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(Re)shaping the self: An ethnographic study of the embodied and spatial practices of women who use drugs

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ABSTRACT

While gendered experiences of drug use have been well-established, understanding how women resist structures that constrain their agency is important for mitigating drug-related harms, especially as overdose has become North America's leading cause of accidental death. Drawing on the intersectional risk environments of WWUD, this ethnographic study examined how gendered expectations of women's drug use, appearance, and comportment influenced vulnerability to overdose within the context of a fentanyl-driven overdose crisis. This community-engaged ethnography, conducted in Vancouver, Canada from May 2017 to December 2018, included in-depth interviews with 35 marginally-housed WWUD (transgender-inclusive) and approximately 100 h of fieldwork in single room accommodation (SRA) housing and an established street-based drug scene. Data were analyzed thematically with attention to embodiment, agency, and intersectionality. Findings highlight how gendered expectations and normative violence impacted women's use of space, both in the drug scene and SRAs. To resist efforts to 'discipline' their bodies, participants engaged in situated gender performances. Physical appearance was also deemed critical to managing drug use disclosure. Participants adopted gendered embodied practices, including altered consumption methods or injecting in less visible areas, to conceal their use from peers and at times, their partners. To resist harms associated with involuntary disclosure, participants often used alone in SRAs or in public spaces. While such practices allowed women to exert agency within constraining systems, they concurrently heightened overdose risk. Findings demonstrate how women engaged in everyday acts of resistance through embodied drug use practices, which increased their agency but elevated overdose risk. Implementing gender-specific programs that increase bodily agency and control (e.g. low-threshold services for personal care, women-focused harm reduction support) are needed to reduce risk of overdose for WWUD.

1. Introduction

Drug use is gendered, resulting in variations in treatment experiences, drug use patterns and outcomes, and reasons for use (Bourgois et al., 2004; El-Bassel et al., 2014; Hansen, 2017; Iversen et al., 2015). However, drug policies, clinical practices, and media and public health discourses often construct drug use among women and gender diverse persons in ways that position them as more vulnerable to drug use and related harms (Pienaar et al., 2018; Keane, 2017; Dwyer and Fraser, 2017; Thomas and Bull, 2018). By constituting drug use among women and gender diverse persons as 'problematic,' these discourses effectively create an issue to rectify (Bacchi, 2015), while simultaneously constructing their bodies as objects of governance (Thomas and Bull, 2018; Boyd, 2015; Du Rose, 2015). Specifically, these narratives produce, reproduce, and reinforce hegemonic notions of femininity and victimization, locating women who use illicit drugs (WWUD) as 'morally deviant' due to the embodied practices of drug use (Keane, 2017; Dwyer and Fraser, 2017; Du Rose, 2017; Ettorre, 2004). For WWUD, gendered discourses of drug use, addiction, and risk operate as a form of biopower by regulating and 'disciplining' their bodies (Hansen, 2017; Keane, 2017; Knight, 2017; Bourgois, 2000) as made evident through policies criminalizing pregnant women and mothers who are suspected of using

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drugs (Boyd, 2015, 2019) and the increasing number of women incarcerated on drug charges (Zinger, 2018). Women's engagement in practices constructed as unfeminine are connected with additional social locations (e.g. race, sexuality, class), and can reinforce women's marginalization through systemic racism, the criminalization of poverty, and gender inequities (Hansen, 2017; Knight, 2017; Boyd, 2019; Boyd et al., 2018).

Built environments are key sites where the regulation and disciplining of women's bodies take place (Malins et al., 2006). Historically, women have been associated with private (i.e. domestic) and suburban space, with public and urban space gendered as masculine (Bondi, 1998). Such heteronormative binaries have been reinforced by built environments and gendered discourses that contextualize public space as dangerous for women (e.g. women need protection) (Pain, 2001; Kern, 2010), impacting how women navigate public areas. These interactions also intersect with social locations and inequities (e.g. sexism, racism) to create heterogeneous experiences for women (Pain, 2001; Parker, 2011). However, the relationship between space and gender is dynamic; not only changing within socio-historical contexts, but also actively resisted and embodied (Parker, 2011; Mehta and Bondi, 1999). Research has illustrated how women negotiate urban space in ways that resist social and structural dynamics (e.g. gendered violence, gentrification) aimed at restricting their movement in public areas (Boyd, 2010; Kern, 2007; Klodawsky, 2006). Thus, women often embody discourses through daily practices that can reinforce hegemonic ideals through their self-regulation of the body (e.g. appearance, passivity) while also enhancing their agency within the built environment (Mehta and Bondi, 1999).

This relationship between gendered expectations, space, and the body has important implications for WWUD. Research has highlighted how the (re)shaping of urban space through processes such as gentrification and revitalization can adversely impact the health-outcomes of WWUD in public or semi-public areas (e.g. washrooms, parking lots) (Malins et al., 2006). The negotiation of multiple risks related to using drugs in public spaces (e.g. criminalization, sexual assault, theft) can further contribute to health harms and impact women's engagement in harm reduction services (Boyd et al., 2018; Pinkham and Malinowska-Sempruch, 2008). Given these social dynamics, WWUD – particularly those who use in public – occupy a liminal space in which their embodied actions contest socio-cultural expectations of 'womanhood' and women's bodies (e.g. maintaining beauty ideals, reproduction) (Malins et al., 2006). It is within this liminal space that actions magnifying WWUD's visibility within urban space (e.g. injecting in public, street-based sex work) can push the boundaries of accepted gendered performance, thereby increasing risk of gendered violence (Malins et al., 2006; Epele, 2002; Epele, 2001; McNeil et al., 2014). Exploring how WWUD resist efforts to discipline their bodies as they navigate the social and built environments is imperative for implementing services better attuned to their needs.

