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The Social Context of HIV Risk Assumption and Risk Reduction Strategies Employed by Injection Drug Users

by

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ABSTRACT

This study explored the social contexts which influence injection drug use behaviours and the risks associated with those behaviours. Social context includes interpersonal relations, peer influences, cultural norms, social situations and settings. The social context of injection drug users (IDUs) in Calgary was explored through in-depth ethnographic interviews with 13 IDUs. Informants were recruited through the local needle exchange program and purposively sampled for maximum variation in order to gain an understanding of the various social contexts surrounding local injection drug use. The findings are presented as descriptive themes and interpretive vignettes of drug use. The informants provided valuable in-depth descriptions of their addictions, their injection behaviours, HIV/hepatitis risk reduction, and the social forces that affect their drug use and their ability to prevent HIV/hepatitis transmission. The findings could prove to be a valuable tool for program planners to customize their harm reduction interventions to the complex social influences surrounding injection drug use.

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I. INTRODUCTION

People who inject drugs are at very high risk for infection with the human immunodeficiency virus (HIV), the causal agent of AIDS. Approximately one-third of all HIV transmissions in North America are linked to drug injecting (see Table 1). The sharing of injection equipment by injection drug users (IDUs) is the second most common means of HIV transmission in Canada, after sexual contact. The transmission of HIV among IDUs ultimately affects the rate of HIV infection in other segments of the population through unprotected sex and mother-to-baby transmission. One of the primary modes for HIV transmission through intravenous drug injecting is the use of HIV-contaminated syringes, needles, vials, spoons, and other injection equipment. International, national, and provincial epidemiologists confirm that HIV transmission through injection drug use is a growing health concern.

Table 1: 1997 HIV Rates due to Injection Drug Use in Canada and Alberta

HIV RATES (1997)	CANADA	ALBERTA
DUE TO INJECTION DRUG USE	863	97
TOTAL NEW INFECTIONS	2598	217
PERCENTAGE	33.2%	44.7%

Source: UNAIDS & WHO, 1997; Health Canada, 1997; Alberta Health, 1997

In Alberta, since 1990 the number of HIV seroconversions due to needle use increased from 5 to almost 45 percent. Nationwide, the proportion of HIV positive tests that can be attributed to injection drug use is steadily increasing. It has been estimated that between 42,500 and 45,000 people have been infected with HIV in Canada. In total, IDUs

represent one-third of all persons who have tested positive for HIV since 1986 (Health Canada, 1997). The statistics are even more staggering on an international scale. Certain regions in India reported infection rates of 73% at drug clinics in 1996. Two-thirds of IDUs in Myanmar (Burma) are infected with HIV and 70% of the 25000 cases of HIV infections in Ukraine have been in IDUs (UNAIDS & WHO, 1997).

II. DEFINITION OF TERMS

In order to proceed with a discussion of the social environment and its role in the HIV risk reduction or risk assumption behaviours of IDUs, it is important to first define the terms and concepts which were used throughout my study.

A. Injection Drug User

An injection drug user (IDU) is one who administers drugs by injection with a needle and syringe. The term "injecting drug user" is used in this study in place of intravenous drug user (IVDU) to include all individuals who inject substances, both legal and illegal, intravenously, intramuscularly, or subcutaneously. This definition is used since injection of any substance or skin punctures where equipment is shared carries the risk of HIV or hepatitis transmission. Injection may be intramuscular, as in anabolic steroid use, or subcutaneous (also known as "skin popping") as in heroin use. However, most IDUs practice intravenous injection. Although intravenous injection is somewhat difficult to execute, the extra effort pays off in faster delivery of the drug effect, and less local tissue damage which can occur when injecting relatively impure black market drugs intramuscularly or subcutaneously. IDUs most commonly inject intravenously in veins on the inside of the lower arm, but also have been known to use veins in the hands, feet,

under the tongue, in the temples, neck, groin, or penis.

For ease of communication in my thesis, I refer to all individuals who use injection drugs as injection drug users (IDUs). I am aware that these individuals should not be labeled with one broad title as identified only by their involvement with injection drugs. They are diverse individuals who share certain lifestyle features, but otherwise should be regarded as distinct personalities. I do not intend to depersonalize my informants or any other individuals who use injection drugs and I am cognizant and sensitive to the issues of labeling.

B. Community

The concept of community is used widely in health promotion literature, but its definition is not always clear. Public health and health promotion discourse often use community to refer to a group of people who share certain characteristics, such as geography (e.g., a neighborhood), ethnicity (e.g., the Chinese community), or age group (e.g., the senior citizen community). However, community encompasses more than simple membership in a group with shared aggregational or relational characteristics. Community derives from the Latin word *communitas,* meaning "common or shared" (Labonté, 1989). In a broader sense, community should be treated as a "locality-bound aggregation of people who share economic, socio-cultural and political characteristics, as well as problems and needs" (Labonté, 1989). The concept of community also implies that the members are a coherent unit who act together for shared purposes, for example expressing their health needs and planning services (Jewkes et al., 1996). According to this definition, to be part of a community its members should feel a sense of belonging or

social solidarity. Not only does the community share social ties or interaction, but it specifically shares a common need. Thus a discourse of sharing is an important element of community. Sharing is "the dynamic act of people being together" and "community is, in effect, organization" (Labonté, 1989).

Despite the consistent theme of "shared ties" that run through the multitude of definitions of community, it should not be assumed that communities are homogenous in all respects (Jewkes et al., 1996). While members may share a commonality that define them as a community, the sub-groups or individuals within the community can still experience conflict and competition. Though it is important to accept community self-determination in principle (as in communities selecting their own health priorities), it is also vital to recognize that what communities do for their own health may be harmful to public health (Labonté, 1989). As an example, Nazi Germany was a strong community, as are many radical fringe groups. However, a major endeavour of this thesis is to determine if injection drug users in Calgary define themselves as a community, and if so, what definition of community they are using.

C. Social Context

Social context refers to "the collective features of the social and physical environments that define the social and behavioural characteristics of and settings for IV drug use and risk for HIV infection in a particular neighbourhood or social grouping" (Watters, 1989). Social context will be used in this thesis to include social forces such as interpersonal relations, peer influences (either constructive or destructive), cultural norms, etiquette, social situations, and social settings. It is also important to specify that social interactions and social situations do not necessarily mean friendly or happy

relations. Conflict and confrontation are integral parts of social context and exert substantial influence on shaping the social environments within which injection drug use occurs.

D. Health Risks Associated with Injection Drug Use

Much of the harm related to injection drug use often results from a combination of limited needle availability, poor hygiene surrounding self-injection, and inadequate injection technique. Injecting with dull needles (those that have been used several times) produces larger punctures than necessary, causing skin, tissue and venous scarring in regular or frequent injectors. Repeated use of damaged sites and improper injection technique may result in abscesses, ulceration, venous scarring, and circulatory damage when veins clog (thrombosis) or collapse (The Lindesmith Center, 1996).

Unsterile skin, syringes, needles and other paraphernalia can introduce a variety of infectious agents. Contracting HIV or viral hepatitis through using injection equipment with traces of someone else's blood is not the only risk. Organisms common to the skin surface can contribute to the development of bacterial infections. The water used to prepare drugs for injection may provide another source of bacteria, virus and other infectious agents (The Lindesmith Center, 1996). Even skilled IDUs with sterile injection equipment and clean skin cannot prevent injecting the insoluble (and/or harmful) diluents and impurities most black market drugs contain. Impurities such as talc, cornstarch, quinine, and fibres of cotton or cigarette filters all have been implicated in damage to cardiac, skeletal and smooth muscle, the gastrointestinal tract and kidneys, local tissue destruction, bacterial growth, neurological lesions, and immunological abnormalities

(The Lindesmith Center, 1996).

Malnutrition, sleep deprivation, poor personal hygiene, high stress levels, inadequate shelter, and poverty — characteristics many heavy drug users share — have a negative impact on the immune system and frequently exacerbate all the previously described harms. In addition, the analgesic and cough suppressing properties of opiates work to mask symptoms of existing illness or injury, until the maladies become severe (The Lindesmith Center, 1996). Dissatisfaction with, fear or distrust of, medical institutions has an additional negative effect on IDUs' health.

E. Risk Reduction

Risk reduction (also referred to as "harm reduction") is a health promotion philosophy which has as it first priority a decrease in the negative consequences of drug use. The risk reduction approach can be contrasted with abstentionism, the dominant policy in North America, which emphasizes a decrease in the prevalence of drug use. Risk reduction tries to reduce problems associated with drug use and recognizes that abstinence is not the only acceptable or important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence; it is consequently an approach which is characterized by pragmatism (Riley, 1995). The approach is based on the belief that moral condemnation of groups at risk will lead to reduction in contact with health services and therefore be counterproductive and that the majority of drug users are willing and able to change behaviour if the right conditions apply. For further discussion of how risk reduction philosophy is applied in practice, see below.

F. Safer Injection Drug Use

While injecting is the most complicated and risky way in which to administer drugs, its health risks can be significantly reduced by ensuring aseptic injection conditions. Aseptic injection can be simply stated as: "New equipment for every hit of drug and hands washed before touching anything or anyone else" (Queensland Intravenous AIDS Association, 1997). Ideally, IDUs should use a new syringe and needle for every injection and are encouraged to stock up on syringes rather than be caught short. If a clean unused syringe is unavailable, IDUs are told to clean the syringe with bleach with no guarantee that the cleaning will be 100% effective against HIV or Hepatitis C. However, some cleaning is better than none at all. If forced to use an old needle, the best practice is for an IDU to use one of his or her own.

Safer injection also includes good vein care techniques, such as rotating injection sites, using a tourniquet that is easy to release before injecting the drug, and applying pressure to the injection site immediately after the hit until the bleeding stops. IDUs are also encouraged to prevent abscesses, septicaemia, and endocarditis by cleaning the injection site with an alcohol swab and using only sterile water to prepare their hit. IDUs should also avoid injecting dirty hits (dirt, hairs, fibres, etc. in the hit) by using a clean spoon and a new filter every time (Queensland Intravenous AIDS Association, 1997).

There are four main measures that IDUs can take to ensure safer injecting: (1) not sharing injection equipment (including needles, syringes, water, spoons, filters, or tourniquets); (2) keeping it sterile by swabbing spoon, injection site and fingers with alcohol beforehand; (3) cleaning up after injections by flushing out the syringe to get out all traces of blood, making bleaching easier if necessary; and (4) safe disposal by

recapping the needle, placing it in a hard rigid walled container and returning the container to the local needle exchange program (Queensland Intravenous AIDS Association, 1997).

III. PURPOSE

The purpose of this study was to explore how the social context of IDUs can either facilitate or impede risk reduction efforts. This study used ethnography in order to characterize the broader circumstances of IDUs' lives, and especially to describe the social networks and situations that impact on risk reduction or risk assumption behaviours within the IDU community. The driving force for this study was our need to understand how social domains can be advantageous or detrimental to current prevention programs, such as NEPs. The project was based upon the supposition that the social networks though which HIV may be transmitted are the same social networks that may be co-opted for HIV prevention. There have been many calls for action with respect to gaining an understanding of the social networks of IDUs and how these networks can be used to the advantage of health programs that aim to reduce the risk associated with injection drug use. This study undertook to reveal the underlying subtleties of social norms, peer pressure, and social roles that may facilitate risk reduction among IDUs.

IV. INJECTION DRUG USE IN CALGARY

Calgary, like many other mid-sized urban centers, has a well-established population of IDUs; estimates of the IDU population range from 2000 to 2500. At the Southern Alberta Clinic (SAC) for HIV/AIDS treatment, 25 patients out of every 100 are IDUs, and it is estimated that province-wide, up to 43% of people who are HIV-positive

are IDUs (Dr. John Gill, personal communication, January 21, 1998).

The predominant drugs administered by injection are cocaine and morphine, with morphine users tending to be of an older generation than the cocaine users. According to word-of-mouth reports from IDUs, since Christmas of 1997, there has been a heroin boom in Calgary. Mortality data also provides evidence that opiate abuse is an emerging problem in Calgary (Poulin et al., 1998). The influx of heroin to the city is cause for concern as it is the availability of cheap, pure heroin that is considered a major factor in the high rate of overdose deaths in Vancouver.

V. PROMINENT DRUGS USED BY CALGARY IDUS

What follows is a brief outline of the characteristics of cocaine, morphine, and heroin and a description of their effects and addiction qualities. An understanding of the effects of each of these drugs is important when considering the risk reduction or risk assumption behaviours associated with their use in various settings and situations. Although social context exerts an important influence over risk assumption or risk reduction behaviours, the physiological and behavioural effects of the psychoactive drugs must also be considered.

A. Cocaine

Cocaine is a powerful central nervous system stimulant which produces heightened alertness, inhibition of appetite and the need for sleep, and intense feelings of euphoria. Cocaine induces an increased sense of well-being, increased garrulousness, elevated self-confidence and feelings of mastery over the environment or, paradoxically, anxiety or even panic. Symptoms of cocaine use include severe agitation, paranoid

thinking, tremors, muscle twitches, nervousness, excitability, memory disturbance and agitation. Cocaine's effects diminish usually within 30-40 minutes and many experienced users inject up to 20 times per hour (over several hours) in very high doses in order to prolong the drug's effects; they are generally aware of the heightened risks attendant on such use and are also willing to accept them. Intense psychological dependence - a persistent craving for the psychological effects — can occur. Some cocaine users will remain moderately to severely depressed over extended periods of time when the drug is not available to them, and they remain preoccupied to the point of obsession with obtaining the drug. The addiction risk of cocaine is among the highest for all drugs of abuse because of two key factors. First, the euphoria produced by cocaine is powerful. Second, since cocaine is highly soluble in water, large amounts can be dissolved and administered by injection directly into the bloodstream. Intravenous administration in high doses permits both very rapid and intense gratification (Cox et al., 1983).

B. Heroin

Heroin has the greatest potential for producing dependence of any of the common narcotic analgesics. This characteristic can be attributed to its extremely powerful euphoric and analgesic effects and its high fat solubility, which permits immediate and intense gratification as the drug enters the brain rapidly after intravenous injection (Cox et al., 1983). North American heroin-dependent users prefer to inject it intravenously, producing the desired effects more immediately and more intensely than with administration by any other route. The effects of heroin use include euphoria, mental clouding, heightened feelings of well-being, relaxation and drowsiness in some, and in others garrulousness and activity. Shortly after administration the user may experience a

drowsy, dreamy, mild dozing state referred to as a "nod." Often there is decreased physical activity, inability to concentrate, apathy, and reduced visual acuity. As the duration of heroin use increases, progressively higher doses are required to produce satisfactory analgesic, sedative and euphoric effects.

C. Morphine

After heroin, morphine has the greatest risk of addiction of the narcotic analgesics in common use. When injected intravenously, morphine can produce intense euphoria and a general state of well-being and relaxation. Morphine's effects include drowsiness, lethargy, difficulty in concentrating, mild anxiety or fear, and blurred vision. As the duration of morphine use increases, the user's ability to concentrate is increasingly impaired. Marked tolerance to many of morphine's main effects can rapidly develop with regular (i.e., daily) heavy use, particularly if the user administers the drug through intravenous injection. Increasingly greater doses are required to produce desired euphoric, analgesic, and sedative effects. With protracted heavy use, and compensatory increases in daily dose to maintain the desired effects, the user reaches a dose plateau where no amount of the drug can produce the desired intensity of effects. At this point, the primary reason for continued use is to avert withdrawal sickness (Cox et al., 1983).

D. Summary

One can see from the above descriptions that the physiological, psychological, and behavioural effects of cocaine, morphine, and heroin have the possibility to impede harm reduction efforts. The chaotic nature of a cocaine high has the potential to create situations of disarray and frenzy, thereby increasing the possibility of needle sharing,

especially when a group of cocaine users are injecting together in one setting. The preoccupation of cocaine users to obtain their next injection of cocaine may cause them to disregard risk reduction measures, such as the use of a new needle with every injection. On the other hand, the lack of concentration and impairment of vision induced by opiate use may also create situations among morphine or heroin users that increase their susceptibility for needle sharing. For example, a sleepy morphine user may not have the energy or concentration to take note of from whom or where a needle is obtained. It is difficult to say which drug creates effects least conducive to risk reduction behaviours, but it is likely that the effects of each drug are mediated significantly by the social contexts within which IDUs administer the drugs.

VI. RISK REDUCTION IN PRACTICE

In the absence of a cure for AIDS or a vaccination for HIV, the most powerful control of transmission is through education, prevention, and risk reduction. Current risk reduction approaches to the prevention of HIV are targeted at those who are already injecting. They include the provision of sterile injecting equipment and safe disposal of used needles, accessible methadone maintenance programs, and education on all levels from national media to peer-based street education (Crofts et al., 1996). Most NEPs distribute cotton filters, alcohol wipes, bleach, and condoms as well as referrals to health care and drug treatment programs. Needle exchange programs (NEPs), as a form of risk reduction, have proven very successful in reducing the possible negative consequences of injection drug use. The basic message of risk reduction can be summarized by the following four statements: (a) get off drugs, (b) if you can't stop using drugs, stop

injecting drugs, (c) if you can't or won't stop injecting drugs, don't share needles (or other drug paraphernalia), and (d) if you can't or won't stop sharing needles, at least disinfect needles between sharing partners using common household bleach (Watters, 1989).

The World Health Organization Global Program on AIDS is based on the belief that through accurate information and intensive education, the spread of AIDS can be stopped. The general principle guiding WHO is: "People who *have learned,* who *wish to use* what they have learned, who are *influenced positively* by others, and who *have the opportunity* and support *to modify their behaviour* will do so" (WHO, 1988, emphasis in original). This study focused on how IDUs can be "influenced positively by others" to reduce the health risks associated with injection drug use. It is important that we understand the needs and perceptions of people who inject drugs in order to develop effective strategies to reduce the health risk factors prevalent among these health service consumers. Much of the existing literature indicates that IDUs are very knowledgeable about the HIV risk inherent in their practices. However, little is known about local conditions or patterns of drug use, interactions between IDUs, and preventive activities as they relate to the spread of HIV among IDUs in Calgary.

Calgary, Edmonton, Red Deer and Grande Prairie have community-based programs, including needle exchange, that have been set up in an attempt to stem the spread of HIV among IV drug users who commonly share drug paraphernalia. NEPs are run on a system that exchanges clean needles free of charge for used needles brought in by IDUs. Participation in a needle exchange program does not preclude sharing drug paraphernalia or other modes of HIV transmission. Many IDUs will simply not bother using NEPs and instead rely on other methods of risk reduction or, all too often, do

nothing to reduce the risk of HIV transmission. In addition to sharing drug paraphernalia, many social and economic consequences of supporting a drug habit can result in high risk situations. Springer (1991) notes at least four relationships linking drug use and HIV/AIDS: (1) transmission through injection equipment, (2) the sex-drug link through several mechanisms (the effect of cocaine on libido, sex for money or drugs, mood-altering substances and risk reduction), (3) immunosuppressive effects of some drugs, and (4) the pediatric HIV-drug connection. Although needle exchange programs have proved to be successful in significantly reducing risk practices among IDUs (Hankins, 1998), there is a need to recognize the imperfections of prevention strategies in order to appreciate where they work and where they break down.

VII. SAFEWORKS CALGARY

SafeWorks Calgary is the only needle exchange program in the city, but has three fixed sites as well as an outreach van. The three fixed sites are located at (1) Calgary Urban Projects Society (CUPS), a community health center for street people in the downtown core; (2) Eighth & Eighth Health Center, a drop-in clinic at the western end of downtown; and (3) AIDS Calgary, a support and resource center for persons living with HIV/AIDS and the community at large. SafeWorks staff operate the fixed sites at CUPS and Eighth & Eighth Health Center, while AIDS Calgary staff run the service at their fixed site. The fixed sites at CUPS and AIDS Calgary operate during weekday office hours, and the fixed site at Eighth & Eighth operates from Saturday to Wednesday evenings (5 to 10 P.M.). The mobile outreach van visits people who do not have access to the downtown sites. The nurses are contacted by pagers and service all parts of the city

from 8 P.M. to 1 A.M. four nights a week.

The NEP at CUPS is an ideal setting for sampling and data collection because it is a large-scale program that serves the Calgary population of IDUs. The program has steadily grown from 1,974 exchanges of 11,558 needles in 1991 to 4,600 exchanges of 178,370 needles in 1994. A return rate of over 95% was reported in 1994 (LeMarquand-Unich, 1995). In 1997, SafeWorks had 767 new registrants and handed out 338,000 needles to IDUs. The latest count of clients who are registered at the SafeWorks NEP is 1200; however, for every NEP client, there are an estimated three people who are non-client IDUs (V. Wheeler, personal communication, October 29, 1997). SafeWorks currently has an exchange rate of almost 100%, meaning that the NEP receives back as many used needles as they give out clean ones.

VIII. LITERATURE REVIEW

A sociological perspective is essential in AIDS behavioural research. HIV risk reduction or risk assumption behaviours among IDUs are inextricably intertwined with psychosocial factors. Because acquiring HIV infection occurs nearly exclusively in specific behavioural contexts, it follows that we should conceptualize HIV risk in interpersonal and social contexts. Studies should examine interpersonal relationships as a key variable, paying attention to their duration, behavioural norms, level of commitment, emotional and material connectedness, and level of dependency (Wermuth et al., 1992).

The following review of the literature is organized to frame and build up to the problem that is the focus of this study. The literature will proceed from evidence of the importance of social context to (1) HIV risk practices, (2) HIV risk reduction, (3)

initiation into injection drug use, (4) education about the risks of injection drug use, and (5) how social context can inform current risk reduction programs.

A. Importance of Social Context in HIV Risk Practices

Sharing of drug paraphernalia is affected significantly by peer-group influences. Therefore, health professionals should be working toward peer-based programs that allow IDUs to become empowered, or to have the ability "to define, analyze and act upon [their own] problems" (Labonte, 1989). There are substantial gaps in the knowledge of the contexts within which IDU drug paraphernalia sharing occurs, and the perception of risk within each context. Within IDU populations, there are gradations of needle sharing; some share sporadically and selectively while others share indiscriminately. Donoghoe (1992) concludes that social circumstances and lifestyle factors are more important aspects of needle sharing than individual choice and motivations. Magura et al. (1989) described the strong impact peer group behaviour has on needle sharing and peer group behaviours, and attitudes conducive to sharing needles and other injection equipment.

There are two categories of reasons for needle sharing (Alberta Health, 1996): (a) sharing out of need, due to issues such as access and affordability, and (b) sharing out of choice or due to the social context. Issues related to the social context of drug paraphernalia sharing include availability of equipment, selection of injection partners, social norms, and peer pressure. Social sharing is more amenable to interventions, while issues that surround the use of used injection drug equipment out of need are more difficult to address. According to the literature, equipment is often shared when someone else administers the drug (Alberta Health, 1996). Over 40% of IDUs occasionally or frequently rely on others to inject them and nearly 60% use equipment supplied by the

person giving the injection. This happens most frequently between male users and their sexual partners. There exists significant opportunities for peer influence during such intimate moments when one person is injecting another. As early as 1982, ethnographers were examining settings and activities that public health officials speculated were relevant to the transmission of HIV. Des Jarlais et al. (1986) described the social organization of shooting galleries in New York City and discovered the actual interactional mechanisms conducive to transmission, such as the tight bond between "shooting buddies" that makes needle sharing an essential element of friendship.

It is important that health planners have a contextual understanding of drug injecting, the culture of drug use, and the stages and form of addiction among different subgroups of drug users (Myers et al., 1995). Such understanding would allow health practitioners and programmers to design and implement risk reduction interventions that will be accepted within, and integrated into, current social networks. Risk practices, such as needle sharing, are shaped by social interactions and social norms. The entire process of purchasing, pooling, preparing, and injecting drugs occurs within a social context, with deeply engrained rituals. It follows that interventions targeted to reduce the risk of injection drug use will also be shaped by social interactions and social norms. In order to optimize the potential role of social context in risk reduction, it is necessary to first gain an understanding of exactly what the social contexts are comprised and what they mean to the IDUs within them.

B. Importance of Social Context in HIV Risk Reduction

Risk reduction behaviours appear most likely to be adopted when they are

ubiquitous and endorsed repeatedly by trusted members of the community. Thus, if bleach or clean syringes are readily available in the settings where IDUs inject drugs, if they have accepted the use of these materials as in their interest, and use is not overly disruptive to their routines and habits, adaptive behaviour can be encouraged (Watters, 1989). By understanding the social context of drug use in a particular social grouping, clues to the design of effective population-wide prevention strategies can be gained. In cities such as Calgary where HIV seroprevalence rates are still fairly low, there are now opportunities to define the unique social contexts of injection drug use that can lead to the design and implementation of effective. If, as has been suggested, the social context of needle use is what will define the trajectory of HIV epidemics among IDUs, the strategies we develop, and our conceptual orientation to the task of prevention must confront the social realities of drug-using subcultures (Watters, 1989).

Risk reduction appears to occur through social processes rather than through individual attitude change; HIV prevention programs therefore need to explicitly incorporate social processes into their intervention efforts. Numerous studies have highlighted that NEPs need to penetrate the social circles of IDUs and to develop a meaningful role within them in order to improve current risk reduction programs (Fitzpatrick et al., 1991; Brook et al., 1994; 1995; 1996; Watters et al., 1990; Stimson, 1992; Watters, 1989; Hassin, 1994). However there have been few studies to date that have provided evidence of how NEPs can integrate, or be integrated into, existing social networks of IDUs.

C. Importance of Social Context at Initiation into Injection Drug Use

IDU peers can have a substantial influence over the level of risk involved when young or first-time injectors are initiated into the IDU culture. The education provided at first injection and the level of risk reduction practiced will shape what a new IDU sees as the cultural norms. Peer pressure at initiation can greatly influence the level of risk reduction an IDU practices throughout a career of injecting.

A recent study (Crofts et al., 1996) found that 88% (n=300) of IDUs were injected by someone else the first time and a substantial number of them (18%) cited peer pressure or the desire to conform as the reason for injecting the drug. Low proportions of initiates were taught how to clean syringes and needles on that first occasion (29% and 34%, respectively). Only half reported using their own needle and syringe when they were first injected; of the remainder 7% reused someone else's equipment without cleaning it properly. Of the IDUs who had initiated at least one other person into injecting, 60% reported having informed their protégés of where to get new injecting equipment, but only 31% informed them of the risks of HIV and hepatitis viruses. Reasons for beginning injecting included situational factors such as unemployment, homelessness and poverty, the influence of the peer group and the influence of a relationship with a friend, lover or sibling as initiators. The first-time injectors who did not inject themselves were most commonly injected by a friend or acquaintance. A small proportion were first injected by a family member, and for females a fifth were first injected by a sexual partner. Only three of these significant others were identified as dealers. Conformity with a peer group was the most common explanation of initiation, and it may be that initiation into injecting is a rite of passage in joining an injecting peer

group. Efforts to prevent injecting and unsafe injecting must continue to be directed as far upstream as possible - early in the IDU's or potential IDU's career.

D. Importance of Social Context in Education about Risk Practices

Canadians rely primarily on the mass media, such as television or newspapers, rather than specialized publications to learn about AIDS (Ornstein, 1989). Most IDUs do not rely on the mass media, but rather on their immediate friends. Therefore, it is important to use peers, sexual partners, family members, and dealers as sources of information for IDUs who have little or no contact with mainstream culture. Three of the common factors associated with behaviour change among IDUs with respect to HIV risk reduction were: (a) talking with drug-using friends about AIDS; (b) talking with sexual partners about AIDS; (c) and talking with family about AIDS. This finding suggests that effective risk reduction should be conceptualized as a social process rather than as the behaviour of an isolated individual (Gold et al., 1992).

Crofts and colleagues (1996) found that among young initiates into injection drug use, the most common sources of information were the media (64%), parents (26%) and peer education programs (10%). It is important to note that even though the major source of information for these young IDUs was the media, the most credible source was peers and peer workers. Accordingly, further development of peer education programs is a most desirable strategy (Crofts et al., 1996).

Contrary to common assumptions about IDUs, in which they are perceived as a difficult and resistant population requiring more coercion than other segments of the community, research suggests that the majority are amenable to changing behaviour

when offered realistic alternatives that do not require lifestyle changes that are, for them, unacceptable (Watters et al., 1990). Consequently, street-based outreach programs may be an effective means of reaching the estimated 85% of IDUs who, for various reasons, avoid or cannot find drug treatment (Watters et al., 1990). This effort must be broad enough to capture adequate data regarding the beliefs, practices, and risks associated with different ethnic, gender, and drug preference subgroups since risk behaviour and HIV exposure can differ substantially within them.

E. Importance of Social Context for Improving Current Risk Reduction Programs

The overall health impact of NEPs is strongly related to the proportion of IDUs who use them. There are an estimated 50,000 to 100,000 injection drug users in Canada (Addiction Research Foundation, 1993). Studies from abroad indicate that NEPs, if optimally designed, have the capacity to reach significant proportions of the local IDU population. Some of the most successful NEPs reach high proportions of IDUs: 34% in Manchester, England and over 50% in the Netherlands. Information gathered by other researchers suggests that, to date, coverage by US and Canadian NEPs has been more limited. American and Canadian NEPs have had contact on at least one occasion with a median of 14.5% of the estimated number of IDUs in those cities and have distributed a median of 2.3 syringes per IDU per quarter (CDC, 1993). In a Dutch study performed in Rotterdam, researchers (Grund et al., 1991) found that at least 60% to 70% of the target group is not reached by the NEPs. Therefore, priority should be given to prevent HIV transmission among the unreached - those who are most at risk (Grund et al., 1991). The low attendance rates of North American NEPs highlight the need to improve current risk

reduction strategies in order to reach a greater proportion of the IDU community. Widespread practice of safer injection is unlikely to occur until social, economic and psychological barriers that deter IDUs from accessing services are dealt with through legislative and policy change.

An evaluation of the Calgary Regional Health Authority's SafeWorks Calgary Project (1997) showed that the market segment that is least likely to be reached through the Calgary NEP is recent injection drug users. These people are most likely in their teens, but the size of this population is not known. Another market segment less likely to register with the program are light, infrequent IDUs. Infrequent users, or "bingers" will be less likely to have a ready supply of clean needles on hand, and thus will be at elevated risk of contracting HIV. NEPs alone cannot distribute sufficient numbers of syringes, and alternative methods of syringe distribution, such as through secondary outreach must be explored. A priority should be to prevent HIV transmission among non-clients - those who are most at risk - by maximizing the positive effect of collective exchangers. Many of the clients who exchange a large number of syringes (over 100) per visit are bringing dirty needles and delivering clean needles for other IDUs, that is, they are practising "collective exchange." The health promotive role filled by collective exchangers is an important avenue through which non-NEP clients can be reached.

Individual exchangers (those who exchange needles only for themselves) are driven by situational determinants, while collective exchangers have included getting clean needles in their daily life as a planned activity (Grund et al., 1992). Users who engaged in collective exchange were more aware of high-risk behaviours and put more energy into health maintenance and hygiene than individual exchangers. Within social

networks comprised of collective exchangers and non-client IDUs there is also more discussion of risk reduction. The needles distributed through the collective exchanges are thus having an impact beyond the user collectives. Beside being available for on-the-spot use, needles are distributed among other IDUs to take home. For many IDUs, the availability of clean injection equipment is a strong incentive to frequent those places supplied by collective exchangers. Grund et al. (1992) and Broadhead et al. (1995) support a community-based approach to needle exchange that is built on empowerment of, and intense participation by, known IDUs to target unknown IDUs for delivery of clean needles.

In a study of NEPs in Montreal, Van Caloen (1997) described an informal network of secondary distribution of new syringes, intimately linked to the NEPs. For example, some drug dealers in Calgary are known to provide sterile needles to IDUs together with the purchased drug for immediate use. Some Calgary clients bring large numbers of used syringes to the NEP which had been collected from a crack house, or a party. Such people who practise collective exchanges have a health promotive role within the IDU community and are an important link between NEPs and those IDUs who themselves don't use the NEPs.

A positive example of an NEP that takes advantage of existing social networks to extend the services of health professionals is the Streetworks Program in Edmonton which uses "natural helpers" to facilitate risk reduction among IDUs (Van Coloen,1997). The "natural helpers" include people within the drug-using community who have a deep understanding of the social networks of IDUs, working together to create an underground health care delivery system. The "natural helpers" may be users themselves, or live in

close proximity to IDUs, giving them an information base which is a "mixture of street lore and health knowledge." The goal of the Streetworks Program is to assist "natural helpers" in providing IDUs with information and tools for safer sex and injection practices. "Natural helpers" experience increased confidence and self-esteem as a result of their involvement in the program.

By furnishing IDUs with an ample supply of needles, NEPs are allowing IDUs to reinforce subcultural norms of sharing, yet in a safe way. IDUs distributing clean needles to other IDUs may experience conflict between the traditional subculture sharing norms with the more recently emerged norms regarding safer use. Donaghoe et al. (1992) concluded that as needle exchanges become more familiar and prevalent, a climate is developing in which the sharing of used injection equipment is no longer the norm. The use of natural settings (e.g., placing the plastic container at user collectives and dealing addresses), the involvement of existing drug user networks, and appeals to IDUs' sense of responsibility may be more powerful determinants of variations in needle exchange rates than psychological characteristics of individuals (Grund et al., 1992).

A major assumption which guided the study is that the people who are most likely to be trusted and have the most influence over non-clients are other IDUs, sexual partners, drug dealers, or family members; these significant others in an IDU's life could potentially serve as "caretakers," or facilitators of risk reduction. Caretakers may include collective exchangers who exchange for other IDUs who inject in the same setting, drug dealers who include clean needles as part of the drug transaction, crack house owners who exchange for IDUs using their premises, or non-IDUs who exchange for sexual partners, spouses, parents, etc. It is important to acknowledge that the same people that

have the potential to act as "caretakers" also have the potential to encourage or reinforce HIV risk assumption behaviours, such as the sharing of injecting paraphernalia.

In a class research project for MDSC 755, I was able to describe four different social settings or scenarios in which injection drug use occurs. The four scenarios within which IV drug use occurred can be described as: (1) weekend bingers at a dealer's safe house; (2) a single mother in her own residence; (3) cocaine addicts in a shooting gallery; and (4) hookers in a crack house. These four scenarios are most likely only a small sampling of the possible range of social settings. The description of the four scenarios, however, demonstrates that it is impossible to provide a general characterization of IDUs. Rather, the project demonstrated that instead of grouping IDUs together as one homogenous group of people, it is important that we recognize that there are many diverse social situations, each presenting unique demands upon HIV prevention efforts that would be impossible to meet simultaneously. What remained for me to explore was how the various settings, situations, and relationships can be converted into opportunity for risk reduction through the action of "caretakers" or needle exchange collectives.

IX. THE GRAND TOUR QUESTION AND SUBQUESTIONS

The grand tour question which directed my study was: "How does the social context of IDUs influence HIV risk reduction or risk assumption behaviours?" Subquestions that helped to answer the larger question included:

- What is meant by "community" and "social network" in the context of drug injecting?
- What are the characteristics of Calgary IDU communities and networks?

