Women’s Stories/Women’s Lives: Creating Safer Crack Kits

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In 2004, a research team comprising researchers and service providers launched the Safer Crack Use, Outreach, Research and Education (SCORE) project, aimed at developing a better understanding of the harms associated with crack cocaine smoking and determining the feasibility of specific harm reduction strategies to reduce the likelihood of harms in an inner-city neighbourhood in Canada. The project included several activities, and the ‘women-centred’ activity of constructing harm-reduction kits is the emphasis of this paper. The data for this study are derived from the field notes taken during kit-making sessions with 200 women and from qualitative interviews with the group facilitators. A salient theme of the analysis was the tremendous support that was afforded to women engaging in this activity. Three sub-themes were also identified: (a) creating a safe space, (b) sharing information, and (c) building community. Women-centred activities are an effective means of creating a supportive environment for women and to learn about women’s perspectives concerning the relevance of these activities in their daily lives.

Crack cocaine use has been associated with numerous health problems for women, including cardiac and respiratory illness, unplanned pregnancies, violence-induced injuries, depression, acute psychosis, insomnia, HIV, HCV, STI, and frequent burns to lips, mouth, and fingers (Butters & Erickson, 2003; Falck et al., 2003; Goodman, 2005; Leonard, DeRubeis & Birkett, 2006; Malchy, Bungay & Johnson, 2007; Shannon et al., 2006; Ward et al., 2005). Additionally, people who use crack cocaine and who are street-involved (by this, we mean experience high degrees of public scrutiny, unstable housing and poverty, and may or may not be involved in illegal activities), report high rates of malnutrition, homelessness, unemployment, and chronic pain (Bungay, 2008; Fischer et al., 2006; Goodman, 2005). Despite the overwhelming evidence of harms associated with smoking crack, little research has been undertaken that specifically examines women’s perspectives on and personal experiences of these harms or that evaluates the effectiveness of strategies aimed at reducing these harms.

In 2004, a research team comprising researchers and service providers launched the Safer Crack Use, Outreach, Research and Education (SCORE) project in the inner-city neighbourhood known as the Downtown Eastside (DTES) of Vancouver, British Columbia, Canada. The project had two main goals: (1) to develop a better understanding of the harms associated with crack cocaine smoking and (2) to determine the feasibility of specific harm-reduction strategies to reduce the likelihood of these harms.²

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² Harm reduction is a pragmatic approach to the social, economic, and health issues associated with the sale and use of legal and illegal substances. The goal of harm-reduction public health policy and practices is to reduce the harms to individuals and communities associated with substance use. The principles of harm reduction reinforce
Project activities included cross-sectional surveys, the construction of crack-smoking harm-reduction kits (kit-making), and the distribution of these kits as an outreach strategy to provide harm-reduction education and equipment and to enhance access to health services. In this paper, we focus on the kit-making component of the project and present the outcomes of our attempts to employ a women-centred approach to this initiative. Women-centred initiatives have been well documented as effective strategies to enhance women’s access to health and social services and to provide safe and confidential venues to learn about women’s experiences (Barnett, 2000; Poole, 2000; Whynot et al., 2006). Thus we designed our approach to: (a) learn from women about their experiences of harm associated with crack use, (b) enhance women’s access to health and social services, and (c) assess the effectiveness of this approach as a strategy to reduce harm among women who use crack cocaine.

**Literature Review**

Over the past two decades, patterns of drug use have shifted, especially in urban, inner-city communities, and these changes have coincided with the increased emergence of crack cocaine (Erickson et al., 1994; Fischer et al., 2006; Goodman, 2005). Although the exact prevalence of crack cocaine use in Canada is unknown, recent research illustrates that crack is one of the most commonly used illegal substance within the DTES, and women report higher rates of use than men (Buxton, 2007; CHASE Project Team, 2005). Earlier ethnographic researchers who focused on women who used crack cocaine claimed that women lost ‘all control’ once they used crack. Female ‘hypersexuality’ and ‘deviance’ were purportedly associated with crack use (Inciardi, Lockwood & Pottieger, 1993) and what was labelled the ‘sex-for-crack’ phenomenon was described by a number of US researchers (Bourgois & Dunlap, 1993; Inciardi, Lockwood & Pottieger, 1993; Ratner, 1993). Feminist ethnographies have done much to dispel earlier claims about crack use being directly linked to female ‘deviance and hypersexuality.’ Maher (1997) and Bungay (2008), for example, illustrate that controlled use of crack is possible. Other research has demonstrated that typifying all users as ‘out of control’ has served to legitimize an increased regulation of women by medicine and the state that results in higher rates of incarceration and child apprehension among women who are street-involved and use illegal drugs (Boyd, 1999; 2004).

