

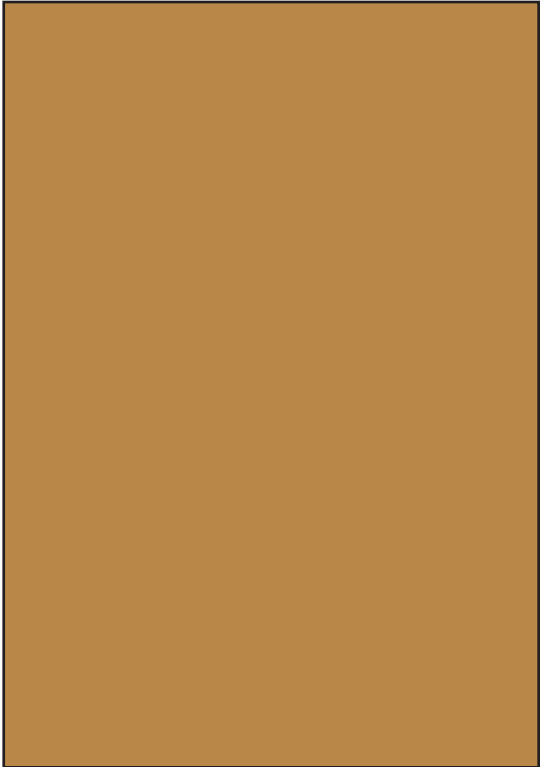
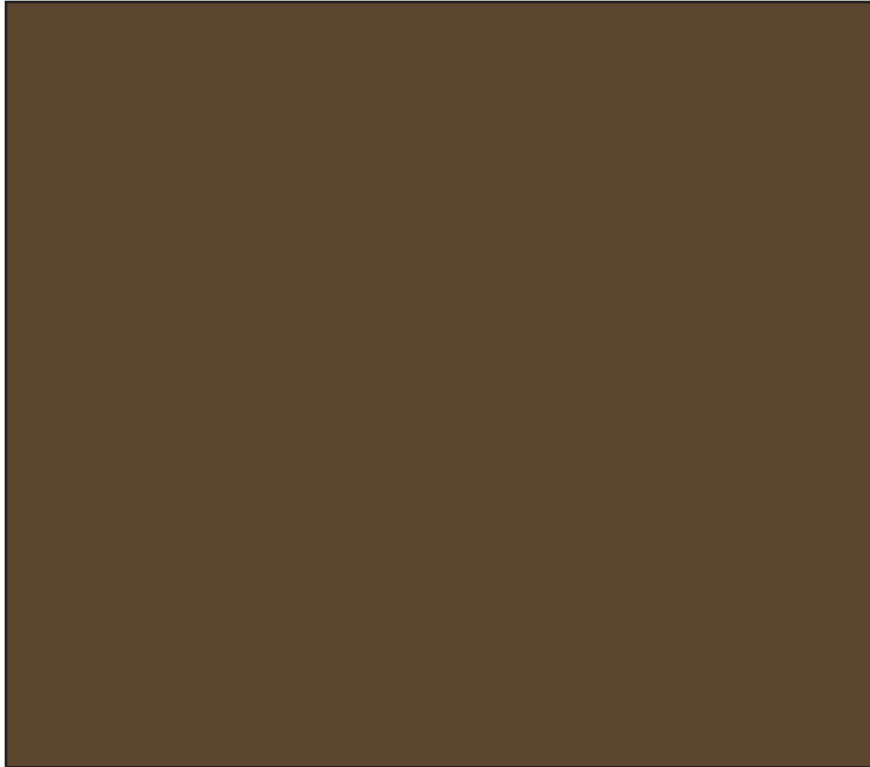
Women-Centred Harm Reduction