- How do social relationships facilitate or impede risk reduction behaviours?
- How do social norms facilitate or impede risk reduction behaviours?
- How does peer pressure facilitate or impede risk reduction behaviours?

The grand tour question and subquestions guided my inquiry throughout the data collection. The actual interview questions asked of the informants were operationalized versions of the above questions (see Appendices E & F).

CHAPTER 2 - METHODS

I. STUDY DESIGN

A. Qualitative Design

Qualitative methods were used because they "stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (Denzin & Lincoln, 1994). Settings, situations, and relationships are important determinants of risk reduction or risk assumption behaviour among people who inject drugs.

Qualitative methods were ideal for understanding the meaning of the events, situations, and actions central to the lives of IDUs and the accounts that they give of their lives and experiences. In order to implement effective prevention, we not only need to know about HIV risk behaviours, but also the meanings behind why IV drug users behave as they do in assuming or reducing risks. "Meaning" refers to cognition, affect, intentions, and anything else that can be included in what qualitative researchers often refer to as the "participant's perspective" (Maxwell, 1997). Qualitative inquiry can be used to understand how situations, actions, and meanings are shaped by the unique circumstances in which they occur. An important strength of qualitative research is that it presents the opportunity to identify unanticipated social domains and influences relevant to risk reduction among IDUs. This study was aimed towards establishing the significance of social domains that were as yet unexplored areas, and to give rich description of these unknowns.

Qualitative study methods allowed me to study injection drug users in settings in which they are comfortable, in an attempt to make sense of behaviours in terms of the

meanings people bring to them. The primary concern of my study was not with generalization (as in quantitative studies), but with developing an adequate description, interpretation and understanding of a specific group of injecting drug users in Calgary.

B. Ethnography

Ethnography is a form of social research which has its roots in cultural anthropology, and is aimed towards describing a culture and understanding another way of life from the participant's point of view (Neuman, 1997). It is particularly useful when the health problem is of considerable concern to the public, and when existing research paradigms (that is, experimental design, or epidemiology) have not provided satisfactory answers to questions or problems concerning the social environment in which HIV is spread, or popular responses to the problem. Ethnography can help to answer some of the complex questions regarding the relationships among culture, injection drug use, and HIV transmission because it offers methods for identifying, observing, documenting, and analyzing culture (patterned beliefs and behaviours) in populations which are difficult to reach.

Ethnographic methods were appropriate for my thesis study because no outcomes could be anticipated and the explanations were believed to lie with as yet unidentified patterns of difference among the IDU community members (Atkinson & Hammersley, 1994). Ethnography places a strong emphasis on exploring the nature of particular social phenomena, rather than setting out to test hypotheses about them. The purpose of my ethnographic research was to describe the meanings and functions of human actions from the perspective of the participants and to tell the inside story and explore the worldview

of those involved. Its primary aim was to understand a culture - its values, knowledge, behaviour, artifacts, and implicit and explicit rules. This study focused on relationship systems within the culture (Marshall & Rossman, 1995). It concludes with a holistic cultural portrait of the social group that incorporates both the views of the IDUs and my own interpretations about IDU social life in a social science perspective (Creswell, 1998). This cultural portrait is an overview of the entire cultural scene and will incorporate all aspects learned about the group in order to show its complexity.

Procedures in ethnography call for a detailed description of the culture-sharing group, an analysis of the culture-sharing group by themes, and some interpretation of the culture-sharing group for meanings of social interaction and generalizations about human social life (Wolcott, 1994). A critical part of ethnography is thick description, a rich, detailed description of specifics capturing events and contexts, thereby permitting multiple interpretations. This thick description is achieved in this study through: (1) in-depth interviews with IDUs; (2) personal communication with other key informants (e.g., SafeWorks nurses); and (3) observation while riding along with nurses in the SafeWorks outreach van. While I did not engage in pure participatory observation (but limited my observations as a passive sideline person), the entire research process of ethnography is participatory, with the researcher and the informants in an egalitarian relationship (see Section II: Research Relationship below). In fact, as the ethnographer is in the learning role (as I was in learning about the social context of IDUs), I am actually below the researched in hierarchical position. Thus, ethnography is collaborative; the social contexts described are co-constructed by my informants and myself (Fetterman, 1986).

II. RESEARCH RELATIONSHIP

As the researcher in a qualitative study, I acted as the facilitator and the interpreter of information derived from the "experts," the interview participants. Ethnography depends on the skill and creativity of the ethnographer as observer, interviewer, and writer in order to successfully introduce the reader to new feelings, new communities, and new cultures (Kotarba, 1990). Due to the illicit nature of IDUs' behaviour, I limited my role in the study to that of a researcher with little personal involvement, as a passive observer, "on the sidelines," who did not deliberately set out to influence events in the field.

As the researcher in a qualitative study, I was the primary data collection instrument. Therefore, it was necessary that I identify my personal values, assumptions, and biases at the outset of the study. I made an effort to assume a non-judgmental approach throughout the various stages of my ethnographic study and to make explicit my more conscious and obvious biases through the process of "bracketing" (Weeks, 1993). Bracketing is a mental exercise in which the researcher identifies then sets aside taken-for-granted assumptions used in approaching a particular issue or group of people (Neuman, 1997). I used several strategies to identify, or bracket my biases and reflect on them, such as journal-keeping, peer debriefing, and reflective field note-taking. For an excerpt of my reflective field notes, see Appendix A. These techniques for bracketing were used at every stage of the study, including data collection, data analysis, and report writing. Although every effort was made to ensure objectivity, these biases shaped the way I viewed and understood the data I collected and the way I interpreted my

experiences. To counteract the possible effects of my own biases, I took certain steps to help ensure the trustworthiness of my findings, as described in Part IX – Trustworthiness.

I entered the study as an individual with a fairly privileged upbringing and had never personally experienced any of the lifestyle associated with injection drug use and/or prostitution. I approached the research problem with a genuine concern for improving the health of vulnerable groups and had worked extensively in the past with people who have physical or mental disabilities, as well as people who are street-involved. Before I commenced the research process, I attended a harm reduction conference in Colorado, where I became familiar with the principles of reducing the health risks associated with injection drug use. I learned that drug addiction always will and always has existed in human society and that "The War on Drugs" punishes first and foremost the individuals addicted to those drugs. I entered the study with the assumption that there exists a "drug culture" with a tight social network of friends. However, this notion was clarified, if not altogether dispelled, as my study progressed.

I participated in the research process by taking the information that IDUs gave me and developing themes as they emerged from the interviews. By probing and inquiring along certain lines of interest, I was integral to the research process, although most of the control over the direction of the interviews was given to the informants. I facilitated the interviews by guiding the direction of the conversations so as to keep the information relevant to the issues that needed to be addressed. I also implemented and maintained ethical standards throughout the interview process.

As expected, I did encounter some central methodological problems inherent to ethnographic research with the IDU community. I was attempting to establish an unusual

but credible identity in the IDU community whose members harbour substantial distrust. I had to make an effort to earn the trust of my informants before it became appropriate to ask personal questions about drug addiction, intimate relationships and events. The IDUs were not willing to give me an interview without first meeting me face-to-face. For example, I had to meet with one particularly nervous informant several times before she felt enough comfort to delve into personal questions about her social life and health. Suspicion towards strangers runs high in communities that are most at risk of HIV, such as IDUs. I had to first make clear to the IDUs that I am in no way affiliated with the police. I then had to establish an identity of who I am and what I do, that I could be trusted, and that I was working to understand and help the community from the points of view of its members. I carried condoms, bleach kits, and new needles to give to the informants in order to communicate that I was trying to help them in a non-judgmental way.

III. THE SAMPLING POPULATION

My sampling frame was comprised of the social networks around SafeWorks clients who practice collective needle exchange. Injection drug users as a population for study present several methodological challenges. The illegality of drug use and the nature of the lifestyle of the majority of IDUs makes it difficult to access the IDU population and carry out data collection at all stages of the process, from initial contact all the way to follow-ups for member-checking. Fortunately, most of the IDUs to whom I introduced myself and explained the research were willing and even eager to participate in the study. However, their willingness alone was not sufficient to ensure an interview. There are

several characteristics of the largely hidden IDU population that posed a challenge in my research. Firstly, simply getting commitment from seemingly interested IDUs and getting them to set up an interview time with me posed significant challenges. Because of their transient lifestyle, many IDUs do not have permanent addresses or phone numbers at which they can be contacted for setting up an interview appointment. Many of the IDUs that I met were in Calgary only periodically and for short periods of time, staying in motels, or with friends or relatives. And if the IDUs that I met were staying with friends or family, some did not want me to phone for an interview and expose them as an IDU or a NEP client. Rather, they said: "I'll phone you, San, and let you know when I can be interviewed." Of course, more often than not, I would never hear from them. Also, my recruitment strategy of circulating pamphlets via the SafeWorks nurses was not successful, in that none of the seemingly interested IDUs to whom the nurses gave pamphlets actually called me for an interview. Perhaps the pamphlets were not enough to convince IDUs to call me, or maybe the IDUs misplaced my pamphlet before they remembered to call me. So, I asked the SafeWorks nurses to ask any interested IDU to give the nurses permission to give me his or her phone number so that I could contact *them.* I managed to recruit two informants in this manner and am grateful to the nurses for their efforts.

A second major barrier to conducting interviews with the IDU population is that they lead fairly chaotic lives and find it difficult to keep appointments. So, even if I was successful in contacting the potential informants and making an interview appointment, I was often left waiting in vain for the IDU to show up for an interview. It was not unusual to set two or three appointments and have to reschedule each before I was able to

successfully meet with an informant for an interview. Most informants were quite willing to spend the average interview duration of one hour with me. Also, because of the nature of drug abuse, many of my informants suffered from addiction cravings, "crashing" from a long binge of drug use, or drug withdrawals, as well as overall poor health. In such poor physical condition, it was unreasonable to expect certain IDUs to sit with me for an hour-long interview, and I would have to re-book the interviews as long as they were feeling ill.

A third characteristic of IDUs that presented a challenge in my data collection was that they tend to be fairly paranoid, nervous, and distrustful of strangers, especially people from the mainstream (non-IDU) culture, such as myself. The stigma associated with injection drug use has socially isolated IDUs from the rest of the population, and it was no small feat to gain the trust of IDUs, especially when inquiring about their illicit drug use behaviours. Many avoid congregation areas, such as CUPS or public restaurants because they feel at odds with the rest of society. One couple that I wanted to interview arrived early for our appointment at CUPS, but left rather than wait for me to arrive because they felt uncomfortable being around other people from the drug scene. Both were trying to get off cocaine, and they had their rent money in their pockets, setting up an uncomfortable temptation for them. One female IDU was very fearful of being found by a man who had been stalking her for the past several months. She was very suspicious of me and unfortunately did not remember giving me her phone number when I first met her at CUPS. I met with her twice, once to deliver a supply of clean needles from SafeWorks, before she felt comfortable enough to give me an interview. Because of her fear of her stalker, this particular IDU refused to meet me in a public place, such as

CUPS or a coffee shop. As a safety precaution, I declined to interview IDUs in their homes, and thus had to interview this IDU in my car.

IV. ACCESSING AND SELECTING PARTICIPANTS

A. Access

The first step that was taken in gaining access to the IDU population was to gain the approval of my research proposal from the Conjoint Health Research Ethics Board at the University of Calgary (see Appendix B). The SafeWorks Calgary program has a fixed site at CUPS (a downtown community health centre for street people) and an outreach van. I have worked at CUPS for over four years and have become a familiar face around the facility. This familiarity was important in developing rapport with informants, as I was asking questions of a sensitive nature about an illegal activity. I made initial contact with the nurses running SafeWorks Calgary at CUPS, following approval of my project (see Appendix C), and asked them to make contacts for me with some key informants who would be information-rich. Key informants were community members who are willing to share their perspective on the social organization of the community: on local and street-based hierarchies; different social groups; hangouts; and common meeting places. Access to the IDU community was facilitated by the trust that the nurses of SafeWorks had already established with their clientele. The nurses served as my gatekeepers into the IDU population by virtue of their accepted status as trusted health professionals committed to the well-being of IDUs.

SafeWorks served as a single site where an intact culture-sharing group of IDUs could be accessed. I also established contacts with potential informants by riding along

with the nurses during their rounds in the outreach van. Because my original intent was to focus on IDUs who don't use the NEP themselves, I recruited primarily through the outreach van because it serves collective exchangers more than the fixed site at CUPS. Collective exchangers, those who exchange 100 or more needles at a time for other IDUs, are most likely to do so at the van (79%) versus CUPS (46%) (LeMarquand-Unich, 1995). I also posted signs around CUPS and gave the nurses pamphlets to circulate among potential informants both at the CUPS site and in the van, during the times that I was not present to recruit on my own. I also asked several pharmacists to hand out my pamphlets to any customer who was purchasing syringes for non-diabetic use, in hopes of recruiting IDUs who are not clients of SafeWorks, but still take HIV risk reduction measures. The pamphlets and signs provided information about the study and included a brief description of my research purpose, what kinds of questions would be asked, a guarantee of confidentiality, and my cellular phone number for volunteers to contact me and set up an interview time (see Appendix D).

B. Sampling Strategy

I interviewed a total of thirteen informants. Sampling occurred using two main strategies and in two phases: (1) the "big net approach" and opportunistic sampling; and (2) maximum variation sampling. For the first seven informants, I used what has been termed the "big net approach" of sampling, in which I approached every IDU that I met in the outreach van (Creswell, 1998). I relied on my gatekeepers, the nurses running the NEP, to identify and introduce me to informants who were regular users of the NEP, who practiced collective exchange (i.e., exchange 100 or more needles at a time), and who

were willing to give me an in-depth interview. My sampling became opportunistic because of the 19 clients that I approached for an interview while riding along in the outreach van, I was only able to contact and meet with seven of them. Even though the SafeWorks nurses distributed approximately 30 pamphlets, I received only two phone calls from IDUs who had been given a pamphlet; no IDUs who had been given a pamphlet by a pharmacist called me. The transient and chaotic nature of the IDUs made it difficult to contact them, and several did not even have permanent phone numbers through which they could be reached.

The last six clients of the SafeWorks needle exchange program were recruited through informal network recruiting, or snowball sampling. Once I had interviewed and established trust with the informants I met through the outreach van, I asked them to refer me to other IDUs who they thought would be information-rich, using snowball sampling. The snowball technique is a method that yields a sample based on referrals made by people who share or know others who present the characteristics that are of research interest (Creswell, 1998). Historically, this method has been widely used in qualitative studies of hidden populations. The identification of such populations requires a knowledge of insiders (in this case, the NEP nurses) who can locate people willing to participate in the study, and this method is particularly applicable when the focus of interest in an area of illegal behaviour, such as in the case of drug abuse (Lopes, 1996).

In the second phase of sampling, I used maximum variation sampling in order to document diverse variations and identify important common patterns (Creswell, 1998). Maximum variation sampling allowed me to understand fully the similarities and differences of information among different IDU groups. I sampled a variation in choice

of drug (cocaine/morphine/heroin), social settings (private home, shooting gallery, etc), types of people (age/gender/extent of drug use), and duration of involvement with injection drugs. This sampling strategy allowed me to gain a reasonably complete understanding of NEP-users as a group of people with diverse preferences and needs with respect to HIV risk reduction. Sampling was purposive; that is, it was based upon my research questions and study purpose, as well as the information-richness of informants. Purposive sampling was a desirable sampling strategy for my study because I was interested in a limited set of behaviours and circumstances among a small group of people.

I sampled to saturation, which means that sampling and interviewing continued until I reached the point of information redundancy. Approximately at the tenth informant, I felt that I had reached information saturation because I hadn't heard any new information for a couple of interviews, but interviewed three more IDUs "just to be safe." It was fortunate that I had interviewed beyond the tenth informant, because the eleventh interview provided some contradictory data that I had not yet encountered.

V. DATA COLLECTION

A. The Data Collection Process

The data collection process included several iterative steps: (1) meeting the potential informant in the outreach van and introducing the study (establishing trust); (2) asking the potential informant for permission to contact him/her for an interview (developing rapport); (3) contacting the potential informant to set up an interview time; (4) meeting with the informant for an interview; (5) transcribing the interview; (6)

performing a preliminary analysis, and (7) formulating new questions to ask informant or subsequent informants. Interviews were spaced about three days apart to allow myself time to transcribe, code, and interpret data from the previous interview. Each interview was approximately one hour in length, depending on the willingness of the participant to converse with me. I conducted in-depth, open-ended interviews that were recorded on audio tape (with the informant's consent) and later transcribed by myself.

B. Interview Data

The open-ended interview format allowed for deep and rich exploration of IDUs' drug experiences. Open-ended, unstructured interviews were appropriate for illicit behaviours such as injection drug use. If I had provided a set of options for questions (as in a quantitative questionnaire) regarding needle procurement, sexual practices, shooting settings, etc., the respondents would have likely picked the answers that were most "socially desirable." Open-ended questions forced the informants to come up with their own, hopefully candid, responses without any suggestions from myself, the researcher. I made a conscious effort to keep the interviews as open-ended and unstructured as possible, where the respondent received no prompts from me on the desirability of certain answers. I attempted to keep all queries neutral in tone.

The in-depth interviews covered various aspects of IDUs' everyday lives, including (but not limited to) past and present drug use, life-style, health and health service utilization, peer influence, initiation into injection drug use, injection settings, and social norms. Respondents were encouraged to volunteer information as informed experts about their world. Interview respondents were chosen to represent ages, genders,

ethnicities, and styles of drug use found in the communities which SafeWorks serves. They were also chosen for their ability to eloquently communicate their drug experiences, everyday activities, and their overall knowledge of drug use in their communities.

Ethnographic research usually involves participant observation as a primary data collection source. However, the study was limited to in-depth interviews for data collection; participant observation was not a viable method of data collection in the proposed study for several reasons: (1) with respect to concerns for my own personal safety, it would not have been advisable to conduct interviews and observe participants in their own homes or within natural settings such as shooting galleries and crack houses; (2) there was inadequate time to integrate myself into the IDU culture and develop the necessary level of trust necessary for direct observation of injection behaviour; (3) I was not interested in the objective reality of what occurs in IDU settings and situations which requires direct observation; rather, (4) I was more interested in gaining the subjective viewpoint of the IDUs (i.e., how they perceived the social settings and situations with respect to HIV risk reduction or risk assumption).

C. The Interview Guide

I began the data collection process with an original interview guide covering basic questions that helped to direct the interviews towards the information that fulfilled the purpose of the study (see Appendix E). The questions in the interview guide are operationalized versions of the grand tour question and subquestions. As a novice researcher, I began data collection uncertain about how to word interview questions, so I wrote a list of questions for myself in the event that I needed to probe my informants with

more specific questions. The interview questions and the order in which the questions were asked were subsequently tailored to specific people and situations. The specific questions asked during each interview varied, depending upon the characteristics of the informant and also depending upon what gaps in information still existed, or what issues had been raised by previous informants.

The questions in the interview guide fell under six major headings and were grouped for ease of reading: drug use questions, sharing questions, social scene questions, needle use questions, social influence questions, and initiation questions. For example, I would always begin the interview by asking the general question: "Tell me what it is like in the places where you go to inject drugs." With some informants, this question would elicit a long narrative, but others would require more specific questions, such as those outlined in the interview guide. As I became more familiar and comfortable during the data collection process, I learned to use silence more effectively and waited for my informants to continue their narratives without interjecting with questions.

After each interview, I transcribed the audio recording, performed a preliminary analysis, and then formulated questions that I either needed to take back to the same informant, or questions that needed to be pursued with subsequent informants. In this manner, my interview guide changed for each informant as it became increasingly more focused and refined (see Appendix F for my modified interview guide used with one of my last informants). As I became familiar with the broad themes which were common across all informants, I chose informants based on their ability to give me finer details and different perspectives of concepts which had been previously discovered.

The interview questions were "translated" to comply with the street vernacular of IDUs. Through my work with this population over the last few years, I have become fairly familiar with street jargon and tried to incorporate street vernacular as much as possible into my interview guide and my interview probing. For example, instead of referring to needles, I instead used the common term of "rigs," and for injection equipment (such as water, spoon, filter, lighter, etc.) I used the word "works."

D. Interview Location

As a safety precaution, I did not interview any IDUs in their homes, as I could have been placing myself in a vulnerable situation. Rather, the interviews took place at CUPS in a private room during hours that the center was open, or in public locations which were convenient for the informants, such as restaurants or coffee shops. Because the interviews were audio-taped, it was preferable to conduct the interviews in a quiet setting, such as a private room at CUPS. However, this ideal interview setting was not always possible, and many of my recordings of interviews were punctuated with pool balls smacking one another, the clinking of beer mugs, or loud conversation in the background. I would usually arrange to meet IDUs at a public location of their choice in order to maximize their comfort level with the interview. One IDU refused to go to either CUPS or any other public congregation area due to her fear of a man who had been stalking her, so we conducted the interview in my car, parked in a strip mall near her apartment building.

E. Field Notes

Throughout the data collection process, I maintained field notes that consisted of: (1) journal notes from my ride-alongs in the outreach van; (2) a contact list of potential informants; (3) personal reflections of my own values and interests; (4) methodological notes, and (5) interview notes. My interview notes included a modified interview guide for each new informant, an interview log (date, time, place), a summary of significant data from each interview, and a list of new questions or issues to be raised in subsequent interviews. These field notes were an important means of bracketing my values, biases, and interpretations. I wrote my field notes while riding along in the SafeWorks outreach van, while conducting an interview to highlight new or particularly interesting concepts, and also immediately following an interview in order to capture my first impressions. During the analysis of each interview, the field notes were used to guide my interpretations and provide context to the interviews, as well as my frame of mind at the time of the interview.

VI. SAFETY AND SECURITY ISSUES

Before granting me ethical approval to proceed with my thesis research, the University of Calgary's Conjoint Health Research Ethics Board required a letter from the Calgary Police Service (see Appendix H). The letter from the Calgary Police Service stated that they: (1) were aware of my study; (2) were aware of my relationship to the IDUs as a researcher, and not a party in a drug transaction (or any other illegal activity); (3) would refrain from using my recruitment as a means of identifying IDUs for law enforcement purposes; and (4) that my research may contain crucial evidence to a

criminal investigation. I notified my informants that I would contact police only if information divulged during an interview led me to believe that the well being of a child was at risk.

I did not visit participants at their homes, or in drug-injection settings, such as shooting galleries or crack houses. As a precaution, I performed all of my interviews in public locations where I could seek assistance in the case of a hostile confrontation with an IDU. However, there was never an occasion where I felt personally threatened by any of my informants. By meeting me for an interview, the IDUs were demonstrating that they were very willing to conduct the interview with me, and trusted me, especially if the SafeWorks nurses had introduced me to the IDUs. The SafeWorks nurses expressed concern about my safety when they learned that I was meeting with one particular IDU for an interview. Apparently, this IDU had a reputation for violence against other women and the nurses were emphatic that I not go anywhere where this IDU and I would be alone. I did have to work a little harder in gaining the trust of this particular IDU, but in the end, I gained her trust and she granted me an interview.

At all times while interviewing, I carried a cellular phone with a quick-dial feature that would allow me to quickly call the police for assistance in case of an altercation. I also always informed a friend or family member where and when I would be meeting the IDU for an interview. As well, the SafeWorks nurses only introduced me to clients whom they knew to their best knowledge to be safe. They did not introduce me to clients who were known to be volatile or violent.

VII. ETHICAL ISSUES

A. Obtaining Informed Consent

Participation in this study was completely voluntary, and verbal consent was obtained after discussing the content of the interview, the procedures for ensuring confidentiality and anonymity, as well as the participant's right to choose not to answer questions. I obtained informed consent from the informants once they were clear about the purpose of the research project, what kinds of questions would be asked, and what would happen to the information.

Because of the illicit nature of injection drug use, and the illegality of the practice of buying or selling illicit drugs, it was essential that I ensure anonymity and confidentiality to my informants. As recommended by the University of Calgary's Conjoint Health Research Ethics Board, I did not obtain written consent. In lieu of a consent form requiring the informants' signatures, I followed the procedures for obtaining implicit consent from my informants. Consent was implied by the IDUs' willingness to participate in the interview. Due to concerns about anonymity, consent forms were not used as they could have revealed the identity of my informants. Rather, at the beginning of each interview, I provided a cover letter (see Appendix G) which explained:

- my identity and affiliation;
- the purpose of the study;
- the fact that participation was voluntary;
- the amount of time commitment that was being requested;
- that a tape recorder was going to be used;

- how confidentiality and anonymity would be guaranteed;
- alternatives to participation; and
- any risks or benefits of participation.

All of the above information was provided when I first met with an informant for an interview, and he or she was given the opportunity to ask questions and give verbal consent to participate. I asked the informant to read the cover letter carefully and then asked him or her to paraphrase back to me the contents of the cover letter in order to ensure that he or she understood the contents. This procedure also helped me to assess whether or not the informant was competent to conduct the interview (i.e., whether or not the client was high at the time). The entire process was tape-recorded and the identity (name) of the informant was not recorded either in writing or verbally. Each informant was assigned a unique identifier, such as a number or an alias. I particularly emphasized to my informants that they should refrain from stating any names, places, or dates during the course of the interview that could identify them in the case of a police investigation. However, in the occasional instance when an informant did give me a name or other identifiable detail, I stopped the interview and rewound the audio-tape so that the statement was erased.

B. Reciprocity

I provided refreshments and condoms or needles for the informants, but there was no reward for participation nor penalty for incomplete interviews. One HIV-positive informant who was particularly impoverished asked me for money in return for his interview once it was completed, but I refused and instead offered him a sandwich, which

he gratefully accepted. I believe that although I was not able to offer material repayment for the informants' time and trust, I did achieve some level of reciprocity. The participants benefited in some way by getting an hour of sympathetic listening and being given a voice and empowered to enact behaviour change. Several of my informants expressed that they were happy that someone was taking interest in their health needs and problems, and that it was therapeutic to have someone listen to their stories with an empathetic ear. Some indirect benefits to the informants could be that they gain insight or learn something; they may improve their personal practices as a result of raised awareness due to my line of questioning; or the SafeWorks NEP that they rely on for clean needles may be improved. On several occasions, I was able to educate my informants on particular HIV risk assumption behaviours, such as the possibility of HIV transmission from a woman to a man during sexual intercourse, or from sharing a filter and spoon.

VIII. DATA ANALYSIS

Data analysis is the process of bringing order, structure, and meaning to the mass of collected textual data. The analysis of interview data is a search for general statements about relationships among categories of data (Marshall & Rossman, 1995). Ethnography involves working primarily with unstructured data, that is, data that have not been coded at the point of data collection in terms of a closed set of analytic categories (Atkinson and Hammersley, 1994). The premise of ethnographic methods is that data should be collected and analyzed simultaneously to allow the basic social, psychological, and structural processes to emerge naturally. Analyzing as interviewing proceeded allowed

me to adjust my interview strategies, and shift emphasis towards those social domains which were not yet fully understood while I simultaneously checked or tested emerging ideas. The flexibility of this method is perhaps most useful because it allowed me to correct mistaken hunches or hypotheses prior to completion of the study. The most fundamental operation in qualitative data analysis is that of discovering significant *classes* of things, persons and events and the *properties* which characterize them (Marshall & Rossman, 1995, emphasis in original).

In particular, the analysis of drug users' language is emphasized, because language is the public storehouse of knowledge that gives meaning, purpose, and direction for everyday life (Johnson, 1990). Data analysis fell into five major modes: organizing the data; generating categories, themes, and patterns; testing the emergent hypotheses against the data; searching for alternative explanations of the data; and writing the thesis. Each phase of data analysis incorporated data reduction as the volumes of written data were organized into manageable chunks, and interpretation as I brought meaning and insight to the words of the informants in the study (Marshall and Rossman, 1995).

A. Organizing the Data

The interviews were tape recorded and transcribed in their entirety to maintain accuracy and to preserve the respondents' own words. The interviews were transcribed as soon as possible after the interview, in order to remember the tone and context of each interview, and to incorporate my fresh impressions in the preliminary analysis of the transcripts. I believe that the time-consuming and sometimes difficult task of transcribing the interview tape recordings was a valuable chore in the preliminary data analysis. By

personally transcribing all of my interviews, I was able to become very familiar with the data. Also, some of the street jargon around drug use would be foreign to a transcriber who was not familiar with the language of this population. Once transcribed, I became familiar with the interview data by reading the transcripts several times. I read through each transcript carefully in order to capture the essence of the account. I then recorded my own reflections and remarks in the margins of the transcript. While reading through the transcripts, I also made note of what data was available and what data was still missing. The transcripts were entered into NUD•IST, a computer qualitative data management program for the storage, coding, retrieval, and analysis of the interview transcripts.

B. Generating Categories, Themes, and Patterns

I used content analysis to identify recurring themes or concepts that arose from the interview data. This phase of data analysis included identifying salient themes, recurring ideas or language, and patterns of belief that link people and settings together (Marshall & Rossman, 1995). As categories of meaning emerged, I searched for those that had internal convergence and external divergence (Guba, 1978). That is, the categories were constructed so that they were internally consistent but distinct from one another. I checked to see if large chunks of textual data was missing coding, signifying that I needed to add codes to account for the data. Also, if a chunk of data had several codes attached to it, I would check to see if some of the codes were similar enough to be collapsed together. Analysis of ethnographic data involved explicit interpretation of the

meanings and functions of human actions, the product of which mainly took the form of verbal descriptions and explanations.

Codes were attached to chunks of varying size - words, phrases, sentences, or whole paragraphs. From the interview data, I was able to identify 12 major themes, or codes. For a list of these codes and their definitions, see Appendix I. Descriptive codes identified and described important themes that emerged from the data, such as "drug use," "initiation," or "HIV and hepatitis." Interpretive codes identified patterns or explanations and included "attitude," "knowledge," or "barriers to risk reduction." I used the codes to classify chunks of data (mostly paragraphs and sentences) from the interview transcripts and then drew linkages between the quotes both within and between interviews. I also linked information from my field notes to the interview data. The coding process is very iterative; each time I coded another interview transcript, new themes would emerge and I would have to add codes or sub-codes, or I would have to collapse codes together which I found to be too similar to be classed separately. As the coding scheme altered for each new interview, I would go back to preceding interviews and adjust the coding according to the new classifications.

C. Testing Emergent Hypotheses

As categories and patterns between them became apparent, I began the process of evaluating the plausibility of the developing hypotheses and testing them through the data. Almost as a natural interview technique, I would question and probe my informants based upon concepts that had arisen in previous interviews in order to assess if the concepts could be further substantiated. I would ask a question in the form of: "I've heard

that ____. Would you agree with that statement?" As part of this phase, I evaluated the data for informational adequacy, credibility, usefulness, and relevance. I determined if the data were useful in illuminating the questions being explored and whether or not they were relevant to the story that was unfolding about the social context of injection drug users. I read and re-read my grand-tour research questions and sub-questions to myself as I proceeded through simultaneous interviewing and data analysis in order to keep my interviews as focused as possible.

D. Searching for Alternative Explanations

As categories and patterns among them emerged in the data, I attempted to challenge the very patterns that seemed so apparent. I searched for other, equally plausible, explanations for these data and the linkages among them. If an informant provided information that was contradictory to existing data, or simply provided insight from another point of view, I naturally pursued the line of questioning until I was able to understand the new information from the informant's point of view. Any unforeseen concepts or interpretations were researched with an additional review of existing literature. I also re-designed the interview guide as data collection proceeded in order to search for alternative explanations of preliminary conclusions.

E. Writing the Report

Writing the final report was central to the analytic process; in the choice of particular words to summarize and reflect the complexity of the data, I was engaged in the interpretive act, lending shape, form, and meaning to large amounts of raw data. Before writing my thesis, my interpretations and conclusions were scattered in my field

notes and in my mind. The process of writing the thesis provided a way to coalesce all of the data and its analysis.

IX. TRUSTWORTHINESS

Rigor in qualitative studies is met by trustworthiness criteria, which are defined as credibility, transferability, dependability, and confirmability (Denzin & Lincoln, 1994). "Authenticity," rather than reliability, is often the priority in qualitative research. The aim is to gather an authentic understanding of people's experiences and open-ended questions are the most effective route towards this end.

The goal of establishing credibility involves demonstrating that the inquiry was conducted in such a manner as to ensure that the social phenomenon under study was accurately identified and described. A rich description demonstrating the complexities of social situations and interactions will be so embedded with the data derived from members of the IDU population that it cannot help but be valid (Marshall & Rossman, 1995). Credibility was assured through member checking, which involved taking coded transcripts of interviews back to the informants to ensure that my recordings and interpretations are aligned with what was intended by the informant. Due to problems with re-contacting all of my informants, I was able to perform member-checking with only two of my informants. Credibility was also established by consulting with my gatekeepers, the NEP nurses, about the issues raised in the interviews and the themes that emerged. During my data collection, I attended a SafeWorks in-house meeting involving Calgary's drug treatment programs, a vice detective, a representative from a Vancouver NEP, and physicians working with HIV/AIDS patients. During this meeting I was invited to share some of my preliminary findings and ask for feedback about my first

impressions, helping to establish credibility of my results.

The second construct proposed by Denzin and Lincoln (1994) is transferability, or the applicability of one set of findings to another context. Transferability of the findings will be left as the responsibility of the reader of the final report, but will be fostered by rich and thick descriptions. Generalizability, in the statistical sense, is not a goal in qualitative studies. Perception and subjectivity, what quantitative researchers would call bias, are essential elements of the data and are a crucial part of the knowledge generated by qualitative research. IDUs' perspectives on events and actions is not considered bias but rather a *part* of the reality that a qualitative researcher is trying to understand. Personal perceptions and subjectivity or bias are essential data and a crucial part of the knowledge generated by qualitative research. The local context and the human story reflected in each individual are of primary interest, not generalizability (Denzin & Lincoln, 1994). It is not my responsibility to provide an index of transferability, rather it is my "responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers" (Lincoln & Guba, 1985). Therefore, those who may try to apply my thesis findings to other populations of IDUs must judge for themselves the extent to which my conclusions and recommendations are applicable to their populations and determine the degree of transferability that is warranted. The primary concern of the study was not with generalization but with developing an adequate description, interpretation, and theory of this population. Local context and the human story, of which each individual and community story is a reflection, are primary goals of qualitative research, and not generalizability (Denzin & Lincoln, 1994).

The third construct for judging the trustworthiness of a qualitative study is dependability, the qualitative equivalent of reliability. The uniqueness of the study within a specific context mitigates against replicating it exactly in another context. However, statements about the study's central assumptions, selection of informants, and my own biases and values enhance the study's chances of being replicated in another setting. As the study progressed, I kept detailed notes on protocol for data collection and analysis so that the procedure might be replicated in another setting. A perception remains that IDUs are likely to be less dependable in their responses to interviews than other populations. This supposed undependability might occur either as a function of their frequently intoxicated state or because of a need to dissemble a stigmatized and illegal lifestyle in a largely hostile societal environment (Ross et al., 1995). In previous studies with IDUs, it has been found that factors likely to increase veracity included familiarity of the interviewer with the subject area, focus of the interview on specific topics and a lack of association between the research and law enforcement authorities (Ross et al., 1995). I attempted to adhere to these dependability-enhancing strategies throughout data collection.

