guided

participant observation data collected. More general field notes (Appendix E Participant Observation Field Notes) were recorded as soon as possible after leaving the site.

Informal interviews, as incidental conversations, occurred with participants and other WUID during observation. These conversations occurred on the street or in the women's section of a downtown shelter. The conversations yielded rich data and were explored with the same curiosity and interest that accompanied the interviews. The content often reflected an incident related to life or healthcare of the WUID that arose in conversation spontaneously, rather than answers to interview questions (Murchinson, 2010). The benefit of these data is that conversation has been recognized (Madison, 2012) as potentially opening the opportunity to explore the content that arises and occurs between an interviewer and participant. In this regard, a chance conversation may alter the dynamics from researcher and interviewee to two people engaged in an interaction (Madison, 2012). To facilitate this engagement, in each circumstance, the researcher maintained a position of curious learner and later documented the notes as contemporaneously as possible.

To review, participant observation occurred in a variety of settings, where a number of activities took place. Such activities varied from healthcare to recreation, with the women receiving primary or supportive care, attending events for people who use intravenous drugs (PWID), or being on the street. A variety of settings enabled multiple observational opportunities to witness WUID in their everyday lives.

Artifacts – Data collection. Collecting artifacts enabled more to be known about what people do and the knowledge they use (Murchinson, 2010). Hammersley and Atkinson stated that “the ethnography of everyday life demands attention to its material features, and how social actors engage with physical things” (2007, p. 134). The artifacts were studied and analyzed for what they portrayed and what they revealed about the downtown culture of WUID and their health. Norum (2008) indicated that artifacts can enrich data from other sources, such as interviews, and describe sources and forms of artifacts (other than the traditional objects). Artifacts can be created

by participants (Norum, 2008). Photographs by participants, for example, can bring attention to alternate perspectives and also communicate at a different level than words. Imagery can be “innovative” and provide new insights (Prosser, 2013, p. 196).

As such, artifacts, comprising various articles and posters, were gathered from places that WUID frequent. Needle exchange program (NEP) equipment (safe injection equipment and naloxone kits) were also collected. Furthermore, WUID were asked if they would accept a disposable camera and take photographs of images they felt were health related. Using this two-pronged approach, artifacts were gathered about the places they attended both *by* and *from* the women. Documentation of the artifacts was captured in a catalogue (see Appendix F) and reviewed using the study questions (see Appendix G).

The women were required to sign a written consent to take photographs, the caveat being that the photographs should not contain identifying features of people, and the camera must be returned with at least five photos. The women received \$20 as compensation for their time and effort. The women also signed the consent a second time to confirm receipt of the money. (See Appendix H Consent to take photographs and receipt of compensation.)

Semi-structured interviews – Data collection. Interviews were undertaken with the goal of learning more about the culture of WUID through listening to the women speak of their everyday lives, that is, “to gain understanding of the informants’ worlds” (Munhall, 2012, p. 310). Interviews were opened by asking participants to describe a typical day. Topics were pursued with further inquiry to explore and enable more depth, thus introducing stories that expanded on some of the essence of life as WUID.

Interview inclusion criteria. The inclusion criteria for this study was determined to encourage adult, homeless WUID who stayed in the downtown urban core of a Canadian city to inquire about recruitment. More specifically, participants identified as female, were 18 years of age or older, spoke English, and were homeless within the downtown area; they also needed to have used intravenous drugs in the last month and for at least six months. Homelessness was

defined as living in a rooming house, on the street, in a shelter or transitional house, or “couch surfing,” the latter referring to sleeping in someone else’s home. The drug used by the participant had to be illicit, or a prescribed oral, injectable, or transdermal drug used intravenously. Anyone who identified they did not meet these criteria was excluded prior to interview. See Table 4.1.

Table 4.1 Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Female, transgender, or identifying as female • 18 years of age or older • Living in downtown core • Homeless (rooming house, street, shelter/transitional housing, couch surfing) • Using intravenous drugs: <ul style="list-style-type: none"> ○ for a minimum of 6 months ○ and within the last month • Injecting or having another person inject them • Using an illicit drug or prescribed oral, intravenous, or transdermal drug by intravenous route • Fluent in English 	<ul style="list-style-type: none"> • Male • Identifies as a male • Less than 18 years old • Living outside the downtown core • Housed • Not injecting drugs intravenously, not injecting drugs within this time frame • Not injecting drugs intravenously (only using a drug by smoking, snorting, or ingestion) • Using a legal drug by the route it was prescribed and intended • Non-English speaking

Interview recruitment. Recruitment for interviews was undertaken through posters (see Appendix I Study Recruitment Poster), business cards (see Appendix J Study Business Card), and referrals by key informants and participants. A verbal indication of support for approving poster displays and a willingness to recruit was obtained from organizations at two women’s shelters, three shelter healthcare programs (two of which were specific to women), and a primary healthcare clinic. Additionally, three health centres and a harm reduction program van, as well as two drop-ins (one specific to women) and the office of an advocacy group for people who use drugs also displayed the posters and offered interview space (see Appendix B Written agreements with stakeholders). The poster detailed the study inclusion criteria, expectations, reimbursement, and contact details in the form of a telephone number, email, and street address (see Appendix I Study Recruitment Poster). The posters were displayed in settings WUID were

known to visit. It was hoped word of mouth by participants and key informants would also assist in voluntary recruitment. Women who were interested in participating were asked to contact the researcher and the interview recruitment screening script was reviewed (see Appendix K).

Difficulty recruiting was an anticipated concern. In their study of HIV risk amongst WUID, Sterk, Theal, Elifson, and Kidder (2003) estimated the need to engage three women to enrol one (Sterk et al., 2003). For these authors, the most common reason for declining participation was the overriding need to use drugs and all that it entails, for example getting money and drugs, and injecting. Sterk et al. (2003) also indicated childcare was a detractor for participation. Moreover, the study noted some of the women who initially declined may have returned later to be interviewed (Sterk et al., 2003). Citing others who described the population as “difficult to reach” and “hidden” (Goode, 2000), Sheard and Tompkins (2008) predicted difficulty accessing participants, but successfully obtained a sample through NEPs, services for PWID, and a snowball technique. Programs for people who use drugs and knowing others who participated in or knew about the study provided access to and trust in the research. In this study, workers and WUID were sought to assist with recruitment. Barrat, Norman, and Fry (2007) specifically explored the benefits and negative aspects in research participation for PWID, and their findings suggest the reasons are multifactorial from personal to an anticipated lack of outcome from the study.

A further concern was that participants might be reluctant to talk about their healthcare experiences for various reasons; for example, WUID may feel shame related to the experience of being judged by healthcare providers (Neale et al., 2007). It was also thought that talking with a researcher, who is a healthcare provider, might be seen as a conflict regarding (a) criticizing the care they wished to receive or had received, (b) negative repercussions evolving from giving evidence of suboptimal care environments, and (c) disclosure of their use of illicit drugs. It was important to ensure participants understood there were no foreseen negative personal consequences, and that privacy was safeguarded. These issues were addressed when obtaining consent.

Recruitment and interviews continued until data saturation occurred. The rationale for this approach is that the relevance of seemingly uninformative interviews was difficult to anticipate in advance or during the interview, possibly providing insightful additions to the study findings. Support for data saturation as a means of determining sample size has been discussed by many writers (Francis et al., 2010; Guest, Bunce, & Johnson, 2006; Malterud, Sierma, & Guassora, 2016; Sandelowski, 1995). Polit and Beck stated that data collection should continue until “a sense of closure is attained because new data yield redundant information” (2012, p. 742). That is, data saturation is reached when new codes (a) fail to appear in subsequent interviews and (b) are found to be present in previous interviews and already accounted for. Accordingly, recruitment and interviews continued until data saturation was achieved. (See Appendix L for a schematic representation of data saturation.)

The interview. The interviews were face to face and took place at participants’ convenience in a private room in one of several locations in the downtown area. It was anticipated interviews would be 30 to 45 minutes in duration, based on previous studies with this population, which illustrated that some WUID become intoxicated as the drugs they have used earlier take effect, they may experience withdrawal, or they may have other priorities and time pressures that limit the opportunity for lengthy discussions (Sheard & Tompkins, 2008).

The interviews occurred between June 23, 2014 and July 30, 2014. They were held in various sites, but mostly in women’s programs, shelters, and healthcare clinics. Thirty-five women were interviewed. One woman did not want to be audio-recorded and reported she did not use intravenous drugs; she was excluded after her interview. Thirty-four interviews were audiotaped and transcribed. Three others were excluded when the review of the interview confirmed the women were housed. Thus, 31 interviews were used in the study. The interviews varied in duration. The shortest was approximately 15 minutes and the longest was just over 54 minutes. The average interview was 31 minutes long.

During the interview, the woman was welcomed, and the consent form was reviewed and signed (see Appendix M for interview consent). During the interviews, content was covered without adherence to a rigid format. This semi-structured approach allowed women to talk about issues they felt were important, enabling a better understanding of a typical day and insight into some of their health beliefs and concerns. The questions were open-ended and acknowledged the researcher as a learner who was curious and interested in knowing more about the life, experience, knowledge, and opinions of WUID. Participants' answers were explored, clarified, and pursued until an accurate understanding was achieved. Probing assisted with clarity of content and enabled thick description. However, more critical to the interview process was a non-judgemental interview style and use of active listening skills (Murchinson, 2010), which involved curiosity coupled with humility and respect.

An interview guide overviewed the topics to be covered but did not directly structure the conversation (see Appendix N Interview guide). This approach allowed the interviewer to focus on content, and enhanced listening. It was also recognized that an open and curious interview style would enable participants to take their conversation in unanticipated directions, thus opening further fields of inquiry and knowledge (Murchinson, 2010). The interview guide, therefore, was available but was not to be used in a manner that would limit the topics of discussion that arose.

Detailed field notes were completed after the interview. The notes recorded sensory observations (for sight and sound), and methodological considerations and personal reflections.

Compensation. To show appreciation for the women's time and for sharing their life experiences and knowledge, \$25 compensation was provided for interview participation. A signed consent was required for participation in the interview (see Appendix M Interview consent).

Data transcription. The researcher transcribed the audiotaped interviews verbatim by hand. Verbal sounds, pauses, and background noises were included in the transcription to assist with correct interpretation of the participant's intention. Marshall and Rossman (2016) suggested researchers think about the potential for problems transcribing and possible solutions prior to the

interview process. Learning the jargon of the WUID, clarifying meaning during the interviews (Marshall & Rossman, 2016), and reviewing field notes for context helped to alleviate uncertainty when transcribing unfamiliar words and their context. Two quality audio-recorders, both supplied with extra batteries and a charger with a small extension cord, helped eliminate some of the practical issues that might have arisen (Marshall & Rossman, 2016). The two audiotape recorders helped ensure high fidelity transcription when the content of one recording was unclear, although the first audio-recordings were intelligible and complete in all cases. All recordings were permanently deleted as soon as a successful recording was confirmed on the audio-recorder. The audio recordings have been placed on an encrypted USB in a secure location as described below.

Field notes. Field notes were initiated on receipt of research ethics board approval, as appointments with those who gave verbal consent and expressed interest in displaying posters began and continued with each interaction and step of the research process. During the research project, field notes were kept regarding informal observations and interactions with WUID, healthcare providers, and other relevant and key thoughts that occurred. The notes were written soon after an encounter to ensure fidelity (Hammersley & Atkinson, 2007; Murchinson, 2010).

These notes served in a contextual manner to provide a wider environmental scan than that provided directly by those from participant observations, artifacts, and organized interviews. They reflected and recorded personal comments, methodological notes, as well as thoughts on preceding interactions and observations (Emerson, Fretz, & Shaw, 2011; Hammersley & Atkinson, 2007; Murchinson, 2010). The field notes focused on recording data that aligned with the research objectives; however, information was not necessarily excluded if it did not align, as there may have been yet-unrecognized relevance (Hammersley & Atkinson, 2007; Murchinson, 2010). Notes of irrelevance were easier to disregard than retrieve retrospectively.

Written paper notes detailed these perspectives, giving further depth to the analysis of the accompanying data collection methods. Rereading the notes developed further insights to the research. Moreover, issues concerning the organization or process of the study that required

change to protect or enhance the research were noted and discussed with the research supervisor. These discussions guided the consideration of process changes during the research.

Research participation and participants. Of the 35 women interviewed, 21 agreed to receive cameras and 17 sets of photographs were interpreted. Nine women from the interviews participated in all three aspects of the ethnographic study. Of these nine women, five engaged in informal conversations during the study period. Overall, almost one third of participants provided data for the three formal aspects of the study providing contributions from multiple perspectives and enhancing what can be known about the culture of WUID.

The women in the study ranged from 27 to 60 years of age, with most being 40 and 50 years old; the substances they used varied. It was not part of the study to ask what drugs they were injecting; however, this information often arose in the interview, revealing that the women commonly used more than one substance concurrently, with only one woman reporting use of a single drug. Seven women did not disclose what drugs they injected. Although oral replacement therapy, such as methadone or buprenorphine and naloxone (as Suboxone), is a “drug treatment,” it is only effective for replacing opioids, thus many women were prescribed methadone and continued to inject crack-cocaine. Moreover, a number of women discussed simultaneous use of methadone and opioids.

Regarding housing, aside from the three interviewees whose data were not included because being housed was an exclusion criterion for this study, all spoke of past experiences and current concerns of losing housing. It would seem the use of drugs, difficulty maintaining an income, high cost of drugs, jail time, and other systemic factors mean that, even though they may be housed at any given point, the participants had experienced homelessness and their housing was transitional. Most of the women lived in shelters or described themselves as couch surfing.

For blood borne infections, no specific questions were asked. However, note was made when participants discussed them. Two women disclosing being HIV positive, and 18 women provided information about their own hepatitis C status, with 16 indicating they were positive.

Thematic Analysis

The process of thematic analysis was adapted from the work of Guest et al. (2012), with additions from others (Byrne, 2000; Hammersley & Atkinson, 2007; Jorgensen, 1989; Norum, 2008) to ensure a thorough analysis. It was applied to each for of data individually, and then to the three forms in unison. This process is detailed here (see Diagram 4.4), and then in the section Braiding the Data.

Thematic Analysis

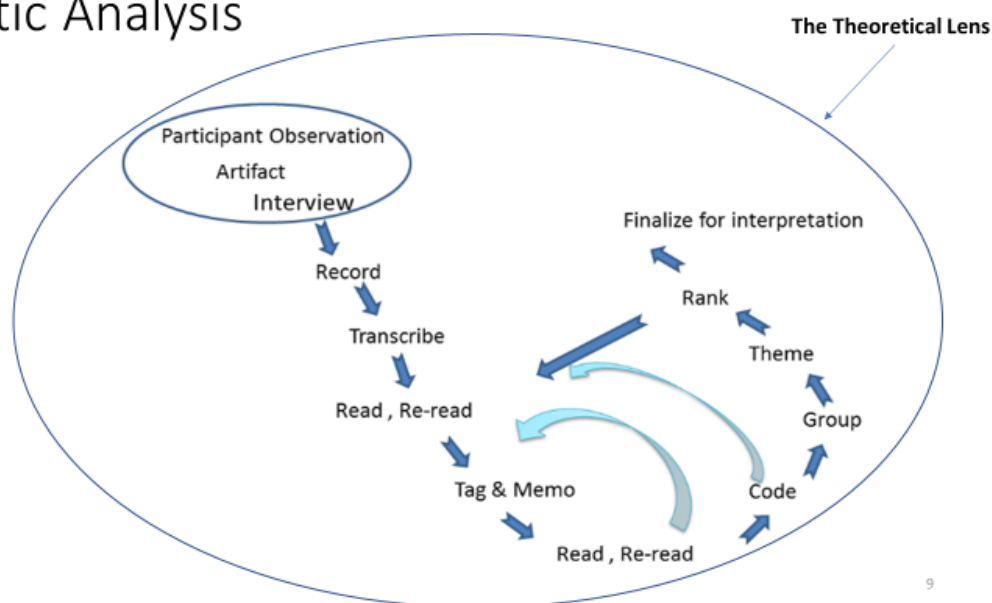


Diagram 4.4 Thematic analysis (Adapted from Guest et al., 2012)

To begin, this study used an inductive method of thematic analysis, as described by Guest et al. (2012). This approach was selected because it helps “identify and examine themes from textual data in a way that is transparent and credible” (Guest et al., 2012, p. 15). Guest et al. developed this approach to capture the “stories and experiences voiced by study participants” (2012, p. 16), and to subsequently use these findings to solve “real-world problems” (p. 17). As

the intention here was to know more about the lives and thoughts of WUID regarding health and healthcare, thematic analysis provided a structure to represent the participants' narrations.

Specifically, data analysis involved repeated reviews of the data – whether observation, artifact, or interview; these reviews occurred separately for each type of data, and then occurred to unify the data (see Braiding the Data below). To assist with this analysis, Ryan and Bernard's (2003) work was utilized, in that terms that were not customary to the local common language acted as cues that drew the researcher's attention. Connector words, such as "because," "if," and "as a result of" were also examined for content that might reveal important information as the participant or a document (artifact) or an observation explained a point through elaboration (Ryan & Bernard, 2003). Specifically, the documented observations and the interview transcripts were read multiple times to gain an understanding of the content, and the artifacts were observed and considered multiple times. The researcher considered Ryan and Bernard's (2003) work with the study questions in mind, and coded the impressions (Norum, 2008). Although Guest et al. (2012) indicated the human brain can identify patterns without objective cues, acknowledging the foregoing connector terms strengthened rigour for a novice researcher (Ryan & Bernard, 2003). Lastly, caution was taken to include and segment items even when the relevance or importance was initially unclear. This occurred because, *a priori*, it can be hard to know which phrases or terms might be useful during analysis; instead, relevance was determined after the fact.

Practically, data analysis involved segmenting identified items. The segments identified a single point on an image or, in text, the start and end of an idea. Once identified, these segments were labeled, which was the process of using one or a few words to describe the content of each segment. The goal with this labeling was to describe the segment content, and to do so using visible elements of the segment (e.g., participants' words, visible items in observation, etc.). Once produced, labels were entered in a code book (an Excel spreadsheet), with the listed codes on the vertical axis and data references on the horizontal axis. This produced an audit trail that readily associated the labels with the raw data. The code book prototype is found in Appendix O.

After these labels were entered in the code book, similarities and differences were noted; those that were similar were clustered to produce groupings of labels that had a commonality. Each of these clusters was then assigned a code, in other words, a term that captured the common content within the clustered labels. Guest et al. (2012) suggested that the more defined codes are, the better consistency of identification in the data and the cleaner the resulting themes become. Each code, consequently, was short and descriptive to cue its intention and substance.

These codes were thus a second level of analysis, slightly more abstract and filtered than the labels and the raw data. As codes were developed, they were defined and added to the code book. Existing codes were accepted or revised when the intent was clarified, or new codes were added. All unique text was coded and reviewed for commonalities. If new codes were similar to existing ones, they were considered with the perspective of being (a) added to the cluster, (b) revising the current code, or (c) adding a new code. Upon determining that a coded item was irrelevant to the research aim, it was discarded in the discussion of findings. This did not mean the finding was incorrect or not noteworthy; it simply denoted a lack of relevance for this specific study. The code book was thus an ongoing iterative work ensuring thorough consideration and complete exploration of the data collected. When the data were coded to the satisfaction of the process, all content under each code was reviewed and sorted into a meaningful sequence.

Some codes, however, did not fit with the developing coding schema. Guest et al. (2012) highlighted that such cases – referred to as outliers – can be negative or deviant cases, with negative cases being those that refer to a point that differs from those indicated by most participants, and deviant cases being those that follow a theme, but deviate from the main thinking of the group and extend the continuum of responses. In both cases, because outliers may provide salient information not discussed by other participants (or may be outright irrelevant), Guest et al.'s (2012) work about the decision to include or exclude outliers was followed. These authors recommended considering the relevance of each case in relation to the study's aims and theoretical framework, and then in relation to whether or not the case represents content that

would change policy or an intervention. If the case was determined to be irrelevant, it was discarded. If the case was relevant, further review occurred to ensure the case was indeed unique and had not been previously identified, or that it represented an addition to an existing theme. A search for an explanation of the outlying case was considered. When the variance was adequately explained, and there was a fit with the existing framework, a decision was made to include the seemingly stray content without changes (Guest et al., 2012). See Appendix P Deviant case analysis. Therefore, the fate of outliers was determined on an individual basis after a thorough and thoughtful review of the data and possible implications of the information within the aims and the broader context of the study. Guest et al. described that this process is important because it helps guard against “cherry picking” (2012, p. 113).

After the coding sequence was completed, including a review of outliers, codes were clustered into themes, which were titled to capture the common point in these codes. These themes were then developed into larger narratives that encompassed the broader sentiments in the participants’ statements and the observation and artifact data. This step completed analysis.

Braiding the data. Traditionally, ethnographic studies combine interviews, participant observation, and the gathering of artifacts to complete a rich and multidimensional understanding of a group or culture (Creswell, 2011; Ellingson, 2011). Denzin and Lincoln (2013) likened the work of qualitative researchers, and amongst them those who engage in ethnography, to the work of bricoleurs, that is, people who make quilts or, in the film industry, montages. In ethnography, data are woven together as a bricolage creating a recognizable ensemble of detail gathered from methods used to create a composite from the individual data. Polit and Beck defined the term as having to do with post-modern qualitative research which utilizes “a complex array of data,” derived “from a variety of sources, using a variety of methods” (2012, p. 721). Kincheloe et al. added that bricolage is an approach in critical ethnography that incorporates multiple lenses to allow “fluidity and goes beyond a traditional triangulated approach for verification” of data (2011, p. 172). Ethnography enables a created melding of voices, images, observations, and collected

matter to formulate an understanding and exposure of a culture – in the current study, that of WUID.

This research understands the observation, artifact, and interview data as braided into a strong representation of the gathered data from multiple sources. The strains entwine and become one another, holding each other together while making individual contributions to the whole. A braid implies that when multiple data collection methods are used, they can illustrate findings with similarities and others that deviate and sit at the margin, thus illuminating difference. Others have used the word weave (Fetters, Curry, & Creswell, 2013), but it is the image of a braid that this study used to represent the thick, nuanced, in-depth description of the data. The components of the ethnography were completed and analyzed and braided into an understanding of the lives of WUID. This enabled an understanding that can inform healthcare provision. See Diagram 4.5.

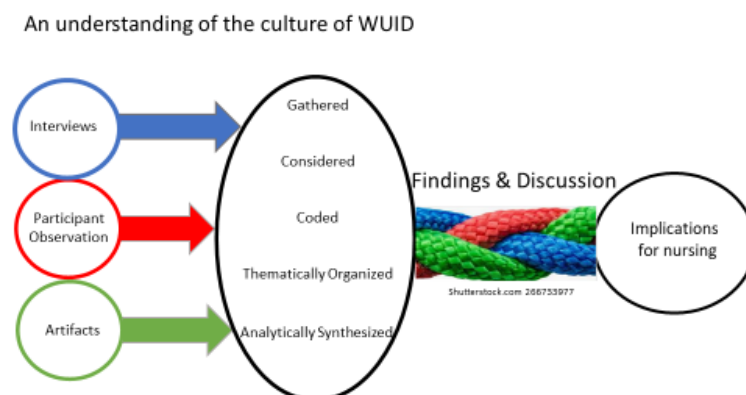


Diagram 4.5. Braiding the data

Rigour

Although rigour has traditionally been considered an assessment of whether or not research follows accepted methods and appropriately represents study data, Lincoln, Lynham, and Guba (2011) argued that the definition of rigour is in flux, and that several philosophical differences suggest that rigour should be maintained and measured in multifaceted ways.

Guest et al. (2012) suggested, as a first step, that researchers should create a detailed record of each step of the research process to formulate an audit trail, which details the ways by which raw data was categorized, clustered, excluded, named, and so forth. This record allows anyone to review the development of themes backward to the raw data from which they originated. For this study, a table showing this process is found in Appendix Q Rigour. Guest et al. (2012) also highlighted that rigour of interpretation can be illustrated by using verbatim quotes and other examples of raw data in the final research report; they posited that this gives readers an opportunity to show that the findings did emerge from, and represent, the raw data.

Guest et al. (2012) also emphasized the importance of recognizing discrepancies between what participants say and what is interpreted. This important stance is accepted by some and rejected by others as less than valid science. It is understood doing ethnographic research is not an objective observation of a cultural phenomenon (Scheurich & McKenzie, 2008). Rather, the ethnographer brings a perspective that shapes and colours the inquiry and the analysis. This is not to say this methodology enables an unstructured and undisciplined approach to research determined only by opinion (Finlay, 2002). Angrosino and Rosenberg (2013) warned that rigour cannot be lost in the acceptance of subjectivity. Careful attention to process helps guard against the research becoming an insignificant, individual opinion about a specific population. Early and accurate notetaking, transcription, and a systematic analytic approach, such as that offered by a code book, contributed to the audit trail and to transparency and trustworthiness here.

Lastly, the idea of verifying data analysis with others is a method some endorse to enhance rigour. While many argue for the merits of member checks to assist with ensuring rigour

in an ethnographic study (e.g., Guest et al., 2012; Marshall & Rossman, 2016; Robinson Wolf, 2012), this study made use of clarification of understanding and agreed-upon meanings of statements provided by participants during the interviews. No post-interview member checks were pursued, as there was a need to protect the anonymity for the women (see Ethics below). Similarly, the process of involving others in the coding process was considered. Rather than involving others within an independent PhD submission completed under supervision, coding was primarily a product of the writer's work. To this end, the iterative process of transcription, reading, rereading, coding, and rereading was undertaken to reflect the collected data. In this case, one person, rather than many, provided the multilayered approach to coding.

Reflexivity/positionality. Another element of ethnographic rigour is reflexivity (Hammersley & Atkinson, 2007). As Denzin and Lincoln stated, "It is no longer possible for the human disciplines to research the native, the indigenous other, in a spirit of value-free inquiry" (2013, p. 26). The researcher brings a perspective, or lens, to the study that is an embodiment of the research (Allen, 2004; Finlay, 2002; Horsburgh, 2003; Marshall & Rossman, 2016; Munhall, 2012; Pelias, 2013). This reflexivity is present throughout the process of this study, starting with when the research questions were formulated, the literature reviewed, the data collected, and the findings considered. Moreover, reflexivity created the perspective of the theoretical framework that guided analysis and interpretation. The researcher is not separate from the research, but integral to it. As Finlay (2002) and others (Reinharz, 1997) have commented, researchers should be aware of, and open to, how their being constructs the sought-after understanding of others. Hammersley and Atkinson (2007) stated that researchers are a part of the social world they study, shaped by the values and history they emerge from. As such, the researcher is not a neutral and impartial contributor (Marshall & Rossman, 2016).

In this case, the researcher has a professional background as (a) a midwife, reflecting an interest in women's health, (b) a primary care nurse practitioner who works with a downtown homeless population, and (c) a public health nurse on a mobile needle exchange van, and

previously at a drop-in for sex workers, many who injected drugs. This work shapes the research and the women who were studied and is integral to understanding the research. The influence of living as a white, middle-class woman on the intersubjectivity with the women of the proposed research demanded consideration, and provided rich opportunities, for reflection.

Ethical Considerations

Considerable attention is rightly given to protecting participants from harm and coercion related to research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada [CIHR et al.], 2014; Davidson & Page, 2012; Scott, 2008; Shuster, 1997). As such, this research proposal was submitted to the University of Ottawa Ethics Board and received approval in June 10, 2014 (see Appendix R). The *Tri-Council Policy Statement* (CIHR et al., 2014) is Canada's overarching research ethics document, and provides guidance on a number of ethical considerations related to research involving people. While there is attention to vulnerable populations in each of the three cited documents, none explicitly identify PWID as part of this group. They are acknowledged, however, as a marginalized population who require special consideration (Anderson & DuBois, 2007; Davidson & Page, 2012; Scott, 2008; Sheard & Tompkins, 2008). Indeed, WUID should be considered especially vulnerable, not only by gender and sex, but also due to ethnicity, involvement in sex work, sexual orientation, possible history of sexual abuse, and intravenous drug use (Lloyd, 2010; Roberts et al. 2010). Therefore, careful attention to ethical considerations was paramount.

First, to ensure access to this marginalized group, recruitment strategies had to be innovative, while also protecting participants' rights. Posters were placed in areas where WUID frequent to enable private consideration of participation. Business cards with the researcher's contact details were available from key informants in the venues and attached to the poster. The recruit was also able to contact the researcher by multiple means, including telephone, workplace, or email, thus providing confidential options to indicate interest in participation. Although noted on

the poster, the inclusion criteria were discussed at the initial contact and during the review of the consent form. Verbal agreement that the criteria were met was satisfactory. No examination or testing was required, contributing to a respectful and trusting relationship.

A time and place for the interview was established at the participant's convenience, provided it was private and safe for participant and researcher. No contact or demographic details were obtained to protect the identity of the recruit and diminish risk of legal action related to illegal drug use, similar to the method used by Buchanan et al. (2002) to protect confidentiality. Together, these elements followed the ethical principles of respect and benevolence.

The requirements of participation were reviewed at the interview meeting to reaffirm informed consent. Understanding the study, what was involved, and what commitment was being asked was important. To be valid, informed consent included that the participant (a) understood what was required of them, (b) comprehended what the study intended to accomplish, and (c) freely and voluntarily agreed to participate. Clarification of aspects of the study were discussed as requested. It was important to ensure potential participants (a) were aware the interview was audiotaped; (c) were informed no demographic or contact details would be taken and that their identification and signature was via a code; (d) were aware the information they gave was confidential, with limits if risks of harm (to self or others), or abuse of a minor was disclosed; (e) knew that, when reporting poor healthcare, the provider would not be informed by the researcher; however, the participant would be given the contact details for the regulatory colleges of the professional (College of Nurses of Ontario or College of Physicians and Surgeons of Ontario) to report the irregular care, if they wished; and (f) could choose not to participate or withdraw from the study at any time without consequence. The recruits were also informed that they could choose to have any part of a partially completed interview tape destroyed or consent to have the recorded tape entered as data for transcription and analysis, and were told the tapes and transcripts would be kept in a locked cabinet in a locked office at the University of Ottawa and destroyed seven years after completion of the study.

Risks. Few risks were anticipated, and most were mitigated. Possible identification as a WUID could have occurred if the participants were seen being interviewed. The interviews were held in multi-use facilities and, therefore, the interaction could have occurred for many reasons.

Next, for ethical reasons, member checking did not occur because it would have entailed follow-up with the participants after transcription, coding, or analysis to clarify details that were unclear to the researcher. This would have required participants' contact details, such as name, address, or telephone number, which could have enabled identification of participants who might face criminal charges if the data were subpoenaed and drug use was identified. Moreover, such information could have permitted police to trace a participant to her address. Arguably, the women, primarily homeless, were transitory and an address or telephone number was unlikely to be valid in the months after an interview; in any case it was felt this risk should not be taken.

A potential concern was identified if participants were paid to recruit others to the study. Paying for peer recruitment has been found to potentially cause harm (Scott, 2008), and thus only voluntary non-paid snowball sampling occurred. Beneficence/non-maleficence are principles that must be considered when research may cause harm (Hofman, 2004). A voluntary sample of self-referred or unpaid peer-recommended WUID helped uphold this principle.

Monetary compensation. Although reimbursing participants can be seen as influential, monetary "incentives" can be viewed as fair "compensation" (Collins et al., 2017; Hughes, 1999; McKeganey, 2001). Money, as compensation for participation by PWID, can also cause the researcher to be concerned a recipient will buy drugs, thus implicating them in contributing to an illegal activity or enabling the purchase of a potentially lethal dose of an illicit drug (Buchanan et al., 2002; Collins et al., 2017; Ritter, Fry, & Swan, 2003; McKeganey, 2001). There has thus been consideration of the compensation not being cash (Ritter et al., 2003). Some studies have used coupons (Hughes, 1999), and even compared in the same study (Deren, Stephens, Davis, Feucht, & Tortu, 1994; Festinger et al., 2005); researchers found these alternative methods were not as well received as money (Collins et al., 2017).

The amount of money should indicate appreciation of engagement in the research, but not entice beyond what would influence the participant's judgement (Davidson & Page, 2012). To determine this sum, similar local studies were reviewed. In 2014, in Ottawa, I-track paid \$25 for an interview, while PROUD paid \$20 for an interview and point of care HIV test. The current study provided \$25 per interview and \$20 for the return of a camera with a minimum of five photographs. It was determined that the amount of money provided aligned with research occurring at the time in a similar population. The participant observation sample was not compensated as they were attending a self-determined appointment, activity, or interaction with a healthcare provider.

In summary, compensation for participation in research is a multifaceted issue; however, the literature indicated that money is preferred, and that participation in research is commonly compensated without regard for the outcome of payment. These principles underpin the decision to use monetary compensation for participation. Accordingly, compensation should be considered in terms of respect for the participant's time, expertise, inconvenience, and out of pocket expenses incurred by the participant as well as enabling a sense of value.

Benefits. The benefit of this study is that it provided a forum for WUID to express their perspectives about their needs and preferences for healthcare. This advocacy role for a hidden and often-dismissed population has been noted by others as a reason why WUID participate in research (Fry & Dwyer, 2001), and precludes the misrepresentation that money is the primary motivator.

Other ethical considerations. There were other concerns foreseen as potentially arising during the study. Sheard and Tompkins (2008) cited several challenges they experienced interviewing WUID. The Australian Injecting and Illicit Drug Users League (AIVL) strongly argues for the use of peers as "key to ensuring more ethical standards in relation to informed consent in IDU research" (2003, p. 18). They go on to state that "by and large, drug users are more comfortable with other drug users and, other users often know when someone is uncomfortable or doesn't understand the process" (AIVL, 2003, p. 18). Peers were not a part of this research

team; however, the WUID who participated provided informed consent, and appeared comfortable with this decision as well as throughout the discussion. Moreover, the women did encourage others they knew to participate, therefore informally acting in the role of a supportive unpaid peer. Two women were self-admittedly high, and one was in withdrawal during their interviews. They did not exhibit any concerning behaviours nor demonstrate a lack of trust. Rather, they seemed at ease with sharing this information with the researcher.

The researcher did not provide healthcare, but if a healthcare need had been identified the participant would have been encouraged to seek medical assistance. Should a recruited woman have exhibited signs of overdose or been suffering from an acute mental health issue, such as psychosis, the interview would have been stopped immediately to obtain emergency healthcare. If the circumstances were not life-threatening, but at the same time not conducive to starting or continuing, the interview would have been postponed or canceled as the participant wished. Appropriate care would have been sought or the participant would have been encouraged to return to a safe environment. Above all, the safety of participants came before the needs of the study.

After completing the research, the participants may have expected that the issues they identified would be resolved. A clear explanation was given that the study was an initial step in securing improved healthcare for WUID through a better understanding of their needs.

There are several important ethical issues to consider when doing research, especially significant when dealing with a population that is vulnerable due to drug use, gender, associated mental health issues, and illicit activities. The University of Ottawa Research Ethics Board provided approval for the study and the permission is appended (see Appendix M). The study protocol and prior consideration of ethical issues that could arise were assistive in avoiding issues and being prepared for potential outcomes. Precautions to ensure the safety of participants were deemed to be important, and their protection from harm was of the utmost importance.

Summary

The proposed research was undertaken using a critical ethnographic methodology. It sought knowledge of the everyday lives of WUID with the purpose of uncovering the hegemony that pervades and influences their lives and interpretation of what constitutes health and when healthcare would be accessed. True to ethnography, the data were collected using multiple sources, including interviews, participant observation, and artifact collection. The process involved a keen awareness of the potential vulnerability of the women participating in the study and a sound ethical approach took precedence over the needs of the study. Data were reviewed multiple times in an iterative process to develop themes; this occurred until data saturation was reached (see Diagram 4.6). The results and findings of the study are documented in the following chapter.

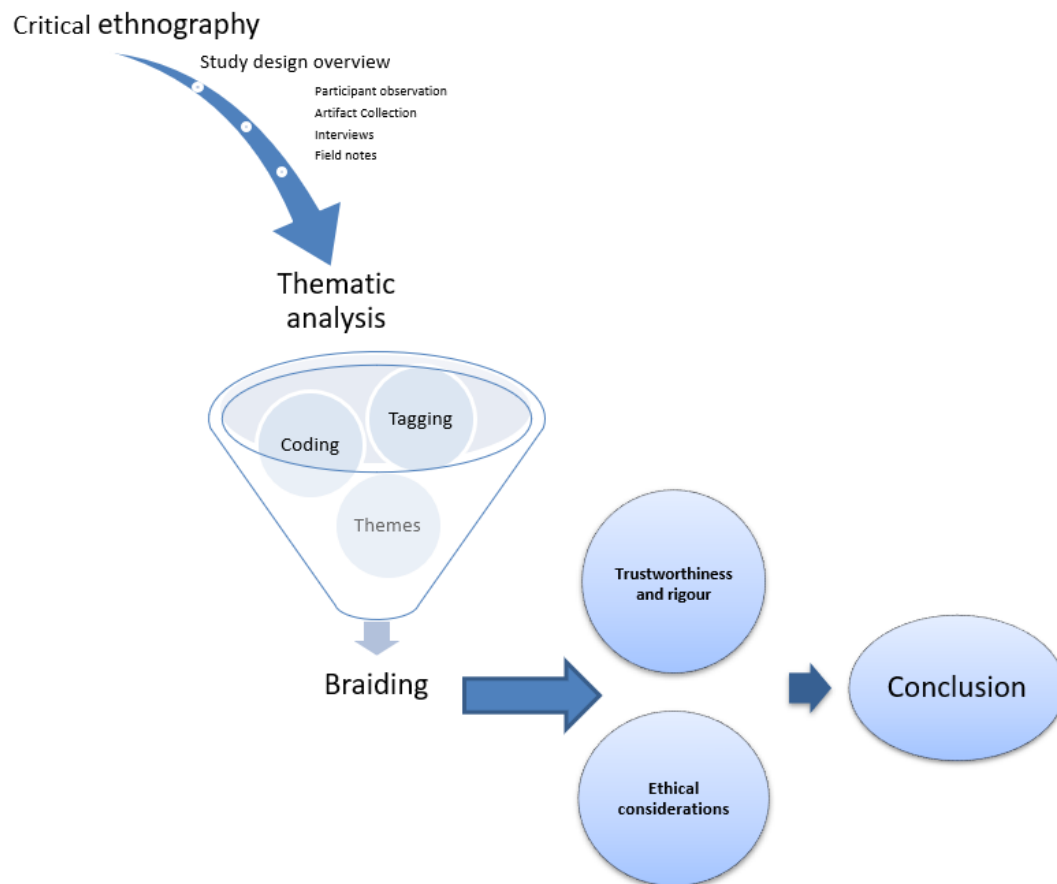


Diagram 4.6. Overview of the study process

Chapter Five: Findings

Chapter 5 presents the findings for each of the three forms of data collection: (a) artifacts, (b) observations, and (c) interviews with WUID. First, the artifacts that were gathered provide an initial impression of the culture of WUID. Additionally, photographs WUID took were catalogued and analyzed based on the research questions. Observation included sketched maps and written records about WUID in healthcare and social environments. Lastly, interview data were collected, and are presented as three main themes within the women's stories. These are (a) an archetypical day, (b) negotiating survival, and (c) valorizing the ideal of being clean. Below, each data collection method is presented, first with an overview of its procedures, and second with the resulting data. The three means of gathering data are then integrated to show the links that helped formulate an understanding of the culture and what was considered important in the lives of WUID.