Understanding these dynamics is particularly important in Vancouver, British Columbia (BC), Canada, which is experiencing overlapping housing and overdose crises (BC Coroners Service, 2019; Collins et al., 2018), the latter driven by fentanyl contamination of the illicit drug supply (BC Coroners Service, 2019). The epicenter of these epidemics is the Downtown Eastside, a roughly 10-block area shaped by drug criminalization, housing instability, poverty, and gendered violence (Collins et al., 2018). This neighbourhood is also home to a high concentration of single room accommodation (SRA) housing (i.e. buildings where tenants rent single rooms with shared washrooms and, if available, kitchen facilities) – one of the few forms of low-income housing accessible to people who use drugs in Vancouver (Collins et al., 2018; Fleming et al., 2019). Notably, the majority of fatal overdoses across North America are occurring in housing (Mack et al., 2017), with approximately 88% of fatal overdoses in Vancouver happening indoors (BC Coroners Service, 2019). Further, WWUD have accounted for approximately 20% of fatal overdoses in BC (BC Coroners Service, 2019), with Indigenous women experiencing eight times as many non-fatal overdose events and five times as many fatal overdoses as white women (First Nations Health Auth, 2017). As such, there is a need to explore the overlapping effects of systemic racism, colonialism, and gendered violence on overdose risk for marginally housed WWUD to effectively address women's overdose vulnerability.

Understanding how gender shapes the spaces where women use drugs and how women produce and resist gender norms through drug use practices is important. Examining how women resist social and built environmental factors aiming to discipline their bodies and limit their bodily agency is critical to developing structural interventions that minimize social and health inequities for WWUD. This work situates the daily lives of WWUD within a gendered drug scene, but draws attention to the various ways that women resist and challenge the processes and relationships that serve to marginalize them. In doing so, this work seeks to center the agency of WWUD.

In what follows, we first frame out the hegemonic forms of masculinity operating in the Downtown Eastside and how women negotiate gender power relations within this context. We then illustrate how gender power dynamics in the drug scene extend into SRA housing in ways that require WWUD to engage in particular practices to minimize risk of harm. Next, we demonstrate how women internalized gendered expectations in ways that became central to their experiences as WWUD. Within this, we describe how women's drug use led to physical changes that not only risked making their drug use visible on the body, but also challenged their ability to maintain gendered beauty ideals. Finally, we illustrate how risks associated with drug use disclosure for WWUD led women engage in embodied drug use practices, which can increase risk of fatal overdose.

2. Methods

This ethnographic study was conducted in Vancouver's Downtown Eastside between May 2017 and December 2018 to examine the impact of overlapping housing and overdose crises on women's risk of overdose. Ethnography has a long-standing history in substance use research, and provides deeper insights into social phenomena than epidemiological approaches (McNeil et al., 2015; Bourgois and Bruneau, 2000; Johnson and Vindrola-Padros, 2017). Undertaking ethnographic research within the context of overlapping housing and overdose crises was critical to capturing the lived experiences of WWUD, while contextualizing agency, risk, and embodied processes (Rhodes et al., 2012). This ethnography draws on an intersectional risk environment framework (Collins et al., 2019). The intersectional risk environment is a type of situational assemblage in which the relations between place, objects, and processes that interact with socio-historical and geographic contexts converge to produce diverse health effects based on social locations (e.g. sexuality, gender) (Collins et al., 2019). In brief, this framework demonstrates the dynamic interplay between social structures, systems, and individuals, highlighting individuals are not independent of their environments (see 41 for a more complete discussion of this framework). As such, the framework situates PWUD as active participants in their intersectional risk environments, while foregrounding the complexities and diverse experiences of PWUD through a focus on social locations. In doing so, the intersectional risk environment adds nuance to our understanding of how health outcomes and drug-related risks are experienced, and points attention to how the agency of PWUD is shaped by extra-individual forces and variegated based on their level of structural vulnerability and experiences of social violence (Collins et al., 2019).

The first author conducted approximately 100 h of fieldwork in SRA housing environments, interventional settings (e.g. consumption sites), neighbourhood areas (e.g. parks), and services frequently accessed by women (e.g. social services, vending areas). Fieldwork undertaken in privately-operated SRAs was conducted alongside a women-specific peer-led outreach program. This involved naturalistic observations

and unstructured conversations with WWUD, service providers, and people within their social networks. Fieldwork allowed for detailed and nuanced observation of the environments in which participants lived (Hesse-Biber and Leavy, 2006). Written fieldnotes documenting observations, conversations, and interactions were written immediately following each session, and situated interactions and observations within social and structural contexts (e.g. building and operational policies, gender dynamics) (Hammersley and Atkinson, 2007; Leslie et al., 2014). Utilizing the extended case method (Burawoy, 2009), fieldwork observations were embedded within geographic, historical, and social-structural (e.g. poverty, gender inequities) contexts to highlight the impact of multiple vulnerabilities on the daily lives of WWUD. Attention was paid to intersectional experiences and how these shaped, and were shaped by, dynamics within the risk environment (Collins et al., 2019).

Participants were recruited through fieldwork, social networks, and posters placed in non-profit-operated SRAs and women-focused services by the lead author and one of two women-identified peer researchers. Ten high-overdose SRAs were chosen for recruitment – five privately-operated and five non-profit-owned and operated – from preliminary overdose data provided by the health authority, Vancouver Coastal Health. Because SRAs rapidly transitioned from being privately-operated to privately-owned and non-profit operated, an additional category was added to capture these changes. SRAs in Vancouver vary in levels of maintenance and access to amenities (e.g. harm reduction supplies, cooking facilities), with privately-operated SRAs often operating with substandard conditions and high levels of violence (Collins et al., 2018; Lazarus et al., 2011). The targeted SRAs were selected to ensure that a range of building environments were documented, including SRAs with overdose prevention interventions, women's-only and transitional housing, and SRAs lacking harm reduction supplies.

We aimed to recruit five participants from each SRA for a total of 50 participants. While this was achieved in non-profit-owned and operated buildings, we encountered challenges when trying to find women living in privately-operated SRAs. We thus expanded our recruitment to WWUD living in any privately-operated SRA, rather than only targeted SRAs. Even with these changes, only 35 women (transgender inclusive) were recruited. These recruitment challenges suggest that WWUD living in privately-operated SRAs may experience high levels of marginalization and social isolation, which also limit their engagement with health and ancillary services.

