GENDER DIFFERENCES IN HIV-RELATED RISK BEHAVIOUR AMONG A SAMPLE OF GLASGOW DRUG INJECTORS

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DECLARATION

I declare this thesis and the research upon which it is based to be my own work and testify that it has not been accepted in any previous application for a degree, that all verbatim extracts have been distinguished by quotation marks and that all sources of information have been specifically acknowledged

Signed.....

Date June 2nd 1992

To Neil and Mick with thanks.

SUMMARY

The lives of drug injectors have most often been described as if they were uniformly experienced by men and women. Closer attention to the pattern, content and style of a drug injecting lifestyle reveals that gender and expectations of gender appropriate behaviour have a good deal of influence on the ways in which drug injecting is experienced. The mediating influence exerted by gender on injectors' lives is also evident in the HIV-related risk behaviour of men and women injectors.

The main aim of the study was to examine the risk behaviours associated with drug injectors in context. For these purposes an ethnographic approach was adopted. Through interviews, observation and a degree of participation in the daily lives of injectors, it was possible to build up a deeper, more detailed understanding of the factors influencing and giving shape to risk behaviour.

Drug injectors were contacted in a wide range of settings. Previous studies have indicated that injectors contacted purely in treatment settings may not be representive of drug injectors in general, particularly since they are more likely to be older injectors for whom drug addiction has become problematic. For these reasons it was considered important to contact injectors who were not in any kind of treatment for their drug addiction.

Data were collected in a variety of ways depending on the particular features of the setting. Men and women injectors were contacted in two treatment settings; a hospital drug and alcohol detoxification ward and a Church of Scotland residential drug detoxification unit. Open ended, informal interviews were carried out in these settings. Injectors were also contacted in a local pharmacy which sells needles and syringes and the nearby needle exchange. Data collection was more compressed in these settings. A short standard instrument was used to record basic information on risk behaviour. However this could be

expanded upon if the person concerned had time and was prepared to talk at length. In addition to this, injectors were contacted on the streets of the local area and prostitute women were met in the red light district in Glasgow city centre. The scope for any kind of formal data collection process in these settings was highly circumscribed. With this in mind data were collected using techniques of participant observation.

The relationship between gender, injecting drug use and the associated risks of HIV infection is considered in terms of the three risk behaviours most associated with injectors, namely; the shared use of unsterile needles and syringes; unprotected heterosexual sex with private partners, and more contentiously; prostitution.

Needle and syringe sharing is known by injectors to carry a high risk of HIV transmission, nonethless it still occurs. It is shown that availability of sterile injecting equipment is but one factor influencing needle sharing. Explanations of this risk behaviour need also to take into account the range of social circumstances which injectors find themselves in and the factors motivating the decision to use the needle and syringe of another. Furthermore it is of some importance to know *who* is sharing with *whom*. Patterns of sociability can be seen to be reflected in the choice of whom to share with and possibly also the pathways of HIV infection. In this respect it is notable that the majority of women injectors were in relationships with men who themselves injected. These women were very likely to report sharing needles and syringes with their partners.

Less attention has focussed on injectors' risks of HIV infection through the practice of unprotected sex. However since the majority of injectors reported being sexually active there clearly is the potential for HIV to be transmitted in this way.

Low levels of condom use were reported in this study. Injectors' reasons for their non-use were in fact consonant with those held more generally by heterosexuals in the population. Whilst perceptions of risk did influence decisions on whether or not to use condoms so too

was it clear that other factors (like embarrassment or finding condoms unpleasant or de-sensitising) were equally, if not more, important. It also became evident that men and women have different expectations of the sexual encounter and how it should be managed. These all have implications for the practice of safer sex. The scope for introducing or sustaining condom use has to be seen in quite different terms where long term relationships are concerned. Clearly these have different parameters to casual sexual encounters or new relationships.

In this study prostitution was only reported by women injectors. The HIV risks associated with prostitution are related to the provision of unprotected sex. However prostitute women report condom use with clients to be an habitual and mundane feature of their sexual contacts with clients. Nonetheless these data indicate that, to an unknown extent, unsafe sex is probably occurring. Analysis of the working conditions of street prostitutes and the particular pressures of having to fund an expensive drug habit, indicated the potential for unsafe sex to occur. Such situations might come about with the compliance of the prostitute or be accidental or be against her wishes or be beyond her control. These situations are all looked at in some detail.

The concluding chapter to this study is a summary of the relative HIV risks faced by men and women in respect of whether it is men rather than women or vice versa who are at greater risk of becoming HIV infected. On a final note the methodological, research and theoretical implications which arose out of this study are considered.

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INTRODUCTION

The relationship between gender, injecting drug use and HIV-related risk behaviours has rarely been considered in detail. Studies on injecting drug users have tended to lump together men and women and treat their experiences as uniform. Relatedly, behaviours which carry a risk of HIV infection have not often been analysed in terms of the possible effects of gender on those behaviours. This study is an attempt to redress the balance since it looks specifically at the influence of gender on injecting drug use, its associated lifestyle and HIV risk behaviours.