Artifacts

Photographs. Twenty-one cameras were given to women to take photographs of anything they thought related to health. Two cameras were not returned, and two sets of photographs were eliminated: in one case, the woman was not homeless; in the other case, the woman did not use intravenous drugs. In total, there were 17 sets of photographs reviewed.

Other artifacts. Other artifacts included needle exchange program (NEP) equipment from a public health site, posters and crafts made by women from a recreational facility, and news articles published by agencies that advocate for people who use drugs (PWUD).

Artifact findings. The artifacts showed self-reliance, identification of drug use as a central activity, and a need for hope and resilience amongst the women. The artifacts included tools, written words in the form of posters, flyers and newsletters, and photographs. See Table 5.1

Type of Artifact	Category	Subcategory
1.1 Tools	NEP equipment	
	Peer-administered naloxone (PAN) kits	
1.2 Written word	Flyers Posters	Grief & remembering events
	Newsletter	Activities & resources for PWUD
1.3 Photographs	Drug use	Drug use spaces
		Scars & injecting
		NEP supplies
	Streetscapes	Devoid of people
		Full of people
	Nature	Flowers
		Fresh food
		Green spaces
	Healthcare	Spaces
		Providers/workers
Recreational venues	Women's only group	

Table 5.1: Categories of artifacts

Tools. The tools the participants could obtain included needle exchange equipment and peer-administered naloxone kits to minimize harm when injecting drugs. More specifically, this equipment included a 1mL syringe with needles attached, a plastic 2mL water ampoule, isopropyl alcohol swabs, individual vitamin C packets, sterile packets containing a cooker (a small tin pan ~2cm in diameter) with accompanying filter and a small 2.5cm pad to press on injection wounds to stop bleeding, extra sterile filters, and blue plastic strips about 25cm long by 2cm wide to use as a tourniquet. This injection equipment is to assist with the prevention of infections and skin wounds, decrease transmission of blood borne viral infections (BBVIs), and promote habits for injecting drugs and disposing of equipment that minimize the transmission risk for these infections.



Photograph 5.1 NEP equipment With permission from Ottawa Public Health

Peer-administered naloxone kits were also available, and came in a black eyeglass case containing two syringes, two needles, two ampoules of naloxone (0.4mg/mL) in coloured plastic enclosures (designed to assist with breaking open the glass ampoule without injury), a reminder card about how to reverse overdoses and provide resuscitation (should CPR become necessary), a small face mask, and a card identifying the carrier as trained to administer the naloxone.



Photograph 5.2 PAN kit With permission from Ottawa Public Health

Community agencies provided these tools to help people who use intravenous drugs (PWID) use clean injection equipment and provide overdose care for each other. While the needle exchange equipment was supplied by many services, such as shelters, community health centres, and public health, the peer-administered naloxone kits were distributed exclusively by the public health department.

The equipment, then, is seemingly provided with an unspoken willingness for healthcare providers to help those who inject drugs, but with the caveat that this assistance must occur in a distanced and removed manner. Equipment is provided, but PWID must take it away, and use it elsewhere; the agency can provide equipment to save lives, but it is the responsibility of the person injecting drugs to take the initiative to save another. Thus, there is a notion created that injecting drugs and overdosing is to remain hidden, away from mainstream healthcare which, in these circumstances, only provides aid from the detached sidelines.

These tools were, moreover, are packaged and presented as sterile, standardized, and ordered. The impression is that of medical equipment, therapeutically organized to treat the subjective drug using body of WUID. This presentation also shows a distinction between the ideas

of clean versus unclean, and the boundaries of order versus disorder. If peer-administered naloxone is to be an accepted overdose prevention tool, it should consider how clean is held out as an ideal to those considered, by many, to be unclean. These objects, the needle exchange equipment and naloxone kits, identified a meeting of two cultures. How the equipment was used was not revealed by observation. The intention and the actuality of use is further explored in the interview findings.

Written word. The items of written words, flyers and posters, identified programs and activities for PWUD (people who use drugs). A review of these showed that most were provider-led, rather than initiated or organized by PWUD. The exception was a PWUD advocacy group, which advertised a weekly breakfast for PWUD. This event was prepared by and offered to the community of PWUD and provided a space to come together and be nourished, both in terms of social interaction and food.

With this one exception, the flyers and posters promoted events related to the sequelae of being directly or peripherally involved in drug use. The events centred around recognizing the death and grief suffered by PWUD and those who knew them. The advertised events recognized those who had died or been mistreated through drug use; for example, the international Overdose Awareness Day, Drug User Memorial Day, and the Day to End Violence Against Sex Workers. These events commemorated tragic outcomes and memorialized the deaths and misfortunes PWUD incurred. There were no celebrations of drug use, only remorse and sorrow.

In contrast, a local peer group, who supports research about PWUD and promotes solidarity and improved conditions for PWUD, produced a newsletter endorsing the belief that PWUD should have a say in the services provided for and to them. Their motto is “nothing for us without us,” which clearly indicates the need they felt for the voices of PWUD to be heard. Additionally, a health centre initiative to serve PWUD published a newsletter promoting services, events, and provided health tips to readers. This brightly coloured, well-laid-out, and “newsy” two-page document is written in an informal and welcoming manner. The harm reduction tone

suggests acceptance, respect, and an interest in the health and safety of PWUD. The newsletter included pieces contributed by PWUD. These newsletters are informative and capture some of the issues PWUD face.

Photographs. The women used photographs to highlight what they thought represented anything to do with health. These tell some of the story of the everyday lives and culture of WUID.

Drug use. The participants photographed items they thought related to (a) places where drugs were used, (b) physical bodily features that identified drug use, and (c) NEP supplies in health care and other environments. As part of this effort, participants provided photographs of rooms and scenes where drug use was evident. These photographs of the space of drug use captured images that are messy and cluttered:



Photograph 5.3 Someone's place where drugs are used.
Photograph by DAK

Regarding the signs of drug use, the photos contained images of WUID with scars and abscesses. It is interesting they have agreed to have their bodies photographed for the research, revealing the evidence they try to hide. What has remained hidden is now requested and provided, perhaps demonstrating an acceptance that what is considered dirty and unclean needs to be revealed.



Photograph 5.4 A woman injecting into her scarred leg. Photograph by 1169DW

Furthermore, the women photographed equipment they obtained and used for injecting drugs. The women may be expressing the idea that clean equipment is important when one is trying to be inclusive of what health means to them. There seems to be an alignment with a consensus that clean equipment aligns with health, and is thus something to desire, obtain, and use.



Photograph 5.5 Stores of injection supplies in a shelter.

Photograph by 0663AM



Photograph 5.6 NEP equipment at a shelter.

Photograph by 0663AM



Photograph 5.7 & 5.8 Convenient packages of 5 a) advertised b) ready for use.

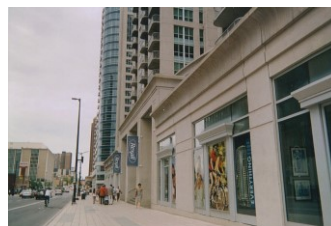
Photographs by 0684MT & DAK

Altogether, this cluster of photographs helps to enhance an understanding of the perceptions of health and drug use within this group of WUID. Succinctly, drugs are injected in places that do not reflect the cleanliness of the equipment they use; the marks of injecting emerge in an exposé of health. The photographs begin to provide evidence of what are considered healthy and unhealthy activities and objects.

Streetscapes. The WUID photographed streetscapes, which were devoid of connection to human life, giving the appearance of isolation, loneliness, and an anonymous existence. The street is empty in one photograph and in another contrastingly full of unknown people, illustrating, one can imagine, a sense of isolation, aloneness, and separateness, despite congestion and business.



Photograph 5.9 Streetscape without people.
Photograph by 0174



Photograph 5.10 Streetscape with anonymous people.
Photograph by 0168LW

The photographs collectively provided insight into the view of WUID of the elements of their lives. While these photographs are not excellent quality, they look stark and disconnected in their focused gaze. When one reflects on being homeless, it would seem there may be a connection with the street as a space where WUID live, as their home, alongside a concurrent sense of not belonging, together with a fear of experiencing negative and uncaring comments about their lifestyle and embodied drug use.

Nature. The participants also photographed fresh fruit, vegetables, flowers, and gardens.



Photograph 5.11 An urban flower garden.
Photograph by 0663AM



Photograph 5.12 Fresh fruits.
Photograph by 0168LW



Photograph 5.13 Greenery in a park.
Photograph by 0684MT

Nature, as represented by plants and food, are socially understood as healthy. The photographs of plants and fresh foods, then, perhaps capture participants' perceptions of a means of being healthy. That is, to eat well, and to enjoy the beauty, quiet, and calmness of nature.

Alternately, the images represent a glimpse into what maybe seen as life outside the culture of drug use. The photographs are taken from a distance, perhaps reflecting the void between homelessness and street life, eating shelter meals, and the desire to be healthier. These images may relate to an aspired life without drugs, of seeking an alternate life, away from the dirt and sense of being contaminated and abject involved in intravenous drug use.

Healthcare. The participants photographed social and healthcare workers, and places they frequent for healthcare, such as downtown clinics, a women's program, a NEP, pharmacies, and a methadone clinic. These photographs captured healthcare workers, WUID, and institutions. It is in these spaces where interactions between WUID and service providers occurs. The photographs are of places where drug use was more likely to be known and accepted. The healthcare venues, by purpose of the task to take photographs of images reflecting health, seem to be considered important spaces relating to health.



Photograph 5.14 A downtown pharmacy.
Photograph by 0270PW



Photograph 5.15 A clinic bulletin board.
Photograph by 0168LW



Photograph 5.16 A clinic desk.
Photograph by 0684MT

Absent from the photographs is images of hospitals, ambulances, and uniformed providers (e.g., paramedics), and so on. While possibly circumstantial, in that there were no nearby hospitals, and no ambulances may have passed while the participants used the cameras, their absence is notable.

Recreation activities. Participants photographed places where they *hung out*. Socializing in a safe environment was possibly part of what they associated with health. Indeed, the need to connect with others is an attribute associated with health. In these spaces, WUID could relax and

interact socially without the pressures of working, buying or seeking drugs, or being seen by police.



Photograph 5.17 A women only recreational program.
Photograph by 06101971GB



Photograph 5.18 Making flowers for PWUD Memorial Day.
Photograph by 0650EM



Photograph 5.19 PWUD advocacy group – drop-in breakfast.
Photograph by 0174

Participant Observation

The observational data showed that, overall, when WUID accessed healthcare in shelters or in a clinic for PWID, they were received and treated in a non-judgemental manner, and they responded, for the most, in the same way. WUID responded to healthcare providers' questions with openness and honesty when they were treated without judgement, and their drug use was acknowledged and accepted. The caveat is the influence of drugs, mental health issues, and sleep and food deprivation, which altered the interaction. For example, a woman who was returning to the shelter program after days of being outside, using drugs and in poor health both physically and mentally, was irate and confrontational with staff as they tried to assist her with a decision to come in to rest and eat. Gentle suggestion, remaining calm and respectful seemed to create an opportunity for the woman to agree to the request. Her safety was the basis of the staff concern and it was paramount to come alongside her perceived needs and enable her to seek refuge. An understanding of the context of behaviours, with the notion of the women's safety as a priority, is important in providing services to WUID. Both the personal interactions and the healthcare environment were observed.

Participant Observation Sites
Interacting with healthcare providers
Healthcare environments
Recreational programs

Table 5.2: Participant observation sites

Interacting with healthcare providers. Seeing WUID as women and accepting their context facilitated care provision and was important but especially so in transitional residential settings, where the women returned for safety and security. In such spaces, the women's interactions were grounded in a timely needs-based dialogue. Meanwhile, appointment-based healthcare was fraught with other factors, including WUID choosing to miss appointments if, for example, they did not desire to attend, had other priorities, such as needing drugs or to work to obtain drugs, or otherwise felt they could not meet with a healthcare provider. Arriving for a scheduled appointment indicated a specific, sometimes mandated or urgent need.

These two environments, although different in setting and intent, were spaces where WUID experienced an openness and acceptance as they are. Although this provided WUID with a space to seek care, in the traditional and broader sense of health, boundaries were set for behaviour, and for the most, WUID maintained expectations. When they were unable to do so, consistent messaging and respect garnered eventual, and at least partial, responses to requests that were intended to enhance the women's safety. While one cannot be certain that all pertinent details were brought forward, it was evident the women were not afraid or concerned to disclose their drug use and related issues during the interactions between WUID and providers.

Healthcare environment. The observed healthcare environments were set up similarly to most primary care clinics, with a waiting room, a reception desk, and examination rooms. In these settings, the reception desk created a barrier between the waiting room and the clinic examination area, where the women would interact with providers. While this is a common layout, in the observed settings, the separation was pronounced. In some observed clinics, the barrier was a locked door, a half-wall gate, or a metal divider that could be pulled down to close the area.

These barriers were imposing and provided a distinct separation between clients and providers. In one community healthcare setting, the door to the NEP was opened, and a barrier did not exist. In this same area, other clinical venues were physically barricaded by solid, locked doors. It would seem there was a strong intent to keep clients out, until they were formally invited in. By controlling entrance and flow, and the client being a visitor in the space, the physical healthcare environment limited access in a way that made it clear that the clinic healthcare staff was in charge.

When healthcare was provided in a residential shelter, the providers were amongst the clients and doors provided less obtrusive divisions. Some care occurred in the women's rooms, which removed the physical and, perhaps, interpersonal barriers. Even here, though, office doors had the ability to become half-wall gates and were also lockable, should staff be absent from the office or need to protect themselves from clients experiencing emotional or physical agitation.

Despite these obvious barriers, observation identified positive and open interactions which occurred in the examination rooms and offices. It seemed that once everyone was in their place at the prescribed time and in the "proper" manner, the playing field was leveled, and participants could begin the business of what brought them together. The women were relaxed in dress and posture, they were interactive and responsive. Healthcare questions were asked, and information was forthcoming. Again, there were differences depending on the circumstances that engaged the healthcare provider and the woman. As noted, the less structured environment meant that interactions could take place in an individual's room, the staff office, or the hallway. Although the environments exhibited means of physically controlling interactions, the result was an amicable interaction, which was manipulated through entrance rituals into, and the use of, space.

Recreational programs. Much of the observation time was spent in a women-only recreational program. Those who self-identified as women were invited to participate in the program if they were at risk for BBVIs; this included women who used drugs or were involved in sex work. The program objective was to provide solace from the routines of life using drugs and selling sex. The program provided activities such as crafts, self-care (haircuts), meals, and games

with small prizes. The women could also access healthcare and the NEP. This environment provided opportunities for self-care, entertainment, and structured activities.

The participants dressed casually and appeared relaxed and comfortable in the environment, where they typically gathered around a large central table and interacted mostly with each other, discussing everyday topics such as clothes, food, and weather. There were also conversations about housing, sex work, and drug-related issues. Some of the activities involved preparation for memorials or other events related to PWUD. The women seemed to know each other, and even when they were unfamiliar to the researcher and new to the program, they were known to the other attending women. It seemed there was a closeness in this community of women that was created through their common concerns and issues.

Attendance dropped around “cheque day” (that is commonly the end of the month when government assistance cheques are issued) and was at its peak in the days leading up to cheque day. At these latter times food was the primary need for those who attended.

Although several staff were present, they often did not interact with the women individually. Instead, they started and guided activities and served meals, as well as being available for individual client needs as they arose. On the surface, it seemed that this group was a gathering, like any other women’s group, providing a social and activity-related area to meet. One might assume that having staff present might assist with conflicts and interactions the women found uncomfortable. Instead the two groups seemed to be distinctly separate and communications were functional and requested rather than interventional. The staff may have wanted to encourage the women through giving space to pursue their social needs independently. It seems the purpose of having the group included creating a safe space rather than to provide therapeutic mediation or to intercede in the women’s interactions.

The overall participant observation finding is that WUID are women whose needs and wants are similar to those of other women. There is, however, an underlying aspect of their lives

and culture: their intravenous drug use and all that the lifestyle entails. The meeting place provided a common space, safety, and comradery.

Interviews

The interview findings are presented as three themes: Theme 1 – an archetypical day; Theme 2 – negotiating survival; and Theme 3 – valorizing the ideal of being clean.

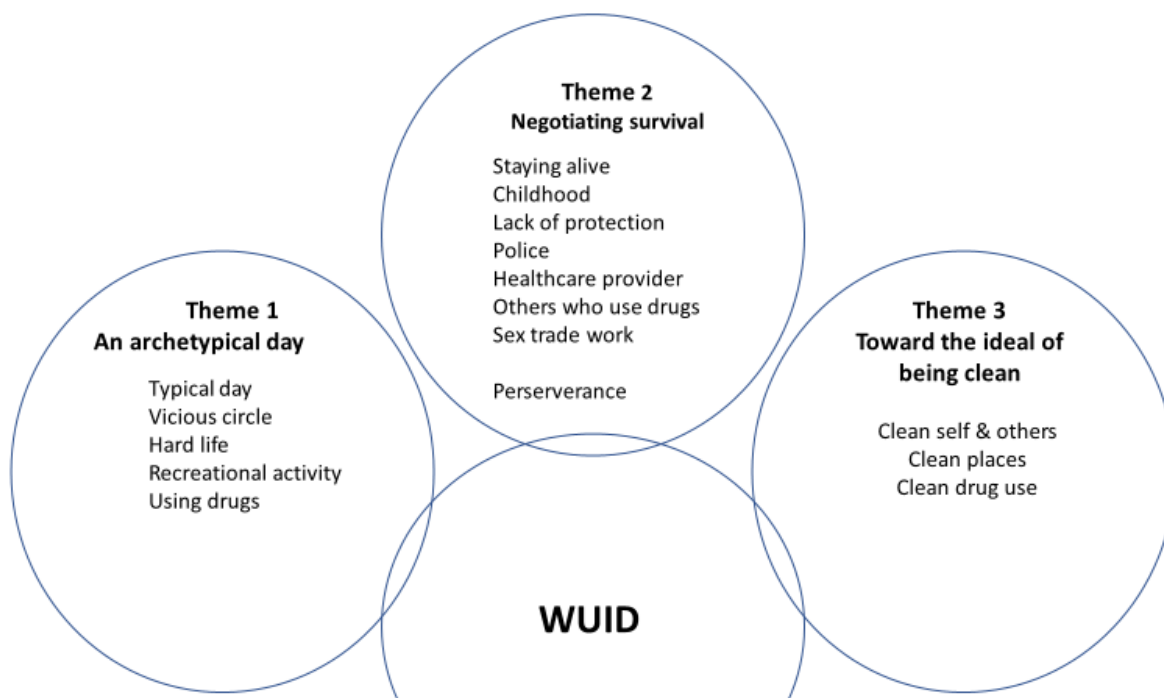


Diagram 5.1: The interview themes

Theme 1 portrays the participants' typical day, from the beginning of the day, and including what is involved in living a day as a WUID. The second theme, negotiating survival, provides some of the cultural nuances arising from the conditions of the social and political environment, with the resulting need for self-interest and self-care to survive. This theme also illustrates some of skills WUID need to manage each day, while being despised by some, disgusting to many, and taken advantage of by others. A lack of protection and recourse to justice means that self-reliance is paramount. The women must be independent, relying solely on their judgement and skills to

survive. The third theme, valorizing the ideal of clean, describes the participants' clandestine lifestyle and their desires to be "clean." Theme 3 illustrates that there are required and needed practices, which camouflage and enable WUID to move unobtrusively between the world where drug use is central, and the realm beyond this world.

The first theme, an archetypical day, covers a broad range of what comprises the life and culture of WUID. The other themes, therefore, discuss similar elements as they endeavour to further describe the culture of WUID. In this case the three themes have been chosen to best illustrate the culture of WUID in this cohort.

Theme 1: An archetypical day. Through the interviews it was apparent there were similarities in the women's days. Theme 1, then, describes an archetypical day, including elements of daily activities and details of drug use and how it evolves.

Participants were asked to describe a typical day. Overall, participants described their days as boring due to their repetition. This boredom was not only cognitive but arose from the relentless and recurring necessary activities and tasks which required perseverance, endurance, and courage; in other words, the day involved the recurrence of activities and undertakings to maintain drug use and survival. As an overview, a day included being displaced, obtaining and injecting drugs, attending recreational activities for PWID, and interacting with associates or persons encountered due to drug use. The study helped understand not only how homeless WUID in a Canadian urban setting spend their days, but also how illicit drug use shapes their culture.

Insight into a typical day. According to the participants, their days often began early and actively, and progressed through a repetitive sequence:

A typical day for me, basically, is getting up in the morning and, because right now I'm staying at a [women's shelter] ... I get up and have my coffee, my cigarette, and typically go out and panhandle to try and get my drug of choice. AJ, 3–10

The participants' days thus start with what appears to be a socially typical day (i.e., coffee and cigarette), and is followed by activities to obtain and use drugs. Another participant described a similar process, but with more insight into the cyclical nature of this existence:

In the shelter, they kick you out at seven o'clock in the morning. Now where can you go? There's nothing open. ... And you can't sit at the shelter. What are they doing – they are corralling us to go somewhere out in the open where we do our drugs and where we get busted. All they're doing is corralling us like cattle, just so they [the police] can make their quota. O, 368–381

As part of describing this typical day, O indicated that her life is controlled by authority figures who direct her activities for their advantage. E similarly described how her typical day is influenced by external factors, but related this more to drug use than to other people:

My normal day is get up, hustle and sometimes, I turn the odd trick. Then I go look, usually I have the one person I go see, or if they're not available, someone else. And then you go through the whole process of finding [drugs]. E, 24–27, 160–165

In all such cases, the day inevitably – and quickly – led to an ensuing and ongoing pursuit of drugs. Two participants described this process:

It's very stressful, the only way I can seem to function is if I have morphine. I am also on methadone. I go pick up money, and then I go find the person I get it off of. AH, 2–8

My typical day is, I go to work, try to get enough to do a hit that'll last me through the day because I was doing just melted down crack, but now I'm back on oxys again, and well, actually, fentanyl patches. So, I spend all day looking for it. All the users use a joke, 70% of the time you're waiting for it, 15% of the time you're looking for the money to get it and five percent of time is just doing it. And it's like that every day. AB, 27–41

The repetitive cycle of working and getting money or capital to obtain drugs is constant in the days of WUID. As with most work, tasks become routine, and there is monotony associated with the items to complete. This leads to, as noted, a boring typical day. X stated,

What's a typical day, wake up, be bored, be bored, be bored, be bored, have lunch, be bored. There's not a lot of stuff you can do when you are homeless. There's not a lot of family you can go to, there's not a lot of places. We're up early, we got to get out early and we're out late, until you can get back in [the shelter] again.

X, 36–43

V expressed a similar sentiment about her drug use:

I hate what's it done, what it makes me become, it's no fun, it's not. It's boring after a while. V, 606–607

Through these quotes, it can be seen that WUID start their days with a need to secure drugs and a focus on activities that enable this pursuit. This need directs what must be done, and thus, the women begin their days with relentless need and intention. There is no expressed joy associated with a typical day. It, instead, appears to be filled with activities associated with the quest for drugs.

Others spoke of a dependence on drugs to get through their day, as getting high helped to block out the negative memories that were in their thoughts. The participant 'I' described this experience in relation to using drugs to be functional and cope with day-to-day life events:

Just getting up and finding a way just to stay in the day, and not get too overwhelmed with life. And you feel like using ... because you want to numb everything. 'I', 3, 9

Drugs, as part of a typical day, were described as a means to, temporarily at least, quell mental and sometimes physical pain and memories. Drugs helped AB come to terms with her treatment as a child and the current relationship with her mother. She stated,

So now that I'm veining [injecting drugs], sometimes I do more ... just to get high, because I don't want to deal with that right now. ... I just don't want to think about it, I want to stop thinking about it for a while. They just stop everything for me for a while, so I can just numb myself. AB, 598–599, 607–612

AA concurred when she stated,

Sometimes I just don't want to feel the hurt, I don't want to feel that pain for just a moment. Just – an escape and it's exactly what it is – it's an excuse to escape, you don't want to deal with things at that moment. AA, 25–33

Dealing with pain and needing to “escape” and “numb” themselves to cope with existing everyday was a component of many of the participants' typical day. Drug use was noted to help diminish their anguish, and so the moments of reprieve that drugs brought appeared to be one factor that drove the women to continue their use.

A vicious circle. Further analysis of the participants' descriptions of their typical days identified this process as a "vicious circle." Everyday life can be understood as repetitive but difficult. One participant stated,

That's the roller coaster ever since. Up and down, on the drugs, off the drugs, slow down on the drugs. Got off the street, had homes, lost homes, got my kids back, lost them again. It's a roller coaster, it's a vicious circle. W, 361–369

The undulating pattern of W's life is evident in her description of the "roller coaster," that is, being up and down, on and off, obtaining and losing homes and children. For others, the precise phrase vicious circle was not used but was implied by the description of a revolving cycle that represented the archetype of their lives:

It was a constant circle all the time, if I wasn't using, I was working, if I wasn't working, I was sitting and using. It just didn't stop, and it just went on constantly, day after day like that. 'I', 34–39

It's like a never-ending circle. I spin, and I spin. It's like I'm on a top and I spin, and I spin, and I spin, ... and then I just stop. Remember those tops – when you were little? You used to play with? That's me. I spin, spin, spin. AJ, 483–492

The women saw their lives as going "around and around" and their words indicated a seeming recognition that this was a potentially hopeless and frustrating situation over which they had little control. Attempts to escape this world, for example by quitting drugs, eventually led back to ongoing immersion in this culture of drug use. The interviews also illustrated that for those who stopped drug use for a period, re-initiation often occurred after a stressful life experience or a change in their everyday patterns of living. For example,

Before I met my spouse, I was clean for fifteen years. And when I met him ... his son died, and we ended up going downhill. We moved to [city] and that's when we started going downhill. We've been addicts since we moved to [city]. We've been here nine years. ... I guess that's how we coped with it. H, 329–334, 345

For H, the loss of her partner's son was difficult for her and her partner, so they started using drugs to cope, and subsequently could not discontinue these substances.

Many participants described desires to discontinue drugs and mentioned strategies to quit. For example, they worked or became involved in recreational and social programs, stayed away

from people who used, and discarded drug equipment; some started methadone. Others considered entering, or had been to, treatment programs. Many, however, found treatment centres could not help them permanently. M had strong feelings on this point:

You sit around and talk about what triggers you. While you talk about what's triggering you, you are triggered, you're wanting it because you're talking about it all the time. That makes no sense. ... People go to treatment ... and what happens? They end up using 99.9% of the time. Why? Because you come out, you're in the same situation as what you went in ... your house hasn't changed, your spouse hasn't changed. ... You get clean for three months in there and then all of a sudden, they kick you to the fucking curb and you're back where you were. ... So, what really good use is rehab? ... It stops you for now, but it doesn't help you in the long run. M, 393–398, 414–420, 435–436, 440

M described how discussing triggers in an artificial environment and then returning women to their pre-treatment lifestyles had little chance of success. The ongoing discussion of drugs and drug use, and the lack of consideration that drug use is contextually influenced, meant the women returned to environments of drug use and their same social circles. The unfulfilled desire to quit drugs is also found in the following excerpt:

I killed me four times. I don't know if it's by the grace of god that I'm here. ... I'm surprised I didn't have a stroke. I don't know how I am here. I can't explain it, but I kiss that drug and I say thank you. ... It's so stupid. V, 348–352

For many WUID, V's dilemma remains unanswered. The vicious circle is a revolving need to use drugs, being in and out of housing and jail, as well as stopping and starting drug use. Also, the women felt wait times for admission to a treatment program were long, exacerbating the cycle and frustration of wanting to quit but being unable to. AJ expressed another point:

I can't do a 35-day treatment centre. What the hell is that going to do for me? I've got from the time I was 14 to 45, a lifetime of addictions, abuse, and shit that I have to deal with. Thirty-five days ain't going to do shit for me. AJ, 652–655

AJ's expression of the futility of current treatment approaches, which she feels contribute to the cycle of quitting and restarting drugs, indicates a need for ongoing and longstanding support for WUID who desire to disengage from drug use. She highlighted how short-term treatment programs are insufficient to address lifelong issues and long-standing drug use.

Instead of treatment, many women described their attempts to reduce drug use, rather than having abstinence as their goal. Strategies included (a) alternate routes of drug use or choice of drug, such as smoking crack or marijuana, (b) having others encourage them to decrease their use, (c) buying smaller amounts of drugs, or (d) passing time another way, such as watching movies. Thus, the goal to lead a “normal” life did not always entail abstinence. However, the need for drugs to assist with coping promoted an ongoing return to the vicious circle. J described her struggle with gaining control of her drug use and accepted her addiction and the life it entails:

I want my life back. I get angry that I have this addiction. But I also accept it and I don't try to come down on myself too much. I used to, but that only leads to deep depression, that leads to more using which, a lot of time, leads to drug suicide. ... It's a struggle, it's a battle everyday to be kind to my addiction and to my life.

J, 519–525

J outlined an acceptance of her drug use and her resolution to use moderately. Without this self-compassion, a return to drug consumption led to depression that could go in two directions: a return to the relentless struggle to use less drugs, or to use more as an inexorable outcome to cope with what is seen as failure. Neither is ideal, and the women grappled with this battle.

A tiring, hard life. The outcome of the vicious circle, as perpetual motion, was a feeling of exhaustion. V described being tired and related this to the constant effort required to obtain and use drugs. Inevitably, however, she felt she had little choice but to continue her pursuit (the vicious circle), despite her torment and exhaustion. V expressed her anguish as follows:

I am sick and tired of having to have a needle in my arm just to be better. I wish I could say I don't need it, but ... that's lying. I do need it. ... It's like damned if you do and damned if you don't. I want to get out of it. I'm tired of using this fucking drug. ... I hate it, I really do. It's awful. I wouldn't wish it on anybody. I'm tired of it, sick and tired of being sick and tired. V, 154–158, 543–549

No matter whether V decided to use or not use drugs, she reported that neither one was a desired option. She was “sick and tired” of her dependence on drugs and her words demonstrate the distain she felt regarding her life. Her need for drugs, nevertheless, overrode her desire to live without drugs. Thus, she lived each day with the difficulty of needing but not wanting drugs.

The participants also described their lives as “hard.” Given the need to live precariously, working, often unlawfully, looking for and using drugs, and repeating the cycle, was “hard.” Given the tremendous strain incurred every day, the women wished they had never started using drugs:

It's a disgusting drug, very disgusting. I don't like it. But I'm here, and I don't like living with it being a part of my life, but I have to. It's hard ... it's a disgusting filthy habit and I don't wish it on anybody. ... If I could do it all over again, would I do it again? Nope. V,
209–211, 326–335

Drug use, for the participants, was thus “dirty,” “disgusting,” and “filthy,” and not a lifestyle to choose again. However, once ensconced, the participants expressed a belief there was little to do to effectively leave it.

Recreational activities. As part of describing their typical day, while the participants recounted various recreational activities, there was often an underlying connection with the use of drugs:

That's where I get my stems and needles, it's usually [needle exchange program at the women's drop-in]. I'm HIV positive so I go to the [another drop-in]. ... And today, I'm going to go to [church drop-in] for bingo. I go there every week on Wednesdays. I go there for lunch. Y, 113–131

Y, then, attached her activities to programs related to different aspects of her life, such as her positive HIV status and drug use. The ability to present oneself in what would be considered common and normal activities, appeared to attract WUID to specific places and activities, even though it was their medical and drug use histories that granted them access in the first place.

Indeed, the programs participants attended were consistently targeted at women who use drugs and provided activities for (a) consuming food, (b) doing arts and crafts, (c) having haircuts, (d) playing games, such as bingo, and (e) winning vouchers, prizes, or other take away items. The programs alleviated the need to be outdoors and served as a safe space.

Men aren't allowed because women feel safer with just women. The men tend to hover, and pinch, and they harass you all the time. E, 428–433

To this end, restricting attendance at these activities to women only was appreciated. The time away from men, or others who might be demeaning or intent on demanding attention or services,

seemed to enable a short opportunity to be less vigilant and provided a break from the vicious circle.

Monetary or material incentives for activities were also a welcomed source of income.

Below, a participant described how this enabled her to obtain new household and clothing items:

I just go down to [service's name]. ... And they give a \$30.00 voucher once every three months for clothing, sheets, bedding, whatever you need. [Another place] ... I can go to, the [church program] and maybe have a game of bingo, and a bite to eat and then go to the community shop and get other stuff.

E, 343, 363–364, 372–373

These programs, which served a need for obtaining injection equipment and essential articles along with activities and food, thus served a utilitarian purpose.

Other activities for WUID included volunteering in programs organized for people who are homeless or PWID. For example, some engaged in picking up discarded needles, or in a peer role.

I do a little volunteer work. ... I cook one meal a week, for homeless people. ... I'm part of the community and they love my cooking. AC, 3, 7, 9

Again, AC has not broken away from her community and thus participates in a program for the homeless, where she feels she belongs and is appreciated for her skills.

Getting drugs. The following subsections describe the processes and nuances of the injection practices of WUID. This sequence further highlights the vicious circle of their lives, which strongly focused on doing what was required to obtain the means to acquire drugs, then obtaining and using these substances. This section details this process, emphasizing its repetitive nature.

1. *Resources for obtaining drugs.* Getting money, trading or selling items of value, or performing an activity were prerequisites to obtaining and using drugs. The means of acquiring drugs was diverse and did not always involve the exchange of goods or cash. Furthermore, activities that helped support the women's drug habit were often time consuming and arduous.

As Q explained,

You try and get money for your habit. That's the hard part. Sometimes it takes 8 hours, sometimes it'll only take an hour, depending. You go out and you take risks.

You try to peddle drugs to support your habit or get a piece of the pie. If I do a run for somebody, he'll give me a little bit, or a wash or whatever. Q, 58–65

Q explained how difficult and varied the means to obtain drugs can be; women must be creative, determined, and endure risks. Getting “a piece of the pie” is to do an activity that involves getting drugs for someone else and, in return, receiving a small amount of a drug. “Doing a run” is to get drugs for another person, which may involve carrying money for the purchase and then the drugs, both of which present the risk of being robbed or being arrested if stopped by police. If the run is successful, the runner will be paid with a small number of drugs, or they will be given the person’s leftover drug residue in the pot where the drug was prepared for use (a wash).

Sex work was also a way to obtain drugs. Most of the participants engaged in sex work; thus, selling sex predominated as a means of generating income. P illustrated this process, saying,

I sometimes work the streets to get money if I have to. I prefer doing that to stealing or anything else, because in my eyes it’s a fair trade between two consenting adults and we are both consenting. I don’t see anything illegal about it. P, 170–177

Whereas P regarded it as a fair exchange for involved parties, not all participants viewed sex work as such. Still others described sex work as mundane and repetitive. U stated,

But as a robot, if I’m getting paid now, that’s fine. Because they don’t have to touch me. ... I do the work. Massage, massage, massage, flip them over, now you’re done, see you later. Nothing. Just – “next one.” U, 599–604

In this quote, sex work is a “robotic” means to an end – that is, a monotonous task to gain capital for drugs. Some, like U who described no touch sex, found, or considered, alternate means of selling sex to make it more palatable. Other women, meanwhile, spoke of only doing telephone sex or oral sex. Moreover, some women had long-standing customers who they saw regularly. This practice was a means to increase safety, financial security, and manage client expectations:

I make sure that I don’t necessarily go out on the street corner and sell my soul. I make sure that I have regular customers that I do go to that I know. ... And they know that they’re not allowed to go across boundaries. ... I have six regular customers now actually, and its money every day. AJ, 271–281, 298–300

These boundaries made sex work more tolerable, and safer in light of the risks that were recognized and, not uncommonly, experienced. As O stated about the possibility of being physically harmed or killed, “That’s sex trade work” (789). Their lives were often jeopardized:

I would spend over a hundred dollars on injection use ... every day and, of course, I would be working the streets for that money. ... It’s a very dangerous way to live. ... If you work the streets, getting into somebody’s car and you don’t know who it is, stuff like that. ... When you do injection use, if you’re doing morphine and stuff, you get very sick, so you have to go on chasing it, and it’s sad.

‘I’, 30–32, 85, 92–93, 97–99

‘I’ described the necessity of risk taking, which overpowered her need for safety. As K stated, she engaged in prostitution to fulfil the need for drugs. She stated, “Prostitution ... I don’t like it, but I do what I have to do” (36, 40). Sex work thus produced both mental and physical sequelae but was seen as a means to maintain the vicious but necessary circle of their lives.

Many of the women also received a monthly welfare cheque, which afforded opportunities to buy drugs. The participants recounted how this money dissipates quickly:

You have to scrimp, and save, and try to con, and everything to get your fix, and then comes the end of the month, you don’t have to do that, so it’s like, “Aahhh bonus,” and everything goes to hell in a handbasket. M, 21–24

Many women also panhandled to gain income, which some described as demeaning. Others seemed comfortable with the role and saw it as a legitimate and preferred means to make money to continue their daily cycle and provide for their needs. S described her day in the following way:

I need at least \$40-\$60 every day, at the market. ... I go to the end of the day. That’s what I do, I panhandle. I go shoot, and then after I go back and panhandle. S, 4–6, 19

However, selling or getting drugs for others, monthly government cheques, selling sex, and panhandling were not the only means of procuring capital for drugs. Activities such as stealing, were also cited as ways to obtain drugs. O described how these activities became more likely as the need for drugs increased. While the cycle continued, certain periods (e.g., withdrawal) needed to be addressed quickly, thus driving a means to obtain capital for drugs quickly as well. O stated,

You don't want to wait, you don't check around to see what you can do, you're going to find the first thing you can sell. You know what it is? It's going to be a crime, it's a nasty situation, but that's exactly how it ends up. O, 650–654

O described the means to obtain drugs as something she needed to do due to an inability to “wait.” “Doing what you have to do” was a phrase many women used:

You do what you have to do, you just try not to get caught. So, it's part of life. ... You do what you gotta do – steal, cheat, lie, work. H, 428–434

Thus, as part of their cycle of obtaining capital to purchase and, ultimately, fulfil their cravings, the participants also described other activities, such as selling bus tickets they obtained, collecting bottles and cans, participating in research, doing odd jobs, lying, conning, borrowing money, selling drug injection or smoking equipment, assaulting men, and having “sugar daddies.”

Drug withdrawal, however, was not the only factor that drove participants to use these other sources of income. The creativity to obtain capital was also driven by a lack of opportunity to secure employment, often due to having a criminal record. As E explained,

Most addicts have criminal records. They can't get a regular job because they want a police record check. So, no one's gonna hire you. ... You want to look good to an employer and you've got this criminal record of maybe theft or possession. And it doesn't get erased, it stays with you the rest of your life. E, 564–569, 585–589

Regular employment, then, was not always possible as the women often had charges related to possession of drugs and prostitution. The viciousness of the cycle of these women's daily lives included permanent criminal records, which limits subsequent abilities to obtain licit employment. These brandings (while on paper) restrict job opportunities, and force WUID to engage in alternate means to obtain capital. Although the women had many means of doing so, as discussed above, many were neither safe nor desirable, thus perpetuating the cycle of danger and crime.