Longitudinal semi-structured qualitative interviews were conducted at baseline and 6-month follow-up. At baseline, 35 women completed interviews, with 20 completing follow-up interviews (see Table 1). The remaining participants were lost to follow-up due to changing contact information (e.g. inactive cell phones, moves), building closures, and ending engagement with services that served as primary forms of contact. Interviews were conducted at our field research office, with one conducted in a participant's room due to limited mobility. Interviews were facilitated using an interview guide that sought to elicit perspectives on topics such as gendered dynamics of the overdose crisis, experiences living in SRAs, and overdose risk. Interviews averaged 45 min in length, were audio recorded, and were transcribed verbatim by a transcription service. Transcripts were reviewed for accuracy by the lead author. Participants received $30 CAD honorarium for each interview. Follow-up fieldwork was also conducted with interested baseline participants, who received $30 CAD after each session. This study received ethical approval from the Research Ethics Boards of Providence Healthcare/University of British Columbia and Simon Fraser University.

Data were imported into NVivo qualitative data analysis software program and analyzed thematically by the lead author with attention to embodiment and agency. An intersectional risk environment framework was used throughout the analytical process to better elucidate the variegated ways in which women's social locations and identities impacted their experiences and shaped their drug-related outcomes. This analysis focused on how gendered expectations of women's drug use and their bodies influenced vulnerability to overdose within the context of a fentanyl-driven overdose epidemic. While questions related to appearance were not asked directly in interviews, these were frequently discussed in both interview and fieldwork settings.

Table 1
Participant demographics at baseline (n = 35).

Participant characteristic	n (%)
Age	
Mean	42
Range	21–57 years
Ethnicity	
Indigenous	18 (51.5%)
White	15 (42.8%)
Other (Black, Asian)	2 (5.7%)
Gender	
Cisgender	32 (91.4%)
Transgender, two-spirit, non-binary	3 (8.6%)
In a relationship	
Yes	21 (60.0%)
No	14 (40.0%)
SRA housing type	
Non-profit housing	19 (54.3%)
Privately-operated housing	9 (25.7%)
Privately-owned and non-profit-operated housing	7 (20.0%)
Overdoses in past year	
None	18 (51.4%)
One	8 (22.8%)
Two	2 (5.8%)
Three or more	7 (20.0%)

3. Findings

3.1. Femininity, violence, and the drug scene

Political, medical, and social discourses that impacted women's bodies and bodily practices were situated in relation to larger, hegemonic gender roles and racialized dynamics that shaped their practices within the drug scene. Through the operation of gender roles in this setting, especially as they pertained to experiences of victimization, participants came to define 'masculine' and 'feminine' qualities. In highlighting what they viewed as masculine, participants regularly drew on discourses of strength (e.g. not being taken advantage of, utilizing violence, being vocal), being resistant (e.g. not contributing to income generation), and sexualizing others. These more active qualities associated with men were in direct contradiction to the more passive qualities participants linked with women. For example, participants explained that men want a "*meek, little female*" who will "*do nothing and even cry*" rather than someone who will "*stand up to them and beat them up*." While participants often resisted hegemonic expectations of femininity (e.g. "*meek*," "*intimidated*"), noting "*that's not me*," we regularly observed men attempting to intimidate women (e.g. standing over women, yelling) in public spaces.

Women enacted practices that resisted gendered ideals around drug use, while minimizing risk of violence. Although men are more often associated with using drugs alone, women's actions often disrupted these associations. Previous experiences or threats of violence resulted in participants being selective about where and around whom they consumed drugs. 'Lydia' (45-year-old Asian woman) explained how using alone increased her safety following an attack:

> *I use at home. In my apartment. I like to be alone, I don't like to do it in public*. [It's a] *privacy thing and safety. I was attacked really bad two years ago. I was taken hostage for four days and I was badly attacked. So I pretty much stay at home now.*

As Lydia's narrative demonstrates, using alone allowed women to better enact agency and minimize potential risks related to the disclosure of drug use to peers. However, such actions simultaneously

reinforced traditional gendered divisions of public/private space, with women excluded from the public arena as Lydia limited her movement in the neighbourhood.

Various participants also engaged in situated gender performances, in that they exercised or 'did' gender in particular ways (e.g. more masculine performances) given social circumstances. In doing so, women sought to disrupt hegemonic notions of 'womanhood' in relation to their drug use, as this was seen as minimizing risks of gendered violence. For example, 'Sally,' a 30-year-old white woman who had just ended an abusive relationship, described how men perceive WWUD:

> *All my life and problems have to do with men, in some way or another.* [Interviewer: Do you think it's the way men view women in the neighbourhood?] *Definitely. Yeah, 100 percent. Men view women as objects and as targets rather than what they are supposed to be, which are human beings.*

Continuing, Sally explained that she had recently paid off $1000 of drug debt incurred by her ex-partner, which had reinforced the precariousness of her safety from men who were owed money. As a result, Sally noted that men in the neighbourhood now viewed her differently:

> *They* [men] *see me as a fucking threat, and as an actual woman … Like a friend of mine said to me the other day, 'You're one of the most hardest working women that I know down here.' … And that's cool to hear, because that guy is a fucking womanizing, chauvinistic pig that has tried to get down my pants many fucking times, and I keep telling him, 'I'm one of you. Don't fucking treat me like that.'*

Altering how Sally interacted with men – especially drug dealers – was imperative to reshaping how they perceived her. While not owing money was threatening to men, Sally later described how positioning herself as 'one of them,' and in this case working for them, minimized risks of sexual violence.

