Injection drug use and despair through the lens of gender

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To begin, close your eyes and imagine an injection drug user in the back alleys or among the dumpsters of a Canadian inner-city area. Chances are that you imagined a man. Now, can you conjure up an image that is even more dismal in terms of the prospects for hope, for health and for survival? The answer is simple — just imagine a woman in the same circumstances.

In this issue of *CMAJ* (page 767), Julie Bruneau and colleagues report their findings about risk and risk behaviours in men and women who inject illicit drugs in Montreal.[1] It is hopeful to see the appearance in print of a report that discusses the circumstances of an often-overlooked population, women who inject drugs. The authors report that the variables independently associated with risk of HIV seropositivity among women who inject — including obtaining syringes at shooting galleries and being out of addiction treatment — may differ from those for male injection drug users. Although Bruneau and colleagues found that HIV prevalence rates were lower among women than among men, they suggest that this finding could be due to differential selection of lower-risk women for their study. In contrast, in our ongoing study of injection drug users in Vancouver,[2] we have recently found that the use of injection cocaine is higher among women and that the HIV incidence rate among women is about 1.5 times that among male users (unpublished data).

Behind these awful statistics are lives of desperation, dispossession and despair. Regrettably, survey data can offer only a partial understanding of the special circumstances of female injection drug users that place them at risk for HIV. To develop deeper insights into the circumstances and complexities of HIV transmission among injection drug users, researchers have increasingly combined both quantitative and qualitative approaches.[3] More specifically, techniques such as participant observation, in-depth interviews and focus groups can help to unravel extremely complex webs of causation. Almost inevitably, these studies reveal that the mechanisms compromising women's injection and sexual safety are intricately and intimately connected to life histories characterized by emotional, sexual and physical cruelty. In an attempt to give voice to the numbers, we present here the life history of Marie (not her real name), based on her in-depth interview with one of the authors (P.M.S.).

When Marie was 12 years old, living in a suburb of Vancouver, she was raped by her father while her brothers slept in adjacent beds. After this incident Marie and her brothers were put into foster care. When she was 14 years of age, a 42-year-old man picked her up from a street corner at dusk. She was already strung out on acid, and she recalls that "he got me wired, he got me doing coke, he injected me that very night. He was a user and a pimp, so he saw me and I guess he knew how easy it would be to get me out on a corner . . . . At first it felt great 'cause men wanted to pay to be with me."

According to Marie, this man became like a father figure for her and showed her love like she had never known. But then he began to beat her, and her predilection for injected powder cocaine intensified. "He said to me, this is what happens to you if you enjoy being with a trick.… He wanted to make sure that all that was in my head was to make money, to get the money and go back and give it to him." She sometimes tried to make her money and run; however, he would track her down, inject her and then batter her, sparing only her face. Controlled by both fear and drugs, Marie's vulnerability escalated. "I just started using a lot, and every time I got into a trick's car, I felt relieved. I could escape." By the time Marie was 17 years old, drugs and tricks had become the only reality she knew. Today, at age 28, although she has survived gang rape, incarceration, miscarriages and 2 suicide attempts (slashed wrists and a heroin overdose), she is infected with both HIV and hepatitis C.

Sadly, this is just one of a multitude of stories with the same underlying themes: power imbalance, physical abuse, sexual coercion, commercial sex work, drug use, vulnerability and despair. Is it any wonder that HIV and hepatitis C are rampant in both women and men? Yet even now, harm reduction strategies such as making tolerant drug treatment readily available,[4] providing access to sterile syringes[5] and establishing safe injection sites[6] continue to be shunned in some quarters.[7] And even among those who find the language of harm reduction comfortable, there are many who do not recognize that such strategies are mere lifejackets tossed into a sea of despair. They may prevent the immediate problem of drowning, but they do little to turn the tide.

Suppose that 7 people die of *Escherichia coli* O157:H7 infection in a waterborne outbreak in a small Canadian town.

Now imagine the justifiable outcry that would ensue. Suppose that just 1 or 2 teenagers die in an outbreak of meningococcal meningitis. Now imagine the justifiable outcry that would ensue. In the year 2000, in British Columbia alone, at least 240 women and men died of injection drug overdoses. Now imagine an eerie silence.

When will we stop terrorizing and start treating those who suffer from the medical condition of addiction? When will we recognize HIV, hepatitis C and overdose deaths in addicted people for the public health crises that they are? When will we confront the root problems of poverty, unemployment and housing that cause so much ill health in our country?

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