Women who use injection drugs: the social context of risk

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Education

Éducation

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Relatively few studies — especially Canadian ones — have addressed the problems and issues specific to women who are injection drug users. Much of what we can say about this group of women must be extrapolated from the literature on HIV/AIDS and from reports on drug treatment programs in the US. Notwithstanding the lack of information about them, women who inject drugs are increasingly visible in our society. Needle-exchange and harm-reduction programs in Canada report significant use by women: for example, women comprise 35% of the approximately 6000 registrants of the Vancouver Needle Exchange[1,2] and were represented in the same proportion in the cohort of injection drug users involved in the Vancouver Injection Drug Use Study (VIDUS).[3] Approximately 20% of injection drug users recruited in Montreal for an observational study of risk behaviours and HIV infection were women.[4]

The urgency of the problems facing these women challenges physicians to develop a more sophisticated understanding of the culture and context in which they live and a more informed approach to their health care.

Women and injection drug use

As Juanita Clarke has commented, because men and and women "inhabit partially different cultural worlds and structural positions. . . . their health expectations and relevancies, their typical sickness profiles, and their illness reports will differ."[5] Although it is common to use gender-neutral language to describe addiction, there is evidence that the experience of addiction and its contributing factors are different for women than for men.

For women, previous sexual or physical victimization may be a predisposing factor in drug abuse. A survey conducted by the US National Institute of Mental Health revealed that the prevalence of drug abuse or dependence was 4 times higher among women with a history of sexual assault than among other women.[6] Among 151 women attending a methadone treatment centre in New York surveyed by Gilbert and associates, 39% had been physically or sexually abused before the age of 16 years and 27% before the age of 13.[7] These findings are consistent with those of other studies involving women undergoing treatment for substance abuse.[8]

Violence — and the fear of violence — are significant factors in the lives of most women and are even more prominent in the lives of women who are making their way on the street, coping with an addiction, or both. Of the 12 300 Canadian women who participated in the 1993 Violence Against Women Survey, 51% reported at least one incident of sexual or physical violence since the age of 16, and 10% had experienced sexual or physical violence within the 12 months preceding the survey.[9] In Gilbert and associates' study, 65% of participants in the methadone program reported that they had been abused as adults; of these, 89% had been physically abused, 71% life threatened, 25% forced to have sex and 20% both physically and sexually abused.[7] Women undergoing treatment for substance abuse are also significantly more likely than their male counterparts to have associated emotional or psychiatric diagnoses.[10,11] The addiction may in fact be secondary to comorbid conditions, which include mood disorders, anxiety and post-traumatic stress disorder.[12]

Insight into the social networks of injection drug users is important to our

understanding of their lives and behaviours.[13] The position and roles of women within these networks differ from those of men, and their drug-injection practices are more likely to be affected by close personal relationships. In an analysis of psychosocial risk factors for HIV transmission among injection drug users, Brook and colleagues[14] demonstrated that a woman's relationship with significant others and family members was strongly associated with needle-sharing behaviour. They suggested that a woman's sense of well-being and her ability to protect herself are more closely tied to her relationships than are a man's. Women are less likely than men to shoot up alone and more likely to be influenced by others to inject drugs. They may take less time to become addicted and are more likely than men to have an addicted partner. Women more frequently than men make money for their habit by working in the sex trade.[15]

Barnard[16] has examined gender differences in needle-sharing behaviours using ethnographic methodology and notes that needle sharing is "seldom a random activity but one which is socially patterned and differentiated by gender." For her female respondents, needle sharing was, like other injecting behaviours, affected greatly by relationships with regular male partners. In other studies of high-risk injection behaviours, women more often than men reported sharing needles with their regular sexual partner, being the second on the needle after their partner and being injected by their partner.[15]

Social context can also affect the ability of women to utilize addiction treatment programs.[8] Close personal relationships, the prevailing norms of their community, and larger social and legal concerns are all important considerations for women in treatment. Women in treatment are more likely than men to be financially dependent and less likely to seek treatment independently. Programs may not be accommodating to women, especially to those with children, and may not always protect women from sexual harassment or violence within their social setting.

Camacho and coworkers[17] reported that among a sample of patients who remained in a comprehensive methadone maintenance program for at least 6 months, women reported less reduction in risky injection and sexual practices than men. The authors suggested that women's social status and economic realities are seldom addressed either in research or in treatment and noted that "approaches that emphasize self-esteem enhancement, assertiveness training, and negotiation skills for women have shown positive results."

HIV and injection drug use among women

The authors of the National Action Plan on HIV, AIDS, and Injection Drug Use noted that women comprise a continuously increasing proportion of people infected with HIV, and that 17% of infections among Canadian women to date have been associated with injection drug use.[18] From 1992 to the middle of 1997, the BC Centre for Disease Control found that injection drug use (as a sole risk factor or in combination with work in the sex trade) was reported by 45% of women who received positive HIV test results.[19] Although women make up 35% of the VIDUS cohort, they accounted for 42% of those found to be infected with HIV when they were recruited into the study.[3]