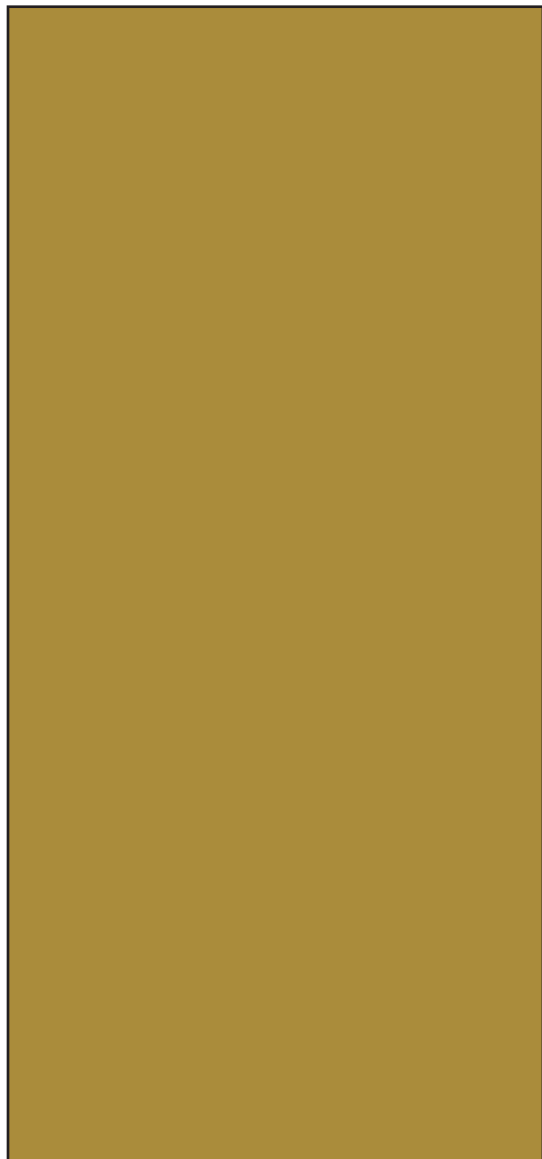
In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a “virtual discussion” of issues, research, and programming related to girls’ and women’s substance use in Canada. The goal of the vCoP was to serve as a mechanism for “gendering” the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada*. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women’s Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP. Its purpose is to stimulate further conversation on gendered approaches to harm reduction.



Gendering the National Framework





Background

Harm reduction approaches to substance use have been a part of Canadian prevention and management efforts for many years. [1] The emphasis has been on decreasing individual harm from problematic substance use through the provision of specific policies and services (e.g., supervised injection facility). However, participants in the vCoP noted that the broader determinants of women's health—such as, poverty, mothering, violence, and social policies—are not well enough accounted for in the design of harm reduction strategies. In order to increase the effectiveness of these strategies, it is pertinent to introduce a gender lens to harm reduction initiatives. In the context of women's substance use, harm reduction cannot simply be about the intersection of one health determinant with the use of substances; it is instead about how many health determinants interact, and in turn amplify or influence the experience of women's substance use.

Harm reduction strategies are commonly discussed from the perspective of the policies and service continuum needed to assist illicit drug users, however, this discussion guide will use a gender-based analysis, including a determinants of health lens, to explore reducing harms associated with women's licit and illicit drug use. While not all encompassing, this resource offers a place to start the discussion on how to bring a gender-based analysis to harm reduction strategies. This discussion guide will briefly introduce some of the intersecting components of harm reduction and health determinants, highlighting the key ways that these elements interact to influence women's health and women's substance use experiences, followed by a list of weblinks and discussion questions. The discussion questions are designed to facilitate the application of a gender-based analysis to addictions prevention, harm reduction, and treatment programming and policy.

Reducing harms across social determinants of women's health

The following sections briefly illustrate and explore the intersection of determinants of women's health, providing highlights of current research and practices that exemplify this perspective related to:

- violence and trauma
- pregnancy and mothering
- criminalized women
- sex work
- housing
- HIV/AIDS

Through these descriptions, it can be seen how understanding harm reduction from a gendered perspective is critical to successfully attending to the needs of women who use substances, and to advancing the effectiveness of harm reduction programming.

Violence, licit and illicit substance use

Girls' and women's experiences of sexual abuse, interpersonal violence, and other forms of gender-based violence are central to their use of substances. [2]

Women drug users are more likely than their male counterparts to experience sexual violence, and other forms of violence. [3, 4] Additionally, substance-using women are more likely than substance-using men to die prematurely due to violence. [5, 6] In Vancouver's Downtown Eastside—an area renowned for high levels of illicit substance use—over 60 women have been reported missing or murdered in the past two decades. A study conducted in this area of Vancouver found that street-level sex workers were deterred from accessing health, social, and syringe exchange services, because of their need to avoid the physical environments where these services were located, where they were exposed to violence and policing. [7]

Increasing attention is being brought to the interrelationships between historical trauma, continuing or everyday violence, poverty, and structural inequities created by these realities, which affect women's access to integrated and effective health services. [8, 9] Structural inequities in access to services hold true for women who use both licit drugs as well. For example, women who have experienced violence are often prescribed prescription drugs with addictive potential for longer than recommended periods and find minimal support for tapering off these drugs and accessing other forms of support. [10, 11] This exemplifies the need for integrated services that account for gendered harms linked to substance use.

Clearly, in order to address the concerns emerging from the many interacting aspects of violence, trauma, and substance use, harm-reducing systems of care need to be characterized by connections across and among services. Linking between services such as: domestic violence and sexual assault

prevention and recovery programs, supports for residential school survivors, sexual and reproductive health services, STI prevention services, supportive primary care, addictions services, housing, legal aid systems, and so forth, would allow for more effective harm reduction programming.

