Injecting practice between sexual partners

A summary of the literature

Loren Brener and Carla Treloar

National Centre in HIV Social Research, The University of New South Wales
NSW 2052 Australia
ph: + 61 (0) 2 9385 6530
fax: + 61 (0) 2 9385 6455
email: l.brener@unsw.edu.au
Injecting practice between sexual partners
A summary of the literature

1 Introduction
Australian surveillance data shows that rates of sharing of injecting equipment are high among sexual partners [1]. However, there is very little recent research in Australia or internationally that addresses hepatitis C transmission (or its prevention) between sexual partners. Most research focuses only on the practice of individuals and does not address risk as it relates to social or sexual relationships [2, 3]. There are relatively few studies that have addressed issues relating to women who inject drugs and much of what we know about risk practices associated with injecting drug use in sexual relationships is drawn from studies of HIV/AIDS [4]. We note this lack of research into risk in a context where there is growing evidence to suggest that young women who inject, especially those new to injecting, may be at increased risk of hepatitis C infection [5, 6].

This review of the literature synthesises some of the main research findings related to transmission of hepatitis C (or its prevention) in sexual relationships, with a particular focus on the experience of women. It has to be noted that most of the research available uses traditional or conventional theories in understanding sexual relationships, specifically heterosexual relationships. The literature suffers from a lack of research grounded in feminist thinking or gender studies. That is, the existing research may perpetuate stereotypical views of women because critical questions about the assumptions of the research method and framework have not been asked.

Some methodological problems with the existing research are also apparent. For example, much of the research available is typically based on surveys; therefore the participants can respond only to the questions posed to them (they are not able to add in issues relevant to their own situation) and can respond only in pre-determined ways (that is, they have to choose one of a range of responses). The methodologies typically used in this literature do not allow for conceptualisations of the experiences of women injectors in sexual relationships that are grounded in their own experience.

Overall, the existing literature focuses largely on epidemiological descriptions of risk practice within intimate heterosexual relationships but is limited in its capacity to explain why partners engage in such risk practice. The literature provides some understanding of women’s experiences but there is little focus on men or, more importantly, the way that risk practice can be produced through the social and relational nature of heterosexual relationships and elements of intimacy, trust, dependency and agency.

2 Main issues in the literature
The following sections outline the main issues raised in the literature reviewed. An abbreviated summary of the issues is presented.

2.1 Differing positions of men and women in the context of drug injecting
The position and roles of men and women in the contexts of drug use and drug-using networks are different. The drug injection practices of women are more likely to be influenced by their social and emotional relationships [4, 7]. In relation to risk for the transmission of hepatitis C and other blood-borne viruses, women injectors are more likely than men to:

- have a sexual partner who is also an injecting drug user [8–12]
- be influenced by their sexual partner to start injecting [4, 7, 10, 13, 14].
- inject with a regular sexual partner (than with friends or other members of their networks) [8, 15]
- share injecting equipment with a regular sexual partner [10, 16, 17]
- use injecting equipment after their sexual partner [8, 18–20]
- be injected by that partner [8, 9, 19, 21, 22].

2.2 Relationship patterns

Women who inject have often formed a relationship with an older man who injects drugs and are initiated into injecting by this older male user [23]. The older man may provide financial and social support for the young woman in exchange for sexual relations and companionship [24, 25]. As age and duration of injecting are risk factors for hepatitis C, there is therefore a greater chance in this situation that the older male sex partner already has hepatitis C [26].

On the whole, women who inject appear to be the more dependent partner in sexual relationships, often having been initiated into injecting by a male sex partner and then become reliant on this partner for their drugs and equipment [23].

Hence social context and interpersonal relationships impact on women's perception of risk differently from men's and are tied to the more traditional role of women as subservient to and dependent on men [24].

2.3 Sharing of injecting equipment and strategic or selective practice

For women, sharing of injecting equipment largely occurs within and appears specific to the sexual relationship [15, 27].

Sharing of injecting equipment may be a selective and strategic act designed to minimise risk, allowing the injector to specifically choose with whom they will share and who they perceive as being too risky to share with [16, 28–30].

2.4 The dynamic nature of sexual relationships

A history of sharing with 'close' others in the past has been associated with preparedness to share with those perceived to be close in the future. This suggests that there may be a perception that the risk associated with sharing equipment with people who are 'close' is low. The concern is that drug-using networks and sexual relationships may change regularly, and so too will those people considered to be socially 'close' [9]. As among the general population, intimate relationships among drug users can generally be described as serially monogamous. So, while the risks involved in sharing injecting equipment may be confined to the boundaries of an intimate relationship, such intimate relationships may change regularly [9, 31–33].

