

# You say 'sharing', I say ...

*When it could be a matter of life and death, it's crucial to appreciate that what's 'sharing' to you may not be 'sharing' to your client*

PEOPLE SHARE INJECTING equipment in different ways which pose different risks of HIV transmission. As well as trying to discourage sharing, services commonly aim to help people move to less risky practices. One key to doing this is to know the risks of various injecting practices. No definitive assessment is available but several relevant variables are outlined in the panel opposite. Some of these will be beyond the individual's control, either because they don't have relevant information or because they can't do anything to change the situation.

There is another obstacle to reducing the risk of sharing – practices which could lead to HIV transmission are not universally perceived as 'sharing', and therefore not perceived as posing any risk at all. What the agency worker means by 'sharing' may not match the definitions used by their clients.

## **An exploration of 'sharing'**

This was a major conclusion of our study in Maidstone which, among other things, investigated reasons for sharing. With few opiate users in the area, the study was restricted to amphetamine users. From contacts at a health authority counselling and information service we 'snowballed' to find interviewees, using known injecting amphetamine users to introduce us to others not in contact with the service. A volunteer ex-injector also provided several introductions.

Other fieldwork methods included 'cold contacting' in pubs, the local soup kitchen and on a campsite used by seasonal agricultural workers. The local drug scene is house- rather than street-based, so valuable contacts were gained when enough trust developed for the field-worker to spend time in people's homes.

The 'facts' on which behaviour was based could be quite wrong

We obtained taped interviews with 27 people aged 21-30. Ten had been injecting for less than five years. Only three women were interviewed despite efforts to include more. Notes were made when formal interviewing was not possible, eg, in pubs or with people wary of being taped. These comprise direct quotes, paraphrases, descriptions of people and places and the researcher's

by

**Neil Hunt, Howard Shelley & Keith Jones**

*Neil Hunt is Service Development Officer and Howard Shelley is Service Manager at the Cornerstone Alcohol and Drug Information and Counselling Service of West Kent Health Authority. Keith Jones is Research Adviser with the authority.*

Research in Maidstone has revealed that drug users have different definitions of 'sharing'. Practices that could spread HIV may not be seen as sharing so not seen as posing a risk. This impedes agencies' and clients' risk-assessment and harm-reduction efforts. Beliefs about HIV and its transmission, on which risk assessments are based, are often inaccurate. Health education campaigns should improve drug users' underlying knowledge of HIV transmission as well as warn against specific risky practices.

thoughts, feelings and evolving ideas.

Field notes and transcribed interviews were analysed using methods from ethnography which aim to build up a conceptual map of the informants' world by testing and progressively refining this analysis against the data (see panel)

## **Many meanings**

When we started to ask about 'sharing', we found people assumed this to mean a range of different things. Generally understood to refer to syringes and needles, some people also included sharing spoons, filters and water. Whether they thought sharing was occurring was also affected by other factors, some of which are described below.

**Intimacy** Using equipment previously used by a close friend, usually a sexual partner, was not always seen as sharing. In one case a man tried to inject his partner but could not find a vein. After several attempts the drug in the syringe was opaque with blood; he gave up and used a syringe he had been reserving for himself. Asked what would happen to the rejected syringe he said he would use it – seemingly oblivious to the contradiction with his assertion of an hour before that he never shared with *anyone*.

**Interval** Sharing was sometimes understood to refer only to using another person's equipment during a single drug use episode, not when it had been used on a previous occasion. One man described sharing a syringe but thought this was safe as he had been with the other man all morning and it had not been used. As more than an hour had elapsed he thought it would be alright because "I heard on a documentary that it only lasted an hour".

## VARIABLES AFFECTING THE RISK OF HIV TRANSMISSION

□ **Prevalence of infection**, ie, whether the virus is likely to be present in the first place. The risk of sharing may be greater in a high-prevalence than in a low-prevalence area. HIV infection rates among drug injectors vary considerably, but are known to be higher in London (6 per cent in 1991/2) than elsewhere in England and Wales (below 1 per cent).<sup>11</sup> Some neighbourhoods, such as parts of Edinburgh, have very high rates of infection. Disease prevalence may also be higher in certain populations, such as prisoners and prostitutes. One study found that one in 10 recently released injectors was infected.<sup>12</sup>

By contrast, the rate of current or previous hepatitis B infection is about 34 per cent among people who inject drugs in England and Wales.<sup>13</sup> Hepatitis C infection rates among UK injectors may be as high as 50 per cent.<sup>14</sup>

□ **Viral load**, ie, how much HIV is in each ml of blood. How much HIV an infected person leaves in/on injecting equipment depends (among other things) on their HIV disease stage. HIV levels in blood peak twice: immediately after infection, and perhaps many years later when the immune system has been weakened, making the person vulnerable to illness. At this stage the level of CD4 cells (essential to immune function) in the bloodstream will have dropped

below about 200 per ml. Sharing with someone at these times will carry a greater risk because there will be more virus per volume of blood.

