

Practices of partnership: Negotiated safety among couples who inject drugs

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Abstract

Despite the majority of needle–syringe sharing occurring between sexual partners, the intimate partnerships of people who inject drugs have been largely overlooked as key sites of both hepatitis C virus prevention and transmission, and risk management more generally. Drawing on interviews with 34 couples living in inner-city Australia, this article focuses on participants’ accounts of ‘sharing’. While health promotion discourses and conventional epidemiology have tended to interpret the practice of sharing (like the absence of condom use) in terms of ‘noncompliance’, we are interested in participants’ socially and relationally situated ‘rationalities’. Focussing on participants’ lived experiences of partnership, we endeavour to make sense of risk and safety as the participants themselves do. How did these couples engage with biomedical knowledge around hepatitis C virus and incorporate it into their everyday lives and practices? Revisiting and refashioning the concept of ‘negotiated safety’ from its origins in gay men’s HIV prevention practice, we explore participants’ risk and safety practices in relation to multiple and alternative framings, including those which resist or challenge mainstream epidemiological or health promotion positions. Participant accounts revealed the extent to which negotiating safety was a complex and at times contradictory process, involving

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the balancing or prioritising of multifarious, often competing, risks. We argue that our positioning of participants' partnerships as the primary unit of analysis represents a novel and instructive way of thinking about not only hepatitis C virus transmission and prevention, but the complexities and contradictions of risk production and its negotiation more broadly.

Keywords

hepatitis C, injecting drug use, needle–syringe sharing, negotiated safety, sexual partnerships

Introduction

Sexual relationships frequently incorporate a high degree of intimacy, collaboration and sharing: this is as much the case for partnerships between people who inject drugs (PWID) as for other partnerships. Yet, the intimate partnerships of PWID have been largely overlooked as not only crucial sources of care, support and stability but as influential sources of practice, including those negotiated around injecting drug use (El-Bassel et al., 2014; Fraser, 2013; Fraser et al., 2014; Rhodes and Quirk, 1998; Seear et al., 2012; Simmons and Singer, 2006; Stevenson and Neale, 2012). Prevailing biomedical and psychological models of illicit drug use and dependence have tended to privilege atomistic explanations of human behaviour while neglecting the social and cultural influences that shape human relations and experiences (Seear et al., 2012; Simmons and Singer, 2006). Similarly, most HIV and hepatitis C virus (HCV)-related prevention and education efforts targeting PWID have focussed on individual-level behaviour and responsibility, effectively eliding not only the influence of broader structural factors, such as social isolation and marginalisation, but the everyday exigencies of intimacy and partnership (Dwyer et al., 2011; Fraser, 2004; Fraser et al., 2014).

An epidemiology of risk has largely focussed on the proximal 'risk factors' linked to viral safety, concentrating on the obstacles PWID face in practising safer injection (De et al., 2009; Sherman et al., 2001; Unger et al., 2006). While mapping the distribution of viral risks and their possible 'determinants', including in relation to factors such as gender, ethnicity, age, duration of drug injecting and geographic environment (Bryant et al., 2010; Morris et al., 2014; Strathdee et al., 2010), these studies reveal little about the complex interpersonal and social dynamics characterising risk relationships, including intimate and sexual partnerships (Fraser, 2013; Seear et al., 2012). The intimate partnership may be viewed as an important site of everyday risk management, shaping how viral and other risks are given particular meaning, and framing how risk-related practices unfold (Simmons and Singer, 2006). The experience of injecting together, for example, may function as a powerful and meaningful form of co-created intimacy (Davies et al., 1996; Rhodes and Quirk, 1998; Syvertsen et al., 2013). Similarly, practices of viral risk, such as unprotected sex or syringe sharing, may be situated as symbols of relationship intimacy and security, thus pointing to risk management as a product of negotiation and emotion and not merely risk calculus (Rhodes and Cusick, 2000).

Here, we attempt to redress the ‘individualising tendency’ of risk-factor-oriented research (Fraser et al., 2015) by adopting a methodology that positions partnerships rather than individuals as a primary unit of analysis (Eisikovits and Koren, 2010; Simmons and Singer, 2006). Drawing on interviews with heterosexual couples who inject drugs, we explore accounts of the sharing of needle–syringes between intimate partners. While health promotion discourses and conventional epidemiology have tended to interpret the practice of ‘sharing’ (like the absence of condom use) in terms of ‘noncompliance’ (Race, 2008; Rhodes and Cusick, 2000; Rhodes and Quirk, 1998), we are interested in participants’ socially and relationally situated accounts or ‘rationalities’. Focussing on participants’ lived experiences of partnerships, and what we identify as protective agencies, we endeavour to make sense of risk and safety as participants themselves do. How do PWID engage with, appropriate and, at times, transform medical knowledge around HCV infection and its transmission? And how have our participants taken up this knowledge and, while not 100 per cent risk-free, incorporated it into their everyday lives and practices in ways that are both pragmatic and sustainable (Kippax and Race, 2003)?

