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Vulnerability to HIV among female injecting drug users

ABSTRACT

OBJECTIVE: To assess some aspects of vulnerability to HIV infection in women users of injecting drugs.

METHODS: Thirteen semi-structured interviews were performed with female drug users (or former users) of injecting drugs, leaving in the East side of São Paulo, in 2002. The script of interviews approached four focal point issues: socioeconomic context and affective relationships, drug use, prevention against HIV and health care. Interviews were assessed through content analysis.

RESULTS: Poverty, absence of strong and continuous affective ties, being expelled from the family and school, exposure to violence, institutionalization, drug use, criminality, and discrimination were constant in interviewees' reports. These aspects made it difficult to adopt practices for HIV prevention such as the use of condoms, disposable syringes and needles, and looking for health care services.

CONCLUSIONS: Vulnerability to HIV infection makes it clear the fragility use have effective access to social, economic and cultural rights, requiring welfare policies of specific population segments such as women (children and adolescents), low income citizens, people living in the outskirts, with poor access to educational, cultural and health resources. This access is complicated especially for those that are discriminated by behaviors such as drug use.

KEY WORDS: Acquired immunodeficiency syndrome, prevention & control. Women. Health vulnerability. Gender and health. Substance abuse, intravenous, prevention & control.

INTRODUCTION

The incidence of AIDS cases infected by injecting drugs decreased between 1994 and 2004, from 21.4% to 9.4% reported cases in Brazil. Among men, reduction went from 27% to 13%, and among women from 17% to 4.3%.^{*} This phenomenon can be understood due to the change to illegal drugs (crack) and to prevention policies.^{**} However, reduction of infection due to injecting drug use varies according to the side. In the East side of the city of São Paulo, in 2005 the number of cases of Aids due to sharing of needles and syringes surpassed the adding of the categories of transmission bisexual and homosexual.^{***}

In the last decades, the notion of vulnerability has been developed and used worldwide to understand and face HIV epidemics,³ denoting that disfavored

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^{**} Boletim Epidemiológico - Aids. Brasília, DF: Ministério da Saúde; 2000; XIII (03). 36^a a 52^a Semanas Epidemiológicas.

^{***} Secretaria Municipal da Saúde. Boletim Epidemiológico de Aids/HIV/Hepatitis B e C do Município de São Paulo. Dezembro, 2005; IX (9): 12-13.

individuals and populations are more susceptible to HIV in the programs and services for dealing with the problem and for protecting and fostering their civil, political, economic, social and cultural rights.

Drug use, especially snorted cocaine, crack, and injecting use psychopharmaceuticals remain as important elements for vulnerability to HIV.*

Vulnerability to HIV infection among female injecting drug users (IDU) is complex and little known. IDU women remain under risk of HIV infection by sharing needles and syringes, unsafe sex, prostitution^{12,18} and experiencing violent situations.^{5,13,14}

The objective of the present study was to assess the element that may contribute to the vulnerability to HIV infection or reinfection among IDU women.

METHODOLOGICAL PROCEDURES

The study was performed with female injecting drug user (or former users), living in the east side of the city of São Paulo, in 2002. Thirteen IDU women were invited to take part in the study. The invitation was made by health professionals called harm reducers who conduct activities to prevent HIV infection. Semi-structured interviews were carried out, and the script approached four thematic areas: socioeconomic context and affective relations, drug use, prevention to HIV infection, and health care.

Interviews, individually performed in a room of the Specialized Care Service on HIV/AIDS, lasted from one to two hours.

Interviews were recorded and transcribed. Transcriptions were reviewed by the researcher and data were systematized according to the content analysis technique,⁴ including field notes.

Content analysis entails three stages: pre-analysis, decoding and analysis. Pre-analysis aims at organizing collected data, using skimming, for a first contact with the text. Decoding (data classification) is transforming gross data of the text into themes, used for categorization. Last, the analysis enables making incongruent and/or relevant occurrences on the intended discussion explicit, in which the discussion intended is the notion of vulnerability.

