Main findings and recommendations for policy and practice

Background to this research

• Approximately 10,000 new diagnoses of hepatitis C (HCV) were estimated to have occurred in Australia in 2014 (1).
• A key route of transmission occurs when two or more people share drug-injecting equipment.
• Approximately 90% of newly-acquired infections are due to the sharing of ‘used’ injecting equipment (1).
• The primary public health measure implemented for HCV prevention is the distribution of sterile equipment and promotion of safer injecting practices for people who inject drugs (PWID). This measure forms part of Australia’s broader harm reduction response to blood-borne virus prevention, including the critical role of peer involvement and education.
• Australia distributes a large volume of injecting equipment compared to other countries (2).
• The National Hepatitis C Strategy (3) promotes ongoing efforts to enhance the distribution of sterile injecting equipment to optimise coverage and access as sharing and/or re-using of injecting equipment remain a concern.
• The Annual NSP Survey identifies that sharing of injecting equipment between sexual partners is important to consider for hepatitis C prevention. Over 50% of survey participants who reported sharing indicated that they had done so with their regular partner (4).
• However, efforts to prevent hepatitis C transmission have tended to overlook the important role social contexts play in influencing people's injecting practices. For couples, an important aspect of the social context of injecting must include the correlation between the emotional intimacy of sexual partnerships and the increased likelihood of injecting-equipment sharing.

• When the social or ‘risk’ environment of injecting is ignored, the individual becomes the primary focus of much HCV prevention. This approach overlooks the ‘real world’ complexities many PWID face in injecting safely, including restrictions within the local environment such as the availability of sterile injecting equipment and the impacts of the illegality of drug use on distribution and access to this equipment.

What did this research do?

• Interviewed heterosexual couples who inject drugs (n=80 participants) and harm reduction workers (n=22 participants) in Sydney and Melbourne. Of the 80 participants, 75 identified themselves as currently in a relationship, while 5 were interviewed on the basis of prior relationship experience involving injecting drug use. These 75 participants reported lengths in relationships ranging from 2 months to 20 years. By their own report, 24 of these couples were hepatitis C seroconcordant (in 13 couples both partners reported living with hepatitis C; in 11 couples neither reported that they had hepatitis C) and 17 couples were serodiscordant.

• Focus tested new hepatitis C prevention messages and a fitpack prototype designed for couples who inject drugs.

Main findings of this research

• The partnerships of people who inject drugs are based on mutual trust, honesty and care. People in couples value their own health and that of their partners, and want to ensure the ongoing security of their relationships.

• Relationships between couples who inject can serve to protect each partner in the couple from ‘external’ threats such as stigma and other aspects of a hostile social environment in which injecting drug use is heavily stigmatised.

• Couples typically report sharing injecting equipment only when no other sterile injecting equipment can be accessed: it is a ‘last resort’. Nonetheless, couples are not indifferent to HCV risk when reusing or sharing injecting equipment. Many couples engage with biomedical knowledge around HCV and incorporate it into forms of ‘negotiated safety’: organising the reuse or sharing of injecting equipment according to each partner's serostatus or genotype.

• While people who inject drugs with their partners are motivated to protect each other’s health and the security of the relationship, their decisions about injecting practice may run counter to advice on HCV risk when they try to balance these sometimes competing priorities. For example, caring for a partner and the security of the relationship may mean reusing or sharing injecting equipment to cope with the immediate demands of drug dependence and withdrawal.
• Couples who inject drugs are not addressed in existing health promotion work:
  - the harm reduction workforce is not equipped or orientated to engage effectively with couples who inject drugs
  - HCV health promotion and prevention materials do not address couples who inject
  - injecting equipment distribution is similarly designed for individuals, not couples.

• It is possible to develop new approaches to harm reduction that address couples who inject drugs. These could include:
  - messages that acknowledge the mutual care and protection within couples and the desire to protect and enhance health for each partner; i.e. that address the emotional basis of the relationship beyond concerns about viral risk
  - redesign of injecting equipment and packaging to promote and support additional discussion about couples-based safety between clients and workers in harm reduction services, and to promote discussion and awareness of practice among couples
  - better recognition of the meanings attached to injecting equipment for couples who inject (such as its role in demonstrating care between partners).