Similarly, 'Denise' (46-year-old white woman) described how she "*took back* [her] *power*" by repositioning herself "*as a beater, not the beatee,*" a more active role that she expressed gained her respect within the drug scene. However, this ability to resist hegemonic gender roles operating in the drug scene was intimately tied to race, as made evident through variations in how participants described regaining agency. For example, white participants frequently described renegotiating their position through situated gender performances thereby minimizing violence as it related to being a WWUD. Racialized participants, however, often expressed keeping their "*head down,*" suggesting an attempt to render themselves invisible so as to minimize harm. These differences reflect the variegated ways that social-structural injustices (e.g. racism, socio-economic marginalization) and gendered colonialism have targeted Indigenous women in the Downtown Eastside (Martin and Walia, 2019), and may have impacted their ability to challenge gender norms in the same ways as white participants.

3.2. Drug use and risk of violence in SRAs

The gendering of spaces extended beyond public spaces and into SRAs, where threats of violence against WWUD, and particularly Indigenous and racialized women, were observed and encoded onto the built environment. Importantly, SRAs often occupied a liminal space in that they were neither fully private nor public spaces. While this fluctuated between SRA-type (e.g. non-profit-operated, privately-owned) and surveillance mechanisms (Collins et al., 2018), their liminality often mimicked public space for WWUD. While conducting fieldwork in a privately-operated SRA with an outreach group, we regularly observed the objectification and sexualization of younger, racialized and Indigenous women who were heavily sedated in hallways and stairwells, which increased their risk of violence. Surrounded by used supplies and other belongings, we twice observed men interacting with these women in ways that increased their risk of sexualization and violence. In one instance, a younger man who had previously confronted the lead author during fieldwork, towered over a woman. After nudging her leg with his foot and muttering sexualized comments about what he would like to "*do*" to her, he then proceeded to take her keys. Similarly, we were told by a man crouched at the feet of a woman in a heavy nod that he was going to "*protect her*." While holding her two bags we later heard him trying to get her to leave the SRA with him. Such observations were described by participants as commonly experienced by women, and further illustrate the extent to which WWUD were targeted by men in the neighbourhood. During earlier fieldwork with this same outreach team, team members noted that intervening in situations related to gendered violence, or potential violence was unsafe; instead, we were told to 'keep our heads down,' and focus on the women engaged in the program.

While women were more at risk of violence in privately-operated SRAs, common spaces in non-profit-operated buildings were also gendered, with men regularly observed as being the primary occupiers of these spaces. 'Katnisse,' a 36-year-old Indigenous woman who had moved from a privately SRA to a non-profit-operated one since baseline, expressed how her body had already been objectified by men in the building:

> *It's just like, they* [men tenants] *expect women to be like hookers inside there. Like, 'Oh, I'll give you some drugs, you know, if you suck my dick.' You know what I mean? And like, get out of here. Like that's so gross. You know, and the way they kind of look at women, it's pretty sad.* […] *And they know they can push around a woman, and women are easier to push around than men.* […] *That's why I don't associate, I don't use down* [i.e. illicit opioids] *in there* [housing-based consumption room]. *I keep myself separate … If I'm too friendly to them, then that's like inviting, right?*

Katnisse was annoyed by these interactions; she had hoped moving from a private SRA to a non-profit-operated building would have minimized these types of sexualization. However, to reduce unwanted interactions and subsequent violence from her partner, Katnisse kept to herself.

The constant threats of violence experienced by WWUD in these settings were encoded on the built environment through graffiti and written threats (see Figs. 1 and 2). While conducting fieldwork at a non-profit SRA, a message written on the door frame leading into the building addressed a woman by name and threatened to cut her hair if she failed to pay her drug debt – a practice described as commonplace, particularly among women as it made their debt (and therefore drug use) visible to others and degraded them. Similar threats related to drug debts were also inscribed onto a woman's door within a private SRA, telling her to "pay up." The visibility of such risks related to WWUD reinforced participants' desires to minimize visibility of their drug use in these spaces. In doing so, women negotiated gender power relations often by hiding their drug use, an enactment of bodily of agency which allowed them to minimize violence resulting from their resistance of hegemonic gendered norms (i.e. being a woman who used drugs).

3.3. Women's physical bodies – perceptions, changes, and gendered ideals

Gendered expectations endemic within this particular drug scene marked by poverty, were internalized and embodied by participants, and often manifested in 'body talk' that dominated discussions during fieldwork. Body talk, or participant's focus on corporeally-related phenomenon, framed conversations and was central to participants' experiences as WWUD. These narratives largely drew on hegemonic notions of femininity in ways that reinforced women's embodied marginality. Achieving such gendered body ideals was complicated by the particularities of drug use and poverty, and challenged what they viewed as an accepted range of gendered performances for women. Specifically, the body talk engaged in signified that women viewed their bodies as deviating from an ideal due to physical changes, often resulting from

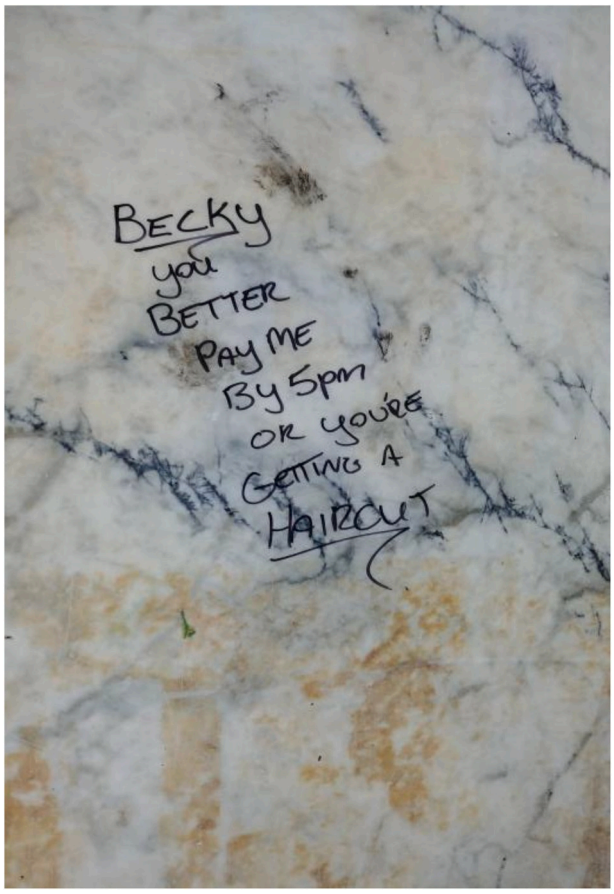

Fig. 1. Threat of violence against women on wall of non-profit-operated SRA.