Thus, from the analysis of the interviews, the elements that related to vulnerability, to HIV and/or poor protection of IDU women's rights, were highlighted.

The study was approved by the Ethical Committee on Research of the Municipal Health Secretariat of São Paulo. All interviewees signed a free informed consent form.

ANALYSIS OF RESULTS

Socioeconomic context and affective ties

The interviewees lived in slums, houses with shared yard, or pensions, two of them lived with partners and the others with relatives.

Twelve of the 13 interviewees had not finished elementary education and one had finished high school. Their ages, occupation, and number of kids are described on Table 1. Eleven interviewees also mentioned begging, robberies, and drug dealing as ways of living.

Six interviewees reported detention at State Foundation for the Minors' Well Being (FEBEM), and seven in prisons.

"... It is because we robbed much money, a lot of drugs, and so we started taking them. (...) It is a mess and the next door neighbor called the police. The police arrived promptly and everybody was beaten and arrested. Then I went to Febem you see? ..." (Janete, 46)

Despite the negative experience of not being free, positive aspects were seen in staying on these places, such as the possibility of school or professional education, showing the exclusion from any kind of education that these women are exposed to.

"...I think that five years was better, I could learn more, much more. I could learn more, the things I did there [in prison] did well for my mind and body. Better than now (...) on the streets, I worked with handcrafts, making chairs, tables, sets (...) that I also learned when I was in prison, after I left, I worked with that..." (Maria, 34)

Family ties were described with complaints of lack of affection and care. The father figure was mentioned by seven interviewees: five had met their fathers, and two were brought up by their stepfathers. Although the mother figure was more present, only two of them had not been looked after by grandparents, uncles, aunts and other relatives for a period in their lives. Three interviewees had become orphans before 15.

Regarding maternal care of the interviewees with their children, nine children were being taken care by relatives or acquaintances and two had died. Hindrance for more extensive care were prisons, drug use, and/or treatment [three were in rehabilitation institutions], lack of money and family support, especially from their partners.

"... then I left my daughter with my mother, my sister. Then I went deep, got high a lot, jacked up a lot [injecting drugs] ..." (Angélica, 29)

* United Nations Office on Drugs And Crime. Brasil: perfil do país. Brasília; 2005 [Accessed on 7/10/2007] Available at: <http://www.unodc.org/pdf/brazil/COUNTRY%20PROFILE%20Por.pdf>

Table 1. Sociodemographic profile of the interviewees. São Paulo, 2002.

Name	Age	Children	Occupation
Maria	34	3	Handcraft (furniture); robbery
Janete	46	1	Professional sex worker; robbery; handcraft; harm reduction; begging
Rosa	23	0	Supermarket
Angélica	29	4	Robbery; collecting paper; maid
Daniela	27	2	Professional sex worker; robbery
Ana	29	4	Maid; professional sex worker; robbery
Tânia	27	1	Professional sex worker; begging; maid
Amanda	46	2	Handcraft; begging
Flavinha	33	2	Supper at a building
Adriana	33	3	Professional sex worker; robbery
Marijane	41	3	Maid; robbery
Lua	40	1	Clerk; professional sex worker
Kátia	29	3	Maid; robbery; professional sex worker

"... no, I don't even know who is the father of my son. Because it was a time that I jacked up a lot, you see? I lived on Praça da Sé [a square downtown], so I was a prostitute you see ..." (Janete, 46)

"... I separated from him when my mother died. Then I came to São Paulo and he stayed there, in Santos. I never heard of him again (...) Daniel, 16, is his son, I don't know if he is still alive, I have never heard of him again." (Maria, 34)

Sexual partnerships reported are many and temporary, with several reports of deaths and abandonment (exchange of partners and domestic violence).

Family violence episodes, including sexual violence before 12 were reported by the interviewees and, for some of them, they justified living on the streets, prostitution, petty crimes, and drug use.