Boyd (2004) also demonstrated that the illegal status of crack shapes a woman’s relationship with the drug. Crack users must negotiate the illegal market that includes theft, inflated prices, and associated drug trade violence. Crack purchased in the illegal market is of unknown potency and quality because adulterants may be added during the manufacturing process. These adulterants often include other illegal substances such as crystal methamphetamine and heroin or non-active ingredients (e.g., baking soda and lidocaine) that allow manufacturers to increase bulk (Bungay, 2008; Goodman, 2005).

Poverty and gender are influential factors in women’s experiences with crack cocaine use. Because of economic constraints, women living in poverty buy crack in small amounts and more frequently than persons from the middle or upper class, thus increasing their risk of drug trade violence and arrest (Boyd, 2004). Frequent crack use has also been reported among impoverished women who engage in sex work, although one cannot assume a causal relationship. Research has indicated that involvement in sex work often arises out of economic necessity because of the limited options for generating income available to street-involved women (Bungay, 2008; Maher, 1997; Spittal et al., 2003; Sterk, 1999). Crack users, especially women, have been shown to be more isolated than other illegal drug users and less supported by outreach and health services (Metsch et al., 1999; Prinzleve et al., 2004). While crack use is not confined to inner-city users, impoverished and marginalized users are vulnerable to a number of risk factors that their wealthier counterparts may not encounter.

Little research has focused explicitly on harm reduction strategies for women who use crack cocaine.
crack cocaine. In Canada, harm-reduction programming concerned with the health of people who use illegal drugs has focused almost exclusively on ‘safer’ injection, including needle exchange programs, a safer injecting site, and opiate replacement therapy. Many of these programs have met with great success, including a reduction in the number of overdose-related deaths, increased access to social and health service programming, and reduced property crime (Kerr et al., 2007; Wood & Kerr, 2006). Harm-reduction strategies such as educational programming and the distribution of less harmful smoking equipment, however, have been met with much socio-political resistance. For example, despite the positive results of a recent harm-reduction initiative in one Canadian city (safer routes of drug consumption, reduced sharing of drug equipment, and increased access to health-related services by people who smoke crack cocaine) (Leonard, DeRubeis & Birkett, 2006), political pressure resulted in the termination of the program. Additionally, within British Columbia, only two regional health authorities offer any harm-reduction programming specific to crack cocaine, although all of the other four authorities have received funding to offer these services.

The Theoretical & Philosophical Underpinnings of the Research Approach

Harm reduction represents both a pragmatic, human rights-oriented philosophy to public health service programming and a series of practices aimed at reducing the harms associated with the use of legal and illegal substances without requiring abstinence on the part of those who access these services (MacPherson, Mulla & Richardson, 2006). These strategies often include the provision of safer equipment for substance use and alternative substances that are legally sanctioned (e.g., methadone), and improved access to a broad range of health and social services. Reduced criminalization of people living with addictions is another strategy for managing problematic substance use where policing is aimed at enhancing access to services rather than arrest for illegal drug use. Harm-reduction strategies also involve people who use substances as active participants in the design and implementation of policies and practices that affect their lives (Jurgens, 2005).

Women-centred approaches to research and health care have much in common with harm reduction. They share, for example, the philosophical concerns for human rights, social justice, and active involvement of the people whose lives are affected by the research, policies, and practices aimed at enhancing their health. A woman-centred approach extends this emphasis and demands consideration of the social, economic, and political inequities that are specific to women (Barnett, 2000). A woman-centred approach draws our attention to the unjust power relations by which these inequities are constructed and requires that research activities take this context into consideration. Therefore, we consider the diversity among women’s approaches to engaging in research, health care, or harm-reduction initiatives throughout all phases of these activities and we create safe spaces where women’s voices can be heard (Whynot et al., 2006).

Feminist theorists have emphasized the importance of women’s voices in the creation of knowledge that accurately reflects the realities of their lives (Collins, 2000; Harding, 2006; Smith, 1999). Women who suffer inequities have significant insights into the factors that contribute to inequities. Women are also knowledgeable about the implications of these inequities for their experiences, including access to economic, health care, and educational resources (Collins, 2000). Additionally, research approaches that embed the construction of knowledge within women’s voices and experiences take up as problematic contextual forces such as poverty, violence, and sexism that shape women’s lives versus women’s actions or experiences in isolation of their context (Lather, 2007). Thus a woman-centred approach allows us as researchers to focus on women’s experiences more broadly in which crack use was one component, not the sole component, influencing their lives.