Fig. 2. Doorway of a woman engaged in an outreach program at a private SRA.

prolonged drug use. These discussions were intimately linked with individualized expectations of presentation of self and how this had been impacted by drug use, and specifically, injection drug use. However, participant's experiences of their body were intertwined with relationships, economic opportunity, and the overdose crisis, and were situated amongst the gendered and racialized drug scene dynamics.

3.3.1. *Hygiene, body odor, and perspiration*

For many participants, conversations about their bodies and those of other women focused on physical manifestations of drug use on the body (e.g. perspiration) and how this was entangled with perspectives of personal cleanliness and physical appearance. This became a source of stress for women as they sought to manage their bodily changes and (re) obtain bodies that they characterized as 'womanly.' For example, 'Hannah,' a 32-year-old Indigenous woman who had started using crystal methamphetamine (meth) to manage her heroin use described how heroin made it challenging to maintain gendered expectations:

> *When I used down* [i.e. illicit opioids] *I didn't give a shit about anything – not about myself, not about my partner, not even about my family back home. … Compared to side* [i.e. meth] *where it's like ah well fuck I have so much there and I can clean – keep myself clean, try to pay attention to my partner when I'm just like zooming around in my room, trying to lie and say I'm not high. Eyes all buggy until I look in the mirror and I'm like holy fuck you're sweating. I was just drowning in my sweat how gross it was. I was like yeah not sexy.*

For Hannah, meth was seen as essential for decreasing heroin use and overdose risk amidst an overdose crisis, but was also viewed as impacting her ability to maintain feminine beauty ideals. Hannah's account also highlights how she perceived meth as altering her facial features (i.e. "*eyes all buggy*") and movement through space (i.e. "*zooming around*") which disclosed her drug use to her partner, and at times necessitated that she used alone. While Hannah viewed her drug use as contributing to unwanted bodily transformations, her narrative also underscores how extreme poverty impacted her ability to maintain individualized expectations of femininity:

> *Before, I'd not give a shit and not noticing how stinky it was until I started cleaning myself up and not having so many shots going into my arm.* […] *I had no senses at all – none. I was like horrified … how the fuck did I smell, right? Like my boyfriend was like, 'Oh come cuddle me' and me not having pit stick on for a good two days and doing side* [meth] *and sweating out all of this toxin. He even got to the point where he bought me body spray.* […] *When I started cleaning up I shaved my legs, my under pits, and I was like, 'Oh my God, no wonder he bought me body spray.'*

Importantly, women's living spaces were cramped – especially if rooms were shared with a partner – with no circulation, and ranged from 100 to 320 sq. feet (City of Vancouver, 2017). Washrooms in SRAs were also regularly observed as closed for maintenance or were too dangerous or dirty to use. While Hannah discussed her body and her ability to maintain gendered norms in relation to her drug use, the overlap of the built environment and extreme poverty further challenged participants' abilities to uphold what they perceived as feminine.

Other participants felt that their drug use had altered their bodies in ways viewed at odds with femininity. Although several participants noted this in passing, 'Megan,' a 28-year-old white woman, frequently illustrated how her heroin use manifested itself in, and on, her body

during fieldwork. In these discussions, Megan described being embarrassed about "*sweating a lot"* which she felt was a result of heroin. To curb these instances, the lead author observed her take small, blue pills from a bag a friend had given her. She explained, "*They're Oxybutynin's. My friend was prescribed them, but a side effect is that they make you stop sweating so she gave some of them to me.*" While Megan's embarrassment around her body were rooted in gendered beauty ideals and the desire to be viewed as attractive to men, she discounted the impact of summer heat and built environmental barriers (e.g. SRA room, no air conditioning).

Other participants distanced themselves from women who they viewed as lacking appropriate levels of hygiene. In these instances, participants linked what they viewed as poor hygiene as incompatible with gendered expectations for women's bodies and impacted how they felt women were perceived by men. 'Angela,' a 42-year-old Indigenous woman, shared that some women "*don't have any respect for themselves*" due to what she viewed as a lack of hygiene:

> *They* [women] *don't have any respect for themselves or the facility* [i.e. social services]. *Like, go to these shelters and shower … It's gross. And they're women. That's the disgusting thing – they're women. And they expect to be treated with respect? Like, they can't even throw their tampons away. Like, that's gross.*

Here, Angela implies that women should be held to a different standard of cleanliness than men. Notably, what Angela viewed as particular women's self-neglect was underlain by structural factors and challenges with the built environment of SRAs (e.g. broken, dirty, or unmaintained washroom facilities, housing instability) that challenged women's abilities to maintain certain levels of hygiene. Angela too noted how "*the bathrooms are fricking gross*" in her SRA: "*I clean it before I use it, and even the shower, the inside – it's gross.*" However, despite structural factors often impeding access to washroom and shower facilities for women, Angela sought to position herself as different from other women through individualized understandings of women's physical appearance. In doing so, Angela sought to maintain a sense of dignity within the context of extreme poverty.