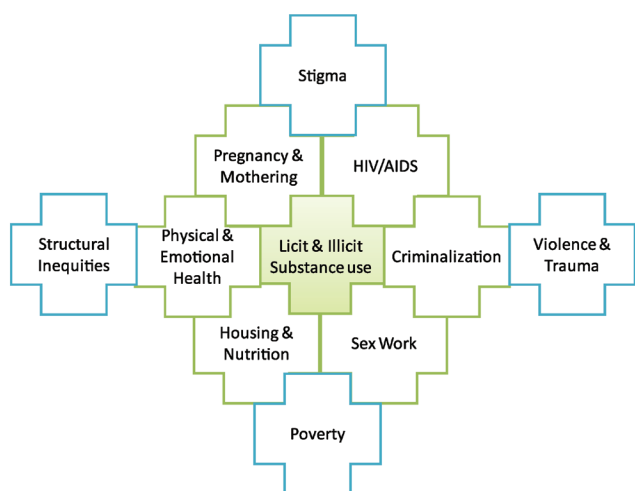
Pregnancy and mothering

Pregnancy, mothering, substance use, and social stigma interact to influence the accessibility of healthcare for women.

Highly negative views of women's substance use deter pregnant women and mothers who use substances from accessing health-related and social services for fear of being judged, treated poorly, and losing custody of their children. [12-15] As a result, the opportunity to respond to women's need for connection, discussion of substance use, prenatal care, overall health care, practical supports, methadone treatment, and other harm reduction strategies are forestalled. These types of information and support, which can improve the birth outcomes of women's children, as well as their own health, are therefore missed. [16]

However, there are cases where gendered harm reduction strategies are being implemented. Non-judgmental, comprehensive outreach programming for pregnant women is now being delivered as a best practice in Toronto, Edmonton, Calgary, Vancouver, Hamilton and many other locations across Canada. [17-20] Key maternity care services are also shifting their service paradigms to assist women to reduce harms associated with illicit drug use in pregnancy and to retain custody of their children postpartum. [21] Mothers are becoming actively involved in identifying strategies for reducing harms associated with their substance use. For example, mothers were involved in developing the Start Thinking About Reducing Second Hand Smoke program. [22]

Despite some advances, particularly in the promotion of harm reducing approaches for pregnant women with alcohol problems, we have a long way to go. To improve the accessibility of harm reduction programming, and reduce gendered harms to women who use substances and their children, we need to counter harsh media representations, eliminate rigid abstinence-only service policies, and address ill formed and punitive drug policy and child welfare policy affecting pregnant women and mothers who use drugs. [23, 24]





Criminalized women

For criminalized women, substance use, mothering capacity, financial insecurity, physical health and emotional health challenges, and for some the impacts of incarceration interact and compound each other.

Criminalized women are most likely to be incarcerated for property crimes such as shoplifting, theft, and robbery [25], crimes that are related to poverty and substance use. Incarcerated women in Canada have high rates of physical health, mental health, literacy, and substance use problems. [26] And yet historically, prison and correctional centre harm-reduction programming related to these overall health concerns has been limited. [27-30] Additionally, approximately two-thirds of Canadian female inmates aged 19–34 years are mothers of children younger than five-years-old. [31] It has been estimated that 25,000 Canadian children are impacted by their mothers' incarceration each year. [32] A range of harms from feelings of guilt and depression, increased use of alcohol and drugs, increased criminal activity, and re-incarceration are associated with separation of criminalized mothers and their children. [33] Aboriginal women are most affected by all the harms related to criminalization, as there is a disproportional representation of Aboriginal women incarcerated in Canada. [34]

Given the strong interaction of health determinants and gendered harms for criminalized women, some agencies are responding with women-centred harm reduction programming and research initiatives. For example, agencies such as the Elizabeth Fry Society are helping community-based and correctional services understand criminalized women's self harm, and are identifying trauma-informed, harm reducing ways of supporting women. [35] Aboriginal women in conflict with the law are also becoming involved in defining their needs for support on substance use issues (highlighting the importance of connection to culture, healing from trauma, and motherhood issues). [36] Criminalized women are also engaging in empowering research projects that define their healing and health service needs within the prison context, shedding further light on what effective gendered harm reduction programming might address. [37-39]

Sex work

Sex workers face significant harms related to the dangers of street work. [40, 41] Harms range from the risk of HIV acquisition, to experiencing discrimination, to conflicts with the law, to being exposed to violence. [42, 43] Yet it can be difficult for sex workers to access information and harm reduction services. [27] The stigma associated with both sex work and substance use operates to affect sex worker's health and limit their access to health care and other supports. [44-46]