2.5 Intimacy, trust and commitment

The act of injecting together may also be part of the bonding experience for sexual partners [3]. Research suggests that people who inject drugs seek out others who use drugs with whom to become sexually and romantically involved. Sharing this drug-using lifestyle is often an important part of the relationship. Injecting may become a ritualised aspect of the relationship which involves the intimacy of sex and drug use and sharing of injecting equipment.

The intimacy developed between sexual partners may create contexts in which precautionary behaviour is reduced. Sharing injecting equipment with a sexual partner may either result in or be indicative of emotional bonding, commitment, fidelity, mutual trust and shared intimacy [3, 9, 34–36]. Feelings of trust and intimacy may also underpin practices of unsafe sex, which may in turn underpin decisions to share injecting equipment. That is, partners may feel that they 'may as well' share injecting equipment if they are having unsafe sex, believing each practice to carry the same risk and the same demonstration of trust and intimacy [28, 37].
Decisions to share equipment may also be tied to notions of a committed relationship between partners who promise not to engage, or report that they have not engaged, in any other risky practices [28, 29]. Such arrangements may generate perceptions that sharing is then ‘risk free’. In such situations the decision to share injecting equipment is tied to beliefs and feelings associated with partners’ fidelity and commitment not to share with others outside of the relationship [32, 34].

On the other hand, a refusal to share or insistence on sterile equipment may suggest distrust and a denial of intimacy [32, 38]. Threatening the status quo of the relationship may lead to violence towards the woman and also jeopardise sources of income, drugs and other materials and threaten the woman’s subsistence [19, 24, 39].

2.6 Seroconcordancy

Sharing of hepatitis C serostatus may also be an expression of intimacy, trust and commitment between sexual partners. Some literature suggests that there is an increased risk of sharing of injecting equipment when both partners in a relationship are aware that they have hepatitis C [34] and issues of re-infection with differing genotypes of the virus are not considered.

Sharing an illness could also be a means of bonding with a sexual partner who is already infected. There are suggestions of this type of discourse in the literature on HIV/AIDS and serodiscordancy[2], where the HIV-negative partner chooses not to adopt safe-sex practices and exposes him- or herself to the potential for seroconversion to HIV. Seroconcordancy in such a relationship is said to improve the quality and intimacy of the relationship and make the relationship easier to negotiate. HIV-serodiscordant couples have reported that their different serostatus created stress and began to shape their identity in their relationship as either the infected or the uninfected partner [40].

2.7 Changing practice

As shown in research on cessation of cigarette smoking, changing the drug-using status or practices within a relationship is also likely to disrupt it [41]. To alter established practices around injecting could mean renegotiating the entire nature and stability of the relationship [3]. Risky injection practices occurring in a relationship are particularly resistant to change [42]. Research also shows that it is far more likely for the non-injecting partner in a sexual relationship with an injector to start injecting than it is for the injecting partner in a relationship with a non-injector to stop injecting [43].

2.8 What can be said about men?

There is a lack of research on injecting partners that focuses on the male point of view. What little there is emphasises the role of men in controlling injecting practice within couples. For example, men are more likely to inject with and borrow used needles from friends than inject with or borrow used needles from female partners [8, 9, 15]. Men have been shown to be more likely to inject with their friends in public spaces such as shooting galleries, abandoned houses or on the street, whereas women were more likely to inject at home [15]. The injecting of drugs and sharing of equipment may be considered an act of masculinity in the context of a peer group [8].

---

1 Having 'seroconcordancy' within a relationship means having the same serostatus (in the case a particular infection) as a sexual partner, i.e. both partners have tested positive (or negative) to a particular infection.

2 An HIV-serodiscordant relationship is one in which both partners are known, as a result of testing, to be of different HIV serostatus, i.e. HIV-positive and HIV-negative.
Conclusion

This selection of literature has provided insight into the unique context of risk for injectors within sexual relationships, especially women. It is important to understand why sharing of injecting equipment appears to occur more frequently in sexual relationships and then to understand the meaning of sharing. Research has shown that even though injecting drug users may know that sharing injecting equipment can be risky and result in the transmission of hepatitis C, injectors have a rationale for deciding with whom they share. This clearly indicates that, for some people, sharing is not an all-or-nothing behaviour but selective and strategic, associated with their perception of risk and dependent on circumstances and social meanings [16, 28, 44]. Hence, the decision to share injecting equipment with a sexual partner may be based on a selective choice either to share in the safest possible manner, to demonstrate trust in and commitment to a partner, or to preserve an intimate relationship and way of life that is valued. It is important to understand these decisions and meanings from the points of view of both partners in the relationship.

Finally, it is important to note that not all women, or men, can be described or categorised by the research findings above. For example, women are initiated by other women [45] and people who do not inject do have relationships with others who do inject. There is little research into the dynamics and injecting practices of people in non-heterosexual partnerships; indeed, there is generally little research on heterosexual injecting couples and very little research from the male point of view.

Acknowledgments

Funding for this literature review was provided by the New South Wales Department of Health.

References