3.3.2. Abscesses, bruises, and track marks

Most participants heavily focused on injection-related abscesses, bruises, and track marks, discussing how such visible markings signified their drug use to others. Importantly, participants noted the implications of involuntary disclosure on increasing risk of violence, compromising work and pay, among other factors. However, women altered embodied drug use practices to minimize involuntary disclosure, including switching method of drug consumption (e.g. smoking versus injecting) and changing where on their bodies they injected. 'Victoria,' a 38-year-old Indigenous woman who had recently switched from injecting to smoking, described: *"It's not a pleasant thing to have to, you know, hide bruises or track marks or whatever."* For Victoria, the transition to smoking was seen not only as something that had "*done* [her] *some good*" and made her "*healthier*," but was also imperative for shaping how others viewed her body. Notably, Victoria stopped injecting because her partner only smokes; a transition first described as "*a conscious decision on* [her] *own, out of respect for him*," but later noted that he had given her an ultimatum. While minimizing involuntary disclosure, Victoria's embodied drug use practices also suggest a minimization of potential harm and increased security as it allowed her to maintain a relationship.

Participants frequently pointed out areas of their bodies where they had abscesses, bruises, or track marks, often noting that they "*really should stop*" or "*cut back*" on their drug use. Some participants viewed such markings as a result of frequent or rushed drug use occurring in washrooms, alleys, or other public spaces in which police may appear. Other participants, however, actively sought places on their bodies (e.g. top of foot, armpit) where they could inject that would not readily disclose their drug use. For example, Lydia (45-year-old Asian woman) described: "*I don't like track marks, so I use my armpit.*" However, if someone was not available to assist her with her injection, Lydia would "*muscle*" it [i.e. inject into the muscle], which she viewed as a better alternative to reduce drug use visibility. Similarly, Megan (28-year-old white woman) explained the impact of track marks on beauty ideals:

> *I don't like jugging* [i.e. injecting into the jugular vein] *at all.* […] *Like I know people that have like done it in their forehead. It just grosses me out. And then, I also don't like the track mark thing, like that's just a really unattractive look, right. Because I don't want to have this just be the rest of my life, right? And I figure, if you have a big track mark on your neck, like it's going to be hard to cover, you know what I mean?*

For Megan, certain practices that disclosed drug use (e.g. track marks) transformed women's bodies into something unattractive. As Megan viewed her use as temporary, remnants of her drug use as made visible through track marks were seen as a potential hindrance in the future.

3.3.3. Changing bodies

Several participants described how their body had changed after injecting for prolonged periods. This body talk was pertinent among both older participants who had been injecting for several decades, and younger participants who had periods of more intense injecting. For example, Angela (42-year-old Indigenous woman) described her venous access as often linked to disclosing her drug use to peers. While accompanying her to an overdose prevention site (i.e. low-threshold drug consumption site), we observed Angela try to inject in a vein located within a large tattoo bearing her ex-partner's name. After several attempts, Angela asked for assistance. Later, Angela described having "*shy veins*" that required her to get help injecting, especially when using around new people and in new places.

Angela's narrative illustrates how her drug use was linked to gendered expectations of women, and fell outside what she viewed as accepted practices. By describing her veins as "*shy*," Angela drew on similar passive language used by participants when describing 'feminine' qualities. In doing so, Angela, like other participants, elucidated how understandings of femininity were largely rooted in invisibility or quietness (e.g. "*meek*," "*little*"). Notably, the anxiety Angela felt when using in new spaces and around new people – namely, at overdose prevention sites – necessitated disclosing her drug use thereby increasing risk of gendered violence while minimizing withdrawals.

Other participants described their weight as being impacted by drug use. Hannah (32-year-old Indigenous woman) explained how her increased drug use caused significant weight loss which not only disclosed her use to others, but also impacted aspects of her body that were seen as feminine (e.g. breasts). In discussing her drug use patterns, Hannah explained:

> *I came down here at 180 lbs. I am probably 100–115 if I'm lucky. I went back home and I was 127 lbs. I came back here in November and I lost probably most of it from November to December. I started gaining it back the beginning of January, because I stopped using heroin, but I picked up side* [meth] *a lot more then. […] I used to be a C38. I had big ass tits … and was almost a size 33 [waist]. Now I'm a 26.*

For Hannah, such weight changes were a source of stress as she worked to minimize involuntary disclosure of her drug use. Again, Hannah faced a complex tension in which she increased her meth use to cut down on heroin amidst an overdose crisis, but in doing so risked increasing involuntary disclosure, which had its own risks.

Weight loss was viewed favorably amongst some participants as it allowed them to better maintain or achieve feminine physical ideals. When asked about her health, 'Ashley,' a 27-year-old white woman who had been living in the Downtown Eastside for less than a year, laughed, saying she was on the "*Jenny Crack Diet*" – a play on Jenny Craig, a popular weight loss company. Continuing, she described how crack

suppressed her appetite:

> *I'm still slimming down, gaining, slimming down, gaining, but I think I'm plateaued at 165, which I never thought I'd see in my entire goddamn life. Before I started doing like the stint of drugs, I was 285. I lost over 100 pounds in a little over a year. But I was, yeah, I was almost 300 pounds and now I'm 165. I'm so happy.*

Importantly, Ashley's narrative highlights how she viewed her transition into drug use positively as it allowed her to achieve a more 'ideal' body. However, this bodily ideal was seen as a balance which could be disrupted by injecting or extended periods of drug use. In relation to other women in the neighbourhood, Ashley described herself as "*still kind of look*[ing] *half-assed normal*" as she only smoked, and attributed this to minimizing her interactions with law enforcement officials as her appearance did not readily disclose her drug use. However, Ashley's positionality – namely, as a "*cute little white girl from a small town*" – also contributed to her fewer engagements with police as her 'whiteness' provided some protection in a neighbourhood in which Indigenous women are disproportionately impacted by policing practices (Martin and Walia, 2019).