The final construct, confirmability, is the qualitative equivalent of "objectivity." A qualitative study is considered objective when another researcher can confirm the findings. The appropriate qualitative criterion for confirmability is: "Do the data help confirm the general findings and lead to the implications?" (Marshall & Rossman, 1994) It is important to recognize that there is no value-free or bias-free design. By identifying my biases, I can easily see how the questions that guide the study are crafted (Denzin & Lincoln, 1994). In qualitative research it is desirable to gain some understanding, even

empathy, for the research participants in order to gain entry into their world. I did, however, adopt certain strategies to balance the bias in interpretation. Such controls included the following: (a) a colleague who played devil's advocate and critically questioned my analyses, (b) a constant search for negative instances, and (c) checking and rechecking the data and purposeful examination of possible rival hypotheses (Marshall & Rossman, 1995). A valuable means of establishing confirmability was an audit by a peer colleauge who arbitrarily selected one interview, and confirmed the entire process of interview transcription, coding, interpretation, and analysis for that interview. The colleague who performed the audit also matched my conclusions to my field notes to ensure that they were consistent. I also had a physician (Dr. Dale Guenter) who is closely involved and familiar with the population check two of my transcripts for their accuracy and relevance in order to ensure that I had not missed any important themes in my analysis.

The results of my interviews are presented as vignettes, which are composites of interview data from several different informants. The situations and settings described in the vignettes come directly from interview data and were not fabricated by myself. As a final confirmability check, I took the vignettes to a focus group of eight IDUs and asked them to read the vignette(s) most relevant to their drug of choice and their social network. I then asked the focus group members to answer three main questions: 1) "Does the situation and setting sound real to you?"; 2) "What could you add or change that would make the vignette more true to life?"; 3) "Do you think I need to write another vignette, and if so, what would it be about?" According to the focus group members, the vignettes were all "true to life" and real according to their own experiences and understandings:

"The setting is definitely real. I have been an IDU for years, and I have entered places where the settings and situations are what is told in the story." Some of the focus group members suggested subtle changes that would make the stories more accurate to reality as they knew it.

X. SUMMARY

Thirteen informants who were involved in some way with injection drug use were recruited through the SafeWorks NEP and interviewed to explore the social context of injection drug use and its effect on HIV risk assumption or risk reduction behaviours. Verbal consent was obtained prior to audio-taped interviews conducted either at CUPS or in public locations. I selected informants who had been involved with injection drugs for varying amounts of time, had experience with various drugs and drug scenes, and had various demographic characteristics. The interviews focused on social interactions, initiation into injection drug use, relationships with other IDUs, social settings and situations, peer influence, and attitudes and knowledge around HIV risk reduction. The transcribed interviews were stored, coded, and analyzed using NUD•IST software. The data was analyzed for themes and descriptions relevant to the research questions.

CHAPTER 3 – FINDINGS: DESCRIPTIVE THEMES

I. INTRODUCTION

This chapter and the following "Findings" chapters provide an overview of the main findings of my study. These chapters will describe the main characteristics of my informants, followed by a classification of the relevant information provided during the interviews. There were eleven major categories of themes, three descriptive, and eight interpretive:

Descriptive Themes:

- patterns of drug use;
- use of the NEP; and
- their HIV/hepatitis status.

Interpretive Themes:

- knowledge and experiences of social forces;
- needle sharing;
- needle use behaviours;
- prostitution;
- experiences of initiation into injection drug use;
- attitudes regarding risk reduction or risk assumption;
- knowledge regarding risk reduction or risk assumption; and
- any barriers that they experience in practising risk reduction.

Because I did not begin data collection with any pre-conceived themes, but only some broad guiding questions, the categories emerged primarily from the interview data. I

assigned either descriptive or interpretive codes to each of the major themes that emerged. Three descriptive codes identified and described important themes that emerged from the data, including "drug use," "use of the NEP," or "HIV and hepatitis." These descriptive themes helped me to gain a general understanding of the lifestyle, characteristics, and addictions of my informants. The presentation of my findings will begin by setting up a psychosocial picture of my informants. The descriptive data in this chapter will be presented as interview excerpts so that the words of my informants serve as the descriptions in and of themselves. The psychosocial context of injection drug use will be set up with little interpretation by myself or support from the literature.

I will then go on in the next four chapters to present the interpretive themes. Interpretive codes identified patterns or explanations and included "initiation," "social forces," "attitude," "knowledge," or "barriers to risk reduction." These interpretive themes covered forces which are motivators or deterrents of HIV/hepatitis risk assumption or risk reduction. In order to give synthesis to the many complex factors that contribute to the social context of IDUs, I will present the interpretive themes as vignettes (descriptive literary sketches). Each story will be composite representations of IDUs and their social contexts created from interview excerpts and observations from my ride-alongs in the SafeWorks outreach van. The vignettes will provide scenarios of IDUs in various social contexts, complete with a picture of how needles and other injection equipment are handled in each scenario. The vignettes will encompass the eight interpretive themes, integrated together into social scenarios of injection drug use. I will attempt as much as possible to use the language of my informants. Each vignette will then be interpreted with the aid of supporting literature.

The last findings chapter (Chapter 8) will discuss the concept of "community" as it applies to IDUs in Calgary. Although "community" was not a major theme highlighted in my interview data, I was able to gain considerable insight into the complexities of defining the IDU community. I included Chapter 8 in order to discuss my findings regarding the concept of community as it specifically applies to Calgary IDUs.

II. INFORMANT CHARACTERISTICS

Purposive sampling allowed me to interview informants from various demographic backgrounds, durations of injection drug use, HIV/hepatitis status, and drugs of choice (Table 2). I present this table not to convince the reader that I have collected a representative sample of IDUs, but rather to illustrate the variation of basic characteristics of my informants.

I interviewed a total of 13 informants, a sample size determined by the point at which I achieved information redundancy or saturation. Of the 13 informants, 12 had used or were using injection drugs. The one non-IDU informant was a valuable informant as he was the owner of a "safe house" for prostitutes, many of whom were IDUs. His "safe house" served as a place for the working girls to go for a place to rest, to get off the street, or to inject their drugs in a safe environment. The owner of the "safe house" was a client of SafeWorks and always kept a supply of clean needles and a disposal bucket for the girls staying with him. While the other 12 IDU informants were able to provide me with insight of the social context of injection drug use through their own lived experiences, the one non-IDU informant provided valuable insight as a witness to injection drug use and as a former drug dealer. Although I interviewed a broad range of

IDUs, they do not easily fit under the three categories identified by one of my informants:

> There are three kinds of people who really shoot dope: the working man who can afford it, then there's the hooker, and there's the man behind the hooker. That's about what I see.

I did not have any informants who I could identify as a "man behind the hooker," otherwise known as a pimp. Of course, my line of questioning did not elicit any information that would reveal them as pimps.

"Drug of choice" refers to the main drug that each informant used on a regular basis. Although almost all of my informants had experimented with other illicit drugs (including prescription medications), their "drug of choice" was most relevant to the social context within which they practiced injection drug use. "Serostatus" refers to the informants' self-disclosed HIV or HEPV status; I did not confirm their self-reports by checking against laboratory reports or medical records. I would have liked to interview more heroin users but found it difficult to recruit IDUs whose main drug was heroin.

Table 2: Characteristics of Informants (13 in total)

CHARACTERISTIC		*# OF INFORMANTS*
GENDER	Male	8
	Female	5
DRUG OF CHOICE	Heroin	1
	Cocaine	6
	Morphine	4
	Cocaine & Morphine	1
	Non-User	1
SEROSTATUS	Hepatitis B	2
	Hepatitis C	5
	HIV	1
AGE RANGE	≤ 20s	2
	30s	7
	40s	1
	50s	3
DURATION OF INJECTION DRUG USE	Range	3 – 28 years
	Mean	10.75 years
	Median	9 years
	Mode	3 years

III. PRESENTATION OF DESCRIPTIVE FINDINGS

The results of my in-depth interviews are presented in the following five chapters. In this chapter, I will explain the 3 descriptive themes, along with their sub-themes and definitions of each. The themes will be illustrated with selected quotes from the interview data, and my interpretation of the data will follow each illustration. In the excerpts from my interviews, "S" represents a quote from myself, the interviewer, and "I" represents a quote from the informant. When I interviewed two informants together, their separate responses are noted as "I (1)" or "I (2)." Following the descriptive themes, I will integrate

the interpretive themes into vignettes in order to illustrate the multi-factored construction of the social contexts of injection drug users in Calgary, as related to HIV risk reduction and risk assumption behaviours.

A. Drug Use

Descriptive data about drug use includes any information about the frequency and duration of drug use, the effects, or the quality or purity of drugs used by my informants. It will also include a description of addiction, drug overdose, the purchasing of drugs, and the use of drugs in the prison system. This category also includes general information about why my informants use injection drugs. Some of the morphine users that I interviewed attributed their addiction to their pain and their need for relief:

> Yeah, myself I use it generally for pain. Some people use it to get high. I've got a hip that comes out all the time. I've got arthritis. I've got a pinched nerve in my shoulder, and I've also got a couple of discs that slip out the odd time.

Another common motivation for illicit drug use is for the relief not only of physical pain, but also for the temporary relief of emotional and psychological trauma left over from a lifetime of hardship:

> I just wanted the high. And I still want the high. It's my escape from reality. It's a common feeling for a lot of people. They get this way because of being shit on and abused...it started when they were a kid, and then they go through shit when they're teenagers, and they're still getting shit and abused on by their parents, then they get a boyfriend or a husband, and it's still the same routine - nothing's changed. So, they go out and try to find some way to escape. They use the drug, use the alcohol, whatever it is that causes you to escape from reality. It's your own little world.

The following descriptions of the major themes of drug use will explore and allow us to gain an understanding of each of my informant's "own little world" when they use injection drugs.

1. Duration of injection drug use

I interviewed a total of 13 informants, but one informant had never used injection drugs. As displayed in Table 2, the 12 IDUs that I interviewed had extensive experience with injection drug use, with an average of 10.75 years of using injection drugs. Although there were two men in their fifties who had been injecting for 20 and 28 years, skewing the average to the high side, all of my informants had been using injection drugs for at least three years. Therefore, the credibility of the results is ensured by my informants' extensive experience with injection drug use and the lifestyle that accompanies buying, selling, and injecting illicit drugs.

2. Frequency of injection drug use

I asked the 12 IDUs how many times a day they injected drugs. Although most of the morphine users injected every day, the cocaine users and the heroin user did not necessarily inject their drug of choice every single day. Because the patterns of injection were so different among the three drugs, I will present them separately.

2.a. Cocaine Users

The frequency of drug injection each day, week, or month depended upon the IDU's source of funds, extent of addiction, psychological and emotional condition, as well as drug quality. For example, one cocaine addict described the many factors that determine the frequency of her cocaine injections:

> I: I came here in April and by May I was a full-fledged addict and prostitute. I was out [on the street] 24 hours a day, sometimes for days on end. I'd start, say, at 12:00 in the afternoon, and be there the next day at 12:00. Pouring down rain, I didn't care, as long as I got paid and got a hit into me. Some people do a big run. I can't do that. I can't go for days and days and then stop. I go for days and days and don't stop.
> S: So, about how many hits a day do you do?

> I: When I'm on a roll? I get through an 8-ball. That's 3.5 grams...about 20 injections. Well, I'll do a big one and then I'll wait for about half an hour, or else sooner if the urges get to me. But once the dope is into me, if I do have it down [at the shooting gallery] sometimes, I'll do a good half and it's worth doing, then I won't need anymore. But sometimes I'll do the cheap crappy stuff that you have to buy more of, and it doesn't work the first time, so you have to do hit after hit. It's the first hit that gives the best high and that's what you're chasing. And that's what you'll always be chasing. Your first hit is basically your best hit because you have nothing else in you. And then you have to try to get the second hit...the second hit always has to be as good as the first hit. And the third one has to be as good as the first one. So, you're always chasing after that high.
> I: At what point do you give up?
> R: When my body gives up...when my body says: "You've had enough." Or else, when I run out of money or I just can't stand to be down there anymore.

As described by this informant, the frequency of injections is dependent on her profits from working as a prostitute, the potency of the cocaine, and the endurance of her body. Like most cocaine addicts, my informant binged until her drug supply was exhausted, or her body became exhausted. Cocaine addicts do many consecutive shots, within half an hour of each other, in order to maintain the high. This information about the frequency of injections with cocaine use is important to consider when discussing HIV/hep risk reduction because the more injections an IDU is administering, the more likely he or she is to put him- or herself at risk of HIV/hepV transmission. This finding is supported by existing research. Stimson (1992) explains that cocaine users are more at risk for HIV infection due to the higher frequency of injecting when people use cocaine and the difficulty of adopting safer injecting practices during binge use.

Not all cocaine users injected every day, but were more recreational users, using only when they could afford a supply of cocaine. Cocaine users are well-known for going on binges, or a "run" of cocaine use. They'd acquire a supply of cocaine and then inject it

all until it was gone. During these "runs" of cocaine use, the IDU becomes preoccupied with the effects of the cocaine and is not even aware of how many injections he or she has administered:

> S: How much do you do in a day if you're on a run?
> I: On a run? Right now I'm on a three-day run. I'd do about $500 worth, that's about two 8-balls.
> S: How many injections is that, would you say?
> I: I have no idea. I lost count after the first one. You don't keep track of how many times you poke yourself. You don't sit there and count how many: "Well, okay, I've done ten shots, I've gotta do 30 more." You know? So, I don't know.
> S: To do an 8-ball, do you know about how many injections that would take you?
> I: I'd say about 10-20.
> S: How far apart do you space your injections?
> I: Uh...it depends how hungry you are for it. If you're really hungry for it, then 20 minutes. If you're not, you space them out every 45 minutes to an hour.

Cocaine users space their injections closely, more or less so depending upon their cravings. The fact that they lose track of how many injections they have done illustrates the IDU's chaotic state of mind while on a "run" of cocaine use.

2.b. Morphine Users

Unlike cocaine users, morphine users do not have to inject as frequently and do not lose track of their number of injections. Morphine users obtain their drug in the form of 60mg or 100mg tablets (referred to as "greys"), which they then grind up, dissolve in water, and inject. One morphine user explained the difference in injection frequency between cocaine and morphine users:

> Cocaine only lasts five-ten minutes and then you want another shot, you know. Whereas, with narcotics you can get by with one or two a day, you know, it's long-lasting. One in the morning, and if I have to, I'll use one at night. If not, I'll take a few Tylenol 3s and I'll just go to bed.

Morphine users also go through periods of elevated drug use, for example, when they obtain a new supply of the drug. These periods are similar to "runs" of cocaine use in that the IDUs will use larger than usual amounts of their drug of choice.

> Usually when I get my prescription I'll treat myself. I'll do maybe three-four greys a day, for about three days and then I taper it off. Now, I'm just down to one grey a day – a 100 mg. My roommate was doing ten 100mg pills a day, ten or fifteen.

Most of the morphine users that I interviewed took morphine regularly (i.e., daily) and averaged about three injections a day. This pattern of drug use is sharply contrasted to that of cocaine users who inject up to 20 times a day.

2.c. Heroin Users

Heroin users in Calgary tend to be recreational users in that they do not have steady access to their drug and must wait until they come across a source.

> I: The thing is, because my choice is mostly heroin, I find that I'm doing it maybe once a month, or something, just because of lack of availability. Like, I just bought a bit today and I haven't for a couple months before that. I just have a small amount...probably half a point – a point being 1/10 of a gram.
> S: So, how many injections would that be?
> I: Well, I was being conservative with it. I'll probably get four out of it.
> S: And how often will you have to do it?
> I: Well, because I'm doing a small amount, partly because, well mostly because I'm having such a tiny bit – I don't want to do it all in one hit, you know, wack it all up. So, in this kind of situation, a half hour to an hour. But I mean, if I had like ¼ of a gram, or something, you know, where you're doing larger hits – 2 to 3 hours.

Therefore, heroin is injected less often than cocaine, but more often than morphine. Heroin use in Calgary is erratic due to the limited availability. When heroin was not available, this IDU would use cocaine instead.

3. Addiction

The informants were very forthcoming about their drug addictions, which makes sense considering that drug addiction and its circumstances consumes a great deal of their energy and attention. The informants described their addiction symptoms and cravings, as well as the withdrawal symptoms when they don't take their drug. Even though there are distinct differences among cocaine, heroin, and morphine users when it comes to psychological versus physiological addiction, the informants all described addiction in similar terms. Therefore, I am not presenting the three groups of drug users separately.

> Because when I'm not doing dope, or cocaine, or whatever you call it, I have to drink, I have to smoke pot, I have to do something to counter-attack it, you know, to take the edge off. I have to. And that's why I need to see a doctor, to get something to help me. Because I get so sick; I get bad.

One informant related her experience of the first time that she acknowledged that she had become addicted to cocaine. This account is interesting in that it highlights the disintegration of social relationships due to the destructive influence of drug addiction.

> I remember one time I slapped my mom out. I had coke once and I slapped my mom out. 'Cause I was in the bathtub. I had just come home from [the treatment clinic] and I had half a gram. And I was sitting in the tub getting high, and she opened the door with a coat hanger and she grabbed my flap and she blew it everywhere and I just lost it. That's when I slapped her. Oh, I cut the phone cord off. I was throwing stuff around. That's when I realized what a coke-head I was.

Another IDU described her addiction to cocaine as a choice between making the supreme effort of drug rehabilitation or following the cravings of cocaine addiction.

> See, it's a choice for me. I could get off if I wanted, but I just don't want to. I can quit. But the cravings are too strong and I just choose to follow them. I just choose to go with the cravings. I just follow the cravings. It's just listening to my body.

Although medical literature states that cocaine is psychologically addictive (see Chapter 1), cocaine users asserted that their addiction and cravings assumed a physical expression.

> They say cocaine is not physically addictive, but I feel sick when I'm craving. I get butterflies, and I get sweats, and I get shakes. I get irritable. I get cranky, bitchy.

> Like, when I decided to quit cocaine, I had those friends that said, "Well, let's get high on morphine. It's not that same as getting high on coke." But morphine is physically addicting, whereas cocaine is more mental. You know, you want to be there and want to experience the high. It's a want. It's not really a need. I have people telling me that they get physically ill if they don't have cocaine, but I tend to disagree. I think it's psychological - cocaine - you feel powerful when you're high on cocaine. And when you're high on morphine, everything's laid back, you know.

Although most of my informants expressed that they would like to get off injection drugs, some have attempted to quit so many times and failed, that they have become resigned to their addiction. One informant expressed the power of his cocaine addiction:

> When the coke calls, you gotta go and feed yourself. When the coke calls, you don't give a damn. You really don't give a damn. You just want the high. You want to taste the coke. You want that buzz. You want that escape from reality for a short time that's there.

A long-time morphine addict described his addiction as an integral part of himself, something that would be very difficult to remove. For this informant, quitting drug use was a distant hope, but not a priority.

> For some people the main thing is pain. But once you've been a drug addict, the main thing is psychological. You know, when you're a drug addict, once it's been in your system, once you've been using 15-20 years, it's hard to just quit. I mean, it's like something's missing from you. You're just not a whole person anymore if you just stop, you know.

Once an IDU has used morphine regularly for an extended period of time, his or

her tolerance of the drug becomes more and more elevated, so that they no longer feel the high. Rather, they continue morphine use only to stave off the withdrawal symptoms.

> When I get my prescription – that's when I do two or three in a day – well, then you get high again. Otherwise, it's just a basic...to straighten out or whatever, whether you're sick or not.

Many of the morphine users that I interviewed said that they had started morphine use for its analgesic effects, and later became dependent upon it.

> I knew I was addicted because I'd learned that, not because they told me I'd become addicted. I'd learned that and the withdrawals were terrible, I tried to throw my pills away, and I ended up getting rushed to the hospital. The pain always comes before the withdrawals. But I'm so afraid of being so heavily addicted, and I can't afford to take all the pain away, and the doctor won't help me because they believe that this is an addiction thing and not pain. I can't take it anymore. You know, the pounding chest pains, you know, I mean - the withdrawals are hard - the tightening of the skin. It's cruel, it's a cruel, cruel drug.
> But it's the only damn drug that will help with the pain that I have.

The heroin user that I interviewed did not believe that he was addicted, and attributed it to the lack of availability of heroin in Calgary.

> Because my choice is mostly heroin, I find that I'm doing it maybe once a month, or something, just because of lack of availability. That's why I moved back from Vancouver, so I wouldn't be inundated with it. So, as it stands now, I'm not really concerned about addiction or anything like that. I like the fact that I do it just every once in a while here, because that way...you know, when you're hooked on it you don't even get high. It's just maintenance. It's just like food or something.

This heroin user regarded his drug use as a recreational event, much like indulging in a favorite dessert, or going out for beers. He preferred the unavailability of heroin in Calgary to Vancouver's ready supply; the relative unavailability in Calgary prevents him from becoming addicted to heroin.

The above interview excerpts describing the drug addiction characteristics of my

informants is powerful evidence of the preoccupation that they have with obtaining and injecting their drugs of choice. Satisfying the cravings of a cocaine or narcotic addiction become a priority in the lives of addicts. Sometimes morphine users are able to maintain their addictions and still function as members of mainstream society, but the cocaine users that I interviewed had all had their lives disintegrate as their cocaine addictions became the all-consuming force of their daily activities.

4. Changes in injection drug use

In order to gain an understanding of my informants' long-term goals with respect to their drug addictions, I asked them if they planned or wished to make any changes in their drug-use in the near future. Cocaine users tended to be most determined to quit or at least decrease their cocaine use.

> Yeah, I'm trying to quit, I'm trying to get clean. It was an everyday habit, but now I'm just a couple times a week. But the cravings set in and I have to go out.

One non-IDU who provided a safe house for female addicts and prostitutes was familiar with the difficulty that cocaine addicts have in getting off. Often the decision to quit cocaine use comes down to a choice between lifestyles:

> I know girls that were heavy-duty users, strictly cocaine, that have quit. Not many, not many - I can count on my one hand. I know one - she went to jail, she come out of jail - she'd cleaned herself up and got a little mixed up there with it for a week and as soon as that week was over, she realized: "Well, what do I want? Do I want my boyfriend and a straight life, or do I want to go back to this?" So, she went back to the boyfriend and straightened herself up and had a baby.

One cocaine user did not feel that he was addicted to cocaine, but decided to quit for a fairly unique reason; he was a transvestite prostitute and didn't like the track marks that

injection drug use left on his arms. Aesthetics was his main motivation for quitting cocaine use:

> I: It was just a decision I made for myself - not being able to wear short sleeves. I like to look good for my customers. My arms were ugly and it's getting warmer out now, so...
> S: Was it difficult to quit?
> I: Actually, no, not really. It's more difficult waiting for the bruising to go away.
> S: Oh, okay. Was that the big motivator, then? Appearance?
> I: Yeah.

Other cocaine users that I interviewed gave different reasons for wanting to quit cocaine use, including the expense and the negative side effects:

> And I just started getting more and more paranoid - paranoid and paranoid. And it just stopped being fun.

> It cost too much every time. I mean, like after you do a run every time - I got tired of it.

Another IDU who had been using cocaine, marijuana, alcohol and heroin for eight years had made many previous attempts to "get clean," but was so far unsuccessful. At the time of the interview, she had resolved to quit drug abuse after an especially dire prognosis from her doctor.

> I: The doctors told me: "'S', you're not going to live past 25. You're going to die before that." Because of my hepatitis C. And they told me that in the hospital. I said: "Can I check out now?" And he says: "Well, you're going to check out anyway." And I said, "Oh, can you tell me what you meant by that? Am I going to die?" And he says, "Yes, you will. You keep this up, you're going to work your liver over and your hep C is going to get the best of you. You're going to be dead by the time you're 25. You're not going to make it past that." Even the doctor upstairs [at CUPS] told me that.
> S: So, are you trying to quit everything, or just cocaine?
> I: Everything.
> S: And how do you plan on going about that?
> I: Well, I'm going into treatment. I'm going back to Saskatchewan this Friday. I'm moving back and spend time with my two kids. I'm going to

> stay with them for a couple of months and in that time I'm going to get into treatment. See, I never thought I would get out of the scene. Once you're in the game you don't get out until you're six feet under.

Whatever their reasons for wanting to quit cocaine, the IDUs that I talked to all agreed that it would happen only when they were ready to make some significant changes in their drug use:

> Yeah...I'm slowly cutting back but it's a long process. It's not that hard. It's just a matter of wanting to.

One cocaine addict had made several attempts to quit his cocaine use, but so far had been unsuccessful. He was neither optimistic nor cynical about being able to quit cocaine, but seemed resigned to the fact some time in the future either he or his addiction would give in:

> I have been trying to stay dry. The best I've done was seven days - whoop-dee-do, hey? But that's okay, at least seven days I've tried. Oh, one day or one month, I will beat it. Or it will beat me, it'll do me in.

One morphine user, after 28 years of use, had resolved to quit for his wife's sake and looked to his spiritual faith for motivation:

> She wants me to get off of it, that's why, like I said, I'm putting a year aside, and I'm going to get my health back, and then I'm stopping completely. And that's a fact of life, that's a fact of what I'm going to do. Like, I have myself down to a half at a time, and I do a half the same way that I used to do one and a half. So, the Lord's on my side. As they say in the bible, you lay all your problems at the alter of the Lord, the good times and the bad times. You lay your problems, and he will fight the good fight for you. That's what I believe.

One alternative for morphine and heroin addicts is to enroll in a methadone program which replaces the morphine or heroin with an opiate agonist administered under regulated and supervised conditions. However, accessibility is a problem in Alberta.

Addicts in Calgary must travel to and find accommodation in Edmonton in order to receive methadone replacement treatment.

> On Friday I phoned Edmonton to get on the methadone program. I'm thinking about getting on the methadone program. But one thing that I wished this city had was a methadone clinic.

One morphine user wouldn't even consider getting off morphine because she feels that its analgesic effects are a necessity for her to function in every day life. Also, getting off her morphine prescription would require admitting to health care authorities that she no longer has pain, and she is afraid of losing her AISH (disability insurance) benefits.

> S: Would you consider doing something like a methadone program?
> I: No.
> S: Why not?
> I: Well, it's okay in the summer time. I can get by. But in the winter sometimes I can't even move. I've got bone spurs in my back and severe arthritis, so sometimes in the mornings I feel like I'm 70 years old. If I don't have morphine, it'd be sort of hard to go out.
> S: So it's not something you'd ever consider quitting?
> I: Well, if I could get to a warmer climate. That's what the surgeon said: "Go to a warmer climate." "If you've got a nice place in Hawaii, I'll stay out there and babysit your house, or whatever." But then if I got off the morphine, I'd probably be cut off my AISH. Because they'd say: "Well, if you don't need your pain killers any more, there's nothing wrong with you." So, then they'd say: "Go to work." But I can't work. I've only got part of my back left, right? And with my hepatitis C and my liver...I've been out of the work force since '81.

Another IDU would not consider quitting her morphine use, again because she needed its analgesic effects, but had considered switching to oral administration of her morphine pills in order to reduce the risks associated with injection drug use. She said that she would be very willing to go into drug treatment if she could find an alternative way to cope with the pain she had experienced ever since a motor vehicle accident years before:

> Because if the medical [field] can't help me, there's nothing I can do. I'm challenging right now. I'm getting close, I'm trying to switch over to

> eating. And/or to get something, even the muscular shots. Something where it's instant, cause I get so bad - I'm so much in pain already, I can't catch it. Like I tend to eat so many of [the pills] because it won't take the pain away. You know, it's such a long, drawn-out thing, it's time-released. It's too late almost. If they can get rid of the pain, I'll throw my butt in the addiction center if I have to, if I can't cope. Cause that's how much I hate it. But basically, see, I've turned, I've gone from the bad and the worst to getting better. Like I'm crawling up. So, I have solutions.

The accounts of attempts and desires to quit injection drug use illustrate how difficult it is for some IDUs to change their addictive behaviours. But it is also important to note that not all IDUs wish to change their drug use and actually rely on their drug (especially morphine) in order to function productively in their family and in society.

5. Drug dealing

The informants provided me with descriptive data of the process of purchasing drugs from various drug dealers, as well as the availability and the cost of their drugs. In order to gain an understanding of how an IDU accesses a drug source, I asked general questions about my informants' dealers.

> I: How do you find a person with drugs? Well, actually it takes one to know one. You can just tell, or else you just ask a friend of yours or a close friend of yours to score for you. A lot of the dealers won't deal with you if they don't know you. That's why I don't have a personal dealer.
> S: How do you get in with a dealer?
> I: I don't know. Because all those people down there, they got their own personal guy, their own personal dealer, but I don't really want one. I think it would be cheaper, but I'd be stoned 24 hours a day if I had my own dealer.
> S: How much is an 8-ball?
> I: About $200, $250.

My one non-IDU informant provided valuable information as he at one time sold drugs, until he was charged with drug trafficking and imprisoned. His account of why he sold drugs provides interesting insight into the motivation of drug dealers who are often

viewed by society as immoral and deviant individuals. He describes his experiences as a dealer and the reasons for why he no longer sells drugs:

> About ten years ago I was selling cocaine and morphine. I got busted, went to jail and did my time. I became a little introverted after I came out of the shell and got back around again, but not dealing. After I got busted, I had a couple of real close friends - a brother and his sister. The sister OD'd on a Friday, and the brother OD'd on a Sunday, just two days later. They were very close friends of mine, personal friends. And it really shook me up. As far as selling drugs is concerned, I feel it was just something that I'd gotten drawn into. I never did sell just for the money, because even when I was selling, I still worked everyday. I still had a job. Selling drugs - I liked...what is the word I'm looking for here? I liked the controlling effect it had on the girls. It was always: "I don't have enough. Please, please, please, please! I only have $45. Please, can you do this for me, please?" I didn't care if I made money. The difference of $5, from $45 to $50, which is $5, was just about my profit that I would have made because the drug was not mine and I was selling for somebody else. At one point I had a falling-out with that person, so then I started buying it myself and flapping it up, packaging it all up, and then selling it. There was more money in that - I won't disagree with that - there was more profit. At that time you were paying $350 for an eighth of an ounce and you do it up into 14 papers. 14 papers you sell for $700 - you know, you double your money. But, like I said...I sold the drugs and I never made any money. I got ripped off a couple of times.

The former dealer asserted that he had never used injection drugs himself, and did not even like the effects of smoking marijuana. He did not care for the loss of control that he felt while under the influence of marijuana and said that he would never try injection drugs:

> Any dealer that uses doesn't deal for very long. It never works out. Some of them start out sticking it up their nose. Some of them start smoking it. Eventually, their curiosity gets the better part of them and they're going to IV it.

Another dealer described the hectic lifestyle that drug dealing creates due to the fact that many IDUs rely on him to provide them with their drug supply:

> When I was selling drugs down there I rented a room just so the girls could use it for a shooting gallery. Sometimes I was too tired to drive home - you know, I'm up for a day at a time with them down there - it's a 24-hour operation when I was selling. There's no part-time dealer. Unless they absolutely cannot get a hold of you, you're a dealer 24 hours a day. As long as they could see my car outside, they were upstairs, banging on the door. They knew where to find me.

One informant explained the attraction of drug dealing as a quick way to make a substantial amount of money. He had at one time been a drug dealer, but no longer deals after he was charged and convicted. However, even the risk of being charged and imprisoned is not a strong enough deterrent for some dealers:

> But jail is no big deal. I don't like it - I wouldn't want to go back. I'm not going to go back, as far as I'm concerned, but jail is nothing. It's no deterrent, whatsoever. If I wanted to deal, if I needed money, I'd be there. I have a friend of mine, right now, that's dealing and never dealt before. He's dealing now. He was stuck for money, so he figured, "Well, it's a fast way to make a buck." It is a fast way to make a buck if you want to make a buck. And he's making it, too.

Many of the morphine users that I interviewed obtained their morphine prescriptions from their own physicians and then converted the pills to injection form:

> I: No, I haven't got a dealer. I have one doctor, who prescribes it to me, every once in a while, every couple of months. Like, he usually gives me 60 - 60mg'ers and I make them last as long as I can, usually a month.
> S: Where do other people get the morphine?
> I: Off the street, I guess, wherever they can. It's been such a long time since I have ever had to go downtown. When I first moved here it was $80 a pill and I used to go downtown with $500 all the time - anywhere between $300-500 at a time. I was supporting three other people's habits. And within five months I spent $17500, almost $18000, me and three other people. But that was so long ago, and I've had to go to jail over it, well, that was one of the reasons. I got nailed for double-doctoring.

"Double-doctoring" refers to the practice of visiting two or more physicians with the same health complaint and obtaining several prescriptions of the same medication, in this case, morphine. One morphine user obtains a prescription for more pills than he needs

himself, and sells the pills for a profit to other morphine addicts. He provides an interesting description of the hassles of having IDUs frequenting his home in search of morphine:

> I: My doctor gives me a prescription for 100 pills every three weeks. I usually sell 50 and then keep the other 50. Sometimes I run out, sometimes I don't sell that many. It all depends on how many people are around that grind me. I sell them in bulk now. I used to sell them single like my roommate does – she sells them $30 a pill or $35. But then I told her I don't want that traffic coming to the house. So, when I get my pills I sell forty or fifty for $20 a piece. Sure, I can make more money, but then you're going to have more junkies coming over and then people want to fix there. And it's too much bullshit. And I'm not that greedy. I'd rather just get a bit of money, then I don't have to meet all these other guys, all these other junkies. Like, the business, and the money profit – that end isn't even worth it in the long run. Too much hassle. Because you get hookers coming over 3-4 o'clock in the morning, 6 o'clock in the morning to score. And they come over with the radio and t.v., and they say: "Take this, or I've got a ring. Can you help me out until I can pay?" You know? It's crazy.
> S: And what's the going rate these days for the pills?
> I: In bulk, it's $20 a pill. I guess downtown they sell them for $40 for one – that's the going rate - $35 to $40.

One morphine addict stressed that her pain was very real and that she was a legitimate recipient of a doctor's prescription for the morphine. Her physician doubted that her pain was legitimate, so she found other people who use morphine to give her their prescriptions. She resented the fact that other morphine users obtained prescriptions under what she considered to be false pretenses:

> I: How I ended up getting my doctor to question me, is because I was going through them so fast in the beginning. So, I couldn't get the pain killers through the doctor because they just wouldn't believe that I have the pain and it was so terrible that I turned to IV use. I could use half a pill intravenously and get the same effect as eating two pills.
> S: So where do you get the drugs if the doctors won't give it to you on prescription?
> I: From whoever - there's many people out there that fake their pain. That disgusts me, to be honest with you. They use old injuries, you know, they

> lie, they cheat. Some of the stuff they do makes me sick. And then what they do is sell the medications. I've found sources where they do have pain but they hold back their pain. They don't have as much pain as they are given, and so they sell it. It took me a long time to find the little old man or the little grandmas that care and know that it's for pain and that's how come they will work something out with me. Each day for my meds it costs anywhere from $40 to $80. That's sick. So, you know, $40 is shooting pretty low. And $60 is pretty average, but you know, my pain is so bad right now I could easy spend a hundred bucks a day. And that's been the regular.