Entertaining a ‘situated’ rationality of risk shaped by its particular social relations lends emphasis to understanding risk as a product of competing interpretation, social interaction, and crucially, negotiation. We therefore also draw on the notion of ‘negotiated safety’. Emerging during the early 1990s, at a stage in the HIV epidemic when *all* unprotected anal intercourse between men tended towards a singular framing in relation to risk regardless of social or relationship context, ‘negotiated safety’ was coined by social scientists in recognition of deliberate sexual risk and prevention strategies practised between partners in gay communities (Holt, 2014; Kippax and Race, 2003). While the term was initially used in the literature to describe the negotiated practice of unprotected anal intercourse within regular partnerships between men of HIV-concordant serostatus, much of the subsequent work tended to focus on negative concordant partners (Kippax et al., 1993, 1997). A combination of factors was identified in the early literature: partners’ knowledge of their respective serostatus; the presence of an agreement; honesty and trust (Kippax et al., 1997). Importantly, what it suggested was that gay men were drawing on their knowledge HIV status and transmission routes to generate protective strategies in addition to condom use (Holt, 2014). Despite the persistence of its detractors, negotiated safety was taken up and promoted by Australian AIDS Councils in 1994, before becoming more widespread in various prevention and education efforts internationally (Holt, 2014). Today, alongside other community-based strategies such as ‘serosorting’ and ‘strategic positioning’, negotiated safety remains part of the HIV prevention and education lexicon (Holt, 2014).

The concept of negotiated safety enables the exploration of risk and safety practices in relation to multiple and alternative framings, including those which resist or challenge mainstream epidemiological or health promotion positions (Rhodes and Cusick, 2000). Understanding risk and safety as ‘fluid’ and in ‘negotiation’, rather than as ‘fixed’ and ‘determined’, also encourages critical reflection on individuals’ practices of agency and accounting in light of their surrounding situations and contexts (Kippax and Race, 2003).

Methods

Purposive sampling was used to recruit heterosexual couples in which both partners identified as PWID. Recruitment took place across four inner-city harm reduction

services within Australia's two most populous states: a needle-syringe programme (NSP) and harm reduction service in Sydney, New South Wales (NSW), and two primary healthcare centres in Melbourne, Victoria. All four were chosen as recruitment sites because they serve as the main needle-syringe outlets for their area. Each is part of a network of publicly funded primary healthcare, NSP and peer-led services established across both NSW and Victoria specifically for PWID.¹ While both Victorian services offer onsite HCV testing as part of their integrated primary care model, the two Sydney sites provide referrals to local primary healthcare clinics for HCV testing.²

Staff from each site directed service users to fliers promoting the study and (with consent) facilitated contact with the research team. Eligibility for the study was then discussed with both members of the couple before arrangements were made to meet at one of the participating sites. Interviews were conducted in private areas set aside within three of the sites (the Sydney NSP and the two Melbourne services). Recruitment focussed on generating a sample of couples representing a range of ages and a balance of HCV serostatus (negative concordant, positive concordant and serodiscordant). The majority of participants comprised couples where both partners agreed to be interviewed. However, in order to ensure a balance of younger participants, a number of 'sole' participants were later included on the basis of their current or prior relationship experience involving injecting drug use.

A diversity of approaches to dyadic-focussed research is canvassed in the literature (see, for example, Caldwell, 2013; Eisikovits and Koren, 2010; Hertz, 1995; Valentine, 1999). Our decision to interview partners separately was, we believed, the most likely to facilitate the emergence of sensitive intra-relationship talk (Eisikovits and Koren, 2010), including negotiations around injecting-related risk and safety. All Sydney interviews were conducted by the first author (J.R.); the Melbourne interviews initially by the third author (S.F.) and then by a research assistant (C.H.). The importance of anonymity and confidentiality was reiterated to all participants, including specific assurances that no information would be disclosed to partners.

