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Research Paper

Injecting drug use: Gendered risk

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ABSTRACT

Background: Research demonstrates gender related differences in drug-use practices and risk behaviours. Females' structural vulnerability stemming from traditional gender roles and gender-power relations may enhance their propensity to experience injecting related risk. In this paper we explore gender differences in injection practices at the initiation event, during the first year of injecting and in the most recent 12-month period, to inform more effective harm reduction strategies.

Methods: Data used in this study were drawn from the Global Drug Survey 2015. The study employs chi-square and logistic regression to assess gender differences in injection behaviours in a sample of current injectors residing in six global regions: North-West Europe; Southern Eastern Europe; North America. South America and Oceania.

Results: Females were more likely than males to report being injected by an intimate partner at initiation (OR = 4.4, 95%CI: 2.2–8.8), during the first year of injecting (OR = 4.8, 95% CI: 2.4–9.3) and in the most recent 12-month period (OR = 2.5, 95%CI: 1.0–6.2). Females reported greater difficulties accessing sterile equipment ($X^2(2,N = 453) = 8.2$, $p = 0.02$) and were more likely to share injecting equipment than males ($X^2(1,N = 463) = 3.9$, $p = 0.05$).

Conclusions: Our findings highlight females' continued dependence on their intimate partner to administer the injection into the first year of their injecting career. Females remained more likely than males to rely on intimate partners for injection during the most recent 12-month period. Females report greater difficulties in sourcing sterile equipment and are more likely to share injecting equipment. We suggest that these findings reflect the broader social structure in which females are disempowered through traditional gender roles and the lack of gender appropriate harm reduction services.

Introduction

Injecting drug use is an important, global public health concern (Csete et al., 2016; Degenhardt et al., 2017; Janulis, 2016; Mathers et al., 2008). In 2015, an estimated 15.6 million people living in 179 countries worldwide injected drugs (Degenhardt et al., 2017). Available data demonstrate that prevalence of injecting drug use varies significantly across countries and global regions, ranging from 0.09% in South-East Asia to 1.3% in Eastern Europe (Degenhardt et al., 2017).[1] Research also reveals the worldwide spread of blood-borne disease, in particular HIV is associated with injecting drug use; global prevalence of HIV among people who inject drugs is approximately 18%. Other risks associated with injecting drug use include: drug dependence, mental ill-health, non-viral injecting injuries and fatal overdose (Ahamad et al., 2014; Degenhardt, Hall, & Stone, 2016; Larney, Peacock, Mathers, Hickman, & Degenhardt, 2017).

Efforts to reduce or prevent drug-use related harms among individuals who inject requires an understanding of practices and risk behaviours at different stages of the injecting career and across different social groups (Csete et al., 2016; Degenhardt et al., 2017; Janulis, 2016; Mathers et al., 2008; Rhodes, 2002). Drug use practices are increasingly understood as existing within, and being determined by, a complex interplay of social, political and economic factors, that together represent the 'risk environment' (Rhodes et al., 2010; Rhodes, 2009; Rhodes et al., 2012). Social epidemiologic approaches conceptualise 'risk' as a product of dynamic interactions between

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[1] The authors note that data on injecting drug use in most African, Middle Eastern and Latin American countries is currently lacking.

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individuals and environments; an interaction that is manipulated and constrained by broader social and political structures (Rhodes et al., 2010; Rhodes et al., 2012; Rhodes, 2009). It is within this framework that the gendered nature of injecting drug use related risk can be understood.

Gender is one of the most prominent social categories in modern society. While gender roles, behavioural expectations and attitudes towards gender equality vary internationally and culturally; globally, gender-power structures consistently endorse dominance of the male gender (Amaro, 1995; Connell & Messerschmidt, 2005). Within the injection environment, unequal gender-power relations are simultaneously expressed and reinforced through injection practices, particularly in the practices of intimate injection partners (Bourgois, Prince, & Moss, 2004; El-Bassel, Shaw, Dasgupta, & Strathdee, 2014; Seear et al., 2012). These tend to endorse traditional, (also referred to as *expressive*) notions of manhood (e.g. dominance and risk taking) and womanhood (e.g. passivity and adoption of male initiated risk) (Bowleg, Belgrave, & Reisen, 2000). Males express power and assert dominance by retaining control over the logistics of injection; supplying drugs and sterile equipment (Bourgois et al., 2004). Alternately, females who inject drugs commonly report being initiated into drug injection by their male partner and tend to rely on their partner for access to drugs and equipment, drug preparation and administration of the injection (El-Bassel et al., 2014; Frajzyngier, Neaigus, Gyarmathy, Miller, & Friedman, 2007; Goldsamt, Harocopos, Kobrak, Jost, & Clatts, 2010; Seear et al., 2012). For females, involvement of an intimate partner as the administrator of the injection may impede their capacity to adopt and maintain safe injecting practices or control the frequency of drug use (Pinkham, Stoicescu, & Myers, 2012). Further, dependence on their partner for the supply of drugs and equipment precludes direct engagement with harm reduction services (e.g. needle and syringe exchange programs), undermines perceived self-efficacy and reinforces relational power differentials. The unequal gender-power relations established and reinforced through dependence on an intimate partner for drug injection can also limit women's capacity to exert control over safe sex practices (El-Bassel et al., 2014; Goldsamt et al., 2010). These factors all serve to amplify the risk of blood-borne disease and violence victimisation among females who inject drugs (El-Bassel et al., 2014; Goldsamt et al., 2010). Indeed, studies show that compared to their male counterparts, females who inject drugs experience higher mortality rates, higher rates of HIV and more injection-related health problems (Des Jarlais, Feelemyer, Modi, Arasteh, & Hagan, 2012; European Monitoring Centre for Drugs and Drug Addiction, 2006; Roberts, Mathers, & Degenhardt, 2010; Uusküla et al., 2017). Additionally, females who inject drugs are three to five times more likely to experience violence than women who do not use drugs (El-Bassel et al., 2014).