Within the kit-making initiative the investigative team strove to integrate central tenets of feminist theory and women-centred and harm-reduction philosophies and approaches. We situated kit making within the broader context of women’s lives (e.g., economic circumstances, relentless risk of violence, care-giving roles) and sought to create a safe space where we could
bring forward the voices and experiences of women (Reinharz, 1992; Smith, 1999). Although there is a dearth of research specific to women-centred harm-reduction programming for users of illegal substances, recent research has demonstrated the importance of creating spaces where women can go to access services where they feel free from potential violence and discriminatory attitudes by service providers that portray women as ‘addicts, junkies or whores’ incapable of managing their everyday lives (Bungay, 2008; Poole, 2000; Shannon et al., 2008). A more comprehensive discussion of how we integrated these philosophical principles and pragmatic strategies into the design, implementation, and data analysis associated with the kit-making initiative follows.

**The Kit-Making Process: Recruitment & Data Collection**

Kit-making sessions occurred, on average, twelve times a month over a period of one year. Each session was an hour long and involved four women from the DTES, two members of the investigative team, and one peer facilitator. The sessions occurred at various locations throughout the DTES, including drop-in centres, women’s housing facilities, emergency shelters, and community health centres. The members of the team chose the drop-in locations strategically to enhance women’s access to services including food, showers, laundry, and group counselling.

Two main recruitment strategies were implemented. One strategy included recruitment by the peer facilitators. Peer facilitators were women who had experience with crack, who were members of a local women’s drug-user group, and who participated in an advisory committee for the SCORE project. Women were recruited from outdoor locations such as the local park or the street. A peer facilitator approached individual women asking if they would like to participate in a project about harm reduction for women who use crack. They did not ask women specifically if they had experience with crack because, as noted by the peer facilitators, it was probable that women living in the DTES would have had some exposure to crack. For the second recruitment strategy, members of the investigative team worked with staff members from the agencies where we held the kit-making sessions. Interested women received invitations with their names, and the time and location of their sessions.

We tried to set up the room in a manner that adhered to a women-centred approach to kit making. The goal was to create a safe space where women could come together, share their experiences and take a break from the constant vigilance that was required on the street to protect themselves and others from the violence and exploitation that was a regular part of their lives (Shannon et al., 2008; Bungay, 2008). Our goal was to learn from women in their own words about their harm-reduction programming needs, and about the contextual factors shaping these needs. It was a chance to participate in what bell hooks (1988, p. 9) refers to as ‘talking back’: “Moving from silence into speech is for the oppressed, the colonized, the exploited, and those who stand and struggle side by side a gesture of defiance that heals, that makes new life and new growth possible. It is the act of speech, of ‘talking back,’ that is no mere gesture of empty words, that is the expression of our movement from object to subject—the liberated voice.”

Chairs were placed around a table set with six workstations. Each workstation had a plastic tray filled with items to make up the harm-reduction kits: rubber tubing used for mouthpieces, lighters, condoms, glass stems, screens, band-aids, and alcohol swabs, harm-reduction information, resource cards, and bags to contain the items. The sessions were co-facilitated by a member of the research team and a peer facilitator, both of whom were active in assembling the kits. A second member of the research team participated in the role of note-taker. On another small table the facilitators displayed a poster with various information cards that women could take with them. The information cards listed resources for health care, advocacy and legal

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3 The reference list identifies sources that provide a more detailed discussion of the philosophy of harm reduction and women-centred research or care.
services, housing, and income assistance, as well as safety tips written by and for women involved in sex work.

Once the women were seated around the table, the research team facilitator welcomed the women to the session. She reviewed the purpose of the project, explaining that the project was aimed at reducing harms associated with crack cocaine use and that the kit-making session was an opportunity for women to come together and share their expertise regarding women’s concerns and resource needs. The note-taker explained the reason we took notes was so that we could keep track of what the women had to say, that everything said was confidential, and that each woman had the right to request that a comment not be written down. Generally, the women were very receptive to having someone take notes. In many instances the women would stop talking or making kits to ensure that the note-taker had written down something they said.

The peer facilitator explained the kit-making process by describing and demonstrating the task for each woman. “It’s like an assembly line. You put the cards and the mouthpiece in the bag, pass it to me, I put in the pipe and lighter and then I pass it to her and she puts in two alcohol swabs, two condoms, and two band-aids, then she passes it to her and she puts in two screens and a chopstick. Then she closes the bag like this and puts the kit in this bin.”