• It is important to acknowledge the serious impact of unequal gender power relations on some couples, including the occurrence of family and domestic violence. The inequities within such couples may seriously limit the injecting-related choices available to one of the partners.

• Failing to recognise the unique issues that face couples who inject drugs, and disregarding their partnerships, means missed opportunities for understanding decision-making around injecting drug use and HCV prevention.

• Failing to acknowledge the strengths of partnerships among people who inject is likely to limit the impact of hepatitis C prevention and health promotion programs.
Recommendations from this research

1. Develop and implement workforce capacity-building strategies for the BBV sector to:
   a) support the harm reduction workforce to strengthen client-centred approaches and challenge stereotypes of couples who inject drugs as dysfunctional, non-caring and co-dependent
   b) acknowledge policy and practice limitations of couples-based work, such as client confidentiality
   c) develop specific skills and competencies for working with couples on injecting drug use and HCV prevention
   d) include couples who inject drugs in the development of workforce strategies.

2. Develop and implement harm reduction/HCV prevention materials tailored to couples who inject drugs that:
   a) challenge existing messages and practices that assume the ‘individual’ is always the target of the message
   b) acknowledge the care couples provide for each other, not only in relation to HCV prevention but in all aspects of their lives
   c) acknowledge that actors at all levels have responsibility for HCV prevention (including health agencies and government, as well as people who inject drugs)
   d) recognise that couples’ decisions about HCV risk may prioritise protection of their relationship as a key outcome
   e) consider the extent to which injecting equipment design and delivery recognise the role of couples in injecting, and in turn, consider options for using equipment design and delivery to better support safer injecting within couples
   f) provide realistic, relevant and tailored advice acknowledging the restrictions and complexities couples who inject drugs contend with in the ‘real world’
   g) promote the participation of couples who inject drugs in producing new harm reduction/HCV prevention messages and approaches; i.e. as partners in HCV prevention rather than as ‘targets’ of it.

3. Consider other programs within the harm reduction, drug treatment and HCV care sectors that are amenable to including a focus on couples who inject drugs. These could include:
   a) provision of naloxone for overdose management (where people who inject drugs are actively encouraged to do so in social settings)
   b) couples-oriented detoxification and opiate substitution treatment (OST) programs (where couples could be assessed and undertake treatment together, if appropriate)
   c) couples-oriented HCV care and treatment (where couples could jointly discuss the challenges involved in undertaking treatment and access support if/when treatment commences, including support for the partner not undertaking treatment, and reinfection concerns). Professional societies (e.g., ASHM, Australasian College of GPs) could contribute to the development of clearer criteria and guidelines to inform practice in this area.
4. Review programs in the broader social welfare field that do not acknowledge the resources of couples, or indeed exclude couples as clients, such as drug rehabilitation facilities, crisis accommodation, and other social services and welfare agencies to which couples cannot usually be admitted.

5. Consider more focused advocacy for reform of relevant laws and regulations around injecting equipment that impact couples. For example:
   
   a) current restrictions on peer distribution are a clear barrier to HCV prevention within couples
   
   b) these restrictions on peer distribution similarly limit workers’ efforts to address the social/relational environment of injecting
   
   c) restrictions on the type of injecting equipment permitted for distribution (e.g. large barrels and butterflies in NSW) also affects couples’ decision-making regarding injecting
   
   d) peer education initiatives are the best method for developing appropriate couples-related harm reduction (including interventions in injection-equipment sharing) as it is through lived experience that more nuanced messages can be designed, delivered and reinforced.

6. Recognise the importance of an enabling legal and policy environment (e.g. Ottawa Charter principles) for all people who inject drugs. This should include the participation of drug users in all processes that affect people who use drugs.

7. Recognise that many of the harms from injecting drug use result from the criminalisation of drug use. This includes acknowledging the impact that criminalisation continues to have on people’s capacity to access healthcare and reduce harm. Researchers, drug user activists and policy makers must work together towards law reform.

8. Further research on same-sex couples is required.

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Additional references


Project publications to date


Rance, J., Treloar, C., Fraser, S., Bryant, J., & Rhodes, T. (in press). "Don't think I'm going to leave you over it": Accounts of changing hepatitis C status among couples who inject drugs. *Drug and Alcohol Dependence.*


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**This research has been presented in:**