As alluded to above, being given drugs in exchange for a favour (e.g., “doing a run”) was also a means of gaining drugs. Having a place where others could use drugs was another reliable means to secure a ready drug supply, which included, for example, offering one's place to others to use drugs, as a drug trial site for dealers, or by means of running a crack house. U described how she used to obtain drugs by allowing dealers to test and prepare drugs in her place:

I went completely crazy with coke. I even had drug dealers coming to cook the coke, so I could do more. I wouldn't let them sell it in my house, but they were allowed to cook the cocaine in large amounts. ... They're done, they leave, there's no conversation, which was okay, I didn't know their names. ... I just knew they were coming in, I set their stuff up, wait, wait, wait, they'd tell me to test it, I'd test it, they'd go ... plus they'd leave me some lines. U, 836–842, 866–871

In this case, drug dealers used the woman's accommodation to prepare and organize drugs they would sell, which U used to her advantage to secure cocaine. AK similarly allowed others to use her housing to inject, with the expectation she would receive drugs for this privilege. She stated,

I remember when I had my apartment last year ... the girls in the neighbourhood who didn't have places to live, they wanted somewhere to shoot, they could always come to my house and do their hit. ... It is bad etiquette to go into somebody's house who uses and use their facilities and not share. You don't do that. It's frowned upon to the point that if you're not going to share, get the fuck out. AK, 182 – 193

The culture of drug sharing is well established, with guidelines for behaviours. In the case of using another's home to inject, there are rules, and those not willing to participate are excluded or expelled. Through this, one begins to understand how the mores of a willingness to help and, at the same time, ensuring one's own needs take priority can align. AK described helping others, but the cost attached was providing her drugs. Those who did not follow this tacit rule did not benefit from AK's house, and had to find another place to inject drugs. There must be a mutual understanding of how this shared arrangement will work, or there is no agreement to be negotiated. For AK, this involved a barter of space for free drugs.

2. Getting, preparing, and using drugs. The following section discusses the precise details involved in how the WUID in this study reported (a) obtaining drugs, (b) preparing to use drugs (getting equipment, preparing drug for use, and finding a place to use), (c) injecting drugs (who injects, where on body injection occurs, and sharing practices), and (d) handling used equipment (disposal or reuse).

Obtaining drugs can be a time consuming and dangerous activity. Therefore, knowing who to buy from and when to buy is a learned requirement to stay safe and well. A knowledge of what

is a good drug and what is not is also important. To ensure self-protection, the participants described the knowledge they acquired to negotiate good drug deals:

I know what it's supposed to look like, what a gram is, what's not a gram, what's a point, and if I think you are ripping me off, I'll tell you. ... "Sorry you lost my business. I ain't going to you." They realize, "Well she ain't no stupid cookie she's pretty smart." AA, 871– 872, 885–891

From this statement, it can be inferred that the vicious circle of the participants' lives was not passive but required astute knowledge and calculated choices. To not squander obtained capital, one needed to have a sense of the size, weight, and so on, of drugs. Not only did AA state that she possesses this knowledge, but she also made it clear she would ensure others were aware of her expertise. The quotation from AA suggests a necessity to primarily look after one's own needs, and the required and associated highly developed skills are basic competencies in this subculture and serve to ensure WUID obtain a fair deal when obtaining drugs.

Buying drugs from a reliable source was also important, as both the quality and content of the drug can be life altering. Tainted drugs could cause adverse reactions or overdose. The participants recounted how a certain amount of street knowledge and luck were an integral part of the purchase of drugs. AA felt she had gained these skills, which provided her with confidence and the self-image that others believed she was a "smart cookie." While such skills and beliefs may have been protective in enabling her to gauge quantity and quality and assist with ensuring others were not able to cheat her, it has become increasingly common to find drugs that are contaminated with substances that are not easily detectable and may cause serious bodily harm or overdose. G summarized the unpredictability and uncertainty of the content of drugs one was buying when she stated it is "luck of the draw" (207).

The next element for injecting preparation is to (a) obtain the equipment from a NEP or from others who have injection equipment, (b) prepare the drugs for use, and (c) find a place to use. Regarding the first item, equipment for injecting, most participants described obtaining equipment from NEPs:

I get access to resources that I need that are consistently available for me, all the time. It's safe, it's supportive, there's no judgement. AI, 56—57

Overall, the women reported in the interviews an awareness of NEPs and used them with positive reflections. They felt these services were useful and gave them the equipment and services they required for drug use. They also found these services non-judgemental:

I drop in and I grab my needles, my equipment there. It's confidential, you don't have to say your name but there's staff there who know you. There's also [mobile van 1] that you can call. And you can call [mobile van 2] after certain hours at night. ... That's where I get my stuff, and my condoms and everything like that. And they also have drop boxes. I collect my needles and put them in a bag in my locker. ... I usually go to [health centre]. I'm usually there two to three times a week.

AJ, 750–762, 766 –769, 781–783

AJ has integrated use of the NEPs into her life. The routine noted here was common to that of others, picking up on a regular basis, feeling connected to the staff and satisfied with the attention and equipment received. There were few negative comments, with most women agreeing the accessibility of NEPs was satisfactory. As AK further noted, she did not share needles because of the NEPs, and did not understand why anyone would share: “There's just this access all the time everywhere and anywhere, for supplies. You got a van that delivers for god's sake” (235—237).

The reasons why sharing occurred, however, were clearly raised by other participants. Although the women were aware of the need to use new and sterile equipment every time and not share needles, it seemed that these activities were not always possible, and reuse occurred. O relayed that sharing occurs more often than people will discuss: “Everybody's out there sharing” (37). As such, despite the accessibility of clean supplies, certain circumstances led to drug equipment sharing. According to the participants, withdrawal was a common reason, as it incites sharing without reflection on health consequences. This reality highlights that the act of sharing is not one of ignorance or a disregard of health (and thus it is unlikely to be addressed through education). Rather, it is a situation of imminent need and physical distress. Exceptionally, U endorsed sharing a needle with her partner when she found she could not inject herself and

required assistance: “I don’t bang [inject] behind anybody, except dumb ass” (735). This finding of “being second on the needle,” however, was restricted to this interview; no other participant raised this point.

In other interviews, some women reported that they had shared drugs in the past but were no longer engaging in the practice due to a negative experience. Unintentional sharing was one such situation, which occurred when people switched needles or syringes. J and K were both wary of this practice and reported that it had happened to them. K said, “Use safe equipment and be around people who are not infected when you’re using” (32–330). Blood borne infections, moreover, impeded some, but not everyone, from sharing. Participant ‘I’ stated,

You share with people if you’re really sick. You don’t even think about it. I contracted hep C that way, but I was careful enough not contract the HIV, but I still got the hep C from using. ‘I’, 106–109

Here, ‘I’ recounted her rationale for, and feared consequences of, sharing. While she expressed remorse about contracting hepatitis C, she felt her carefulness prevented HIV acquisition, although both infections are transmitted similarly, and it was not evident what care she took. Other participants, however, did detail the specific steps they had taken to minimize infection acquisition. For example, some noted that they mitigate the risk of infection incurred through reuse of equipment by bleaching or boiling the needle that was to be shared. G described,

I have shared a needle before, but the person cleaned it with bleach and stuff ... and then they boiled water and stuff. G, 239, 243

This statement contradicts public health messaging about single use sterile equipment, suggesting that, as required, the participants applied a more sophisticated – albeit not necessarily effective – set of strategies to simultaneously use drugs and mitigate risks. Thus, the procurement of clean injection equipment from a NEP is well intentioned but can be jeopardized by the needs of others or a strong need to use when withdrawing from or craving drugs. These strong influences were described in ways that made them seem as though they undermine efforts to avoid infection and are an important consideration for public health concerns.

The topic of preparing drugs for injection was not addressed by many. Some learned, and others guessed, at the process of preparing fentanyl patches. Despite the possibility of injecting a potentially lethal dose and knowing of others who had overdosed, or having personally experienced an overdose themselves, the women continued to prepare these drugs for injection:

I've been using fentanyl patches. ... You just buy a piece. You put it in the water, scrape around, heat them up a little, and suck them up and that'll work. I don't know if that's the right way, but it's been working for me and it takes away the craving and helps with the pain. AB, 133–139

Again, drug use takes precedence over personal safety. AB had a long history of using injection drugs before an extended period of not injecting. She was gaining knowledge to reacquaint herself with current practices, but she had not reached out to her peers for help on how to fix her drug of choice. Furthermore, fentanyl is unevenly distributed through the topically applied patch, which leads to an unpredictable dose in each of the “pieces.” AB's discussion demonstrates the peril of injecting without full knowledge of the drug, its dose, and how to prepare it.

Drugs are often fixed in a cooker. As explained above, the cooker is a small tin pot-shaped item that is heated, usually by a lighter, to heat the drug and other ingredients such as water or vitamin C. This process breaks down the drug and enables it to be drawn up with a needle through a filter into the syringe to be injected. Two of the women spoke of using vinegar to break down drugs for injection. Vinegar is caustic to veins due to its acidity, thus, packaged Vitamin C is advised. AB indicated no one had shown her how to use Vitamin C powder provided by the NEP, so she continued to use vinegar, as she was familiar with this process:

I just melt down crack and use whatever I melted down, it's so much easier. [I use] just vinegar. Nobody ever showed me how to use Vitamin C. AB, 51–56

Here again, a lack of knowledge is witnessed to cause potential harm. While the equipment is given out by NEPs, it seems there is a lack of teaching about how to safely prepare drugs. It was also clear that some of the NEP-distributed equipment was not suitable for the changing consumption patterns reflected in current drug habits of WUID. One participant noted that larger cookers, other cooking equipment, and heat sources were desirable (AK).

Preparation for injecting also included licking the needle. When a few of the women were asked about this practice, they agreed that they engaged in it. The purpose was varied and included to test the drug, taste the drug for quality, and check the integrity of the needle. One woman (J), in reference to checking for a barb on the needle by licking it, indicated she would rather cut her tongue than ruin her vein. The issue with this approach, however, is that there are many bacteria in the mouth, which can be transferred to the blood upon the needle entering a vein. Severe infections can arise from the introduction of bacteria into the blood.

The women indicated they used various public and private spaces, both indoors and outdoors, to inject drugs. Injecting outside was less desirable due to fears of public and police scrutiny, and fears of missing their veins with the needle when they attempted to inject quickly due to potential observation. W talked about being arrested when she used outside one time:

It's my own fault, my own stupidity. ... I know better. When you are sick, and you don't have the energy to walk ... you'll just sit down where you can and do it. ... I tend to be more discreet about it, but I didn't give a shit that day. I was so sick I just wanted to do it. ... I happened to look up ... and they were right there. I was like, "Oh shit" ... and the cop went, "Shit." Oh well, what can you do? If I could have thrown it on the ground, stepped on it. ... Didn't matter, he took it.
W 255–259, 271–272, 309–320

The place of use was mostly a matter of convenience and necessity. A few women mentioned they injected in venues such as public toilets. Z described women "hiding behind the [parked] cars because the [side] mirror is right there, and the girls use their neck (506– 508). Some of the other women concurred with the idea of neglecting the need to use clean equipment, describing using dirty needles and water, in unsanitary environs when injecting outside, thus risking infection. There was also the risk of perpetuating the public's disgust of injection drug use if the injection was witnessed. A few women said they would use anywhere and everywhere, accurately describing the sum of where the WUID of this study could have been found injecting. This precarious use of space was driven by need, giving rise to potential issues such as infection, damaged veins and skin wounds, arrest, and harassment.

Also warranting careful attention and skill was the act of injecting, which was a process that others would do for the woman or the woman did herself. Additionally, in this discussion, some of the culture of women injecting others will be discussed. The women of this study reported injecting themselves, although most had experience with being injected by others. Although some women described absolute trust of others, most were determined to inject themselves due to the potential repercussions of having someone else inject them. For those who had others inject them the most common reasons were (a) difficulty finding veins, (b) needing to use a vein in a hard-to-reach area, and (c) to be injected in the jugular vein.

Overall, however, the women in this study were more likely to self-inject and reported that having another person inject them was undesirable because they feared damaging their veins. Healthy veins are an essential element of successfully injecting drugs, relieving dope sickness and cravings, and getting high:

The first time I used I didn't hit myself, somebody did it for me. ... There was one day, I got a pill, but I couldn't find somebody I trusted to hit me, so I had to do it myself. ... It's not like you get to practice, you just gotta do it. ... I had track marks everywhere, my hands were blue and purple and red, and it was insane. Now I don't even have track marks... I know how to do it... It's kind of like growth, and that's learning. AI, 136 152–171

Trial and error preceded competency in self-injection. However, the need not only to learn the skill but also to perfect it is evident in AI's words. She was proud of her independence with injection. Her resolve enabled her to master her injection practices to fit her needs. It may be concluded that determination and self-reliance were important factors in the decision to learn the skill of injecting independently.

Some of the cohort injected not only themselves but other people, as they were recognized as having skill with this procedure. The caveat was that they would not inject someone if the person was not already actively using. AE was known for her assistance with injecting and explained, "If they had used before, and they just couldn't get it, they were missing, I would help them out" (536–537). Clearly AE had been approached by people, but she, like others, had rules

that guided who they would help. As T stated, “I would help them, but ... I’d have to see track marks. I wouldn’t want to give somebody their first needle” (499–501).

This may be, in part, because the women recognized what drugs had done to their lives and did not want to be a part of taking someone else down the same path:

I would never wish this on my worst enemy. Addiction is such an evil, evil being. I wish there was never, ever an addiction problem. I wish there was never such a thing as crack, I wish there was never such a thing as cocaine or heroin or oxys or percocets or morphine or whatever drug you are putting into your arm or fentanyl patches.
AJ, 500–508

AJ’s statement here clearly speaks of how much the women despised what addiction had meant to their lives. While not wishing it on their “worst enemy,” it seems they also would not wish this “evil being” on anyone naive to injection drug use. While being able to accept their own drug use, they believed this was not a lifestyle that others should follow.

Regarding the actual drug use, the women, for the most part, injected into their arms/hands and legs/feet. Others tried to hide their injection marks by using more covert parts of their body, such as behind ears or knees, between toes, under the tongue, or in the breast, groin, or eye:

I don’t poke things in my arms. ... I put it behind my ears. ... I know where to go, I can feel it. ... I do it behind my knees. ... I’ve even done it in my eyes.
AA, 724–729, 736, 748–752

Although a few of the women were too frightened to try injecting in the jugular vein, many had:

He’ll help me if I can’t do it. ... If I can’t get it, he’ll usually get me in the neck, and if he’s not around then I usually try very hard to get it wherever I can. H, 94–97

The rationale for injecting into a neck vein varied from it being the only vein left and an easy vein to inject into due to size, to because the high is fast and strong. W explained,

Easier, bigger vein, always accessible and you get higher faster. It hits fast, because obviously it’s close to your brain. Some people do it themselves, but I can’t, I’ve never tried to do it myself, but you could. W, 451–460

In short, the women described injecting wherever they could access and preferred bodily locations that were less apparent. Although some, such as W, were reticent to inject in areas of the body that were considered risky, others chose areas that enhanced the quality of the high. Keeping

their bodies free of marks and avoiding visible evidence that might invoke stigmatized remarks from others seemed to often involve hiding the site where drugs are injected. The women described that hiding their ‘track marks’ was important to avoid both negative comments and being identified as WUID.

Notably, along with injecting the drugs they had prepared, the women also saved their own or others’ “wash,” which is the term used to describe the drug residue left in a cooker after use. The women talked about not sharing their needle, but they had shared their washes or used the washes of others. Washes were regarded, by the women, as low to no risk for spreading infections. A discussion with one of the women who was HIV positive (Y) indicates she shared washes with other HIV-positive people if “they [were] pretty clean” (459). Although no further explanation was given, she acknowledged she was aware she was putting herself at risk when using the equipment and drug residue of a person infected with a BBVI. However, to this Y stated,

I don’t care sometimes. I know there’s other strains of hep C out there and this and that, I don’t think about that. I’m banging anyways, I don’t care, add another thing to my list. Y, 478, 481–483

Most women who shared a wash or asked for a wash did so to resolve dope sickness, that is, withdrawal symptoms. AK explained,

There’s sharing of dope. People help each other out. I share – it’s really weird it’s almost like an “honour amongst thieves” kind of thing. If you know somebody that’s really sick and ... you’ve got a lot of dope, you’re going to give that person a wash, at least, so they’re not sick, because one day when they’re getting a hit, they are going to help too. AK, 210–217, 225–226

The wash is a commodity that can be traded, sold for cash, given with the intention of there being a debt owed, or given as a gift to assist someone who is in need and suffering from withdrawal or cravings. The wash is a commodity with varying uses, and as such is a prime item in the culture of drug use and WUID. The wash the participants described also gave further evidence to some of the rules of etiquette and culture of WUID. It is important to “help each other out.”

Lastly, the participants discussed equipment disposal. The women noted numerous ways to dispose of their used equipment including hiding it and putting used syringes down water

sewers. They also described throwing away their needles on the ground. This was not preferred, but often the quickest and easiest way to be rid of evidence of drug use, while outside:

Where are all these dirty needles going? Because a lot of people just poke and throw. A little bit of rainwater washes them down the street or something. ... We're going to ... throw it down the drain or something. So, the drain is going to wash it somewhere else, which is really stupid. O, 714–721, 731–733

The participants also reported using biohazard containers to dispose of needles. The containers, when filled with used equipment, were often then returned to a NEP or community biohazard disposal bin. Z indicated she used such NEP supplies, and W stated, “I’m always sure to drop off my dirty ones in the boxes” (470).

From the women’s statements, the biggest deterrents to safely disposing used syringes and other equipment is the lack of conveniently and discreetly located biohazard containers. When AA spoke of carefully wrapping needles and discarding them, she was asked about her use of the NEP box for disposal outside the shelter where she stayed. She retorted,

You’re not going to do it right in front of here ... where the police are. You’re going to do it somewhere else ... wherever you can’t be seen. AA, 423–425, 431

As well, the large, stationary NEP boxes were reported to be easily broken into, and any remaining blood and drug in the disposed needles was extracted for use by the person who retrieved the cache. The consequences of reusing discarded gear also points to the need for secure and timely disposal. Thus, getting rid of used gear was problematic on several levels, despite readily available biohazard containers and pick-up or drop-off services. Although most women preferred using a biohazard bin, some circumstances prohibited it.

Withdrawing from drugs. Withdrawing from drugs, known as being dope sick or craving drugs, was a strong driving force underlying many of the risk-related cultural norms accepted by this cohort of WUID.

1. *The need to use when withdrawing.* AJ stated that using drugs, for her, was less about the high and more about the need to avoid being dope sick. The women endorsed dope sickness

as the prime motivation for stealing to obtain money for drugs, taking risks selling sex or injecting, and sharing injection equipment or washes, when that would not be the woman's usual practices. To summarize this experience, O used the phrase "when you're dope sick, you're dope sick" (37–38) and explained, "You don't care what you use, and you don't think about it" (40) to illustrate the recklessness that occurs when one experiences symptoms of withdrawal. T stated,

Because you need to get high that second, you're sick. And you need that warm, fuzzy feeling that instant and you can't wait. I've seen people pick up needles right off the ground and use them ... I have. T, 474–478, 483

Clearly, avoiding withdrawal and cravings is primary, and the drive to avoid this feeling motivates action without concern for potential consequences. Thus, many of the negative consequences of drug use may have their origin in the lack of ready-to-use supplies and drugs.

2. Prevention of withdrawal. The women also talked about the ways they try to prevent experiencing the symptoms associated with withdrawal from drugs. They plan ahead, for example, to have enough resources to buy extra drugs for later, or they use whatever drug they can obtain rather than their preferred drug. Some women found methadone or Suboxone helpful, while others found that alcohol or marijuana reduced symptoms. Additionally, some reported trying to break the cycle of needing and getting drugs by entering a drug treatment program. However, W commented that while a woman waits to get into treatment, she is "still out there selling [her] body and doing what she needs to do every day" (46). It seems evident from what the women said that needing to use drugs is forceful in the lives of WUID.

Finding a place to stay. WUID also spoke of the pressing need of finding a place to stay and to rest, which is an important task, whether it be to secure somewhere to sleep through couch surfing, booking into a shelter, sleeping outside, or continuing to take drugs around the clock. E expressed the stress associated with not knowing where she could go:

It's a worry, not relaxing, not knowing where you are going to bed down, especially in the winter months. And I try to stay warm, there's a lot of services out there. E, 332–337

While E acknowledged an abundance of services, it seems that finding a warm place to sleep is not easy. V also talked about the need to constantly be looking for somewhere to stay:

Where am I going to go? Am I going to stay at this place? ... And, so, I'm basically couch surfing, with him. I've been on the street now for at least a year and a half and it's been hard, couch surfing. If they want you there you sleep, if they don't want you, then you have to go to a shelter. And then the shelters are all full. So, basically you don't know where to go ... Nothing is permanent – you spend two hours here and then you're back and then, what's happening next, what's my next step? What am I going to do after this? Where am I going to go, what am I going to do? V, 20–24, 85–90, 132–138

As V expressed, finding a place to stay is a constant stress, and the women found this lack of predetermined place to go, especially at night, difficult. Not knowing where they might sleep was described as a source of worry and personal safety. However, AJ illustrated this process as follows:

I live every day; I wake up every morning and it's a start and if I have a place to sleep at night – it's an ending. ... I do the best, to my ability to stay alive for that one day because I don't know what tomorrow is going to bring. AJ, 167–178

The women were concerned each day and each night that they must find a means to continue to survive. The night provides little amnesty, as they must continue to fend for themselves in an uncertain world that is full of dangers and potential harms, and uncertain accommodations.

Social interactions. Specific to the culture of WUID are their interactions with others. The initial discussion will illustrate the relationships of WUID with others, including children, intimate partners, men, the general public, and police. These interactions place WUID in the world, tell of their impressions of what others think of them, and give information about what they think of others.

1. *Their children.* It is clear the women struggled with their role as a mother. Some of the women tried to maintain the appearance of what they considered “normal” family life while using drugs. AJ described looking after her son:

I made sure every single day I got up and made my son breakfast, I always made him his lunch and we always went out for play dates and I was a mom. ... But at night, no one knew the other side of my life, and I was ... making \$1000 a night. AJ, 446–453

For AJ, the need to live a two-sided life, as a mother by day and making money by night, was essential to continuing to use drugs while raising a child. This double life was common in the interviews, especially in relation to maintaining appearances for children and drug use.

Some women were in touch with their children who were older, or those who were cared for by family members or children's services. Others were predeceased by or estranged from their children. Regardless of circumstances, relationships with children were complicated and complex. However, the women spoke in such a way that it was evident there was a bond with their children, irrespective of the nature of their affiliation. Often, too, their children or grandchildren were the motivation toward their goal of abstinence from drug use:

I have a daughter ... and I want to be there when she falls in love, when she gets married, when she has my grand baby. ... But I don't want this [drugs] to overtake my life anymore. ... I want to be alive. J, 96–99, 104, 348

As is evident in this quote and throughout the interview data, WUID are indeed mothers who care about their children, who made decisions based on the best choice given their circumstances, who suffer anguish as they struggle with familial bonds and their lives as women with addictions. While the participants often described these relationships as difficult and complicated, they also described how children give them a reason for going on, and a much-needed purpose.

2. *Intimate partners.* Further to family relationships, the women spoke of intimate partnerships (all of which were heterosexual), with the nature of these relationships varying. Whether their partner used drugs or not, drug use was often a point of contention. Sometimes this use was kept a secret from a partner, involved harmful practices, or illustrated power imbalances.

Contrary to what is commonly thought, that male partners initiate women into intravenous drug use, only two women described being introduced to injection drugs by a boyfriend. AF, who had previously smoked crack and had not injected drugs, stated,

I kept going out to work and he was sick of seeing me go out there, it was bothering him, and he said, "Okay, you are going to stop jonesing there right now, and stop

craving it,” he says, “Give me your arm,” and he gave me a hit. It was his needle and he gave me hep C. AF, 330–334

Abruptly, AF was introduced to injecting drugs by her partner and she acquired hepatitis C. Descriptions such as this were rare, however, and the women more often maintained that it was their choice to inject drugs, and not their partner’s. To this point, AD talked about insisting that her partner inject her:

I don’t think he feels very good about it. ... I badgered him quite a bit ... and he made me promise him that I wouldn’t do it unless I was with him. AD, 166, 176, 180

Another woman whose partner introduced her to injected drugs explained,

I was with him for a few years before I even started it. It was my decision. I’m a big girl, I know right from wrong. It was my decision. H, 118, 122–125

Here, then, the women insisted they had made the choice to inject drugs, despite apparent protests from their partners. Their independence is pronounced and may align with the everyday skill of survival needed to exist in the world of using drugs.

Another aspect of the experience of WUID and their intimate partners is provided by W.

She expressed in the following excerpt how much women give up when they use drugs:

I just find it’s hard for women. Men just tend to pick up and move on whereas the women hold all the feelings and we carry the children and we lose so much more. We lose our family, we lose our dignities, we end up turning to selling our bodies and doing things that we would never think that we would do. ... It’s like they don’t have feelings, let’s move on the next one, type thing. W, 15–24

As exemplified in this excerpt, intimate relationships with men were often temporary. Sometimes they provided security, and occasionally a steady supply of drugs. However, these relationships were not always amicable and further discussion of the sexual harassment and physical threats they sometimes posed will be further discussed in Theme 2 Negotiating Survival.

3. *Public opinion.* In general, the participants believed that the public provided concrete evidence that WUID were disrespected and stigmatized. Their day-to-day experiences were interspersed with negative and degrading comments and actions from others who publicly

rejected any identification with the community of people who use drugs. AF described her experiences:

“Hey, whore, slut, go suck a cop” – oh, they’re really awful to us. All the young pimps, guys in cars, “hey blowjob there.” It’s bad. ... They’ll throw eggs at girls, it’s really bad. They threw a glass of water at me a few weeks ago, a cup of water. ... It’s embarrassing standing there and “blowjob!” It’s awful they’ll yell out “crack head.” I hear it every day I think, “fucking crack head.”

AF, 569–573, 580, 602, 616, 625–629

The quote demonstrates that WUID sustain countless insults and opinions citing personal defamation each day. They are dehumanized by such comments that demonstrate a view of WUID as a “blowjob” or a “crackhead.” Certainly, this depersonalization creates a relentless reconfirmation of their apparent lack of worth. AK summed up public opinion when she stated,

I really find that society does look very badly on women with addiction issues. ... We are looked upon more like mother earth, we are supposed to be nurturers, mothers. We’re supposed to take care of everybody. We’re not supposed to get sick; we’re not supposed to have problems like that. And if you do, you’re bad, and it’s really unfair. ... That’s the biggest thing for me, is the stigma, attached to the addiction. And women get treated very badly, the addicts. ... We’re not allowed to be like that we have to be perfect, society puts us on a pedestal and some of us fall off. AK, 14–23, 595–597, 602–603

WUID in this study were aware of the negative and often brutal reality of being detested and despised. Their quotes also suggested that they were cognizant of being verbally hated and yet being the regular and consistent sex partners to the same public mass. Being witness to the two sides of the love/hate displayed by others may put WUID in a precarious, yet potentially powerful, place.

You think ... working girls, is a problem and without working girls there wouldn’t be any drug use? Come on, I’ve seen lawyers, I seen doctors, I seen psychiatrists – pick up from my dealer I know, “Oh I’m just a weekend user,” you’re still an addict. If you can’t say no on the weekends, you’re still an addict. “No, I’m not, I’m just an occasional user,” you can fool yourself maybe, but you can’t fool everyone around you. M, 474–478

Their intimate knowledge of those they serve who concomitantly stand with others who sequester and dehumanize WUID further separates and isolates the women by their required silence. The irony is not lost on them. They have taken note of those who condemn them and their actions,

and found they are not always so dissimilar. Instead the women have found that similarities exist, yet they are denied by those who hypocritically continue their lives unabated.

4. Relationships with others through drug use. WUID interact with a number of persons solely because of drug use. This includes those who sell drugs, police, and other PWID.

4.1 People who sell drugs. The WUID had frequent contact throughout the day and night with people who sell drugs. The interaction could be a simple transaction, or fraught with danger, deceit, and conflict. Most of the women bought their drugs from people they knew and trusted, and it seemed that favours assisted when interacting with people selling drugs. For example, M stuffed drugs down her leg cast so that the person she was buying drugs from would not get caught by police. U provided apartment space to test and store drugs for people dealing cocaine. It was clear from U's words that if this arrangement had been discovered by police that she would take the blame: "What can I say? Well, 'I'm a drug addict and I need lots, so, just to make sure, I have a kilo okay?'" (849-850). It seems there is a significant power differential between WUID and those selling drugs in this commercially based relationship, and it is the women who agree to "take the fall." Perhaps they feel the person selling drugs will be indebted to them and help them out in a time of need. The full extent of this relationship and whether it is gender biased requires further exploration.

When money was in abundance, such as at the end of the month when welfare or disability cheques arrived, the women would call drug dealers who, it seemed to them, had planned for this time of high-volume sales.

They come with wings on, you'd swear they had a jet underneath the hood of that car because they are right there. Any other time, it's like, "Okay give me twenty minutes," and half an hour and 45 minutes later you are still waiting for the fucking asshole. But come cheque day, they're there. M, 468-471

WUID interact regularly with people who sell drugs. This calculated interaction can be one of stress and one which requires careful negotiation. The women however, reported being capable

of providing favours that obligated the seller to them; thus, they may hope that they are building equity and providing security for a time when they too can ask for a favour.

4.2 The legal system. The police, and the legal system altogether, are a constant presence in the lives of WUID. The illegal activities that are inherent in injection drug use, such as possessing, buying and selling drugs, interacting with people buying sex, stealing, and violence mean that the women commonly came under police surveillance. Many of the women have had criminal charges laid against them, and jail time was not uncommon. Some found jail boring and were tired of going back. For others, the interlude allowed time for self-care. R discussed getting tested for hepatitis C and other BBVIs while in jail. She stated, “I was in jail and there was nothing else to do and I wanted to get it done” (R, 484–486).

Other women felt going to jail was a favourable outcome as it provided a reprieve from their daily lives (i.e., the vicious circle), allowed time to look after health needs, and enabled them to feel “taken care of” (U, 49). U further explained the opportunity jail afforded:

Sometimes I don't mind going to jail because they take care of me. It's not that bad in there; and I heard even if you do something bad, or worse even – the penitentiary is even better. ... Not that I'm going to do anything, but if something happened where I hurt somebody bad enough – you got your cottage, you go to school, you come out with a degree – I'm thinking fucking bonus. But I could never get past two years, plus a day. I'm lucky that way, I guess. But it's unfortunate that I have to go away; but I'm thinking that I would like to do that to become something – because out here I can't, does that make sense? U, 550–564

Jail time then creates time for self-care, and sometimes offers a more promising future than life outside of jail. Interacting with police and the legal system is a large part of the subculture of this cohort of WUID. More will be said about the interactions of the women and police in Theme 2.

4.3 Other WUID. The final group who are a part of the women's community are other WUID, amongst whom there is a sense of comradery and, paradoxically, deep-seated mistrust. Comradery is illustrated in several ways. Some women described themselves as being called “mom” and having taught others survival skills, such as how to eat while appearing to shop, or how to sleep in a park without blankets. They also shared with each other strategies for staying

safe. Z spoke of watching women engaged in sex work and checking they came back after being picked up by a client; another provided emergency care of stab or bullet wounds when people were reluctant to go to the hospital. O was known for her skill draining abscesses. Other examples of this comradery included helping with injections, checking in on or taking the peer-assisted naloxone training to assist during an overdose, teaching self-defence, and helping to identify drugs that had been tampered with. Other women spoke of helping those who were experiencing drug withdrawal. Any knowledge or assistance that could be offered to other WUID was felt to be an obligation:

There's just so many outside circumstances that contribute, that I have a better appreciation for, now that I'm older. I realize to some degree we're all victims of it, and I guess, it matters what you do with that knowledge, and with knowledge comes responsibility. AD, 803–814

The women clearly have a sense of community and responsibility to others in need. However, trust was also an issue for many. When discussing trust, the women often made reference to a person they bought drugs from, their intimate partner, or regular sex work customers. It seemed that these relationships had been tested and proven to be trustworthy over time.

On the other hand, women expressed a deep and general mistrust of other people who used intravenous drugs. Many women indicated they had offered friendship and assistance to others but had learned that their efforts were taken advantage of and, as there was no reciprocation, they had given up trying. N described this evolution:

I used to feel sorry for other people, but now I don't. ... It's just like, "You go get your own shit, I've got my shit to deal with." It's like, "Fuck you" sort of thing, it's just the way it is. N, 420–421, 429

Overall, the social and occupational interactions of WUID which were depicted are notably complex. Both involve safety risks and require an underpinning need to look after one's own self first to survive. Although a typical day involves a variety of activities, and interactions with a number of people, there are few opportunities which allow a reprieve from potential danger.

Nevertheless, these women continue to survive the vicious circles that are their lives. Such self-reliance will be further explored in the next theme.

Theme 2: Negotiating Survival.

As mentioned in the previous theme, the women in this study exist in a social world within another world. The interdependence with others is complicated and complex, involving trust and mistrust. This section reviews the findings about how WUID strive to achieve self-preservation in myriad kinds of violence by negotiating survival and maintaining resilience. While some of these findings overlap with Theme 1, it is because there is a striking amount of violence in the lives of WUID. Because it plays such a primary role in shaping the culture of WUID, the theme of violence and the resulting need for resilience is extracted and more thoroughly examined to ensure a more profound understanding of the influence on the culture and lives of WUID.

Staying alive. During the interviews, WUID recounted stories about what they had endured and survived. The WUID were able to sustain themselves by learning what they must do to stay alive; they had gained the proverbial “street knowledge” to protect themselves from harm. Indeed, WUID live in a world within a world. J described her life using drugs as entering a different world, which she found unfamiliar even after living the life of a WUID and returning to it after she left jail.

It was new to me, I didn't get into the drug world until my late 20s, due to personal trauma, and I just went crazy on it like a baby with a new toy. J, 58–59

I was faced with coming out into the world, not on the drugs anymore. And I had to relearn how to live. J, 74–77

This other world can be seen in these quotations as an environment in which getting what one needs and staying alive involves overcoming many obstacles. Maintaining personal safety was viewed as an accomplishment, and thus survival was a common theme for the women. They recognized their struggles and the traumas they had been through and questioned why or how they survived. The women were well aware they had achieved something by remaining alive. As Q noted,

I survived this shit storm, I've had enough. I'm gonna write a book. I'm going to. ... Nobody would believe it. They would be, "There's no way this woman survived that." Well yeah, I did, I beg to differ. Q, 254–262

Q describes her life as "shit storm" which descriptively enables some insight into the life of WUID.

Q felt that, while her life story would read like fiction, it instead would tell the tale of what it is to be a WUID. It is with certain determination that WUID have survived day-to-day battles. As well as a sense of pride and accomplishment at their ability to stay alive, the women described how they found strength within themselves. As M stated,

I'm an addict. I am not totally proud to be an addict, but I survive. And I survived from where I began in life, until now. I'm 44 years old and I survived that long, so I better be doing something at least half decent, my health isn't the greatest, but I'm still surviving. M, 590–596

Certainly, the women depicted how cunning and expert skill must be developed and maintained to survive on the streets and in the world of drug use. As M noted, this negotiation and day-to-day existence does not yield "the greatest" health, but it does ensure survival. Evidence of this required skill is in the descriptions the women provided of being violated in many ways, multiple times:

It's amazing to me that I'm still alive. ... I could have been killed several times. ... I've had guns to my head, knives to my throat, been choked out. Sorry, I don't mean to cry. I was choked, I've been beaten unconscious, just to live this life.
AJ, 474–483

Clearly the women have had experiences that have required a strong will to survive and continue to pursue life. Although this is an accomplishment, this meager and endangered manner of living should not have to be tolerated.

Childhood experiences. To survive, the women learned early in life that they could only rely on themselves. To begin, the women often related stories of their childhood that were implicit in their life trajectories, level of trust, and self-reliance. M discussed the early years with her mother as follows:

My mom was an addict and an IV drug user. ... She was so full of narcotic. I can remember growing [up] seeing syringes on the table, and picking up wine bottles and putting them away, holding mom's hair back so she could puke in the toilet,

cleaning up. I'm six years old, cleaning my mother up because she puked on herself. M, 98–99, 101–105

Q described similar memories of her childhood and mother. She stated,

My mother was [an] alcoholic, she bled out at 33, everywhere, her liver exploded. ... She was what you'd call a functional alcoholic, which was weird because I didn't think my mom was alcoholic because she worked all the time. ... I figured it out when I had to fill up her mickey every morning, go sweep the snow off her car and get it warmed up for her before she went to work, get myself ready for school, then get home after school, do all the housework, or I'd get a beating when she got home. Q, 279–283, 287–288, 292–294

Looking after themselves began early and was a consistent part of the participants' childhoods. Those who were entrusted to provide these children with guidance and protection were not able to do so, and the parental role seems to have been reversed. Moreover, and maybe due to a lack of parenting skills provided to them, many of the women in this cohort were in foster care as children where their trust in the world, to be cared for and loved, was denied. AC described her childhood:

I was abandoned as a baby. Neglected and abandoned. When the children's aid took me off the reserve, I was suffering, big time, from malnutrition, head lice, impetigo. So, when my foster family had gotten me, they had to separate me from the rest of the family, so there was a lot of small traumas. Things that I am sure have an effect on my living. When I went to the trauma workshop I worked on my sexual abuse from my foster father, but I've never worked on my abandonment issues. AC, 123–138

The women spoke of situations where they had had to take on responsibilities and, as children, lived in conditions that are not considered acceptable. The participants' matter-of-fact tones and fact-related stories were devoid of emotion and anger, although there was resentment for how they felt this treatment led them to live the lives they did. The words portrayed a tolerance of the way their childhood was experienced.

Lack of protection from authority figures. There is a common, implicit trust in those who are sanctioned to protect others in society from injury. However, WUID learn they cannot turn to these authorities with confidence or trust. As noted, a need to rely on self and not others began early in their lives. Indeed, WUID have had, and continue to have, poor experiences with their

families, the police, who they should be able to depend on for safety, and healthcare professionals, who should provide empathetic care.

Police. The women tended to avoid police whenever possible because they reported having been both violated and disappointed by them. AF stated,

I never call them. I just seen a lot of cops, growing up, through my brothers. They beat my brothers up and a lot of stuff. They were just young.

AF, 183, 188–192, 196

O related a recent incident when she had woken up and realized she had been beaten. She neither called the police nor reported the incident. Instead she “licked her wounds” (O, 445). Her rationale for not reporting the crime was as follows:

Because I have a record for prostitution and everything else. “What? Did you try and rob one of them or something?” That’s the first thing they say. Do you really want to go to them and tell them you are hurting? No, no, not whatsoever.

O, 449–455

O also reported she had facial bones fractured during an altercation with police. As a result of this incident, and despite plastic surgery, part of her face remained immobilized. She had also witnessed others being beaten – both incidents which undermined her confidence in police.

I’ve watched them smash some guy’s head up off the bars down at the (shelter) and the blood was just pouring anywhere, and then they saw and they’re saying, “Nobody seen nothing eh? Because if you did you know we’re coming back for you.” What are you going to do? O, 1035–1041

E had had similar experiences with police and felt that, while not all police were corrupt, there were a number who were. This influenced how she interacted with police. She stated,

They don’t treat me very well. ... They think that people are poor, and they can just do whatever they want with them ... not the whole force, but I’d say most of them. And even if they are with a partner, and maybe the lead does something and the other cop doesn’t like it, he can’t speak up. ... “Hey, you shouldn’t be treating her like that. You are there to protect the public.” Why am I not being protected? Why are you in this line of work? I’m pretty blunt when it comes to cops and they don’t like that. I usually root for the other guy if I see someone being abused by a cop. ... I’ve seen things happening downtown and I don’t like it. Kicking them in the – down there, abusing them. Why do you treat these people like that?