The peer facilitator made it clear that in this particular assembly line, everyone should work in a relaxed manner, and that there was no rush or quota. In order to generate a trusting environment, facilitators did not ask any of the women to sign a consent form but they were provided with an information sheet describing the project purpose and their rights as participants. This strategy has been used successfully in other research with similar populations (Bungay et al., 2006; Shaver, 2005). Ethical approval was obtained for this project from the Behavioural Ethics Review Board at the University of British Columbia.

Once the session was underway and each woman was engaged in her tasks, the discussions tended to flow smoothly. Women often started talking with little prompting about a wide variety of topics. Near the end of the hour the research team facilitator began to wrap up by letting the women know we were almost out of time. Each participant received twenty dollars for her time and a certificate of completion. The women appreciated the certificate because it specified that they were ‘consultants’ and acknowledged women as expert knowers in the creation of knowledge about the realities of their daily lives (Harding, 2006; Lather, 2007; Smith, 1999).

Approximately 200 women participated in the kit-making sessions, constructing 14,000 kits. Many women participated in more than one session. Although no specific demographic or substance-use questions were asked of women, information on these topics arose from the general flow of conversation and was recorded in field notes. The women ranged in age from their early 20s to early 60s and represented diverse social, cultural, and ethnic backgrounds. Most women were living in extreme poverty and many experienced unstable housing. The women currently used or had used illegal drugs; some were dealers and others were engaged in treatment and recovery. Many of the women worked as street sex workers and also experienced complex physical and mental health issues concerns. The majority expressed a reluctance to access formal health care services unless they were extremely ill, a full discussion of which is published elsewhere (Bungay, 2008). Women who identified themselves as Aboriginal represented almost half of the sample. This finding, while disturbing, was not unexpected, given the research that has illustrated the intersections among colonization, poverty, substance use, and unstable housing among the Canadian Aboriginal population (Robertson & Culhane, 2005). During this time we also conducted structured qualitative interviews with the two peer facilitators and the two research team facilitators about the benefits and challenges of the kit-making initiative.

**Data Analysis**

The field notes taken during kit-making sessions were the predominant sources of data for this paper. The data were imported into word processing software, and files were created for each individual session. Initially the data were read by two members of the investigative
team and preliminary coding structures were devised. This preliminary coding occurred as an iterative process throughout the data collection, a common practice in qualitative research (Sandelowski, 1995; Thorne, Kirkham & O’Flynn-Magee, 2004). Once the preliminary codes were created, the field notes were divided among three pairs from the investigative team. Each pair repeatedly reread its data set and highlighted themes and differences within the data. All of the pairs then met together on several occasions, as a larger group, to review their analytic themes and to finalize the themes identified.

Emerging from this analysis were several themes that reflected women’s health concerns, the contextual factors influencing their health, and the value of the kit-making sessions as a source of support. In this paper we explore the kit-making sessions as a harm-reduction initiative informed by the central tenets of women-centred care discussed previously. Reports pertaining to the other analytical themes will be published separately.

**Findings: Women Coming Together as a Source of Support**

The kit-making sessions provided women with a support they experienced in three related ways: (a) creating a safe space, (b) sharing information, and (c) building community. The support developed over time through women’s interactions with one another inside and outside the sessions, as well as with members of the investigative team.

**Creating a Safe Space: A Room of Their Own.** The lack of safe spaces for women is a serious problem in the DTES and other urban areas (Robertson & Culhane, 2005; Wilson, 1992). The women who participated in the kit-making sessions live in an environment filled with threats of violence, particularly given that they are often in public spaces where they have few options of escape from potentially violent interactions with men or from exploitation by others within the neighbourhood (Bungay, 2008; Shannon et al., 2008). As one woman commented, “It is hard to find a safe place to talk. Even at home, the walls have ears.” Of the women who had housing, many felt unsafe in their own homes or rooms, as men often refused to leave or friends would ‘drop by to check out your place’ as a potential place to spend the night or to steal belongings. The women spoke of being afraid of being alone, and needing to ‘keep their heads down’ and their ‘mouths shut’ in order to avoid trouble. They were constantly approached, especially if they had something that others wanted (food, drugs, money, etc.). Some had no place to sleep, and would come to the kit-making sessions cold, wet, and hungry. Basic amenities such as clean bathrooms, heat, and quiet, secure places were a luxury. They wore the effects of harsh street life: many appeared fatigued and had noticeable bruises or cuts.