Cusick [47] identified the need to broaden the harm reduction agenda from a focus on drugs specifically, to include promoting health among sex workers. She and others emphasize that in the case of sex workers, harm reduction

must examine ways of reducing inequities and challenges associated with entering and exiting sex work. [48, 49] For example, in a study in 2002, a study showed that less than half of the street-level sex workers entered sex work to support an existing drug habit. [50] Rather, they were propelled into street-level sex work by financial need. This finding was confirmed in recent research by a Canadian coalition of sex workers. [48]

In an attempt to address the intersecting needs of sex workers, and mitigate associated harms, the Mobile Access Project (MAP) in Vancouver, BC, serves as a mobile drop-in center for sex workers on the street. The mobile drop-in centre offers a place where women can report “bad dates,” receive resource information and referrals, peer counselling, free condoms, clean needles, emergency medical care, and a safe respite. [51] By offering these services in a manner that is accessible and responsive to women sex workers’ immediate needs, MAP exemplifies women-centred harm reduction strategies.

Housing

Often homeless girls and women are not visible in ways similar to homeless boys and men, as they are ‘under-housed’ versus living on the street. [52, 53] As such, their housing needs are often overlooked in harm reduction strategies. This is problematic, as unstable housing conditions are associated with poorer physical health, mental disabilities, fewer social supports, minimal education, traumatic histories, and little employment history, as well as vulnerability to HIV contraction, alcohol and drug use, and victimization. [54-56] Homeless women are at high-risk for sexual assault. [57] Gender-informed harm reduction strategies acknowledge that adequate housing for women and children is essential to mitigating harms and improving health.

Homeless and domestic violence shelters are part of a continuum of housing needs for women who use licit and illicit drugs. [58] In BC, the Atira Women’s Resource Society offers multiple levels of transition/housing supports for women at various stages of homelessness and recovery from mental health and substance use problems. Sheway, a program for substance using mothers in downtown Vancouver, has shed light on how even a minimal addition of financial support over short periods of time can help mothers secure adequate housing, which in turn reduces a range of harms, and often allows women to retain custody of their children. [59]

HIV/AIDS

Decades into the AIDS pandemic, women are disproportionately impacted by HIV infection. [6] A range of health determinants—including physical, social, economic, and public policy dynamics—interact to put women at risk of HIV infection.

A study of women who were HIV+ in Vancouver’s Downtown Eastside showed high uptake of health and social services, yet limited attention to HIV care, with only 9% of the women on antiretroviral therapy (HAART). [60] In this case, self-reported barriers to accessing treatment were largely attributed to misinformation and misconceptions about treatment. Speaking more broadly, issues surrounding HIV prevention and treatment for women have been summarized by the Vancouver based Positive Women’s Network as follows: 1) no prevention method that women can control without cooperation of her sexual partner; 2) acute biological vulnerability to infection during unprotected heterosexual intercourse (while treatments are still mainly tested on men); 3) controlling partners who limit safer sex, access to health care, support, and financial resources; 4) social expectation to be caregiver to immediate and extended family members limits women’s self-care opportunities; 5) unequal economic power; and, 6) the repercussions of disclosure can equal disaster for women, their children, and their safety. [61] Issues related to pregnancy and mothering are also relevant to reducing harms related to HIV – women who are HIV+ need to be able to access non-judgmental medical care to receive ARV medication which prevents in utero transmission of HIV, medication which is nearly 100% effective if pregnant women with HIV are supported in taking them. [62, 63]

A participatory action research project involving women who use drugs in Vancouver has documented the health inequities and barriers to accessing a wide range of services—including primary health care, and harm reduction services. The research resulted in recommendations for opportunities to improve policy and practice to enhance quality and continuity of primary care for women who use drugs. [64] This study exemplifies core principles of harm reduction and women-centred care – that women/drug users definitions of their needs need to be respected, that human rights to healthcare need to be honoured, and that efforts to make care safe and empowering for women are important. [1, 65]

Examples of women-centred harm reduction

Provided below are examples of women-centred harm reduction programs that offer a scope of services intended to respond to intersecting determinants of women's health.

Atira Women's Resource Society

(www.atira.bc.ca/housing.html)

Atira demonstrates women-centred harm reduction in action. Atira Women's Resource Society is a community-based organization that supports all women, and their children, who are experiencing the impact of violence committed against them and/or their children. Atira's approach is multi-faceted including housing, advocacy, education and support. Combining staged housing, from emergency to long-term, with women-centred services such as 16-step groups and wrap-around support. Atira offers a variety of services for pregnant and parenting women through the Maxxine Wright Community Health Centre, including pre and post-natal medical care, substance use counselling, safety planning as well as food programs and many other services. Emphasis is placed on providing comprehensive women-centred care and wrapping support around women and their children.