□ **Infective volume** The less infected blood is left in/on the equipment, the smaller the risk will be. The minimum amount of blood which can cause infection is likely to be less than that visible to the naked eye. Hepatitis B can be transmitted in less than 0.0004ml of blood – about 1/500 of a drop.<sup>15</sup> In one study 0.0012–0.260ml of blood was left in a used syringe<sup>16</sup> and in another about 0.01ml.<sup>17</sup> How much may be left on spoons, filters and shared water is unknown and will vary with injecting method.

□ **Viability of the virus**, ie, how much has been inactivated. Depending on the amount initially present, the level of moisture in the environment,

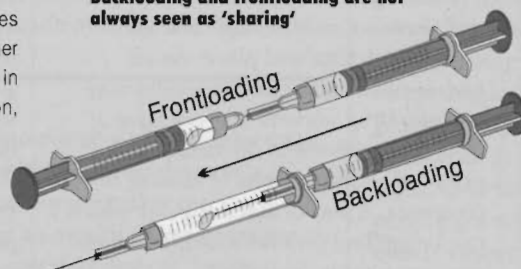
and whether it has been exposed to ultraviolet light, at room temperature HIV may remain infectious for days or even weeks outside the body.<sup>18</sup> It survives better in moist dark conditions. Retained moisture in a syringe stored in a pocket or cupboard may provide exactly this environment.

□ **Different 'sharing' practices** Practices such as sharing spoons, filters or water and back/frontloading (see diagram) clearly pose a theoretical risk of HIV transmission. Documenting and quantifying this risk is harder. Some studies have found that booting (flushing back) and sharing cookers (generally spoons) are not linked to HIV infection. However, their methodologies mean caution is needed in interpreting the findings.<sup>19</sup>

Another study found that 14 per cent of the HIV infected drug injectors they sampled said they had never shared needles and syringes, though sharing of spoons was commonplace.<sup>20</sup>

Backloading has been found to independently predict HIV infection in a study which found that 11 per cent of injectors who had not shared syringes and needles in the previous two years had nevertheless received drugs by backloading.<sup>21</sup>

Backloading and frontloading are not always seen as 'sharing'



**Cleaning** 'Sharing' for some people only meant sharing *uncleaned* equipment, though we found a variety of cleaning practices which would not ensure safer injecting. One man who "never shared" later referred to using his friend's cleaned equipment, evidently having excluded this from his definition of sharing.

**Backloading and frontloading** These are ways of using syringes to accurately share out drugs (see diagram).<sup>1,2</sup> No one spontaneously described these practices but the first person we specifically asked had used these methods. There was, however, no universal term for back/frontloading in our area. Information on the prevalence of these behaviours in the UK is scant. Recent research from Glasgow found the term 'halving' was used by six out of 14 female prostitute drug injectors.<sup>3</sup> In 1993 in Maidstone we found that four out of 15 people who had injected in the past month had frontloaded or backloaded.<sup>4</sup>

**Lending and borrowing** 'Sharing' was used sometimes to refer both to lending and borrowing equipment, sometimes only to borrowing. It has been argued that to minimise risktaking, drug workers must influence values towards lending as

well as borrowing.<sup>5</sup> In *Health of the Nation* targets, 'sharing' includes passing on and/or receiving used equipment.

**Muddling** Sharing was not always understood to embrace accidental mixing of injecting equipment. Muddling arose either because the systems people used could not reliably differentiate people's equipment, or because the effects of drugs sometimes led to uncertainty about whose equipment had been used. This form of sharing has been previously reported.<sup>6,7</sup>

**Direct/indirect sharing** When quantifying the number of people with whom they had 'shared', injectors were sometimes unclear whether using another person's equipment meant they had also 'shared' with everyone who had previously used the equipment – epitomised by the Department of Health's poster of a row of arms punctured by a single needle with the slogan: "Sharing your mate's works means sharing with everyone he's ever shared with."

### Perception of risk

People interpreted the risks from different forms of sharing in varied ways. Using a needle just used by someone

else, without any attempt to clean it, was reported very rarely and accurately perceived as a high-risk activity. By contrast, sharing spoons and filters was common, but fell outside many people's understanding of sharing and was often seen as a low or nil-risk activity.