Some of the IDUs who obtained their drugs from the street had become very familiar with the different means of accessing dealers and their drug supplies. Heroin is sold in "flaps," in portions of 0.10 grams, folded within a piece of paper (most commonly, lottery paper). One heroin user described how he obtained heroin, a relatively scarce drug in Calgary, as compared to cocaine or morphine. Obtaining a supply of heroin seems to be all a matter of knowing the right people and having the right connections:

> I: Oh, cocaine is ridiculously accessible. There's five dealers over there and there's a 24-hour line, and stuff. The city's pretty much flooded with it, well as far as my circles go. Coke is pretty easy to come by in Calgary. For an outsider, it's hard, it's hard to find coke, but for whoever who knows the ins and outs of this city, it's sure easy.
> S: So, how do you find out if there's some heroin available?
> I: Well, usually the guy – he phones around or he'll do deliveries if he doesn't want people going over where he's staying.
> S: So, what's the going rate these days for a flap of heroin?
> I: Well, Calgary's quite expensive. You're paying anywhere from $40-$50 a point, a point being a tenth of a gram. Yeah, pretty much twice what it is in Vancouver.

Some drug dealers are known to sell needles along with the drugs, but one IDU explains that the motivation for selling needles is not necessarily for risk reduction:

> S: Do you know of drug dealers who will supply a new needle with the drug?
> I: Yeah. There really isn't too many that won't. They usually charge $2 a piece or if they're feeling generous, they'll give it to you. They make money on the needles, too. It's a whole money thing.

> S: So, it's not exactly out of the goodness of their hearts, or something.
> I: Naah. They're not being safety-conscious. They are promoting: "Hey, I've got them here, $2 a piece. If you can't go the drug store and go get your own." You know. If they don't use them themselves, why should they have the hassle of keeping them around? They're not going to sell as much of the drugs if they don't supply the means.

The above descriptive data about the drug dealing networks, systems, rules, and dynamics provides important information when considering the social context of injection drug use. Many of the relationships between IDUs are directly related to the tensions surrounding the illegality of drug dealing and purchasing. A drug supplier can easily become an IDUs best friend, or simultaneously an IDUs worst enemy, depending upon the price the dealer is asking for the drug.

6. Drug quality

One of the most dangerous aspects of injection drug use is that the quality and potency of drugs purchased on the street are completely unregulated and IDUs have no way of knowing what they are getting. Miscalculating dosages of hits could prove fatal, and the lack of regulation of street drugs poses one of the chief risks of injection drug use. I asked my informants if they had ever experienced problems due to poor quality or high potency of drugs purchased off the street, and what precautions they took to protect themselves from a "bad hit" (i.e., injecting impurities or overdosing).

> Like with cocaine, I always test the waters. Cause, if I get a score from someone I don't know, I'll just do a little hit, try it out, see what it's like. And see if I can handle more, or less, or if I should do less or more. I always test the waters. I don't go in and do my regular big whack, or big hit.

The ability to gauge potency of a drug and judge appropriate dosages of each hit comes only with experience. The challenge is that each supply of drug is different in purity and

potency, and it is often only after the first hit that an IDU can assess the quality of his or her drug.

> Well, I'll do a big one and then I'll wait for about half an hour, or else sooner if the urges get to me. But once the dope is into me, if I do have it down there [at the shooting gallery] sometimes, I'll do a good half and it's worth doing, then I won't need anymore. But sometimes I'll do the cheap crappy stuff that you have to buy more of, and it doesn't work the first time, so you have to do hit after hit.

One IDU had a particularly frightening incident during which he injected cocaine of unknown potency and experienced an overdose. At the time, he was inexperienced in injection drug use and mistakenly relied on another, more drug-tolerant, IDU to measure his dosage.

> A long time ago a friend and I went in on half a gram of cocaine, and it was really, really pure stuff – like it was all in a big chunk. And we sort of just divided it and his tolerance level was a lot higher than mine because he was a pretty heavy user. So, he didn't really take it into account that I'd probably need less. And he injected me, because at that point in my life I wasn't able to do it myself. And I just fell back and it was a really scary experience – I thought I was going to die.

Some dealers have been known to add other more addictive substances to cocaine in order to increase the likelihood that their clients will become addicted, thus increasing their business prospects.

> Well, lately, I've heard that there's quite a bit of heroin around. They're cutting the coke with heroin, and a few of my friends have died. I don't know if you've ever heard of S.D. – he died about two weeks ago. He was only 33. Because all he fixed was cocaine. They say he O.D.'d on cocaine. But I've heard from a few people that they cut it with heroin so you can get wired faster.

Often, IDUs' only protection against receiving and injecting "bad hits" is to learn through word-of-mouth from other IDUs in their social networks about what dealers are reputed

to supply good quality or poor quality drugs. I will next discuss the feelings of paranoia that accompany injection drug use.

7. Drug effect – paranoia

A common cognitive effect of cocaine or opiate use is feelings of paranoia and fear. Almost every informant described feelings of paranoia, either their own or that of other IDUs. Sources for paranoia included the illegality of their drug use, the social undesirability of drug use, and the mistrust of other IDUs or dealers.

> I: Yeah, I can't walk out in public when I'm high. There's no way. I get too paranoid.
> S: What do you get paranoid about?
> I: Oh, paranoid that people will find out that I'm an addict. If there's a window open, I'll want to shut it, because I don't want people seeing in and see that I'm getting high. I don't want people to know that I'm an addict. It's nobody's business. I get paranoid around people. I have to be alone or I have to be with someone I really know.

Many IDUs will not use the SafeWorks Calgary NEP because of feelings of paranoia about being revealed by the program to the police. One collective exchanger explained why some IDUs are paranoid about using the NEP:

> S: So, why do you exchange needles for other IDUs?
> I: Because they're real paranoid. CUPS is close to the cop shop. You don't have to use your real name in here [at CUPS]. And even if you don't use your real name, they fear that all that information's going to the police, or photographs, you know...it's big paranoia, no matter what you tell them. All of them - they're all paranoid. They think you're all a bunch of 'narcs. They do. "Oh, I'm not going to meet that van, you know. There's going to be an unmarked cop car, you know, behind the van, and as soon as I get the needles, they're going to follow me home, and they're going to bust me." I went through that for a year. I figured it was going to happen to me. Then I finally grew a brain.

The same paranoia that prevents many IDUs from accessing the SafeWorks Calgary NEP also impeded my ability to recruit IDUs to my study. I asked one of my informants if he thought it would be possible to recruit and interview non-NEP clients:

> The very nature of what they're doing is illegal, so it'd be pretty hard for you to break in there, because they're paranoid as is, because they're doing something highly illegal and even if they trust you, a police car might be watching the house, and they see the [NEP outreach] van parked outside and they might recognize that you're the van, okay, and know something is going on there, and go in and arrest everybody. So, it'd be pretty hard to break into a circle of those druggies.

The paranoia about being charged with illicit drug use or possession is a dangerous deterrent for IDUs who are in need of medical care, especially in the case of drug overdoses. One IDU described an incident during which he had an overdose of cocaine, and his friend was too paranoid too take him to a hospital emergency room:

> S: Did he take you to a hospital?
> I: No, he just calmed me down, and stuff. That's a big danger, too, is people a lot of times - they won't call a hospital because they don't want to get the cops over and shit like that. So it's kind of a bad situation if you're not careful in that aspect.

When I asked one cocaine user to describe the setting of the shooting gallery where she went to purchase and inject cocaine, she explained the mindset of the other IDUs. She explained that paranoia was not always focused on being discovered by the police, but rather many IDUs are distrustful to the point of paranoia about other IDUs in the shooting gallery:

> I: Everybody's paranoid that they're going to get ripped off by somebody. You never know what's going to happen in one of those places. Someone could be there that owes so-and-so thousands of dollars, you know.
> S: So, it's not necessarily paranoia about cops, or getting busted?
> I: That's usually the last thing I was thinking of. It was usually about other druggies or dealers.

The feelings of paranoia described above are a significant force in preventing IDUs from accessing health services, including the NEP, which in turn places their own health in jeorpardy. These feelings of paranoia pervade the everyday lives of IDUs, placing a great deal of stress on them, and preventing them from developing meaningful relationships with others. I directly experienced the effects of the IDUs' feelings of paranoia in that I was unable to recruit any IDUs who were not clients of the NEP due to their general mistrust of individuals outside their social networks.

B. USE OF THE SAFEWORKS CALGARY NEP

This category includes information about IDUs' use of the SafeWorks Calgary NEP, including both collective and individual exchanges, as well as some information about IDUs who choose not to use the NEP. All of my informants had used the SafeWorks NEP and gave generally very positive assessments of its services. Although this thesis project was in no way meant to provide an evaluation of the SafeWorks program, it is important to acknowledge the feedback of clients. They also make some very valuable suggestions for the program's improvement. Although I was unable to recruit and interview any non-NEP client IDUs, I was able to collect some valuable information about why non-clients were reluctant to use the NEP. I asked NEP clients about IDUs' knowledge of the NEP, their comfort with the NEP, and how they heard about SafeWorks.

According to one NEP client, more IDUs need to be made aware of the SafeWorks NEP:

S: Do you think that most IDUs know about the program?
I: I don't think so. I think they know about CUPS itself, but I don't think

they know about the NEP.

I was also interested in learning how clients came to use the NEP and how they overcame any possible reluctance:

> I: It took me a while before I was trusting enough to go to CUPS. I didn't want anybody knowing, because I was young and everything. I always thought there would be cops there watching and follow me home, or whatever, until I built up the trust to go here. For a year I felt like that.
> S: What helps to build up the trust for the NEP?
> I: Oh, just getting it in my head. Because I was really messed up when I first met you women. I was messed up, paranoid. After I'd straightened out a little bit and I started using less, that's when I started getting my head together and I knew you's weren't out to get me. Well, first my buddy S. started going there and then I went.
> S: Good, so it took a while, though hey?
> I: It took about 6-9 months.

The time lag between initiation of injection drug use and accessing a NEP was quite high in this informant. This finding is supported by a 1997 program evaluation of the SafeWorks NEP (then called the Injection Drug Education and Prevention Program). The evaluation reported that the population segment that is least likely to be reached through the program is recent IDUs, most likely those in their teens. Another group of IDUs less likely to register with the program are light, infrequent IDUs (LeMarquand-Unich, 1997).

One important means for a client to gain enough trust with the NEP to access its services is having a friend use the NEP and giving his or her recommendation.

> S: How long have you been using the program?
> I: Uh...three years.
> S: How did you find out about it?
> I: Well, through another friend. Because I had 300 [used] needles and she said, "hey I know where you can get rid of those." I said, "Oh, yeah? Where?" She goes, "Here's the phone number. Call them!" "Oh, yeah, right on."

The SafeWorks clients were generally highly satisfied with the NEP's services and appreciated the generosity and concern of the nurses running SafeWorks. One client did express that he would like the program to be open for extended hours:

> Well, this place...if SafeWorks was open 24 hours a day, that'd be great, because the coke dealers are out 24 hours a day. So, when you run out, you run out, you know. You've got no bleach, you've got no money to pick up needles. What the hell!? You're going to do that drug anyway, because it's calling. If you're craving for it and you're hungry for it... 24 hours in the van, you know, the van or in the office, or whatever. The van's always quicker - you don't have to move. Just like the dope dealer: "Come to me!" And they come.

Another SafeWorks client said that the only way that the program could be improved would be to increase awareness of the program and its services. This client said that he had tried to inform other IDUs of the NEP, but with limited success:

> S: Is there any way that you can think of to expand the NEP, or to improve it?
> I: Offhand, no. Just make people more aware of it that you can go there.
> S: How would you do that?
> I: I don't know how you would do that. Because I've talked to some people until I'm blue in the face and still had to come here and get their needles.

Another informant expressed that most of the IDUs in his social network used the NEP or at least were aware of its existence. And if they themselves did not directly access SafeWorks, they had friends that would access the services on their behalf.

> I (1): I don't think there's too many people that shoot up here in Calgary and don't know about this place [SafeWorks]. It's pretty well known.
> I (2): And if they don't have enough nerve, it doesn't take much to find a hooker out there that they know does it and does go to the needle exchange, you know, somebody that will run to the drugstore for them because they don't want to be seen by anybody.
> S: So, people in one way, or another, will have access to the program, even if it's through other people?
> I (2): Oh, yeah.
> S: Good. So, of those hundreds of IDUs that you know...say you know 100 of them, of those 100, how may would you think actually use the

> program?
> I (2): 90% of them. I would say 90%, yeah. There isn't too many people....there aren't too many people out there that when push comes to shove won't actually come in here. And when their name's not asked, or anything, they figure they got away with something.
> I (1): The girls are good. They will deliver them to you. All you have to do is phone them and say: "I'm at such-and-such a place." And they'll bring you needles. They make it pretty easy for you.

Although some of my informants exchanged needles at SafeWorks only for themselves, I tried to recruit and interview collective exchangers for their health promotive role. The discussion of my informants' use of the SafeWorks NEP will thus focus upon the role of collective exchangers, as they play such an integral role in extending the reach of Safework's harm reduction activities. I will then go on to discuss information I collected about IDUs who do not use the SafeWorks NEP and provide explanations as given by those who supply needles to non-NEP clients, the collective exchangers.

1. Collective Exchangers

Collective exchangers are clients of the NEP who exchange 100 or more needles at a time for at least one other IDU. Collective exchange has been defined as "making large amounts of sterile needles and sharpsafe containers available at strategic places in the drug scene so that clean needles are always available in those places where drugs are being used" (Grund et al., 1992). Usually clients have to prove to the nurses running the NEP that they are IDUs (by showing their track marks), but the nurses will also provide needles to people who are supplying others who are unwilling or unable to use the program themselves. For example, the "safe house" owner does not use injection drugs himself, but exchanges large numbers of needles for the working girls that he shelters.

One IDU explains his role as a collective exchanger:

> I: The only reason I get the needles and I share it with my friends is because I know they haven't got the sense in their head to use one syringe every time, to get 300 at a time, you know. They use the same one over and over. It makes me sick, really. If somebody wants to use my needle, I usually have 2-300 there, you know, which I help...like, I said the other night in the van. I help about 3-4 friends of mine who are too cheap to go to the pharmacy and they're too paranoid to meet the van, so I supply them. They usually phone me and ask me if I have any machines. Or any artillery, or any toys.
> S: So, about how many needles do you exchange for them...is it every week, or how often?
> I: It's about every week to two weeks. I usually give away half of them, if not more.

Another IDU exchanges large numbers of needles at a time with almost unlimited access because she is has hepatitis C and the SafeWorks nurses recognize the importance of having a plentiful needle supply as a means of preventing HIV/hep transmission:

> I: I usually do exchange and I get new needles. See, I can get 500 if I want. If I wanted to right now, I'd say: "Give me 500 needles." She would give them to me.
> S: Do you have to bring in 500 used needles?
> I: No. Cause people with hepatitis C or HIV - they can get needles any time they want. They can get as much as they want because they have that.

One informant expressed why she performs collective exchanges for her fellow IDUs, demonstrating a good awareness of the risk of HIV transmission:

> S: So, why do you care what other people do with their needles?
> I: Why do I care? Because, I mean if I ran out of needles, I'd sure want somebody else to give me a needle. I used to pick up needles off of the street when I didn't have no needles. I used to go looking around for the needles where the hookers do their needles and pick them up. Instead of going to the container and grabbing one and bleaching one out, even though I bleach it, it could still have some of that germ in it. Even though you do it six times, it still could have some.

Another collective exchanger who is HIV-positive has experienced the lows of injection drug use and has developed a compassion that motivates him to supply other IDUs with clean needles:

> S: So, why do you care?
> I: I care because I'm part of the human race, and like, I have been down so far that it has started to look like up to me. And I don't want that [HIV infection] to happen to anybody that I know. And if I can intercede and you know, head it off at the bat, so to speak, I will. That's what I hope I can help these individuals I was with, you know, by giving the needles.

The SafeWorks NEP will provide large amounts of needles to IDUs on the condition that they: 1) return used needles approximately equal to the number of clean needles that they take; and 2) don't sell the needles that they are given for their own personal profit. One IDU explains why she would not consider selling the needles at the shooting gallery, even though she knows of other IDUs who do sell the needles given to them by SafeWorks:

> I: There's an old lady that lives in that house, okay, she's about 50 or 60 - she usually treats me pretty good. She takes care of what I leave there. If I leave it there, she makes sure that it's there for the next time I come. So I go down there with 100 rigs - and she keeps them. She says: "Why don't you sell them for $5 a piece?"
> S: Do people sell them, the ones that get them from the NEP van?
> I: Yeah, I've seen people sell them. I've seen people sell the boxes for $25 a piece. Not me. Why would I? I need them. If I sell them, then I have none and I have to call the NEP again.

Whether needles are supplied at a shooting gallery depends upon the person(s) responsible for running the shooting gallery. One IDU explains why he thinks some shooting galleries would not supply free rigs to IDUs:

> Yeah, sure if I had a place downtown, or fairly close to downtown where most of the people use, I wouldn't mind having a box of rigs there and if someone came over, I'd say: "Here, take them. But get out. Don't use them here." Just make them leave, you know, because I don't want a bunch of

> people sitting in my house doing that. You can get in trouble if you say, "Here's a needle." And I say, "Oh, well, if you got a needle, can I use it here?" So, uh...you know, you don't want them there so, it's easier for some people if they say, "No, I don't have any there." They do have them there but they don't want the people to hang around. They want to get rid of them, so they say, "Sorry, I don't have any needles. Go find your own." Just to get them out of the house. Because if you tell them you got a needle, then they'll...you know, drug addicts are very manipulative, so they'll do a little begging and crying until you let them and say: "okay, go ahead. You can do it here." You know, and then somebody else drops in ten minutes later and there's a couple of them there, and all of a sudden the house is full of people and that's the last thing you want.

On the other hand, some shooting galleries do have a supply of new needles and the owners do not have any qualms about supplying needles to the IDUs that frequent the shooting galleries. One IDU describes how one shooting gallery owner (also a drug dealer) unabashedly performs collective exchange:

> There's nothing bashful or shy about that guy - he'd walk into CUPS with a big box under his arm and walked out with two cases of the rigs. He didn't care.

An IDU explained that some shooting galleries supply needles to the IDUs and also explains the motivation of the drug dealers running the shooting gallery:

> However, there are a couple of shooting galleries I know of where they do have needles. I don't know if they get them from the van, or what. I guess they get them from the van. I don't know if the van comes to their house and they meet them on the street, or what. But they do have a box of syringes, you know, and they will give you one. Because they want you to stay there because they know that one hit later, in five minutes, you're going to want another one. So, they'll give you a needle anytime and say: "Oh, sit down, and do it here." Because they know that if you got any money that you're going to stay there until every last penny is gone, and so those are the only people that will give you the needles - the people that want you to stay there longer and buy more drugs off of them.

This quote demonstrates that a drug dealer's business is good motivation for supplying needles to IDUs, and that even if his intentions are not directly harm reduction, the

outcome is desirable, whatever the motivations are. One of my informants used to own what he called "a revolving door" (or shooting gallery) and exchanged needles for the approximately 30 IDUs that used his shooting gallery each day. The heroin user that I interviewed explained that he exchanges for other IDUs because they are young (teenagers), live with their parents or boy/girlfriends, and don't want their family or significant others discovering that they use injection drugs:

> S: So, back to your acquaintances, or people you know that inject – how many of them would you say use the NEP?
> R: Geez, probably not many. I know of two other people.
> I: Oh, is that it?
> R: Yeah, and I really, to reiterate, think it's because of their living situation, it's not wanting to get found out.
> I: So, what do they do for clean needles?
> R: Usually they come by here, or they come by my other friend's place, who has the same kind of deal. You know, they come over, they use and they dump it in the bucket. So, it's just nice and contained and people aren't leaving needles around. I just think that everyone should have clean needles that are using. I don't really have any qualms about doing that. I think some people are a little bit paranoid.

Collective exchangers also fill an important role by not only supplying new needles, but also by facilitating the safe disposal of used needles, usually in the yellow hazardous waste containers supplied by SafeWorks. An IDU who frequents a shooting gallery that supplies needles describes that she does not carry a needle supply with her, so depends on the shooting gallery owner to give her clean rigs:

> S: Don't you exchange enough for yourself?
> I: I'm not in one place all the time, so...the place that I go to down in Bowness, they've always got, always got new needles. Even if I have to sit there and use a whole box in one night.
> S: So, the person that owns the place exchanges?
> I: He gives out new needles.

Certain IDUs have taken it upon themselves to serve as collective exchangers for other IDUs and fill an important role:

> Have you ever exchanged needles for other people?
> I: Yeah. All the dope houses.
> S: Oh, you do? Can you tell me about that?
> I: Well, I just gather them all together and phone and make sure that they have more than enough needles.
> S: About how many do you exchange at one time?
> I: It could be anywhere from 500 to 1000.
> S: Wow. Is that once a week, or how often?
> I: Uh, when the dope houses were really happening, it was probably a couple times a week.
> S: That's a lot of needles. So, do other people do that too - exchange for others?
> I: Uh...I don't know.
> S: So, are you counted on as the person to do it, or will someone else take care of it if you don't?
> I: Somebody else eventually takes care of it.

Thus, we can see that there are some very important collective exchangers in Calgary who significantly expand the reach of the SafeWorks NEP. Collective exchangers include dealers, "safe house" owners, shooting gallery owners, as well as IDUs who inject for a small number of friends. The needles distributed by collective exchangers are also having an impact beyond the shooting galleries or safe houses. Besides being available for on-the-spot use at place where IDUs gather, the needles are being distributed among other IDUs to take home. For many IDUs, the availability of clean injection equipment is a strong incentive to frequent the places supplied by collective exchangers.

> I: Have you ever introduced anybody to the program?
> R(R): Sure, I have.
> I: How many people?
> R(R): I can't say how many people. I would just tell people: "Do you know where I can get the free needles? Where's the needle exchange?" And I tell them: "You can go right here or there's a van that drives around." I mean, if you phone them...if you're in a crack house and you phone them and say: "Look, I've got 500 dirty needles here. Do you want to bring me some

> clean ones?" They'll deliver them to you. They have a pager that's set up for that. A lot of the crack houses depend on that for that service.

Collective exchangers also play an important health promotive role by educating other IDUs who may not be aware of the SafeWorks services.

2. Non-NEP clients

Ideally, I would have liked to interview IDUs who did not use the SafeWorks NEP in order to understand why not and what changes the program could make to increase its use among IDUs. I asked one of my first informants if it was possible for him to introduce me to an IDU who was not a client of the NEP:

> I: In the real world, it would be, yes. You know, but the way that these individuals think, dear, they're just so paranoid that anyone else, you know, that even comes near their circle, is automatically repelled, automatically.
> I: So, you don't think it will be possible to talk to them?
> R(L): I would not think so, to be honest with you, very honest. Because they are likely to think you're a cop. And I can speak for all of them because I know how their heads work. I do.

All of the informants I spoke to were reluctant to introduce me to non-NEP clients. Because I was unable to access any informants who were not clients of the NEP due to their lack of trust, I relied upon the insights of collective exchangers for developing an understanding of why IDUs do not use the NEP themselves. I believe that the information provided by collective exchangers about non-NEP clients is credible in that at one time, all of my informants had to go through the process of learning about the NEP and developing enough trust to access its services.

> I: Did you have a problem at first developing trust to use the program?
> R(R): Yeah. Yeah, I didn't want anybody knowing, because I was young and
> everything.
> I: So, how did you finally get around to using the program?

R(R): Well, first my buddy S. started going there and then I went.

The collective exchangers who I interviewed all understood the misapprehension and reluctance of non-NEP clients and were willing to assist other IDUs by accessing the NEP for them indirectly:

> I (1): If they won't go and get themselves clean needles. I don't think nothing about bringing a bag of dirty ones in and saying, "Hey, I have a friend that's too stupid to come here."
> I (2): I've gotten needles...I never had dirty ones. I just went and got clean ones for them.
> I (1): Yeah, because they're too afraid to come in here themselves. They think it's a big...you know that the cops are going to bust them.
> I (2): I just know that there's people still out there that are afraid to come in because they think all the information goes to the police and it's right behind the cop shop.

The fact that the fixed site of SafeWorks at CUPS is directly behind the Calgary Police Service head office contributes to some non-clients' paranoia about being discovered by law enforcement officers. Two of my informants explained that there is not adequate knowledge among IDUs of Safework's services, and that even they themselves had only just recently become aware of the range of services offered by SafeWorks:

> I (1): They're all too paranoid. I was too when I first met you people.
> I (2): Some people are unaware. I didn't know there was a van service myself.
> I (1): Right, there's a lot of people that don't know.
> I (2): Until the other night, I wasn't aware that SafeWorks delivered.

In order to increase the reach of the SafeWorks NEP, I asked the informants what would help to convince IDUs to use the program:

> I (1): A ball, chain, and hammer. No, you'd have to really talk to these individuals because they are on the outskirts of society. They are so paranoid. It sort of makes me sad, you know, because I sort of know these individuals and I might not like a lot of them, you know. They don't have to like me. I'm not the best man at all, but I'm a sensible man, anyway, I do

> think I'm sensible. And if I happen to give somebody some advice, it's usually sound advice. And it hurts if you're giving somebody advice and you find out that they're throwing it out the window.
> I (2): If I could just add - you were asking what would help build trust for the NEP. What would help is if you could make the city police go along and make a few public service announcements and say: "We know that there's a problem. And we give our word on this and that...We will not follow the van. We will not do that." You know, I know it would help me if I was to hear the chief of police say the problem is worse than us trying to pinch you for pills. You know, if they said: "Don't worry about it."

I was also interested in the role of collective exchangers in educating non-NEP clients about SafeWorks. One IDU had tried to educate his peers about SafeWorks and convince them to use it, but they actually preferred not to access the program directly:

> S: Do you educate those guys that don't use the NEP?
> I: I try, but it's like having a conversation with Santa Claus, there. I get more answer out of that guy there, than some of these mucks.
> S: Is that they just don't care about...?
> I: They don't care. They don't care. They have their own way of looking at things and I'm not going to try to help anyone. If they want to listen to me, fine. And if they don't, that's fine too. It isn't as though I don't care. It's just I am trying to, and it usually doesn't work out. You can't really change how people think. A couple of people are still going to school and they live with their parents and they don't want it around their house, basically. Or, they're living with a girlfriend, you know, who isn't down with them using intravenous drugs. So, a lot of it's kind of just their living situation, where they just don't want anything around there.

Similar to the non-NEP clients who feared being discovered by their families or significant others, one collective exchanger explained how his roommate did not use SafeWorks for fear of being discovered as an IDU by social services:

> S: Why doesn't your roommate call the NEP van herself?
> I: She just doesn't want anybody to know she uses. She doesn't get a prescription like me, so...and she's on welfare, and that, so she doesn't want it to get around that she's a junkie. There's too many ramifications. She could lose her kids, or it could come up in court. She tries to keep it low.

The data about IDUs who are reluctant to use the NEP demonstrates the need to address certain policy and legislative issues. The marginalization and stigmatization of drug users in general, and those infected with HIV in particular, are key barriers to progress against the epidemic. Policy changes need to be made to reduce these barriers. Placing these individuals at the margins of society reduces their access to health promotion services, such as NEPs, ultimately placing the community-at-large at greater risk of HIV. For example, the Criminal Code should include laws that favor a medical approach over a criminal one to the problems of drug use. The illegal status of drugs makes the user afraid to go to health or social services, increasing marginalization.

C. HIV and Hepatitis

The "HIV and Hepatitis" category includes any references to HIV/AIDS or hepatitis (B or C) such as information about IDUs getting seroconversion testing, their serostatus, risk, and knowledge of risk. My informants were all quite well-informed about the risks of HIV/hep transmission and some had a strong sense of self-preservation:

> I'm deathly scared of AIDS or HIV, or Hep C. I don't want to die. I mean, I'm an addict, but I still don't want to die. I want to take care of my health the best I can. Well, I don't want to die. I don't want a death sentence. If I ever found that out, I'd do a big whack and just kill myself...I think that people, even though they are users, I think that they should care about themselves. I think that even though you're an addict you should be able to look at your own life, think about your own life, and things you want to do with your life. Don't let yourself get away with it. It's not worth killing yourself over. Like me, I wouldn't pick a needle out of a bucket, right, and just pull the cap off and fill up my fix, no way. I'd like to live to be at least 50, or 100.

Another IDU felt a strong responsibility to his wife and knew that any risks that he assumed would place his wife at risk as well. His relationship with his wife served as a strong motivation for reducing his risk of HIV or hepatitis transmission:

> I have been married 4 times. Now this marriage here is going on to 18 years. And if I ever came home with a disease, I would be killing my wife. And I have too much respect for my wife, and my friends for that matter. If they were to use my syringe, and if I had AIDS, let's say, right - they would be getting AIDS from me, and I can live without that thought.

One informant reported that not all IDUs feel the same level of caution and self-preservation with respect to reducing the risk of contracting HIV or hepatitis. I asked one prostitute informant about the level of concern about HIV/hepatitis prevention among other IDUs and/or prostitutes:

> There are people who don't care. Like, I've seen people: "Let me use your needle." Like, I've seen it but I've never really given it to them. Some people don't care about much. Either they're HIV-positive and feel they've got nothing to lose, or else they just don't care. That's why there's so much HIV. That's what I'm scared of, man. I'm so fucking scared of that disease.

Some IDUs do not even want to discuss the risks of HIV and hepatitis, even when a collective exchanger is making the effort to educate others. It is also important to note that even though IDUs may be fully aware of the risks of HIV/hep transmission, they may not necessarily act upon that knowledge:

> S: Do you ever discuss HIV or hepatitis with other people?
> I: Yeah, but basically if I try to open up a conversation like that everybody tells me to shut my yap, so I don't talk about it with anybody. I don't think people want to talk about HIV when they're IV drug users. Because I guess they're fully aware of the risk, but I don't think anybody wants to fully acknowledge it.

An IDU explained that she makes an effort to educate herself about HIV and takes precautions to prevent HIV transmission. She also tries to share her knowledge with other

IDUs, but finds them to be unreceptive listeners. She suggested a possible education or discussion forum for interested IDUs and/or prostitutes:

> I: Even though my boyfriend, he's my monogamous partner, we still use condoms. He's always asking me: "Why?" And I say, "Well, I don't know what you got. You don't know what I got." Yeah, even though we've been together for a while. I don't want him to get anything from me. And the thing with HIV is that it pyramids - when you sleep with somebody you're sleeping with everybody they've slept with. You know, I've done a lot of reading on it. Everything that I see about it, I have to read. Like, if I'm walking down the street and I see an article on it in a magazine, I'll buy it. Just because I want to know. I want to know lots more.
> S: Do you ever educate people about AIDS?
> I: Nobody ever wants to listen to me. I mean, they're all stoned up, and they want to sit there and talk about AIDS? They're not going to listen to that. That's what I think CUPS should do once in a while. They should put a big thing up there on the window, get some AIDS people in there, that would be a seminar on that for people who really want to know, addicts that want to know. It doesn't necessarily have to be only for IDUs, it could be prostitutes, it could be anybody.

One IDU believed herself lucky to have negative HIV test results, as she recalled several incidents when she may have shared injection equipment with other IDUs known to be HIV infected:

> S: Have you been tested for HIV?
> I: Yeah, I just got tested. Well, you know what...I went out using with four people that have HIV, five now. Five. I was getting high with B at the what you call it there, and I don't know if I used his needles or not, because I was too high. And then I used with D and T - they both have HIV and I don't know if I used either one of their rigs. And then I went to D and we went and got an 8-ball and got a room at the Cecil and I used his rigs. I still come out negative! I'll worry about it when I have it. [laughs]

The above informant felt that eventually she would test positive for HIV and that she would face the consequences *when* she contracted HIV, as opposed to *if* she became HIV-positive. Another IDU who knows that she has hepatitis C admits to having let another IDU use her needle. According to this informant, it is not uncommon for those

with hepatitis (or HIV) to knowingly allow others to use their infected injection equipment:

> I: Actually, you know what? I think I shared with someone. Yeah, and I didn't tell him that I had hep C. Everybody's guilty of that. There's not one person out on the street that can say: "Hey, I've never let anybody use my needles or that. I never pass on my hep C." You know, some people just go out and do that intentionally. Look at that woman in Germany - what 5000 guys that she had possibly infected with HIV just because she had it?
> S: Have you heard of people actually doing that intentionally here in Calgary?
> I: There's a few slimy people that do that, yeah. But everybody knows who has HIV downtown. So, if you use with those people, everybody's all careful that they don't, that they have their own needles and stuff.
> S: How would you know that they have HIV?
> I: People tell other people and it gets around.

One IDU was able to recall the exact incident during which he contracted hepatitis C from another IDU and explains his motivation for the risk assumption behaviour:

> I: I learned the hard way. I'm pretty sure - I narrowed it down and I know where I got sick and I know it was from a dirty needle. I'm pretty sure I know the guy I got it from. He's in Kelowna. We just bought some coke and we had the one needle. And I wanted some really bad. You know? I rinsed it out with water...I didn't see any blood, but you know, that doesn't really matter. I didn't have any bleach. I just wanted to get high.
> S: Now, did he warn you? Did you know that he had hepatitis C?
> I: He didn't know at the time, but he does now.

As illustrated in the above interview excerpts, the sharing of injection equipment, and subsequent HIV or hepatitis transmission is a very real part of the lives of IDUs. In the following four chapters, I present vignettes of injection drug use in Calgary in order to illustrate the complexity of the social contexts. While reading the vignettes, the reader should also keep in mind the factors discussed in this chapter: duration and frequency of drug use, the kind of drug being used and its physiological and psychoactive effects, the

cravings that accompany drug addiction, the stresses of drug dealing, the variable quality of street drugs and the possibility of overdose, feelings of paranoia induced, and the IDUs' HIV or hepatitis serostatus.

CHAPTER 4

VIGNETTE #1 – PROSTITUTE ON THE STROLL

I. INTRODUCTION

This vignette depicts the situation of a female prostitute who is also an IDU. Her character and actions have been created as a composite of the information from six different informants who were either presently or had in the past worked as prostitutes. One of the prostitutes was a male transvestite, and the other five informants were females. Except for one morphine user, all of the prostitutes that I interviewed were cocaine addicts. Part of the vignette's descriptions are also compiled from my observations during the nights that I rode along with the nurses in the outreach van. I observed the strolls as we passed out condoms and needles to the working girls and also listened to the dialogue between the nurses and the prostitutes.

II. GLOSSARY

In writing the vignettes, I made an effort to remain true to the data from my informants and follow their words as closely as possible. This is primarily achieved by using their lexicon and their street vernacular. Preceding each vignette, I will provide a glossary of the street terms used and provide a definition in case the reader is not familiar with the language.