Fir Square Combined Care Unit

(www.bcwomens.ca/Services/PregnancyBirthNewborns/HospitalCare/SubstanceUsePregnancy.htm)

The first in Canada to provide care for substance using women and their substance-exposed newborns in a combined unit (mothers and babies room-in together), the Fir Square program provides non-judgmental assessment, detoxification, care and support to substance using pregnant women. Guided by a harm reduction philosophy, the overall aims of the program are to help reduce substance use and related risks, to help women gain confidence with parenting and, ultimately, to support mothers and their babies to safely stay together after they leave hospital. The program meets the needs of women through collaboration with community groups and with child welfare services, as well as through the provision of addiction services, and education about infant development.

Wish Drop-in Centre Society

(www.wish-vancouver.net/index.cfm)

The Wish Drop-in Centre provides services for women in sex work, or seeking to exit sex work, in a non-judgmental, nurturing environment. In addition to providing essential needs, such as nursing care, hot meals, showers and clothing, Wish provides referrals to substance use treatment, rehabilitation housing, and shelters. Opportunities to alternative lifestyles are supported by the Wish Literacy and Learning Centre. Wish also partners with other groups to provide opportunities for research and services, including the Mobile Access Project, a mobile drop-in center for sex workers on the street. (www.wish-vancouver.net/index.cfm?go=site.index§ion=programs&page=map)

Community-Based Research with Criminalized Aboriginal Women

(www.addictionresearchchair.com/creating-knowledge/national/cihr-research-project/)

This study is a community-based collaborative research project between the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse and the University of Saskatchewan. The project examined the role that identity and stigma have in the healing journeys of criminalized Aboriginal women in treatment for illicit drug use. In efforts to share the findings of the research, a powerful music video called From Stilettos to Moccasins was released giving voice to Aboriginal women healing from drug abuse, addictions and problems with the law, together with those who are helping them on their journey (www.youtube.com/watch?v=1QRb8wA2iHs). Hopefully, through a better understanding of the experience of criminalized Aboriginal women, treatment services can be improved to meet their needs and the needs of the community overall.



Moving forward

Clearly the territory of reducing harms related to women's substance use, and related health and social concerns is inviting action. The way in which women's health determinants act and interact need to be taken into account in all we do; the damaging effects of the intersections between poverty, experience of violence, racism, gendered patterns of drug use/harms, and lack of support for mothering are critical to address. We are beginning to acknowledge how a combination of work on structural interventions in legal and policy arenas, physical and social environmental changes such as access to safer sex work and supportive housing, improved support through a seamless service network, as well as support for peer driven action will be important.

Discussion questions

The following questions are intended to support direct-service providers, program leaders, and system planners in reflection on their current practices, policies, and procedures.

1. What have you noticed about the links between poverty, mothering, substance use and violence? How might these interconnections impact the care a woman receives?
2. Consider your understanding of harm reduction. In what way, if any, has the information in this discussion guide influenced your understanding?
3. How might your program link with other women-centred harm reduction programs?
4. How is the role of trauma understood in your service? How does this translate into policies and program development?
5. If a pregnant woman with substance use problems were to describe her initial interaction with your program, what might she say? How would she feel? What might be some of the barriers to receiving care? What are the strengths of your service that would encourage her to come back?
6. How does your service work to address some of the stigma and barriers women face in accessing services? Are there specific needs to be addressed for pregnant women? What about for women in conflict with the law?
7. Why is it important to shift from a continuum of harm reduction services lens, to a determinants of health lens? How might this impact your program/policies? How does this involve the greater community?
8. What training is available to support service providers in using a gender-informed harm reduction approach?

Weblinks

Peer Support

Women's Harm Reduction International Network (WHRIN)
www.talkingdrugs.org/womens-harm-reduction-group
The WHRIN works to create and maintain an international network for women and those working with them who are engaged in HR in order to share resources, disseminate materials, provide a forum for discussion and a basis for advocacy and training.

Housing

The Street Health Report – Women and Homelessness
www.streethealth.ca/Downloads/SHResearchBulletin-2.pdf
This bulletin provides a comprehensive overview of the physical and mental health, well-being, access to health care, and daily realities of homeless women in Toronto.

Coming Together: Homeless women, housing and social support

www.comingtogether.ca

The website describes an arts-based community research project exploring how women and transwomen who are marginally housed in Toronto built support networks with each other in order to survive.

HIV/AIDS

Positive Women's Survival Kit (International Community of Women Living with HIV/AIDS)

www.icw.org/files/Survival%20Kit.pdf

This education resource is based on the shared experiences of women living with HIV around the world. A range of topics are covered including pregnancy and mothering, relationships, sex work and women in prison.

Integrating gender into HIV/AIDS programmes

www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf

This tool helps programme managers and health-care providers in the public and private sectors integrate gender into HIV/AIDS programmes they wish to set up, implement and evaluate so they are more responsive to women's needs.