Semi-structured interview schedules were organised around the core themes of injecting drug use, HCV and intimate partnership. Participants were asked to describe the nature of their current relationship (including other sexual partners), their knowledge of HCV and its relevance to the relationship, their experiences injecting with partner/s and with friends, and their experience accessing harm reduction services. Interviews took between 30 and 60 minutes. Each participant was reimbursed US\$20 for their time and travel expenses. The study was approved by the Human Research Ethics Committee of The University of New South Wales. Written, informed consent was obtained from all participants.

Interviews were digitally recorded, transcribed verbatim and de-identified to ensure participants' anonymity. Each participant was given a pseudonym to preserve anonymity. The authors collaborated on the construction of a coding frame, guided by a previous partnership-related pilot study (Sear et al., 2012) and by the existing literature. Transcripts were then entered into a qualitative data management program, NVivo 9. Consistent with positioning 'the partnership' as the basic unit of our analysis, all transcripts were organised within NVivo as couples. This meant that any narrative detail subsequently extracted for analysis was immediately identifiable as belonging to a

broader story of partnership as much as an individual account. Summaries of each theme file or 'node' were subsequently produced by one researcher (J.R.) and then reviewed by all authors to further assist identifying concepts and support emerging hypotheses. This article focuses on the node that collated all data concerned with needle-syringe sharing within partnerships, analysed with particular attention to participants' accounts or rationalities of sharing consonant with a 'negotiated safety' framework. Extracts cited are identified by participant pseudonym, age and HCV serostatus, along with their partner's corresponding details.

Findings

The dataset comprised 34 couples and 12 'sole' participants, with equal numbers of men and women ($n=40$) ranging in age from 19 to 61 years. Duration of relationships varied from 2 months to 20 years. Nine participants were in part or full-time employment, with nearly all receiving some form of social welfare ($n=71$). Over half the participants identified as 'Anglo-Australian' and nearly a quarter as Aboriginal or Torres Strait Islander ($n=17$). In this article, we have focussed our analysis on the 34 couples for whom we have *both* individual partner accounts of their shared partnership. Of these, 26 or approximately 75 per cent reported sharing *within* their partnership. Only one participant reported sharing with someone other than their partner, while eight couples reported never sharing. Of the 26 couples who reported sharing needle-syringes, 20 believed they were HCV concordant (8 HCV negative and 12 HCV positive) and 14 discordant (8 HCV-positive men and 6 HCV-positive women). Serostatus was determined by self-report and in several cases partners offered conflicting accounts. There were also cases where participants reported that their serostatus had changed during the course of the relationship – through treatment, spontaneous clearance or seroconversion. Hence, we have classified participants by serostatus as reported at the time of interview.

The following analysis mobilises the concept of 'negotiated safety' (Kippax et al., 1993) in relation to needle-syringe sharing within intimate partnerships. It does so via the discussion of three key themes identified within participant accounts: the importance of 'trust' in enacting intimate partnerships; the sharing of 'intimate knowledge' with regard to partners' negotiations and decision-making around safety; and, the question of 'unevenness' in negotiating practice.

'Trust' and the practice of partnership

For most participants, 'trust' was *the* recurring trope of their relationship narrative. Often characterised as the absence of secrets, trust played a crucial role not only in the maintenance of intimacy generally but in negotiations around injecting practices and viral management specifically. For couples such as Patrick and Pam, trust reflected and enacted the ethical substance of their partnership:

I've always just found that honesty is the best policy ... It's my life: I look after myself and I look after my loved ones. And if people don't like the way I live my life that's their problem, not mine ... [K]nowledge is power isn't it? I like to know what's going on ... [Pam] and I are

both very open and honest people ... I don't understand couples that like skulk around behind each other's back doing things. Lying and cheating ... it just doesn't work. Either you want to be with your partner or you don't. (Patrick52pos.(Pam50neg.))

For many participants, *trust* – and by extension, *safety* and *security* – was the distinguishing feature of shared drug use with their intimate partners. Here, safety and security meant more than simply the avoidance of viral danger. The presence of a trusted partner functioned as a form of emotional (as well as risk) management: reducing uncertainty and anxiety, and heightening a sense of security. For these participants, trust functioned as a form of relational boundary: socially, emotionally *and* virologically inoculating the partnership from the perceived risks posed by those outside the partnership. Its presence served to distinguish intimate partnerships from other forms of social relationships:

Interviewer: What do you think it is: being able to share with your partner but not with other people?

Christine: Because I know Craig. I know that there are no more secrets behind the hep C ... If he's sick and I'm sick, the one thing I understand is that we both have the same problem: if we shared strains, then we've both got the same shared strain. It's unfortunate we got to that point, but as long as no one else comes into the mix I feel safe. (Christine26pos.(Craig29pos.))