Date – a john (or a customer) of a prostitute or the transaction of sex for drugs/money

Eight-ball – a unit of cocaine equal to 3.5 grams

Fix – to inject narcotic drugs

Fixing date – a date in which the john supplies and uses injection drugs with the prostitute

Flag – to draw blood up into the syringe to ensure that the drug is entering a vein

Hit – an injection of drugs

Rig – a needle or syringe

Rocking date – a date during which the customer has sex with the prostitute

Safe – a condom

Score – to purchase drugs

Snow – cocaine

Stroll – street(s) along which prostitutes stand and wait for customers

Turning tricks – working as a prostitute; exchanging sex for money or drugs

Works – a set of the equipment needed to inject drugs. From a risk reduction approach, complete works consist of a cooker (or spoon), a filter, a tourniquet, a lighter, alcohol wipes, bleach, distilled water, a sharpsafe disposal container, and a supply of clean, sterile syringes.

III. VIGNETTE #1 – PROSTITUTE ON THE STROLL

A native woman in her early 30s stands on the street corner waiting for a set of headlights to come her way. She is cold and wet because it has been raining and it has been an hour since her last date picked her up in his warm truck. She has been turning tricks straight for the last 18 hours but won't stop until she has the $250 that she needs to score an eight-ball. She works the streets to support her cocaine habit. Everything she makes goes back into cocaine. Some of the money goes into a restaurant meal here and

there, or a hotel room, but other than that, money for cocaine is her priority.

The cravings are getting bad and she nervously fumbles the syringe in her coat pocket. Finally, she can't wait, and rushes across the street to the gas station, gets a key from the attendant, and locks herself in the washroom. She prepares the last hit of her supply of cocaine. She fumbles around in her coat pocket for the cocaine, and her works - a length of pantyhose, and her syringe. The rig has been used so many times that the numbers on the syringe have started to wear off, but she only brought one rig with her when she started working yesterday. She pulls the plunger out of the syringe and scrapes off the residue of her last hit from the rubber tip. Careful not to waste any of the precious white residue, she drops the tiny scrapings back into the syringe. She gingerly unfolds the Lotto 6-49 paper and funnels the snow into the syringe, careful not to waste a single grain of the fine powder. She turns on the hot water at the sink and lets it dribble into the syringe until it's about two-thirds full. She puts the plunger back into the opening of the syringe and holds it at the end while she quickly shakes up the cocaine and water with quick flicks of her wrist. She holds the syringe up to the light bulb above her head. The white powder is not completely dissolved – she can still see tiny chunks floating around in the murky water, but she wants to hurry and get back out on the street.

She takes the orange cap off of the needle tip and holds the rig in her teeth as she whips off her wet coat, shoves up her sleeve and wraps the pantyhose around her upper arm tightly. She finds her favorite vein easily in the dim light because it is marked by scars and bruises from many, many previous hits. She doesn't have any of those little alcohol wipes, so she wipes her arm with some wet paper towel. She clenches and unclenches her fist until the vein protrudes from her thin arm and she pushes the needle into it. She grimaces in pain as she moves the dull

needle around in her arm, looking for the vein. Finally, she flags some blood. With her teeth, she wrenches the pantyhose off her arm and plunges in the hit. She takes a moment to enjoy the surge of relief, closes her eyes, and rolls her head back. When she opens her eyes, the needle is still sticking out of her arm. She yanks it out, puts the cap back on the needle, tosses it in the general direction of the garbage bin and pulls her sleeve down. The hole where the needle just was oozes some dark blood, but she doesn't have time to wait for it to stop bleeding. She thinks she hears a cop's siren outside. She stuffs the pantyhose back into her pocket, puts her coat on and rushes outside.

Now that her last hit of snow is moving through her veins, her paranoia about being caught by the cops sets in. She runs around behind the gas station to hide from the imaginary cop car and huddles there in fear for about half an hour until her tremors calm down and she can relax a bit. Suddenly, she becomes anxious to find an eager date with a wad of cash in his wallet. She would have liked to hold out for another half hour, but she knows that the cocaine will help obscure the shame of her next encounter with a stranger. She needs to sell herself to get the drugs, but she needs the drugs to sell herself. She never goes to work on the street when she's straight. She loses a piece of her integrity every time she goes out there straight. She can't do her work if she is fully aware of what she is doing. Her boyfriend has told her not to go out working when she's high because he fears that one day she'll be robbed or worse: "You have to be in control of things. You can't go out there and be stoned out of your skull and expect to take control of a situation. That's how people get killed." But she's not the only girl out there who is high. All of the girls are boxed out, either stoned or drunk. They do anything that will keep them high and help them to forget. If they black out, all the better.

A middle-aged well-dressed man pulls up in a family sedan and rolls down the passenger side window. He makes an offer to the prostitute:

"I'll give you $200 to do it without a safe." She is tempted; it would normally take her four or five dates to make the same amount that this guy was offering. She is about to get in the car, but thinks of her boyfriend and the possibility of contracting HIV and passing the virus on to him. She says: "Sorry, buddy, but you've got the wrong person." He shrugs, points to another girl down the street and says: "It's your loss, baby. I can go to her and get everything for $40 without a safe." She yells as he starts to pull away from the curb: "Well, you go for it, man. Don't bother coming to me!" He drives to the next block where the car briefly paused beside the other working girl before she climbed into his car. The other prostitute is known on the stroll for her cheap prices. She does everything and anything that her customers want for $40 and has no problem doing it without a safe. The $40 is enough for half a gram of cocaine and her cheap prices make it easy to get customers. The other working girls hate her and she has been assaulted on more than one occasion by other prostitutes who resent the standard she is setting for their stroll.

A familiar truck pulls up. This time it's a younger guy, an oilrig worker looking to spend his earnings, just like every month when he gets his pay cheque. She is happy to see him because he's one of her faithful fixing dates. Sometimes they have such a good time fixing together that it doesn't even turn into a rocking date. She climbs into the truck and she spots a syringe on the floor. She immediately asks: "Do you have anything to fix?" He grins and says: "I'll give you some of my coke if you don't charge me." She agrees; even though she needs the money, her cravings are starting to scream again and she never turns down a hit of cocaine. He parks in a lot behind a warehouse, turns off the ignition and leans over towards her. She holds up her hand: "Wait until I get some of this into me." He sits back and tosses over a vial, with about a gram of snow inside. She searches each of her pockets and then remembers that she threw away her rig. (Composite of interviews #1, 5, 6, 7, 9, 10)

IV. DISCUSSION

With increasing enmeshment in drug use, women working in the sex industry have fewer options in both the mainstream and drug-using society. Their roles as employees, wives, and mothers become limited and strained. Therefore, they have fewer economic and social resources available to them. Their involvement in the criminal justice system is more extensive. Engaging in safer injection behaviours becomes more difficult for these women and less likely. I will discuss the multi-factorial barriers to risk reduction that prostitutes face with respect to preventing HIV, hepatitis, or STD prevention. In a study by Simon et al. (1993), three major lifestyle factors were found to function as barriers to prostitutes engaging in risk reduction behaviour. Prostitutes who were more economically dependent on prostitution, perceived less control over the hustling encounter, and reported increased pleasure from sexual activity with their customers were more likely to engage in risk assumption behaviour.

Prostitutes have been identified as one risk group whose lifestyle makes them both particularly vulnerable to infection and a potential conduit of HIV, STDs and hepatitis to society at large. Drug injecting prostitutes are at high risk of contracting STDs, hepatitis, and HIV due to the combination of both injection and sexual behaviours. Not only are they engaging in sexual activity with multiple partners whose health status is unknown, but they are also placing themselves at risk if they agree to provide unsafe sexual practices in exchange for their needed drugs. Kail et al. (1995), show that activities related to prostitutes' injection drug use place these women at greater risk of contracting HIV than do their sexual practices. Women who trade sex for money and/or drugs are less likely to use new needles on any consistent basis or to clean old needles

and are more likely to share needles with others compared to women who support themselves by other means (Kail et al, 1995). The prostitutes that I interviewed provided only sketchy information about their sex work, but did provide valuable and in-depth information about the link between injection drug use and prostitution.

For female IDUs, prostitution offers a quick way to make enough money to support a drug addiction without requiring them to enter the work force of mainstream society. One prostitute describes her work as a last resort:

> I pawned my things because I'm so desperate. I don't want to prostitute myself. But I don't have anything else to sell. You know, I can see why people turn into hookers, and sell drugs, and do this and that, because of the fact that it's such a clutching thing.

The link between injection drug use and prostitution is reciprocal in the long run because, while the latter may be initiated by the need for money to finance a drug addiction, the relatively high levels of income generated by prostitution may encourage higher levels of drug use (Frischer et al., 1993). Many working girls support a boyfriend and his drug addiction as well as their own by working the streets. One SafeWorks client that I met while riding along in the outreach van worked as a prostitute out of her own home in order to support her and her boyfriend's morphine addictions. The two of them used $300 of morphine each day and the prostitute was excited about a $600 date that was coming to her apartment soon. She needed some new syringes quickly in order to get her morphine fix before her date arrived. Her boyfriend would stay in the next room during the transaction to listen in order to make sure that it didn't turn into a "bad date," or an abusive encounter. The prostitute was anxious waiting for the SafeWorks van to arrive, but chose risk reduction behaviour by waiting for a supply of clean, sterile needles. She

stated that she did not want to bleach a needle from the disposal bucket because her boyfriend had had some friends shooting up at their apartment and she did not want to risk HIV or hepatitis transmission from using one of their needles. The prostitute of my vignette felt a strong motivation towards risk reduction because of her concern for her boyfriend. Her personal relationship with her boyfriend motivated her to deny unprotected sex in interest of not contracting a disease that could then be passed on to her partner. In a study by Brook et al. (1995), support from one's significant other was found to enhance the likelihood of lower drug use and decrease the probability of needle sharing.

One prostitute who I interviewed lived with a boyfriend who wanted her to quit her cocaine habit. His concern for her could potentially assist her in quitting drug use altogether, or at least encourage risk reduction behaviours. She described him as caught in a catch-22 because even though he did not want her to do cocaine, he would sometimes give her money to purchase it so that she would not have to go work the streets for the money. By giving her money, he assisted her in continuing her cocaine habit. He also forbade her to inject in their apartment, probably intending to deter her from using cocaine. But he only succeeded in forcing his girlfriend to go to shooting galleries to inject coke, a setting in which she would be much more vulnerable to risk assumption behaviours such as needle sharing.

For many working girls, there is a vicious circle between prostitution and injection drug use: "I have to be high to sell myself, but I have to sell myself to get high." Two of the female prostitutes with whom I spoke stated that they definitely required a fix of their drug of choice (morphine or cocaine) before they would be able to go out and

turn tricks. The drug high allowed them some level of cognitive shielding from the shame and degradation of prostituting themselves. The female prostitute who was addicted to morphine needed her drug primarily to anaesthetize her back and arthritis pain, but also needed the morphine "to calm her nerves." Two of the prostitutes that I interviewed disclosed that at times they had even been so high on alcohol and other drugs that they had actually blacked out. The next day they could not recall any of the events of the previous night while working on the stroll. Such a high level of impairment would place the prostitutes in situations in which they would be more likely to adopt risk assumption behaviours and less able to make wise risk reduction choices with respect to both sexual and injecting activities. The male transvestite that I interviewed stated that he would never go out on the hooker stroll if he was not completely alert and capable of reacting to possible gay-bashing. To him, going out to work with a cocaine high would be a foolish endangerment to his own safety. Another of the female prostitutes stated that she could not go out to work on the street if she was "strung out" on coke because she would feel too paranoid and would end up fleeing from her date.

The prostitute featured in my vignette refused to provide sexual services to a date without using a safe because none of my informants reported to ever having accepted a condomless date. However, they did report that other working girls are known to accept condomless dates for extra payment. The more lucrative condomless dates may attract women whose financial needs are high because of their own or their partner's drug habit and are therefore likely to agree more quickly to the absence of a condom (Jesson et al., 1994).

According to two of my informants who had been on fixing dates, the customer purchases the drug and then hires a prostitute because "they just want somebody to do it with."

> Usually if a person was picking a girl up to do cocaine, sex was the last thing on their mind. They might have thought they wanted to have sex, but once they start doing cocaine, it's: "Oh, let's do some more cocaine first. Let's do some more cocaine first." And they never actually get to the sex. A lot of guys that go out and do that - it's the thought of being caught with a bad girl, you know, I think. "Oh, what am I going to do if my wife catches me spending all this money?" You know, it's a totally different Jerry Springer show.

The possibility of HIV transmission on a fixing date occurs when the date provides the drugs but not the sterile equipment needed to safely share the drugs.

The fact that the prostitutes may spend stretches of days working the streets highlights the valuable role played by the SafeWorks outreach van. The van visits girls on the strolls and hands out condoms and needles, offers a warm place for them to sit for a few minutes, and also administers blood tests for HIV or hepatitis. The composite prostitute portrayed in the above vignette is faced with a dilemma between HIV/hep risk reduction behaviour or risk assumption behaviour. She has been placed in a situation in which she must decide whether to fix with the used needle lying on her date's truck floor, or to abstain from injecting until she has obtained a clean needle.

There are several contextual factors which would impact on the prostitute's decision between risk reduction or assumption behaviours. If her drug cravings are severe enough, then the forefront thought in her mind is to get a hit of cocaine as soon as possible. Ideally, from a risk reduction viewpoint, the prostitute and her date should page the outreach van or go to a 24-hour drug store to buy clean needles. However, she could

also decide that she can't wait for the SafeWorks van to arrive or take the time to find a drugstore when she has a vial of cocaine in her hand, ready to be injected.

There is also the problem of having a sterile water supply with which to prepare her hit. There are rain puddles outside, which some IDUs have been reported to use when injecting in parks or back alleys. Of course, using water from such a contaminated water supply would be a risk assumption behaviour in that the IDU could contract a very serious infection. A risk reduction approach to preparing a hit of drug would be to go to a public washroom and at least use tap water. Ideally, the IDUs should use a sterile water source, such as the distilled water distributed by SafeWorks. However, owning and carrying a complete set of works as described in the glossary above is not feasible for many prostitutes. The circumstances of their work may afford them less opportunity to think about obtaining equipment ahead of time. A more chaotic life and longer and larger drug habit may mean greater urgency upon getting the drug to administer the drug.

Often, the fixing date is someone that the prostitute knows and has fixed with in the past. If they do not have two clean needles between them, he may use it first and try to convince the prostitute that "he's clean," or free of HIV or hepatitis virus. Or he may mistakenly believe that it's safe to share a needle with the prostitute because she tells him she's "clean," or free of HIV or hepatitis infection. Negotiating oneself out of such a situation requires considerable skill and conviction, qualities which many prostitutes may not possess when faced with a ready drug supply and severe drug cravings. My informants all asserted that they were very insistent that their date use a condom when engaging in sexual activities, but they were less vigilant about needle sharing.

Four of the six prostitutes that I interviewed disclosed that they had tested positive for hepatitis C. Some of my informants reported that there are other prostitutes who are fully aware of their positive serostatus, but continue to practice unprotected sexual activities and share injection equipment with their dates. According to my informants, some IDUs and/or prostitutes have a fatalistic attitude about their HIV or hepatitis status and feel that they have nothing to lose. One of my informants expressed her own sense of resignation: "Well, I'm going to die someday and it won't be long because I'm hep C positive." One male prostitute is known on the gay stroll to engage in unprotected sexual activity with his clients even though he knows that he is HIV-positive. Another female prostitute explained the apathy of some other prostitutes with respect to protecting themselves and their clients from disease transmission:

> Well, some people don't give a shit. Like, some of them broads down there...I've heard there's one girl down there on the stroll, doing everything for $40 without a safe. I don't know what they're thinking. Maybe they got it and they just want to give it all away. You know what I'm saying? In my own mind, that's how I see it. I feel that people with HIV, they have nothing to lose, so they want to share their misery.

Many prostitutes will go to shooting galleries or dope houses – buildings where drugs are sold and injected – in between dates in order to maintain the high that they need to do their work and to spend the money that they just earned. Most of the shooting galleries are in close proximity to the main hooker strolls so that, as one of the SafeWorks nurses explains, "Girls can go out and get $20 for a blow-job, and then into the dope house for a hit of coke, over and over again several times a night." There are known shooting galleries in Forest Lawn, Bowness, and Inglewood. However, there are none on the A stroll where the higher-end prostitutes work. The prostitutes on the A stroll

are not known to use injection drugs for the main reason that the track marks are aesthetically unappealing to high-paying johns. All of the female prostitute IDUs who I interviewed worked either on the B stroll or the C stroll. Two of my youngest prostitute informants had also worked at the "kiddy stroll", where most of the prostitutes are juveniles (under the age of 18). The one male prostitute that I interviewed worked the "gay stroll" or "boy's stroll." The next vignette will describe the setting and a situation inside one of the shooting galleries frequented by prostitutes and other IDUs.

In summary, the vignette of the prostitute highlights several important social contextual factors which influence risk reduction or risk assumption behaviour choices. The major influence on risk reduction was the prostitute's relationship with her boyfriend who not only encouraged her to get off cocaine, but also to refrain from using cocaine when working on the stroll. Her concern for her boyfriend's health also motivates her to refuse a condomless date. Major social forces influencing the prostitute's risk assumption behaviours include lack of needle availability, competition with other prostitutes for high-paying dates, injection settings such as public washrooms, a car, or shooting galleries, being high while working, and experiencing severe drug cravings. Also, the "fixing date" could try to convince her that he is disease-free. This vignette demonstrates the complexity of the social context around risk assumption or risk reduction behaviours for prostitutes. Interventions for women who trade sex for money or drugs should focus on supplying sterile injection equipment to the prostitutes while they are working, culturally sensitive counseling about the risks of unprotected sex, and also encouraging and making accessible drug treatment, which is the only means to ending the vicious circle of prostitution and drug addiction.

CHAPTER 5

VIGNETTE #2 - SHOOTING GALLERY

I. INTRODUCTION

Shooting galleries in Calgary are constantly in flux as they are discovered and shut down by the police. There are at least five operating around the city at any one time and most are located around the three major hooker strolls. They are usually apartments or houses where IDUs congregate to buy and inject drugs. Shooting galleries can be as impermanent as a hotel room which a dealer uses as he moves from place to place. The only shooting galleries that I have heard about from my informants were focused around cocaine use.

Shooting galleries are important social settings in the lives of many cocaine users because they are a known and fairly quick source of cocaine. Every cocaine user that I interviewed had been in a shooting gallery at least once and was able to provide me with in-depth descriptions of the settings and situations inside. Although some shooting galleries are "cleaner" than others, (i.e., have stricter rules about needle disposal and tidiness), I have depicted a shooting gallery that epitomizes some of the worst injection practices reported by my informants. One of my interview questions was: "What is the worst thing you've done or seen others do with respect to drug injecting?" Much of the data that I collected from this inquiry is included in the following vignette, which is a composite of data from seven cocaine users.

II. GLOSSARY

Coke, Dope – cocaine

Fit – the needle or syringe

Jugging – injecting intravenously into the jugular vein

Wasted – high on mind-altering drugs; impaired

III. VIGNETTE #2 – SHOOTING GALLERY

The green house is run down and poorly maintained. It is just a block away from the hooker stroll. The working girls are constantly coming inside with money and leaving again when they need to make more. There are four separate entrances into the building but there is only one open window next to a door at the front of the house. The rest of the windows are boarded up with plywood. The lighting is very dim and some of the rooms are not lit at all. Sometimes there are 40-50 IDUs including pimps and prostitutes in the house at any one time. Today, there are about 20 people scattered around the house, in the kitchen, in the bathroom, in the bedrooms, in the furnace room, in the hallways, and the living room. Inside the living room there is an old tattered and stained couch, saggy armchairs and a few kitchen chairs. The only furniture in the rest of the house is an old mattress on the floor one of the bedrooms. Rigs are scattered all over the place and plastic buckets are placed here and there. It's a rough place. The people are in various states of cocaine highs and are all here for one purpose: to buy their dope and shoot it up until either their money runs out or their bodies give out. Their main focus is to get high as quickly as possible. The gathering is not friendly or for social comradeship. They all know one another on an acquaintance level, but none would consider the others as friends. The majority of people are injecting in small groups of two or three, and some are sitting alone. There is no party atmosphere here. There is no music playing because they all have their ears tuned for the possibility of a cop car pulling up outside the house.

> Doing dope is *not* fun. You just gotta have it, that's all. It's not fun, though. It's not fun being paranoid. There are always problems in those places. Girls getting thrown out 'cause they get weird when they get high and they strip all their clothes off or they start looking, digging around, peeking out the windows, and stuff.

The atmosphere in the shooting gallery is fairly unpleasant, tense, and hostile. Some of the people in the house are very aggressive. Not only are the IDUs paranoid about cops busting into the house, but they are also paranoid about the other druggies or dealers. There's no outright violence at the moment, but everybody's paranoid that they're going to get ripped off by somebody else. At any moment someone could pull out a tire iron, and people will fight. At the door and window several IDUs are calling back and forth: "Shhh! What's that? The cops are outside. There's somebody outside that window." "Turn that light back on! I'm trying to do my fix!" "No! Leave it off for a second!"

Everybody has his or her own reaction to the coke. Some of the druggies display bizarre and disturbing behaviour. One woman is sitting in the corner shaking her head violently back and forth. Another man stands in the corner and turns circles. An emaciated man thinks he has something on his face and picks incessantly at his skin. Another woman takes off her shoes, runs around the block and bursts back in the door for her next hit of cocaine. Others are just lounging around the house in a daze, "enjoying" their highs. They gather here because this is where the coke is. Some pool their resources – money and drugs – but that is the extent of their social interactions in this place. There are three people gathered around the one open window and another person peering out the peephole in the door. Whatever the coke users fear most comes out in their paranoia. Most of them are paranoid about cops busting in.

The shooting gallery is owned and run by a dealer and there is little regulation over how needles are disposed of in the building. He does call the SafeWorks van every second week, or so, and once in a while yells at

the junkies in the house for being such slobs with the needles. The dealer does not actually live in the shooting gallery, but lives in a "safe house" that is kept secret from his customers. He puts a trusted friend in charge of the shooting gallery when he is not there to sell the drugs to the IDUs.

There are several empty boxes that once held the 1 c.c. sterile syringes provided by the SafeWorks NEP. There are also several overflowing yellow waste containers with syringes poking out the hole of the lid. There are no more sterile needles left in the house and people have started to look for a rig to use for their next coke hit. Against one wall is a long table with drug paraphernalia strewn over it – cookers, lighters, filters, vials, alcohol wipes and lots of needles. Some of the IDUs mark their own needles by scraping numbers off the syringe, but some of them pick up any random needle from the table to use. They may rinse the used needle in some warm water from the kitchen sink or use the little vials of bleach someone brought from SafeWorks. But some don't rinse the needle at all because they want to have the little droplet of cocaine left from the last user of the needle. Some break the needle tip off the syringe when they're finished with it, but others yank the needle out of their arm and toss it directly on the table as they feel the coke wash over them.

There is blood spattered on the walls, on the floor, and on the counters of the kitchen and bathroom. People have thrown their rigs in the corner behind the door instead of in the sharpsafe container. There's a scattering of bloody old tissues around the waste paper basket in the bathroom. Several old needles are lying on the floor behind the toilet, under the sink, and in the medicine cabinet.

One IDU yanks the needle with the syringe still half-full out of his arm and passes the syringe to a woman who plunges it directly into her arm to finish off the coke that's left. Two IDUs are sitting on the kitchen floor, jugging one another in the neck. Another IDU is sprawled in a corner of the kitchen with her eyes closed and the rig still sticking out of

her arm. Another IDU is digging around in his arm with a needle, trying to get a vein somewhere in the mess of track marks up and down his arms. In the bathroom, one IDU is slouched beside the toilet and is too wasted to stand up to go to the sink, so he pulls water up into the syringe from the toilet for his next hit.

Around 4:30AM, the needle supply is running low and by 5:00AM there is not a single clean needle left in the building. Some people put their needles away in a place that they'll try to remember the next time they do a hit. Others mark their rig with a scratch or burn the plunger end with a lighter so they'll know which is theirs. An IDU yells out to the guy in charge of the shooting gallery: "Call SafeWorks! We're out of rigs!" The guy left in charge by the owner goes across the street to the pay phone to call the outreach van and gets their recording stating that the NEP will not be open again until business hours. The nearest open drug store is a 40-minute walk away.

(Composite of interviews # 1, 2, 4, 5, 6, 8, 9)

IV. DISCUSSION

Shooting galleries, where needle sharing with large numbers of IDUs often occurs, have been identified in several epidemiological studies as key settings accounting for high HIV incidence in various North American cities. For example, San Antonio, Texas, has a low rate of HIV infection (1.6% HIV-positive) among a street sample of IDUs, in contrast to New York City, where 50-60% of IDUs are HIV-positive. One of the key reasons for the difference in HIV prevalence is that in San Antonio, there are fewer shooting galleries. New York City, on the other hand, has many shooting galleries (Vogtsberger et al., 1993).

The social environment of shooting galleries and the kinds of people that use them make the settings very high risk in terms of HIV or hepatitis transmission. Cross-

sectional studies show HIV positivity to positively correlate with needle sharing and the frequency of injecting with used needles, sharing needles with strangers, use of shooting galleries, frequency of injection, length of addiction, prostitution in females, number of injections with cocaine, past imprisonment, and number of sexual partners injecting drugs (Stimson, 1992). The fact that shooting galleries are most often frequented by large numbers of cocaine users, prostitutes, and heavier users highlights the multiple factors associated with shooting galleries that place IDUs at risk of HIV or hepatitis infection. Cocaine use alone is a risk factor for HIV transmission because there is a higher frequency of injecting when people use cocaine. Also, cocaine users experience difficulty in adopting safer injection practices during binge use, as described in the above vignette. There is also an association between cocaine use and high risk sexual activities (Stimson, 1992).

Shooting galleries are an important element in the social networks of IDUs not only because they provide a relatively safe place to inject drugs in terms of hiding from the police, and provide access to needles and syringes, but because they offer an arena for socializations among fellow IDUs and a degree of protection in case of a drug overdose. However, the shooting gallery also presents many situational factors which impede risk reduction among IDUs and facilitates risk assumption behaviours. Shooting galleries are nodes in an informal social network where members of various social groupings of IDUs gather to purchase and inject drugs. There is a wide variety of people in a shooting gallery at any one time – some who seem apathetic about risk reduction, and others who are very conscious of the risks of disease transmission. One of the IDUs that I interviewed only went to the shooting gallery to purchase and inject her cocaine because

her boyfriend forbade her to shoot up in the apartment that they shared. She did not feel that she could rely upon the shooting gallery owner to supply the clean needles, so she would take her own needles with her whenever she went to the shooting gallery. However, not every IDU in a shooting gallery is as conscientious as she is. She explained the range of people in the shooting gallery:

> Some people I know that have HIV I have no qualms about them being around me because other than the fact that they do drugs, they're totally very protective about you know, if there's any blood from shooting up, they clean it up right away. I know other people that just let it run down their arm, drip on the floor.

There are frequently violent conflicts among the pimps, prostitutes, and dealers that frequent most shooting galleries. Two separate informants recounted incidents of violent conflict between themselves and other IDUs, including a stabbing, which occurred in a shooting gallery setting. Both informants told me that the conflicts arose over a drug transaction dispute wherein one IDU was accusing another of stealing drugs or one IDU was cheating another. Another informant reported that she believed that she had contracted hepatitis B from a violent incident at a shooting gallery during which she bit her opponent.

There is more opportunity for needle sharing in shooting galleries, simply by virtue of the higher concentration of people under one roof. The potential for HIV or hepatitis transmission is very high since any needle sharing that does occur is not confined to a cohesive social circle, but is diffused among many people (up to 50) that could be strangers to one another. The poor lighting and generally unhygienic conditions make it more likely that there will be unsafe injection practices resulting in poor vein care or infections. In the case of an IDU overdosing in a shooting gallery, there is no

guarantee that the other IDUs will take the overdose victim to an emergency department or call an ambulance. As discussed in chapter 3, sometimes overdose victims are left to die because the shooting gallery owner fears having his or her operation shut down by health or law enforcement authorities. One informant recounted that he was in a shooting gallery when another IDU overdosed, but the shooting gallery owner refused to seek medical care for the overdose victim for fear of "drawing heat" or attracting the attention of the police.

Some shooting gallery owners play an important health promotive role by providing a supply of needles, bleach and disposal containers to their customers. A shooting gallery owner is also advancing his drug business by providing an on-site needle supply. By providing needles to his customers, he ensures that the IDUs will stay around to buy his drugs until their money runs out. However, some dealers are reluctant to provide needles to their customers for fear of their home becoming a shooting gallery. By providing a needle for immediate use along with the hit of drug, the IDU will demand to inject on the dealer's premises. I interviewed one shooting gallery owner (and dealer) about his motivation for providing needles to IDUs:

> S: So, why do you care about what they do with their needles?
> I: Because I believe in....it doesn't matter what you want to do with your life, just do it wisely. There's no reason for AIDS or hepatitis to be the epidemic that it is. A little common sense with everybody. And I know that it's sometimes easier said than done. It shouldn't be such a big problem. I wouldn't want anyone to contract AIDS or hepatitis, or anything like this...I don't know, it's just not something you'd wish upon somebody, you know.

Some dealers do not provide needles for free, but charge their customers for each new syringe that they supply. Selling needles is just another way for some dealers to make a profit from IDUs.

Among IDUs, needle sharing occurs under many circumstances: inability to access a supply of clean, unused needles, social interaction with other IDUs, or inability to make sound (healthy) decisions at the time of a hit. If an addict needs a hit *now*, he or she is not likely to consider the consequences, which in the case of HIV/AIDS or hepatitis, are very distant and intangible compared to the cocaine supply sitting in front of them, ready to be injected. Several of my informants expressed that when they are craving cocaine, their sole priority is to get a hit of cocaine, no matter what needle they are using:

> I really didn't care if I got HIV or hep. When coke calls, you don't give a damn if the next guy's got it. If that's the only needle in the house, alright, and you run out of bleach, the hell with it. You just want the coke high, so you don't give a damn. You just might as well hand a guy a .45 or the girl a .45, because when the coke calls, you don't give a damn. You really don't give a damn. You just want the high. You want to taste the coke. You want that buzz. You want that escape from reality for a short time that's there. I didn't care about it to start out with. So, it doesn't really matter if it's now or later. I just wanted the high. And I still want the high. It's my escape from reality. It's a common feeling for a lot of people. They get this way because of being shit on and abused...it started when they were a kid, and then they go through shit when they're teenagers, and they're still getting shit and abused on by their parents, then they get a boyfriend or a husband, and it's still the same routine - nothing's changed. So, they go out and try to find some way to escape. They use the drug, use the alcohol, whatever it is that causes you to escape from, from reality. It's your own little world. When they're pulling the fit out of their arm, all they're thinking about is: "Where am I going to get the next one?"

Another IDU explained that sometimes the IDUs in the shooting gallery are too high to pay attention to whether they are using a clean needle or not. And often, like my

informant, IDUs feel fatalistic about contracting HIV/hepatitis; she had attempted suicide several times and tried to hang herself as recently as two months before my interview with her:

> When I get high I just put my needle down and I'll do my little trip. When I'm done my trip and I come down, I look and I go, "Okay, now which one is mine?" You know? So I just grab a needle that looks good. I don't care. I didn't - now I do, after the fact, after I went and got myself hep C. I thought: "Augh! I'm going to try to kill myself anyway, so if I get HIV it's no big deal."

Using clean needles in the shooting gallery is highly dependent on the availability of new needles. Thus, there is a great deal of potential for a NEP to help improve the safety for IDUs in shooting galleries. It would be ideal to have an IDU who uses the shooting gallery to be responsible for exchanging the used needles for clean ones. One of my informants reported that she occasionally exchanged needles for the entire shooting gallery, but her motive was not entirely altruistic. The nurses at the NEP had helped her repeatedly in her attempts to "clean up" and get off drugs, and she felt too embarrassed to bring in her own used syringes and let the nurses know that she was back using drugs again. She would therefore bring in a full bucket from the shooting gallery to conceal her own used needles. In the social setting of shooting galleries, there is likely to be high levels of HIV-transmission due to the fact that most of the IDUs in these settings are very impaired and incoherent, and also due to the fact that there is no organization of a needle supply and needle disposal. It is essential that the NEP make attempts to intervene in these high risk social settings.

In the vignette, when the supply of clean needles runs out, there could be a long delay before a new supply of needles will arrive. And because the only source at this time

of night is a drug store, the overseer of the shooting gallery will probably not be willing or able to pay the money necessary for the large number (e.g., 200 needles) of rigs necessary to supply 20 or more IDUs for the next five hours. Although the SafeWorks program has a policy of emphasizing the use of a brand new needle as preferred to bleaching a used needle, the next best risk reduction option for the IDUs would be to reuse their own needles. If they are not sure which needles are their own, they will have to bleach someone else's used needle. However, the IDUs may not use the proper bleach cleaning technique, increasing their chances of becoming infected with HIV or hepatitis. Some IDUs expressed that they are reluctant to use a bleached needle:

> I don't bleach. I'm afraid of the bleach, actually. There's gotta be some residue of bleach in that needle. You know, it's left on my clothes when I wash my clothes - I can smell the bleach. If I put it in my dishwasher, I can smell the bleach on the plate, and stuff like that. The thought of actually injecting that into my arms. Like, what does that do to your insides? I'm already putting enough chemicals into my body without that. I thought I tasted it one time when I shot up after I bleached the needle. I just didn't like that.

Another IDU expressed dislike for bleach because it is distributed in the same kind of small plastic bottles as is the distilled water given out by SafeWorks. She witnessed another IDU mistaking the bleach bottle for a water bottle and using the bleach to mix the cocaine which he then injected. This problem is a hazardous and highly preventable deterrent for IDUs who may consider getting bleach from the NEP. Simply by changing the colour or shape of the bleach or water bottles, SafeWorks could prevent IDUs mistaking one for the other. Some IDUs who are reluctant to use bleach, or do not have any available, mistakenly believe that other cleaning methods will be effective:

> I've seen cases where a person had HIV and he fixed cocaine and there was no other needle in the house and there was no bleach. And this other

> girl, she had a flap of coke that she wanted to do. And the guy said: "I've got HIV. You can't use my needle." She says, "Aaah, give it to me anyway." And she took the dish soap and she said, "This works just as good." And she cleaned it out with dish soap about three times and then used it. And I don't think dish soap is anything like bleach, because you know, it was just Sunlight soap. Every crack house, every shooting gallery, you'll see the same thing.

Sometimes, the IDUs are in such a rush to get the hit of cocaine that they don't use any cleaning agent before using someone else's needle:

> Because they're too lazy to, you know how it is - they're in a crack house, and they're all in such a big rush and they're: "Here, let me use your's." And they say, "Well, I'll just rinse it out." And they rinse it out with water, and they use it, you know.