Sex Work

Wish Drop in Centre Society

www.wish-vancouver.net/index.cfm?go=site.index§ion=about&page=mission

To increase the health, safety and well-being of women working in the sex trade in Vancouver's Downtown Eastside, WISH provides a range of services and supports and engages in advocacy, community education, and relationship building.

Sex Professionals of Canada (SPOC)

www.spoc.ca

The SPOC provides information about legal, health and advocacy issues surrounding sex work and sex workers rights.

Pregnancy and Mothering

National Advocates for Pregnant Women

<http://advocatesforpregnantwomen.org/>

The US based National Advocates for Pregnant Women (NAPW) seeks to protect the rights and dignity of pregnant and parenting women, and those who are most vulnerable including low income women, women of color, and drug-using women —through involvement in court challenges to punitive reproductive health and drug policies and public education efforts.

A Visceral Grief: Young Homeless Mothers and Loss of Child Custody

www.urbancentre.utoronto.ca/pdfs/researchbulletins/CUCSRB34Novacetal.pdf

This research paper from the Centre for Urban and Community Studies describes the experience of young homeless mothers who lose custody of their child and the service interventions available to the mothers.

Criminalized Women

Caught in the Net

www.aclu.org/drug-law-reform/caught-net-impact-drug-policies-women-and-families

This US report advocates for drug laws and policies that adequately take into account the needs of women and their families, and address the root causes of women's involvement with illegal drugs.

Girls and Young Women

It's a Girl Thang! A Manual on Creating Girls Groups

www.mcs.bc.ca/pdf/its_a_girl_thang.pdf

This Canadian resource presents an innovative girls group program model which uses a relational/cultural framework to guide the prevention and intervention of at risk and marginalized girls. Girls were invited to share their experiences and help shape the manual.

What's your problem? – Claymation project

www.youtube.com/watch?v=HSPedmfqR5U

Researchers and support workers collaborated with an Aboriginal Girls Group in Chase, BC to create this claymation project with a message around date rape and alcohol.

Summary

This discussion guide was prepared to assist individuals and agencies working on the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances* with the application of gender-based analysis. Hopefully it will be a useful resource in the development of "gender-informed" harm reduction initiatives by those working on the Framework, and by others interested in improving policy and practice related to substance use and addiction in Canada.