The kit-making sessions provided a safe space for women to rest or experience a distraction from the emotional and physical pain and difficult situations in their lives. Occasionally, women fell asleep in the sessions, because they had been up for several days or had recently taken their methadone. In most cases, the remaining women, without consulting each other or the facilitator, and usually without judgment or complaint, took over the sleeping woman’s station. Their willingness to share the work of making the kits allowed the woman to rest. In one instance a young woman said that she had been up for four days to avoid going home for fear of violence by her husband. Early in the kit-making session she fell asleep. This example illustrates the woman’s belief that the space was a safe one for her: outside the space she was not safe to sleep; inside the space with other women she had a temporary reprieve. While the space was created by kit-making initiative, it was made safe by the support of the research team and the other women present.

Establishing the kit-making session as a ‘safe place to be’ was vital to the success of the session and this feature was enhanced by the peer facilitators. After one of the sessions, one of the peer facilitators commented: “Sometimes it helps having a peer there. It helps them, makes it a little more comfortable, and lets the conversation sort of open up a little easier so that they don’t think that there’s any ulterior motives out there than, you know, for the best interest of themselves and, and for everybody else. So, for me I think a lot of it’s just the support and just sort of making them feel comfortable and opening up the, the doors for, for what you guys do
as well.”

The sessions were also considered a safe space to make money. Many women arrived early for a session so that they would not ‘lose their spot,’ as it provided a safe legal way to be paid for their expertise and time: “It means so much to get together like this and it means I didn’t have to do a date [sex for money].”

In the chatter about day-to-day life, the kit-making sessions provided a sense of normalcy or stability. The women emphasized that attending the kit-making sessions provided a relaxed and safe atmosphere where you could enjoy ‘just talking.’ They commented that “the conversation is good, it is healthy conversation.” Women consistently said that they were happy to be present and that they enjoyed themselves: “It’s been a pleasure. Thank you.”

Sharing Information: The women felt free to ask questions of one another and often shared information. The topics varied but for the most part focused on everyday issues such as access to health and social services. Occasionally, women discussed their experiences of exploitation and their uncertainty about the appropriateness of others’ actions towards them. Some women living in single occupancy units described disruptions from people in positions of authority. One woman inquired, “I was just wondering if the fire inspectors have to give you notice before they come into your room?” Two women in that session were vocal in their response, saying “That’s not right. They have to give you written notice,” and “They have to give you two days notice.” Following discussions like these, women believed that learning about the rules may enable them to better advocate for themselves in similar situations in the future.

Some of the older women saw it as their role to pass on information about available services to the younger women. They described services and gave detailed explanations about specific service providers to approach, useful ways to approach them, and how women and residents of the DTES were treated. For example one woman advised, “There are good doctors at [clinic] but I’m always having to wait, when I see him. He is really good, but it takes forever.” Another women warned, “It’s a little rough there. You don’t want to wait in the lobby.”

Crack use information and health education were other topics. The women provided tips to each other about ‘bad dope’ (i.e., crack mixed with impurities), as reflected in the following excerpt:

“Bad dope was due to the fact that they are putting all kinds of shit in it; they are even putting Orajel in the dope [crack] now…. one of the ways that you know the dope is good is that your lips go a little bit numb when take that first puff, so people [dealers] are putting Orajel in it to make people think that it is good dope.” They also provided tips on how to smoke more safely: “To smoke right you need to be turning your pipe all the time and you need to go slowly. Don’t overheat it.”

The work of making the kits triggered discussions about harm-reduction practices and health issues. For example one woman, asked, “What’s with the condoms? What does smoking crack have to do with condoms?” Another asked about female condoms and admitted, “I always wanted to know but I was too embarrassed to ask.” The research team facilitator was able to answer these questions and provide important information about the link between unprotected sex practices and the transmission of infections. The posing of questions also permitted the investigative team facilitator to generate additional educational discussion. Of particular importance was the association between sharing crack-smoking equipment and infections, including HCV and pneumonia (Buxton, 2007; Haydon & Fischer, 2005; Fischer et al., 2008). For example, she explained that because many people who smoke crack have open sores, certain infections may be able to spread through blood, particularly HCV. In response to learning about infection transmission through sharing mouthpieces or pipes, one woman exclaimed: “You just made me a one-pipe lady.” This declaration seemed a transformational experience and modelled behaviour change for the other women. As one of the peer facilitators commented: “For me it’s just helping the girls be aware. Like harm reduction to me is educating and making people aware of how it is that what they may be doing or not doing is safe or unsafe.”