Nearly all participants described rules or codes of conduct they had negotiated with their partner around injecting drugs with others. Following these 'rules' was integral to the maintenance of trust and intimacy within the relationship. Most participants explained that their preference to inject only with their partner was underpinned by a sense of safety. Here, 'safety' appeared to be synonymous with 'trust': it was participants' trust in their partners that allowed them to feel safe. Safety was also about the absence of the potential trouble of 'owing' others (drugs or money), negotiating the division of drugs, dealing with accidental overdoses and so on. Injecting with others required vigilance, so for many participants it was preferable to do so with a partner where things followed a predictable, familiar and comforting routine.

For couples like Fred and Fran, the decision not to inject with others was part of their on-going negotiation and maintenance of a shared ethos and practice of partnership. For others, such as Craig and Christine, occasionally injecting with others required the strict enforcement of injecting and disposal procedures. Such decisions not only established the practical limits of these participants' partnerships with regard to injecting drug use, it also served as a meaningful, co-created sign of their mutual trust, commitment and exclusivity:

[I]t's not only my life I got to worry about. Once I inject with them [others], I'm going to be bringing it on to her [Fran], so I have to take care of her too. (Fred29pos.(Fran29pos.))

Craig: [Sharing] happens sometimes when we haven't got fits. [However], we have a strict policy: if someone else uses and they want to dispose of it in our bin, then they've got to scratch off a number, the number has to be removed, so then I know and [Christine] knows that that's not ours. (Craig29pos.(Christine26pos.))

'Intimate knowledge' and the negotiation of safety

Many couples, both serodiscordant and seroconcordant, practised forms of 'negotiated safety' in a strict biomedical enactment of the term: as the reduction of risk based on a shared knowledge of each partner's HCV serostatus or even genotype. Almost without exception, participants insisted that while they had shared needles with their partner they would not contemplate doing so with anyone else. For couples like Pam and Patrick, negotiating serodiscordance was both a meaningful expression and co-created practice of partnership that reproduced their sense of togetherness, their 'we-ness':

Pam: Every now and then when we have been stuck and we've only got one fit between us ... [Patrick] will make sure that I use it ... then he'll rinse it and use it ... Because he has [HCV] and I don't ... And he wants to keep it like that.

Interviewer: It sounds like on those occasions you've been very aware of Patrick's hep C status and so you've gone first?

Pam: Yeah ... he just wouldn't have it any other way. [Negotiating serostatus] isn't really an issue for people like us that are partners and are faithful, and are loyal and stuff; I just think there'd be a lot of people out there that keep secrets. (Pam50neg.(Patrick52pos.))

The negotiation of safety within intimate partnerships can be reasonably explained as simply an expression of the familiarity and trust that comes with intimacy, sometimes also depicted as an 'equivalent' to unprotected sexual intimacy (Harris and Rhodes, 2013; Lenton et al., 2011; Seear et al., 2012). What was noteworthy among our participants, however, was the enabling role played by the particular types of knowledge participants had about their partners' injecting practices, viral serostatus and medical check-ups. In some instances, attaining access to such knowledge appeared to act as a catalyst for the establishment of intimacy and trust. As Suzie46pos.(Seth34pos.) explained, 'when we got together we both went and got blood tests done, looked at each other's blood tests, knew exactly what each other had'. In other circumstances, access to intimate knowledge was a *consequence* or reflection of the emotional closeness of the partnership. As Fran29pos.(Fred29pos.) puts it,

I know [Fred], I love him, it's different. We've been together for so long, we know so much about each other and we're just so close. Whereas other people, I don't trust, I don't know their life. I know his life.

Participants trusted their partners, at least in part, because they were witness to the intimate practices of each other's daily lives. Being continually physically proximate as well as emotionally close facilitated the co-creation of intimate interpersonal knowledge, in turn enabling the establishment and maintenance of mutual trust and collaborative forms of viral risk management:

Interviewer: If you weren't in a relationship, would you share?

Belinda: [If] we were just best friends and we didn't have a sexual relationship, no I wouldn't ... We use always 100% together, all the time for the last 10 years ... so I see his practices. With

friends and associates, I don't know what they're doing, they could pick them up in the gutter. (Belinda36pos.(Bob46pos.))

Interviewer: So why would it be that you don't share with them [people other than partner]?

Cath: Because I don't know what they've got I suppose, but with [Colin] I'm sort of with him every day, all day: I know what he does. I know he wouldn't share with other people. (Cath33neg. (Colin29neg.))