Sharing injecting equipment was more likely between sexual partners. However, underlying assumptions about sexual and sharing fidelity were not always accurate. Men in particular, who were more active in the amphetamine market, were likely to share with other people but not disclose this to their partner.

In the case of one couple, interviewed separately, the woman explained that she shared with her partner but neither shared with anyone else. That same evening the man – after checking the interview was confidential – revealed that he shared with a friend but that his partner was unaware of this.

Contrary to laboratory evidence, most people thought HIV died if it was outside the body for anything from a few seconds to a few minutes. Some people were quite sophisticated in their risk assessments, but the 'facts' on which these were based could be quite wrong.

There was also very poor awareness of

## A RISK ASSESSMENT CHECKLIST

To be confident that risk has been properly assessed, and opportunities for harm reduction fully exploited, as far as possible all the sources of variation described in this article need to be investigated, including:

- whether and how *spoons, filters* and *water* for injection are shared as well as *needles* and *syringes*;
- how *lending* and *borrowing* are understood and the values and practices applied to them;
- whether *backloading* or *frontloading* are used. Absence of a local term to describe these may make it harder to identify their extent. Before questions can be asked about whether it occurs the person may have to be educated about what is meant by the terms;
- whether *cleaning* means that sharing is not regarded as happening and the adequacy of any such cleaning;
- whether situations occur where *muddling* of injecting equipment arises;
- whether sharing with partners or close friends is not perceived as sharing (*intimacy*). This seems especially important with regard to HCV infection. Sexual transmission is, at best, inefficient for this virus, but it may easily be transmitted via shared injecting equipment. Even if a couple have unprotected sex it will still be important for them to avoid sharing injecting equipment as this may allow HCV transmission;
- how the *interval* between use and reuse of injecting equipment is applied to the understanding of sharing.

## ANALYSING THE MEANING

Our data was analysed using methods from ethnography including:<sup>22</sup>

- *informant analysis* – analysis of interview data to obtain a picture of the world in which the informants live;
- *respondent analysis* – investigation of informants' "ways of thinking about the world etc. and how these depend on the social and physical environment";
- *progressive focusing* – development, and perhaps redirection of research ideas according to what is discovered as fieldwork progresses;
- *constant comparison* – "continually comparing segments of data [allowing] for the emergence of categories and of the relationships between them";
- *analytic induction* – searching for falsifying evidence by examining different cases, modifying the theory until no further falsifying evidence can be found.

hepatitis B (HBV) and none of hepatitis C (HCV). That HBV is more robust than HIV was not appreciated.

Heating the drug in the spoon was sometimes seen as having a sterilising effect although the brevity of boiling raises doubts about how reliable this is. Bleach was rarely used because it was seen as potentially dangerous if injected. Sterilising fluid for baby's bottles was sometimes used.

Whether blood was visible affected perception of risk. If it could not be seen, sharing was more likely.

### Educational strategies

While there is scope for addressing health education campaigns to specific practices (eg, backloading), there are reasons to believe that these should not be the sole focus.

The range and complexity of such practices are considerable and may change with time and place. As yet undescribed and/or new practices may emerge. Drug workers may not have a complete overview of the nature and extent of all the variants of sharing in their area. A way of assessing risk which can be applied generally to different and new practices is desirable.

One strategy is to enable drug users to assess risk by applying their knowledge of the virus to the scenarios relevant to them.<sup>8</sup> Our finding that people apply a core set of beliefs about HIV to their practices is consistent with this approach.

To do this successfully they need underlying knowledge about HIV transmission, viability and deactivation,

as well as about specific practices. This would allow them to be more autonomous in evaluating and managing risk across a range of situations.

Attention to the social context of sharing is also vital. Often people perceived a risk but still shared. One HIV positive respondent found it difficult to refuse to give his equipment to others because he did not want to reveal his infection. Sexual partners and close friends face special difficulties in suddenly refusing to share without giving offence. The broader ethic of sharing ('not seeing a mate go without'), reported in Glasgow, also seemed relevant in Maidstone.<sup>9</sup>

To further reduce sharing, we may need to enable people to manage high-risk sharing situations. Discussing and rehearsing responses may be productive in individual cases, but we also need to influence underlying subcultural values and expectations.

Probably only a proportion of injectors will be receptive to information expressed in such terms and convert it into practice – Stimson's "rational" drug users.<sup>10</sup> But these can be expected to inform the practice of other injectors through social networks, thereby having a broader impact on the cultural norms and practices of other injectors.

It's worth reminding ourselves that although HIV infection may be a health priority, the greater robustness of HBV and HCV means that sharing variations should also be assessed for their ability to transmit infections other than HIV. Practices which do not transmit HIV may still spread these other infections. ○

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