E, 86–88, 95–100, 104–119

Others, including AB, noted they were treated like “scum”:

The cops look at you all the time. You feel like scum of the earth. ... They don't understand why you are doing it [drugs]. They treat you like garbage, right away. They figure you're some dirt bag. They don't even take the time to figure out what's going on, who you are. AB, 615–627

These witnessed and experienced incidents with police were not isolated. The women spoke of brutal and unnecessarily forceful encounters with police. Their treatment was described in terms of animals such as being corralled like cattle (O, 381) and blocked in like a “pigpen” (O, 605). They reported how they had been humiliated and unjustly treated by an organization and a public institution that should protect and ensure their safety, rather than jeopardize it.

Moreover, as well as experiencing first-hand or knowing of others who had experienced physical violence from police, several women had, themselves, been fearful of treatment they might receive from police while being arrested. AC spoke of an incident that occurred while she ran a crack house:

I was passed out when they raided me, and I woke, I didn't even hear them bang the door open – all I felt was a gun, a muzzle on my forehead. AC, 705-710

Y also had the police raid her apartment:

About nine cops came in my apartment, guns at my head, all kinds of guns – a pump gun, fucking laser gun, fucking had this little light shining at my head.
Y, 80–82

These incidents recount what seems to be the overuse of force and weaponry against women who are not only unarmed, but also asleep or otherwise unaware of the need for police. Certainly, a loss of trust in authority figures who are mandated to protect is reasonable when one examines the experiences of WUID.

Healthcare providers. Other authority figures who often lack the ability to build trust and provide support to WUID include healthcare providers. The result is that many of the WUID in this study reported that they avoid healthcare because of treatment they or others had received in a time of need. AC described this sentiment and experience succinctly:

I wouldn't feel good. I'd probably feel really bad because I think they'd judge. We've got a hard enough life. I would not go somewhere to get healthcare and to be judged. AC, 924–928

This quote has a profound message for healthcare providers. To act in such a manner that people avoid the healthcare they need and deserve is cause for concern. The women related stories of others they knew who had prolonged seeking healthcare due to poor treatment experiences, who were then in very serious condition, if not palliative, by the time they reached out for help.

AH had been to the hospital several times and her impression was that those who inject drugs are treated differently. She stated,

At the hospital they do [treat you differently] because you are an addict you are not like the rest of them. I'm not really sure, but I just feel, sometimes I'm being judged because I'm an addict, an addict versus a straight person. AH, 154–161

These experiences isolate and demean WUID. AH noted her perception that she was treated differently than others, indicating there are two types of people seeking healthcare, those who are “addicts” and those who are “straight.” The participants’ perceptions of such a two-tiered system creates shame attached to these interactions and consolidates the poor self-image WUID have:

I got no veins left, there's nowhere to go, even you go to the hospitals, they try my legs and they go, “You've got nothing, well we'll try this vein here – but don't [you] use it.” I'm so embarrassed, but that's what happens sometimes. I don't want to go because they can't even get bloodwork out of me. U, 658–661

Being judged and treated differently made the women feel “embarrassed.” These feelings of shame, which were created by healthcare provider treatment, made it challenging to re-engage.

The women expressed a lack of compassion and care from healthcare providers, specifically feeling they were compared with others and judged to be second class because of their addictions. Indeed, when identified as a WUID, several women spoke of being “red flagged” at hospitals. AJ described this sentiment succinctly:

Definitely judged, definitely. First in the hospital, as soon as you tell them that you're a drug addict they won't give you anything, they won't give you medication. “Oh, you're a drug addict, what are you going to do? You're going to shoot up.” I can walk in there with a broken arm or a broken leg or something like that and they'll give you ibuprofen. Because they know. I'm red flagged from hospitals, which means basically, if I go in there, unless I'm dying, they won't even give you drugs. AJ, 1024–1033

The women spoke of being “red flagged” or identified with a marker on their chart to

alert healthcare providers that they used injection drugs. The implication is that the woman is unpredictable, may abuse medications given to her, and that this information is critical to her care. From this quotation, what it appears to more likely do, however, is set up WUID to be seen as addicts who are deceitful and dangerous, not as women with health needs.

Others who use drugs. It was previously mentioned that WUID learn to not implicitly rely on others or turn to friends for emotional support and counsel. While the women do rely on each other for some drug-related health issues, such as therapeutic management of abscesses or washes to allay withdrawal symptoms, they still remained wary of trusting others when it came to drugs and injecting:

I don't trust anybody else that I know, especially because they're probably going to be high. I figure, if I'm going to do the damage, I'll do it myself and not have somebody mess up on me. AC, 201–207

Thus, while the women socialized and interacted with others, it was not possible to “let their guard down” for fear of being taken advantage of. The utmost vigilance was required. A few of the women also indicated that injecting with a partner could be dangerous. J described that having staff in the small shelter where she stayed provided protection from her abusive partner. He had physically harmed her in the past, and she felt it necessary to live apart from him. J explained, “My boyfriend, he's really abusive and possessive and I can't live with him, he's extremely abusive. I'm protected from him here” (J, 178–181).

Another woman called tourniquets, often called “ties” in lay terms, “neck ties” (K, 70). When asked to clarify the meaning of this term, the participant replied as follows: “I'm use to my boyfriend putting [the tourniquet] around my neck” (K, 278). In other words, this participant's partner was tying the tourniquet around her neck to assist with injecting her in the jugular vein – a practice that, while effective, remains inherently dangerous, possibly made more so when the person applying the tourniquet may be using drugs concurrently.

Men were also portrayed as taking advantage of women, for example forcing them into sex work. AJ described what involvement with a man did to her life when she was 16 years old:

I met this man, I was 16 years old, and ... he promised me the world. He basically kidnapped me, held me in a motel room, beat me, raped me. I was his sex trade. ... Nasty, dirty, old, stinky men that wanted young girls – and back then you didn't have to use a condom. ... He'd take our money, he would shoot us up, buy us drugs, and made sure we were high, even if we didn't want to be ... Can you imagine – 16 years old having between 12 to 20 men on top of you every day?

AJ, 324–328, 391–394, 408–411, 416

Taken and confined in the sex trade at the age of 16 had a profound effect on this woman's life. Although not all women recounted such stories, most carried an awareness of their vulnerability and need to protect themselves from men. O described what was like living on the street with men and a mutual need for drugs. She described this inherent tension she faced:

The guys we live with on the street and stuff, sometimes they're really dope sick, and that's when they do get aggressive with us, but what are you going to say, we live with them and we don't say nothing. ... The guys get physical with us to take our dope, because they know we can go out and hook again.

O, 1089–1093, 1113–1115

U summarized this situation when she said, "With friends like that we don't need enemies. It's just another miserable person to sit and use with. I know that because I'm a drug addict" (U, 221–226).

As discussed previously, people who sell drugs have a certain amount of control as they maintain the drug supply, and thus are a further source of danger because they have an item that the participants want. Moreover, this situation can be manipulated in many ways, one of which is home takeovers, which result in an absolute and profound loss of power and the ensuing violence:

You've got to worry about dealers who say, "Can I come and sit at your place for a while," next thing you know, you've got five to six boys sitting in your house and it's no longer your house, because you owe them. You're fucked. ... It's their home now, it's their crib, you have no say over what's going on and that's tough because you see everything. ... Just disappear, your furniture gets demolished, if you've got pets they are scared or abused by these guys. You get told to "shut the fuck up" and go into the corner, or they'll throw you a fucking hit, and say, "Here, shut up."

M, 172–182, 194–195, 198–202

This type of "reign of terror" in a woman's home is often continued until she leaves, which typically entails her losing her home.

However, interacting with people who sell drugs is essential. Drug dealers supply the needed and wanted drugs, and while they themselves may not be fully aware of the content and composition of what they are selling, they are known to provide reassurance that their supply is of quality. Unfortunately, whether or not their statements are true, the women are at the clemency of those selling drugs. P described how drugs can be replaced with other substances and sold:

I've heard of it happening to a lot of other people as well. People just replacing the beads because they have the empty capsule, and they need money to buy their own drugs. It's just really sad to do that to other people. I just don't understand how these people can go to sleep at night with a clear conscience. P, 530–539

P had experienced buying a drug under false pretense and was saddened by this occurrence. More importantly, while she did not understand this cruelty, she was not upset or angry. Instead, she accepted this as a potential occurrence and dealt with it. Interestingly, though, she was disappointed in this behaviour, noting how it is an overt but common violation of the code of conduct amongst this cohort. As S summed it up, “I hope it's going to be good. Sometimes it wasn't good, sometimes I get good shit” (38–41). Thus, the women are vulnerable and subject to the violence incurred by the supply and demand of illicit drugs. Given that the power is unevenly balanced in favour of those who sell drugs, the women expressed that they must endure and survive the nuances of cheating and deception that are inherent in the sale of illicit drugs, or drugs for illicit use.

Sex work. The women also spoke about the dangers they encountered being WUID and “working girls” (H, 24; W, 110). As described, WUID are at risk of harm; however, they are doubly at risk given the need to raise capital to secure their drugs, which is often accomplished by working in street-level sex trade. W described this as follows:

To me, of all the professions out there, its drug dealing and prostitution. They go hand and hand. And they are two very dangerous games you can play out there. Even when you are out there selling drugs you are still playing with your life. You are taking the chance of people ... robbing you at gunpoint or whatever. The women are taking the chance ... they're out there selling their bodies... being beaten, corralled. W, 130, 143

W spoke with a complacent knowledge of the violence that WUID endure. She described sex trade work and selling drugs as risk practices. Both must be accomplished while remaining hidden and without recourse of the law should harm be incurred. From the interviews, it could be understood that there is no means of predicting or preventing the inevitable; there is no appetite for inviting the police into any altercations or harm, such as being robbed or beaten. W believed the women are taking a chance and are playing with their lives when they engage in such covert activities. Q spoke further about having been violated several times in the previous weeks, including being beaten and held captive by a sex trade client:

I have been assaulted five times within five weeks, I can't take much more. ... [The assaults were related to] using, prostituting. I had a razor to my throat, he cut the inside of my mouth, he left a boot mark on my back, pulled my hair. He was extremely violent, he forcibly confined me. I got out of it because I fought him for 30 minutes. I was bruised from head to toe. It was horrible. I screamed, my voice box still isn't back, my vocal cords from all the screaming and yelling and him strangling me and – whatever. It wasn't fun. All because I wanted to go to the bathroom. Q, 92, 105–110, 137–144

Clearly, the women experience physical violence during their work. Physical assault is not uncommon for this group of WUID, and the lack of authorities to turn to, as noted earlier, only makes this violence more likely and less stoppable. Along with the brutality inflicted by clients, the women also suffered at the hands of their pimps. U had had a horrific experience:

I had to get out of (city) in the back of a van or I wouldn't have lived, I wouldn't have made it out. I was bought and sold by pimps, beaten up, see the scars and, just beaten up and sold, bought and sold – well that goes on, it's a world inside of a world. U, 109–111

When asked about contacting police to pursue justice, U stated,

Frig no, because too many people I know passed away that way, and you people think it's so easy to walk away. In (city) you can't. So, I came here in the back of a van, hiding, scared to death. U, 111–115

The fear in U's words is evident, as she escaped "scared to death." It is also disturbing to note her words "you people think it is so easy to walk away" which speaks to the disparity between what is believed to be possible for WUID to do and the realities in which WUID live which make

change almost impossible. J also spoke of her experiences of being almost fatally assaulted doing sex trade work:

You are out on the street prostituting and when you are doing that you are playing with your life. Personal experience, I almost lost it. Thank heavens I have a really big mouth and I'm either very stupid or very persistent, and I screamed until I got myself help ... because that saved my life. The woman that heard me screaming went to the office [and got a man to help] who ... smashed into his car to stop him.
J, 712–720, 728–729, 741–742

As can be read from this quotation, personal safety was considered to always be in jeopardy during street-level sex work. The women also knew of others who have been killed or committed suicide because of the challenges they had living with the risks and consequences of prostitution.

W stated,

Some of the other girls I've seen go through that. They were given beatings for things that some of the things that other girls did, so men take it out on all the working girls, not just the one that did it, they think because one did it, the rest of them are going to do it, they want to make sure they don't. ... I've already lost two girlfriends and they were badly raped and beat until the point they couldn't handle dealing with what happened to them and did what they did to themselves and they found them in the trails. It's very sad. W, 106–126

Despite the unknown and the known danger, and thus the risk to their lives, most of the women who spoke of the violence associated with sex trade work reported that they continued to sell sex to obtain drugs. It seemed that, although they were aware of the danger, it was not sufficient to negate the need to sell sex to support their drug use. 'I' had greatly reduced her injection drug use and she reflected on how her intense use of drugs endangered her safety:

I think I was pretty much blocking everything out with drugs, I didn't really care about anything. I didn't care about myself, I didn't care about my safety, I didn't care about anything but finding my means to use drugs. So, it narrows everything down to drugs and working. 'I', 74–79

As described in these quotations, the overwhelming dangers that WUID encounter every day through their work, without the protection or safety afforded by friends or police to assist them, speaks to how precarious survival is on a day-to-day basis.

Staying safe. This cohort of WUID in an urban setting, who were homeless, explained the means by which they survived and tried to stay safe from the dangers they encountered. As

discussed, some women looked after the safety of others by giving advice or watching what was happening on the street. Moreover, related to sex trade work, some attempted to increase safety by offering only oral sex, and some only worked for trusted regular customers. These strategies enabled them to avoid many of the drug- and sex trade work–related dangers and risks. With no one to turn to, staying in a safer environment becomes the only option. There are few shelters exclusively for women, but they have 24-hour staff, and traffic in and out is monitored.

Therefore, being aware of the hazards and potential difficulties that they may encounter throughout the day enables WUID some degree of planning and avoidance. As the quotes illustrate, harm reduction, in terms of the type and place of selling sex, staying in safe places, and ensuring behaviour is meeting expectations are important safeguards to assist with survival.

Perseverance. Despite the lasting effects of past, current, and ongoing violence, plus the sequelae and stigma of drug use, and the challenges of poverty, the women in this study also demonstrated hope and positivity. In other words, nevertheless they persisted:

I was explaining this the other day to somebody that it feels like I'm in a cocoon, and I'm waiting to get out of the cocoon and, hopefully, eventually get to treatment and spread my wings and become a butterfly, eventually one day, and be free of all the demons and all the addictions that are a part of life. AJ, 116–123

While acknowledging the difficulties and struggles in their lives, the women hoped for the future and spoke about aspirations and dreams. AJ envisioned a transformation from her current life to one in which she would be free of her demons and dependency on drugs.

With AJ as an example, this cohort of women had determination and a faith that there is a reason to be here and a life to live, and that they will move forward. AD reflected,

I often wondered, why would god let me go down this path? I really knocked my head against the wall for a long time over this and cried myself to sleep so many nights, and I just didn't understand. I'm still not thrilled with it, the fact that I went down this path in life, but ultimately, I believe in god and obviously he knew I was going to go down this path before I did. ... I just have to trust that there's a reason for it and all this bad will come to good for something. AD, 751–760

AD expressed her hope that all she had suffered and been through was for a reason. She hoped that “all this bad [would] come to some good,” thus giving her a reason to endure the life she lives. What that would look like is as yet undetermined, but AD, and others, would “trust that there’s a reason.”

Also, recognition from others, though scant, indicated to the women their own importance, which gave them hope that their lives were meaningful and that someone believed they were worthy of kindness and love. These positive interactions encouraged the women to feel they had self-worth and reasons to live. J reflected on what her mother’s help meant to her:

She couldn’t even have me in the house ... because she couldn’t trust me, and that almost killed my mother. But I robbed her ... of her jewelry, and she still would come and bring me little treats and bring me suppers, homemade spaghetti. ... She always gave me that little bit of hope. That’s what kept me going through the years. J, 567–572, 579

J described her mother as giving her hope, enough that she could keep going, as she mattered to someone as a human being. To have this kind of hope gave J a reason to dream of a future:

It took years to get here, seeing death, and a lot of loss, and a lot of my own personal pain to get where I am at today. It’s hard though, because if you can get to this point, it takes a lot of faith, and a lot of times being on the street for many years, you begin to lose faith. It’s sad. People themselves lose faith in life, faith in the future. J, 538–551

J had experienced tragedy, suffering, and loss. Somewhere and somehow, however, she believed that things would improve. V, on the other hand, seemed to have lost hope:

I hate using. If you’re an IV user, you have to live with it day by day. ... And it’s a part of my life, it’s with me for the rest of my life, it’s going to haunt me. ... It’s not fun and games, I need it to survive, to live. V, 7, 11–12, 14

While discussing her future, V stated she had no way out; she explained how compelling her drug use was and, furthermore, how she felt compelled to continue using drugs:

If you had a choice to have everything in the picnic basket, what would you pick? That fucking drug. ... Sickening, disgusting. ... I feel sad and it makes me sick to my stomach, it does, it really does. V, 626–629

However, unlike V, most women demonstrated resilience and continued, as AJ did, to dream about a life without drugs and trauma. They found hope through the support and assistance on

their life journey. AC described working with others on her sexual abuse and trauma and went on to say,

That's what I'm shooting for next, is working on [abandonment] and hopefully that'll probably have an effect but being a future grandma will have an effect on my psyche too. I want my son to be able to trust me to have the grandchild.

AC, 142–152

The women, then, have been deprived of unconditional love and care, beaten and robbed, and had no formal recourse for criminal events or bodily harm; in short, they tried trust and were let down. This constant deprivation and abuse becomes central to their perspective of the world and their need to be vigilant and to trust no one. Despite this, they demonstrated great hope and resilience to stay alive and be forward thinking. As AJ stated, “It’s just a day like any other day, and it sucks. It sucks, but I’m alive. I definitely am” (670–677).

O expressed how worthless and invisible WUID feel when she was speaking of people who had used drugs and died. She questioned how others viewed the humanity of WUID:

But then who cares because we're drug users. That's the way the public looks at it. Just another drug user off the street, all fine and good. ... Why? Because he wasn't prime minister, or he wasn't a priority, or he didn't own a Sears company. Because that's exactly what matters to people and yet everyone is a human on an equal basis, has a mother and a father somewhere and maybe some brothers and sisters – it doesn't matter if they don't want anything to do with us or not. We all have good in us, I don't care who you are, and that gets totally ignored. ... I thought it was supposed to be you treat every human equally. Is that not right?

O, 412–416, 56–573, 583–585

O provided a somber explanation of the lack of acceptance WUID experience in terms of rights and respect. She appealed to the morality of basing importance and stature in materialistic terms with a reminder of the commonalities between people and the need to recognize positive attributes in everyone. The resilience and hope O demonstrated through her observations directly calls into question the rationale for treating WUID as less than worthy. Indeed, it illustrates the need to survive in a world that depicts one as different and thus requiring strategies to maintain life.

Theme 3: Valorizing the ideal of being clean.

The final theme that emerged from the data was that of cleanliness, which indeed represents a strategy to negotiate the other world, outside a community of people who inject drugs. At times during the following discussion the language about “clean vs. dirty” may be interpreted as stigmatizing and judgemental. However, the term is presented with the intention to capture the participants’ sentiments about cleanliness. This appears, at times, to propagate stigma about WUID, but it is meant to solely illustrate what the women saw as an aspiration, something that made them feel more “normal” and demonstrated following a broader society’s mores. It is by no means a judgement or a comparison but rather a description of the women’s observations, to remain true to the ethnographic approach and to maintain rigour, as WUID described their typical day and culture.

Although the participants used the term clean in many ways, they primarily employed it to describe how they attempted to camouflage their identities as WUID within a broader disapproving society. The words spoken by the women will be discussed here to gain an understanding of the continuum of clean and dirty, and their ongoing valorization of the ideal of cleanliness and the struggle to cleanse themselves. The discussion will provide an opportunity to know more about the culture of WUID through (a) their efforts to be clean, and (b) their attempts to conceal bodily evidence of intravenous drug use.

Clean. Cleanliness is a state the women sought to achieve. Clean can be defined as free from dirt, marks, or stains. Being clean was held as an ideal, one to be attained so that one was able to blend into, and gain acceptance and inclusion in, the broader mainstream society. Clean was a desired state; it pervaded the multiple contexts in which the women used this term. The differing ways participants employed the term clean are explored in the following dimensions: clean people, clean from drugs and disease, clean self, coming clean, clean environment, using clean.

Clean people. The research participants referred to people who were clean as free from using a substance or having a condition they regarded as dirty, contaminated, or impure. In other words, a clean person did not use drugs, had no communicable diseases, was washed and groomed, and told the truth. These components of being a “clean person” will be further described from the comments the women made during their interviews.

1. *Clean from drugs.* Many of the women used the colloquial term clean in conjunction with quitting drug use. Quitting drugs had varied meanings. For some, clean from drugs meant being on an oral opioid substitute, such as methadone or Suboxone. For others, it meant stopping opioid drugs but continuing to inject other drugs, while still others felt they would not be clean from drugs unless they had discontinued the use of all recreational substances and prescribed narcotic drugs. T described her interpretation as follows:

I'm 35. I'm trying to be clean and do my life and so I have a meeting with [a worker] at [a health centre] to talk about treatment. I won't go on methadone and I won't go on Suboxone. If I'm gonna get clean, I don't want nothing. T, 49-53

In contrast to T's approach, H continued to smoke and inject cocaine and stated, “Getting on methadone was the best thing I've done. I've been clean off the pills for three years now” (H, 385-386). Clearly, while opinions about what it means to be “clean off drugs” differ, the overall intention described a process of making changes that reduce illicit drug use. As AK described,

My doctor gets pissed at me too, because he sees the opiates in my system and he's like, “You can't be doing that nah, nah, nah” and I'm like “I know,” but the thing is I'm not using every single day like I was before. AK, 393-395

The women, then, have a common goal of getting clean but the definition varies and can mean reducing drug use, limiting drug choices, or eliminating drug use all together. This intention was commonly discussed as a goal for the future, or one that had been attained, lapsed, and sought to be re-established. The women would express being clean in various phrases when they discussed their plans about drugs use. H stated,

Like I said it's hard. If I want to get clean, I have to really want to do it. I've done it once before, and I will do it again when I am ready. I don't know when that will be, but it will eventually happen. ... It's just when I am ready. H, 373- 377; 411

As noted above, discontinuing drug use was something many of the women aspired to. AC was one of the women who was striving to “get clean,” and she presented her story in the context of her current desire to stop using drugs. She also spoke about being clean as “normal.” She stated,

I’m a regular joe now. I have my coffee, go to my volunteer work. I try to stay away from downtown. The furthest I try to go is (clinic). They help a lot there, they’ve got their harm reduction program, I get involved in that a lot. I’ve just started to see the addictions counsellor, and they’re going to be getting groups. So, my everyday thing is going to be pretty normal, and trying to stay clean. AC, 776- 794

Being clean, in the context of drugs, was something the participants aspired to, that had variable meaning, and that was understood to be a direction their lives should take. The goal was to be clean, in whatever form of reducing drug use that was acceptable to each woman. The women positioned the varying states of drug use against their interpretation of clean. The use of the term clean, in relation to quitting drug use, reflects their preferred cleanliness of a more or less drug-free life, and the ability to be liberated from their life associated with dirt (which was how the women described the drugs they used). Cleanliness was valorized while drug use was contrasted and measured against this ideal.

2. *Clean from disease.* The women spoke frequently about their health. Although most were concerned about BBVIs resulting from their drug use, their general health also belied their desire to be clean from disease. The experience of disease and illness was contrasted and absolved, for some, by making efforts to be clean, in a bodily manner. AJ stated,

I have major health issues right now. I have hep C, I have an eating disorder, my immune system is down, and I have blisters on my feet and everything, but I try, and I make sure I’m a very clean person. AJ, 942 - 944

The women were less direct regarding disease being associated with dirt and being dirty. Regardless, it was clear that hepatitis C and HIV were viewed as distasteful and, moreover, associated with activities such as using dirty needles and being deceived. They, in short, were seen as unclean. W was one of the women with hepatitis C and she explained,

I tell everyone I’m hep C. ... I tell them in case they catch it and they say, “Well you never told me you had it” or something. It’s dirty. W, 463- 466, 481-485

The women were continually at risk of contracting BBVIs for many reasons, including that the social environment of injection drug use meant that PWID did not always disclose their infection status to others. Even when the status was known the women remained at risk and feared becoming infected and thus dirty. As a general sentiment, therefore, the women in this study feared acquiring such infections, which they viewed as dirty:

And it really does scare me being around needles and stuff because you never know if you're going to reach into a drawer or something one day and get pricked by a dirty needle. AIDS scares the hell out of me. Hepatitis C as well. He's got hep, but I was lucky enough not to ever have contracted it. AD, 211- 215

As with AD, the women wished to stay "clean," meaning infection free, and used their knowledge to help prevent the acquisition of BBVIs. Unfortunately, others, who the women shared drugs or injecting equipment with, were not always forthcoming with information about their BBVIs or not careful to dispose of used equipment. The women were often shocked by the news that someone had let them use their injecting equipment or drugs without disclosing their hepatitis C or HIV status. AJ stated,

I've only shared a needle once in my life and unfortunately afterwards the girl told me "Oh by the way I have hep C and I have HIV" and I was "Oh you fucker," I was like so choked. I said, "Are you fricking kidding me?" She was like "no, no, no" so I went and got checked right away. I find out that I had hep C and avoided the HIV for some reason. God must have been on my side that day. AJ, 832- 839

It is evident that this participant was upset that she has been deceived and that her cleanliness was at risk. To allay her fears of infection, and thus of the association with dirtiness, she sought testing. She felt some relief and was thankful that she had only been infected by hep C and not HIV. The women were clearly wary of being betrayed by others who had the potential to be infected and passing the disease to them.

Further evidence of this distinction is found in a closer review of the health concerns women described. It seems that the women more readily sought care for generic or perhaps "mainstream" health conditions. These conditions would be those that women, in general, are subject to as health issues; for example, the women disclosed diabetes, stroke, cardiac

conditions, cancer, epilepsy, and osteoporosis. The cohort also described several musculoskeletal concerns including pain, fibromyalgia, and knee replacements. Other health conditions discussed were visual acuity changes, urinary tract infections, dental concerns, motor vehicle accidents, anaphylaxis, and cholelithiasis. The discussion of these conditions indicates that the women were aware of health issues, and that they were concerned enough to seek care and be diagnosed. Thus, one could conclude, they brought forward for examination what they saw as health issues not aligned with drug use.

Regarding preventative care, when WUID in the current cohort were asked about how they looked after their health, they cited being clean and taking showers, walking, taking multivitamins, and trying to rest and sleep. Doing testing for sexually transmitted and other blood borne infections, securing food, having pap tests and/or mammograms, seeing a dentist or doctor were also stated preventative care activities. It is noteworthy, in a discussion of what is colloquially known as a “clean bill of health,” that there was a trend toward looking after generic health issues that many women may acquire and less so with those related to drug use. Thus, the interviews provided evidence the women sought healthcare for these general conditions, while they seemed reticent to do so for any ailments that could have arisen from injection drug use. The women wanted to portray themselves, in their terms, as clean, rather than be identified as being dirty and defiled by drug use and the health consequences they incurred.

Sometimes, to avoid detection and identification as dirty, the participants sought peer assistance for treatment of abscesses rather than risk revealing their injection drug use to healthcare providers. AF pointed to a scar and described how her friend had lanced the abscess:

It's a friend of mine that ... cut my arm there and she squeezed it out and cleaned it all up and look, I only have a tiny little scar there. She did it pretty good. She had her boyfriend put pads under my arm and she was cleaning it and squeezing it, and she was pouring water as it was coming out, and she did it perfect!

AF, 245, 250-252

When asked which she would prefer for care between her friend and a hospital, she stated she would choose her friend. Not only was she pleased with the result of the procedure, but also, she

did not have to endure disdain or judgement from healthcare providers or others. Some of the other women described being called on by peers, who were in desperate states of health, for care:

I've taken bullets out of people; I've stitched them up. ... [Once] I heard a bang on my door, I opened my door, he falls in, he's all stabbed up, I fixed him up. They don't want to go to the hospital because then the police get involved, and then when the police get involved it's all this problem. It makes it more complicated.

AA, 572, 586-594

These examples provide insight into how they women ensured that what they considered their dirtiness was not exposed and examined. The women's statements indicate that they sought care where negative attitudes did not exist, where criminal charges would not be incurred, and where care and attention would be provided without the judgement of healthcare provider scrutiny. It seemed that conditions associated with drug use may have been considered dirty and aberrant, as they were acquired due to injection drug use and were thus best kept hidden. The pursuit of healthcare needs clearly aligned with the ability to be perceived as someone who did not use drugs, or alternately, to seek care where WUID were accepted as they are, without the experience of being judged and condemned.

Additionally, many women knew of the peer-administered naloxone program, but only a few had completed the training course to obtain a kit. WUID appeared to prefer their own remedies and sighted numerous approaches they would use to treat an overdose before using naloxone.

I just smack them across the face, talk to them, whatever it takes. ... I've pounded their heart, I've given them artificial respiration, I've thrown them in cold water, I've thrown hot water. There's so many, it just all depends on how far someone's gone, and then it all depends if they're taking an epileptic fit or a seizure at the same time. Anything is possible out there on the street. O, 107, 111-116

They viewed the kits as a clear indication to others that they used opiates and the women wished to avoid this attention, especially from police. As T stated about naloxone training, "I am thinking about doing it. I think I should, but the cops see that [kit], and you get labeled and I just got off all my charges. So that's the last thing I want to be carrying around" (219 - 227). They noted and avoided the too obvious sign that the naloxone kit indicated an unclean and drug-associated life

and also the unclean and abject potential to overdose. It seems that the healthcare-provided overdose kits created fear of recognition as a dirty and deviant WUID.

3. *Clean self (persona, hygiene)*. As part of their focus on cleanliness, several women described their need to shower and have laundered clothing. They perhaps wanted to present themselves as capable of maintaining personal hygiene, and thus as the idealized “clean” body. Illustrating this point and their desire to pass as what they considered a “normal” citizen, the women described their attempts to attend to personal hygiene and mode of dress:

Now that I’m living in the shelter, I take a shower every day... I try and make sure I’m a very clean person. I do my laundry, I make sure I have clean clothes. If you were to look at me you wouldn’t think, “Oh look, she’s a homeless drug addict.”
AJ, 939, 943 – 953

The outward cleanliness of their person can be understood as a reflection of their worth or, perhaps more accurately, a deflection of what they believed they were lacking. AJ’s statement indicates her perceptions that hygiene and wearing clean clothes meant she would not be identified as “a homeless drug addict.” The cleanliness camouflaged her unclean, displaced, drug addicted body, a disguise she intended and felt was important as part of moving about in society.

V, more specifically, noted her perceptions that being clean and groomed made a difference to how one was treated in a healthcare facility. She explained,

For example, if you go there and you’re all cleaned up in a nice suit and you’re all high class dressed and then you put somebody like me – who do you think they are gonna pick first? They’re gonna pick that suit before they put me in.
V, 378 – 401

V believed that those who are “cleaned up” and clothed in “suits” receive preferential treatment, while, conversely, for those who used drugs, there was going to be a longer waiting time for care.

However, the ideal of the clean self goes further. U, for example, spoke of earlier years when she was married, struggling to maintain her sobriety, and she had had a baby:

We had a son ... and then the true (me) started to come out. ... I was grieving for me, screwed up with this baby, I loved him so dearly. He was probably the cleanest baby in the world because I washed him with sterilized water for months.
U, 337- 338, 341-344

Because cleanliness was felt to be important, the value of being clean may have been imposed outwardly, through this child. Perhaps, as U became “dirtier” with her drug use, she compensated by cleansing the baby meticulously. Thus, while her own ideal clean self could not be maintained, she attempted to achieve this through mothering, by keeping her baby bathed and clean.

Also noted in the interview data was the knowledge that living outdoors compromised cleanliness. Creativity was used and enabled street living to accommodate personal cleanliness.

I hardly ever took a shower, hardly ever had a bath because I was living on the street, but what I would do is take a whore’s bath. ... You go into any gas station, whatever, you go into the bathroom, you take whatever you can, paper towels or whatever, and wash your body down. AE, 340- 344

This external cleanliness was also considered, by some, to be important for sex trade work.

Especially when you were hooking, trying to make that money, you gotta smell clean ... I mean people stank so bad that even the perfume wouldn’t keep them clean. I always carried soap in my pocket. I don’t care, if I had no soap, I’d go jump into somebody’s swimming pool and take a bath. AE, 350- 355

It would appear the women felt drug use devalued their general respectability in society. By being physically clean, both in body and attire, they were able to negate some of the despair they felt, and the disgust others directed toward them.

4. *Coming clean.* The last usage of the term clean, to be discussed in the context of this third theme, is that of “coming clean.” While to “come clean,” as in to tell the truth, is a common colloquial expression, it was often used by WUID to mean letting someone know they used injection drugs. This was a common sentiment expressed in the interviews, as exemplified below:

I don’t come clean with a lot of people, not even my doctor. I keep it aside because that’s my personal life. They say you should always tell you doctor everything, but no, because they look down on you. I hate to say it. My family too, they don’t know. ... It doesn’t matter how much a person loves you, they look differently at you. ... A lot of the time drug users don’t come clean because they can’t get the pills they need when they are in pain. E, 451 – 464, 478, 496-498

Maintaining the parallel life of a WUID and the appearance of a woman who does not use drugs was important for many of participants. In this context they were unable to come clean to others, including their family and healthcare providers, fearing their reactions and rejection.

In another context of coming clean, the women felt they were deceived by persons who did not come clean with them. T revealed an experience she had when she was asked to help another woman who was having difficulty injecting herself. As noted, it is taboo to initiate others into injecting drugs; however, the woman lied, stating she was a long-term WUID. Not knowing it was the woman's first-time injecting, T assisted, later recalling someone saying the woman was subsequently overdosing, as she could not tolerate the dose she had requested. T stated,

“Yo, I just sold to this girl, look at her colours,” and she fell and I'm like “Oh my god. She never did this [inject drugs] before.” I was so mad! I said to a passerby, “call 911” because I didn't want to do it. I was afraid I was going to jail. T, 529 - 536

From the interviews, several comments could be interpreted to mean that being deceitful to gain what one wants or what one wants to avoid is part of the culture derived from a need to survive. Recounting stories and not actually coming clean is thus an essential part of ensuring one gets what is needed; hence, the young woman did not come clean and tell the complete story of her difficulty injecting so someone would assist. As well, T did not come clean about being the person who had injected the woman and left someone else to call 911.

Another example of the usefulness of deceit to get what one needs is relayed by AK:

I've gone as far as to call up churches and stuff and tell them lies and get them like to bring me money, tell them “I've got kids, no food – can you help me out?” and it's horrible, the things I've done, the lies I've told to get money is really bad. It's survival, it really is survival. AK, 305- 316

AK, then, described how she would lie to obtain supplies (food, clothes, shelter). She did this, not with any malice or ill intent, but rather to assist with meeting the necessities of her own survival. Without recourse to sufficient income or the opportunity to work, AK had no apparent choice but to call on others for assistance.

Additionally, WUID were often reluctant to tell their healthcare providers about their drug use. Their words indicate they wanted to present themselves as drug use free or, if they endorsed drug use, it was to those who they felt were or would be non-judgemental and respectful of their choice to use drugs. AC stated,

I think they realize that a percentage of their clients are from the street, so they seem to be very helpful about stuff like that. They are very caring about it, even when the nurse is taking blood and she sees I've been injecting and missing, because that's trauma for my arm they'll give me some time for the swelling to go down and come back, give me a chance to stay clean for a while so they can take the blood from me. ... I told the doctor about it. I'm not worried about going back there if something arises again. But these places that deal with people that use ... are the best for anyone to go to for help. But the mainstream, I'd be too scared to [go]. AC, 831 – 844, 914 - 920

AC has found a healthcare facility where she feels safe to disclose her drug use. Mainstream healthcare, however, left her feeling frightened. Others avoided detection with healthcare providers by “skirt[ing] around” (AD, 597) their drug use. They reported using less stigmatized drugs or informed care providers they used their prescribed drugs orally. Most of the participants reported that they often did not often share with healthcare providers that they injected drugs. X described this:

I'd go to the doctor's and she'd ask me to bring my pills with me and I'd bring them, I had all my bottles. She didn't know I was injecting, and I had the same amount of pills I'm supposed to have. X, 341 – 344

Additionally, when asked about having her urine tested for drugs, X concurred the doctor did the required testing to be sure X was taking the medication and not diverting it (350-354). The tests were, of course, providing evidence of her use, but not whether she was taking the medication by the intended route. In the end, she did not fully 'come clean' with her prescribing provider.

When the women told healthcare providers about drug use, they were cautious. It was important to have a trusting relationship, often long-standing, with someone they felt would not be judgemental. J had known her healthcare providers for many years and had confided she used injection drugs:

He's actually been my doctor, we figured it out yesterday, 16 years. ... I've been seeing him since just before I contracted the hep C. ... There's no point in lying because they need to know. Especially if they don't know what's wrong.
J, 416, 420, 428- 430

More often, the women had negative experiences and reactions with being honest about their drug use with healthcare providers. Sometimes they were confronted with the knowledge of a

provider being aware of their intravenous drug use because they had a definitive condition secondary to injection drug use. When the women expressed that they had had poor healthcare experiences, there were common elements. They felt disrespected and cited instances of verbal abuse and blame.

Unfortunately, I find as soon I say that [I use drugs] ... they get a little different, they get a little insensitive ... just rude. They don't treat you like you are a sick person. [And you actually see them change?] It's instant. Drug addicts could be faking, "could they be hallucinating?" They always think you are off the charts or something, and they don't think you are really there. ... That's why I stay away from them. G, 332- 333, 341- 348, 356

V gave another example of how she envisioned the care she receives, as compared to others:

They don't help addicts, they just push you away. They don't care about you. If you say you're on the street they don't give two shits about you. It's how they treat you.
V, 380-384

Healthcare providers get "insensitive" and don't give "two shits." It would seem that these women are seen as "addicts" rather than as "sick persons" who also use injection drugs.

Clean places. Clean places are environments that are considered as being safe and free from disease and potential arrest. They were described as havens from the daily life of being dirty, often outside, and having nowhere to settle undisturbed and out of harms' way.

Clean environment. The women mentioned private homes and a safe injection site (SIS) as places they felt provided the advantage of a clean space. Being indoors may be the common element; however, not all indoor venues offered what was required. AC described what it was like to inject in a public bathroom: "I've done it in restaurant bathrooms or coffee shop bathrooms, and stuff like that. But, that's not good to do it in there because it's a public place" (AC, 511–515). One participant said, "If you go somewhere, like a house, somebody's apartment, you feel safe there because it's clean" (V, 308–309). Other spaces, such as an SIS, which provides a clean and protected environment to inject in, were also laudable. Q contrasted the environment of an SIS to injecting drugs in outdoor spaces. She stated,

If they had a safe injection site, it would be a lot better. We definitely need it ... If you're outside, you are taking a risk all the time. You don't have a cooker, you're

going to grab a bottle cap, and you are going to do it anyway. And it's not sanitary.
Q, 454–456, 461–464

Indeed, outside spaces were viewed as dirty by many of the women. V further explained,

If you do it outside, it's dirty, you have to use a puddle for your cleaning, for your water, you have to use dirty needles, old needles that you had, dirty stuff.
V, 311–312

These are notable examples of outside being associated with undesired injection use, risk, and dirt. In contrast, the women noted their preference for a clean indoor environment. N commented in response to a question about her thoughts on SISs:

That would be so nice, because sometimes we have to look for a place to go because we are so sick sometimes, we don't care where we are going, a good spot sometime would be nice. Where it's clean and everything. N, 487–491

Clearly, the women in this study valued being in the realm of a clean space for injecting drugs.