Here, participants incorporated elements of biomedical knowledge into their intimate knowledge of each other and their trust relations. Biomedical 'evidence' enabled trust relations to be applied: *practised*. In order to negotiate the minimisation of risk around sharing (and despite both being HCV-positive), Seth (34pos.) and Suzie (46pos.) drew on scientific knowledge current at the time of interview regarding interferon-based treatments of HCV according to genotype. Their decision for Suzie to inject first was based on their mutual understanding that interferon-based treatment for her genotype 3 was of shorter duration and more effective than Seth's genotype 1A: better to risk transmission from Suzie to Seth than vice versa. Couples such as Fred and Fran, Ava and Alan, similarly drew on their awareness of HCV genotypes or 'strains' to inform their decision-making around drug and equipment use. This is not to reduce participants' knowledge of one another to a biomedical risk calculus but rather to illustrate the ways in which the 'biomedical' was both accommodated *within*, but also in turn *enacted* in, participants' trust relations:

Fran: [W]e found out we've both got the same strain, and we know we both don't have anything else. We always have blood tests ... he's the only person I'll share with. (Fran29pos. (Fred29pos.))

[W]e are pretty vigilant about the practice [of injecting]. Because there's different strains of hep C. [Ava] might have hep C and I might have hep C, but different strains. If she gets my strain it might ... you know, make it worse. (Alan48pos.(Ava33pos.))

Just as we need to appreciate trust's emotional, relational and social dimensions, so too do we need to recognise its historicity: remade over time through the lived experiences of the partners involved, in the context of historical shifts in biomedical and other knowledges (Rhodes and Cusick, 2000). For couples such as Seth and Suzie, Jenn and Jim (below), their perceptions of risk changed in accordance with the emotional dynamic of their partnerships: reconfigured within the safety and security of a growing intimacy:

Interviewer: And so you guys didn't, you didn't try and distinguish your fits from [your partner's] fits sort of thing?

Seth: There were times earlier on in the piece, like if we just had one fit each, we're going to reuse them later. We'd wash them out, and one of us might burn an end or something, but as time wore on and we sort of realised that we were going to be spending quite a lengthy period of time together, not just a fling kind of thing, it'd develop more into something like 'ours'. (Seth34pos.(Suzie46pos.))

Interviewer: So would it have been different in the past [sharing]?

Jim: At the start it was, because we weren't aware of what we had. But only since we both found out we had the same hep C it was like, well my blood is your blood and we're going to marry ... So for now [we're] happy to share ... we're two partners become one. (Jim32pos. (Jenn31pos.))

While negotiations and decision-making around viral safety were, at least in part, emotionally constituted – in Seth and Suzie's case, mirroring their emerging commitment to one another – they were not necessarily indifferent to or outside biomedical reasoning. For couples such as Jim and Jenn, Fred and Fran, their change or 'relaxation' of attitude towards sharing equipment involved the integration of serology results within the private landscape of their partnership. This integration of the biomedical within the intimate was enacted in different ways within and across partnerships. Jenn, for example, emphasised the biomedical, 'I found out we both had it [HCV] and we had the same genotype ... I know this is bad but if we have to share I'm not as worried now'. Jim, on the other hand, referenced biomedical knowledge alongside a Western trope of romantic partnership: of 'two partners become one'. Fred, too, accommodated his knowledge of HCV and the 'strain' he shared with his partner Fran within a romantic ideal: 'we've checked out each other's bloods ... so we are aware of exactly what we've got ... And because we're soul mates for life, it doesn't really matter'. For both couples, negotiating safety was materialised through the coming together of biomedical knowledge and intimacy: an integration of biomedical and social knowledges embodied in practice.

For these couples, what counted over time in the process of negotiating safety was not simply the growth of emotional closeness coupled with the accumulation of intimate, inter-personal knowledge, but their exposure to biomedicine. Here, negotiations around safety did not follow a predictable or linear path over the course of couples' relationships; greater trust and commitment did not inevitably lead to a 'relaxation' of attitudes and practices around sharing. As Suzie, for example, learnt more about viral genotypes and began considering the possibility of treatment, her own and Seth's approach to viral-risk management returned, once more, to being – as Seth put it – 'a lot more vigilant'. Similarly, Shelly and Steve explained that going through treatment expanded their biomedical knowledge, prompting them to rethink their previous practice of sharing equipment:

I was one of those people that [said] 'yeah I've got hep C too ... it's [sharing] fine' ... But now that I have been more educated on hep C, I'm a lot more wary. I will not share his even [Seth's equipment] any more ... I won't risk getting another genotype ... No way! (Suzie46pos. (Seth34pos.))