References

1. Government of British Columbia, *Harm Reduction: A British Columbia Community Action Guide*. 2005: Victoria, BC.
2. Logan, T., et al., *Victimization and substance abuse among women: Contributing factors, interventions and implications*. Review of General Psychology, 2002. **6**(4): p. 325-397.
3. Pinkham, S. and K. Malinowska-Sempruch, *Women, Harm Reduction and HIV*. 2007, International Harm Reduction Development Program of the Open Society Institute: New York, NY.
4. UNODC, *HIV/AIDS Prevention and Care for Female Injecting Drug Users* 2006, United Nations Office on Drugs and Crime: Vienna.
5. Miller, C.L., et al., *Factors associated with premature mortality among young injection drug users in Vancouver*. Harm Reduction Journal, 2007. **4**: p. 1-7.
6. Spittal, P., et al., *Drastic elevations in mortality among female injection drug users in a Canadian setting*. AIDS Care, 2006. **18**(2): p. 101-108.
7. Shannon, K., et al., *Mapping violence and policing as an environmental structural barrier to health service and syringe availability among substance-using women in street-level sex work*. International Journal of Drug Policy, 2008. **19**(2): p. 140-147.
8. Bungay, V., et al., *Women's health and use of crack cocaine in context: Structural and 'everyday' violence* International Journal of Drug Policy, in press.
9. Shannon, K., et al., *Social and structural violence and policing in mitigating HIV risk of drug-using women in survival sex work*. Social Science & Medicine, 2008b. **66**(4): p. 911-921.
10. Currie, J.C., *Manufacturing Addiction: The over-prescription of benzodiazepines and sleeping pills to women in Canada*. 2003, British Columbia Centre of Excellence for Women's Health: Vancouver, BC.
11. Poole, N., et al., *Substance use by women using domestic violence shelters*. Substance Use & Misuse, 2008. **43**(9): p. 1129-1150.
12. Poole, N. and B. Isaac, *Apprehensions: Barriers to Treatment for Substance-Using Mothers*. 2001, British Columbia Centre of Excellence for Women's Health: Vancouver, BC.
13. UNODC, *Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned*. 2004, United Nations Office on Drugs and Crime: Vienna, Austria.
14. Boyd, S.C., *Mothers and illicit drugs: transcending the myths*. 1999, Toronto: University of Toronto Press.
15. Stadnyk, B., K. Kennedy, and C. Smith, *Women Who Inject Drugs: Who We Are: The View from Here*. 2007, AIDS Programs South Saskatchewan: Regina, SK.
16. Burns, L., et al., *Methadone in pregnancy: treatment retention and neonatal outcomes*. Addiction, 2007. **102**(2): p. 264-270.
17. Hume, L. and N. Bradley, *Reaching Mothers and Children Affected by Substance Use*, in *Highs and Lows: Canadian Perspectives on Women and Substance Use*, N. Poole and L. Greaves, Editors. 2007, Centre for Addiction and Mental Health: Toronto, ON. p. 257-262.
18. Watkins, M., & Chovanec, D, *Women working toward their goals through AADAC Enhanced Services for Women*. March 2006, AADAC: Edmonton, AB.
19. Poole, N., *Evaluation Report of the Sheway Project for High Risk Pregnant and Parenting Women*. 2000, British Columbia Centre of Excellence for Women's Health: Vancouver BC.
20. Sword, W., A. Niccols, and A. Fan, *"New Choices" for women with addictions: perceptions of program participants*. BMC Public Health, 2004. **4**: p. 10-11.
21. Abrahams, R.R., et al., *Rooming-in compared with standard care for newborns of mothers using methadone or heroin*. Canadian Family Physician, 2007. **53**: p. 1722-1730.
22. AWARE. *Start Thinking About Reducing Second Hand Smoke*. [cited 2010 February 22]; Available from: <http://www.aware.on.ca/resources/resources-service-providers>.
23. Boyd, S.C., *From Witches to Crack Moms: Women, Drug Law, and Policy*. Revised 2nd ed. 2006, Durham, NC: Carolina Academic Press.
24. Klee, H., M. Jackson, and S. Lewis, *Drug Misuse and Motherhood*. 2002, New York, NY: Routledge.
25. Bayes, S. *A Snowball's Chance: Children of Offenders and Canadian Social Policy*. Available from: www.elizabethfry.com/A_SNOWBALLS_CHANCE.pdf
26. Hume, L., B. Grant, and A. Furlong, *Substance Abuse Programming for Women in the Criminal Justice System*, in *Highs and Lows: Canadian Perspectives on Women and Substance Use*, N. Poole and L. Greaves, Editors. 2007, Centre for Addiction and Mental Health: Toronto, ON. p. 333-340.
27. Gahagan, J., L. Rehman, and A.M. DiCenso, *Access to HIV prevention, care, treatment and support programs and services among women in the national prison system: A Canadian perspective*, in *International Conference on AIDS*. 2004: Halifax, NS.
28. Martin, R.E., et al., *Drug use and risk of bloodborne infections: a survey of female prisoners in British Columbia*. Canadian Journal of Public Health, 2005. **96**(2): p. 97-101.
29. Rehman, L., et al., *Harm reduction and women in the Canadian national prison system: Policy or practice?* Women & Health, 2004. **40**(4): p. 57-73.
30. Small, W., et al., *Incarceration, addiction and harm reduction: inmates experience injecting drugs in prison*. Substance Use & Misuse, 2005. **40**(6): p. 831-843.
31. Correctional Service of Canada. *Mother-Child Program*. Available from: <http://www.csc-scc.gc.ca/text/prgrm/fsw/pro02-5-eng.shtml>.
32. Cunningham, A. and L. Baker. *Invisible Victims: the Children of Women in Prison*. Voices for Children December 2004; Available from: www.lfcc.on.ca/Voices_Report-Invisible_Victims.pdf.
33. Salmon, A., *Briefing note addressing concerns about the closure of the Alouette Correctional Centre for Women's Mother and Baby Program, announced on the grounds of infant safety*. 2009, BC Women's Hospital: Vancouver, BC.
34. NWAC, *Aboriginal Women and the Legal Justice System in Canada*. 2007, Native Women's Association of Canada Ottawa, ON.
35. Dell, C.A. and T. Beauchamp, *Self-Harm Among Criminalized Women*. 2006, Canadian Centre on Substance Abuse Ottawa, ON.
36. Dell, C.A., et al., *Beginning with our voices: How the experiential stories of First Nations women contribute to a national research project*. Journal of Aboriginal Health, 2009. **5**(1).
37. Martin, R.E., et al., *Healing fostered by research*. Canadian Family Physician 2008. **54**(February): p. 244-245.
38. Women in 2 Healing. Available from: <http://www.womenin2healing.org/Who%20We%20Are/who%20we%20are.html>.
39. Martin, R.E., et al., *Primary health care: applying the principles within a community-based participatory health research project that began in a Canadian women's prison*. Global Health Promotion, 2009. **16**(4): p. 43-53.
40. Spice, W., *Management of sex workers and other high-risk groups*. Occupational Medicine, 2007. **57**(5): p. 322-328.