Having a clean place to live. Having a clean place to live was not expressed as clearly as the women's disdain for their current homelessness. However, they made it clear a home was associated with privacy, tidiness, and clean living, while being homeless was associated with chaos, dirt, and risk. Their hope was to have their own place, but they also acknowledged past experiences of having "a place" and the challenges that could bring. One woman contrasted her experience being housed with her current homelessness, bringing up what it meant to have a place (to be inside as a preferred space), and associating injecting outside with the potential for danger and arrest. X stated,

Being homeless is a bad thing. When I was living in (city) I was an everyday user, but I had my own home, I could do what I needed to do, I was safe, I was inside, I didn't have to be out. Now I'm homeless, I'm living out of (shelter). I don't do stuff by myself, I do it with my boyfriend. We got to find some place to go to do it, to start with, and before you know it the cops come around the corner, and whatever.
X, 91–100

This excerpt indicates a home is safe and allows freedom; it embraces clean living, while being homeless entails being observed as a deviant person and implies dirt and unlawfulness. U, who was also staying in a shelter, wished to clean up the physical environment in which she lived.

I stay in shelters. ... Some of them are not well kept and I don't understand why. ... When I'm there I don't mind fixing anything, "give me a paint brush," god damn it, "let's fix up the kitchen a little bit, let's put some Mactac up" because it's just all tearing apart, you see the wood rotting, "let's fix something ladies!" U, 43–48

U's conversation described her loathing of the rundown and dirty surroundings she experienced living in a shelter. Instead, she wished to have a clean space and to make it more "presentable," spruced up, and clean.

Many women spoke of their past experiences with having their own housing. R related how she kept her apartment clean, shampooing the carpets, and using commercial air fresheners. She was, however, disgusted with the cleaning habits of a woman she knew:

She is so dirty. She mentioned that the [cat] had a litter in her living room and I said, "Oh you must have put some blankets down," and she said, "No they did it right there on the carpet." Not only that, she's stayed there a year and she vacuumed three times. ... She's so dirty, there's been a pot of soil spilled over three months ago that's still there. She's got cat litter in the bathroom, just on the floor. It's a health hazard. R, 201–209, 214–224

R's disgust with filth and unhygienic practices is reflective of a preference for cleanliness and order. What is perceived as proper order and cleaning rituals is not supported by her friend and she found this abhorrent. W related that being clean was something she neglected when using intravenous drugs and listed this as a benefit of being on an opioid substitute. W stated,

You're taking care of yourself better, you're not out there chasing the drug every day or find the money to get it. ... You are able to take care of your everyday things, your doctors, your groceries, pay your bills, clean your house. W, 72–76

It was evident that the women were uncomfortable with unclean and disorganized living. A clean house was associated with being clean of drugs, enabling time and focus to be placed on doing "everyday things." Many women relayed the importance of a clean environment to live in and emphasized the importance of this cleanliness. In general, a clean house equated to being free of the hectic lifestyle drug use entails (i.e., the vicious circle). They also judged others who did not ascribe to being clean. Shelters and street living cannot provide the hygienic, safe surrounds that a place of one's own or another's can provide. They again expressed their desire to achieve clean and avoid dirty.

Clean drug use. This section describes how the women were aware of public health messaging around “clean equipment,” such as sterile equipment for injection, ensuring a clean person and environment (hygiene), and refraining from sharing drugs and equipment. The use of the term clean regarding injecting practices was most often about attempts to prevent infection.

Clean equipment. Most of the women reported being particular about using clean injection equipment, which they often obtained themselves or through others from a NEP. The women were consistent in their perception that the use of clean equipment was preferred and endorsed. For example, AF stated, “I use clean stuff. If he didn’t have it, I’d go get it” (451). AD was also intent on ensuring everyone around her using drugs had clean supplies: “Those boxes [of needles] came from the (shelter). They had the cookers, everything was clean. I’m pretty particular about that” (AD, 334–336). Many women were adamant they only used clean equipment with statements such as, “I’m always safe, I always use clean needles, I always have clean utensils” (AI, 55). AK further explained her understanding that having clean equipment was important to preventing illness:

And I think even for cleanliness purposes, not even about the sharing stuff, but just because it’s ideal when you’re injecting, to be as sterile as possible, as clean as possible, because then it reduces your chances of cotton fever. AK, 749–754

While the women consistently spoke of clean equipment as a “must have,” their conversations often evolved into stories of sharing and using equipment that they or others had injected with. While the women would often recount and endorsed mainstream public health messaging, they nevertheless described situations in which their actions betrayed this understanding. In other words, these women’s narratives contained a conflict between what they stated was ideal and preferable (not sharing) and their actual practices (which included sharing). O stated that it is not uncommon to reuse equipment:

At night we have nowhere to get needles, and no changes, and we don’t have nowhere to throw them, and you have to have a dirty one to get a clean one. ... And Javex, I don’t care what anybody says, Javex don’t clean that needle out. All of them are looking for a fix on the street, wherever we can find one is what we do. O, 30–49

O explained how having access to clean injection equipment led to alternate and, according to the underlying public health messaging that pervades this statement, less acceptable means of trying to use clean equipment (e.g., sterilization by means of bleach). Indeed, O suggested that while some people clean their needles with bleach, she did not endorse this practice and did not feel it actually adequately “cleaned” equipment. In the end, the dirtiness of the used needle persists. The women had received and tried to follow the recommended practices; however, their needs were, at times, more compelling than the need to have unused, sterile equipment.

In conclusion, the women reported and tried to adhere to the use of clean injection equipment as an ideal that is widely promoted and recognized to reduce the possibility of BBVI transmission. This practice can be disrupted, however, by the forceful need to use drugs, which overcomes the intention to use clean, unused equipment. The participants were clear on this point: although sterile (clean) equipment was seen as ideal, it was not always practical in real life when experiencing withdrawal symptoms, when there was no clean equipment on hand, or when there was a need to use quickly with whatever was available.

Clean skin. The participants felt that the blemishes, scars, and marks left on their skin were both unsightly and public evidence of injection drug use. Concealing that which is unclean is a large part of these women’s lives. They dressed in ways they believed belied their injection drug use, such as wearing clothing with long sleeves. The women also injected in parts of their bodies and places in the environment that kept drug use hidden. Thus, the women presented an exterior appearance that was clean and untarnished. AJ and U spoke of their external self-image and the importance of presenting themselves as women who do not inject drugs:

The way I’m dressed today, you would never know I am a homeless person, and you won’t know that I’m a drug addict. ... It’s summertime, I don’t want people to see track marks on my arms. I like wearing spring dresses. I like looking pretty. So, I shoot in the back of my legs, and I shoot in my toes where nobody can see.

AJ, 582–563, 905–913

I believe most people won't think I am an IV drug user, by looking at me or by talking to me, unless I show my arms. ... It's little secrets I have, because I figure, if I look okay on the outside you don't know how screwed I am on the inside.

U, 71–72, 167–169

Camouflaged as people who do not use drugs, the women felt they were able to go unnoticed amongst others on the street, in waiting rooms, in shops, and in other places that do not focus on drug-related activities. The clandestine lifestyle is, in part, related to trust, based on responses of others to their injection drug use, and also their desire to live, or at least portray, a “normal” life. As clearly noted, the women wanted a clean exterior to mask what they felt was a “screwed” up interior. In other words, the goal was to have a pristine appearance to belie underlying dirt.

As well, the women injected in areas of their body that are not easily observed. This practice again gives their skin the appearance of being clean and free from traces of injection drug use. The goal was to hide this practice, and to produce an illusion of so-called cleanliness.

I'm a functioning addict, I can fit in and nobody would know if I was high or not. ... I don't poke things in my arms. ... [It's] very hidden ... you'd never know.

AA, 490–492, 724, 738, 744

AI, likewise, described how she seeks to conceal her drug use, and her desire to do so. She also described an important belief that this concealment is only possible for the uninitiated. Those who inject drugs can see what she thought were telltale signs, notwithstanding the person's efforts to mask and clean away these signs. She stated,

It's very visible, it's very apparent, you can kind of tell from a person's lifestyle, what's going on with them. We all try to not be as noticed as we possibly can be, but at the same time, it's very apparent, to people who know telltale signs, what's going on. And, I already have enough things, like self-conscious things about myself, that I would rather not be walking down the street and have track marks on my arms, scabs from that or bruises because it just makes it that much more unpleasant, the fact that I have to put a sweater on, every day outside in the hot sun at 23 degrees. I can be myself as much as I can be myself knowing that I'm kind of not. AI, 193–208

The WUID in this study described going to great lengths to avoid track mark and other evidence of their injection drug use. This helps them feel they can go unnoticed as WUID. As AI stated, though, “I can be myself knowing that I'm kind of not.” The manner in which the women live,

indicates a double life which means continually negotiating two worlds, and attempting to mask the practices that others see as unclean. Figuratively and literally walking into and out of the two cultures means being vigilant to knowing when and where they can be WUID without worrying about the “telltale signs” that reveal their drug use in an environment where this practice is not accepted. Having a clean appearance allows them to move more freely within the two cultures and enables them to “pass” as clean bodies.

Additionally, the women spoke of cleaning and caring for their skin at the site they were choosing to inject. This cleaning was most often discussed as using an alcohol swab, part of the equipment distributed by NEPs, prior to injecting. They felt this practice would prevent infection, which was undeniable evidence of injecting drugs. Track marks and infections that left scars and blemishes were regarded as unsightly and further signified intravenous drug use to others. It was the dirt one could not wash off. One woman indicated that “being a drug addict, and especially intravenous, you have the evidence that makes life almost impossible” (J, 224–226).

J was particular about preventing infection: “I am extremely clean, and I get afraid of all these skin diseases. I disinfect and clean it and cover it right away. I’m really conscious about this” (J, 386–389). AF stated as well, “I have a couple of other marks that you can’t see, because I do it clean, really cleanly for myself” (AF, 447). Clean skin, then, is seen as paramount to avoiding the marks and blemishes of injection drug use, and a primary consideration amongst these women. AI clearly demonstrated the importance of cleanliness while injecting, as well as choosing a discrete place on her body to inject. Thus, she was able to prevent telltale marks on her skin:

I’m, “dude, you know you’re hitting up your veins like fucking 25 or 20 times a day,” like I do mine, it’s a one-stop shop, I get it all the time, I never miss. I take care of it, it’s clean and nobody sees it. AI, 783–785

Others, such as AC, in her discussion, talked about the importance of cleansing with alcohol swabs and the frustration of needing to use so urgently that this safeguard is neglected.

Knowledge and the enactment of the knowledge are on two different levels of intention:

I can't use the back veins at all because they were infected. I had one of the strongest antibiotics to take down the swelling and everything. And that was from not using alcohol swabs, and then not being able to hit, and not washing the needle after every time I tried, having dried blood on it, and stuff like that. I wasn't thinking, you can't think clearly when you're high and you just want to get that in. ... I did have alcohol swabs, but I just had to get that hit in me. AC, 369–385

WUID appear to have internalized the message to clean their injection site by using alcohol swabs to prevent infections. However, as AC described, their actions may betray their intention as many reported having abscesses and cellulitis. Again, the discrepancy between knowledge and action was clear. V also bemoaned the changes in her skin which she related to injecting for many years:

It's not fun. It gives you track marks. I used to have beautiful arms and now my arms are so full of track marks, and my legs are full of track marks and my feet.
V, 200–201

Thus, the women reported and strove to maintain unblemished skin by cleaning with alcohol swabs prior to injecting. However due to circumstances, perhaps when they were dope sick or outside without the full complement of injection equipment, their resolve to do as public health has instructed faltered. Once again, the portrayal of cleanliness is deemed to be significant by WUID and, and they noted their disappointment with being scarred and marked.

Sharing equipment and drugs. As noted, the use of the term clean, in relation to injecting practice, was often about attempts to prevent infection and thus to strive for an appearance that was clean. A further means to prevent infection was the women's judgement of cleanliness of other PWID, in terms of their ability to share equipment and avoid contracting an infection. To address this, some women carried extra equipment for others to prevent them from sharing. In this way, they were able to provide a clean needle to others, rather than having them reuse or share. Q specified what she felt her role was in preventing such sharing and reusing of equipment:

I carry needles, clean needles, clean pipes for everybody all the time, as much as I can. And all the clients down there or wherever, they're like "(Q) got a pipe? (Q) got a needle? A cooker?" I've got them trained. Saves a lot of dirt. Saves a lot of disease from going around. Q, 437–449

As is evident in this quote, Q was aware of the need for others to have immediate access to clean injection equipment. That the women knew and asked for her indicates an intention to use clean.

Q felt she had prevented “a lot of disease” and “dirt” by the use of clean equipment. She saw this accomplishment as valiant because she had provided clean gear and saved the women from so-called contamination. T detailed her own practice of giving “fresh stuff” in these words:

I always use my own and if people are with me, I'll give them fresh stuff and if they want my wash, they can have it, but they're not using my needle or nothing.

T, 463–464

There is also a line drawn between what is clean and what is dirty. The wash is open to all, while the needle itself is not considered clean enough to share. Thus, clean includes unused injection equipment and washes, while a used needle is dirty, and not acceptable to share. In contrast, using medicalized standards, all used equipment is contaminated and dirty (i.e., not sterile), but it is evident the women see this differently. AK concurred that drugs were shared, and as above, mostly in the form of the leftover drug residue in the equipment used to heat and mix the drug (the wash). She also, however, endorsed sharing needles:

If you are really sick, and you don't have another needle ... for sure, because that sickness is the most horrible feeling. You feel like you are dying. AK, 244–249

Thus, while the women cited public health messaging about infection control and prevention which were known and implemented whenever possible, the messaging at times seemed to be simply recited. Withdrawal could overpower this knowledge, compelling drug and equipment sharing.

Contracting hepatitis C by sharing and using the others' drug equipment was endorsed by several women. Furthermore, Y, who was HIV positive, spoke of judging the risk of acquiring a BBVI by assessing how clean the other person appeared to be. One might assume the cleaner in appearance, the less likely they were thought to have one of such infections. However, this premise also included those who had a positive BBVI and, in actuality, it was wholly non-predictive of their likelihood of viral transmission:

I've done somebody else's wash. You ask them, “You gotta a wash just to help me through?” Yeah, I've done that. But that's all you want to do, like if the other person is HIV, and they are pretty clean, then I do, I have. ... I don't share my wash, but if I know they are HIV then it's different, but if they are not, I tell people I'm HIV. But I'm pretty good, I'm pretty responsible with that. Y, 454- 459, 465– 468

Y then has limits and rules around who she will share with. When the person is “clean” (in appearance and extrapolated to mean in relation to viral infections and transmission), there is no need to consider whether they have a BBVI. Moreover, from what Y stated, she tells others she is HIV positive, but what is not said is whether she would give her wash, or not, to another person, or whether she would let them decide after having stated her HIV status.

The women felt used needles were both undesirable and dirty, yet some maintained the belief that sharing was safe if the needle was cleaned. G affirmed she had shared but felt she had done so carefully because she had cleaned the equipment. What the women believed was that it was important not to share used equipment or drugs. However, their attempts to follow public health recommendations regarding sterility were foiled by the need to quell strong feelings of being unwell caused by withdrawal, along with an understanding of the efficacy of cleaning practices and what constituted a low risk of infection when sharing. Thus, these women strove for cleanliness, but were often swayed to use dirty to alleviate cravings and sickness.

Unclean drugs. Lastly, the practice of using unclean drugs arose during the interviews in three ways. First, the drug was physically dirty and not appealing. Second, the drug was dirty due to misrepresentation (the drug was sold as desired drug but contained another substance). Third, the correct drug was obtained but in an incorrect quantity (less than negotiated).

To illustrate, a physically dirty drug is just that, dirty. The participants talked about their drugs in literal terms of being dirty and filthy. D described how the dirtiness of the water and, subsequently, the filter had disturbed her. She stated,

I inject, and I am thinking, “What am I thinking?” Some of the crack they cook in dirty water. I notice, why is that filter dirty black? I’m injecting that? I must be crazy. I’m thinking I’m not doing it no more, I have had enough. No more. D, 253–255

This lack of cleanliness associated with the drug itself is not appealing to WUID. The thought of dirt entering their bloodstream, it seems, is enough for some women to reconsider injecting drugs.

Secondly, drugs were also described as “not clean” if they were misrepresented or altered for another’s advantage. These “dirty” drugs were described as a nuisance, but could potentially,

in some cases, have had unintended fatal consequences. The women indicated they used dealers they trusted to minimize the risk of receiving bad drugs. As N stated, “I get a supply from the same guy I see all the time. It’s the same person, so I know it’s not tainted with anything” (533-540). However, there were others who had been misled by dealers, and what they had expected had been switched for another drug. P had this experience:

I have gotten hydromorphone, which are capsules with beads in them, that had Effexor in them, and I felt like I was going to die. I was so sick, and on top of being dope sick, I injected that, and ... I just felt like I was going to die. P, 517–525

R, AH, and AI spoke of tainted cocaine. Being “unclean” in this context meant the drug was altered with other various substances. AF revealed her arm and said, “There is some stuff that had crystal meth in it and that’s how I got all this there. Scars, see. It’s awful eh? It won’t go away” (541- 545). Moreover, R had, herself, contributed to the distribution of bad drugs:

I never felt right about that, but the crack was so bad I had to give it away. There was a time that there was diesel in the powder. I couldn’t smoke it, so I gave it to this pregnant woman. She was using anyway. R, 606–610

For these women, impure drugs were seen as polluted and offensive, with the term “clean” signifying that the drug was exclusively what it was supposed to be. Dirty, in this context, thus meant that it had been diluted or mixed with another substance, making it less pure. J and U had similarly received drugs with differences between what they had expected and received when their partners helped them inject. As a consequence, J had difficulty trusting her boyfriend to inject her. She relayed, “Sometimes he is stupid and gets too high and he doesn’t realize what he’s doing, and I watch my drugs like a hawk. What is he putting in there?” (J, 339 – 342).

Thirdly, the amount of drug could be in question. As described earlier, W was very careful to let people know she knew “what a gram is” (W, 871) in order to avoid shortfalls in what she was paying for. U similarly indicated even her partner was not trustworthy:

He’s a greedy addict. You’ve gotta pill and instead of splitting it, he only gives me a little bit, “You fucking son of a bitch, I paid for it.” [He would say] “I need it more than you, or I’m going to be sick.” I’m so sick of hearing this for 18 years.

U, 749–753

Furthermore, the woman had faced other challenges with unclean drugs. When asking others to help them inject they needed to take care as the syringes could be switched and they could potentially be injected with a placebo, water, or less potent drug. K stated,

There's a lot of sneaky people out there, they like to trade syringes. On purpose. They want the drugs that are in the other person's needle and stuff like that. ... They switch syringes. K, 332–336, 341

The women who had experienced switching did not speak as though they were surprised, and rather, expressed that it was their responsibility to expect and observe what was occurring.

The rules of clean drugs appear to be always in play. The expectation of fairness, then, can be assumed to not be a value that is upheld in the culture of WUID. To further illustrate this situation, S detailed an experience she had: “Yesterday I paid, and they didn't give me the dope” (S,191). When asked what eventuated she stated, “Nothing, I came back here” (S,199).

Summary

In summary, the three types of data collection (artifact, participant observation, and interviews) have been reviewed and braided to illustrate the lives of WUID.

Certainly, some of the artifacts revealed a bias toward remembering death by overdose and the issue of premature and frequent mortality life as a WUID brings. The artifact photographs provided information about the culture of WUID by identifying what they considered to relate to health. There is a notable contrast between images, which seem to depict activities promoting health (NEP equipment, clinics, food types) and that which is seen as unhealthy (used equipment, consequences of injecting such as skin marks and damage, death, and separation from society as a whole). This contrast is seen throughout the artifact collection, which includes such items as handmade paper flowers, prepared by the women, which are colorful and bright but created to play a part in the darker memorial events.

The injection equipment and peer-administered naloxone kits, while being articles that assist WUID to stay alive and well, at least in a public health sense, can be understood as further

proof of an “us versus them” divide, with one world being sterile and clean and the other based on the practicalities and necessities of drug addiction within a hostile society.

Secondly, participant observation enabled insight into interactions with healthcare providers and gave further testament to the lives of WUID. While healthcare providers appeared to welcome and integrate WUID into the healthcare-related interaction, further consideration and analysis indicated that the women were still segregated, and a sense of “us and them” pervaded. While many healthcare providers assisted the women to feel accepted and respected, gave of themselves, and negotiated health and wellness options for the women, it was clear elsewhere that barriers existed both the physically and metaphorically.

Observing WUID in a recreational or social setting enabled further understanding of the everydayness of their lives. To enable a reprieve from the street, WUID were encouraged to attend programs that fed and clothed them and offered them activities and items to take away. Even in the most accepting and tailored environments, WUID remain separated from others. They are seemingly excluded from mainstream programming while being encouraged to attend other activities promoted for WUID. Overall, WUID were structurally challenged to be included in society. There were many barriers, both seen and unseen, that did not allow the gap between WUID and others to be closed. As Haritavorn states, “The environments involving patterns of injecting behaviour, combined with the social meanings dictating how women should behave have become the harm that women face in their everyday lives” (2014, p. 117). The third area of study, the interviews, also underwent thematic analysis, which assisted with a further understanding of the culture of WUID.

The three themes that have been discussed are (a) an archetypical day, (b) negotiating survival, and (c) valorizing the ideal of being clean. First, discussion of an archetypical day involved the central concept of a vicious circle, which pervaded the descriptions of the women’s existence as they pursued and used intravenous drugs. This repeated struggle to manage each day and the challenges it held was punctuated by moments of reprieve when interacting with

social and recreational activities, mostly organized by those who invited the women to participate. The everyday quest to pursue and use drugs involved the details the women provided regarding how capital was obtained and the actual injection of drugs. The vicious cycle of using and not using drugs emerged as a pattern for many participants. Certainly, living this vicious circle included descriptions of their daily lives (related to waking up, seeking and using drugs, and repeating), but also extended to attempts to quit drugs. This task-orientated detail clearly illustrates the required and demanding steps which involve interactions with others both inside and outside a community of people who use drugs. While the women need to trust others, these relationships were based on caution and the prerequisite primary need to look after oneself. Instinctual and learned survival skills are required to negotiate the dangers and risks incurred while obtaining and injecting drugs. Each day, then, generally begins with the repetitive prospect of surviving the elements, finding the means to use drugs, and using drugs to cope with past trauma and current needs. Additionally, the women participated in recreational activities, and some were women specific. Interestingly, the women attended programs that were not serving the general public, but WUID. This artificial yet compelling exclusion to some groups and activities further separates WUID from the mainstream culture. Although the programs are an important contribution to the lives of WUID, they may also perpetuate the isolation of their community.

A typical day for this group of WUID was generally busy and necessitated getting what they needed and doing “what you gotta do” (AE, 140; H, 434). The knowledge, planning, and skills shown by this group of women belies the common understanding of a life filled with chaos and careless, impulsive decisions. Instead, clearly illustrated, is a culture of calculated, careful, and deliberately planned life of sustainability. As well, there are clear norms of behaviour that the women strive to maintain. However, the ongoing and never-ending pursuit of personal space and safety, drug supplies, and basic needs is an exhausting and relentless activity.

An archetypical day for WUID entails a cycle of working for, buying, and using drugs. WUID have a variety of creative and sustainable means of supplementing or obtaining capital;

however, these are sometimes dangerous, may be illegal, and thus can result in grave consequences. Moreover, interactions with family, intimate partners, the public, people who sell drugs, the police and legal system, and other PWID may also pose risk. Juxtaposed with this risk, however, their day can be interspersed with recreational activities for PWID and volunteer work in communities of PWID. In contrast to what may be commonly believed, the actions of WUID are neither chaotic nor threatening to others. The women strive to manage their day, stay positive, and negotiate safety. A different way of life appears to be challenging and, without structural and societal changes for the women to alter their lifestyle, perhaps an unattainable goal. To this end, more must be said about the experiences WUID survive and how they maintain their hope to live and become something other than a WUID.

Second, violence permeates the lives of WUID and underpins their culture – that is, the culture requires cautious trust, an acceptance that the actions of others require an understanding of the needs of others to survive, “honour amongst thieves,” (AK) and the primary need for their own self-preservation. The women have experienced the continuum of violent acts throughout their lives, and these shape the very basis of their perceptions and beliefs. From childhood, the women grew and adapted to their environment and circumstances, creating, in part, their culture. WUID have been threatened with guns and knives, beaten, and choked, illustrating a life of ongoing abuse, whereby one can never be sure when one’s life may next be threatened, nor what circumstance or actions will enact such wrath. Also, it seems they must learn to accept this danger. For example, sex work is dangerous, difficult to leave, and compelling because it helps maintain the vicious circle of drug use. Sex work can be a lucrative and simplistic, in many ways, means to generate the resources to procure drugs. Street-level sex work is nevertheless dangerous and without protection and safety. The women, however, in a measure of risk versus benefit, continue to find street-level sex work an acceptable means to an end, that being drugs. Additionally, without confidence in the protection offered by the law and its officers to assist with basic human rights, the women were vulnerable and further at risk of being prey to others. This

social injustice further estranged WUID from seeking the recourse to justice they, as all people, are entitled to.

Furthermore, the cohort had numerous experiences of healthcare that resulted in them feeling shunned and ashamed because of the social violence they suffered from healthcare providers. It seemed that conditions associated with injection drug use may have been considered dirty and aberrant and were thus best kept hidden. The pursuit of healthcare needs by WUID clearly aligned with their ability to be perceived as someone who does not use drugs, or alternately, to seek care where they were accepted as they were, without judgement or condemnation. The experience of judgemental healthcare served to further isolate WUID from services and providers who could be assistive, and instead widened the gap between illness and health. The violence, whether physical, verbal, sexual, or structural all culminate in depriving WUID of the respect and dignity they deserve. To continue each day in this environment, the women required hope and resilience. The need to preserve one's life from the onslaught of systemic, personal, and witnessed trauma required self-reliance and astute vigilance.

This theme of violence shows something of the women's daily lives and what it takes for them to survive. Their existence depends on others, but is fraught with violence, misdeeds, and a mistrust of most people they interact with. Indeed, violence is central to their lives. However, despite this turbulence, these women persevere and continue to live. They demonstrate great strength and determination as, against many odds, they persist in a world that is not only indifferent but also negative toward them, and which seems to want to efface them. Indeed, the culture of WUID entails daily danger and threats to life and well-being. The women experience pervasive violence and ongoing and consistent abuse. Their existence is at risk from a number of sources and there is little recourse other than to protect themselves, trust no one completely, build resilience and strength, and sustain hope that things will improve. The culture also involves activities and behaviours that have developed to ensure their lives are sustained. The women

battle these destructive influences with, as AJ stated, dreams of leaving the cocoon and becoming a butterfly – free of demons and addictions.

Third, the insular existence of WUID demands camouflage and attempts to attain both personal and environmental cleanliness. This section illustrated the culture of WUID and how the women attempted to present themselves as clean of drug use and in health, and how their interactions with others were often considered better by not “coming clean.” Not coming clean may be a learned response from a need to survive by whatever means are necessary, and from the experience of abjection verbalized by others which subsequently encouraged secrecy. WUID find being clean can assist with negotiating the world, but also with feeling better about themselves. A discussion of cleanliness and dirt featured predominantly in the women’s discussions. Hygiene, dress, and additionally drugs and the associated equipment help to illustrate the valour of cleanliness, whereas dirt, disarray, and deceit are seen as exemplifying what is believed about WUID and the need to be deflected. Firstly, attention to personal appearance through maintaining clean self and attire was integral to assisting the women in moving seamlessly within the everyday life of the society in which they lived.

Secondly, getting what one wants is critical to the ongoing pursuit of survival and the avoidance of withdrawal symptoms. For the most, it is important to appreciate that each person is concerned for their own needs above others as a necessary consideration of survival. Drugs can be contaminated with fillers, switched for less desired and costly drugs, and stolen from someone one has offered to assist. It is also essential to understand, however, these behaviours are not considered criminal or evil, but rather as a means to an end. The behaviour is expected, accepted, and understood – albeit not welcomed.

Thirdly, the women reported and tried to adhere to the use of clean injection equipment as an ideal that is widely promoted and acknowledged to reduce the possibility of BBVI transmission. This practice can be disrupted, however, by the compelling need to use drugs, which overcomes the intention to use clean, unused equipment. The participants were clear on

this point: while sterile (clean) equipment was seen as ideal, it was not always practical in real life when faced with withdrawal symptoms, no clean equipment on hand, or a need to use quickly with whatever was available. Their attempts to follow public health recommendations regarding sterility were foiled by the need to quell strong feelings of being unwell caused by withdrawal, along with an understanding of the efficacy of cleaning practices and what constituted a low risk of infection when sharing. Thus, these women strove for cleanliness, but were often swayed to use dirty to alleviate cravings and sickness.

This attempt to appear to live clean in the midst of what is considered, by some, as dirtiness is something WUID recognize in themselves, and they attempt to foil the appearance of the latter. Being clean, and concealing evidence of injection drug use, when being dirt-free was neither achievable nor fully possible, was aspired to. The women endeavoured to blend in with what they considered to be sought-after values, created through the hegemony which constructs, and subtly commands, social behaviour. Cleanliness, and clean living free of drugs, as an example, were central to the women's thinking and actions, and were identified as a key attribute of the culture of WUID.

The associated behaviours of being clean, as described in this study, were at least in part the cultural norms which WUID employed to exist within a larger environment of disgust and distaste for their lifestyle. They consistently described evidence of cleaning themselves, their environment, and their drug use practices. The women actively pursued a state of cleanliness by laundering, bathing, cleaning their surroundings, and using sterile needle exchange equipment. These activities were apparently pursued to enable them to be viewed as a person who valued and incorporated cleanliness into their lifestyle. By extension, this external cleanliness was held to be a false representation of an otherwise "unclean" body and lifestyle, secondary to injection drug use. The activity of becoming clean encompassed being physically dirt free, as well as chemically clean from drugs. However, the goal of being a clean person, while pursued, seemed

to evade full attainment. As the interviews progressed, the WUID conceded that they reused drug injection equipment, relapsed into drug use, and made derogatory comments about themselves.

Additionally, the women further altered their identity as WUID by concealing their drug use from others who they considered would see this aspect of their persona as unacceptable. The women spoke of the means they used to keep their drug use secret, that is, by hiding the physical evidence, and also by verbally denying or avoiding suggestion of their lifestyle with others who may be judgemental. To avoid the stigma of being considered less worthy, dirty, and disgusting, the women in this study reported not disclosing their drug use, especially by the injection route, unless they were confident a healthcare provider or other would not judge them or consider them as less deserving of respect.

No matter how they attempted to make themselves be or appear clean, these women continued to believe they were inherently flawed and dirt-ridden due to their drug use. As such, the women seemed to be on a continuum that at one end was situated in self-contempt and squalor and at the other a valorized ideal of cleanliness and purity.

The concept of clean pervaded the interviews, and while the participants used the term clean in many ways, underlying their usages was an overall desire for cleanliness. Clean was the preferred state, and sanitization was valued, as it helped create access to a society the WUID did not feel part of. The world of “suits,” (V) and people with cars, homes, routines, and jobs was known, yet largely foreign. Their attempts to be clean included actions to remove dirt, marks, and stains from their bodies, environments, and equipment, while being wary of the deceit and dirtiness of others who used drugs and, lastly, avoiding any disclosure of drug use. When cleanliness could not be obtained, the women covered and concealed evidence of this practice. The WUID, then, sought after clean as a marker of normalcy and virtue on a continuum of clean to dirty.

In summary, by braiding together the findings associated with the artifacts, participant observation, and interviews, the culture of WUID was found to be one of surviving risk and danger

in a world of, from the broader society's perspective, filth that evolves from the illicit use of drugs. To live as WUID, it is paramount to develop mores that are self-protective, and assist with maintaining their clandestine needs and, paradoxically, outward appearances upholding the hegemony of the broader society in which they are situated, yet which simultaneously seeks to efface their existence. To minimize the consequences of an illicit life requires a furtive existence which entails concealment of self while accomplishing what is required to maintain one's needs. Thus, the culture of WUID involves living in the midst of two worlds and negotiating survival in both, when both are inherently violent toward these women.

Chapter Six: Discussion, Limitations, and Recommendations

The following chapter will provide further discussion of the findings with reference to the writings provided by Foucault, Deleuze and Guattari, and Kristeva. The findings also align with Goffman's *Stigma* (1963) and *The Presentation of Self in Everyday Life* (1959), reinforcing the utility and importance of his work. However, the work of the others helps better explain the findings and discussion generated here. This discussion proceeds with attention to (a) the paradoxical clean/dirty continuum, (b) abjection, (c) risk, (d) governmentality and (e) resistance. The opportunity to reflect on the research process is discussed in the reflexivity section, prior to a review of the limitations of the study. Finally, the concluding recommendations, which have been derived from the knowledge garnered from the women who participated on this study, are outlined.

Discussion

Ethnography can allow voices to be heard in naturalistic settings to provide a depth of understanding that is not possible through quantitative approaches. By observing WUID and the objects and others they interact with, together with formal and informal interviews, three themes emerged. The first was that an archetypical day illustrates a difficult life in a community that revolves around unrelentingly activities related to drug use. Second, interactions with others were predominantly cautious, and a lack of trusting others ensured the women learned early to care and rely exclusively on themselves for survival. These women nonetheless believed their lives could be and would be different. Third, founded on an abject life, rejection, and intense monitoring, their attempts to be clean (i.e., to pass as someone who does not use drugs, to become cleansed of both drugs and violence) was common. In short, disgust of self and by others perpetuated a desire to pursue a clean and "normal" life.

Such findings are important because, while the extant literature provides an understanding of people who use intravenous drugs (PWID), there is more to know, especially in the geographic context of an urban Canadian setting with a focus on WUID. Within the available literature, WUID have often been studied from the perspective of having HIV or being at risk of HIV acquisition. Their lives, preferences, and experiences were often ignored, in favour of understanding the women as vectors of HIV transmission. The current literature, moreover, subsumes women within studies involving men, leading to the norms of the men and women who inject drugs to be indiscriminately clustered into an amorphous whole. For these reasons, this study was initiated, and the findings further examined.

Certain phrases are repeated in the available literature, such as “being second on the needle” (Csete & CHLN, 2006) or initiated into intravenous drug use by a man who is often the sexual partner of a WUID (Hser, Anglin, & McGlothlin, 1987), yet these findings were not strongly identified in the current study. Perhaps geographic or regional differences, or an evolving epoch related to women’s rights and independence have led to these changes. For whatever reasons, the women of this study did not predominantly endorse some of the practices that have been accepted as the way WUID are and what they do. This discussion will continue to cogitate what is known and accepted about WUID and assist with rethinking what is complacently known and held as true by “exposing the foundations that underpin the apparent truth-value of a certain concept or idea” (Holmes, Murray, et al., 2006, p. 182). These finding of an archetypical day, negotiating survival, and the binary struggle of striving to be clean and living dirty, consequently, raise a few points for discussion, specifically about (a) the paradoxical clean/dirty continuum, (b) abjection, (c) risk and (d) governmentality and (e) resistance. The discussion will address how power/knowledge and discourse produce, stratify, and other WUID. Compounding these aspects of the lives of WUID is the structural violence of stigma, which gives rise to resistance. The discussion thus addresses how WUID live between two worlds, under constant observation, considered by themselves and others to be abject, and how these circumstances create risk.

Together the listed concepts ultimately describe the subculture of WUID in a Canadian urban centre and further illustrate the vicious circle around which their lives revolve.

Clean and dirty. During the study, it was evident that the women used the words clean and dirty often, and in different contexts. These words denoted their beliefs about their own lives and circumstances and drug use as “dirty” and contrasted with their aspirations to be “clean.” WUID bridge that dichotomy by endeavouring to make several aspects of their lives clean. This binary relationship is an assemblage of clean and dirty and comes together to represent the two spheres, or stratifications, of clean and dirty, others and drug users, straight and “substance abuser.” It is a melding of two states that appear diametrically opposed, but which are quite interrelated.

Little has been said in the extant literature about cleanliness regarding WUID. Sheard and Tompkins (2008) and Malins, Fitzgerald, and Threadgold (2006) did note some references to cleanliness in their study, as did, however briefly, Gelberg et al. (2004), Taylor (1993), and Rosenbaum (1981). In their collective works, they spoke primarily of the women preferring clean injection equipment and desiring to have unmarked skin and clean homes. Like the women in the current study, the use of dirty equipment was considered as undesirable. Unmarked skin was important to self-presentation as one who did not inject drugs, and cleanliness was seen as a quality that exemplified a normal life illustrated by a clean home and self.

Deleuze and Guattari’s (2000) work can help explain these findings. Indeed, from the perspective of these authors, WUID and the utilization of needle exchange program (NEP) equipment are part of the striated space of injection practices. When using the harm reduction resources of public health and other agencies, the unspoken message is that use of the sterile equipment will make the lives of WUID better and also, these actions will save their lives. Even though WUID are permitted, even encouraged, by harm reduction services to engage this stratum of healthcare, they are to remain aloof, anonymous, and counted. Thus, WUID remain as other, on a separate stratum. Moreover, if WUID do not accept the expectation of the public health norms

of a drug-using body, that is to use clean equipment, they become out of place or improper in the striated space of others who are considered clean and respectable, and instead are regarded as improper, out of place, and looked down on (Ettorre, 2004). Thus, the drug-using body is allowed in, but only on the terms stated by another, which in this case is the healthcare provider. In other words, those who are dirty (WUID seeking healthcare) may enter into clean spaces (healthcare settings), if the norms of the clean space are maintained. This is an example of a Deleuze-Guattarian fold, wherein WUID interpret the rules and actions of another (the healthcare provider) and internalize them to act appropriately as they are simultaneously interpreted as a drug-using body, tolerated, and even invited, but on set terms that must be recognized and followed.

Being seen as clean, from the outside, was important to the participants. As noted above, they hoped to disguise their drug use from others (Malins et al., 2006), which, for some, entailed the cleanliness of hygiene and dress, whereas for others it manifested through behaviours and was validated by others' comments. Cleanliness, in this circumstance, exemplifies Deleuze and Guattari's fold. The women mask their inside to meet expectations of the outside, folding perceived mainstream society values into themselves. Thus, that which is outside the self becomes the inside of the self as part of being projected back to the outside world. Not only is personal hygiene of concern, but also the use of clean injection equipment (using a NEP, not sharing), ensuring the environment is clean (working as a needle hunter, using a biohazard container) are also part of the schemata. These activities and behaviours assist with presenting WUID as clean and attending to body boundaries and environmental hygiene. WUID take what they perceive as social beliefs about cleanliness and internalize them, also enacting them so that their inside and outside align with the expectations of others (outside). Masking their inside and outside with the outside they perceive is projected by others enables them the ability to move amongst those outside their community of PWID.