Shelly: In the past when we both were hep C positive and we both had the same strand, and we knew that, we weren't too concerned ... If we didn't have clean syringes we would just use our old ones and I'm sure I used his and he used mine ... but we don't do that now [that Steve has completed HCV treatment]. (Shelly34pos.(Steve33neg., following treatment))

The 'unevenness' of negotiations

Participants' negotiations around safety, along with their implementation in practice, were necessarily enacted within relational and social environments that were themselves continually shifting and evolving. Even within the same relationship, the meaning of 'safety' was fluid, shifting over time and across place. For some couples, their negotiations around sharing, including who would go *first on the needle*, appeared to prioritise the risk of overdose. For others, the injecting process became organised, at least in part, around the dilemma of diminishing venous access (the less-used the needle, the sharper it is, the greater the likelihood of successfully finding a vein). For Seth and Suzie, the process of negotiating safety around genotype (discussed earlier) was further complicated by a number of additional factors: from a difference in injecting skills to fears around public and police detection:

I always went [injected] first I suppose ... [I]f the gear was too strong, or something like that, I would be the one to overdose first ... If Cath goes first, I don't want anything to happen to her. (Colin29neg.(Cath33neg.))

[N]early all my veins are destroyed so I inject in my neck now and my groin ... [T]hat's why I usually get to inject first, that's why [Bob] usually helps me because it's so hard for me to get [myself]. (Belinda36pos.(Bob46pos.))

Interviewer: And so how do you work out who's going to go first?

Suzie: Because he's got Genotype 1, I'd always like go first because I've got Genotype 3 ... I'm quicker too ... He takes too long ... [W]e're doing this stuff outdoors, so you've got to be constantly looking for police or other people ... we have to be quick and fast. (Suzie46pos. (Seth34pos.))

We are not proposing here that these couples were necessarily indifferent to viral risk but rather drawing attention to the 'unevenness' of negotiations: to the presence of other 'risks' being of greater immediate priority than viral risk and the shaping or disrupting of negotiations by other things. Negotiated safety is an uneven and evolving process according to context, which in turn has a bearing on the internal dynamic of relationships and communications within them. Participants' partnerships were regularly forced to contend with a myriad of competing factors and 'risks' – emotional, physical, viral, structural – in their negotiations around safety. While negotiated safety was a fluid and dynamic process for all of our couples, inevitably differentiated, at times, by the relational politics of power and gender, only two female participants provided accounts of the sort of gendered iniquities or abuses cited in the literature (Bourgeois et al., 2004; MacRae and Aalto, 2000; Wright et al., 2007). Both Mandy and Rachel reported a grossly curtailed capacity to influence the injecting process due to their partners' dominant and controlling conduct. Both reported distress at not only their partners' insistence on injecting in public, but by the risk (viral and otherwise) that accompanied these episodes. Mandy's account was most striking in the admission – the only one reported among all our participants – that she would rather inject with

friends: 'my friends, they'll stop and listen to me and they'll take more time to be clean if I ask them to, rather than my partner'. For Mandy, and arguably Rachel too, the negotiation process was confounded by what appeared to be an explicit disparity in power, not only with regard decisions around drug use, but the relationship more generally:

Interviewer: Do you share injecting equipment with your partner?

Mandy: Sometimes, all the time actually ... it's pretty scary sometimes what I see, because [Mike] does the mixing of the dope ... we never go home and have it, whereas I, if I had it my way, we'd be taking the drugs home, and it would be a whole lot cleaner ... [I]t's got the point where I've just given up. It's like I think: 'Well I've got hepatitis C now' ... [I]f I say something you know, I get shot down in flames ... (Mandy45pos.(Mike37pos.))

Interviewer: Do you inject together?

Rachel: [H]e can't wait to go home and have it. We'll stop in a laneway or whatever and have it. I get really paranoid but he loads mine up and I have it anyway ... He asks me to get everything out and he'll just do it ... It's just always been that way, even if when I'm buying it he takes over. (Rachel41pos.(Robert42pos.))

Discussion

Without exception, intimate partnerships played a central role in the lives of our participants. Despite the ambivalence, disappointment – even disaffection – reported by some, partnerships invariably represented participants' primary source of material and emotional comfort, support and security. For many, their intimate partnerships functioned as an 'emotional refuge' (Syvertsen et al., 2013) and form of 'social protection' in an often hostile world (Rhodes, Rance, Fraser & Treloar, forthcoming). Partnerships were also instrumental in shaping how participants thought about, negotiated and practised blood-borne virus prevention. Negotiating safety was a complex and at times contradictory process, involving the balancing or prioritising of multifarious, often competing, risks. While we recognise the critical role played by broader forms of social structural vulnerability and marginalisation in shaping and constraining participants' 'private' lives and relationships, our analysis here has been principally concerned with participants' accounts of what they do *within* partnerships.