"... I left home when I was 12, and went to the streets. Then I started sniffing glue and all kinds of drugs, right? (...) My mother, that was involved with another man, right, and this man ended up doing all kinds of things to me, he raped me. Then I got very upset, my mind went crazy, right? And I became a prostitute. That is when I started taking drugs, I injected on a disco the first time...." (Tânia, 27)

Eleven of the interviewees experienced physical violence when living on the streets (drug use and/or prostitution) or in other contexts, involving several aggressors such as: sexual partners, drug dealers, friends, and other drug users.

"(...) he put the gun on my head, now you are going to have sex with everybody. What could I do? I had to do what he wanted or he would have killed me right there..." (Tânia, 27)

Drug use

Six interviewees started to use drugs between 12 and 15, and the others between 16 and 18. Usually, the use was associated. Drugs mentioned by interviewees were: alcohol, inhalers, marijuana, cocaine (snorted or injected), crack, anticholinergics, and appetite inhibitors used without medical prescription.

For five interviewees, start of drug use occurred together with school evasion, and living on the streets during adolescence, including prostitution, robbery, theft, and drug dealing.

"... I left home when I was 12 and went to the streets. Then I started sniffing glue and all kinds of drug, right? (...) I left school when I was 13, never got back to school..." (Tânia, 27)

"...[I left school] because I was ashamed (...) everything that happened [family conflicts] at home, she [the mother] talked about with the neighbors (...) the girls [neighbors] studied with me, and then, you know, when they arrived at school started spreading the rumors (...) Even the teacher too (...) I started to use this [drug] because I felt extremely upset (...) and she said if I wanted to live there I had to respect her [mother] (...) wash the kitchen, clean up, being obliged to cook, I couldn't stand that (...) otherwise she would kick me out; the next day (...) I just jumped out of the window and got the streets (...) from there I went to Febem ..." (Ana, 29)

Drug use was understood by interviewees as a way to react to grief, lack of affection, revolts, embarrassment, violence, and lack of money. Eleven interviewees mentioned negative aspects regarding the use: losing children, discrimination, feeling worthless, health hazards, worsening of faced problems.

"... I didn't have a father, only a mother, the family was very poor, I did not have means for anything. So, I met the world of drugs, and I was going to have everything I didn't have at home..." (Janete, 46)

"... these years living on the streets, I went to a hotel, a man forced sex with me [first sexual intercourse]. He said he was going to change the money and left me in the hotel. I shouted: - God help me not to fall apart! It was terrible; I suffered a lot on the streets that is why I am addicted to drugs..." (Ana, 29)

Regarding use of injecting drugs, friends, partners and even siblings were the ones giving the first shot.

"...I just snorted cocaine, you see? Then, I saw people injecting and I felt like doing it, then I injected..." (Angélica, 29)

"... since I was 16, I am 34 (...) they inject drugs! I used to think: I want to know what it is like. (...) Then we went to the stairs of a building (...) then, one injected the other." (Maria, 34)

There were reports where sexual partners facilitated the first contact with drugs and even supported the use for some time. But, in other cases, they started to control or forbid the use.

Among the interviewees, injecting drug use was done in groups (friends and/or affective partner), in isolated places (their own home or friends houses). In case of the emergency of helping friends overdosing, strategies such as placing a spoon on the mouth and/or pressing the chest of the person were used, they did not look for emergency services. Fear of police intervention, discrimination of health services, and their own use of drugs explained this refusal, increasing the vulnerability of these women.

"... I got carried out. Then she started swallowing her tongue (...) and when I realized (...) but I couldn't care less that she dropped dead, you see? (...) I took it the whole night (...) then I left her there [the deceased friend] and left, otherwise I could go to jail...." (Janete, 46)

"... then I took a higher dose because I wanted more (...) and she grabbed me, pulling my tongue that was swallowing. And when I woke up I was all hurt, bitten, I woke up with my arm swollen..." (Ana, 29)

Prevention against HIV infection

Information on HIV and strategies of self care differed among the interviewees. Those that started sex life and drug use before the 90's did not have information on the chance of HIV contamination. The others stated that they had heard a "rumor" about "AIDS" and that they were concerned with purchase or cleansing of syringes, but with rather inaccurate skills and knowledge.