The vignette above emphasizes the importance of having an ample needle supply in the shooting gallery. Ideally, the shooting gallery owner should never let the needle supply go below the last 100 syringes, as it does not take very long for 20 or more IDUs to go through one box of clean syringes. The shooting gallery owner would have been wise to call the NEP ahead of time in anticipation of an event of running out of clean syringes. It would also be advisable for the shooting gallery to have a supply of syringes in every room of the building where IDUs will be injecting. Some IDUs may become so impaired by their cocaine use that they are unable to even go to the next room for a clean syringe. In the setting of a shooting gallery, as in any setting, needle availability is the best measure towards ensuring that IDUs will not share needles or reuse needles, simply because it is less painful to inject with a brand new needle:

> I myself, and most other people would rather use a new needle than a used one for the simple fact that it's sharper. Because after you've been using needles for a while, your veins start to go on you and you want to use a new needle because you can hit yourself better than if you used a used needle. Like those disposable needles are only supposed to be used once, and then you throw them away. You know, they get dull, so it's hard. So,

> sure if there's a box of new ones there, anybody in their right mind is going to use the new one, for the simple fact that...even if they didn't know about AIDS, which is like you say, highly unlikely, then uh...it just makes sense to use a new one because you can fix yourself so much easier than using a used one that's dull.

Needle sharing is more likely to occur among users of certain kinds of drugs. Cocaine use was found to be one of the major variables predicting needle sharing (Brook et al., 1995). People who share needles in a shooting gallery are more likely to be more extreme risk-takers because they are sharing with strangers, versus those who share needles with familiar people. Needle sharing is also linearly related to heavy drug use and abuse, as is illustrated in the IDUs of the vignette above. Frequent use of cocaine or heroin, compared with less frequent use of either drug, independently increased the risk of needle sharing with familiar people. Moreover, frequent use of cocaine, but not heroin, increased the risk of needle-sharing with strangers. One possible explanation is that very frequent cocaine users are less discriminating than very frequent heroin users and are more likely to engage in extremely risky behaviour, such as needle sharing with strangers, because of the psychopharmacological effects of cocaine (Brook et al., 1995).

Cocaine users who inject in a shooting gallery may possess personality factors which increase their susceptibity to needle sharing, including poor intrapsychic functioning, as measured by low ego integration and low self-esteem, as well as poor control of emotions, as measured by impulsivity (Brook et al., 1996). IDUs experiencing depression and anxiety are more likely to share needles with strangers, as in a shooting gallery. One possible explanation is that people who are very distressed may take enormous risks in order to administer the substances that reduce their painful affect (Brook et al., 1996).

In summary, shooting gallery settings are central to the social context of cocaine use in Calgary, and are nodes of social gatherings that place IDUs in situations and settings with many inherent risks. Intervention programs and policies should be customized to focus on shooting galleries as they are settings in which needle sharing and HIV or hepatitis transmission are more common than in other settings.

CHAPTER 6

VIGNETTE #3: MORPHINE DEALER

I. INTRODUCTION

I interviewed five morphine users who shared several common characteristics. They were all older than the cocaine users and included the IDUs who had been injecting drugs for the longest period of time. Morphine users described a very different lifestyle and injection setting from other IDUs, namely, cocaine and heroin users. The primary clinical use of morphine is for the management of moderately severe and severe pain. Some of the morphine users initiated out of curiosity or the desire to experiment, but others initiated morphine use for clinical reasons and then became addicted to the narcotic analgesic. When injected intravenously, morphine can produce intense euphoria and a general state of well-being and relaxation. However, after a user has been injecting morphine for a steady and prolonged period of time, he or she no longer feels the desired effects of euphoria. Rather, the user continues to administer morphine only to avert withdrawal sickness.

Perhaps due to the relaxing effects of morphine, its use is not as socially oriented as is cocaine. Shortly after a morphine injection, users experience drowsiness and enter a dreamy, mild dozing state, known as "the nod." Thus, morphine users do not gather so much for the social interaction, but more for reasons of accessing the drugs which are available only through physicians' prescriptions.

II. GLOSSARY

Grays, peelers – morphine tablets (MS-Contin) of various doses. Usually morphine users have "grays" which are 100mg gray-coloured tablets. There are also

green tablets (15mg), purple tablets (30mg), peach tablets (60mg), and red tablets (200mg).

Double-doctoring – the practice of visiting more than one physician for the same medical ailment in order to receive more than one prescription of a desired drug.

Bender – a binge of drug use above and beyond what would normally be used on a daily basis to maintain an addiction

Buzz, wired – the high of drug use; the feelings of euphoria and well-being and suppression of the sensation and emotional response to pain.

III. VIGNETTE #3 – MORPHINE DEALER

The house is well-known among morphine users as a reliable source of grays. The owner is a morphine user in his mid-50s who has been using for the last 28 years, and injects only in his own home. He has hepatitis C, probably from sharing needles with his ex-girlfriend. They used to fight a lot and he thinks she'd go sleep around or shoot up with other guys to gain revenge.

Even though he is a morphine addict, he leads a fairly "normal" lifestyle, and has more stability than most of the other IDUs that he knows. He does not have to seek employment in mainstream society because he gets a monthly disability cheque for the back injury that he sustained while working construction several years back. He initiated morphine use out of curiosity while experimenting in the 70s. He now uses the morphine partly for pain management but mostly to hold off the withdrawal sickness. He deals morphine from the prescription that he receives from the several physicians that he visits each month. He has served prison time for his double-doctoring in another province, but the profits are a good incentive.

He usually injects in his own home and only permits four or five select friends inside to inject with him. He likes to be home where he can relax and enjoy the morphine. When he nods off after a hit, he likes to be in the security of his own place where he knows that his drugs and rigs will be sitting there waiting for him when he wakes up, just as he left them.

At the beginning of each month when he gets his disability cheque and his morphine prescription, he treats himself to a bender and injects three or four grays a day. His customers, with their own welfare cheques, flock to him during this time, as well, to purchase a share of his prescription. People buy 40 or 50 pills from him for $20 each. He no longer gets a buzz off the one or two pills that he injects each day of the rest of the month. As soon as he gets his prescriptions they all sit around, everybody digs in and fixes for a couple of days until he tells them to get the hell out. They want more and more of his morphine and it is usually a struggle (sometimes violent) to get them out of his house. He was involved in one violent confrontation with a guy that was shooting up at his house last month. His guest was up in his bedroom searching for his supply of pills, trying to steal them. He kicked the jerk out of the house but not before giving him a beating with a baseball bat.

He goes down to CUPS about once a week to get himself a supply of needles, but tells his customers that he doesn't have any rigs if they ask for one. He doesn't give them needles because he doesn't want them hanging around and turning his place into a damned shooting gallery. When his friends come over they usually bring their own needles because some of them like to use the 3 c.c. syringes and he only uses the 1 c.c. syringes. The rules of his house are very strict – people are only to use a clean needle, and a used needle goes into the yellow bucket. He tells them to clean up after themselves, but sometimes he'll be left to clean up the blood on the walls or floors, or pick up a needle discarded carelessly.

He and his friends gather around with their peeler, help themselves to the kitchen drawer for their own spoon and crush their pills. They all cook it up around the stove and then they each fix in their own part of the house. Somebody goes to the bathroom, or somebody goes to the kitchen, or bedroom, or living room. When the bucket gets full, he takes it down to CUPS the next time he needs more rigs.

The atmosphere in the house when everyone is shooting up is pretty mellow. They watch TV or play cards and listen to music. Some of them are sick because they haven't had a score for a few days, and they are in withdrawal. Others just want to get wired. Most of them have had habits for years. They are pretty quiet as they each nod off from the morphine hit and half-doze for the few hours that the hit lasts.

Sometimes he takes a bus and goes to visit friends out of town, so he brings his drugs already prepared in syringes. It's handy to have the prepared syringes ready to go in his duffle bag when he's on the bus. He just goes to the back washroom, warms the syringe under the hot water tap, and shoots it up as the bus rolls along. He's been robbed of his pills before, so instead of bringing the pills, he takes the prepared syringes, which people are less likely to steal. He offers to share them with his friend who doesn't even ask how many grays are in there, but just warms up the syringe under a tap and sticks it in his arm.

(Composite of interviews #2, 4, 7)

IV. DISCUSSION

Because the morphine dealer does not want to invite IDUs to stay at his house to inject their morphine, he refuses to supply them with injection equipment even when they request it. This unwillingness to supply clean needles facilitates risk assumption behaviours in his customers, as they may be in too much of a hurry to shoot up their morphine to go find a new sterile needle, either from a drug store, or from SafeWorks.

The IDUs are even less likely to search out a new needle if it has been a few days since their last hit and they are suffering withdrawal symptoms. One of my informants explained the problems associated with supplying needles to other IDUs:

> Yeah, sure if I had a place downtown, or fairly close to downtown where most of the people use, I wouldn't mind having a box of rigs there and if someone came over, I'd say: "Here, take them. But get out. Don't use them here." Just make them leave, you know, because I don't want a bunch of people sitting in my house doing that. You can get in trouble if you say, "Here's a needle." And I say, "Oh, well, if you got a needle, can I use it here?" So, you know, you don't want them there, so it's easier for some people if they say, "No, I don't have any there." They do have rigs there but they don't want the people to hang around. They want to get rid of them, so they say, "Sorry, I don't have any needles. Go find your own." Just to get them out of the house. Because if you tell them you got a needle, then they'll...you know, drug addicts are very manipulative, so they'll do a little begging and crying until you let them and say: "okay, go ahead. You can do it here." You know, and then somebody else drops in ten minutes later and there's a couple of them there, and all of a sudden the house is full of people and that's the last thing you want.

The arrangement of the morphine dealer allowing only four or five friends come to his home to share his morphine and inject with him is a common social situation among morphine users. There is limited needle sharing in such settings because: 1) each IDU brings his or her own needles to the house as some prefer different sized syringe barrels; 2) the IDUs in the vignette preferred to inject privately in separate rooms, so that their injection equipment is kept separate; 3) a dose of morphine lasts several hours and even when on a binge, the IDUs will probably only inject up to three times a day; and 4) even if the people in the dealer's house do share their needles, their tight social circle of four or five people is not likely to share outside the group, so any blood-borne disease such as HIV or hepatitis will be kept contained within that group. Unlike shooting gallery settings, where there is an overlap of many friendship groupings under one roof, in the morphine dealer's house the overlap of friendship groupings in sharing situations is

less likely to occur. Without the mixing of blood from members of large numbers of social or friendship groups of IDUs there is a less efficient means of viral transmission (Watters, 1989).

When the dealer in my vignette takes prepared syringes to his friend out of town, and the friend accepts the prepared shots without question, he is practising risk assumption behaviour. He may claim that he trusts the dealer and is not concerned about the contents of the syringe, but there is no way for him to be completely assured of its contents. Even the dealer is amazed by his friend's lack of caution:

> I: He doesn't know what the hell he's getting. It could be heroin or coke in there, or whatever. It's just like: "See you buddy, have a good trip." That's how greedy these guys get – as long as they're getting it for free, they don't really care exactly what's in it. A lot of the guys I know just want the dope in them – they don't care if it's been a used needle, or whatever. They don't ask questions.
> S: Do you see that as a problem?
> I: Well, yeah, sort of. It's greed and stupidity. Sure, you're getting high for free, but what if you're getting hepatitis C or something like that? They don't think of the long-term effects. They just think of now, right? And then they pay in the long run. If they're going to be greedy like that, I guess they deserve it. I don't question them. It's up to them. Well, it's my dope and they're getting it for free – they're not paying me.

Other IDUs told me that they would never buy a hit already prepared in the syringe and that they insisted on seeing the gray (or the MS-Contin pill) before they would prepare their hit. Morphine users are thus less susceptible to overdose or bad hits because the drug is sold in tablet form, with set dosages (usually 100g pills) and regulated purity.

All of the morphine users that I spoke to emphasized that there is a very distinct difference between themselves and cocaine users. The morphine users generally see themselves as more responsible and less chaotic than cocaine users.

> There's not a whole lot of narcotic users left in the city and the ones that are - they're a different breed. They have a little more knowledge and they're not in a rush all the time like the cocaine people are to get more and more every two seconds.

Morphine users attribute the difference in safety with respect to needle use to the different effects of cocaine and morphine. Morphine users become mellow and sleepy, whereas cocaine users are agitated and energetic in their high.

> Whenever I did morphine I knew whose needles they were. It was just relaxing. Because I was tired, I was coming down and I was ready to go to sleep, so...I put things away and I knew it was going to be there when I woke up. I'd just want to be alone at home, because I'd get sick on it. When you're going to get sick on it, you just want to nod out for a bit.

Another IDU explained the difference between cocaine and morphine users in terms of HIV/hepatitis risk reduction behaviours:

> The people that are using coke, that I've seen, they tend to be a lot more careless with their needles than with the morphine or the heroin because the down-high lasts a lot longer than the coke does. The person will do a shot of coke and then ten minutes later they'll want to do another one. Whereas, with morphine or heroin you can go for a couple hours before you want another one.

One IDU who had at one time used cocaine, but was currently a morphine user explained the difference between cocaine and morphine users. He feels that cocaine users are mostly responsible for the transmission of HIV among IDUs and attributes it to the chaotic lifestyle and risk assumption practices of cocaine users:

> There's a big difference between cocaine users and narcotic users, as far as sloppiness goes, and uncleanliness goes. Like all the drug addicts, narcotic users that I know, they're careful, you know. They use a new needle every time and just do it at home and don't run around. Whereas cocaine addicts they'll do it anywhere. They use anybody's rig. They'll do it in a back alley. They'll do it anywhere. You know, they're two different classes of people. That's where most of the AIDS is coming from, and the HIV, is from the cocaine, not the narcotics. In this city...in Vancouver, it's both, yeah it's heroin and cocaine in Vancouver. But in this city it's mainly the

> coke users that are spreading the AIDS in the community. The narcotic users that are like me and L, there aren't that many of us left in the city, and we're careful because, I mean, uh...we're not in a rush to do it every five minutes. So, you know, we have lots of time to go to the exchange. And that way you're able to monitor yourself a little better because you do one in the morning, and throw the needle away, and then you don't need another one. So there's a big difference between heroin and cocaine. The cocaine users are the ones that are spreading all the HIV and the AIDS. Because there's so many places, and I can't believe that...if you try and teach them they won't even listen. And some of them are so stupid - they'll mix them up in the needle, instead of putting it in two different spoons at least. One person will shoot half and pull it out of his arm, and hand it to the other girl. You know, so the blood's already in there. And she'll use it, you know. And I say: "Why didn't you just split it in the first place and you use your own needle?" You know, you can't talk to those people. They're cocaine addicts. I was into it myself for about a year and a half and I know what it does to you. You lose a lot of control over your life. With narcotics you can live a normal life. You know, you can work, you can live a normal life, you can be fairly normal. But on cocaine, you can't. I was into it heavy for about a year and a half and it just destroyed my life. I mean, I lost all my values. I hurt my family. I did things...you know, I'll always be ashamed for the rest of my life. But even with the cocaine, at least I was careful with the needles.

The point that the above informant makes in regards to injection settings is supported by evidence from another informant. The informant above stated that cocaine users tend to inject "anywhere," including back alleys, whereas morphine users tend to confine their drug use to their own home or the home of a friend. One cocaine user that I interviewed stated that she prefers to inject outside in the summertime, down by the riverbank, because she likes to be secluded when she does drugs. She doesn't want other people to know that she is an IDU. Harm reduction is facilitated in that she is not likely to share needles with others or become involved in any conflicts. But she is also engaging in risk assumption behaviour in that she is not near anyone in case of an overdose and she probably does not have a sterile water source. Another cocaine user who was homeless at

the time that I interviewed stated that he injected outside, in public buildings, or in back alleys because those are the settings in which he lives.

Interestingly, even though most of the morphine users that I interviewed saw their drug use as less risky than cocaine use, one couple gave a contradictory viewpoint. They had both used cocaine and morphine in their drug injection careers and stated that the opposite is true, that morphine users are more prone to risk assumption because of the fact that they nod off and are not aware of their surroundings:

> I (1): People on morphine and heroin fall asleep and leave the needle anywhere. You don't know...they pick it up and: "Oh! Here's my drug!" They're careless with their needles.
> I (2): They're less careful with their needles. More people I know that do cocaine are more paranoid and they want to have things cleaned up and put away right away. Like, "Don't leave that laying there. Put it away if it yours. That way you know it's yours." And a person on morphine is just laid back and puts it down, and an hour later, he might put the cap on. You don't know how long it's been there, who's picked it up, if somebody's poked their finger on the end of it because they didn't know it was there. You know, you don't know anything like that. And they just don't think about that - if their drugs are still left in the needle.
> I (1): Well, with morphine it's just that you're sleepy, you're not in a paranoid state, anyways. You're relaxed, and you lay back...
> S: Okay, so you see the paranoid state as making you more careful?
> I (2): Yeah. Well, it did for me.
> I (1): You're more aware.
> I (2): You're more aware. You want to put your needle away so nobody sees you sitting there with a needle. Whereas a person on morphine or heroin probably doesn't really care. They're high and they're going to be high for quite a few hours compared to cocaine. They're more laid back. They're not always thinking about the next time they're going to get high. They're enjoying their high now. Whereas, with cocaine you're always thinking of that next one.

The informants above believed that the paranoid, agitated state of cocaine users facilitates risk reduction in that they are more vigilant over their needles and less likely to be careless.

Morphine users may be at lower risk of HIV/hepatitis infection simply because they don't inject as frequently as cocaine users. Infrequent drug injectors typically have lower levels of needle-related risks, compared to high-frequency drug injectors, and thus are more limited in how much they can change about their injection practices (Camacho et al., 1995).

CHAPTER 7

VIGNETTE #4: HEROIN USER'S APARTMENT

I. INTRODUCTION

Because heroin is relatively rare in Calgary, there are few IDUs who use heroin only. The one heroin user that I interviewed stated that his drug of choice is heroin, but that when it is unavailable, he uses cocaine. The following vignette describes a heroin user's apartment and the process by which a young woman is initiated into injection drug use. The vignette is a composite of the data from my interview with the heroin user, as well as data from other informants about their initiation into injection drug use. I have assigned three of the individuals in the vignette with fictional names for ease of reading. The individuals depicted in the vignette are all fairly young because most of the IDUs that I interviewed initiated injection drug use when they were in their teens.

II. GLOSSARY

Chipper – drug users who use small amounts of drugs on an irregular basis

Flag – to draw blood up into the syringe to ensure that the drug will enter a vein

Junk, Smack – heroin

Junkie – heroin addict

Mainlining – injecting a water solution of heroin into the bloodstream

OD 'ing – overdosing

Snorting, Doing Rails – sniffing the heroin powder

Speedballs – mixed heroin and cocaine

III. VIGNETTE #4 – HEROIN USERS APARTMENT

For the first time in two weeks, a heroin supply is available to IDUs in Calgary. The dealer delivers to his customers' door because he doesn't want the IDUs flocking to his place and have it turn into a shooting gallery. A 30-year-old man named Max is on the phone to notify his friends that he has snagged $125 worth of some junk. They are all only chippers but still crave the heroin. It is their favorite drug and they make plans to get a share of the limited supply. Like Max, most of his friends do both cocaine and heroin, sometimes as speedballs. They arrange to meet at the local pub for a few beers and then afterwards go back to his apartment to do the heroin which they've been craving for weeks. They are all young, ranging in age from 17 to 28. They share the same curiosity and the excitement of experimentation with different mind-altering drugs. Some of the younger IDUs still live with their parents and others live with their boyfriends or girlfriends. After he has notified four of his shooting buddies, his next call is to the SafeWorks van. He is the van's first stop of the night and he gets his HIV antibody test results back from the nurses. It's negative. He breaths a sigh of relief. They advise him to get tested again in three months. Max grabs 50 - 1c.c. syringes from them, along with a handful of condoms and alcohol wipes, a couple rubber tourniquets, and a little baggie of the new filters that look like mini tampons. He leaves the works at his apartment to go meet the rest at the pub.

Fairly drunk already, six of them head back to Max's place above a record store dowtown. With them is a girl, Sally, who is the new girlfriend of one of the guys in the group, Don. She has snorted heroin before, but has never injected anything in her life. She is eager to get a share of the dust but Max is reluctant to give her heroin to snort. He only has a quarter of a gram of smack and says to Sally, "Well, we'll give you some if you shoot it." Max is just being cheap by insisting that she inject the smack because people who do rails need a lot more to get the same high than a

smaller dose that is mainlined. She agrees because she has seen her boyfriend and his friends inject before and thinks to herself: "Well, everybody else is doing it. I want to try it." Max has enough for all six of them to get high for the next few hours. They each give him $20 for their share of the smack. Sally doesn't have any cash, but Max likes her walkman, so she trades it for her share.

Max has introduced several other friends to injection drug use, some to cocaine and some to heroin, and offers to initiate the new girl. Max is usually willing to show others how to shoot up, depending on their disposition and age. Generally speaking, though, with the people that he hangs out with, he'll give them the benefit of the doubt. If they want to try it, he won't encourage it, but his point of view is that if they're going to try shooting up, they may as well be with someone who knows what they're doing, so that they don't puncture a vein or do too much. He always teaches new IDUs to try to rotate injection sites so that they're not always shooting up in the same area and end up damaging a vein. He teaches them how to flag and to loosen the tourniquet before they inject. He also teaches them how to be clean and not to use their own rig more than three times. Most importantly, he instructs them to take it easy at first and just to go slow, not to go for the big, huge hits.

While Don and Sally wait in the living room, Max and the three other guys go to the kitchen. They dump a chunk of the fine ivory-coloured powder into a spoon and gather around the stove as it cooks over a burner. They stick one of the filters from SafeWorks in the spoon and each draw up their share of the smack into the syringes that Max left out for them all to use. Don brings two filled syringes into the living room from the kitchen. Even though Max offers to help Sally do a hit, Don says that he'll show her how it's done. Don has been a junkie for over five years and has built up a fairly high tolerance and thus injects quite large doses in order to feel the desired effects. He tells Max: "I know what I'm

doing, man." He sits on the couch and shows Sally how to tie off her arm until a vein protrudes and he picks up one of the syringes that they've just filled. He selects the syringe with the least heroin solution for Sally. He shows her how to stick the needle in, releases the tourniquet, and shoots it into her. Max comes in from the kitchen after doing his hit and sees Don shooting himself in the arm. Max grins and asks Sally how she likes it. Her head is back with her eyes closed and she moans and says, "It's a completely different high. Oh my god!" Max and Don assume that she is enjoying herself and laugh as they feel their own hits washing over them.

Each of the six of them react to the heroin in their own way. Three of the guys put on some loud music and slam dance around the kitchen. Max and Don lounge on the sofa and relax, staring into space. Don has started to nod off. Sally mumbles: "I'm so damned dizzy! What's that noise? Tell those guys to shut up." Max goes over to Sally at the other end of the couch and stands over her: "Are you okay, babe?" Sally has started breathing with very slow, shallow and irregular breaths. Her face is flushed and she is sweating. "Oh, shit! Don, how much did you give her, man? She's fucking OD'ing!"

(Composite of Interviews #3, 6, 7, 10)

IV. DISCUSSION

In vignette #4, the owner of the apartment, Max, has facilitated risk reduction amongst his IDU friends by ensuring that they have an ample supply of clean needles, alcohol swabs, tourniquets, and filters on the premises. Although they are sharing the heroin and preparing it in one spoon, they are only drawing up the heroin solution with new needles, so the cooker and filter is kept sterile.

There are several opportunities for risk assumption behaviours during the initiation of an inexperienced IDU. The initiate is probably unwise to the safe dosages of

the drug, opening up opportunity for possible overdose. Also, the initiate is unlikely to be carrying his or her own sterile syringe and is at the mercy of the experienced IDU to supply sterile injection equipment. The experienced IDU may try to convince the initiate not to be concerned about HIV or hepatitis transmission and the power dynamic between the experienced IDU and the initiate is such that the initiate will have to concede to the conditions set by the experienced IDU. Furthermore, the individuals in the vignette have all been impaired by alcohol and their judgement may be less than rational.

Each of the informants provided me with information about the first time they had ever injected drugs. For some, the experience was pleasant, but for others it was a frightening and hazy experience. Some of the IDUs that I interviewed could not clearly remember their initiation into injection drug use. I asked one informant what she was taught the first time someone showed her how to inject drugs:

> I don't know. I didn't know anything about needles. I didn't even know that she had needles on her. I didn't even know how we were going to do the coke. I was green. I didn't know anything.

I was also interested in understanding the motivation behind trying injection drugs and asked the IDUs *why* they first tried injection drugs. One IDU explained that she had been around injection drug use since she was very young and it was actually by watching her mother and her mother's boyfriend inject that she learned how to do it herself:

> I: I don't know why I started, really. Maybe because it was seeing my parents do it for ten years of my life and that. I don't know why I did it in the first place. Maybe it was because I had nothing better to do. Everybody in my family was gone away from me.
> S: How did you first get into it?
> I: Um...being around my mother's boyfriend, and my friend, S. And I started working on the streets. And it was just being around people that were on the streets downtown.
> S: Okay, so did you start because you were curious, or was it an escape...?

> I: Probably an escape. I wasn't curious because I'd seen it for ten years. And I'd even helped my mom fix herself and I'd seen her do it every day. And I didn't like it and I don't know why I did it.

Sally of my vignette wanted to try injecting heroin because she felt left out when her boyfriend and his friends were injecting. One of my informants began injecting morphine because her husband did, and she explains her desire to experience what her husband felt:

> I just decided to try it and see what it was like since my husband was using long before I was. He was pretty dead-set against it. I wanted to try it and I told him: "Well, I can try it with you, or sooner or later, I'll try it behind your back, so..." I did it to try it out and I'd seen how my husband got when he injected with friends and I just felt like an outsider. It seemed like when you're not doing drugs and someone you're close to is, you can tell that they're in a world of their own when they're doing the drugs. And I just felt like an outsider when he was doing it. So, I thought I'd try it and see what it was like. And well, I got sick to my stomach for about a day, but other than that it was alright. I finally could understand where he was coming from then.

Some of the IDUs were not able to inject themselves when they first started using injection drugs and relied upon other more experienced IDUs to inject for them. One informant recounted how he relied upon his roommate to inject him until she became too impaired to do it and he was forced to learn on his own:

> We were just doing 60mg – we'd split that and get high. It was just sort of like a weekend thing, just something new for the high and I was getting a prescription for 60mg morphine tablets. We never got that much into it but I didn't know how to fix myself. But she was drunk quite a few times, and I'd have to score, or whatever, and I'd have a rig and I'd tell her to hit me, and she's too drunk and says: "Well, if you want to be a junkie, you've got to hit yourself." You know, here I am making a mess – I'm spilling all over, or else I've got a rig full and she'd throw it against the wall and break the needle and waste the dope. So, finally you learn, right? So, I learned. I looked like a pincushion. One arm was all ballooned up and I hit an artery once – and your whole hand blows up like a balloon. When I got upped on my medication, that's when I got into it. When I got up from 60mg to 100mg that's when I got myself wired. And once I knew how to fix myself, I was my best customer worth stabbing.

Don taught Sally proper injection techniques and waited until he had administered her hit before shooting up himself. Max in the vignette above had introduced several of his friends to injection drug use, and was fairly conscientious about teaching them proper risk reduction methods of preparing and administering the injections. However, not every new initiate is taught risk reduction at the time that they are introduced:

> S: Did they teach you about safe use of needles?
> I: No. [laughs] No, they were pigs. They'd just – the thing was plugged and they'd just leave it sitting on the table or let it go in the carpet and they'd just get another syringe and draw up some more and leave a rig here and blood there. It was very unsafe practice, or usage I guess, whatever you want to call it.

Generally, my informants did not have fond recollections of their first time injecting drugs. Some even resented the person(s) who introduced them to injection drug use and the resulting addiction:

> I don't want anyone to get hooked because of me, so therefore I don't want to show anyone, or inject anyone for that matter. If you don't know how to use a needle, I don't believe in teaching you. I'm not going to be the one that puts you there. I will never give anybody their first shot of drugs. If they didn't know what they were doing, then I just said, "It's not going to be me that puts them into doing it." After I was in it for a few years and you know I didn't think I was ever going to get out of the drugs, I just cursed the person that gave me my first hit. Without them, I would never have tried cocaine.

While the above informant will never introduce anyone to injection drug use, people who are interested in experimenting with injection drugs are likely to try with or without the assistance of a knowledgeable and experienced IDU. New injectors are less likely than other more experienced IDUs to have salient knowledge about drug-related HIV or hepatitis transmission and are less likely than other more experienced IDUs to attempt risk reduction (Kleinman et al., 1990). From a risk reduction viewpoint, new initiates

should be encouraged to seek the assistance of a veteran IDU so that they can be taught proper injection techniques, safe needle handling, and safe dosages. While I would not condone IDUs recruiting new initiates into injection drug use, an IDU who is asked by an inexperienced initiate could be assisting that person with risk reduction by teaching safer injection behaviours.

In the above vignette, Sally's overdose occurred due to several contributing factors. Firstly, Don and Max did not find out how much or for how long Sally had snorted heroin. Thus, they were incapable of gauging her previous exposure and tolerance to heroin. Secondly, in preparing Sally's hit, Don and the others did not compensate for her smaller body size and inexperience in the intravenous mode of administration, which induces a much more rapid and intense response to the drug. Because Don had developed a tolerance to heroin over a period of five years, he was accustomed to much higher doses than would be safely tolerated by a new IDU. He and the others should have prepared a much smaller dose for Sally. Thirdly, upon administering the heroin to Sally, someone should have monitored her response more closely, giving themselves time to respond to her overdose before her life was threatened.

Several of my informants also provided information about the risks of and incidents involving drug overdose. One ex-dealer who has been in the drug scene for 20 years explains that sometimes overdosing is such a frightening experience for IDUs that they quit their drug use:

> I can't count on my fingers and toes and your fingers and toes how many people I've known that have died, have OD'd because of drugs. Some of them it sinks into, some of them it doesn't. Some of them have gone to treatment centres. Some are straight now.

Another dealer described an overdose that he witnessed after selling drugs to an IDU. When I asked him to tell me about the incident, he told me that he had seen a girl "doing the chicken." I was unfamiliar with the phrase, so he explained:

> Why they call it the chicken is, because if they were standing up, IV'ing, and all of a sudden their legs are going to rubber and they're going down, they're dropping - they're OD'ing. This one girl came in - I don't know - she bought a gram, I guess. She put the whole gram in the spoon and I was too tired. I wasn't paying attention. I was half asleep. Jesus, the next thing I know - I look and there she is just flip-flopping around on the floor. Oh my god! My heart went pump-pump-pump-pump! And that was the first time I'd ever seen it. Even though my ex was epileptic - she didn't go into all-out convulsions. I said, "Oh, boy." So, I ran downstairs and I got her boyfriend, and I said, "Hey, she's doing the chicken up there, man." He's up the stairs in about three strides, entered the room and he knew what to do with her.

One of the important messages pushed to IDUs by the harm reduction movement is: "Never let somebody else prepare your hit for you." In the vignette, Sally should have taken a more active role in preparing her heroin shot so that she could monitor the dosage. The following excerpt of an interview with an IDU who was in a shooting gallery explains why this message is so important. It also illustrates the strong link between the paranoia of police discovering illegal drug use and the high risk of death by drug overdose among IDUs:

> I: Well, this one time this guy fixed up a rig for somebody else, eh? And he put in major coke and this guy was just [rolls eyes back and shakes] - overdosing. And then the other, the woman at the house, she's like running around: "We gotta clear everybody out." She's telling me this. And she's asking me: "What are we going to do with his body?"
> S: He hadn't died yet, had he?
> I: No, but she assumed that he was going to die.
> S: Did anybody take him to the hospital?
> I: No, they didn't want any heat on the house. Because there was coke there. So, I mean, they'd rather just let you die. And then throw your body somewhere. That's what I'm sure happened to S.M. - she was probably in

> the same house and OD'd and they just laid her body out straight in a back alley and threw a needle nearby....
> S: So, what happened to that guy, do you know?
> I: No, I took off. I didn't want anything to do with any body, or...
> S: Why would that guy prepare him a shot that had so much cocaine in it?
> I: Maybe he was trying to kill him. I don't know. You never know what people think downtown.

Initiates into injection drug use are also susceptible to overdose as they are too inexperienced to judge their own dosages and rely on others to prepare their hits and shoot them up:

> I'd done injection drugs when I was 17. T's and R's [Talwin and Ritalin]. I quit. I had an overdose on that. I got shot up with too much. I didn't even know how to mix it up or anything. Some friends of mine did it for me. They racked me full of too much one day and I passed out, got scared, and quit.

All of the above interview excerpts illustrate how crucial the fears and actions of IDUs and dealers are to other IDUs in situations of drug overdose. These situations could mean death for an overdosing IDU if his or her companions are overly fearful of discovery by the police. Initiation into injection drug use is a pivotal moment in the life of an IDU in terms of learning safe injection techniques that will reduce their risk of HIV or hepatitis infections.

CHAPTER 8

THE IDU "COMMUNITY"

I. INTRODUCTION

One major assumption of discourse around injection drug use is that there is a pervasive "drug culture" to which all drug users belong. This supposed "drug culture" was held in my mind as a given construct. I assumed that drug users in Calgary, indeed in any city, identified themselves as part of a group of people who share a common geographical area, common needs and concerns, and felt some coherence with one another. In other words, I assumed that drug users belonged to a community, as bounded by the drug using sub-culture.

When discussing the concept of community with respect to IDUs, it is important to consider that they are clearly an oppressed and stigmatized group. The act of using illicit drugs in itself creates stigmatization and pushes IDUs away from the mainstream social center. Although using drugs may also produce social cohesion among one's IDU peers, it does so at the expense of moving drug users away from the mainstream (Moore & Wenger, 1995). Secondly, IDUs who belong to racial (such as First Nations groups) or sexual minority (such as homosexuals and prostitutes) groups experience even greater stigmatization. Lastly, poverty pushes individuals even further to the margins of society. Although the compounded stigmatization of drug use, racial or sexual minority, and poverty does not necessarily prevent people from organizing to further their health and political interests, what it can do is reduce the resources available to the people. Their marginalization also can cause people to view their misfortunes as a sole function of their personal shortcomings and failings, rather than as shared problems that can be addressed

collectively. One promising possibility is that IDUs use stigmatization to prompt them to organize around their labeling and their stigma, as the gay community has so successfully been able to do (Moore & Wenger, 1995).

II. THE CONCEPT OF COMMUNITY

According to HIV prevention literature, the most effective means to address preventing HIV transmission is through behaviour change, and this can be achieved only through effective education strategies and community mobilization. Effective prevention programs must be community-based and culturally appropriate, but the challenge is in defining the "community" and the "culture."

In some health promotion literature, community is treated as "a locality-bound aggregation of people who share economic, socio-cultural and political characteristics, as well as problems and needs" (Jewks & Murcott, 1996, p. 558). Community differs from a "group" in that its common traits must include social interaction. In its common use, a community may not necessarily be bound geographically. A group of people that are linked by bonds or issues can also be considered a community (Rubin & Rubin, 1992). However, it is important to note that the group of people still shares social interactions and common needs.