The woman who injects drugs, however, remains as other by violating established social stratifications to be "productive," that is be a mother, seek education, be employed, and not

engage in illicit activities. In using drugs, WUID de-stratify themselves, and are seen as other. Healthcare providers, through NEPs for example, then attempt to re-stratify these women – at least in part – by having them use sterile equipment and by having them engage in safer injection techniques in acceptable geographic locations. The WUID who refuse this are further marginalized.

It seems that clean and dirty divide the two worlds of those who use drugs and those who do not. The women see the mainstream world as orderly and clean, and the discourse also supports this assumption, as they try to emulate such behaviours and appearances. WUID try to (a) “pass” as clean, and thus try to be clean and to not be uncovered, and (b) demonstrate to themselves that they are not the abject othered WUID body. Additionally, the custom of keeping the drug world and self equally clean was evident in these women’s reported attempts to bathe, launder their clothes, do their hair, and keep a tidy house. The stratification as drug using women entails folds and a line of flight as women aspire to, and strive to, achieve what they perceive as a normal life by internalizing and representing clean and distancing themselves from dirty.

Being clean is considered part of respectability (Malins et al., 2006). The WUID in the current study also indicated that cleanliness (related to injecting) was an important moral indicator. There is an association with “being good” aligned with “using clean.” The women spoke of always using clean injection equipment as an important element of their life and expected behaviour. They had clearly internalized the desired conduct. However, it seems the more public health and others promote the distribution of clean injection equipment, reaching out to meet WUID where they are at in their lives, the more WUID try to appease the values of harm reduction, and the more sanctions WUID will experience if they can not meet these expectations. In other words, as the availability and accessibility of resources to follow social dictates of cleanliness increased, so did the admonishment for those who did not engage in these services. Thus, when one can not adhere to the “use clean” expectation that is supported and believed to be best practice one might be inclined to hide any deviations from following the public health mandate. This may be

accomplished by providing the “right” answer to a question or proposing the “right” action (correct and moral in the context of the prevalent hegemony) and to hide any misdemeanours. The progression of the interview content evolved from “I don’t share” to “I do sometimes,” to “everyone does – more than you know.” This progression is a part of the survival WUID face each day; that is, to hide the dirty, exclaim and expose the clean, and avoid penalty, including being looked down upon, having derogatory labels attached to them, or being “red flagged” at a hospital.

Sheard and Tompkins also found from their participants that efforts were made to ensure clean needles were used, or at least reported to be used. The women in their study described the used needles of others as “dirty” (2008, p. 1542), and their statements indicated they viewed anyone who used them as “repugnant” (p. 1543), an acknowledgement that the message to always use clean injection equipment had been integrated. Also aligning with the ideal of cleanliness, Vitellone (2003) wrote of the sterile syringe as representing the concepts of clean and safe, and that it enabled PWID to portray themselves as people who upheld social or moral standards, notwithstanding the use of illicit substances through injection. The reactions of the WUID in Sheard and Tompkins’ (2008) and the current study also reflected public performance and demonstrated the women understood clean needles were to be used. “Everything clean” was the public health phrase parroted by some. Others detailed how they not only had clean equipment for themselves, but also enabled the morality of others by carrying and distributing supplies from the NEPs to others, thus saving them from the spread of dirt and disease from used needles.

Homeless Canadian WUID wanted to follow social and moral standards, despite the very act they were following being considered a blatant disregard of these rules. There is thus an interesting point about violating the rules, and yet following them (at least in a changed way). Those who violate the rules outright are “the worst.” So, there is a hierarchy that appears – a stratification Deleuze and Guattari might say, that ranks WUID according to cleanliness: those

who are abstinent are the most clean (so the best), whereas those who reuse and share needles and have skin marks are the most unclean (so the worst).

As noted through the study interviews, it became evident that although the women would espouse and repeat public health messages about sterile and so-called safe injection practices, they did not always enact their words. Withdrawal from opioid drugs and cravings made it nearly impossible to resist the need to use whatever drugs and equipment were available. Washes, drugs, and needles were commonly shared. Here the presented image followed the expected discourse of clean and good, which was later unveiled to be what would be considered dirty and diseased. The women discussed when they had reused their own or others' equipment, including contaminated water and drugs (such as a wash) to alleviate their strong need to be high and avoid withdrawal symptoms. The message to use clean was seemingly well versed, and some did not want to implicate their own practices, but spoke of others who scrounged through abandoned apartments, broke into injection disposal boxes, and injected whatever remnants they could find in the discarded syringes.

Not surprisingly, along with rejecting the idea of being like others with injecting habits considered unclean, the ability to blend in with the public provided relief from scrutiny and an ease of movement (Malins et al., 2006). As a double fold, the appearance of WUID involves cleanliness and freedom from marks that reveal their identity as WUID. This appearance is a sought-after goal, helping to reduce others from noting their use and initiating further humiliation and disgrace to already poor self-image and -esteem. The masquerade provides an opportunity to avoid public ridicule, by disguising obvious signs of intravenous drug use.

The participants also reported that the sight of discarded used needles was regarded as dangerous and disgusting. Biohazard bins from the public health unit were available to ensure the capture and containment of such dirt and disease. The women endorsed the use of these bins and explained that discarding needles and used injection equipment outside of these bins was unacceptable. This discussion illustrates the point that people who use biohazard containers are

responsible, versus the undesired so-called junkie who recklessly disposes of needles and cares little for public safety and cleanliness (Moore, 2009). However, the women also described that bin placement was a reason for non-use. Attempts at cleanliness are thwarted once again, as the means of disposal are provided by neoliberal thinkers who purport to believe and engage in harm reduction, but do so through their own lens (often of privilege), without considering the needs (to avoid being detected or, even worse, arrested) and desires of WUID (to follow public health suggestions), nor taking direction from them regarding how a biohazard bin can be transformed to better suit their needs.

Another unforeseen outcome of this process of neoliberal solutions was that this cohort of homeless WUID were reluctant to carry even the smallest of biohazard containers carefully designed for personal use. Like the peer-administered naloxone kits, carrying a container for used injection equipment defines one's identity as someone who uses injection drugs. The bin becomes the signifier of abhorrent behaviour accompanying the marked and diseased body that the participants attempted to hide. The consequential – and unsurprising – preferred action was to toss the used needle, as this requires little time and can assist with avoiding the attention of others, including that of the police, which might lead to arrest. Also, when the priority is on identifying where the next drug is coming from and how it will be obtained, sanitation ranks low. That is, while clean is desired, actions that could be identified as dirty take priority in a situation where drugs are needed.

Malins (2004a, 2004b) also noted this ideal of cleanliness, or rather the association with dirt that accompanies injection drug use, in a study of WUID in Melbourne. A downtown environment, where many people went to inject, was cluttered with rubbish, and considered dirty and disgusting because of discarded injection paraphernalia. Malins et al.'s (2006) study provided an example of WUID who altered their drug using environment by cleaning it up and using a garbage bucket placed in the area. The WUID in this study (Malins et al., 2006) sought to maintain cleanliness so the area where they used drugs would remain open to them. They hoped others

would not object to the use of the site for drug use if the area was kept clean and that they would blend in with the downtown business district more readily. As Malins et al. concluded,

If women are injecting in dirty spaces, if women articulate and perform themselves in terms of dirt and disease, or if others treat them as though they are dirty, diseased or dangerous, then it is unlikely that the connections which form between women injecting drug users and shoppers, traders, police, residents and passers-by will be positive ones. These “junkie” foldings will inevitably have an impact on the bodily practices of the general community: they are body–space foldings with material, bodily, implications. Women injecting drug users do, however, resist negative foldings by performatively constructing themselves and their spaces as “clean” and “responsible,” or by folding themselves into retail city space.
(2006, p. 524)

Cleaning the environment was seen as having potential to bridge a relationship with others who live in the mainstream social world, such as pedestrians, consumers, store owners, and tourists (Malins et al., 2006). This action by WUID was thought to constitute a sign of good faith, of their humanness, and of their recognition of what is considered proper by mainstream social standards. This assemblage of WUID and other society members forms an important point of interaction and further demonstrates the folding of clean and dirty.

To explain further, the women in this study spoke about the importance of maintaining public space and of appearing to be a functional and worthy part of the social assemblage. They were concerned about needles left in public spaces, such as washrooms. Their goal, accordingly, was to engage in these practices without being seen (which included being seen at the time, leaving remnants of the activity, and leaving marks on their bodies) so as to maintain their identities as women who did not inject drugs. As part of maintaining the space and their bodies, the women attempted to ensure the spaces they used would be available to them again at a later time. The women in this study were like those in Malins et al.’s study (2006), who sought to maintain social expectations of cleanliness in an attempt not to be excluded from the social assemblage, and thereby continue to be eligible to share spaces with others.

Not only did the participants endorse the use of clean injection equipment and spaces, they also had much to say about “becoming clean from drugs.” It was a cyclical pursuit that

matched much of the circular nature of their lives: the daily efforts to obtain drugs and to find safe places for drug use and rest, and of wanting to quit drugs but continuing. It was the women's ambition to live what was perceived to be a clean, "normal" life that thematically presented itself in conversation. A normal life was further described as being a loving, involved grandmother or mother, going to school, gaining housing, and receiving respect from the police and others.

The current study participants reported beliefs and desires which corresponded with hegemonic discourses that position injection drug use as immoral and not dependent on context or situation. As part of this discourse, WUID are told the means to virtue and the solution to their depravity is to stop using drugs. To attain this allegedly necessary goal, mainstream discourses instruct women that, if they enter treatment, all will be well. As the women discussed, however, treatment programs were difficult to enter due to wait-lists and challenging entry requirements, such as abstinence. The women also noted that, once through a program, they were declared successfully rehabilitated and "clean from drugs," although after rehabilitation, they were often discharged back into the same community they had left, and little changed in terms of friends, acquaintances, and the presence and accessibility of drugs. As such, the women returned to a social context of drug use. While cleanliness from drugs is aspired to, and the women internalized the goal of abstinence, a return to drugs and the life the women had left is seemingly an inevitable part of the vicious circle of their lives. This cycle illustrates the disparity and futility that can be experienced with living dirty and desiring clean.

Moreover, there is the discourse of "coming clean" about drug use. As a means of remaining hidden, the women did not always disclose drug use when asked. Often, the process and idea of coming clean was not thought to be possible or advisable, given the reactions they might receive. WUID have learned it is often better to avoid and evade the scrutiny that is inevitable when they disclose injection drug use, including to family, friends, and healthcare providers. To maintain the respect and love of others, most of the women chose not to disclose their drug use to anyone other than acquaintances who use drugs. It was a process of disclosing

to those who were similarly abject, and thus perceived to be less stigmatizing toward them. Coming clean can be detrimental to valued relationships, and the women chose who they tell of their “dirt.”

As noted, the ability to blend in with the general public also provides relief from scrutiny and an ease of movement (Malins et al., 2006). As a double fold, the appearance of WUID involves cleanliness and freedom from the marks of injection drug use. Anything that reduces the chance others might suspect drug use is sought after. If not achieved, the women may encounter further humiliation and admonishment to add to an already poor self-image and self-esteem. The masquerade provides an opportunity to avoid public ridicule by disguising obvious signs and denying drug use. In this way, the women attempted to fold the perceptions of social normalcy onto their outsides so others would not consider that their insides were abject.

The basis of this Deleuze-Guattarian double fold is experience. WUID anticipate public behaviours from prior exchanges. Often it was believed that avoidance was the most appropriate action to avoid further degradation. It may be, however, that the fold of subjectivity is enacted. In the interviews, for example, participants suggested that when someone walks down the sidewalk and veers across the street to continue their walk, they may interpret this action as a direct avoidance of their projected disgust. Perhaps, though, the person simply crossed the street for other reasons. However, for WUID in this study, this movement can create a personal sense of causation, based on her own sense of self-worth and ability to create repulsion in others. Whatever the rationale for crossing the street, this is the perception WUID have of their world and self.

A review of the use of clean and dirty in the extant literature and the current study reveals that the concepts are determinations of subjectivity. The concepts separate WUID from others and delineate what is acceptable practice within drug use. It is also evident WUID have absorbed and internalized public health messages but are unable to fully enact the idealized mainstream measures of infectious disease prevention and thus of following and abiding by social norms of

cleanliness. The limitations to apply self-care measures, within a disempowered and vulnerable population, are evident (Epele, 2002b). Clearly, dirty is viewed as bad and clean is associated with morality, goodness, and purity. Attempts to emulate the desired attributes are frustrated by experiences of being marginalized and complicated by acts of resistance. While the predominant hegemony calls for self-discipline and control, WUID are disenfranchised and not provided with the opportunities or tools to explore what could work contextually to assist with their needs.

Abjection. Women's bodies, historically, have been viewed as diseased and leaking; there is much to monitor and much to contain (Davis & Walker, 2010; Petersen & Lupton, 1996). However, WUID are considered doubly worrisome, as not only are they viewed in terms of the usual leaking of menstrual fluid, and carriers of disease, they magnify the categorization because they inject drugs and may sell sex to multiple people. Leaking, additionally, comes from the marks left by injecting, and the resulting abscesses and superficial skin lesions created by picking. Selling sex means potentially leaking vaginal, anal, and oral orifices, and the possibility of the lesions of syphilis – all which may ooze disease. The disease carrier state may also include HIV and hepatitis C, along with other transmissible infections. Their often-malnourished bodily appearance portrays the women as unhealthy, diseased, and potentially contagious, and is consequently seen as a further threat to others. Their bodies have been raped, beaten, and sold, and thus regarded as used and tarnished. In short, they are viewed as diseased and polluted.

Because of these perceived characteristics, WUID are regarded as abject. They are vilified and shunned as “matter out of place” (Douglas, 1985, p. 40), and as that which “disturbs identity, system, order. What does not respect borders, positions and rules” (Kristeva, 1982, p. 4). Drug use and prostitution, especially at the street level, is commonly viewed as repulsive (Rhodes et al., 2007). As the foregoing discussion implies, WUID are not considered as fulfilling societal expectations of woman, mother, and wife (Boyd, 2004; Boyd & Marcellus, 2007; Ettorre, 2007; INPWUD, 2014; Murphy & Rosenbaum, 1999; Roberts et al., 2010; Poole & Isaac, 2001). It is believed they do not respect their bodies in the way others do, and they defy their maternal

position in society, seeming to prefer drugs to raising a child. WUID appear to reject the rules of sanctioned behaviours through their use of drugs, physical altercations, and sex trade work. There is a multiplicity of ways WUID are considered abject. As Kristeva stated,

Abjection ... is immoral, sinister, scheming, and shady: a terror that disassembles, a hatred that smiles, a passion that uses the body for barter instead of inflaming it, a debtor who sells you up, a friend who stabs you. (1982, p. 4)

Kristeva's words were not directed toward WUID, but reflect the lives of these women, who are considered "immoral, sinister, scheming, and shady" because they "barter" their bodies, sell each other out, and have friends who are untrustworthy (Kristeva, 1982, p. 4).

In reviewing Lupton's (2013, 2015) work on disgust and the abject, there are four categories that align with abjection and WUID. Three of these categories have relevance to the current discussion. These are the category of, firstly, "animal reminder," secondly, "liminal disgust," whereby both appearance and behaviour are reviewed, and thirdly, "matter out of place." In reference to Lupton's animal reminder category, taken in the literal sense, the women in this study felt like the treatment they received from others was likened to that of an animal. Certainly, there was an element of WUID being regarded and treated in the same manner as animals, in other words, less than human. They discussed feeling like they were being corralled, and that they were in a game of cat and mouse. The concept of being corralled was also expressed when the participants spoke of being "red zoned". Both of these terms or phrases imply that movements are restricted to certain geographical areas. These restrictions can be imposed by a virtual fence such as those required through legally binding terms when one is red zoned. These red-zoned areas are often where the women stay, eat, and receive clothing and assistance with social matters. As women are prohibited from these areas, without access to services that assist with survival, they are often compelled to obtain necessities by other means, including those that are illicit. This structural violence propagates the vicious circle that is the life of WUID and leads to the women being further considered abject related to the criminal activity required for them to obtain the items they were banned from getting in the usual manner.

However, Lupton (2015) described both animal reminder and liminal disgust as prompting people to think of the ‘animalness’ that belies human presentation and the inevitability of death and decay. More abstractly, Lupton’s animal reminder refers to bodily “openings..., ... physical sheddings or secretions (2015, p. 4). As Kristeva noted,

The body must bear no trace of its debt to nature: it must be clean and proper in order to be fully symbolic, in order to confirm that, it should endure no gash other than that of circumcision. ... Any other mark would be the sign of belonging to the impure, the non-separate, the non-symbolic, the non-holy. ... Any secretion or discharge, anything that leaks out of the feminine or masculine body defiles.
1982, p. 102

Contrary to what enters the mouth and nourishes, what goes out of the body, out of its pores and openings, points to the infinitude of the body proper and gives rise to abjection.
1982, p. 108

WUID leak, and blood is viewed as abject – not only menstrual bleeding but also blood from areas that have been disrupted (Kristeva, 1982). WUID have veins that are inflamed and infected, emitting pus, and leaking holes in the skin from picking and missing the vein with the needle, bleeding from puncture wounds where needles have interrupted skin integrity. Blood is implicated in numerous ways, coming from the arm of a woman who injected; a woman who is HIV positive; an open wound on the hand of the woman helping, open and exposed, the unseen blood in the wash – a hidden danger, sinister in its apparent absence. Blood is seen and is liminal, the in between of infected and not infected, the ambiguous uncertain state that uncomfortably sits between infectious and safe.

In the case of WUID, their damaged veins and scarred marks from injecting drugs render them animal. Societal expectations of youthful skin that is unmarked and unblemished are disrupted and, instead, the skin is punctured, marred, and marked. It is gaunt, dirty, and blemished. The women lamented the loss of intact, unscarred arms, and found their bodily changes abhorrent.

Along with finding themselves having an animal-like appearance, the women noted their peers whose bodies and health were riddled with holes and disease. They found this state of

being objectionable, perhaps as they feared the reflection of themselves. This liminal disgust also related to what oozes from the body (Lupton, 2013). For WUID these marks are created and magnified by the structural nuances that enforce the need to use drugs in unsanitary environments, to inject hastily without the privilege of preventative sterility, to ignore the signs of infection because they feel unable to seek healthcare given the reception of healthcare providers and lack of attention to their personhood, and instead to continue their life, made even more clandestine by the evolving and intensified portrayal of abjection.

The WUID in this study also reflected on the physical spaces where they injected as detestable. Injecting in public was viewed as an activity out of place; the street and sidewalk are meant for traffic both pedestrian and vehicular. It is the action of injecting oneself with drugs rather than walking, taking in scenery, and engaging in conversational chatter in these public spaces which is seen as repugnant and creates disgust. The street becomes altered, a striated space that has been misused, where behaviours considered uncivil and unhuman occur. Injecting drugs is abject and disrupts spaces that are otherwise segmented according to hegemonic dictates.

Additionally, abject in an animalistic sense is the place on the body that is injected. The accepted “civilized” use of needles for injecting drugs, that is in the medical sense, means that needles are inserted into the body as a clean/sterile procedure by trained and regulated healthcare professionals. This act is for safety and therapeutic care, not for recreation or pleasure. Needles are placed in the arm for the most part but can be seen in other sites when the challenge and need are unusual and beyond routine circumstance. WUID inject into their bodies without as much attention to cleanliness and place as the site is chosen for accessibility and for its clandestine location. The repulsion is clearly illuminated in the words of the WUID both as they review how they are seen by others, and how they see both others and themselves. Furthermore, the places, space, and body are animal reminders of what is not civilized and instead are considered improper sites for bodily injecting and therefore shunned.

Lupton's second category of disgust and abjection is that of liminal disgust and refers to crossing cultural boundaries. There are multiple aspects of life as a WUID that transgress societal expectations of what is expected and accepted. Lupton recognized that both behaviours and appearances illustrate the abject. She, like Douglas (1966/1985), suggested that liminal disgust arises because societal order and the reigning governmentality are threatened by those who do not conform (Lupton, 2013). This non-conformance, or resistance, is tantamount to rebellion. Not the rebellion of outright force, but the ongoing need to reject externally sourced expectations. The images and results of these behaviours and appearances shock and distress. Injecting in dirty spaces, through wounds and into holes in their body, the leftover and remaining scars and distorted skin are all found to be abject.

Epele's participants spoke of the importance of hygiene and felt that women who did not clean their skin before injecting did not care for themselves: "Their bodies are not very pretty. They do not respect themselves. They don't care" (2002b, p. 54). Kristeva similarly spoke of the "boundaries of the self's clean and proper body" (1982, p. 73) and considered a loss of continuity in purity and cleanliness of the skin as an "impairment of the cover that guarantees corporeal integrity, sore on the visible, presentable surface" (1982, p. 101). Certainly, there is a common cultural preference for hygienic bodies free of odour, marks, and stains. The outcome of neglect to these, dirt and dirtiness, is considered a source of abjection, which requires avoidance. The women of the current study followed this dictate, indicating that a clean body and clean skin are desired. However, the practice is not only to present oneself as respectable, but also a norm that enables one to judge others and be judged by others inside and outside of the community of WUID. Should skin be broken, marred, infected, or oozing, this symbolized less than acceptable standards, indeed perhaps reckless drug use. Furthermore, this was a standard that seemingly no one was able to achieve or adhere to, thus WUID believed they were always less than they should be, dirty and disgusting – seen as the abject to be looked down on, shunned, and avoided

to prevent the acquisition of contagion and treated with disrespect because of being associated with these vilified bodies.

Furthermore, actions can be liminally abject according to Lupton (2013). According to the women of the current study, biohazard bins were reportedly broken into for the purpose of extracting drugs from used syringes. Injecting unknown substances and disease into one's body from anonymous and unwitting donors reflects the unimaginable. Retrieving leftover drug, and consequently blood, from a used syringe found in an apartment or out of a needle disposal box is regarded as abject. All the fear of contracting a life-threatening disease is revealed in the revulsion and disgust created by these actions. This further divides the women as they other themselves and create an internal hierarchy amongst a group seen by outsiders as homogenous. Indeed, multiple women reported having hepatitis C and HIV from sharing needles – from having engaged in an abject activity and becoming the abject. They reported about others who had been known to participate in these heinous acts and described their own horror that this could happen and the feared consequences of the act.

As part of abjection, researchers identified that many WUID are also disgusted by the action of injecting drugs into some areas of their body (Epele, 2002b; Sheard & Tompkins, 2008). The women in this study created a hierarchy of injection sites: Injecting in the arms and legs was acceptable, but the use of other parts of the body, such as the breast, neck, groin, and genitals, were all equally abhorrent. Still, some used these forbidden areas and explained the purpose, such as hiding track marks from view or because they were unable to access a vein elsewhere. Regardless, these approaches to injecting were described as disgusting and marked these women as more abject. It would seem the more private body parts are not preferred for injection.

The third category of Lupton's discussion on what is abject considers Douglas's work about "matter out of place" (1966/1985, p. 40). Having children watch people injecting, using when pregnant, and initiating others into using intravenous drugs are all considered undesirable. These examples of cultural rules would be considered "matter out of place" for WUID (Douglas,

1966/1985, p. 40). It is not inherent that activities and things are abject; it is rather their meaning within a context which is abhorrent, again, showing that the issue is not drug use per se, but drug use within the contemporary sociopolitical system. This does not negate, however, the real-life experiences endured by these women, and the behaviours they consequently engage in to survive and hide themselves. The women, as noted, try to disguise their “uncleanness [as] matter out of place” (Douglas, 1966/1985, p. 40). WUID have an identity that is considered abject by the public, by the police, by healthcare providers, and by themselves. They are thought of as matter out of place; they are the skin on the milk described by Kristeva:

When the eyes see or the lips touch that skin on the surface of the milk – harmless, thin as a sheet of cigarette paper, pitiful as a nail paring – I experience a gagging sensation and, still farther down, spasms of the stomach, the belly; and all the organs shrivel up the body, provoke tears and bile, increase the heartbeat, cause forehead and hands to perspire. (1982, pp. 2–3)

It is thus inevitable that given the contextual interpretation of WUID they are considered disgusting and are spurned. The manifold considerations of the culture and life of WUID mean, at least for the society which they inhabit, that they are abject in body and action.

As Lupton (2013) stated, those who are othered and shunned are those who, for example, do not contain their bodily excretions, or abolish norms of behaviour as they are accepted in the context of the society in which they coexist. The current research illustrates that WUID pursue their needs with acknowledgement of the rules and a level of acceptance. They endeavour to atone for their indiscretions and become another by camouflage and clandestine habits. Not always successful in their attempts, they have been described and treated as exhibiting animal reminders and liminal disgust and represent matter out of place, both in actions and appearance. Thus, WUID are considered to be disgusting and abject.

Risk. Fitting with the theoretical framework of this thesis, Lupton (2013) described how risk is bounded by discourse. What is and is not risk is shaped and determined by time and sociocultural context. Douglas and Wildavsky (1983) described risk as a cultural phenomenon and explore how the political is implicated in the construction of what is and is not considered

risky. Risk also depends on the perception of those observing the action (Lupton, 2013). For some risky action is adrenaline charging while, for others, it is a matter of frightening circumstance and chance associated with danger. The ability of public health to regulate what is and is not risky is well documented (Lupton, 2015; Petersen & Lupton, 1996;). In terms of risk of sexually transmitted and blood borne infections and public health harm reduction, mandated and regulated programs have evolved. The programs define who is considered a good citizen, as demonstrated by those individuals who regulate their behaviours according to what public health states about reducing risk. This includes using condoms, ensuring clean injection sites and sterile equipment are used, and subsequently, that used equipment is not shared. Additionally, this person also disposes of used equipment in a safe manner (in a biohazard container). Good citizens follow these rules and do not expose themselves or others to disease. In this regard, risk is less about the avoidance of an inherently dangerous activity, but a mechanism to socially regulate the abject.

Defying the risk or disregarding “proper” advice to cease a behaviour or initiate another more healthy (i.e., less risky) alternative is considered defiance at best and stupidity at worse. Responses to health concerns are socially constructed and determine, in part, one’s subjectivity. Thus, WUID are considered to make poor choices when they continue to use drugs and maintain a lifestyle that puts them “at risk.” Moreover, the programs also espouse an interest in the collective safety and health of others (Petersen & Lupton, 1996) to generate a rationale and validation for their concern in people’s lives.

Of note, while drug use is often considered to be an individual choice, this is only an opinion supported by the prevailing hegemony that leads one to believe drug use and its ensuing lifestyle are intrinsically wrong. The women, who have been compelled to steal from, rob, and beat others, and lie to and deceive those who care about them, are propelled by the idea that drug use is wrong. As such, WUID are required to use means that are equally as unacceptable to obtain drugs. In total, a lack of structure to support drug use entails the corollary that there is little to protect or enable WUID to make other choices. The culture is one of need and involves

fulfilling such needs by whatever means necessary. As few WUID have not obtained a criminal record, there is little that is legal that will assist with enabling their lives. Thus, even the so-called bad choices are only bad when one considers societal understanding of what is good and bad from a broader societal perspective. The options are simply a matter of limited choice, and exclusively do not align with prevailing hegemonic norms. That is, injection drug use is not inherently problematic; it simply does not align or function well within the current sociopolitical system that puts WUID at risk.

For WUID, this image and the understanding of risky citizen is magnified. Not only are they subject to the physiological leaking of the feminine body, but also to that of injection drug use, which creates more openings from injecting and having other inflammatory and infected fluids leaking from wounds and abscesses. Petersen and Lupton described the societal view of sex workers as a “swamp” or “holding tank” of infection (1996, p. 79), implicating them as a source of risk, danger, and disease to others.

Furthermore, women are admonished to be responsible for disease prevention, by requesting condom use, and getting regular medical examinations and STI testing. WUID have the additional role of being requested to be tested for blood borne viral infections (BBVIs) and blamed for the lack of condom use with partners and customers as well as for their disregard of public safety with needle disposal. Their image as bad citizen is clearly established. As such, WUID are thought to pose a risk to self and others and thus require more surveillance, and management. WUID are an anomaly and felt to be dangerous through non-compliance with social rules of engagement. In such a role, Douglas associated the ensuing danger as pollution: “A polluting person is always wrong. He has developed some wrong condition or simply crossed some line which should not have been crossed and this displacement unleashes danger for someone” (1966/1985, p. 113). Douglas (1966/1985) further explained this danger puts others at risk, which adds another layer of blame. WUID, specifically, are seen as having crossed the line of societal impropriety and are thus perceived as rightly being to blame. Douglas (1966/1985)

went on to state blaming also enables a solidarity within the group, thus creating a like identity and further opposing the other.

For the WUID in the current study it is abundantly evident that from a public and general health perspective or discourse they are “at risk.” The women inject drugs that have no quality control applied to them, they use equipment that has been used and thus have the potential to harbour pathogens, they sell sex to strangers whose intent is not always fully realized and may include harm to the women, they are homeless and without the safety a home affords. Their interactions with others can be verbally violent, and actions can be physically damaging. To survive WUID must rely on their inner strength, “street smarts,” and an ability to detect and avoid danger. Because they rarely have someone to turn to, such as trusted family or friends, or police, WUID are especially vulnerable. Their abjection leads to further risk.

When one is “at risk” there is also the effect of being othered. That is, one becomes the focus of discourse that entails how a group is different from the normative behaviours of a society: “Otherness is dangerous because it confounds order and control ... represent[ing] the unknown ... the dissipation of boundaries and the realization of our own limits” (Lupton, 2013, p. 173). Because discourse assists with communicating expectations of what is considered normal, it follows that what is accepted to be said and done and what is not is derived from contextual discourse. If one does not follow expectations the difference becomes illuminated and questioned. As these questioned behaviours exhibit resistance from expectations, subsequent suspicion and stigmatization is sanctioned. It is the other who is different, defiled, dangerous, and perhaps diseased. The other, as different, creates concern and sometimes fear. Who is this who refuses to be like us? They are other, and as such are marginalized, stigmatized, and risky. The women in this study clearly expressed a sense of being othered. Through words and actions, such as being shouted at, hearing obscenities and names, through to abuse and attempted murder, WUID are othered and thought not to be worthy of recognition as fully human.

Risk then infers fear (Lupton, 2015) of becoming that risk. To hold the othered at bay it is necessary to maintain separation. Assumed to be without bodily control, WUID threaten social order (Douglas, 1966/1985). Difference makes socially normative people anxious. Without social control there is danger and threat. Returning to Douglas, “polluting” people are seen as wicked both because they have transgressed cultural norms or taboos and because others feel they may create danger by their actions (Lupton, 2013). WUID constitute such risk as they resist cultural expectations, reject normative behaviours, and are seen as choosing pleasure over purpose (Lupton, 2013).

As Malins et al. stated, there are both “social and moral discourses regulating what ‘good’ women should and shouldn’t do with their bodies, and where ‘good’ women should and shouldn’t be seen” (2006, p. 509). Of these bodies and places, WUID represent some of the most least desired, by societal standards, women that can be portrayed. Identities are formed and altered based on both the place women are found and the way they incorporate the space into their being. For WUID, space is laden with risks, of being identified and ridiculed, of being arrested and punished, of being pinched and mauled, of being sick and dying. This is the everyday vicious circle of WUID, where trust of others is restrained, and the women walk alone in this place, aware of the dangers that besiege them.

As WUID negotiate everyday challenges that bring them into danger and put them at risk, they must continue to navigate the vicious circle that propels them. Standing alone, amongst those who despise and fear them, WUID are put in a vulnerable and targeted position. Taking risks is a part of the culture of WUID and they wittingly continue to defy these encounters, suffer the consequences, and continue to pursue that which they must do.

Governmentality. While above, the concepts of clean and dirty were discussed regarding their social significance, at this point, attention will turn to understanding the social regulation related to that which is “dirty,” in other words, that which is abject. Both Lupton (2012) and Douglas (1985) implicated dirt in the biopolitics of governmentality. Lupton (2012), as well, wrote that what

enters and exits the body is important to public health, safety, and population control. The image and presentation of clean may, therefore, be a form of resistance to the biopolitical control of dirty. If dirty is considered bad and to be controlled by public health, for example, ensuring mouths do not cough bacteria, penises and vaginas do not emit gonorrhea, and holes in the skin do not let out hepatitis C and HIV, then the action required is to be clean and germ free. If that is the goal and the tendency is to do otherwise, because of the imperative to sell sex or inject drugs with whatever equipment is available, then the façade of compliance requires an external appearance of cleanliness. The Deleuzian fold and the subsequent ability of WUID to pass as following mainstream dictates becomes a form of resistance. The pervasive power that enables governmentality gives rise to this desire. The net of cleanliness is tossed widely through advertising and products that take up rows of pharmacy and grocery store shelves. Moreover, even the NEP is based and evaluated on this assumption and valuation of cleanliness: How many clean needles are dispensed, and how many used needles are retrieved and thus kept off the streets and placed in biohazards and black box receptacles? If one presents as clean, attention is deflected. Keeping their drug use a secret, outside of a community of PWID, is an important survival skill – and a form of resistance.

To return to Deleuze and Guattari's (2000) assemblages and, in particular, the double-pincer archetype, it is important to identify what the authors called the content and expression of the fold. In simplified terms, assemblages are, at least in *A Thousand Plateaus* (Deleuze & Guattari, 2000), described as the linking of associated concepts which together have a function, that can be altered and remodeled, but at any moment have an articulation that involves content – that is the action or the being; and expression – that is the manifestation. In relation to WUID, an example of the content of an assemblage is the public health concern regarding BBVIs (i.e., efforts to contain the loss of diseased and contaminating bodily fluids), and the expression is that of compliance with efforts to limit disease transmission (i.e., using clean supplies and properly disposing of used supplies). Together, this formulates the double-pincer assemblage that

portrays an image that details what is not acceptable, and guides WUID, who are identified as improper and abject, about how to demonstrate appropriate behaviour. This guidance is not personal but emerges from structurally imposed values that coerce and co-opt populations to comply, or at least give the impression of compliance. The expression, of using clean equipment for example, is not always possible given the structural imposition and expectations placed on WUID to follow mandates while being criminalized. As WUID “fail” to comply with expectations of hegemonic mores, they are then a part of the resistance that undermines what is anticipated by the pervasive powers that encourage conformity. In other words, while acknowledging public health messages to “use clean,” and portray themselves as “good citizens,” the forbidden dirt and spread of disease are ongoing.

And so the public façade which placates the powers that dictate what can and cannot be said and done is betrayed by those who cannot conform, who see their own plight as a double bind, straddled between, first, the two worlds of expectations “policing the boundaries of the body” (Lupton, 2012, p.34) and, second, whereby these women transgress expectations and alter established order and expectations (Kristeva, 1982). Not only is bodily containment of fluids displaced by injecting, but also the space that cannot contain injecting is seen as inappropriate and unclean, and symbolic of what should not occur. Being protected by the walls of confined space, such as a home or a safe injection site (SIS), is seen as more hygienic and safer. The assemblage of WUID, needle, and place of injecting is tied into the complex image of dirty and the image of clean as they juxtapose each other. This grouping occurs under the guise of cleanliness, and a façade of hegemonic values that positions cleanliness (and its pursuit) as ideal and necessary.

The women in this study were aware of, and often described, how their life was directed and controlled. The women spoke of being railroaded, that is pushed or coerced toward compliance with hegemonic values and, in the context of the interacting with authorities, they felt they were playing a game of cat and mouse. They described being under surveillance, and a few

clarified their reservations about SISs as an example of being counted and identified as WUID – which was something they wished to avoid. Although such sites assure anonymity, their bodily presence would be proof of drug use. Other activities, such as picking up NEP equipment, on the other hand, could be for others and could be deflected. The presented body at a SIS can only be allowed access as an injection drug user. Moreover, carrying a peer-administered naloxone kit, at the time of this study, was restricted to those who used opioid drugs. Subsequently, the women would be counted, known, and categorized, again something some of the women feared and wished to avoid. However, to know more about what populations are doing and how to engage them, which enables serving the hegemonic powers, they must be found, identified, and laid bare. To know how to change behaviour, one must observe, measure, and count those who need such order. Engaging in the double fold and presenting an exterior that embodies hegemonic norms is thus a mean to avoid such surveillance and resist the dictates that impose cleanliness.

In their everyday life as homeless WUID, the women experienced the manner by which authority controls and steers them in desired directions, as established in codified rules and social expectations. This is governmentality as described by Foucault (1975/1995). The institutional powerhouses, such as those involved in legal matters, governance, and health are the main sources of behavioural mandates, and they execute their will through their ability to survey and analyze trends of individuals and populations, determine what one should and should not do, and then create or enforce policies that attempt to realize these rules. In this case, the focus is primarily on the (un)disciplined body and the medicalized body.

Watching from afar, however, with no direct interaction, disengages the power of governmentality and enacts the illusion of free will. Certainly, WUID are caught in the dilemma of both finding services and, at the same time, being identified through them. Either way, the assemblages identify, control, and otherwise make them more vulnerable to, for example, police involvement, social rejection, and subjugation. This omnipresent awareness can only drive WUID

further away, underground, to disengage, somewhere they can be left alone, more than anonymous, they can become non-existent.

Alternately, some WUID strive to be the disciplined body, one that follows the expected rules of behaviour. WUID do follow requirements and regulations of the “good citizen” where able and when the request does not impede their foremost needs. The women spoke of families, had children and partners, were interested in their appearance, had held or aspired to be employed, and sought to have their own homes. In these regards, they obeyed – or at least sought to comply with – mainstream behavioural social dictates. The cohort of women also acknowledged that routine preventative healthcare was important, and many had attended to this need. Despite such compliance, these women were also noted to be “deviant” by authorities as, for the women of this study, drug use preceded the need to obey the law, to remain publicly sober, and to avoid disease and cure illness. Health and safety were secondary considerations to the pursuit of drugs and the activity of drug use. The self-care and the discipline required of a docile and conforming body appears to be set aside. Instead of care of self in the traditional and expected sense, there was more emphasis on self-care related to withdrawal, survival, and fulfilling needs. The women lived close to the edge, with bodies that resisted norms and defied expectations, but which, in many cases, they attempted to hide and disguise.

Governmentality, from a Foucauldian perspective, can, in part, be understood in term of panopticon observation. This watchfulness serves to regulate behaviour as those who are watched try to avoid behaviour that will not be tolerated. Thus, no hand needs to be laid, no punishment needs to be dispensed; in other words, the prisoners, aware they are being observed, comply with expectations without having to be physically forced to do so. This assemblage of controller and being controlled is common in the lives of WUID. The women gave specific examples related to being watched by cameras and being in situations where the police could detain and arrest them. Furthermore, from the observational data, at downtown shelters, the front desk or office, have several cameras homed in on areas inside and outside the shelter. They

project images of those in and around the building, and continuously monitor activity. The women spoke of cameras that were able to pick up on who was disposing of injection equipment outside the shelter. While the public purpose of biohazard containers is to ensure disposal of these items to avoid risk of others being punctured (i.e., help keep used needles off the street), they can also be understood as having the alternate purpose of being tools to help observe who uses them (and drugs by extension) and then question these persons on entry to the shelter. The seemingly harmless and inert biohazard bins thus function as mechanisms of control. It would seem the panopticon aspect of governmentality is currently employed in these neoliberal prisons, which house the marginalized and populations who are deemed “difficult to control,” such as WUID.