Many factors serve to increase the already significant risk of HIV infection for women who use injection drugs. These women are often unable to negotiate safer sex because of personal histories of sexual abuse or because of the superior power and physical strength of their sex partner. As with needle-sharing behaviours, unsafe sexual practices are more common among women who report a history of childhood sexual abuse. A woman's ability to protect herself in a sexual relationship may be eroded by the emotional consequences of sexual victimization, including low self-esteem and the recurrent selection of abusive partners.[20-22]

Women drug users often work in the sex trade to support both themselves and their male partners. Data from VIDUS indicate that this sex trade work further increases their risk for HIV infection and that the more clients they report, the higher is their risk.[3] Of a group of sex trade workers in Harlem, only 41% reported that they always used condoms with paying partners. This study reported high levels of psychological distress among the women associated with such factors as perceived risk of AIDS and recent rape.[23]

The psychological impact of previous victimization can be compounded by the social context of injection drug use. Wallace[24] has shown that the breakdown of supportive social networks in impoverished, pressured communities disempowers women such that they are "driven into formal prostitution or informal exchanges of sexual favors for male 'protection' in the absence of such empowerment, regardless of their level of AIDS awareness." Men who pay to have sex with very young girls on the Vancouver streets pay more for sex without a condom. The desperation of these adolescents and their personal histories of abuse make it difficult for them to refuse.

All women are vulnerable to sexual assault: 39% of Canadian women surveyed in 1993 reported a history of sexual assault,[9] and women with HIV, addicted women and women working in the sex trade report even higher rates.[7] In the British Columbia Positive Women's survey, 53% of women with positive HIV test results reported having been sexually assaulted as an adult, and 12% reported that their HIV infection occurred after a rape.[25] A history of sexual assault may increase other risk behav-

iours. In a case–control study of the HIV outbreak among injection drug users in Vancouver, women who reported a history of nonconsensual sex were more likely to report that they shared needles.[26]

Public health education strategies to address risk for HIV do not work well among women with more immediate concerns. They may postpone HIV testing because they do not perceive the risk, or because the risk seems small compared with the consequences of spouses or child-protection authorities discovering they are HIV positive.[27] Women often consider a semi-exclusive relationship to be protective and will forgo condom use with their main sexual partner, a common practice among sex trade workers. A woman's insistence on condom use by her main partner may be risky because of the implication that she herself may be infected.[28] Many women who have participated in qualitative studies of their experiences in relation to HIV status have spoken about other conditions such as poverty, violence at home or on the street, responsibility for children and the fear of rejection if they discover and then disclose that they are infected.[29]

HIV treatment may not be as accessible for women who use drugs as it is for men. VIDUS data show that women users are only half as likely as men to receive appropriate antiretroviral therapy.[30] Various factors could account for this, including the differential effects of social pressures, level of practitioner experience or bias.

Injection drug use and pregnancy

Pregnant women who inject drugs face the same issues in their close relationships and social contexts as have been described earlier. However, some of these issues become more urgent during pregnancy. Most women who use injection drugs live in poverty, supporting themselves and sometimes their male partner with a combination of government assistance and prostitution. If they choose to complete a pregnancy they must find additional support, preferably away from prostitution, including ways of paying for better nutrition and accommodation.

Pregnant women and women with children fear admitting drug use because of the well-founded belief that they will lose their babies. In 1992, Loock and associates[31] made a retrospective estimate of the proportion of babies born with significant antenatal exposures over 2 years in several Vancouver neighbourhoods. In the Downtown Eastside, this proportion was about 30%, and at the time of the study *all* of the exposed babies were in government care.

Fear of the consequences of disclosure may be one reason why the likelihood of prenatal drug use is underestimated by health care providers. Hospital-based screening studies in Vancouver, Montreal and Toronto have shown prenatal drug exposure prevalence rates between 3.8% and 12.5%. Estimates vary but are consistently higher than the numbers indicated by self-reported drug use and up to 10 times higher than the numbers of exposed infants diagnosed clinically.[32,33]

Pregnant women are often highly motivated to reduce or eliminate their drug use out of concern for their baby and a desire to achieve a more stable life.[12] However, there may be few resources available to assist them.[8] Lack of access to treatment for women, especially pregnant women and women with children, is a significant problem across North America.

How the physician can help

The challenges facing a practitioner in assisting a woman who is an injection user can be disheartening. However, women who use injection drugs have a right to receive, and certainly need, respectful, high-quality medical care that takes into account their addiction. As with any patient, the first step is to establish a trusting, nonjudgmental relationship in which honest communication about drug use is possible.

Physicians should educate themselves about the dynamics of injection drug use in women, particularly the importance of familial and social contexts and associated psychological factors.[10] Assisting the patient with addiction management strategies is important; this may include referral to local substance abuse treatment programs or referral to (or provision of) methadone maintenance. Unfortunately, the treatment of injection addictions can be difficult, and failure — at least in the short term — is common. Therefore, although abstinence is a worthy long-term goal (and greatly facilitates most other medical care), it may not be one that is immediately achievable or even shared by the patient.

Other goals may be more immediately practical, such as providing harm-reduction education to reduce associated risks such as exposure to HIV or hepatitis C, or improving the patient's personal support network. Establishing a working relationship, achieving easy access to and continuity of care, developing an addiction management strategy with the patient, providing appropriate medical assessment and treatment, identifying and managing comorbid conditions and improving outcomes for babies and other children are all valuable and potentially achievable primary care outcomes.[34]

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