Another way that women shared information was by telling and listening to personal
stories, which was not an unexpected finding, given the abundance of feminist research that has illustrated the effectiveness of storytelling as a means of sharing knowledge (Collins, 2000; Harding, 2006; hooks, 1998). Whether they shared anecdotes or painful life experiences, the telling of stories was a key feature of the support women received. Women discussed their experiences of loss, illness, and violence, as evidenced in the following excerpt:

*I heard this noise. It woke me up. I went to my window and I saw that one man was holding a woman with her arms behind her back while another man hit her with something like a crowbar or something like a stick. I called 911 and when the ambulance came the woman said that she couldn’t go to the hospital and that she told them that she couldn’t go because her boyfriend would beat her up. I heard her say, ‘My boyfriend will beat me up. I can’t go.’*

In this case, the woman telling the story was strengthened by having her story respectfully heard. After she finished, the other women in her group nodded quietly and engaged in conversation about the degree of violence that women living in the DTES experience. They acknowledged the persistent risk of violence and that it ‘felt good’ to talk about this issue. Women also found that their stories had common threads:

The two women both said that they had “daughters down here.” They talked back and forth about the fact that their daughters live and work in the DTES, and are using crack and doing sex work. They both expressed worry and concern for their daughters and stated that they wanted to help them out of it. Typically, one or two women in each group took the lead sharing stories and were validated by having others listen and support them. Just having other women listen to their problems provided the women with support. Often one or two women were quiet during the session and seemed to feel supported by listening to others’ experiences. The peer facilitator spoke quietly to the young woman beside her: “You have been pretty quiet honey. Is there anything you want to talk about?” She spoke very softly to the woman and leaned in slightly towards her. The woman at Station One smiled and looked at the peer facilitator with her head lowered and just raised her eyes and said that she really didn’t want to talk. “I am happy to just do the work.” The peer smiled at her and said that she didn’t have to talk. She could just hang out, but if she wanted to talk at any point she could “just jump right in.” While this conversation was occurring, the other women in the room were quiet and also smiled at the young woman at Station One and kept making their kits. Whether sharing stories or listening, women’s presence and contribution was usually respected.

Sometimes, women shared empowering experiences about moments of fear or isolation that inspired other women. One woman talked about completing a university course and was congratulated by the others around the table. Another woman shared information about an Aboriginal and education session she attended. She explained, “It helps me to understand my history.” She told the others in her group that a new program was starting and they could sign up for it. At the end of one session, one woman wished another “good luck!” in her efforts to deal with the negative impact of residential school. Another woman spoke about completing a three-year core training program about HIV. She is now able to speak publicly about HIV. She said, “That’s my journey in life, to prevent one person from going downtown, from tweaking like I did.” The conversation was often light-hearted, as when women who knew each other recounted having fun working together and the parties that they had been to in the past. Others caught up

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4 The residential school system began as early as the 1840s in Canada and continued until the 1980s. The system was a combined Church- and government-run school system designed to “westernize” Aboriginal people. Children were separated from their families and lived in schools where they were forbidden to speak their native languages or to engage in what were deemed “non-Christian” religious practices. Many Aboriginal peoples suffered severe psychological, physical, and sexual trauma in residential schools, and the damage inflicted upon Aboriginal people continues to affect the health and well-being of individuals and communities today (Smith, Varcoe & Edwards, 2005).

5 It is important to note that during this project Robert Pickton was on trial for the murder of six women from the DTES. While he has since been convicted of these murders, it was estimated that as many as fifty women were reported as missing by friends and families in the DTES.
Building a Community of Women: Intricately related to the processes of sharing information in a safe place was the experience that we described as ‘building a community.’ Women stated they felt supported “as a woman within a community of women” and that they felt strengthened by belonging to this community. Women offered one another support and reported that the sessions were a great way to meet and get to know other women who could serve as a resource when they were outside the group. Often during the sessions, claims would be made like “sisterhood is important” and “women’s issues are important.” A bond among many of the women was apparent both inside and outside the sessions. As one woman noted, “If you notice that you haven’t seen a woman in a few days then you start to get worried and you start looking for her. We watch out for one another. This is really important with all the women going missing.” In many instances this bond contributed to women offering varied forms of support in other contexts:

The woman at the second station asked the woman in the first station if she had ever heard about the VANDU [Vancouver Area Network of Drug Users] woman’s group. She said no, and then she went on to tell her that it was a woman’s only group that met every Saturday and that sign up was at noon. People got a three dollar stipend and that the meeting started at one o’clock and there is a smoke break in the middle. And then there is dinner and stuff at five o’clock. The younger woman sat quietly listening and looking at her. Then the peer smiled and said “you should come out hon, it is really a nice thing.”