"...I didn't know anything, I used with one, then other used, another person came used too. I think that is how I got the virus..." (Maria, 34)

"...inject to clean (...), inject a bit of water, then it got wet and that was it, you see? But not like that, you see? No, without any bases or information, even more, nowadays with all these diseases!..." (Angélica, 29)

Only one interviewee stated the use of condoms at least once in her lifetime. Trust in friends and fixed partners, the use of drugs, the desire for pleasure, and the belief that men are responsible for prevention (because they imagine that they are more "experienced") were the referred reasons for unsafe behavior.

"...no because now I live only with him, I have sex with him, and I only get satisfied by him. We only use drugs in our house, and only that. We only meet [with the people they share drugs and syringes] with someone that is inside [the house], that goes there..." (Tânia, 27)

"...many times injecting and, sometimes, you can drink or smoke, you can get more excited with that! (...) then you don't care about anything. (...) even your husband that is used to using condom will not use condom...you go high..." (Angélica, 29)

The involvement of many interviewees with prostitution, robberies, traffic, and prison were factors that contributed to risky behavior, such as sharing needles and syringes and unsafe sex.

"...marijuana was more common and cocaine. To buy I did some crochet, I sold them and so, got some money [in prison] ..." (Maria, 34)

"...I did not use condoms and it was the worst side of town [worked as a sex professional]. The region of Praça da Sé is the worst area. Can you believe that I even had sex with a beggar! I was high on cocaine, only because the beggar had cocaine..." (Janete, 46)

Regarding HIV infection, five interviewees stated they were seropositive. Four believed they had been infected through sex and one through blood. Three were seronegative and five did not know their serum state.

Among seropositive interviewees, four did not follow procedures for care or prevention (to re-infection) after being aware of their serologic situation.

"...after I knew I was seropositive, if I infected anyone? Ah! Absolutely, on purpose, just for fun, two guys..." (Janete, 46)

"...I had unsafe sex, I just wanted the drugs and I knew I was sick, I didn't care if I was preserving someone else's life (...) I came here once in a while, I took medicines once in a while. There was no treatment, right dude? I never lasted, I have been on treatment for five years, and I had never taken the right medication, right dude?..." (Daniela, 27)

As health care occurred usually in emergencies, symptoms of AIDS triggered the search for test and treatment. Use of drugs and constant moving (due to prison, traffic, running away from drug dealers and/or police, to follow partners arrested in other cities, among other reasons), were seen as hindrances for continuous treatment of seropositive interviewees or for adherence to health services.

"...I had to, because I found out HIV in 98, I found it out because I got pneumonia right?..." (Janete, 46)

"...I took medicines every now and then. (...) Then when I got pregnant of the girl I was going to Uberlândia, I did not take drugs all the time, then what happened? I started taking the medicine more correctly, right? I had a great trouble with the time for medication..." (Daniela, 27)

Health care

Interviewees reported they feared the reaction of health care professionals, especially accusations, and for this reason they stated they looked for health services only in extreme situations.

"... fear, it seems that the police will get involved, [IDUs] are afraid of taking the exam and then they will find out that they are drug users and they will be sent to prison, they are afraid of that..." (Janete, 46)

There was no consistent interruption of the use of drugs during pregnancy, which made it difficult to look for medical services to perform prenatal care.

"... I was not going to do prenatal, because I worked 8 hours and I had a fixed hour to start. I had to start at 9h, so I would get up early and go to her house [friend] and took them [drugs], it was impossible to do prenatal..." (Ana, 29)

In most cases, the search was encouraged by an acute demand (accident, pains, and aggressions) rather than scheduled regular appointments.