3.4. Keeping drug use private

3.4.1. Privacy in space

Women commonly positioned their drug use as something to be kept private, which often led them to use alone. Maintaining such privacy was seen as imperative to minimize being judged by peers or observed while using or intoxicated. Participants' anxieties of being judged suggests that they were aware of how their embodied practices were at odds with broader expectations of women's bodies. By securing privacy, however, women often experienced more pleasure in their drug use as they were not concerned about how others perceived them. For example, 'Susan' (57-year-old white woman) described:

> *I won't do drugs outside. Never have. I don't know, it's just me. I wouldn't want to sit outside and I don't know why, maybe I might react differently. Or people might think, 'Oh look at her,' it's like, you know?*

Susan's concerns about being watched and judged while using were echoed by others who sought more private spaces to consume alone, including private washrooms and stalls, vacant alleys, and their rooms. 'Tina,' a 40-year-old Indigenous woman, felt that others watching her use would be "*embarrassing*." "*I don't want anybody to know or everybody watching me get high or my face or whatever, right?*" However, while using alone in private spaces increased women's experiences of pleasure in their drug use, it simultaneously heightened their overdose risk.

How women felt they were perceived by their peers based on their appearance was a source of persistent deliberation that impacted their embodied drug use practices. Maintaining a specific image, for partners, family, or peers was described as leading to them using alone, thereby increasing overdose vulnerability. For example, Hannah (32-year-old Indigenous woman) highlighted how she hid her use from other tenants to insure her family was unaware:

> *Where I stay, I don't like people knowing what I'm using, how much I'm using, or if I'm using. You know, I'm a closet junkie.* […] *A lot of people know me there* [in the SRA] *right and once my family starts looking for me they'll be like, 'oh yeah' and I don't know if they'll say something about it or what not. Because the person I'm seeing right now he's from the same home town. Yeah and a lot of shit went on back home.*

While Hannah sought to protect her family from her current drug use, others kept their use private because they described not being "*proud*" of it or not wanting to be disrespectful to others by using in public spaces.

Some participants also expressed how keeping their drug use private by primarily injecting and using alone was critical to maintaining their relationship. For these participants, their partners had either stopped injecting, stopped using heroin, or had stopped using drugs completely. While some participants used meth with heroin to minimize their partners suspecting they had continued using heroin, others resisted pressures placed on them by their partners by finding more secluded ways to use and enjoy heroin. Tina highlighted this dynamic with her partner:

> *I don't know if he'd be angry with me, but he probably wouldn't like it. So I try not to bother him cause I know that I could probably stop. I just, I don't know, I feel like it's just like a little treat.* [40-year-old Indigenous woman]

For Tina, who described her partner as becoming more controlling, heroin allowed her to gain pleasure out of her use, while enacting agency as she resisted efforts to control her body. Tina thus regularly sought out the washroom in her SRA to smoke heroin alone, locking the door to maintain privacy from tenants and her partner. This need for participants to maintain privacy in their drug use to uphold feminine ideals and maintain partnerships simultaneously increased their overdose risk as they often chose to use alone. Additionally, women's experiences of racialized and gendered violence in this drug scene might further underlie their self-isolation during drug use, as using alone was an act of bodily agency often positioned as necessary to minimize risk of physical and sexual violence. This collective form of risk reduction undertaken by WWUD, and particularly by Indigenous participants who described using alone as their preferred option, was a rational strategy for minimizing such harms. However, using alone also exacerbated women's risk of fatal overdose, likely contributing to disparities in overdose deaths between Indigenous and non-Indigenous women in the province.

3.4.2. Bodily privacy

Because women's drug use was in many ways stigmatized, participants noted hiding their drug use through gendered embodied practices, which allowed them to better enact agency over their safety. While this largely shaped women's practices of using or injecting alone, it also impacted where on their bodies they used and how they used (e.g. inhalation, injection, snorting). In describing her experiences in the neighbourhood, Ashley (27-year-old white woman) explained:

> *I find that men down here or that come down here, if they see you fucked up, then you're nothing. They don't give a flying fuck of you as a person. And actually, I'm having a lot of issues – 'cause I'm a woman. If I say something, I have to say it like, four or five times for them to believe me.*

However, Ashley felt that she could minimize involuntary disclosure of her use as smoking had not impacted her physical appearance. Despite risks of violence, Ashley preferred to use with "*a few, core key men that are older and have been using for a long time*" who she felt were "*going to make sure it's safe instead of rape* [her]" if she were intoxicated.

Women, and particularly Indigenous women, also highlighted how drug use disclosure could increase their risk of violence from men, and minimize their income through sex work. 'Jessica,' a 45-year-old Indigenous woman who was a sex worker, explained:

> *I'll never use in front of the dates.* [Interviewer: Is that for safety purposes?] *That too, yeah. Because if they see you vulnerable like that, they won't pick you up again.* […] *Or else they'll get one up on you and they'll give you the cheaper price next time. Just a bunch of weird things like that. Total power, right?*

As described, drug use disclosure created space for men to disempower women and increased risk of violence. For Indigenous WWUD, and especially those of whom were sex workers, further contributed to their socioeconomic marginalization, as well as the overlapping racialized and gendered violence epidemics they faced in the neighbourhood (Martin and Walia, 2019; Culhane, 2003; Shannon et al., 2008; Oppal, 2012). Women were thus able to gain more control over their well-being

(both physically and economically) by minimizing who they used in front of. However, other participants chose to use with select clients as this granted them drugs and a higher price for clients. In these instances, woman challenged gender stereotypes and enacted certain gendered performances that improved their income and drug-related needs.

4. Discussion

This research explores the relationship between overdose risk, violence, and gendered expectations amongst marginally-housed WWUD. In doing so, we illustrate the synergistic relationship between these factors, highlighting how they created and reinforced each other in the lives of WWUD. Despite occupying and regularly engaging in gendered spaces in which violence against women was normalized, participants actively resisted social-structural dynamics that aimed to reinforce their marginality. By taking up gendered embodied drug use practices and engaging in situated gender performances, women were able to better negotiate processes aimed at disciplining their bodies and controlling their drug use. While participants' drug-related practices increased their agency, it simultaneously increased overdose risk as they more often used alone.