In another situation in which a woman was without a home, one woman commented, “Hey, that could be any of us. It is OK if she wants to crash with me. I don’t know her and I might lose some stuff, but what the hell. I would rather she be safe.”

Women described watching out for each other, and again, the older women expressed a sense of responsibility for helping younger women. “I tried to run her off the street a few years ago. You know, I said to her, sweetie, you are way too young to be hustling out here. You need to be somewhere safe. I found out back then that she was like 23 and that was a few years ago. She just looks so young. Maybe she will come to some of the groups or something. We’ll keep an eye out for her.”

It was also apparent that many women were not necessarily free to engage with other women outside of these sessions. One woman explained that she “didn’t get out much” and had to tell her “man” everything she did. The hour-long sessions provided an opportunity to escape from this monitoring and to talk with other women. Moreover, the work of the kit-making sessions strengthened any tentative bonds that existed between women.

The sense of community also was evident in how women explicitly supported one another in the moment. This was most readily apparent during women’s conversations about their drug use practices. Women offered each other encouragement for trying to reduce drug use and when women discussed ‘slipping’ (using when they were trying not to), they were compassionate with one another. Supportive phrases such as “It happens to the best of us hon,” were common, as when one woman who experienced an addiction with heroin was comforting another who spoke about slipping and the challenges of trying to not use.

Women also provided support in the moment when others in the group were struggling to complete some of the tasks involved in kit making. One woman for example, commented to another about how she was handling the work at her station when the women commented she was “slow” and feeling tired: “You are doing a great job hon. I know it is hard to do this stuff when you are tired and this is probably the only chance you have had to sit still.” Light-hearted teasing built a sense of intimacy through its familiarity. As women laughed and churned out black humour about the absurdity of their lives, they built a sense of community through releasing these shared experiences. It was apparent to us that the women enjoyed the sessions. They talked about it being ‘fun’ and a ‘nice thing to do.’ At the close of the session they would frequently ask to be kept in mind for future sessions.

Perhaps one of the biggest successes was that women believed that the kit-making sessions
had taught them important things about each other and how women interacted with one another. When asked about what she thought the kit-making sessions accomplished, one of the peer facilitators commented:

Well, patience, how to be sort of a team player, to work as a team, rather than working independently. Even like putting the kits together, the women are sort of learning how to communicate with each other and sort of work with each other rather than working against or competing with each other.

This sense of belonging to a community of women was reinforced by participating in work the women believed was worthwhile and by contributing their expert opinions about the issues discussed. In recognizing all that they each had to offer, the women felt a sense of strength that they could contribute in a meaningful way. As one woman stated, “It makes me feel useful for a change”; another commented, “I feel like I have done something worthwhile.”

At other times, the lack of resources in the DTES and the limited opportunities to participate in the kit-making activities due to the restrictions of the research funding contributed to competition. Women vied with each other to participate in the kit-making sessions. Many women expressed frustration at being unable to participate in all of the sessions. Sometimes a lack of availability contributed to tensions between women who were participating and those who were not. We attempted to resolve this issue by working with the peer facilitators to recruit as many new women as possible and were proactive in discussing with women why it was important to provide many women with the opportunity to participate. Most women responded positively that they understood the need to ‘share opportunities’ and they became advocates for this process within the neighbourhood, although they acknowledged the challenges they faced in helping other women have these opportunities, given the significant economic deprivation they faced on a daily basis.

Over the course of the year we experienced many other challenges within the kit-making sessions. Not all of the sessions ran smoothly. At times there was tension between women in the groups and the women would argue with one another. In other instances women would roll their eyes or make faces while another woman was talking. In one instance a woman would slap the table next to the person beside her in an attempt to encourage a woman to work faster. The peer and investigative facilitators were usually able to defuse these situations, and in most instances the women would accommodate themselves to the circumstances so that the work of kit making could continue, as seen in the following field note:

One woman was talking over everyone else—she went to the bathroom. The other women were complaining about her being hyper: “She never stops talking.” When the ‘annoying’ women came back, they were inclusive of her. The other women replied to her, “You had to pee. You do what you gotta do, hon.”