Rather than recognised as a unit of analysis in its own right, the partnerships of PWID have tended to be either overlooked by the literature or discounted as dysfunctional and drug-driven (Fraser, 2013; Keane, 2004; Seear et al., 2012; Simmons and Singer, 2006). Notable exceptions have, however, underscored the need to take seriously their affective dimensions and emotional dynamics (see, for example, Rhodes and Cusick, 2000; Rhodes and Quirk, 1998; Seear et al., 2012; Syvertsen et al., 2013). The management of risk and the negotiation of safety among such couples, they argue, need to be understood not just as exercises in rational calculation but as an integral part of how couples actively 'do' or *enact* intimacy – as caring, secure and trustworthy. In stark contrast to the routine 'dehumanization and distortion' (Simmons and Singer, 2006) characterising popular

representations of couples who inject drugs, many of our participants emphasised notions of love, trust and commitment in their accounts of partnership.

This article is based on a study designed in a way that potentially affected the data in unintended but important ways. Recruitment involved self-selection and voluntary participation from both partners, and as such necessitated a level of mutual decision-making and cooperation. This may have reduced the likelihood of making contact with couples whose relationships were affected by issues of inter-partner violence and abuse. We note that while only two female participants provided explicit accounts of diminished power and agency in regard to negotiating safety with their partner, we cannot be sure that such experiences were not more widespread among participants. Although qualitative methods are well suited to capturing contextual and relational complexities beyond gender norms and stereotypes (Fraser, 2013) – including decision-making around drug use – we acknowledge the limits to our claims-making regarding the apparent absence more broadly of gendered inequity within our dataset.

Our analysis has revisited and refashioned the term ‘negotiated safety’ from its origins in HIV-prevention practice and sought to extend its explanatory efficacy to couples who inject drugs. We too have considered how our participants engaged with and transformed medical knowledge in an attempt to fashion their own prevention strategies in ways that reflect both the possibilities and the constraints of their situation. Our participants consistently reiterated the importance of trust, honesty (‘the absence of secrets’) and the presence of an agreement or ‘rules’. For both gay men and couples who inject drugs, negotiated safety as a form of viral risk reduction relies on the coming together of the biomedical and the intimate: on sharing and incorporating knowledge of each other’s serostatus within a relational context of honesty and trust.

While there are viral specificities which differentiate the practice of negotiated safety among gay men compared with couples who inject drugs – the presence of HCV genotypes, for example – we do not want to reduce such negotiations to simply a question of biomedical acumen or risk calculus. Divorcing the role of people’s emotional lives from their decision-making processes – including choices made around drug and equipment use – risks constructing accounts in which lived, embodied intimacy is missing (Rhodes and Cusick, 2000). ‘Negotiated safety’ is a negotiation in the sense of couples coming to a (seeming) consensus to enact a risk-reduction decision or action, as well as in the sense of being produced through the relational effects of biomedical knowledge merging with embodied knowledge about the sense and meaning of relationship. Negotiated safety is at once a coming together of different forms of knowledge – of reasoned action *and* the embodied or emotional.

For our participants, negotiating safety required balancing the emotional dimensions of the partnership alongside its pragmatic functions (Rhodes, Rance, Fraser & Treloar, forthcoming). Selective sharing with one’s partner was framed by many participants as a means of keeping their partnership safe (including virologically) from ‘irresponsible others’ (Fraser, 2004): a means of keeping *us* literally and symbolically distinct – safe – from *them*. For gay men, on the other hand, the practice of negotiating safety has typically been in the context of open relationships where the focus has been on how to *include* others safely within the (sexual) dynamic of their relationship. For our couples, the trust invested in their relationship was intimately bound up with the intimate

knowledge they had of each other; others could not be ‘known’ – and therefore trusted – in the same way. For serodiscordant couples in particular, while this would appear to contradict normative understandings of viral risk which suggest that danger actually lies *within* the relationship, it does not – unlike for HIV-serodiscordant gay partnerships – preclude the practice of negotiated safety. For nearly all our participants, risk (both viral and otherwise) was invariably reconfigured and relocated: as coming from *others* and from the *outside* (the partnership, the home and so forth). Selectively sharing with one’s partner, albeit as a ‘last resort’, was nonetheless still about prioritising and enacting the value of intimate partnership and the protective effects of relationship: something participants reported not countenancing with anyone else.