41. Whynot, E., *Women who use injection drugs: The social context of risk*. Canadian Medical Association. Journal, 1998. **159**(4): p. 355.
42. Werb, D., et al., *HIV risks associated with incarceration among injection drug users: implications for prison-based public health strategies*. Journal Of Public Health (Oxford, England), 2008. **30**(2): p. 126-132.
43. Mehrabadi, A., et al., *Gender differences in HIV and hepatitis C related vulnerabilities among Aboriginal young people who use street drugs in two Canadian cities*. Women & Health, 2008. **48**(3): p. 235-260.
44. Benoit, C., D. Carroll, and M. Chaudhry, *In search of a Healing Place: Aboriginal women in Vancouver's Downtown Eastside*. Social Science & Medicine, 2003. **56**(4): p. 821-833.
45. Benoit, C., L. Shumka, and D. Barlee, *Stigma and the Health of Vulnerable Women, Research Brief #2*. December 2009, Women's Health Research Network of BC Victoria, BC.
46. Shannon, K., et al., *Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work*. Social Science & Medicine, 2008. **66**(4): p. 911-921.
47. Cusick, L., *Widening the harm reduction agenda: From drug use to sex work*. International Journal of Drug Policy, 2006. **17**: p. 3 - 11.
48. Strega, S., L. Casey, and D. Rutman, *Sex workers addressing treatment*. Women's Health and Urban Life, 2009. **8**(1): p. 42-53.
49. Rekart, M., *Sex-work harm reduction*. The Lancet. **366**(9503): p. 2123-2134.
50. Dalla, R., *Night moves: A qualitative investigation of street-level sex work*. Psychology of Women Quarterly, 202. **26**: p. 63-73.
51. Janssen, P.A., et al., *Peer support using a mobile access van promotes safety and harm reduction strategies among sex trade workers in Vancouver's Downtown Eastside*. Journal Of Urban Health: Bulletin Of The New York Academy Of Medicine, 2009. **86**(5): p. 804-809.
52. Erickson, P., King, K., & YWIT, *On the Street: Homelessness in Young Women*, in *Highs and Lows: Canadian Perspectives on Women and Substance Use*, N.P.L. Greaves, Editor. 2007, Centre for Addiction and Mental Health: Toronto, ON. p. 51-58.
53. Khandor, E. and K. Mason, *The Street Health Report 2007*. 2007, Street Health: Toronto, ON.
54. Elifson, K.W., C.E. Sterk, and K.P. Theall, *Safe living: the impact of unstable housing conditions on HIV risk reduction among female drug users*. AIDS And Behavior, 2007. **11**(6 Suppl): p. 45-55.
55. Dinning, B.L., *The Experience of Homeless Women: Considerations for an Effective Harm Reduction Response*. April 2005, Cornerstone Women's Shelter: Ottawa, ON.
56. Freund, P. and D. Hawkins, *What Street People Reported About Service Access and Drug Treatment*. Journal of Health & Social Policy, 2004. **18**(3): p. 87-93.
57. Khandor, E., & Mason, K., *The Street Health Report 2007*, in *Street Health*. 2007: Toronto, ON.
58. Poole, N., et al., *Substance Use by Women Using Domestic Violence Shelters*. Substance Use & Misuse, 2008. **43**(8/9): p. 1129-1150.
59. Salmon, A. *The Impact of MEIA-funded Support on Sheway Clients*. Presentation at Network Action Team on FASD Prevention Biannual Meeting. 2010. Victoria, BC.
60. Shannon, K., et al., *Access and utilization of HIV treatment and services among women sex workers in Vancouver's downtown eastside*. Journal of Urban Health, 2005. **82**(3): p. 488-497.
61. Summers, M. *Women and HIV*. Presentation at *Presentation for Exploring Social Locations: Women's Health & Policy in Canada--Public Lecture Series*. March 17, 2008. Vancouver, BC: Women's Health Research Network and SFU Institute for Critical Studies in Gender and Health.
62. WHO, *PMTCT Strategic Vision 2010 -2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals 2010*: Geneva, Switzerland.
63. Csete, J., R. Pearshouse, and A. Symington, *Vertical HIV transmission should be excluded from criminal prosecution*. Reproductive Health Matters, 2009. **17**(34): p. 154-162.
64. VANDU Women CARE Team, *"Me, I'm Living It": The Primary Health Care Experiences of Women who use Drugs in Vancouver's Downtown Eastside*. 2009, British Columbia Centre of Excellence for Women's Health and the Women's Health Research Institute: Vancouver, BC.
65. Payne, S., *In-Hospital Stabilization of Pregnant Women who Use Drugs, in Highs and Lows: Canadian Perspectives on Women and Substance Use*, N. Poole and L. Greaves, Editors. 2007, Centre for Addiction and Mental Health: Toronto, ON. p. 249-255.

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