**DISCUSSION & CONCLUSIONS**

Guided by the tenets of a woman-centred approach to research and health care, feminist theory, and harm reduction, we aimed to create a safe space for women to learn about their experiences with crack cocaine and associated harms, to disseminate information about crack use and harm reduction, and to enhance women’s access to health and social services, including harm-reduction programming. The bulk of harm-reduction programming in Canada has emphasized the reduction in the spread of blood-borne infections and has employed gender-neutral approaches. The present study documents the tremendous benefit of women-centred approaches to harm-reduction initiatives in a variety of ways. First, we reinforce the work of others (e.g., Koskela, 1999; Poole, 2000) who have shown that women-centred spaces create positive effects in the everyday lives of women. In this case, safe spaces were women-only (only women were permitted to join in the sessions), thereby offering a reprieve from women’s often tumultuous relationships with men. Additionally, women were able to build a sense of community that extended beyond the confines of the kit-making relationships.

There is a clear link between creating safe spaces and telling stories. In A Room of One’s
Own, Virginia Wolf (1981) for example, makes a strong connection between safety and storytelling, recognizing that women are often disadvantaged in finding their voices: “A woman must have money and a room of her own if she is to write fiction; and that, as you will see, leaves the great problem of the true nature of woman and the true nature of fiction unsolved” (p. 1). While the women in this study were not creating fiction, it is clear that safe spaces were necessary to permit the free exchange of ideas and support. The stories that the women shared were not simply about their circumstances; they were vehicles for transformation and support. Similarly, Czarniawska (2004) notes that stories can be powerful tools for support and organizational change. The kit-making sessions showed women’s efforts to support one another even in the face of many obstacles. Through storytelling the women communicated with one another about a range of topics that affect their everyday lives and devised strategies to mitigate some of these harms.

In Canada we face significant barriers to integrating safe spaces for women within the realm of harm-reduction programming specifically and health care more generally. Provincial and federal governments have recently cut services, welfare support, public housing, and community-based programs such as legal aid and mental health services contributing to the loss of women’s safe spaces (Creese & Strong-Boag, 2005). Although the impact of these cuts to women’s spaces and programs has yet to be fully investigated women-only programs and spaces are closing in Vancouver and elsewhere throughout the country, leaving women with few options for a safe space of their own.

Through a woman-centred approach that acknowledged women’s contributions as expert ‘knowers’ or ‘consultants’ concerning the realities of their lives, we were able to justify the payment of research honorariums as compensation for their time. This financial compensation, although minimal, was safe income and an alternative to sex work. Viable alternatives to sex work are urgently needed in Vancouver’s DTES. Recent cutbacks to public income assistance (the primary source of income among people in the DTES) and complicated application processes have resulted in fewer people receiving assistance (Wallace, Klein & Reitsma-Street, 2006) and left many women destitute (Creese & Strong-Boag, 2005). Furthermore, there are few job opportunities for women (Bungay, 2008). Long-term solutions to women’s poverty are needed and must incorporate realistic and safe work-training programs, affordable housing, and increased access to income assistance (Pivot Legal Society, 2006).

Participating in harm-reduction work such as kit making reinforced women’s positive sense of their abilities to contribute to harm reduction in their own neighbourhood. The integration of peer facilitators encouraged mentoring and supported the peers in developing skills that might help them become leaders in grassroots harm reduction initiatives. The importance of drug-user activism in promoting positive change in policy and programming has been well documented (Jurgens, 2005), and initiatives such as our kit-making sessions reinforce women’s role in such activities. Harm reduction requires a grassroots approach. Through working with women in their own community, we demonstrated that women who use crack can and do provide harm reduction education to each other. Storytelling was a particularly powerful educational strategy, and future harm reduction initiatives with women may benefit from this approach. The women’s stories reflect the need, in developing harm reduction programming, to pay attention to the broader context of their everyday lives such as poverty, violence, exploitation, and a sense of having no safe space. Nor can we assume that all women will benefit from the same approaches to harm reduction. Further research is needed to explore the diversity among women’s experiences and harm-reduction programming needs. This research must include investigation of the experiences of Aboriginal women, given the significant over-representation of Aboriginal women in this project and the well documented affects of colonization for Aboriginal women’s health (Browne, 2003; Browne, Smye & Varcoe, 2007).

In conclusion, women are experts about their lives, their voices must be heard and abstinence is not an essential element of a program designed to meet their needs. A women-centred approach to meeting women who use crack ‘where they are at’ (e.g., in their own
community within the full context of their lives) highlighted for us as researchers the value of women’s input into the planning and implementing of programs aimed at reducing the harms in women’s lives.

REFERENCES