Our findings highlight how resistance of gendered norms was framed against the everyday violence experienced by women within a drug scene. Previous research examining injecting patterns of WWUD has illustrated how injecting dynamics (e.g. women second on the needle, drug use controlled by male partner) reinforce the objectification and subordination of women and contribute to experiences of interpersonal violence (Iversen et al., 2015; Epele, 2002; Fraser, 2013). Our study adds to this by demonstrating how marginalized women engaged in subtle acts of resistance (e.g. using in secluded spaces, using without partners, hiding their use from partners) to challenge their subordination and regain agency within a context of pervasive violence against WWUD. Within a street-based drug scene, marginally housed women, including those with male partners who used drugs, engaged in spatialized and embodied drug use practices (e.g. using alone) to minimize risk of violence related to drug use disclosure and by doing so, increased drug use pleasure. Efforts to obtain private space to use alone are contradictory to most research which has found that women are less likely to inject alone compared to men (Hagan et al., 2007; Sherman et al., 2001), and often prefer to use amongst people they trust (Cruz et al., 2007; Kerley et al., 2018). These differences may suggest that the rates at which women, and particularly racialized and Indigenous women, experience racism and gendered violence in our study setting are so high (Martin and Walia, 2019) that using alone was seen as safer despite overdose risk. This also may partially explain the large disparities in overdose deaths between Indigenous and non-Indigenous women (First Nations Health Auth, 2019). Understanding these complex dynamics that shape women's preferences to use alone is critical to informing overdose prevention interventions that better suit the needs of women.

Moreover, our findings highlight how space was structured in ways that necessitated vigilance in how WWUD interacted in public (e.g. alleys, sidewalks, washrooms) and private areas (e.g. bedrooms, SRAs). This finding echoes previous research elucidating how fear of violence can restrict women's engagement in public spaces, including drug scene settings (Pain, 2001; Parker, 2011; Mehta and Bondi, 1999; McNeil et al., 2014). Specifically, our findings detail how women sought to minimize risk of gendered violence by often keeping to themselves. In developing and engaging in this collective response to minimize risk of violence, WWUD in this study were able to better meet their needs given a lack of funding prioritization for programs aimed at addressing violence against WWUD. Unlike previous research that has documented women's continued engagement in public areas despite efforts aimed at restricting their movements in these spaces (Mehta and Bondi, 1999), our findings highlight how participants' acts of resistance were enacted through embodied drug use practices. In securing more private drug use spaces, women could consume drugs or use in certain ways (i.e. inject) that were otherwise inhibited by their partners. While such negotiations in space provided women more control, and at times minimized risk of violence, it simultaneously increased overdose risk as this meant using alone. Here, it is evident that women's ability to use in the ways they most desired were prioritized over disclosing their drug use, which not only increased their risk of violence, but also restricted their control. Integrating safer environment interventions (Rhodes et al., 2006; McNeil and Small, 2014) (e.g. peer-witnessing programs, technology-based overdose prevention interventions) into SRAs that are gender-attentive and culturally-safe may thus reduce overdose risk for women in these settings. Further, funding programs that bolster the current practices and preferences developed by WWUD (e.g. one-on-one peer witnessing programs in SRA rooms) is also critical to minimize overdose risk for WWUD who prefer using alone, while enabling them to assert their bodily agency during drug use practices. Previous research has called for safer environment interventions and harm reduction services that increase accessibility and agency for women, including provision of childcare and accommodation of injecting partnerships (Boyd et al., 2018; Pinkham et al., 2012). This research adds to the literature, turning attention to the need for gender-attentive safer environmental interventions within low-income housing.

Recent research has examined the transformative relationship between prescription drug use and gender, with the corporeal side effects of drug use (e.g. lactation, sexual disfunction) able to disrupt and problematize gendered identities as it makes and remakes subjectivities through consumption (Flore et al., 2019). In this study, gendered beauty ideals largely structured how participants experienced being WWUD. While often rooted in hegemonic notions of femininity, women's narratives suggest that corporeal changes due to drug use was at odds with gendered expectations, thereby illustrating a dialectic relationship between women's use of illicit drugs and how they viewed themselves as women. Like previous research on the impact of visible markings (e.g. scars, abscesses) on economic marginalization and experiences of violence for sex workers (Ettorre, 2004; Epele, 2001), our research highlights how physical manifestations of drug use led to involuntary drug use disclosure amongst women, which could negatively impact their social relationships, risk of violence, and economic opportunities. Importantly, we add to this literature by describing the practices taken up by women to minimize involuntary drug use disclosure (e.g. changing consumption method, using alone), thereby decreasing risk of interpersonal violence but increasing overdose risk. These complex dynamics highlight how drop-in spaces for women with access to services aimed at personal care are needed as these could further address structural barriers of SRAs (e.g. broken or shared washrooms) in the short term.

This study has several limitations. Findings are specific to a neighbourhood with a large, street-based drug scene, which may minimize the adverse impacts of women's public drug use as open drug use is more normalized. Further, transgender, two-spirit, and non-binary persons were under-represented in this research, which may obscure their specific experiences and overdose risk. Gendered expectations and internalization of such norms may also vary for sexually and gender diverse persons and are thus not captured here. Future research focusing on unstably housed gender diverse persons who use drugs is imperative to better highlight additional dynamics impacting their overdose risk and embodied practices. Additionally, drug use disclosure was not directly explored in interviews, but arose organically throughout the course of the study. As such, there may be additional complexities related to involuntary disclosure that are not captured here.

This research provides important insight into how marginalized women's bodies are often the site where social-structural factors (e.g. socio-economic marginalization, interpersonal violence) and hegemonic notions of femininity coalesce in ways that not only discipline WWUD, but also increase their risk of overdose. This work turns attention to the daily acts of resistance women engaged in to push back against everyday social-structural and cultural violence that aimed to control and

discipline their practices as WWUD. To effectively reduce overdose risk amongst marginally housed WWUD, we must consider how gendered ideals intersect with socio-economic marginalization, gendered violence, and criminalization in racialized and gendered ways within public and private spaces. Understanding the ways that these synergistic relationships produce variegated risk amongst women can better inform overdose-related interventions and public health strategies that are more attuned to the needs of WWUD.

Declaration of competing interest

None.

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Appendix A. Supplementary data

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