Of issue, this focus on the control of deviant bodies means that WUID may often have their more complete personhood left unnoticed and disregarded. Their totality can be overlooked when a healthcare provider views the woman with a clinical gaze and sees her as an embodiment of drug use. Thus, risk for sexually transmitted and blood borne illness will be assessed, and abscesses will be lanced, but routine care may be overlooked as the healthcare provider focuses on the immediate, the obvious, and the life-threatening. In actuality, the healthcare provider often attends to the socially marginalized behaviours and outcomes to the exclusion of regular and routine care. There are several books written to address the healthcare of people who use drugs (e. g. Beaumont, 2006; King & Wheeler, 2007; Petersen & McBride, 2002), which focus primarily on the consequences of drug use. Thus, healthcare providers have been encouraged to think of WUID as vessels exhibiting the health perils of drug use and they, therefore, may ignore routine health practices. Indeed, it seems WUID have missed being recognized as women and are seen instead as drug-using bodies. It is thus unsurprising that these women attempt to fold the appearance of social normality onto their exteriors, and thus prevent healthcare providers from exclusively assessing their internal folds (in Deleuzian speak) for the sequelae of drug use.

The medical gaze Foucault spoke of (1963/2010b), whereupon healthcare providers examine patients and, through questioning and examination, diagnose the concern at hand, while

the patient waits passively for the results of the expert's inspection and pronouncement, was faulted when the ability and tendency of patients to question and ignore the advice they were given came under consideration. This resistance, as Lupton (2012) described, creates a need to recognize the space between bodies; that is, the context and subjectivity of the patient made the health encounter a shared communication rather than a unidirectional directive from expert to the observed. The organs of the body, observed and analyzed by medical techniques, symbolized by the stethoscope (Armstrong, 1994), became one with an ability to engage in a discourse of self-assertion. For WUID this assertion became a line of flight, stratified and territorialized in the process of becoming, yet constantly in the process of breaking free due to the social and physical constraints. When bodies are territorialized through a discourse that implies power over, the other is capable and able to resist. In this regard, this occurred with, for example, ongoing drug use and disregard for sterile equipment. As Lupton described, the relationship "is reflective and dynamic, constantly defining and redefining itself, and it is able to re-territorialize by drawing on alternate discourses" (2012, p. 114). WUID engage in such a process.

WUID are not of themselves a risk or at risk; it is the discourses of risk that perpetuate the concern. However, because they are identified through discourse as an "at risk" group the implied corollary is that they are vulnerable, powerless, or dangerous, not only to themselves, but also to those around them (Lupton, 2013). Public health initiatives are an example of the identification and attempts to ameliorate what is considered risky behaviour through the persuasion of media and mandates. To ignore these messages is thought to be akin to being foolish and the actions taken that incur risk, senseless. A lack of self-governance, noted via forms of surveillance and monitoring of a population, induces action to curtail the activity and encourage required behaviour. These maneuvers are neither punitive nor corporal; they are persuasive and gentle (Foucault, 1975/1995). Lupton (2013) indicated it is populations that are altered by employing strategies to gently herd (railroad) them toward what is expected and needed, in order to assist with reducing danger and enhancing health, through an acceptance of the suggestion and increased effort to

self-regulate that which is undesirable. However, for populations who are marginalized, or resistive or disruptive of social order, individual repercussions may be unleashed. This may come in the form of “expert assistance” or “detainment and imprisonment” (Lupton, 2013, p. 131).

Foucault discusses governmentality and healthcare. For Foucault, the medical gaze is a micro-form of behavioural regulation that aims to train people to engage in a governance of self. By comparison, the panopticon is the macro-aspect of the same observation, taking the principle from individuals to populations. While the women felt they were personally observed and inspected by the healthcare profession, family, and friends, they also felt under the broader watchful eyes of institutions, such as those related to the law and health, as well as the public at large. However, while being aware of what should be done, the study WUID could not always conform, and pursued their often hidden and secretive everyday activities. The women of this study also rebelled against healthcare by relying on and preferring lay knowledge and treatments. WUID do not use statistical analysis or evidence-based practice guidelines to determine their health choices. Instead, they choose to avoid recrimination and degradation. The invisible but perceived power that persuades can also create resistance. In the case of healthcare this is manifested in pursuing more traditional resources (their peers, folklore) for medical assistance.

Thus, resistance is an integral part of governmentality, despite upholding the ideal of not being an oppressive “power down” mechanism of control (Cameron et al., 1995; Foucault, 1976/1990; Perron et al., 2005; Smart, 2002). As such there are values and cultural norms that are not prevalent in the world of WUID, and in fact have been openly disregarded. Other mores have also been established. Assemblages such as (a) pregnancy and drug use, (b) youth and drugs, and (c) introducing someone to intravenous drug use were not morally nor readily acceptable to WUID. To further explain, being pregnant was a poignant reminder that their lifestyle endangered the health of others and illustrated what they felt was their failure as women outright, and as mothers, more specifically, when they were unable to keep their children. The induction of someone into injection drug use was seen as inappropriate, as it was something the women

“[wouldn’t] wish on anyone.” Also, introducing a person into injection drug use was likened to condemning them to a prolonged life of the trauma and indignities.

As well, the women saw the hypocrisy in the stigma they were subjected to because of their drug use, specifically commenting on the others they saw in socially or occupationally esteemed positions who used drugs yet who do not draw the same negative attitudes. It seemed, to the women, professionals might be “getting away” with straddling the two worlds of drug use and not using illicit drugs, something the women desired but could not achieve. These people were considered to be mismatched assemblages, ones that did not fit together, and were disruptive to the established assemblage of the subculture of homeless WUID in a Canadian urban setting. Some persons, such as those noted above, were incongruous within the strata of injection drug use. They were “out of place” in their striated spaces of drug use and unsettled the clean versus dirty divisions that clarify who they are and who is included and excluded from their specific subculture of homeless WUID.

In summary it is not that WUID inherently are abject, nor that they are risky or that their lives are a continuum modulating between the valour of cleanliness and detested dirtiness – rather, it is the prevalent and accepted discourses that guide what is considered to be the truth and an accurate portrayal of values. The governmentality of the time and place persuades one to consider living as a good citizen and determines what constitutes a bad citizen; WUID are thus subject to the pervasive and persuasive powers that meld and mold a society and also formulate their own mores and values.

Resistance. Resistance is a war machine. It disrupts the status quo and that which is stable. It creates new possibilities, experiences, and ways of being and of understanding. The current and long-standing reign of positivist truth and revelations of what is right and wrong provides an episteme which involves an accepted knowledge that drug use is wrong. Drug use is particularly shunned if those involved are not productive, that is, do not follow the common work ethic, do not follow the lawfulness of respecting the property of others, use illicit drugs, and inject

rather than snort, swallow, or smoke drugs. Further marginalizing the population of drug users is being female, and their lack of being “good” as nurturing role models and as mothers. In contrast exist those who work, obey the law, remain sober, except for the occasional weekend transgression, raise productive children in a home that is cultivating and loving, and gain community and societal recognition. The governmentality that promotes behaviour in ways that are wanted and rewarded by the state is succeeding in the latter and failing in the former. These words reflect the chasm between the pervasive power and knowledge, the discourse of what should be, and the everyday lives of WUID, as they enact the war machine and disrupt expectations.

One of the outcomes of governmentality is the stratification of people in society as it stands and has stood for many years – in other words, the status quo. The episteme, the accepted and pre-eminent thinking, comes to be known and accepted by the manner that institutions, such as government, legal bodies, healthcare, and others operate. These societal systems emanate knowledge (what can be said) and power (who can say it) ensuring that preferred behaviours continue (Foucault, 1972/1980). Expectations are clearly stated, as in the law, or nudged and shaped in a subtle manner (as in social norms) to elicit desired behaviours. Healthcare providers, with their gaze into and upon patients also reinforces these norms. Those who reject or do not follow requirements are othered, that is, stigmatized, marginalized, and taunted. They are pushed to the margins and silenced. As Holmes and O’Byrne stated, “Stratification assumes a political function – most notably because it both produces distinct territories and assigns items to these identifiable areas, with some being elevated to superior positions and others to inferior ones” (2012, pp. 48–49). However, as Holmes and O’Byrne (2012) asserted, through the work of Hardt and Negri, regimes expand and grow, which entails further inclusion and, in this process, further divisions, stratification, and degrees of acceptance. The inclusion is welcomed, and in terms of WUID, they are recruited to work as peers in healthcare settings and as research assistants. The women spoke to being board members in different organizations, and some assisted with

preparing supplies for needle exchange and safe inhalation programs. The power-endowed persons are inviting the othered WUID to join their ranks and expand the stratosphere. However, they are not hired as peers of the organization, but rather as peers of other WUID, provided tokens or piecemeal pay without benefits, or they are simply volunteers. In effect WUID are offered to do the work and will of the empire, while remaining stratified in a position of unequal standing. The empire becomes, as Holmes and O'Byrne described, "a self-perpetuating and ever-expanding system of hierarchy and dominance" (2012, p. 53). However, with each inroad, the war machine progresses. WUID learn skills, make allies, and become more able to advocate for themselves.

In seeming contrast, the women in the study defended themselves against derogatory public opinion, often clarifying their worth, despite the lack of social acceptance due to behaviours interpreted as unclean, unlawful, and distasteful. The sentiment expressed by the WUID in this study was that they are not intrinsically bad people; rather, they follow particular social paths in a context of abuse, disregard, and difficulty. These women were thus adamant that, despite being considered abject for their drug practices, they were human beings with value and worth.

Despite the belief they are not bad people, as yet another Deleuzian double fold, the women internalized the idea that they were dirty and abhorrent. To explain, the fold of what they experienced from the outside becomes part of their inside. Many women said they were not "proud" of their drug use or the things they had done for drugs. They also used the term "bad" to describe themselves. The women described having a dirty habit, that the sex work they engaged in was degrading, and that they had few choices about what they needed to do; what they did for drugs and the act of injecting drugs was often despised but necessary. Thus, the external messages of society's beliefs have been internalized and applied by WUID to themselves. They fold the outside norms onto their external being, in an effort to have others believe that their external appearance is aligned with the state of their inside self/fold. Thus, their efforts to avoid detection belies the identity. Regarding their self-perceptions (as they cannot disguise who they are from themselves), they have folded these external perceptions into personal beliefs. In this

case, the internalization of self-degradation creates the outcome: they view themselves negatively and with self-degradation. As Kristeva said,

If it be true that the abject simultaneously beseeches and pulverizes the subject, one can understand that it is experienced at the peak of its strength when that subject, weary of fruitless attempts to identify with something on the outside, finds the impossible within; when it finds that the impossible constitutes its very being, that it is none other than abject. (1982, p. 5)

The participants in this study reported such feelings of self-abjection, as they recognized the dissonance between the life of a WUID and the life they aspired to. The women believed they were “matter out of place” (Douglas, 1966/1985, p. 40), as demonstrated in the discourse they engaged in throughout the interviews. They used derogatory terms, such as “unclean,” to describe themselves. The descriptors varied from being bad to “junkie.” The abject self meant they were often thinking about or were on a line of flight, whether through hopes of returning to school, quitting drug use, or anticipating reconnecting with family. Certainly, they were struggling with who they have been, who they are, and who they might be.

Nevertheless, WUID are capable of great resistance in the form of resilience. They are survivors and, with the awakening of their voices, become aware of their political power. The motto “nothing about us without us” (CHLN, 2006) speaks to this issue. Currently their voice is heard through interpreters, that is drug advocacy groups, champions, and researchers. The war machine that is on the move inquiring and demanding reinterpretation is within the empire. The war machine demands acceptance, a recognition that the lifestyles and needs of WUID are valid. This recognition requires a review and deconstruction of the hegemony that powerfully creates and maintains truth. As such, should victory be declared, the war machine will add the success to others that have been promoted; it must then move on to other targets and another purpose. The role of a war machine is to fight for whatever cause is in need, without bias. Its job is to fly into enemy territory, the “pilot” being ever evolving and the “fly zone” ever changing, the intent being the only constant, in this case to reveal alternate truths about who is worthy and what characteristics of people can be integrated and accepted. The war undertaken is not the “war on

drugs” but rather the “war for drugs.” This battle will be long fought but each inroad assists with eventual takeover. Currently, the battle is fought on the SIS front and the contest has brought drug use to the fore of public opinion and enabled voices to be heard. Through this endeavour, WUID are more aware of their status as humans requiring the same rights as others. Resistance, then, incorporates a recognition of the plight of being stratified, and reaches out to the place of other.

The ability to resist often gets WUID in trouble, that is, arrested or warned. Resistance is met with defiance and, subsequently, the power differential is enacted. The subtle but powerful capacity of the result of governmentality to guide behaviour is set aside, and the stronger force of the law is unleashed. This power underlies governmentality in all aspects, such as enforced treatment for not complying with public health requirements, arrest and jail time if not able to follow the law, and so forth. While those with recognized and sanctioned knowledge lead the means of encouraging self-regulation, there is the background of power hovering and waiting to act. The war machine of resistance from WUID is clearly active as they avoid healthcare, continue illegal and societally abhorrent practices, and in fact, defy what are accepted and expected social graces. The women, in turn, are met by the deadlock of the law, which is, however, eroding and changing, while the WUID move toward being recognized for the rights and humanity they deserve.

Summary. These aspects of a life as a WUID give pause for thought. A review of the constant strife incurred by the dichotomy of clean and dirty, the persuasive attempts of the hegemony promoted by the current elements of governmentality, and the abjection suffered, all cumulate in a life of risk and resistance.

In these results, the continuum of clean versus dirty was central. The participants raised this point frequently and described how it was commonplace in their subcultures. When looked at using Deleuze and Guattari’s, Kristeva’s, Lupton’s, Douglas’s, and Foucault’s work, it was clear that clean could be understood as that which has been positioned within society as the most

desirable. It was a signifier for the characteristics and behaviour of the good citizen who embodies and has internalized social rules. Dirty, in contrast, was the repulsive other and that which is abject, out of place, and stigmatized. It causes discomfort and distress. It is rejected, marginalized, and abused. The women in this study felt they were inherently dirty but sought to appear clean in efforts to decrease physical and emotional abuse by society in general, by family and friends, and by healthcare providers. To use Deleuze's language about the double fold, because they felt that inside (an inside fold) they were dirty, they attempted to appear clean (an outside fold) by portraying social norms externally; their goal was that people would consider them clean (inside) because they had a camouflage of cleanliness (outside). This masquerade was a daily struggle for the women, as they simultaneously lived the vicious circle that is their lives: the daily repetition of waking, being expelled from their sleeping locations (often shelters), seeking resources to obtain drugs, obtaining and using drugs, and avoiding personal and structural violence throughout.

When one considers their humanity, it is disturbing that life could be as WUID live theirs. Despite a life of what is considered illegal activity, being shunned and sidelined, under constant surveillance, and alongside words and actions of hatred, these women resist and survive. They endure physical and emotional harm, and yet continue. The strength of WUID is remarkable, that every day is fraught with seemingly unsurmountable challenges is exhausting, and the behaviour and action of the society that surrounds them is reprehensible.

Reflexivity/Positionality

The need to consider reflexivity or positionality is an important consideration in the process and rigour of qualitative research. Such a reflection can illuminate some of what context meant for the research, the researcher and the participants.

Firstly, working with WUID and those who are homeless both on the mobile needle exchange van and in primary care both in and out of the clinic space prepared me to be

comfortable with the participants. This meant within the interactions there was no fear or concern for personal safety, as may be the case for others less familiar with interacting with WUID.

On a day-to-day basis, clinical practice does not necessarily allow nurses to explore some of the daily occurrences in the lives of WUID. Instead, their specific healthcare needs take precedence. Talking with this cohort of WUID presented an opportunity to listen to what the women would say about their daily lives and the tacit knowledge of their culture. Perhaps this curiosity enabled the women to feel comfortable in disclosing personal and intimate aspects of their lives.

I am, though, a white middle-class woman and as such the interviewed women may have been some difficulty in trusting my understanding of their lives. Some differences would have stood out, for example I was dressed casually in clothes bought new from a store. Other characteristics would have been more covert- I do not have a criminal record (and cannot to be a registered nurse), I have not sold sex to survive (or any other reason). I have never personally experienced being dope sick or to be “doing what I gotta do” to ensure that I can get drugs.

Additionally, there was another obvious issue worth not, that of power imbalance. I have socioeconomic advantage: I am educated, I am a nurse, and I am in the position of asking the women to answer my questions and discuss their life. To this end, throughout the data collection and analysis field notes were kept reflecting the emotions, feelings and experiences that occurred.

The women, though, had been involved in other research studies and had previously interacted with researchers. In particular, there were three studies that had occurred in the recent past. Thus, they had been exposed to and were experienced talking about themselves to research interviewers and academics. Also, curiously, no one asked me about myself. Perhaps they felt the boundaries were set – I was there to interview them; they were there to answer questions and speak about themselves.

It is likely, though, that the women saw me as someone who would support public health harm reduction policies and supplies. This is possibly why the beginning of the interviews often followed the theme of “I use clean rigs, I don’t share” and later evolved into such disclosures as sharing needles and syringes that someone else had just used.

One woman who attended an interview, had recently been a client at a small women’s shelter. She was very surprised to see that she knew me but after the initial adjustment to this knowledge, she started to talk. It was one of the most informative of the interviews, as she related how she had lied and cheated others for money for drugs, discussed how to cook fentanyl patches and shared the unspoken but known rules that existed when using someone else’s space to inject.

Another observation that created consideration was during the women’s only recreational program. There were several staff who attended the program to assist, for example, with meal preparation and serving. They seemed to understand their role as secondary to allowing the women to be able to chat and interact with the other women. I was “new” and inquiring; therefore I would sit at the table with the participants and do, for example, that evening’s craft (if there were enough supplies). In short, while not saying much but being present I remained engaged. The women who were present did not seem to mind; they talked about all kinds of things- bedbugs in their apartments, obtaining new clothing items and the like. Although I felt that I was accepted in a group of women talking to women, I was also very aware that the interactions demonstrated that while I was with them, I was never of them.

I have also re-met many of the women since the research. Many have cycled in and out of the shelters. We often stop to chat. I do not know their names, only their faces and their stories. We do not talk about how we know each other, perhaps they do not remember, or do not feel the need to do so. Possibly, instead, they feel the need for anonymity remains. It is rewarding to see them again as I feel honoured to have been a tiny part of their lives, as they shared so much with me.

Moreover, and further to reflexivity, there was further recognition the participants had further effect on me. This process was not unilateral, although the information sharing might have been. There have been three women that I know of, who have died since the study. It saddens me to think of their tumultuous lives ending – possibly and likely in violent ways.

Also, it was not until I was almost finished transcribing and coding interviews that I was unexpectedly overwhelmed by the sheer volume and depth of the violence expressed by the women who were interviewed. Writing about this experience assisted with deeper reflection and enabled a clearer understanding of what profundity violence interplayed with their lives.

In summary, suffice it to say that the both parties in the research partnership can be and were influenced by the process and the content that is an integral part of doing an ethnographic study.

Limitations

The study has provided some important insights into the lives of WUID who are homeless in a Canadian urban centre. Together, with the insights and valued contributions of the WUID into the study, there are also some limitations.

Firstly, the interview cohort was relatively older with an age range of 27-64 years, and the majority of women were in their forties. An overview of studies about WUID reveals that many have an older-aged cohort (see Boyd & Boyd, 2014; Epele, 2002a, 2002b; Haritavorn, 2014; Hofman, Strenski, Marshall, & Heimer, 2003; Magee & Hurliaux, 2008; Miller & Neaigus, 2002; Millson & White, 2014; Neale et al., 2014; Olsen et al., 2012; Ramos, Aguilar, Anderson, & Caudillo, 1999; Sheard & Tompkins, 2008; Sterk et al., 2003; Wright et al., 2007). One could postulate from the stories and the absence of younger women participating that younger women are earlier in their drug “career” (Rosenbaum, 1981), and thus perhaps more heavily engaged in their activities and survival. A more intense use of drugs may have limited a woman’s ability and opportunity to call and attend a scheduled appointment. Participant observation in shelters and

drop-in programs enabled an opportunity to include some younger women. Future studies should focus on younger women specifically.

Secondly, the study did not seek to collect data on which drugs the women had and were currently using. There may have been benefit in distinguishing a drug-specific cohort. Those women who used opioids spoke of the intensity of the need to avoid, and if necessary, treat withdrawal symptoms. It was in this precarious state of need that risks were often taken. The woman using cocaine or crack had cravings for drugs and took extraordinary measures to get their drug of choice, but the need was not driven by the fear and avoidance of being dope sick. Accordingly, studies that focus on participants specifically using a substance may reveal different outcomes, needs, and actions. As such, the outcomes reported here may be an artifact of the substances these participants used.

Thirdly, the interviews took place in the summer months and the time of year may have both benefited the research process and altered it. There may have been more women without housing than in the winter, when it is more important to have a secured place to stay. However, the warm weather may have been of benefit and assisted with women attending interviews as there were few no shows to interview appointment times.

Fourthly, the women may have been under the influence of drugs. Having considered this, there were two women who stated they were high, and another stated she was in withdrawal at the time of the interview. One interview with a woman who was high, and thus “on the nod” or in other words drowsy, was shorter than other interviews; however, there were no other noted differences.

Fifthly, the recruitment to data saturation for the interview component of the study was of short duration. Between June 16, 2014, when the posters were placed, and July 30th, 2014, a total of 35 interviews were held. This pace of interviewing, initiating participant observation, and artifact collection may have limited the depth of field notes and initial review and coding. However, the field notes were written, and the interviews reviewed for clusters of similar information

(emerging themes related to “clean” and using NEPs, the repetitive use of vicious circle) and new material to further explore (the rates of hepatitis C infection, injecting in necks, and sharing washes) emerged and directed subsequent questioning.

Despite these limitations there are several recommendations that have been enabled in anticipation of the forthcoming interest and reconsideration of the treatment of WUID.

Recommendations

This thesis highlights some important areas of future work, and recommendations for nursing in the domains of education, practice, administration, policy, and research.

Regarding education, undergraduate curricula should incorporate WUID into discussions about community care and maternity care. Courses on primary care should also include material on WUID. It is hoped this background of compassionate care will assist with moving nursing practice forward such that WUID are seen not only as a vessel of drug use and BBVIs, but also as women who have experienced trauma, are striving to cope and exist in a manner driven by survival and reliance on self, and in need of sensitive nursing care. Indeed, the goal is to help students understand the needs of these women for respect, non-judgemental attitudes, and a willingness to be where the woman is at. Nurses who work with WUID are encouraged to role model their care perspective and preceptor students to further enlighten their understanding of this sometimes feared and sequestered population and enable them to reach out with an appreciation of the humanity, rather than disgust, that should be offered WUID.

As active and numerous frontline care providers, who are often the first or only point of contact for many patients, nurses have a responsibility to provide services that encourage WUID to participate in the care they require rather than being humiliated and degraded. While this sounds rote, respectful and non-judgemental care is paramount. The importance of accepting drug use, as well as meeting the women where they are at and what they are capable of is critical to an evolution of trust. Working with WUID where they are at, rather than relying on a medicalized perspective and knowledge, is important. It situates these women as deserving of care.

Negotiation, flexibility, and an ability to think laterally is likely to achieve a more positive outcome than singlehandedly enforcing an abstinence-based, paternalistic approach to care.

Regarding administration, it would be beneficial to change hiring practices in the areas of healthcare that assist WUID to extend to peers, in other words, to women with lived experience. Employment rules would need to assess criminal records on an individual basis and could offer positions in NEPs, SISs, emergency departments and primary care. Having a working knowledge of what WUID experience and live is an asset to building trust and rapport. Working alongside healthcare providers and given training and guidance, peers can provide supportive, appropriate care, taking into consideration the circumstances and context of the women's lives.

In a broader sense, nursing has an active role in promoting policy change. In the forefront would be lobbying or becoming members of committees that have the legislative power to change policies that would allow SISs and encourage a proposal for women only services, including those of broader healthcare services. Additionally, the decriminalization of currently illicit drugs or a request to enable the release of controlled substances to those who require the drugs based on addiction are paramount and fundamental changes required to enhance the lives of WUID. Preventative and supportive legislation can also be sought around parenting while using intravenous drugs. More funds should be allocated to early years programs to assist those who have been disallowed to parent due to their drug use, thus building skills and ability and strengthening, rather than punishing, their parenting skills.

Another important means of change is that of research. Nursing research is capable of providing the quantitative data policy makers request, with the addition of rich qualitative research data that situates the lives of WUID and can be used to appropriately tailor nursing interventions to align with the needs and preferences of these women. Some areas of further research include knowing more about coupled relationships, injection practices, and the underground economy of drug use. The woman in this study talked about the roles their partners play, but the current topic of everyday life only seemed to skim the surface of the issues arising from relationships. Although

the women spoke of their injection practices, there is much to be known about the nuances and detail that will assist with improving the health of WUID. Finally, the economy of drug use is complex and necessarily should be further understood in order to determine the decisions and manner in which WUID think and act. These are three areas of knowledge development that have arisen, and peers should have roles in garnering this cultural knowledge. As noted above, their connection with the life and women will be instrumental in moving the health of WUID forward.

Some of the content that is provided through the discussion is that of the Deleuzian fold and the need to ensure healthcare providers are aware of how they act and react, and how they internalize and interpret WUID as the WUID simultaneously engage in the same fold with healthcare. As healthcare providers, we represent the other world; we are bearers of the power and knowledge of the hegemony that insists WUID are less worthy, less human, less good, and less entitled. Healthcare providers can be the meeting ground between the pervasiveness of governmentality and those stratified as a marginalized and stigmatized population.

Healthcare providers also need to recognize that the war machine with the mission of the acceptance of drug use has arrived and is actively continuing the mission. We should also work toward letting the war machine win the battle. WUID are no less human. Hope and resilience come from within, from the core of the very being of WUID. However, it should be amplified and supported with meaningful actions and interactions.

There is a dichotomy of the worlds: one being that of drug use (and worlds within this world such as the world of human trafficking); the other being that which is seen as “normal” (those with families, jobs, children). Bridging the two is challenging, and currently what is offered to bring the two worlds together is treatment programs. This is a one-sided invitation of the hegemony to amalgamate as one world. Abstinence may not be the solution, or the goal. Being able to use drugs in a manner that allows one to consider making the choices that one desires, rather than ones that drugs jeopardize, is a change society should strive for.

Summary

The above recommendations provide a small portfolio of what is needed and what is possible for the lives of WUID to remove them from the everyday survival and violence that defines their lives, inflicted by structural beliefs and practices, perpetuated by a culture that believes the position of WUID as low life is valid and guaranteed by a stringent policing and legal system. The voices of WUID have been heard, they have been listened to and portrayed in this dissertation. It is time, now, to start the change that determines a legacy of humanization and caring for each other.

Chapter Seven: Summary of the Thesis

With a knowledge that WUID have complex and severe health issues coupled with a complex social status that involves stigma and disgust, the research problem, to explore the culture and everyday life of WUID to know more about how to provide appropriate healthcare, was determined.

The literature reviewed both substantiated and enhanced what was known of WUID. Several studies confirmed that WUID have health, legal, and social issues compounding their lives. The culture, however, was less well known as the literature explored more about what WUID do, rather than seeking to discover why. What was needed was an exploration of the culture, that is, what underpinned the actions, beliefs, and behaviours of WUID.

Critical theory was chosen to be the theoretical basis for the study as it endeavours to understand people and their culture within the context of social justice. What appears to be obvious and understood can be superficial and is not always the only interpretation due to the influence of the prevailing and transparent hegemony. While WUID have been generally viewed by many as less than human, and at best improper examples of women, there is much to be known about this population and how subtle political and social forces influence the perspective of what WUID are and do.

Following from the theoretical perspective, critical ethnography formulated the methodological approach. While critical ethnography follows the same elements as traditional ethnography, that is artifact collection, participant observation, and interviews, it endeavours to uncover some of the nuances of a culture that are derived because of the barriers and facilitators imposed by the ebb and flow of power. To this end the study included artifact collection, including photographs taken by participants about anything they thought was related to health; participation observation, which involved observing WUID in healthcare settings and social/recreational venues; and the completion of 35 interviews with WUID with 31 meeting inclusion criteria.

Therefore 31 interviews with transcribed and underwent theoretical analysis and coding. The resulting braiding of the three elements of the study evolved into themes.

Thus, the findings were described using three overarching themes: (a) an archetypical day, (b) negotiating survival, and (c) valorizing the ideal of being clean. The archetypical day provided an overview of the culture of WUID as an exploration of the social interactions between the women, men, their families, healthcare providers, drug dealers, police, and the public. Each of these communications indicated that WUID experience limitations in establishing relationships that are trustworthy and devoid of dysfunction. Instead the women learned to trust themselves and to act in ways that ensured their own needs were primary. Additionally, the women described their drug use in detail. Several aspects of finding and using drugs were clearly harmful. The actions, however, result from need based on circumstances that evolve from a life that is primarily derived from being devalued and associated with illegal activity.

Secondly, the amount of personal and systemic violence was found to be large, and the impact of this trauma profound. The women were beaten, robbed, and sexually assaulted. As well, they had been arrested, ostracized, and degraded through name calling and legal proceedings. The women, however, continued to hope for a better life, one that was free from the burden addictive and illicit drug use produces.

Finally, the third theme was determined by the commonly used phraseology related to being clean. Clean was spoken of as a desired state when the women discussed drug use (clean equipment and skin, clean as in stopping drugs), clean living (clean place to stay and to use drugs) and telling the truth (the colloquial "coming clean"). Overwhelmingly the dichotomy of clean versus dirty was evident as a central part their discussions. Clean was a state to be valorized while dirty only confirmed what the public believed, and their own self-esteem envisioned as their worth.

These themes led to a discussion which was based primarily on the work of Deleuze and Guattari, Foucault, Goffman, Kristeva and Lupton. Using their work allowed several aspects of

the culture of WUID to be further explored. These are (a) the paradoxical clean/dirty continuum, (b) abjection, (c) risk, (d) governmentality, and (e) resistance. Both the fold and striated spaces help to further the understanding of how WUID live in two worlds, illustrated by dirty versus clean. Kristeva's writings were primary to further eliciting the common usage of the term dirt and disgust that describes WUID. Foucault's literature on governmentality helped to formulate an understanding of how pervasive power influences the institutions and lives of citizens, thus creating circumstances that enforce the need to consider drug use and homelessness as undesired. Lastly Lupton, who built on the philosophical writings of Foucault, Douglas, and Kristeva, helped to further explain the culture of risk as it applies to WUID. This theoretical discussion supports the theoretical framework for the study and furthers the understanding of the culture of WUID.

The thesis makes several recommendations which have as their basis the goal of changing nursing practice to assist the health of WUID. Policy changes to decriminalize drug use is primary to altering the violence homeless WUID endure. In the more immediate, an expansion of the currently legalized drug alternatives should replace current black-market sources. Additionally, services such as SIS and NEP must expand and strive for ways to manage these programs in a way that will increase inclusiveness. Management decisions to employ peers in supporting WUID through healthcare and basic need acquisitions, housing for example, are currently required and will undoubtedly assist with furthering a means to enhance the health of WUID.

Certainly, this sequestered population of women has been inhumanely treated, without an understanding of what creates and sustains their culture of living homeless and using intravenous drugs. This thesis has as its purpose to know more about the culture of WUID and makes several recommendations to enhance their health and well-being based on the findings that evolved from a critical ethnographic study.

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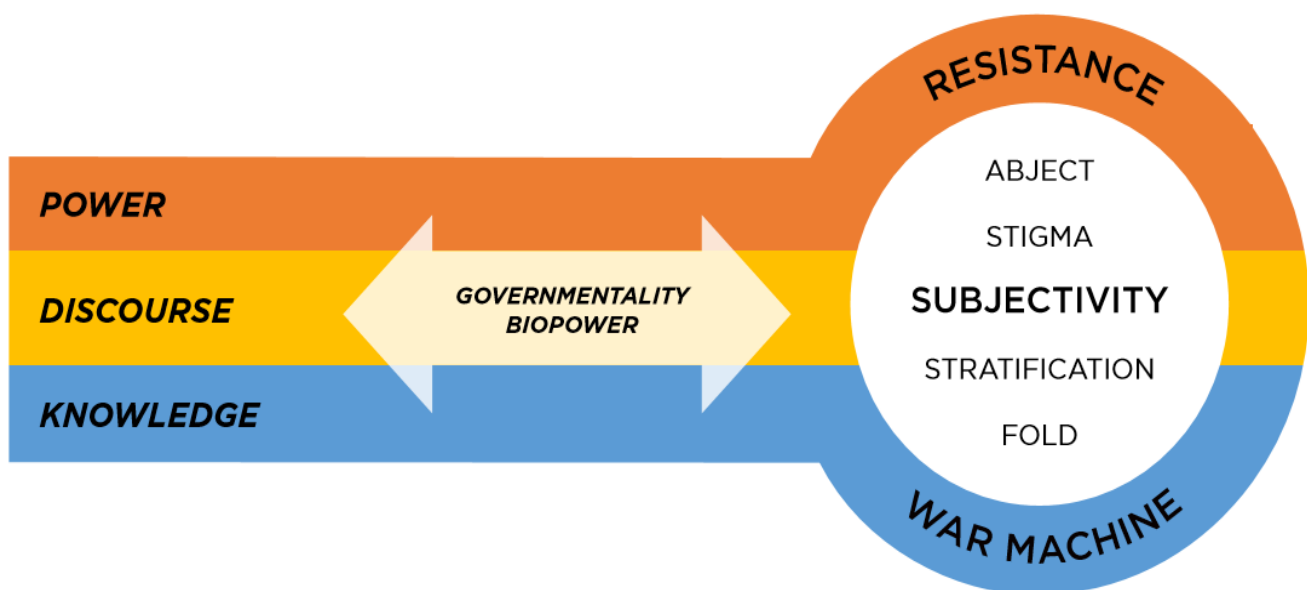
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Appendices

Appendix A

Theoretical Framework

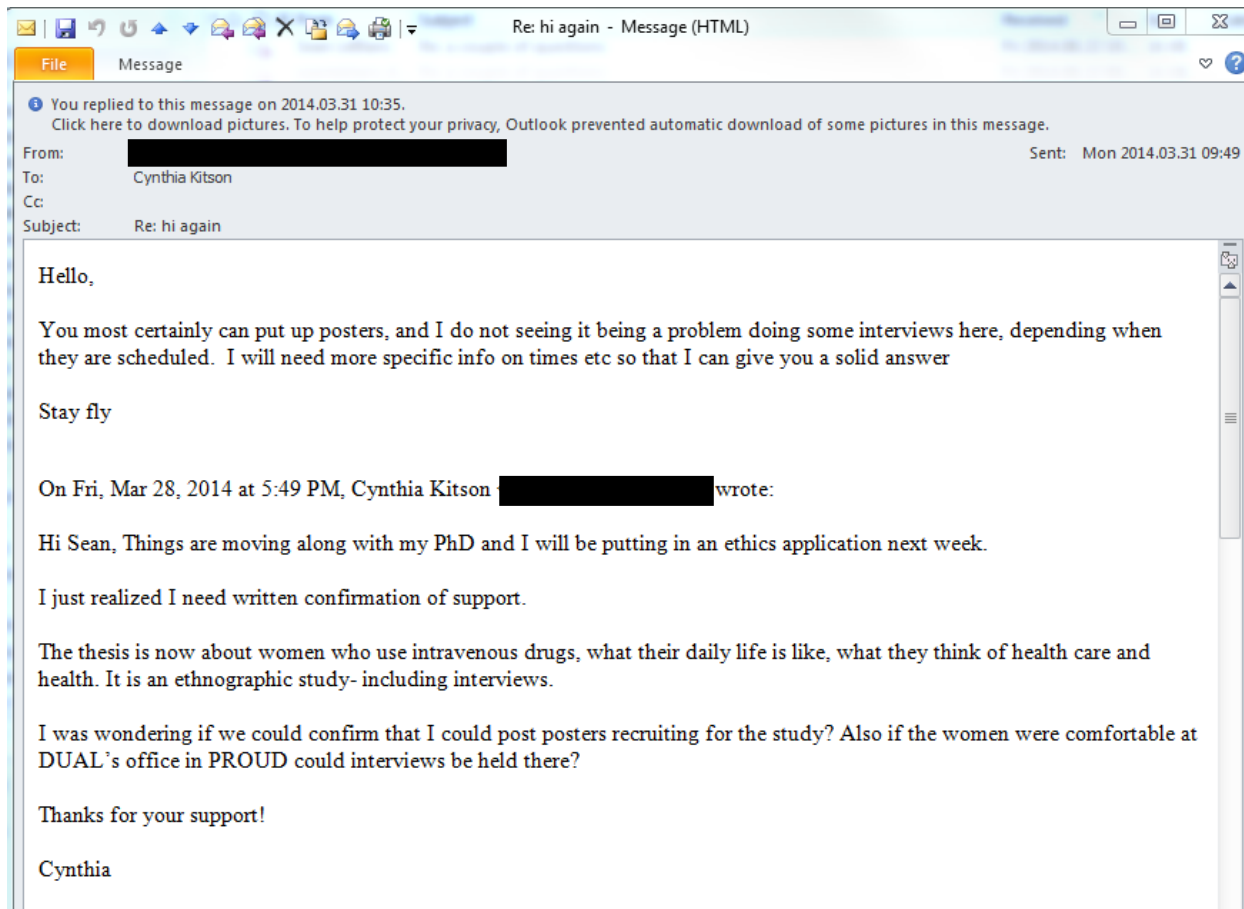


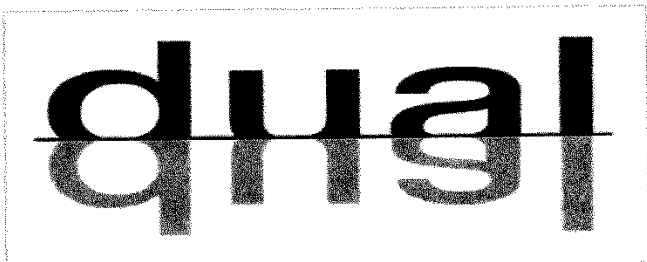
The Theoretical Framework based on the work of Deleuze & Guatarri, Goffman, Foucault, Kristeva

Appendix B

Written Agreement with Stakeholders

Drug Users Advocacy League





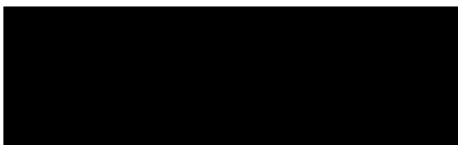
June 3, 2014

Dear To Whom It May Concern,

This letter is to confirm support for Cynthia Kitson's ethnographic research about women who use intravenous drugs. We would be in agreement of displaying posters that recruit participants for her research.

As well we understand Cynthia is requesting a private office/room for interviews. We would be able to accommodate this request if the space is not occupied or she is able to book the room in advance.

Yours sincerely,



Drug Users Advocacy League

Somerset West Community Health Centre



June 9, 2014

To Whom It May Concern:

This letter is to confirm support for Cynthia Kitson's ethnographic research for her PhD in Nursing. We understand that the project is currently in the process of receiving ethics approval- our support is conditional on that approval being finalized.

This research project is intended to learn more about women who use intravenous drugs, their culture and the implications for their health and health care services. As we serve a population of people who inject drugs, we believe we may have women that would be interested in participating in this research. We will also be very interested in the findings and their implications for how we work with women who inject drugs.