Conclusion

While the concept of ‘negotiated safety’ has been well utilised within the HIV literature on men who have sex with men, it has rarely been explored within the field of illicit drug use and HCV. Similarly, our positioning of participants’ partnerships as the primary unit of analysis represents a novel and instructive way of thinking about not only HCV transmission and prevention, but the complexities and contradictions of risk production and its negotiation more broadly. Within liberal Western contexts, drug users’ capacity to reason and make decisions (Wolfe, 2007), be fully rational subjects (Seear et al., 2012) – even their inclusion as members of the human community (Moore and Fraser, 2006) – are all routinely subjected to doubt (Rance and Treloar, 2015). Hence, it is all the more important to not only acknowledge the integrity of intimate partnerships between PWID, but to recognise that such partnerships are both ‘reasoned’ *and* ‘embodied’ (Rhodes and Quirk, 1998): capable of not only enacting their own form of ‘prevention ethics’ (Race, 2008) but made up of lived emotion and affective experience.

We argue that at a service, programmatic and policy level, failing to acknowledge and work with the strengths, knowledges and practices of partnership among PWID will continue to limit the impact of HCV prevention and health promotion programmes. Such an acknowledgment, we maintain, needs to be contextualised within a redistribution of responsibility for HCV prevention beyond simply those injecting to include social structures and institutions. It needs to be accompanied by a determination to address the shortcomings that have tended to characterise HCV testing: of poor diagnosis experiences; confusion regarding the meaning of different tests; inadequate counselling and follow-up (see, for example, Seear et al., 2012; Treloar et al., 2010). The individualising tendency of existing models of needle–syringe distribution similarly needs to be challenged, requiring a redesign of equipment packaging and presentation to reflect not only the sociality of injecting but the diversity of meanings needle–syringes carry for many of their users (of care, fidelity and so forth) (Fraser, 2013; Fraser et al., 2015).

Our findings echo calls within HIV prevention to move beyond narrow, individual-level, cognitive-based models of health behaviour (El-Bassel et al., 2014; Jiwatram-Negron and El-Bassel, 2014; Montgomery et al., 2012). Recent interventions in the field have emphasised a conceptual and motivational shift from a ‘self-care’ orientation to a ‘relationship’ orientation: from independence to interdependence and ‘communal coping’ (Lewis et al., 2006; Montgomery et al., 2012). While our analysis has been

principally concerned with participants' accounts of what they do within partnerships, we recognise that for many couples, chronic structural vulnerability, hostile social environments, and the multiplicity of competing demands associated – directly or indirectly – with drug use and dependency, all form part of both the production of risk and attempts at negotiating safety (Fraser and Seear, 2011). In our continued efforts to understand and prevent the transmission of HCV, as well as address the dynamics of social exclusion, we need to better acknowledge and work with the sources of intimate knowledge, trust and negotiated safety created and enacted within the partnerships of those who inject drugs, as well as identifying the viral risks. We need to better recognise not only the reasoned relationships of couples who inject drugs but the disciplinary effects of their social contexts wherein structural forces shape not only what is 'reasonable' but what is possible.

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethical Approval

The study was approved by the Human Research Ethics Committee of The University of New South Wales, Australia (reference HC12430). Written, informed consent was obtained from all participants.

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Notes

1. Data from the annual Australian needle-syringe programme (NSP) Survey (Iversen and Maher, 2015) indicate that among participants heroin was the most commonly injected drug in both states until 2014, when in New South Wales (NSW) it was exceeded by methamphetamine. In our study, heroin was cited as the 'drug of choice' by a clear majority of participants from both states, followed by stimulant-type substances, including methamphetamine.
2. In Australia, over 230,000 people are estimated to be living with chronic hepatitis C virus infections. People who inject drugs remain disproportionately affected, with approximately 90 per cent of newly acquired infections due to the sharing of contaminated injecting equipment (The Kirby Institute, 2015). In 2014, the prevalence of HIV among NSW and Victorian

participants in the annual Australian NSP Survey was 2.5 and 1.7 per cent, respectively, while for HCV it was 55 and 67 per cent (Iversen and Maher, 2015). Rates of HCV testing in NSW were 51 per cent for the previous year (with 85% ever tested) and 60 per cent in Victoria for the previous year (with 90% ever tested) (Iversen and Maher, 2015).

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