"... that's what happened, I had a fight with one of the girls and she kicked me [on the stomach]. Then I went to the gynecologist, you see?..." (Janete, 46)

"... and at the time I was very high (...) they did not want to put the serum on me because my arm was no good, you see? [because of injecting drug use] Then I suffered to deliver, I suffered a lot because of the drugs. He got stuck (...) He was born with lack of air in the heart (...) he wanted to use forceps. (...) the doctor (...) he asked for all examinations. (...) 'You use drugs, right? (...) I am not going to give you anything, if I give you something I'll kill you (...) You could go to

jail, if I call the police from here, if I call, I will report you..." (Ana, 29)

FINAL CONSIDERATIONS

The notion of vulnerability, used here as an analysis area, includes not only individual information and behavior as accountable for susceptibility to infection to HIV,³ but also the access to public policies for the control of HIV infection and social aspects, such as the access to work, home, education, information, political participation, as well as cultural guidelines of gender, race and generation. These three dimensions of vulnerability are complementary and e synergetic, and can only be separated for assessing purposes, as seen in Table 2.

Experiences reported on lack of affection, lack of family care and violence in family relations contributed to the start of drug use,* and are a context that may hinder the self-image, resulting in anti-social, self destructive and risky behaviors,² leading to greater vulnerability to HIV infection.

Leaving home and living on the streets by the interviewees reinforce the situation of homeless women, reported by Fisher et al (1995):⁹ they are women that are in greater risk of drugs exposure, violent situations, and HIV infection.

Regarding social vulnerability to HIV infection, the elements mentioned by interviewees shows a specific picture of poverty associated with lack of public policies to ensure social, economic, and cultural rights. In this picture, we can highlight the difficulty to maintain access to school and to health services, the living in places marked by illegitimacy, marginality, and violence, and recurrent inclusion in rehabilitation or corrective institutions.

Poor access to several institutions by the women interviewed except for those for repression, must be taken into account as an element that conditions and models vulnerability to HIV, as well as drug abuse, and living in violence and crime situations.

Involvement of drug users with the illegal drug market and sex market is recurrent among extremely poor populations.^{6,14} Insertion of the interviewees in marginal and illegitimate spaces, marked them as¹⁰ "criminals", "drug addicted", and "prostitutes". These stigmas reinforce social exclusion, hindering access to public health services and education, and to materials for HIV prevention, due to fear of discrimination and criminalization regarding drug use.

* Salinas T. Violência intrafamiliar y consumo de drogas: una perspectiva boliviana sobre la problemática. Cochabamba: COPRE; 1999 [Accessed on: 7/10/2007]. Available at: http://www.cicad.oas.org/Reduccion_Demanda/esp/documentos/DocumentosB/violenciaintrafam.doc

Table 2. Aspects of the vulnerability to HIV infection among IDU. São Paulo, 2002.

Characteristic of the group studied	Dimensions of the Vulnerability	Deprived rights
Exclusion of the job market and inclusion in illegal activities	Social: insertion in the job market	Right to work and social security ^{*,**}
School exclusion	Social: access to education	Right to education and to professional education ^{*,**}
Few access to public health services, including threshold adherence to treatment to AIDS	Programmatic: access, quality and organization of health services, as well as services for treatment of AIDS	Right to use the best level of mental and physical health, access to health care. Treatment and prevention of epidemic diseases ^{*,***}
Hindrance of more extensive care of children and little participation of partners	Social: access to social services of support and care for children and maintenance of motherhood and specific programs for changing traditional rules of gender	Sexual and reproductive rights (information on family planning, maternity protection and responsibility of both partners for children care) ^{*,****}
Living under poverty	Social: financial resources	Access to material goods and adequate conditions for them and their families: housing, basic sanitation, electricity, water supply, transport and food ^{*,**}
Stigma and discrimination by health professionals	Social: stigma and discrimination; Programmatic: training and supervision of health professionals regarding welcoming specific populations	Equal rights, equal access to public services of their country, mental integrity ^{15,****}
Not consistent information on prevention of HIV infection; perception that drug use contributes to unsafe sex	Individual: information; beliefs; desires, attitudes Programmatic: access to Harm Reduction Program Social: gender relations	Access to information on sexual and reproductive health ^{****,**}
Prostitution during adolescence	Social: physical and social well being	Protection of sexual exploitation ^{15,****,****}
Living under situations of physical, psychological and/or sex violence, during childhood and life	Programmatic: access to protection services of violence victims and encouragement and prevention of gender equality Social: inequality in gender relations	Eliminating all kinds of violence both in the public and private areas ^{****,****}