We will support the project by displaying posters to recruit participants for her research. The poster will be displayed through our NESI program (Needle Exchange and Safer Inhalation), in both the mobile NESI van and onsite at Somerset West Community Health Centre.

Yours sincerely,

Executive Director

55 Eccles Street
Ottawa, Ont. K1R 6S3

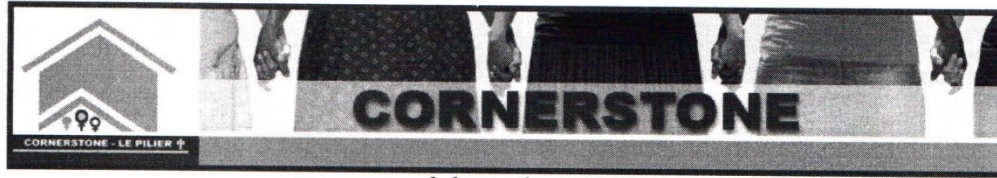
Tel:
General 613-238-6210
Health 613-238-1220

Fax:
General 613-238-7595
Health 613-235-2982

www.swchc.on.ca



Ontario's Community
Health Centres
Les centres de santé
communautaire
en Ontario



Emergency Shelter and Housing for Women

June 2, 2014

Cynthia Kitson
c/o Inner City Health Team

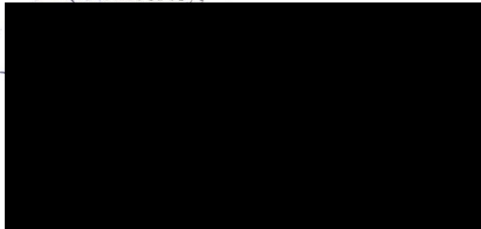
Dear Cynthia,

We, at Cornerstone Women's Shelter, have reviewed the idea of your research proposal Women who use intravenous drugs: The culture, their views of health and health care. We are in agreement with:

- 1) Displaying recruitment posters for interviews with women who use injection drugs.
- 2) Allowing you to observe health care interactions with the residents who agree to have the researcher sit in on their appointment.

We will arrange a date and time to meet and discuss final arrangements when the submission has been passed by ethics.

Yours sincerely,



Choose Hope

172 O'Connor St., Ottawa, ON K2P 1T5 Tel: 613-237-4669 Fax: 613-237-5659
"www.cornerstonewomen.ca"



Ottawa Inner City Health Inc. / Santé Urbaine d'Ottawa



To Whom It May Concern:

This letter is to confirm that Cynthia Kitson has received approval to conduct research in the Ottawa Inner City Health Programs and, to observe our clinical staff. As all our programs are operated in facilities which are owned by member organizations of our corporation, I am also confirming that I have consulted with, and obtained consent from the owners of these buildings to allow Cynthia to conduct research on their premises. This permission extends to the following locations:

Shepherds of Good Hope-1073, 1075 Merivale Road, 256 King Edward Street, 233
Murray Street
Cornerstone-171 O'Connor, 314 Booth Street

If you require any further information please do not hesitate to contact me directly.

Sincerely yours,



Email from [REDACTED]

26/3/2014

Hi Cynthia, glad to hear you are making progress on the PHD. I have no problems with posters or interviews but will ask our friends at Shepherds if they have any concerns?

[REDACTED]
5 Myrand Avenue Ottawa Ontario K1N 5N6

613 562 4500
[REDACTED]

Email from [REDACTED]

26/03/14

Not a problem at all Cynthia- both on the posters and utilizing space- you could use the medical office or one of our meeting rooms- the only person other than you utilizing the medical office is Denise on Tuesday and Thursday mornings, so if you needed to do interviews during these times just let me know and I can book you a meeting room.

I will also forward your request to [REDACTED]

[REDACTED]
Transitional Shelter Services
Shepherds of Good Hope
[REDACTED]

Email from [REDACTED]

27/03/14

Hi Cynthia,

I would be happy to display some posters over at [REDACTED] believe several of our women would be happy to be part of this study.

Please let me know if I can assist you in any way.

Thank you for considering our residents.





**Sandy Hill
Community Health Centre**
Centre de santé
communautaire Côte-de-Sable



Late entry letter for: June 27, 2014

August 2, 2016

To Whom It May Concern:

The Sandy Hill Community Health Centre, Oasis Program, provides harm reduction-based medical and social services to people living with or at risk of HIV who experience barriers to accessing mainstream health services. Our target clientele includes people who inject drugs, people who smoke crack and people who are involved in street level sex work.

In June 2014 Oasis provided Cynthia Kitson with verbal permission to access Oasis with the purpose of completing part of the data collection required for her ethnographic study about women who use intravenous drugs. She attended a staff meeting June 26, 2014 to present her research proposal. Staff consensus was gained, allowing Cynthia to attend Oasis for the purposes of her research.

Specifically, Cynthia was able to attend Women's Day, a program for women, and, with signed consent from the health care provider and client, health care appointments in the clinic. She was also, with prior arrangement, able to utilize meeting space to interview women who consented to participate in the research interviews.

This letter acknowledges and formalizes the approval from Oasis for Cynthia's research work.

Yours sincerely,



Sandy Hill Community Health Centre

221 Nelson Street, Ottawa, ON

Oasis Program / Programme Oasis:

221 rue Nelson Street, 1st Floor/1^{er} étage Ottawa, Ontario K1N 1C7

Tel/Tél: (613) 569-3488 • Fax/Télé: (613) 569-3484 • info@sandyhillchc.on.ca • www.shchc.ca

Apr 1 ★

Dear Cynthia,

Thank you for your request to put up posters to recruit women who use intravenous drugs for your study. I understand the study will endeavor to learn more about their every day life, what they have experienced in attending health care and their thoughts about health and what that means to them.

If there are women who would feel comfortable having their interview [REDACTED] can most often accommodate this request with some advanced notice.

Sincerely,

[REDACTED]

May 14 ★

[REDACTED]

To Ms. Cynthia Kitson, student, University of Ottawa

Dear Cynthia, This email is in response to your request to hang recruitment posters for the research study that you are undertaking to satisfy the requirements of your studies at the University of Ottawa.

I give permission to you to hang the posters related to your study. Please contact Andrew Cheam, Manager, when you are ready to deliver the posters.

Choose Hope!



[REDACTED]

THIS MESSAGE IS INTENDED ONLY FOR THE ADDRESSEE. IT MAY CONTAIN PRIVILEGED OR CONFIDENTIAL INFORMATION. ANY UNAUTHORIZED DISCLOSE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS MESSAGE IN ERROR, PLEASE NOTIFY US IMMEDIATELY SO THAT WE MAY CORRECT OUR INTERNAL RECORDS. PLEASE THEN DELETE THE ORIGINAL MESSAGE. THANK YOU.

CE MESSAGE EST STRICTEMENT RÉSERVÉ À L'USAGE DE L'INDIVIDU À QUI IL EST ADRESSÉ. IL PEUT CONTENIR DE L'INFORMATION PRIVILÉGIÉE OU CONFIDENTIELLE. TOUTE DIVULGATION DE CETTE COMMUNICATION EST STRICTEMENT PHOIBÉE. SI VOUS AVEZ REÇU CETTE COMMUNICATION PAR ERREUR, VEUILLEZ COMMUNIQUER AVEC NOUS IMMÉDIATEMENT ET ENSUITE DÉTRUIRE CE MESSAGE. MERCI.

Appendix C

Participant Observation Consent (1 copy for researcher and 1 copy for participant)



Université d'Ottawa
Faculté des sciences
de la santé
École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Consent Form- Health care providers who are involved in the participant observation

Research copy: There are 2 copies of the consent form, one of which is ours to keep.

Name of the study: Women who use intravenous drugs: The culture and implications for health and health care

Researcher: Cynthia Kitson NP PHC, PhD(c)

Contact at the University of Ottawa: Dr. Patrick O'Byrne, RN, PhD, School of Nursing

Phone: [REDACTED]

Purpose: To know more about what women who inject drugs think about health care. The study would like to know more about the daily life of women who inject drugs, their experiences with health care, and what might help women who inject drugs to receive health care.

This study is being conducted independently from the organization you are associated with while providing care. It is part of a research study in requirement of a PhD degree at the University of Ottawa.

Your role: To allow the researcher, Cynthia Kitson, to observe health care interactions between yourself and clients who are women who use intravenous drugs.

Your Participation: To provide care for the client as per your norm. The researcher will be observing the client's interactions and responses.

Risks: No risks are anticipated, although it is possible the client will temper their responses in an attempt to please the researcher or provide a positive response in order to ensure the healthcare provided is seen in a positive light.

Voluntary participation: Both yourself and the clients are under no obligation to participate in the research study. Should you wish to see anyone privately, despite the client agreeing to have the researcher observe the healthcare interaction, your wishes will take priority. Should you agree to have the researcher observe, and circumstances change during the appointment so that you are no longer in agreement, you may indicate to the researcher to leave.

Benefits: It is the aim of the study to present the findings from the study so there will be a better understanding of the health care needs and the way health care could be given to women who inject drugs.

Confidentiality: You will not be identified in publications related to this study. For your signature on the consent a code will be provided so that the women you are seeing for healthcare cannot be identified through medical records or notes. Anytime the results of the study are published, direct quotes from the interviews will be used, but real names will not be given. It will be known the study took place in a city in Canada.

Data storage: All notes taken by the researcher will be confidential, and any identification of participants will be noted by use of the code. All notes will be kept in a locked cabinet in a locked room at the university for 7 years. The notes will then be disposed of in a secure manner.

The research is being conducted independent of the organization that provides health care at this site. The research is a part of the researcher's studies at the University of Ottawa.

Agreement to participate: You _____ (code) _____ agree to participate in the research study conducted by Cynthia Kitson, School of Nursing, Faculty of Health Sciences, under the supervision of Dr. Patrick O'Byrne as described above and you understand that you may withdraw consent at any time.

Participant code written by the participant: _____ Date: _____

Researcher's name _____ Researcher's signature _____

If there are any questions regarding the study please contact either:

- 3) Protocol Officer for Ethics in Research at 613 562 5387, ethics@uottawa.ca, or at the University of Ottawa, Tabaret Hall, 550 Cumberland St, Room 154, Ottawa ON K1N 6N5.



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University of Ottawa
Faculty of Health
Sciences
School of Nursing

☎ 613-562-5473
☎ 613-562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Consent Form- Health Care Participant Observation

Participant Copy There are 2 copies of this consent, one of which is yours to keep.

Name of the study: Women who use intravenous drugs: The culture and implications for health and health care.

Researcher: Cynthia Kitson NP PHC, PhD (c)

Contact at the University of Ottawa: Patrick O'Byrne, RN, PhD, School of Nursing

Phone: [REDACTED]

Email: [REDACTED]

The purpose: To know more about what women who inject drugs think about health care. The study would like to know more about the daily life of women who inject drugs, their experiences with health care, and what might help women who inject drugs to get health care.

Your Role: You are being invited to participate in the study because you are receiving health care.

Your Participation: The researcher will sit in the room where you will receive health care and take notes during the health visit.

Risks: You may be observed being asked by the health care provider if you consent to have the researcher in the room during your visit. Also it is possible you may be seen talking to the researcher by someone who is aware of the research topic. In this way you might be identified as someone who uses intravenous drugs. All talking will occur in a private space or room to protect your confidentiality.

If answering any question makes you feel uncomfortable, you may indicate your wish not to answer the question or to continue the conversation.

Benefits: It is the aim of the study to provide policy makers and health care providers with the findings of the study so that a better understanding of the health care needs and service delivery for WUID can help to make changes to how health care is provided.

Confidentiality and Anonymity: The information you provide is seen as requiring the utmost confidentiality. It is possible to have research notes requested by a legal authority. To this end, no personal identification will be required so that there is no traceable evidence linked to you. The study will use exact quotes from participants but no real names will be given. It will be known the study took place in a city in Canada. Any publications or presentations about this study will abide by the same rules of confidentiality.

The limits of confidentiality may be exceeded if the discussion during the appointment reveals child abuse, current active suicidality or homicidality. By law these behaviours must be reported.

Data storage: All notes will be kept in a locked cabinet in a locked room at the University of Ottawa. The data information will be kept for 7 years and will then be destroyed in a secure manner (confidential shredding).

Voluntary participation: There is no obligation to participate in the research. If you choose to participate and then wish to withdraw or chose not to answer any questions there will be no consequences. You will be asked regarding your wishes for the data already gathered and your choice of

- 1) having all the notes related to your appointment destroyed OR
- 2) allowing the researcher to keep the notes up until your decision to end participation. The same rules of confidentiality and security will still apply to the information you have provided.

The research is being conducted independent of the organization that provides health care at this site. The research is a part of the researcher's studies at the University of Ottawa.

Agreement to participate:

I, _____ (code) _____ agree to participate in the research study conducted by Cynthia Kitson School of Nursing, Faculty of Health Sciences, under the supervision of Dr. Patrick O'Byrne as described above and I understand I may withdraw my consent at any time.

Participant code written by the participant _____ Date: _____
 Researcher's name_Cynthia Kitson_ Researcher's signature _____

If there are any questions regarding the study please contact:



3) Protocol Officer for Ethics in Research at 613 562 5387, ethics@uottawa.ca, or University of Ottawa, Tabor Hall II, 550 Cumberland St, Room 154, Ottawa ON K1N 6N5

Appendix D

Study Questions and Participant Observation Notes

Item	Observation of WUID during a health-related appointment	Observation of Healthcare Environment
Everyday life of homeless WUID in the downtown core		
1)	comments related to what it took to come to the clinic if it was difficult or facilitated	what does the set up/environment say about how the clinic fits in with everyday life of a WUID?
What predominates day-to-day life?		
2)	what are they talking about in regard to their everyday tasks and how this visit fits in or not	<p>what are the women doing, do they leave as other activities take precedence over waiting?</p> <p>is there a needle exchange?</p> <p>or a black disposable box on site?</p>
How do WUID ensure they get what they need?		
3)	<p>what facilitated coming how did they make sure they came to the clinic?</p> <p>do they ensure they get attention?</p> <p>do they talk to the receptionist and make their needs known?</p>	<p>what are the hours, are they posted?</p> <p>accessibility- note stairs, doors</p> <p>is it on a bus route, easy access ie most clinics are in the residence</p> <p>do they make an appointment or walk-in</p> <p>is there easy access to the receptionist?</p>
How do WUID understand the notion of health and how have they experienced healthcare		

<p>4) a & 4) b</p>	<p>any participant information re: their health and what made them come this time or another (I really needed to see you today because...)</p> <p>What brought the client to be seen for a healthcare-related matter</p> <p>comments related to not coming (I would have come last week but)</p> <p>reasons the women attend- PC or emergency care, meds, reproductive needs?</p>	<p>is the clinic set up for emergency care, primary care or both?</p> <p>is there health promotion material posted, available</p> <p>is there equipment for women's healthcare?</p> <p>reasons the women attend- PC or emergency care, meds, reproductive needs?</p>
<p>How do WUID think healthcare could be made better</p>		
<p>5)</p>	<p>do they seem comfortable and open in this environment?</p> <p>do they make any comments about how they think the clinic could work better for them?</p>	<p>what are the hours</p> <p>is there somewhere to sit?</p> <p>do the women change the environment- move chairs around?</p> <p>has the clinic changed based on client feedback?</p>

Appendix E**Participant Observation Field Notes**

date time and place observed	observational notes	theoretical notes	methodological notes	personal notes

Adapted from Polit & Beck. (2001) p. 283

Appendix F**Artifact Catalogue**

artifact collected	date, time	context (place)	context (circumstance)	content	impression/interpretation

Appendix G

Study Questions and Artifact Collection

Artifact- home remedy	Artifact- posters, papers, news about WUID or healthcare topics for women	Artifact- photographs
Everyday life of homeless WUID in the downtown core		
what does the item tell about day-to-day life of WUID	is this a program/poster/topic specific to WUID? Who is invited? Who is not invited?	what is the sequence of the day, when does the day start and finish? who is in the photos? What food do they eat? How are the people dressed? What are they doing?
What predominates day-to-day life?		
POPP kits? what does the item tell about what is important to WUID?	what aspects of health are addressed? what aspects of WUID life are being addressed	what topics/subjects most frequently noted in the photos
How doe WUID ensure they get what they need?		
is the item felt important to getting what they want i.e. a needle and syringe? Grocery cart?	is transportation covered? is there food offered or other services?	what do the photos indicate about activities that assist with getting what they need?
How do WUID understand the notion of health and how have they experienced healthcare		
what does the item indicate about how WUID regard their health? how does the item empower self-care	what are the topics? What are the hours?	what does the photo show about knowledge or experience of health

what does the item say about mainstream healthcare?	how are they invited? What will their role be?	are their photos of places women go for healthcare? Or other activities- drop ins
how do WUID think healthcare could be better		
<p>what aspect of healthcare does the object replace?</p> <p>does the item enable remaining a hidden population</p>	was the topic determined by a needs assessment? Were WUID consulted?	are their photos of desired items- home, food, clothes

Appendix H

Consent to take photographs and acknowledge receipt of compensation (1 copy for the researcher and 1 copy for the participant)



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infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Consent for taking photographs for the study

Photographer Copy: There are 2 copies of the consent form, one of which is yours to keep.

Name of the study: Women who use intravenous drugs: The culture and implications for health and health care.

Researcher: Cynthia Kitson NP PHC, PhD (c).

Contact at the University of Ottawa: Dr. Patrick O'Byrne, RN, PhD, School of Nursing

Purpose: To know more about what women who inject drugs think about health care. The study would like to know more about the daily life of women who inject drugs, their experiences with health care, and what might help women who inject drugs to get health care.

Your Role: You are being asked to take 5 photographs of "anything" about health. As the researcher cannot be with you during your day, the photographs will assist with knowing and understanding more about the everyday life and health of women who inject drugs.

Your participation:

- 1) You will be given a disposable camera.
- 2) Take at least 5 photographs of anything you think is related to health.
- 3) Take photographs that do not make it possible to identify people. For example, no faces or identifying information (e.g. tattoo) should be in the photographs. An arm with an access would be okay.
- 4) You will receive \$20 to compensate you for:
 - a) the time spent taking the photographs and
 - b) returning the camera to Cynthia
 - c) within a week
 - d) with a minimum of 5 photographs.


Risks: You may be asked what you are doing by a bystander or someone who thinks their photo is being taken. Please explain you are taking the photographs as part of a research project that you are participating in. You will be given a card with the researcher's contact details to give to the person should they have further questions.

Data Storage: All photographs and cameras will be kept for 7 years and then securely disposed.

☎ 613 562-5473
☎ 613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Date camera received _____
Signature Code _____
Researcher Signature _____

Date camera returned with a minimum of 5 photographs _____
Compensation of \$20 received yes
Signature Code _____
Researcher Signature _____

If there are any questions regarding the study please contact:


3) Protocol Officer for Ethics in Research at 613 5625387, ethics@uottawa.ca, or the University of Ottawa,
Tahiret Hall, 550 Cumberland St, Room 154, Ottawa ON K1N 6N5



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☎ 613 562-5473
☎ 613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Consent for taking photographs for the study

Research Copy: There are 2 copies of the consent form, one of which is yours to keep.

Name of the study: Women who use intravenous drugs: The culture and implications for health and health care.

Researcher: Cynthia Kitson NP PHC, PhD (c).

Contact at the University of Ottawa: Dr. Patrick O'Byrne, RN, PhD, School of Nursing

Phone: [REDACTED]

Email: [REDACTED]

Purpose: To know more about what women who inject drugs think about health care. The study would like to know more about the daily life of women who inject drugs, their experiences with health care, and what might help women who inject drugs to get health care.

Your Role: You are being asked to take 5 photographs of "anything" about health. As the researcher cannot be with you during your day, the photographs will assist with knowing and understanding more about the everyday life and health of women who inject drugs.

Your participation:

- 1) You will be given a disposable camera.
- 2) Take at least 5 photographs of anything you think is related to health.
- 3) Take photographs that do not make it possible to identify people. For example, no faces or identifying information (tattoo) should be in the photographs. An arm with an abscess would be okay.
- 4) You will receive \$20 to compensate you for:
 - a) the time spent taking the photographs and
 - b) returning the camera to Cynthia
 - c) within a week
 - d) with a minimum of 5 photographs.

Risks: You may be asked what you are doing by a bystander or someone who thinks their photo is being taken. Please explain you are taking the photographs as part of a research project that you are participating in. You will be given a card with the researcher's contact details to give to the person should they have further questions.

Data Storage: All photographs and cameras will be kept for 7 years and then securely disposed.

Date camera received _____
Signature Code _____
Researcher Signature _____

Date camera returned with a minimum of 5 photographs _____
Compensation of \$20 received yes
Signature Code _____
Researcher Signature _____

If there are any questions regarding the study please contact:



3) Protocol Officer for Ethics in Research at 613 5625387, ethics@uottawa.ca, or the University of Ottawa,
Taharret Hall, 550 Cumberland St, Room 154, Ottawa ON K1N 6N5

Appendix I

Recruitment Poster

RESEARCH STUDY FOR WOMEN
 Study approved by the University of Ottawa Research Ethics Board



Do you inject drugs?

Do you have experience with going to the hospital or to a clinic?

Are you an English speaking woman (transgendered or identifying as a woman), 18 years of age or older who is homeless in downtown [redacted] and currently injecting drugs for at least the last 6 months?

IF YOU SAID YES to these questions:
 Would you like to help with a research study that hopes to learn more about women who inject drugs and their views on health and health care?

What's Involved?
 The study involves a 30 minute interview.
 To say thank you for your time and help by completing an interview for the study, you will receive \$25

Research Opportunity
 Participants will be selected on a first-come, first-served basis.

In photos by: [redacted]

To find out more or to arrange an interview contact the researcher at [redacted] by text or phone; or email her at [redacted]. You can also drop by the Mission clinic and speak to Cynthia.

Appendix J

Study Business Card



uOttawa

Cynthia Kitson

[Redacted]

Find Cynthia at:

The Mission Clinic Shepherds of Good Hope

[Redacted]

Appendix K

Interview Recruitment Screening Script

Recruitment script for women interested in an interview:

Once the potential participant has reviewed the poster and contacted the researcher the recruitment script will be as follows:

“Thanks for contacting me about the research. We think there is a need to improve the healthcare that women who inject drugs receive, and to do this we need to talk to women and find out what their lives are like, what they think about health and what experiences they have had with healthcare”.

“We are looking for women who are over 18, who don’t have a stable home (so they are living in a shelter or on the streets for example), in downtown ██████ and have been injecting drugs for over 6 months and, also, in the last month. Do your circumstances fit this description? We are taking women for interviews on a first come, first served basis”.

If Yes:

“If you decide you would like to participate in the research it would mean we would get together and talk for about twenty minutes to half an hour. I would ask you some questions about what your everyday life is like, how you look after your health, and what health concerns you have as a woman who injects drugs. Also, I would be interested in having you tell me about what it’s like for you to get healthcare. Good experiences and bad experiences. The conversation would be audio taped so I can accurately remember what you said. You would be given \$25 for your time and for sharing your experiences”.

“The research has nothing to do with the place that you saw the poster- it is being conducted out of the University of Ottawa as part of my studies there”.

“Do you have any questions about the research that you wanted to ask, anything that would help you to decide if you want to participate or not”?

“If you agree we can review the consent form and you can ask any questions you have. You will be asked to sign the consent form. The signature you use will be a code because it is important to maintain confidentiality and protect your identity. There will be 2 copies of the consent form one that you can keep and the other is for me”.

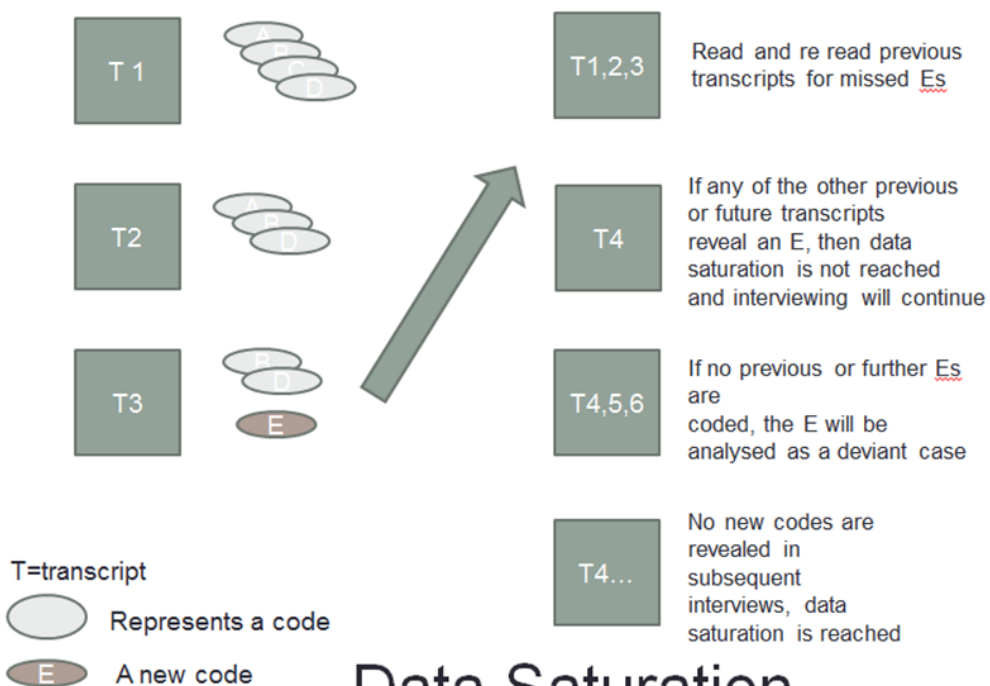
If No: (they don’t meet inclusion criteria or aren’t interested)

“Thanks so much for thinking about participating! I really appreciate your interest”.

If appropriate to add: “If you have any friends who you think might want to be a part of the research - ask them to be in touch with me. Do you need a business card”?

Appendix L

Data Saturation



Data Saturation

Adapted from Guest et al. 2012

Appendix M

Interview Consent (1 copy for the researcher and the other for the participant)



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Faculté des sciences
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École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

☎ 613 562-5473
☎ 613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Consent Form- Interview

Research Copy: There are 2 copies of this consent form, one of which is yours to keep.

Name of the study: Women who use intravenous drugs: The culture and implications for health and health care

Researcher: Cynthia Kitson NP PHC, PhD(c)

Contact at the University of Ottawa: Dr. Patrick O'Byrne, RN, PhD, School of Nursing

Phone

Email:

Purpose: To know more about what women who inject drugs think about health care. The study would like to know more about the daily life of women who inject drugs, their experiences with health care, and what might help women who inject drugs to get health care.

Your Role: You are being asked to share what your day to day life is like, and your thoughts about health and health care in an interview for this study because you are a woman who injects drugs.

Your Participation:

- 1) There will be one interview that will take about 30 minutes.
- 2) The interview will be audiotaped, however this is an option and you may ask not to be taped.
- 3) The interview process will include asking you to talk about:
 - a. what your daily life is like
 - b. what you think about being healthy
 - c. what you think of health care services
 - d. what stops you from getting health care
 - e. what makes you go for health care
 - f. what can be done to make health care better
- 4) The interview can take place at the Mission Clinic, Brigid's, the Special Care Unit for Women or Hope at Shepherds of Good Hope, Cornerstone, or other agreed upon location.
- 5) You will receive \$25 to compensate you for the time spent, and any costs incurred.

Risks: You may be seen talking to the researcher by someone who knows about the research. In this way you might be seen as a woman who injects drugs. All precautions will be taken to meet in a private room. If answering any question makes you feel uncomfortable, you may indicate your wish not to answer the question or to continue the conversation.

Voluntary participation: There is no obligation to join the research study. If you choose to join and then do not want to answer a question or you want to end the interview, your wishes will be respected. You may also choose to stop the interview at any time. You will be asked what your wishes are for the data that I already taped. You will have the choice of:

- 1) having all of the audiotape erased OR
- 2) allowing the researcher to keep the tape up until when you chose to stop.

Benefits: It is the aim of the study to present the findings from the study so there will be a better understanding of the health care needs and the way health care could be given to women who inject drugs.

Confidentiality and Anonymity: The information you provide needs the utmost confidentiality. It is possible that the study tapes and/or notes taken by the police. Your name will not be taken as part of the research. In case the police take the tapes and/or notes, there will be no evidence linked to you.

Anytime the results of the study are published, direct quotes from the interviews will be used, but no names will be given. It will be known the study took place in a city in Canada.

If during the interview you talk about current or active child abuse, current or active plans to hurt yourself or others the limit of what can be kept confidential will be passed. By law these behaviours must be reported.

Date storage: All tapes and notes will be locked in a locked room at the university for 7 years.

The tapes and notes will then be disposed of in a secure manner.

The research is being conducted independent of the organization that provides health care at this site. The research is a part of the researcher's studies at the University of Ottawa.

Agreement to participate:


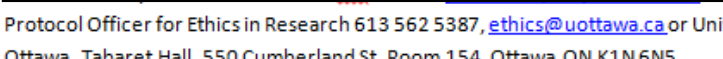
I, _____ (code) _____ agree to participate in the research study conducted by Cynthia Kitson School of Nursing, Faculty of Health Sciences, under the supervision of Dr. Patrick O'Byrne as described above and I understand I may withdraw my consent at any time.

Participant code written by the participant _____

Date: _____

Researcher's name, Cynthia Kitson, Researcher's signature _____

If there are any questions regarding the study please contact

- 1) 
- 2) 
- 3) Protocol Officer for Ethics in Research 613 562 5387, ethics@uottawa.ca or University of Ottawa, Tabaret Hall, 550 Cumberland St, Room 154, Ottawa ON K1N 6N5.



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451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Consent Form- Interview

Participant Copy: There are 2 copies of this consent form, one of which is yours to keep.

Name of the study: Women who use intravenous drugs: The culture and implications for health and health care

Researcher: Cynthia Kitson NP PHC, PhD(c)

Contact at the University of Ottawa: Dr. Patrick O'Byrne, RN, PhD, School of Nursing

Purpose: To know more about what women who inject drugs think about health care. The study would like to know more about the daily life of women who inject drugs, their experiences with health care, and what might help women who inject drugs to get health care.

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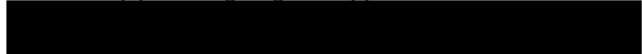
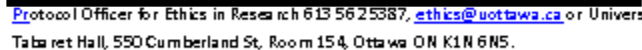
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I, _____ (code) _____ agree to participate in the research study conducted by Cynthia Kitson School of Nursing, Faculty of Health Sciences, under the supervision of Dr. Patrick O'Byrne as described above and I understand I may withdraw my consent at any time.

Participant code written by the participant _____ Date: _____

Researcher's name_Cynthia Kitson_ Researcher's signature _____

If there are any questions regarding the study please contact

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- 3) Protocol Officer for Ethics in Research 613 5625387, ethics@uottawa.ca or University of Ottawa, Tabaret Hall, 550 Cumberland St, Room 154, Ottawa ON K1N 6N5.

Appendix N

Interview Guide

Item	Question
Everyday life of homeless WUID in the downtown core	
1.	<p>Teach me what it's like to go through a typical day being you?</p> <p>What is a typical day?</p> <p>For example, how did yesterday go? Was that a usual day for you?</p>
What predominates day-to-day life?	
2.	<p>What is the main thing you do every day?</p> <p>What activities fill your day?</p>
How do WUID ensure they get what they need?	
3.	How do you make sure you get what you need?
How do WUID understand the notion of health and how have they experienced healthcare	
4a	<p>Do you consider yourself healthy? What does being healthy (unhealthy) mean to you?</p> <p>How do you know when you are healthy? sick?</p>
4b	<p>What is it like to seek healthcare as a person who uses intravenous drugs?</p> <p>Is it different because you are a woman?</p> <p>Please tell me what your experiences of healthcare have been...</p>
How do WUID think healthcare could be made better	
5	<p>What would make it easier for WUID to go for healthcare?</p> <p>What would encourage you to go to see your doctor or nurse practitioner?</p>

	What has made you seek healthcare in the past?
--	--

Item	Question	Rationale
Everyday life of homeless WUID in the downtown core		
1	<p>Teach me what it's like to go through a typical day being you?</p> <p>What is a typical day?</p> <p>For example, how did yesterday go? Was that a usual day for you?</p>	<p>Glaser said "the best way to approach a subject is to say to the person 'teach me'" - so they're co-investigators (Stern, 1989, p. 183)</p>
What predominates day-to-day life?		
2	<p>What is the main thing you do every day?</p> <p>What activities fill your day?</p>	<p>Open ended question about common activities can help to know more about priorities and what is important in the life of a WUID.</p>
How do WUID ensure they get what they need?		
3	<p>How do you make sure you get what you need?</p>	<p>Open ended, a variety of answers are possible therefore the answers aren't directed and may give insight into how WUID achieve their persona; goals on a daily basis (getting food, drugs, shelter). Their strategies may enable a better understanding of how to establish healthcare.</p>
How do WUID understand the notion of health and how have they experienced healthcare		

4a	<p>Do you consider yourself healthy? What does being healthy (unhealthy) mean to you?</p> <p>How do you know when you are healthy? sick?</p>	<p>Personal information about how they consider health, deeper understanding about health would assist</p>
4b	<p>What is it like to seek healthcare as a person who uses intravenous drugs?</p> <p>Is it different because you are a woman?</p> <p>Please tell me what your experiences of healthcare have been...</p>	<p>exploring experiences with healthcare as positive or negative</p> <p>learning more about whether women are seen as different</p>
How do WUID think healthcare could be made better		
5	<p>What would make it easier for WUID to go for healthcare?</p> <p>What would encourage you to go to see your doctor or nurse practitioner?</p> <p>What has made you seek healthcare in the past?</p>	<p>Insight from the perspective of the consumer can be helpful in understanding how to provide healthcare service.</p>

Appendix O

Codebook Prototype

Theme: demeaning treatment (by healthcare providers)						
interview topic	code	brief description	full definition	when to use	when not to use	example from text
Q4b experience of healthcare	name calling	being labelled	a derogatory term is used by an HCP while caring for the participant, meant to categorize them as less than deserving	apply this code to all references the participant notes to being devalued through labeling	do not use this code if the HCP is making a derogatory observation- about i.e. track marks, clothing, smell do not use it when there is a blame attached to the comment (you deserve this health condition because you do this to yourself)	you are just a junkie
	unjust treatment	waiting, being ignored	the participant describes being treated differently than others	the participant is comparing treatment of self to others and finding a negative difference	do not use this code if they also give a rational reason why they were treated differently	they kept seeing other people first, and they came in way after me
	inflicted pain	being unduly hurt	an action by the HCO caused pain beyond what would be anticipated or felt to be necessary	the participant describes a physical procedure that they felt was done in a manner that	if the participant is describing a painful procedure but not implying	they didn't even freeze it, they just cut me open

				purposely produced pain	any intention to cause pain	
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Adapted from Guest et al., 2012

Appendix P

Deviant Case Analysis

Steps to take:			
From the first round of analysis develop an interpretation of the data			
For each interpretation search the data for cases that don't fit			
Finding a negative case:			
	Is the case related to the study's objectives?		
	If no:	If yes:	
	Ignore the case	Is it unique or on the continuum of a theme?	
		If it is not clear reassess data for explanations for the outlier	
		Look at outside information from, for example, the literature search, local experts	
If an explanation is found, incorporate it. If not, the theoretical model may need revision, or the case can be abandoned			
Ensure the variance is adequately explained by the model and then decide whether to include it in the analysis (and possibly revised collection of data) and the study report.			

Adapted from Guest et al. p. 115-117.

Appendix Q

Rigour

Concept	How to achieve	What will be done
Research Design		
ethnography	data gathered via various approaches	gather artifacts, interviews, observation
Data Collection Stage		
train in collection techniques	purposeful questions, probing techniques	<p>have a plan of topics to be covered, will ensure each is reviewed with each participant</p> <p>review interviewing techniques with each audio tape in order to revise and improve question delivery and probing technique</p>
adjust structure of instrument to fit goals and structure of the study	<p>structure allows better comparability</p> <p>ok to be less structured for exploratory research, or single data collectors</p>	review audiotapes to ensure codes are covered and revise codes and definitions as needed
monitor data as it comes in	review how the interview went for quality and consistency	after each interview- review within 24 hrs sooner if possible
elicit information from participant after summarizing	have participant review so ambiguities and things that are unclear can be clarified	reflective listening and summarizing during the interview will enable participants to review what they have said and will ensure what they said has

		been heard and interpreted as they meant it to be
Data Analysis		
transcribe data using the transcription protocol	<p>verbatim account of data collection event</p> <p>using a transcription protocol ensures that transcription is done consistently and is of the appropriated type for the analytic aims</p>	<p>transcribe within 24 hrs</p> <p>code as per codebook</p> <p>add tags, memos to note possible new codes or reflective comments</p> <p>each line should be identified L111 (line and interview) for easy retrieval for review</p>
develop and use a precise code book	<p>descriptive and precise to enhance intercoder reliability</p> <p>can use it again in a different study</p> <p>codebooks serve as documentation of the themes relevant to a given study, provides easy access to code meanings for internal reviews</p>	<p>start with code definitions as suggested by Guest- may need revision as new information from the data arises</p> <p>if we look at HC needs of women, then the same codes may at least in part reflect those of men if a second study is done</p> <p>review and ensure the “meaning” of the code is not evolving without recognition of this</p>
use multiple coders and intercoder agreement checks	<p>check re: bias and variance in interpretation</p> <p>iterative revision improves precision of codes</p>	<p>will do this alone, multiple times to ensure consistency and</p> <p>revise as required</p>
external and/or peer review of coding and summaries	outside review facilitates coding reliability- checks individual bias and variance	will request periodic reviews with supervisor

create an audit trail	document analysis steps and codebook revisions- increase transparency facilitates internal review of processes and ability to accurately replicate procedures if desired	will keep a separate record of all research activities, like a diary (dates, what was done and the rationale)
triangulate data sources	if analyzed properly convergent data from different source/methods validate findings if divergent this needs review as well	will analyze data from artifacts, observations and interviews to see if there is convergence used the technique of braiding the data divergent data will be of interest and need to be explained as per Appendix H
negative case analysis	consciously include negative case in an analysis migrates analyst bias by forcing the analyst to look for and report any evidence contrary to prevailing patterns identified in the data	will look for, report any outlying cases as per Appendix H
support themes and interpretations with quotes	use of verbatim quotes increases the validity of findings by directly connecting the researcher's findings to what the participants said	will include use of relevant and poignant quotes to illustrated findings

Adapted from Guest et al., 2012

Appendix R

Ethics Approval

File Number: H05-14-08

Date (mm/dd/yyyy): 06/10/2014



Université d'Ottawa University of Ottawa
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Patrick	OByrne	Health Sciences / Nursing	Supervisor
Cynthia	Kitson	Health Sciences / Nursing	Student Researcher

File Number: H05-14-08

Type of Project: PhD Thesis

Title: Women who use intravenous drugs: The culture and implications for health and health care

<u>Approval Date (mm/dd/yyyy)</u>	<u>Expiry Date (mm/dd/yyyy)</u>	<u>Approval Type</u>
06/10/2014	06/09/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

Please note that participant observation (asking to sit in on client/patient visits) at health care sites may only occur at centres for which permission has been granted (specifically for participant observation).

File Number: H05-14-08

Date (mm/dd/yyyy): 06/10/2014



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Protocol Officer for Ethics in Research
Chair of the Health Sciences and Sciences REB