IDUs have been described as belonging to a "culture of survival" (Moore & Wenger, 1995). The social organization of IDU subculture is driven by economic deprivation and the common bond of being outcast by society. They are a disenfranchised group; that is, they are outside of mainstream society and services because of their lack of conformity to social norms and/or societal prejudice and bias. These factors create the need to share resources, including the purchase and sharing of drugs and injection

equipment, as well as food, shelter, recreation, and other necessities of life. Although there is often competition among IDUs for drugs, for money, and even for injection equipment, patterns of mutual support are also common. The common bond of being outcast and economically deprived explains much of the violence against the community, society, and each other. When access to food, shelter, recreation, and the other necessities of life are denied a disenfranchised population, the result is an extremely unstable and volatile social system. IDUs live with the constant challenges of arrest, unstable housing, and little secure income. HIV/AIDS is not the greatest threat (Lloyd et al., 1994).

Social support is an important function of the IDU community. Social support can be seen as the emotional, instrumental, and financial aid that is obtained from one's social network. Social support has six major functions which mutually benefit the members of a cohesive community. Firstly, members of a community achieve intimacy, or the provision of an emotional climate in which individuals may express their feelings freely and without self-consciousness. Community members also share a sense of belonging, or a sharing of experience, information, and ideas through relationships and common objectives. Inclusion in a community also lends opportunity for nurturant behaviour, giving members an emphasis on obligations and duties towards others in addition to receiving support from others. IDUs involved in a cohesive community may benefit from a reassurance of worth wherein his or her membership in the community attests to an individual's competence in some role and his or her worth, resulting in increased self-esteem. Members of an IDU community can provide assistance to one another, either in the provision of tangible goods (e.g., injection equipment) or task oriented services (e.g., gathering and disposing of used needles, bringing new ones). Finally, members of a

community receive mutual guidance and advice, such as through the delivery and exchange of information about health and/or street news (Berkman, 1984).

Social support was manifested in many different forms among my informants. Family members supported IDUs in their efforts to quit their drug use and seek drug addiction treatment. The desire to preserve or restore personal relationships with family members and sexual partners was a strong motivator for many of my informants to try to overcome their drug addictions. The boyfriend of one IDU would help his girlfriend overcome cocaine withdrawals by providing her with encouragement and sometimes beer "to take the edge off." The safe house owner provided a safe and peaceful environment for prostitutes to inject and also encouraged them to quit their drug use.

III. THE CONCEPT OF EMPOWERMENT

IDUs are faced with the somewhat daunting task of creating change within their social and political environments with limited resources available to them and little societal support for their efforts. Advocating for significant policy and program changes such as those I recommend in the following chapter requires significant empowerment on the part of the IDUs who will be most impacted by such changes. Empowerment is the only avenue for IDUs to challenge their internalized powerlessness while also developing real opportunities to gain control in their lives and transform their various settings so that they can reduce the health risks associated with injection drug use.

The health outcomes of powerlessness and empowerment are often unrecognized , despite considerable research which documents the role of powerlessness in disease causation, and conversely, of empowerment in health promotion. Powerlessness, or lack

of control over destiny, has been identified as a risk factor for disease. It has been alternatively referred to in social and political science literature as "alienation," "learned helplessness," or "internalized oppression" (Wallerstein, 1992). Powerlessness is generally defined as an objective phenomenon, where people with little or no political and economic power lack the means to gain greater control and resources in their lives (Wallerstein, 1992). The combined challenges of drug addiction, illegal activity, feeling helpless, and having limited financial resources contribute to the powerlessness of some IDUs to enact significant and positive changes in their lives. IDUs face the vicious circle of poverty, malnutrition, drug addiction, and unemployment. People in low socioeconomic positions have greater structural constraints and fewer opportunities to gain access to resources. Their life demands, low levels of education, and the chronic stressor of powerlessness, exceeds their abilities to exert control in their environments (Wallerstein, 1992). This lack of a feeling of control over one's destiny may ultimately lead to disease, such as HIV/AIDS or hepatitis, because the IDUs may not feel capable of taking the necessary measures to reduce their risk of infection. The lack of self-organization among IDUs has prevented collective responses to programs or policies that would facilitate risk reduction.

The goal of health promotion programs targeting IDUs might be empowerment of the IDU community, enabling them to assume control and mastery over their lives in the context of their social and political environment. Empowerment is "a social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice" (Wallerstein, 1992). Activities leading to

empowerment among IDUs would include having IDUs identify their own problems and possible solutions, increasing participation of IDUs in community activities leading to improved social settings with reduced social and physical risk factors, engendering a stronger sense of community among IDUs, and creating stronger personal and political efficacy. It is important that IDUs identify with others as a member of a community and participate with others in organizing for community change, and actual environmental, policy or program changes.

A few highly-motivated health promotive individuals, such as collective exchangers, do not on their own comprise a healthy community. Empowerment is never an individual outcome measured in isolation from the social context. This ethnography has provided a picture of the social context surrounding injection drug use and the relevant social forces that will impact on the IDU community's efforts to achieve empowerment and significant population-wide behaviour change. Before empowerment is possible, all members of the IDU community need to feel perceptions of social support, community connectedness, self-worth, ability to help others, empathy, and a belief in the mutability of harmful situations, as well as overcome feelings of paranoia towards one another. An essential element of community empowerment is for the members to develop a social identity. According to Moore and Wenger (1995), individuals who are marginalized and oppressed, but have no collective identity, do not organize for political action. As long as people individualize and internalize their oppression, they tend to blame themselves for their hardship. Thus, "group consciousness is a critical precondition to political action" (Moore & Wenger, 1995).

IV. CHARACTERISTICS OF THE CALGARY IDU COMMUNITY

I discovered that IDUs in Calgary generally distrust one another and do not even consider fellow IDUs as friends. The social networks (or webs of social relationships) are large, and most of my informants stated that they were acquainted with at least 30-50 other IDUs:

> S: About how many other IDUs do you know?
> I: Mega - all my friends are IDUs. I'd say about 50 others.
> S: How close are you with them?
> I: Not very close at all. I'm just their acquaintance. I wouldn't consider them friends. I just know them to see them. Like, sometimes I'll score from them.
> S: Why don't you consider them your friends?
> I: Because they're addicts. I don't trust them. They don't care as long as they got their hit. They're willing to lie and steal from their friends to get their hit. I don't like that. I'd rather give it to them than have it ripped off. They say, you know, can I have a hit - I say, sure, you know, just take it.

It is important to emphasize that even though IDUs may generally distrust one another, they still are in essence a community by simple virtue of their shared lifestyle, needs, and challenges. Collective exchange is a significant manifestation of the feeling of community with other IDUs among some concerned individuals. Collective exchange has been defined as "making large amounts of sterile needles and sharpsafe containers available at strategic places in the drug scene so that clean needles are always available in those places where drugs are being used" (Grund et al., 1992). I was impressed by the strong health promotive role played by several of the collective exchangers with whom I spoke. Even if these collective exchangers expressed that they do not feel a sense of community with other IDUs and do not consider them friends, they still expressed a level of concern about the health of other IDUs. This caring feeling can be compared to the level of concern in professional health care workers. A doctor or nurse may not feel any

level of friendship, community, or even trust towards his or her patients, but still cares about their health. In much the same way, collective exchangers are providing needles and in some cases education to other IDUs for the simple reason that they care about the health of their peers.

> S: Do you consider other IDUs your friends?
> I: No, I think they're dogs. But I would rather have even an animal use something that isn't going to make them sick.

Collective exchange has been documented as a community-based approach to needle exchange that is built on empowerment of, and intense participation by, known IDUs to target unknown IDUs for delivery of clean needles (Grund et al., 1992). Places where collective exchangers supply needles become attractive to other IDUs who may not use the NEP for themselves. Policymakers and health practitioners might capitalize on the strengths and strategies of those who report that they consistently use sterile needles and distribute sterile needles to other IDUs.

One IDU who was trying to kick his cocaine habit explained that other IDUs failed to be friends when they did not support his efforts to quit cocaine, but rather tried to get him to use again:

> S: About how many other IDUs do you know?
> I: Hundreds, hundreds. At least a hundred I could say, yeah.
> S: And about how many of those people would you say are actual friends?
> I: Not many. [laughs] Not many. It's probably only about ten of them that I actually trust or consider my friends. When I decided to come clean I judged who were my friends by the people that....if I came downtown, they know I'm trying to quit, but: "Oh, let's go and do one. One won't hurt you." And I'm like, "You're not my friend. You're not supporting the fact that I don't want to be on cocaine anymore, so..." I'm still civil with everybody that I knew but I know who's going to encourage me to stay off it and who's going to try and make me get back on it.

Being inside a drug user network is important for an IDU with respect to finding a

reliable and steady source of their desired drug.

> How do you find a person with drugs? Well, actually it takes one to know one. You can just tell, or else you just ask a friend of yours or a close friend of yours to score for you. A lot of the dealers won't deal with you if they don't know you.

One morphine user highlighted the importance of having trusted members of the community to supply her with morphine because she was unable to procure her own prescription for MS-Contin. She also expresses the animosity she feels towards other IDUs for their callousness in trying to obtain a supply of morphine:

> It took me a long time to find the little old man or the little grandmas that care and know that the morphine's for pain and that's how come they will work something out with me. I've never had to prostitute myself. But do you know how many low-lifes would sell their mother? I've been robbed of my medications. How I ended up getting my doctor to question me, is because I was going through them so fast in the beginning, and it was because, you know, I was giving them away cause I was taking care of so many people. Like I've learned you know, to - like, okay, right now - my pharmacist has four waiting there for me. I'm not going to rush to get them because you have people swarm me around. They'll almost watch me: "Can I take you to the doctor? It'll only cost you a minute." One girl owed me seventeen 100 milligram pills. That would be 8 and 1/2 days for me. And do you know what, she walked away from me. Just walked away and left me with withdrawals and in so much pain, screaming. It's pretty cruel. So no, as far as friends - I don't have a whole ton of people. And because the fact that there's a whole circle - you know it's always drawing, sucking, sucking. I don't want it - I'd rather keep them all away from me. I've been ripped off by so many people. And I don't like the people. And I didn't think I could hate people because I have so much love in my heart. But I hate those fucking junkies. And I hate that part of me. And I hate the fact that I use the needles. But I'm not, like I said, I don't have a lot of drug addicts, like junkies, who are friends because I've kicked all of them out. I wouldn't hesitate to call 9-1-1. And that might seem like I'm a rap, but anybody interferes with my children and their safety, that's where it's at.

A morphine user explained that much of the conflict and animosity between IDUs arises because of disputes over the purchase and lending of drugs. He states that fellow IDUs are friendly only when they want another's drugs:

> I: You don't trust a junkie. They're friends when you've got dope, right? Just like if you won $1000, well, you figure you've got lots of friends, right. But when your money's gone, they're not even going to say hi to you. It's dog eat dog out there, I'll tell ya'.
> S: Is there any sense of community?
> I: Well, you all sort of clique together. But you don't trust them. You give everyone a deal and you help them out, but when you're sick, they make you pay, right. You might give them two pills to top them out but the time you're sick, they'll say, "Oh, you still owe me $30 from the $60." And you try and remind them, "Do you remember that time?" "Oh, well, that doesn't count. These aren't mine. They're somebody else's." You know, you hear every story in the book. I've heard it all in my four years. They'll punch you out. They'll rob you for it. They'll set you up. Like, I've had people phoning my doctor because I wouldn't sell to them or give them a deal, you know, just because they see my doctor's label on the bottle. And they couldn't get around him, so they phoned my pharmacist. But that's how dirty these guys can get.

Another misconception that I held is that IDUs can be viewed as one unit and that together, they all form a cohesive community in terms of shared needs and challenges. However, I quickly learned that there are at least two very distinct groups of IDUs in Calgary — the cocaine users, and the morphine (or opiate) users. Several of my informants emphasized the significant differences between the two IDU groups that differed by much more than their drug of choice. I asked one informant about the division between cocaine and opiate users:

> I: Yeah. It's sort of like a subculture. Everyone sticks to their own little group. It's just like, everybody - people that use morphine are the down's and they pretty much stick to themselves. And the people that use cocaine or other up's - they stick to themselves and it's just sort of like...you stick to your own kind. We pretty much keep to our own little groups.
> S: Why do you think you all keep to your own little groups?
> I: It's just that people who prefer the down will just relax, sit down and watch a movie while they're high. And the up are bouncing around and off the walls, and they've gotta do this, and they've gotta do that. They get real paranoid. So, it just doesn't match to have the two groups in the same room. People that like to get high on morphine or heroin or anything don't trust people that are on cocaine. And people on cocaine don't really trust people that are on morphine or heroin 'cause you just sleep, and you

> know...it's two totally different circles. Some people enjoy the both of them. So, they're in both the circles.

In my interviews, I pursued information about the linkage between sense of community and concern for others regarding HIV/hepatitis transmission. Specifically, I wanted to know if the IDUs felt enough concern for other IDUs that they would make an effort to intervene in behaviour placing another at risk of HIV/hepatitis infection. One IDU with hepatitis C explained his willingness to disclose his serostatus in order to preserve the health of another IDU:

> I don't let anybody near my blood. You know, I know enough to prevent that. I have never, ever been shy about telling...if I was hurt or something, telling somebody, "Look, I have hepatitis C. Don't touch my blood." You know, that's never bothered me.

One IDU reported that he knows of another male prostitute who continues to trade sex for money despite knowing that he has HIV. The informant expressed disgust with his acquaintance and did not feel like making the effort to convince his acquaintance to stop working the strolls:

> I: I know this asshole guy who has HIV but he's still working the stroll like it's nothing.
> S: Have you ever tried to convince him otherwise?
> I: He's gotten to the point that I can't even tolerate talking to him because everything has to do with drugs and where he's going to get his next hit. I just don't want to have anything to do with him. My life is my life. And how they get so far into drugs that they don't really care about what they get, I really don't know. Because my life is my life. And if people are into it that much and want it that badly, that they have no concerns, I really can't be bothered with them.

Another IDU articulated his belief that an IDU with HIV should not be stigmatized and should not feel ashamed in admitting his/her serostatus:

> I know some people who have AIDS or HIV and they don't want to tell you that. Whether it's out of spite, or...they think they've got it, so

> everybody else should have it. As you know, misery enjoys company. Versus, this guy who we're talking about who's had it so long, he's right up front...he says: "Listen, I'm homosexual and I have full-blown AIDS." You know, so right away you're forewarned, you know. So, naturally you don't say: "Oh, do you have a needle I can use?" But some people I know will not admit it. I don't know why. I know if I had it, I would tell people: "Listen, you know, I've got HIV, or I've got AIDS." You know, it's nothing to be ashamed of. Anybody can get it. But some people are ashamed of it so they don't tell anybody. It's silliness.

Some of the IDUs that I interviewed stated that they had at one time or other attempted to act as peer educators or service deliverers and felt frustrated in their attempts to positively influence other IDUs. One IDU described how he tried to recruit non NEP-clients to use the SafeWorks program and explains his motivation for wanting to help others reduce the risk of HIV or hepatitis infection:

> S: Do you educate those guys that don't use the NEP?
> I: I try, but it's like having a conversation with Santa Claus. I get more answer out of that guy there, than some of these mucks.
> S: Why do you think that is?
> I: They don't care. They don't care. They have their own way of looking at things and I'm not going to try to help anyone. If they want to listen to me, fine. And if they don't, that's fine too. It isn't as though I don't care. It's just I am trying to, and it usually doesn't work out.
> S: So, why do you care?
> I: I care because I'm part of the human race, and like, I have been down so far that it has started to look like up to me. And I don't want that to happen to anybody that I know. And if I can intercede and you know, head it off at the bat, so to speak, I will.

Another collective exchanger expressed his dismay in his failed attempts to reach the fellow IDUs whom he tried to educate:

> They are on the outskirts of society. They are so paranoid. It sort of makes me sad, you know, because I sort of know these individuals and I might not like a lot of them, you know. They don't have to like me. I'm not the best man at all, but I'm a sensible man, anyway, I do think I'm sensible. And if I happen to give somebody some advice, it's usually sound advice. And it hurts if you're giving somebody advice and you find out that they're throwing it out the window. That hurts me, that hurts me emotionally.

One informant explained that she feels concern for other IDUs and has an interest in helping her fellow cocaine users try to reduce the risks of HIV or hepatitis transmission.

> S: Have you ever seen anybody dip into the bucket for a used needle?
> I: God, no, I've never seen that. If I ever seen that, I'd slap them. "What is wrong with you? Here, take one of mine." No, actually I've never seen that and I'd be pretty upset if I did. Because I think that people, even though they are users, I think that they should care about themselves. I think that even though you're an addict I think you should be able to look at your own life, think about your own life, and things you want to do with your life. Don't let yourself get away with it. It's not worth killing yourself over.

Other IDUs don't feel responsible for preserving the health of others, but rather see risk reduction as an individual responsibility. One informant, quoted below, shared a needle with her sexual partner and felt little responsibility for transmitting hepatitis C to her partner through needle sharing:

> Oh, she was really choked at me. I said: "Listen, I didn't even know I had hep myself. How the hell was I supposed to know? And besides that, you were the one who wanted to shoot up my blood, so get lost." You know? If you want to use my needle, you're just shit out of luck.

The attitude of the above informant is in sharp contrast to the concern expressed by the previous informants who felt a moral responsibility to help other IDUs reduce the risks of HIV or hepatitis infection.

V. IMPLICATIONS FOR INTERVENTION PROGRAMS

Behavioural adaptations appear to be most likely to succeed when they are ubiquitous and endorsed repeatedly by trusted members of the community. Thus, if clean syringes and bleach are readily available in the environments where IDUs inject drugs, and if they have accepted the use of these materials as in their best interest and not overly intrusive to their routines and habits, adaptive behaviour can be encouraged. I hope that

this ethnographic data can be used by program planners and policy makers to understand the social organization of drug use in the Calgary community before refining their intervention plan and entering the communities. If, as has been suggested, the social context of needle use is what will define the trajectory of HIV epidemics among IDUs, the strategies we develop, and our conceptual orientation to the task of prevention must confront the social realities of drug-using subcultures.

In a San Francisco NEP, the work of Community Health Outreach Workers (CHOWs) penetrate the social circles of IDUs and develop a meaningful role within them. The role of a CHOW is of health educator and advocate. These CHOWs would have a range of health promotive roles, from making referrals to drug treatment programs to specific instruction and distribution of risk reduction materials, to explicit instruction in safer sex. Ideally, risk reduction programs would use the existing social networks of IDUs as a primary mechanism for the diffusion of HIV/hepatitis risk reduction knowledge (Watters et al., 1990).

That social processes are important in changing HIV/hepatitis risk behaviour is also consistent with the intrinsically social nature of both illicit psychoactive drug injecting and sexual relationships. IDUs teach each other about how to inject drugs, share information about obtaining drugs, and often actively cooperate in obtaining drugs and injecting equipment. The findings reported here strongly suggest that AIDS prevention programs for IDUs should explicitly incorporate social-influence-oriented change processes (Des Jarlais et al., 1995).

Within a social change approach, it would be important not to limit the numbers of needles and syringes that could be exchanged per visit. The NEP staff could identify

persons who were regularly exchanging very large numbers of syringes (and presumably distributing injecting equipment to other IDUs) and encourage collective exchangers. These high-volume exchangers could then be given special training in information about AIDS, proper injecting techniques such as the use of alcohol wipes, discussing risky sexual behaviour with other IDUs, and in encouraging IDUs to come to the NEP for other services. They would also be encouraged to take alcohol wipes, condoms, and other supplies to distribute to other IDUs. Thus, they would be considered as unpaid auxiliary outreach staff for the NEP. Prevention programs can enlist influential members of drug-user networks to act as agents for other members. They can also recruit members of frequently interacting networks of IDUs for group-level interventions. Building upon social processes to change behaviour offers a major advantage: it utilizes peer influence to initiate and maintain behaviour change, rather than requiring the prevention program itself to directly and repeatedly reach all persons at risk (Des Jarlais et al., 1995). The psycho-emotional benefits of acting as a peer outreach worker (collective exchanger) may alleviate feelings of stress, and even assist that collective exchanger in addressing his or her own drug addiction (Berkman, 1984). Safer injection behaviours for IDUs lead to healthier behaviours in other areas of their lives. These include practicing safer sexual behaviours, raising self-esteem, caring about themselves and others, improving both physical and emotional health, developing better personal hygiene and seeking healthier living environments (Lloyd et al., 1994).

Health promotion practitioners could begin adopting an empowerment education approach. The first step is listening to IDUs' life experiences and making IDUs into co-investigators of their shared problems in their community. This ethnography has made an

important contribution to this important first step. The problems and barriers identified in this ethnography could become the basis for health promotion program planning or policy changes. Secondly, dialogue could be developed about issues identified during the listening phase in a way that health practitioners and IDUs participate as equals to interpret the community's problems together. IDUs in this way will begin to develop a belief that they can make a difference in their own lives and in the lives of other IDUs.

One positive example of empowerment activities is the "Street-Hype" newsletter published by SafeWorks that involves input and feedback from IDUs as to its content concerning health and street issues. IDUs are invited to periodic meetings (with free pizza as an incentive to attend) to discuss their concerns and information that they would like to see disseminated through the newsletter.

VI. CONCLUSIONS

As a community, IDUs generally are motivated to prevent HIV or hepatitis infection. Presently, peer education and health advocacy occur on an informal basis. There are certain highly motivated individuals in the IDU community who have a strong commitment to making individual efforts to help others reduce the risks of HIV and hepatitis transmission. Key figures who adopt these roles, such as collective exchangers, could be encouraged to act as outreach workers as part of interventions which place IDUs and their everyday lives at the core.

Intervention programs can and do operate without enlisting the support and leadership of IDUs. However, programs such as NEPs could be more effective if drug users were actively enlisted to help in 1) distributing risk reduction materials, 2)

disseminating health and street information, and 3) guiding the direction and policies of programs. IDUs have the potential to organize, but attempts to involve IDUs in risk reduction programs must take into account the impediments of poverty and stigmatization. IDUs are more likely to focus their energies on survival than organizational activities, such as attending meetings. However, creative incentives for IDUs to become involved could be effective in recruiting their assistance. I would speculate that the IDUs currently involved in collective exchange could possibly be willing to become more involved in a peer education role.

CHAPTER 9 – DISCUSSION

I. CONCLUSIONS

The primary mode for HIV and hepatitis transmission among IDUs is the sharing of contaminated injection equipment. These activities take place under social conditions that vary widely among different groups of IDUs. This ethnography has allowed me to describe the social context, or the collective features of the social and physical environments that define the social and behavioural characteristics of and settings for injection drug use and risk for HIV/hepatitis infection in particular social groupings. Although I have presented four vignettes which encompass the range of social contexts relevant to my informants, there are possibly many more contexts which could be seen to impact on HIV/hepatitis risk reduction behaviours. As shown by the vignettes, injection locations are varied among IDUs. Some inject in several variable locations such as apartments, shooting galleries, public washrooms, cars, or parks. Others inject in fewer and more stable places, such as their apartment or a friend's place. Some inject in large shooting gallery settings with up to 50 strangers, while others inject only within small friendship circles. These injection settings and patterns of locations have immediate consequences on risk-taking.

This ethnographic study has examined the specific social environments that constitute separate ecologies of risk for different subgroups of IDUs. The ethnographic findings demonstrate how variations in injecting practices in different social groups are influenced by cultural, social, and economic factors. This ethnography provides a contextual understanding of drug-taking, the role, meaning and significance of drug use among different groups of IDUs, the culture of drug use, and the stages and form of

addiction among different IDU subgroups. In the social context of the contemporary drug scene, needle sharing is a common behaviour among IDUs; however, some types of individuals are much more likely to share than others, some social contexts promote needle sharing more than others, and the users of some drugs administered intravenously are more likely to share than the users of other types of drugs. The most common reason given by IDUs who share needles despite their awareness of the risk of HIV or hepatitis transmission is that they needed to get a hit of their drug and had no clean needle available.

There is an informal network of secondary distribution of new syringes, intimately linked to the NEPs. Some IDUs get their new syringes from their dealers or even from the shooting galleries where they go to purchase and inject their drugs. Some dealers are known to provide new syringes together with the drug for immediate use. The social interactions of IDUs concentrates around the multiple exchange strategies between them, particularly lending drugs to one another when one or the other is short of a drug supply, or offering sexual services for drugs. Some IDUs obtain a limited number of syringes (for example, as many as will fit in one's coat pocket) for their short-term needs, while others take a greater quantity (in the hundreds) for personal use and/or collective exchange. Users who run out of new syringes are more prone to sharing with others. It appears that users who engaged in collective exchange were more aware of high risk behaviours and put more energy into health maintenance and hygiene than individual exchangers do. Individual exchangers are more driven by situational determinants (such as the availability of drugs), while collective exchangers have included getting clean needles in their daily life as a planned activity.

The IDUs who have unpredictable usage patterns are likely to go through the sequence of first obtaining the drugs, and then having to find a syringe. Needle sharing depends both on practical factors such as the inability to access new needles and not owning a set of works, in addition to attitudes conducive to sharing (e.g., low tolerance of withdrawal symptoms, concern about insulting friends, fatalistic beliefs). In general, the qualitative data confirmed the findings from other investigators that peer group behaviour, not owning injection equipment, fatalism, and more severe drug addictions were correlated with needle sharing behaviours (Brook et al., 1996).

Numerous findings support the value of primary prevention programs that will reinforce peer norms among IDUs. This research project was conducted in order to describe and understand the role of other IDUs, drug dealers, family members, sexual partners, and crack house landlords in promoting or facilitating risk reduction strategies among IDUs. All of these people can be seen as potential caretakers (Watters et al., 1990) for an IDU and can provide encouragement of risk reduction through referral to drug treatment programs, specific instruction in and distribution of materials for disinfecting injection equipment, distribution of sterile needles, and explicit instruction in safer sex.

II. IMPLICATIONS AND RECOMMENDATIONS

The results of this ethnography could lead to improvement of health care for IDUs through culturally sensitive practices, respect for other's perspectives, and better targeting and tailoring of interventions. This ethnographic study has lead to a better understanding of health beliefs and practices of the IDU community, as well as a better understanding of health and illness behaviours.

A. Peer Outreach

A viable and worthwhile program goal of the local NEP could be to use preexisting social networks of IDUs as a primary mechanism of knowledge diffusion and risk reduction material distribution. Programs might try to integrate drug users in policy-making, program development, and program evaluations. Creating dialogue among motivated IDUs is an important first step towards involving them more actively in peer outreach programs, as suggested by one of my informants:

> I think they need to talk about...I think that a whole bunch of drug users should get together and discuss it. I think they need to be made aware, fully aware, of all the risks. That's what I think CUPS should do once in a while. They should put a big ad up there on the window, get some AIDS people in there, that would be a seminar on that for people who really want to know, addicts that want to know and do something about it. It doesn't necessarily have to be only for IDUs, it could be prostitutes, it could be anybody.

Outreach projects which are community oriented seem to have particular promise. Outreach might include working outside of normal service settings, on the streets, in pubs, clubs, cafes, shooting galleries, or other venues where IDUs congregate. Such outreach services would offer provision of syringes, bleach, condoms, on-site testing for HIV or hepatitis, and the provision of advice and counseling. The NEP could hire staff, or at least recruit volunteers who are recovering addicts or other persons familiar with the drug-using community as outreach workers.

Engaging IDUs in peer-group-directed prevention efforts is both feasible and promising (Grund et al., 1992). In Calgary, collective exchange occurs when: 1) IDUs exchange for other IDUs who inject in the same site; 2) drug dealers exchange for their customers; 3) dope house, safe house or shooting gallery owners exchange for "friends"

who use their houses. Collective exchange is partly responsible for the high exchange rates at the SafeWorks program (usually around or over 100%), i.e., the NEP receives at least as many used needles as it gives out clean ones. The Edmonton Streetworks Program uses "natural helpers" within the drug using community, who are people with a deep understanding of the social networks of IDUs (Taylor, 1997). The "natural helpers" are either users themselves or live in close proximity to IDUs. They have an information base that is a mixture of street lore and health knowledge, which is integral to them being able to create a kind of underground health care delivery system. The goal of the Edmonton Streetworks Program is to assist natural helpers get IDUs information and tools for safer sex and injection practices, and to keep them safe and healthy in their sometimes risky work. Natural helpers experience increased confidence and self-esteem as a result of their health promotion involvement (Taylor, 1997).

As we move through the second decade of the global HIV/AIDS epidemic, refinement of targeting and prevention strategies, including creating a social environment conducive to change, is required. Program planners might consider using existing social networks of IDUs as a primary mechanism for the diffusion of HIV/AIDS risk reduction knowledge and materials. Behaviour changes can not be explained without taking into account the specific social environments contexts in which these behaviours occur (Stimson, 1992). NEPs that target the individual only are inadequate in addressing the multiple social influences upon risk reduction. Targeted interventions would be enhanced significantly by creating a social environment conducive to behaviour change, such as through the support of helping relationships and the use of counterconditioning (Prochaska & Norcross, 1994). Helping relationships are those in which an individual

helps the IDU identify ways in which the IDU can change his or her behaviour or environment in healthier directions (see p.107). Counterconditioning includes stimulus control, or managing the presence or absence of situations or cues that can elicit risk assumption behaviours, such as choosing not to frequent shooting galleries.

B. Program Recommendations

Local NEPs could be expanded to include as many clinics and pharmacies as possible, especially 24-hour pharmacies, in order to increase the availability of clean injection equipment. It would also be worthwhile to consider 24-hour operation of the SafeWorks program, as expressed by the following informant:

> Well, if SafeWorks was open 24 HOURS a day, that'd be great, because the coke dealers are out 24 hours a day. So, when you run out, you run out, you know. You've got no bleach, you've got no money to pick up needles. What the hell?! You're going to do that drug anyway, because it's calling.

Other important prevention efforts include providing outreach worker services for IDUs and prostitutes, and drug dependency clinics with flexible prescribing regimes to stabilize dependent and chaotic users and to reduce their drug use. Even though I interviewed only one IDU who reported that he was HIV-positive, his situation highlighted several important issues for preventing adverse consequences of HIV. Individuals who are HIV-seropositive, especially those who are poor and/or homeless, need support emotionally, medically, and socially. Society needs to fight coercion and stigmatization through education, counseling, dialogue, acceptance, and togetherness. For example, the IDU who was HIV-positive was living in the homeless shelters and was faced by the significant challenge of obtaining three meals a day in order to take his medications which need to be taken with food. HIV treatment services should account for

the basic life challenges faced by IDUs and facilitate optimal treatment. It is most important for health promoters to use a multi-faceted approach such as: 1) providing user-friendly, culturally-attuned drug information; 2) providing counseling and support; 3) making health services as accessible as possible; 4) enlisting cooperation from the police; and 5) expanding the services of NEPs to reach more IDUs. SafeWorks Calgary has integrated its program with community-based health services at CUPS, 8th and 8th Health Centre, and AIDS Calgary, and provides a mobile van service.

It is important that the SafeWorks NEP encourage IDUs to take as many syringes as they think they will need and not to limit too strictly the number of syringes distributed. Although IDUs should be encouraged to use a new needle every time that they shoot up, if they do have to use a used needle, they should be encouraged to clean the needle with common household bleach. Health practitioners should allay fears of bleach by explaining the proper cleaning techniques (see p.124). Also, bleach should be distributed in bottles that are visually distinct from the bottles in which water is distributed in order to avoid possible mix-ups between bleach and water. Finally, IDUs need information about how to prevent, identify, and deal with overdose or adverse reactions to dirty hits (see pp. 146-147). Education could include how to prevent injecting dirty hits or excessive dosages; the physiological symptoms of an adverse reaction; basic first aid measures (such as rolling the IDU in the recovery position and ensuring an open airway); as well as the procedures that will follow if 9-1-1 is called for medical help. Newsletters distributed by the NEP would be an ideal medium for the dissemination of such information. Collective exchangers could also distribute pamphlets and put up posters in natural settings to help educate their peers.

C. Summary

In summary, there are two main areas of worthwhile recommendations supported by my findings: those concerning peer outreach, and those concerning existing programs in Calgary. Peer outreach should be encouraged by creating dialogue among motivated IDUs and involving IDUs in programming and policy decisions. Peers can facilitate HIV/hepatitis prevention among other IDUs not only by becoming involved in collective exchange, but also by disseminating information, counseling about the risks and consequences of HIV/hepatitis, and encouraging other IDUs to access health or treatment services.

Program-specific recommendations include extending the hours and locations of the NEP, providing extra assistance to HIV-positive individuals who are street-involved, and increasing education about bleaching and overdose prevention and management.

III. DISSEMINATION OF STUDY FINDINGS

In order to have an impact on decision-making in regards to the well-being of IDUs, the results, conclusions and recommendations of this ethnography must be disseminated to key players in the health, social, and justice systems. I will attempt to disseminate this study as widely as possible through three mechanisms: 1) a handbook of the four major vignettes and a description of the other important themes; 2) oral or poster presentations at conferences and to local service delivery agencies; 3) publication of journal article(s) in order to reach a national or international audience. The handbook of the vignettes will be given to local service agencies so that health care providers and counselors can gain a better understanding of the social context in which their clients are

living. Such an understanding will facilitate awareness of the multiple challenges that impinge on an IDU's attempts to reduce the risk of HIV or hepatitis transmission through the sharing of injection equipment. The service provider's awareness will lend sensitivity and (hopefully) creativity in their approaches to IDUs' behaviour change challenges.

To date, the study will have been or will be in the near future orally presented to: 1) the Canadian Society of Epidemiology and Biostatistics 1998 Student Meeting (November 21, 1998); 2) Department of Community Health Sciences M.Sc. students, University of Calgary (December 4, 1998); 3) AIDS Calgary HAS Coalition — Prevention and Education Cluster (December 9, 1998); 4) SafeWorks Calgary Needle Exchange Program (December 16, 1998); 5) Qualitative Methods Conference, Edmonton (February 18, 1999). Any presentations given prior to my oral defense and formal research review focused on methodological or ethical questions, applications of a behaviour change model, verification or validation of interpretation of data themes, and implications to the practice field. Any findings introduced were identified as "preliminary" and were presented for discussion purposes only. Presentations will also be made to nursing, social work, and medical students, the Calgary STD Clinic, downtown walk-in clinic staff, psychiatric emergency staff, and the Alberta Non Prescription Needle Use (NPNU) Consortium.

IV. BARRIERS TO PREVENTION OF RISK ASSUMPTION BEHAVIOURS

The behaviours studied in this ethnography must be understood within the context of the study community, where the rate of HIV infection among IDUs is fairly low, illicit drug use is policed yet the sale of injection equipment through pharmacies to prevent the

spread of HIV is not considered illegal, and HIV preventive education and a legal needle exchange program exists. In such an environment, social stigma and laws still contribute to covert injection drug use and reluctance among many to seek the assistance of service agencies or medical centres. Marginalization and stigmatization of IDUs, and especially of those who are HIV-infected are key barriers to progress against the epidemic. Compliance with safer practices is unlikely to occur until social, economic and psychological barriers that deter IDUs from accessing services are dealt with through legislative and policy change.