Previous research demonstrates gender differences in drug-use practices, risk behaviours and injecting related harms (Ahamad et al., 2014; Doherty, Garfein, Monterroso, Latkin, & Vlahov, 2000; Evans et al., 2003; Pinkham et al., 2012). These stem from prevailing gender roles and behavioural expectations that endorse male dominance and impede womens' access to financial, political and social resources (Quesada, Hart, & Bourgois, 2011; Wingood, DiClemente, & Raj, 2000). These differences influence risk of disease, violence and poor health.

While gender-related differences in drug use have been elucidated in the literature, most studies focus on drug injection initiation. Less attention has been given to understanding whether these differences persist throughout the injecting career. Here we assess gender differences in injection practices and risk behaviours at initiation, during the first year of injecting and in the last 12-months, in a sample of current injectors. The aim is to improve our understanding of gender differences across injecting careers to inform more effective harm reduction strategies.

Gender norms, structural vulnerabilities and injecting drug use

Despite efforts towards equality, traditional notions of gender continue to underpin social structures around the world and influence gender roles in key institutions including the labour market and family unit (Connell, 1985). Research indicates the lower social status of the female gender (Matud, 2017); women earn less than their male counterparts and are more likely to be in part-time or precarious employment (Socias, Koehoorn & Shoveller, 2016) (Williams, 1989). As a result, women are more likely than men to lack financial independence. Financial dependence on male partners can disempower women, undermine their self-efficacy, impede access to education, social, political and health resources and in turn, makes them more vulnerable to violence, disease and poor health (Matud, 2017; World Health Organisation, 2008). Women express greater unmet health needs and report poorer access to services than men (Socias, Koehoorn, & Shoveller, 2016). This may be a result of gender-power relations, structural forces such as women's position in the labour market and gender roles around childcare and domestic duties (Socias, Koehoorn & Shoveller, 2016).

Gender roles are underpinned by *gender norms* that define what society considers appropriate male and female behaviour. They are also influenced by individual level factors such as age, income, level of education and race as well as sexual orientation (Shields, 2008). While cross-cultural differences exist (Weziak-Bialowolska, 2015), most traditional gender roles endorse female passivity while encouraging male privilege and dominance. Socialisation into these traditional roles impacts peoples' expectations of themselves and others. While traditional female roles focus on family and domestic duties, with little emphasis on financial independence, traditional male gender roles are focussed on the provision of financial support and dominance (Bowleg et al., 2000). Roles and responsibilities assigned to women and men, as well as their positions in the labour market, family and community, influence their capacity to exert control over their environment, social network and behaviours (Matud, 2017; Wingood et al., 2000).

Traditional gender roles and unequal gender-power relations can be perpetuated in the injecting environment (Morris et al., 2014) and, coupled with females' structural vulnerability (Quesada et al., 2011), enhance their propensity to experience injecting related risks. Women in intimate injecting relationships, who rely on their male partner to supply and administer drugs and sterile equipment, may have little power to negotiate safe injecting practices (El-Bassel et al., 2014; Morris et al., 2014; Seear et al., 2012; Socias et al., 2016). Further, females' financial dependence on their male partner coupled with greater family responsibilities may limit their capacity to learn about, travel to and engage with harm reduction services independent of their partner.

A compounding factor is that women, as the minority amongst injecting drug users, are not always prioritised in health programs or harm reduction services. Gender-neutral initiatives may not adequately address the health risks unique to females who inject drugs, such as issues related to blood borne viruses and reproductive health; sexual health and intimate partner violence (Pinkham et al., 2012). These initiatives may also fail to recognise the unique challenges females who inject drugs experience as a result of broader structural inequalities and gender-power relations. For example, females' dependence on their intimate partner for help acquiring drugs and injecting equipment (Roberts et al., 2010) may make it difficult for females to adopt safe injecting practices or to reduce injecting frequency. As some couples perceive sharing equipment as a sign of trust or intimacy (Latkin et al., 1998), refusal to share equipment may be interpreted as a sign of distrust and betrayal (Latkin et al., 1998; Seear et al., 2012) threatening the relationship and even leading to violence (El-Bassel et al., 2014). Further, given the greater propensity for females' injecting and sexual social networks to overlap (Hotton & Boodram, 2017), relationship dynamics that impact the power structure within the injecting context also play out in sexual contexts, limiting females' capacity to negotiate