* Organización de las Naciones Unidas. Pacto Internacional de Derechos Económicos, Sociales y Culturales Adoptado y abierto a la firma, ratificación y adhesión por la Asamblea General en su resolución 2200 A (XXI), de 16 de diciembre de 1966. Washington; 1966 [mentioned on 07/10/07]. Available at http://www.unhchr.ch/spanish/html/menu3/b/a_cescr_sp.htm

** Organização das Nações Unidas. Convenção sobre a eliminação de todas as formas de discriminação contra a mulher. Washington; 1979 [mentioned on 07/10/07]. Available at: <http://www.dhnet.org.br/direitos/sip/onu/mulher/lex121.htm>.

*** United Nations. Report of the Fourth World Conference on Women; 1995 Sept 4-15; Beijing, China. Washington; 1995 [mentioned on 07/10/07]. Available at: <http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en>

**** Organization of American States. Convención interamericana para prevenir, sancionar y erradicar la violencia contra la mujer "Convención de Belém do Pará". Washington; 1994 [mentioned on 07/10/07] Available at: <http://scm.oas.org/Reference/spanish/CONVENCIONES/CONVENCION-BELEM%20DO-PARA-MUJERES-S.doc>

Repression to drug use and being arrested also concur for these women to present unsafe behavior, either by the use of drugs in hidden and far away places, or by the difficult access to prevention materials within the institutions (however, no difficulty for drug access).¹⁶

Difficulty in the use of condoms is common among women that do not use drugs. This situation is understood by the cultural behavior of genders,⁸ that guide the way to experience sexuality, the choice of partners,¹¹ and the possibility to negotiate the use of condoms.¹⁷ These behaviors reflect on the reports of the interviewees in the belief that, because they had a

greater knowledge, men would be responsible for prevention care, or in the trust placed on the faithfulness of a fixed partner.

The fact that interviewees only looked for health services in emergency situations, together with the fear of the reaction of professionals, shows the perception of their stigma and the fear of discrimination.¹⁰ Thus, virtual access to health services does not ensure their conscious use because of the hindrances noticed by them. Therefore, in spite of the formal quality of citizenship, the interviewees profited little from being citizens in the every day life,¹ even less than the

population facing poor economic conditions, but not the discriminations mentioned here.

In the perspective of programmatic vulnerability, the harm reduction program was strategic to assess IDUs and make information and materials available for HIV prevention. However, the program was not enough to assure consistent use of health services or adherence to treatment by interviewed HIV-seropositive women.

In the individual scope of vulnerability, within the life context of the interviewees, with frequent and constant threat to physical integrity, HIV prevention, aiming at avoiding future harms becomes relatively important,⁸ and makes protection strategies lose their meaning. Thus, strategies for prevention and care of the infection and reinfection among interviewees differ from those recommended by health technicians. But, even when the interviewees had consistent information on HIV prevention, the different meanings given to behavior

and group relations led to conflicts between the reason, desires, and compulsion for drug use.^{7,12}

According to other studies, the interviewees are aware that drug use lead to several hazards⁸ and they see it as a way to react and resist to experiences of economic and affection deprivation.⁶

In face of the fragility checked for the access and adherence of IDUs to public health services and to specific programs of prevention of re-infection and treatment of AIDS, a new behavior of health professionals is necessary requiring capacity building and improvements to fight discriminations and providing better welcome and care.

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