Many IDUs have personal perceptions of being at low risk for HIV infection. Also, many feel machismo cultural values. For some, risky behaviours provide pleasure or satisfaction, overriding potential negative consequences. Trust in personal relationships between IDUs and sexual partners works against safer sex or injection practices. Often, IDUs lack the negotiation strategies necessary to refuse sharing a needle with an injection partner or require a sexual partner to use a condom. Other IDUs have a fatalistic attitude about developing AIDS. Some of my informants related that many IDUs believe that luck plays the largest role in getting HIV or hepatitis. Risk behaviours can change under appropriate environmental contexts and also when the IDUs possess the necessary skills to exercise prevention knowledge.

V. FURTHER RESEARCH

I have presented four vignettes which encompass the range of social contexts relevant to my informants. There are no doubt other contexts which could be seen to impact on HIV/hepatitis risk reduction behaviours. Further study could include exploring

other important domains such as psychological, law enforcement, social services, housing, and economic contexts around injection drug use and HIV/hepatitis risk reduction. Policy makers and program planners need to address the fact that patterns of drug-using behaviour reflect powerful structural factors such as poverty, unemployment, and housing conditions. Further research would be worthwhile in studying the relationships between the various structural factors that interact upon drug users.

Much work on behaviour change needs to be done with newer recruits to drug injecting, occasional injectors (or "chippers"), those living away from high drug use urban areas, women, and those in the prison system. Most of the research to date has been conducted on continuing drug users, and little is known about the impact of AIDS awareness on initiation of and to injecting, on trends to less harmful routes of administration, or to abstinence from drugs. A worthwhile research endeavour would be to explore how experienced IDUs can be assisted in teaching risk reduction to new initiates into injection drug use. Further study could be conducted to explore how the events around initiation into injection drug use can be made safer.

Further research would be valuable for exploring more data about motivation to change injection behaviours, such as factors of perceptions of risk and concern about being susceptible to getting AIDS. Perceived vulnerability to HIV, a factor found to be a reliable indicator of future behaviour change by other investigators (Elk et al., 1996), was not investigated. Based on Prochaska's TTM, further studies could explore the stages IDUs go through in terms of changing needle-use behaviours. Cognitive readiness and awareness of the need to change personal habits are important constructs to apply in behaviour change interventions. Applying general concepts and terminology from the

"Stages of Change" model, participation in outreach intervention might help IDUs with sufficient cognitive readiness to advance from the "contemplation stage" — where participants are aware of a problem and are considering taking action — to "preparation and action" stages — where overt behaviours are changed (Prochaska et al., 1997). The implications are that by assessing intervention clients according to risk and motivation levels, it might be possible to tailor interventions more precisely to meet individual needs. In particular, persons with high risks but low motivation would need special efforts and engagement strategies. Intervention strategies need to be customized for the type of drug used, the kinds of settings the IDU frequents, and other situational or relationship constraints (Camacho et al., 1995).

Further research should also be performed about the effectiveness of prevention efforts approaching the problem of HIV infection among IDUs from three main levels: 1) primary prevention of HIV infection by encouraging safer sex and needle use, and making needle exchange available as widely as possible; 2) preventing the adverse consequences of HIV infection among IDUs, such as through increasing access and treatment services to HIV-positive individuals who are also addicted to drugs and preventing HIV-positive individuals from passing on their infections to other IDUs or to sexual partners; and 3) preventing conditions that place people at risk of HIV infection, such as improving the safety of natural injection environments, and intervening with youth to prevent the lifestyles of prostitution and drug addiction. For example, there should be further study of why people become enmeshed in the drug using lifestyle and how injection drug use can be averted from a social intervention viewpoint.

Interventions that are conceptually based and group-specific and that provide

information, motivation, and behavioural skills, have the most impact on risk reduction behaviour. An intervention that encompasses these aspects, therefore, needs to be developed in this high-risk population (Elk et al., 1996). This study highlights the need to refine and target prevention strategies, including the creation of a social environment conducive to behaviour change. Interventions need to be targeted to consider the characteristics, attitudes and behaviours among specific subgroups such as prostitutes, heroin users, morphine users, and cocaine users. Evaluation and intervention studies are necessary to identify the most effective program components. Further studies of HIV or hepatitis risk reduction must investigate ways of making treatment and risk reduction programs more accessible. This could include evaluation of services which have attempted to make themselves more "user friendly." Those services which have attempted to identify and remove perceived barriers, including fear of law enforcement consequences, that keep people away from services could also benefit from some exploration of outcomes.

Finally, based upon my findings, a viable and valuable extension of my research would be to help develop a peer education or peer outreach program to expand the reach of the existing NEP. Further research would be necessary to design an incentive-based peer outreach model that would facilitate the distribution of risk reduction materials, counseling, and education by "natural helpers" (Taylor, 1997). Although peer outreach does occur to some extent in Calgary via collective exchangers, there is no formalized program specifically targeted to facilitating such important health promotive activities.

VI. STRENGTHS AND LIMITATIONS

There are strengths and weaknesses in any study. I will discuss those relating to this ethnographic investigation under two main categories: sampling and data collection.

A. Sampling

My original intent was to sample both NEP clients and non-clients. I had planned to first recruit collective exchangers and then use snowball sampling to recruit IDUs for whom collective exchangers supplied needles. However, as sampling progressed and I continually asked collective exchangers to refer me to a non-client IDU, it became clear that I would not be able to access IDUs who were not clients. Therefore, I over-recruited highly motivated participants in terms of their AIDS concern and awareness, and was not able to gain the direct data of non-clients. If I were to do this study again, for example, in another city, I would make more efforts to recruit non-NEP clients. Recruiting non-clients would require allowing myself a longer period of time for data collection, through several rounds of interviews, first with clients of the NEP, and then with acquaintances of the clients who do not use the NEP (via a process of snowball sampling). Information from non-NEP clients would be valuable for exploring the reasons why many IDUs are reluctant to use a NEP, and what barriers exist for IDUs in accessing NEPs.

As a result of my selection bias towards highly motivated individuals, the social contexts and situations may be much more high-risk than reported by my sample of highly motivated IDUs. By interviewing only the motivated elite, I may have heard about injection behaviours that were biased towards risk reduction beyond the levels of safety exercised by the general population of IDUs.

However, I was successful in gaining an understanding of the motivations behind

collective exchange and was able to describe in detail the important role played by the motivated elite among IDUs. And despite being unable to directly interview non-clients, I was able to gain an understanding about barriers to accessing the NEP indirectly through interviews with NEP clients. Of course, all IDUs who use the NEP at one point did *not* use the NEP for various reasons, and thus were knowledgeable from their own experiences about why other non-NEP clients would feel reluctant or be unable to access the NEP. Therefore, what originally appeared to be a weakness in my sampling, turned out to be a strength in that I was able to gain an in-depth understanding of the motivations of collective exchangers. This information will help readers to design programs that take full advantage of the health promotive potential of collective exchangers.

Regarding the possibility that the social contexts reported by my motivated elite informants may be exaggerated towards risk reduction behaviours beyond the levels of risk reduction practiced by the overall IDU population, there are again possible strengths associated with this sample. Descriptions of social settings with high levels of risk reduction can serve as important examples of how injection drugs can be administered in a safe and responsible social setting, and lend hints to service providers of how to improve less safe injection environments. Despite the fact that I only interviewed the motivated elite, I gained numerous reports of highly risky injection behaviours that have either been practiced by my informants themselves, or have been witnessed by my informants.

Another way that the sampling could have been expanded would be to include purposive sampling of various ethnic groups, especially First Nations IDUs. I was able to recruit only two interviews from IDUs of First Nations ethnicity and heritage. This

subgroup of IDUs would face social barriers above and beyond other IDUs because of the combined challenges of their ethnicity, social class, neighborhood of residence, level of educational attainment, economic well-being, cultural orientation, and access to health care and health information. Although it may require extra effort to develop rapport with First Nations IDUs, the extra effort would be worthwhile in gaining the perspective of people who face a multitude of social, political, financial, and structural barriers.

Other than under-sampling First Nations people, I was able to gain the perspectives of a wide variety of IDUs for various drugs of choice, gender, duration of injection drug use, HIV or hepatitis serostatus, adult age ranges, and age at initiation into injection drugs. Although I interviewed a range of adult ages, I would have liked to interview more youth, especially recent initiates into injection drugs, as most IDUs begin injection drugs in their teens or early 20s. However, this investigation was limited to participants 18 years of age or older by the University of Calgary Conjoint Health Research Ethics Board to protect the human subjects.

B. Data Collection

As the researcher in a qualitative study, I was the facilitator and the interpreter of information derived from the experts, the interview participants. Ethnography depends on the skill and creativity of the ethnographer as observer, interviewer, and writer in order to successfully introduce the reader to new feelings, new communities, and new cultures (Kotarba, 1990). The method of open-ended, unstructured interviewing employed by qualitative research had many advantages for the study of the social context of IDUs. The open-ended interviews involved free recall, where the respondent received no prompts

from the interviewer on the desirability of certain answers. All description began as neutral and I made a conscious effort to keep all queries neutral in tone. The open-ended interview format allowed for deep and rich exploration of IDUs' drug experiences.

Ethnographic research usually involves participant observation as a primary data collection source. Due to the illicit nature of IDUs' behaviour, I limited my role in the study to that of a researcher with little personal involvement, as a passive observer, "on the sidelines," who does not influence events in the field. In the criminal context of injection drug use, participation in injection behaviours was neither feasible nor desirable. This study was limited to in-depth interviews for data collection; participant observation was not a viable method of data collection in the study for several reasons: (1) concerns for my own personal safety and it was not advisable to conduct interviews and observe participants in their own homes or within natural settings such as shooting galleries and crack houses; (2) inadequate time to integrate myself into the IDU culture and develop the necessary level of trust necessary for direct observation of injection behaviour; (3) I was not so much interested in the objective reality of what occurs in IDU settings and situations which requires direct observation as in gaining the subjective viewpoint of the IDUs, i.e., how they perceive the social settings and situations with respect to HIV risk reduction or risk assumption; and (4) there would have been a strong reactivity effect, i.e., my presence as an outsider would undoubtedly influence the injection and other behaviours of the people being observed and I would not be achieving a "real" picture of natural settings and situations.

Another limitation of my data collection was that I only interviewed informants in public places, such as noisy coffee shops, restaurants, and even a pool hall. Although

such interview locations were essential for ensuring my personal safety, I believe that I may have lost some valuable information by limiting my interview locations to public places. Because I did not visit IDUs in their homes, I did not collect any observational data, which would have been a valuable supplement to my interview data. Also, by having to meet at public locations, I lost at least one informant who refused to be seen in public because she feared a man who had been stalking her. Also, I experienced frustration in attempting to meet with informants. Often, I would have to make three or four attempts at meeting an informant before I was successful. The informants would either be late for the appointment, cancel at the last minute because they were sick, or forget about the arrangement altogether. In my field notes, I journaled that I felt frustrated and even annoyed in my many attempts to meet up with informants for interviews, and I acknowledge that my annoyance may have affected the interview, if not in its content, then in its tone. I believe that I would have had greater ease in meeting my informants if I had been able to go to their homes to conduct the interview, rather than requiring them to travel to a public location.

However, I acknowledge that the limitations placed upon my data collection were warranted and necessary for several reasons: 1) I was a novice researcher in the subject area, as well as with the study methods; 2) the natural settings of injection drug use are perceived as dangerous settings for a female on her own; and 3) both the University of Calgary and the Calgary Police Service had liability concerns that had to be considered. If I were to continue my studies with this population, I would make attempts to become more of an insider and incorporate some participatory action research in further investigation. This M.Sc. thesis research has given me invaluable research experience and

has helped to establish my credibility as a researcher in this field and as a trusted observer of the IDU culture.

VII. SUMMARY

The information provided in this study of the social context of IDUs provides information to guide program planners in developing services based on behaviour change models to modify high risk injection behaviours. The research purpose of this study was particularly well suited for a qualitative study. The goal was to gain an understanding of the particular contexts within which IDUs act, and the influence that these contexts have on their actions. I was able to understand through a small number of in-depth interviews how events, actions, and meanings are shaped by the unique social circumstances in which these occur. Informing individuals about behavioural risks is a necessary, but not sufficient, component of effective risk reduction efforts. This ethnography has highlighted elements of knowledge, motivation, and personal/social environment barriers as important determinants of behaviour changes. In studying the social context of IDUs, we should not consider social relationships, initiation into injection drug use, social settings, or knowledge and attitudes about HIV/hepatitis prevention in isolation. Therefore, in writing the vignettes, I tried to capture the multi-factorial interactions of the relevant individual and social forces in order to reflect the real lived experiences of my informants.

VIII. FINAL REFLECTIONS

I learned many important lessons and have experienced fundamental changes in myself through the course of this ethnography. I have learned some valuable research

skills and gained a deep appreciation for the power of qualitative methods for exploring another culture. I have also learned what it means for IDUs to be part of a community and the strong role that certain motivated individuals play within the IDU community in protecting or improving the health of others. I confronted the dilemma between making injection drug use safer for addicted individuals (as in risk reduction) and promoting the end goal of overcoming their addiction and ending their drug use (as in abstinence). I realized that the formidable task of overcoming an addiction will only be confronted if IDUs first can gain control over their injection practices in that their injection behaviours are as safe and healthy as possible, and reduce their street and criminal involvement. Finally, I learned that IDUs are individuals with hopes, dreams, and needs that are often overlooked by mainstream society as IDUs are labeled and stigmatized because of their drug addictions. I will conclude with one final quote from an informant:

> I treat the needle with a lot of respect. But you know, it already took a part of my life away. I mean, I feel unhealthy. I don't have my bright smiley eyes anymore. It's a bummer because I haven't done anything wrong. It's not my fault where I was born and who my mom and dad were and it takes a while to develop the fact that, hey man, you had a screwed-up life, dysfunctional, how can I make it right? And I have made my mistakes. But right now, like I said, I'm paying for them - big time. But I hope there's an ending to this.

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Interview # 9

APPENDIX A

INTERVIEW CHECKLIST

- ✓ Interview Guide
- ✓ Consent Form
- ✓ Tape Recorder
- ✓ 2 Tapes
- ✓ 2 Sets of Batteries

TIME 2:00 pm
DATE April 7/98
PLACE CUPS

1. Log interview time / place.
2. Introduction (build rapport)
3. Ask interviewee to read consent form
4. Test microphone
5. Ask interviewee to paraphrase contents of form
6. Start with casual questions. CHECK IF TAPE IS RUNNING.

NOTES

Couple - male & female [mid-30s], wanted to be interviewed together. 3rd attempt to meet - successful finally! First time we were to meet (2 wks ago), they showed up 1½ hr late and I had to leave for class. The 2nd time (last week), they showed up an hr earlier than we had agreed. They left rather than wait because they felt uncomfortable hanging around old acquaintances from the drug scene - they're trying to get off coke & felt tempted to buy (had rent $ with them at the time). So my frame of mind today: annoyance, but wore off after they explained last week.

- Good data overall. ♀ did all the talking, had to really probe ♂ to speak up.
- Evidence of chaotic lifestyle: difficulties in mtg up with me for an interview. But they (esp ♀) were very willing & eager to participate.
- ♂ started using T's & R's (?) ← Talwin and Ritalin
  Talwin - synthetic opiate ("poor man's high")
- not current IDUs, quit one year ago, but

still valuable as informants who are familiar with IDU scene - can perhaps give ♀ perspective of ex-users who have "gotten out" and can look back with a different (outsider (?)) perspective.

- ♂ admitted to needle sharing → hep C
  ♀ claims to never have shared, but attributes hep C to being in a fight (biting?), then later says maybe from sharing spoon or filter.

N.B. "sharing" = sharing <u>needles</u>. IDUs I've talked to don't mention other equipment (e.g. filter, spoon)
* Interesting data: that morphine users are <u>more careless</u> about needles than coke users ∴ ∴ more likely to transmit HIV. Opposite data from all others so far. Good data from IDUs who have tried both Coke & Morphine scenes.

<u>SOCIAL FORCES</u>

- don't consider other IDUs as friends
- bad 1st experience (overdose) @ initiation, didn't note where needle came from.
- mistrust among IDUs
- did drugs as a way to meet friends
- reluctant at 1st to use NEP
- discomfort being around CUPS when trying to get off.

<u>Further Q's</u>

→ "What kind of help do you need when you try to get off the coke? Did anyone help you?"

→ "Do you feel a sense of community with other IDUs?"

THE UNIVERSITY OF
CALGARY

Faculty of Medicine
Office of Medical Bioethics

1997-12-18

Dr. A.R. Vollman
Department of Community Health Sciences
The University of Calgary
Calgary, Alberta.

Dear Dr. Vollman:

RE: The Social Contact of HIV Risk Assumptions and Risk Reduction Strategies Employed by Injection Drug Reviewer
Student: Ms. San Patten Degree: MSc

The above-noted thesis proposal has been submitted for Committee review and found to be ethically acceptable. Please note that this approval is subject to the following conditions:

(1) a copy of the informed consent form must have been given to each research subject, if required for this study;
(2) a Progress Report must be submitted by 1998-12-18, containing the following information:
    (i) the number of subjects recruited;
    (ii) a description of any protocol modification;
    (iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
    (iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
    (v) a copy of the current informed consent form;
    (vi) the expected date of termination of this project;
(3) a Final Report must be submitted at the termination of the project.

Please note that you have been named as a principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Ian Mitchell, MB, FRCPC
Chair, Conjoint Health Research Ethics Board

cc: Dr. L.R. Sutherland (information)
Ms. San Patten

C:\OFFICE\FORMS\THESIS.WPD

APPENDIX C

CRHA
Calgary Regional Health Authority

Population Health

November 7, 1997

Ms. San Patten,
Student,
2035 - Ursenbach Road N.W.
Calgary, Alberta
T2N 4B7

Dear Ms. Patten:

Re: Thesis Proposal

Regarding the above Thesis Proposal, I am pleased to inform you that you are approved to proceed with your study.

We wish you the best, and look forward to receiving a copy of your report.

Sincerely,

Charlotte Kenney, Secretary
for Dr. Sandra Gutsche
Leader,
Health Assessment and Surveillance

320 - 17 Avenue S.W., P.O. Box 4016, Station C, Calgary, Alberta T2T 5T1
Tel: [403] 228-7400 Fax: [403] 541-6621

APPENDIX D
RECRUITMENT PAMPHLET AND POSTER

VOLUNTEERS NEEDED FOR STUDY

"The Social Context of HIV Risk Assumption and Risk Reduction Strategies Employed by Injection Drug Users"

30 min to 1 hour interviews

You can provide valuable information that will help us prevent the spread of HIV.

Please call San Patten if interested in helping!
830-9710

APPENDIX E

ORIGINAL INTERVIEW GUIDE

My study is about the social scene of injection drug users in Calgary. We need to understand the social context so that we can improve HIV/hepatitis prevention programs for IDUs. I will be asking you questions about your drug use, your injection practices, and the Calgary community of IDUs.
Please read the information sheet carefully. It tells you about your rights in participating in this study. [allow informant to read form]
I have to stress the point that even though I will keep anything that you tell me confidential, the Calgary Police could subpoena my records. So, we just have to make sure that you don't use any names, places or dates when you answer my questions. Also, we will not have any record of your real name. Give me a name that you'd like me to use as a code name.

DRUG USE QUESTIONS

- Which drugs are you currently using? Which drugs have you used before?
- How long have you been using injected drugs?
- Are you trying to make any changes in your drug use patterns?
- Where or from whom do you usually get your drugs?

SOCIAL SCENE QUESTIONS

- Please tell me about the scene where you shoot up most often.
- Who do you usually inject drugs with?
- Where do you usually go to inject drugs?
- Indoors / outdoors?
- Private home / shooting galleries?
- Your home / someone else's home?
- What kinds of settings do you inject drugs in? Anyplace else?
- What is it like in those settings? What happens there?

SHARING QUESTIONS

- Have you ever shared needles/cookers/water with another IDU? Are you currently sharing?
    - [if yes] Why do / did you share the needles, etc.?
    - [if yes] How long have you known the person you're sharing with?
    - [if yes] What makes you trust them enough to share their needles, etc.?
    - [if no] How have you avoided sharing needles, etc.?
- Do you ever share drugs with other IDUs? How do you split up the drugs?
- What kinds of situations or places are most tempting for sharing needles?

NEEDLE USE QUESTIONS

- (for NEP clients) Do you exchange needles for other IDUs?

  - [if yes] Who do you usually exchange needles for?
  - Why do you exchange needles for them?
- (for non-NEP clients) Why don't you use the NEP?
- (for non-NEP clients) Why do you think other IDUs don't use the NEP?
- (for non-NEP clients) Where do you get your needles from?
- What is normally done with the used needles where you go to inject?
- Do you know of any ways to kill HIV or HEPV in the needle between sharing partners?
  - (if yes, bleach) How did you learn to do this?
  - Who taught you?

SOCIAL INFLUENCE QUESTIONS

- About how many other IDUs do you know? How close are you with them? Would you consider them to be your friends?
- Are there people that are 'central characters' in the drug scene (people that everyone knows)? What kinds of roles do they play in the drug scene? (Dealers? Owners of shooting galleries or dope houses?)
- How do other IDUs influence what you do with your needles? Do they influence you in a positive or negative way?
- How do you influence other IDUs when it comes to what they do with their needles?
- Do you ever feel pressured to use needles either in a healthy or risky way? Who pressures you? How do you respond?
- Do you look to others for help with HIV risk reduction or do you believe it's your responsibility?
- How could others help you to be more careful about preventing HIV or hepatitis?
- What could you do to help other IDUs prevent getting infected with HIV/hepatitis?
- Are there certain people in the drug scene who provide more help than others with HIV risk reduction?
- (for collective exchangers) What difference does it make to you whether other IDUs have or use clean needles or not? Why do you care what others do with their needles?
- Do you know of people who have sold sex for drugs?
- Do you sell drugs? Syringes?
- Have you ever bought a syringe from another IDU or from a dealer?
- Do you discuss HIV/AIDS/hepatitis with others? What do you talk about?
- Do you know of other IDUs who are HIV- or hepatitis-positive?

INITIATION QUESTIONS

- How and when did you first start injecting drugs?
- Do you remember the first time you injected drugs? Can you tell me about that time?
  - Who was there? What was it like? Do you think it was done safely?
  - Did the person teach you anything about safe injection (like vein care or HIV/hep prevention)?

APPENDIX F
MODIFIED INTERVIEW GUIDE

Same preamble (New or modified questions in italics)

DRUG USE QUESTIONS
- How long have you been using injected drugs? Which drugs?
- Are you trying to make any changes in your drug use patterns?
- Where or from whom do you usually get your drugs?

SOCIAL SCENE QUESTIONS
- Please tell me about the scene where you shoot up most often.
- *How many people are there at any one time?*
- *Do you know everyone there?*
- Who do you usually inject drugs with?
- Where do you usually go to inject drugs?
  - Indoors / outdoors?
  - Private home / shooting galleries?
  - Your home / someone else's home?
- What kinds of settings do you inject drugs in? Anyplace else?
- What is it like in those settings? What happens there?

NEEDLE USE QUESTIONS
- *(for NEP clients) Where did you get your needles before you used the NEP?*
- (for NEP clients) Do you exchange needles for other IDUs?
  - [if yes] Who do you usually exchange needles for?
  - Why do you exchange needles for them? *Why do you care what other IDUs do with their needles?*
  - *Approximately how many people come to you for clean needles?*
- (for non-NEP clients) Why don't you use the NEP?
- (for non-NEP clients) Why do you think other IDUs don't use the NEP?
- (for non-NEP clients) Where do you get your needles from?
- What is normally done with the used needles where you go to inject?
- Do you know of any ways to kill HIV or HEPV in the needle between sharing partners?
  - (if yes, bleach) How did you learn to do this?
  - Who taught you?
- *What's the worst thing you've seen someone do with their needles?*

INITIATION QUESTIONS
- *Were any of your friends using injection drugs when you started?*
- Do you remember the first time you injected drugs? Can you tell me about that time?
  - Who was there? What was it like? Do you think it was done safely?

- Did the person teach you anything about safe injection (like vein care or HIV/hep prevention)?

SHARING QUESTIONS

- Have you ever shared needles/cookers/water with another IDU? Are you currently sharing?
  - [if yes] Why do / did you share the needles, etc.?
  - [if yes] How long have you know the person you're sharing with?
  - [if yes] What makes you trust them enough to share their needles, etc.?
  - [if no] How have you avoided sharing needles, etc.?
- Do you ever share drugs with other IDUs? How do you split up the drugs?
- What kinds of situations or places are most tempting for sharing needles?
- *Do you think there is a difference in needle sharing among people who are regular users or addicts vs. recreational users?*
- *Do you ever get so high that you forget or disregard needle safety?*

SOCIAL INFLUENCE QUESTIONS

- About how many other IDUs do you know? How close are you with them? Would you consider them to be your friends?
- *Do you feel a sense of community with other IDUs?*
- Are there people that are 'central characters' in the drug scene (people that everyone knows)? What kinds of roles do they play in the drug scene?
- How do other IDUs influence what you do with your needles? Do they influence you in a positive or negative way?
- How do you influence other IDUs when it comes to what they do with their needles?
- *How do others influence you when you try to quit drug use?*
- *Would people be insulted if you refused to use their needle?*
- Do you ever feel pressured to use needles either in a healthy or risky way? Who pressures you? How do you respond?
- Do you look to others for help with HIV risk reduction or do you believe it's your responsibility?
- How could others help you to be more careful about preventing HIV or hepatitis?
- What could you do to help other IDUs prevent getting infected with HIV/hepatitis?
- *What do you think people need to talk about?*
- Are there certain people in the drug scene who provide more help than others with HIV risk reduction?
- (for collective exchangers) What difference does it make to you whether other IDUs have or use clean needles or not? Why do you care what others do with their needles?
- Do you sell drugs? Syringes?
- Have you ever bought a syringe from another IDU or from a dealer?
- Do you discuss HIV/AIDS/hepatitis with others? What do you talk about?
- Do you know of other IDUs who are HIV- or hepatitis-positive?
  - (if yes) Do you know how they contracted HIV (sexual contact / needle use, etc.)?

APPENDIX G

CONSENT FORM

Research Project Title:
The Social Context of HIV Risk Assumption and Risk Reduction Strategies Employed by Injection Drug Users

Investigator:
San Patten (M.Sc. Student)

Supervisor:
Ardene L. Vollman, (Assistant Professor, Faculty of Nursing)

Sponsor:
Health Canada - National Health Research and Development Program
Department of Community Health Science, University of Calgary

This information sheet, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

- The purpose of this research project is to understand the social factors that influence injection drug users to practice risk reduction or risk assumption behaviours.
- Interview participants will be asked questions about their social networks and how they help others or are helped by others to reduce the risk of HIV.
- The interview will take about one hour and will be audio-taped with your permission.
- Please refrain from using any names, or other details that could identify people when you are talking during this interview.
- Being part of this interview is voluntary. Participants who are being interviewed will not have to answer any questions that they do not want to.
- If anything you tell the interviewer means that a person under the age of 18 needs help, San Patten shall have to tell this to the Child Welfare authorities.
- Being part of an interview will have no effect on your relationship with the needle exchange program or CUPS.

- San Patten will get information from the interviews. Your answers to the questions will be kept confidential and you will never be identified. A code will be used in place of your name on the transcripts. The audio tapes will be destroyed once San Patten has completed her thesis.

- San Patten will give you a copy of the transcripts from the interview and a copy of the final report for you to check over. At that time, you may tell San Patten if you have any concerns about the accuracy of the reports.

Your agreement to proceed with the interview indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

San Patten
Phone: 830-9710

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990, or the research supervisor at 220-8053.

A copy of this consent form has been given to you to keep for your records and reference.

CALGARY
POLICE
SERVICE

Community and Police
Working Together

1997 December 16

Ms. San Patten
The University of Calgary Faculty of Medicine
Department of Community Health Sciences
3330 - Hospital Drive N.W.
Calgary, Alberta
T2N 4N1

Dear Ms. Patten:

I have received your letter dated December 12, 1997 respecting your research on risk reduction strategies involving intravenous drug users. In your letter, you seek reassurances from the Calgary Police Service under four issues. I would like to address these separately.

- First, I can state that your activity will be brought to the attention of the various area commanders, so that they might brief the members of the respective patrol areas of the possibility that you may require emergency assistance.

- I can also state that I will advise area commanders that you are conducting research. I cannot, however, provide them with assurances that you will not be a party to any illegal activity. That will be dependent on your behaviour and it would be imprudent for any officer to provide a blanket indemnification for activities of others. I am attaching a copy of the definition of "trafficking" found under Section 2 of the *Controlled Drugs and Substances Act* for your information. The offence of trafficking is made out under a variety of circumstances and it would be in your best interest to thoroughly acquaint yourself with these prohibitions and ensure you do not become a participant in a criminal act based on ignorance of the law. Furthermore, persons who use controlled substances, especially those who use these substances intravenously, may be involved in criminal activities other than the offence of possession of narcotics. In the course of your interviews, the participants may engage in criminal acts in your presence. The extent to which you might be a party to an offence would be dependent on the specific circumstances at the time.

133-6th Avenue SE, Calgary, AB
Canada T2G 4Z1 (403) 265.3330

- I do not see any value in Calgary Police Service members following you as your research project evolves. I cannot give any assurance, however, that one or more of your interview subjects is not a target in an ongoing investigation. Hence, your activities might come under police scrutiny as a matter of coincidence. Moreover, conducting your research under concealment to avoid the possibility of police scrutiny could expose you to serious risk and harm. I trust you will take measures to avoid any unnecessary risks.

- I cannot guarantee that you would not have evidence material to an offence or offences. As with the assurances you sought earlier, I am not in a position to predict what you may witness as you carry on with your project. As such, you could have crucial evidence which assists a subsequent investigation. You will be meeting with persons who may potentially commit a variety of criminal acts to financially support their dependencies. Some of these acts may involve harm to persons other than yourself. I would expect you will consider your obligations as a citizen of Canada under these circumstances.

I regret I could not provide you with the required assurances. Please contact me at 268-5900 if you have any further questions.

Yours truly,

T. Chowanec, Sergeant
OFFICE OF THE CHIEF

Attachment

cc. S/Sgt. Cullen. Drug Unit #712

APPENDIX I

LIST OF THEMES, SUB-THEMES, AND DEFINITIONS

(1) /DrugUse
Definition: any reference to drugs - their use, their effects, their quality/purity

(1 1) /DrugUse/MorpHer
Definition: Interviewees who are morphine or heroin users

(1 2) /DrugUse/Cocaine
Definition: interviewees who are cocaine users

(1 3) /DrugUse/Duration
Definition: Length of time interviewee has been injecting drugs

(1 4) /DrugUse/Frequency
Definition: Number of injections (or amount) per day, week, or month

(1 5) /DrugUse/Addiction
Definition: characteristics of addiction

(1 5 1) /DrugUse/Addiction/Cravings
Definition: IDUs' experiences with drug cravings

(1 6) /DrugUse/Changes
Definition: any changes IDU is making in drug use

(1 7) /DrugUse/Dealing
Definition: description of the IDU's source of drugs, also drug prices

(1 8) /DrugUse/Quality
Definition: the quality of drugs - any bad hits (impurities, laced drugs)

(1 9) /DrugUse/Paranoia
Definition: Feelings of paranoia in IDUs due to effects of drugs, or fear of police or other IDUs

(1 10) /DrugUse/Multi-drugs
Definition: descriptions of IDUs using more than one drug (at once or over time)

(1 11) /DrugUse/Overdose
Definition: any references to drug overdose incidents, and what action would be taken in the event of OD

(1 12) /DrugUse/Prisons
Definition: any references to drug use in the prisons

(2) /Demograph
Definition: demographics - age, sex, race

(2 1) /Demograph/Gender
Definition: gender of interviewee

(2 2) /Demograph/AgeRange
Definition: approximate age

(3) /Initiation
Definition: Information about interviewees' inititiation into injection drug use

(3 1) /Initiation/Age
Definition: Age of interviewee when he/she began injecting drugs

(3 2) /Initiation/Who
Definition: Who introduced the interviewee into injection drug use?

(3 3) /Initiation/Teach
Definition: What was the interviewee taught about needle use at initiation?

(3 4) /Initiation/Why
Definition: Why did the interviewee first start injection drug use?

(3 5) /Initiation/Needle
Definition: switch from sniffing or smoking to injecting; if they were injected by someone else (initiator)

(4) /NEP
Definition: Use of Needle Exchange Program

(4 1) /NEP/Collective
Definition: Collective exchanging - 100+ needles exchanged each time for other IDUs

(4 2) /NEP/Individual
Definition: Individual Exchanging - exchanging needles only for oneself

(4 3) /NEP/non-clients
Definition: characteristics or descriptions of non-NEP clients (and their motivation)

(5) /HIV&hep
Definition: any references to HIV/AIDS or hepatitis - incl testing, serostatus, risk, knowledge of serostatus

(6) /Social
Definition: Social aspects of injection drug use

(6 1) /Social/Settings
Definition: Social settings and atmosphere (shooting galleries, apts, etc)

(6 2) /Social/Situations
Definition: social situations in which IDUs inject - kinds of gatherings, attendance,

(6 3) /Social/Other IDUs
Definition: number of other IDUs that interviewee knows, relationships

(6 4) /Social/Support
Definition: social support from other IDUs, significant others with respect to needle/drug changes

(7) /Sharing
Definition: any accounts of needle or drug sharing and the situations in which sharing occurs

(7 1) /Sharing/Drug Sharing
Definition: description of how IDUs share drugs – in powder form, once mixed in the spoon, in the syringe?

(7 2) /Sharing/Paraphernalia
Definition: descriptions of situations or reasons why an IDU shared drug injection equipment

(8) /Needle Use
Definition: any reference to needle use

(8 1) /Needle Use/Vein Care
Definition: any reference to needle use with respect to vein care

(8 2) /Needle Use/Disposal
Definition: any reference to needles with respect to how they are disposed of

(8 3) /Needle Use/Needle supply
Definition: descriptions of where an IDU gets needles supply, from whom, where it's stored, etc.

(8 4) /Needle Use/Injecting
Definition: descriptions of the injection process – locating a vein, where on body, etc.

(8 5) /Needle Use/Bleaching
Definition: descriptions of when / why an IDU uses bleach to clean syringe

(8 6) /Needle Use/Shot Preparation
Definition: descriptions of how an IDU prepares a shot – including mixing, filtering, heating, syringe

(9) /Prostitution
Definition: any reference to prostitution (for drugs, $, or using drugs w/ a date)

(10) /Attitude
No Definition

(10 1) /Attitude/Risk Assumption
Definition: attitudes explaining or describing an IDU choosing to assume risks

(10 2) /Attitude/Risk Reduction
Definition: Attitudes explaining or describing an IDU choosing to reduce risks

(11) /Knowledge
No Definition

(11 1) /Knowledge/Services
Definition: an IDU's knowledge re: NEP services, drug treatment services, etc

(11 2) /Knowledge/hep&HIV
Definition: an IDU's knowledge re: HIV/AIDS & hepatitis - its risks, symptoms, etc

(12) /Barrier to Risk Reduction
Definition: barriers encountered by IDUs in attempting to change their high-risk behaviours