As one of the great organising principles of society, gender has a ubiquitous influence on the social world. From the cradle onwards, males and females are brought up to recognise the social world as bounded and defined by gender and expectations of gender appropriate behaviour. Drug injectors although involved in a deviant activity are still primarily socialised into the dominant culture of which they are a part. The fact of being involved in an illicit lifestyle does not neutralise the influence of gender on behaviour. On the contrary, gender is so pervasive a feature of social organisation that it exerts a powerful influence over the ways in which men and women experience a drug injecting lifestyle. Men and women face differing socio-structural pressures and circumstances which result in gender distinct patterns of behaviour. These derive in large part from expectations of behaviour appropriate to the gender roles of men and women.

There are important behavioural differences in the pattern, style and content of a drug injecting lifestyle for men and women. These differences are also apparent in the HIV-related risk activities of men and women injectors. The HIV risk behaviours associated with drug injectors are the shared use of unsterile needles and syringes, unprotected sexual contact and prostitution. These are socially patterned behaviours which can also be seen to be mediated by the influence of gender. Some

risk behaviours are more likely to be found among male injectors, others are more evident among females. The patterns in risk taking behaviours among injectors can be related to particular socio-structural circumstances which make the experience of injecting drug use gender distinct.

Gender related differences in the HIV risk behaviours of men and women are best evident where the focus is the social context within which risk behaviour takes place. Without doubt it is important to know something of the frequency with which HIV risks are taken and the numbers of people who might potentially become HIV positive as a consequence of taking these risks. So too, however is it important to have some sense of the range of factors which motivate risk behaviours and the situations within which they take place. Small scale qualitative studies are able to provide this perspective on risk behaviour informing an understanding not only of how and what risks are taken but why they are taken in the first place. Examining the behaviour of injectors in context most clearly revealed gender differences in the experience of an injecting lifestyle and so also the risks of becoming HIV infected.

In the opening chapter the epidemiological and sociological literature as it relates to HIV\AIDS in the global context is reviewed. Particular attention is paid to the HIV-related risks associated with injecting drug use. Activities thought to carry a high risk of potential HIV transmission, namely, the shared use of unsterile injecting equipment, unprotected sexual contact and, more contentiously, prostitution, are reviewed under separate headings. It can be seen that although the epidemiology of HIV is generally well researched, there are few studies which look specifically at the dynamics of HIV spread within populations of drug injectors. Such factors as who shares with whom and in what circumstances are rarely considered. There are still fewer reports on the impact of gender on injecting drug use and the associated HIV risks.

The chapter which follows on from this sets the context for the study as part of a wider Economic and Social Research Council (ESRC) study looking at the HIV risks of young people living in an area where injecting drug use was prevalent. The location of the study in Glasgow is described with reference to the socio-economic circumstances typical of the research subjects.

This chapter also describes the methodologies used for the purposes of data collection. Although a mix of different research techniques was used the study was pre-eminently qualitative in scope as the specific aim was to examine the social contexts of risk behaviour. The methods used to collect the data and the various settings within which research subjects were contacted are described. Importantly, this chapter considers the cross cutting influences of the research setting and, relatedly, the roles the researcher was attributed. The concept of membership is used as an analytic device to evaluate these influences. In social research it is inevitable the quality of the relationships established with research subjects should have an impact on the kinds of data collected. Appendix 1 discusses the means by which these data were analysed. Appendix 2 contains copies of the formats used for semi-structured interviews in treatment settings, the pharmacy and needle exchange.

Chapter 3 is largely based on an examination of the literature on gender differences and the experience of injecting drug use. Where apposite, data collected from the study are presented. This chapter is not based substantially on findings from the study, rather it is intended as the natural springboard for analysis of those specific behaviours which are HIV risk related and are the substance of chapters 4, 5 and 6. The broad outline of male and female gender roles and the expectations implicit within them form the initial focus of chapter 3. These relate to gender distinctions in the pattern and content of a drug injecting lifestyle. Drug injecting is described in terms of being a career which passes through three stages; initiation into injecting

drug use; absorption into and preoccupation with the lifestyle and finally burn-out; the point where drug injectors become disaffected with the lifestyle or find it increasingly difficult to sustain. At each stage gender related differences in the management and experience of a drug injecting career are pointed out.

The HIV risks associated with the shared use of unsterile needles and syringes are considered in chapter 4. Even despite the high levels of knowledge of the HIV risks of sharing needles and syringes, it was apparent that some degree of sharing persisted. The first question posed by this chapter is why this should be the case. Although a lack of availability might in some cases explain needle and syringe sharing, the thrust of the argument is to show how sharing behaviour relates more broadly to the social circumstances within which injectors find themselves. Some of these situations are more likely to be experienced by women than by men and vice versa.

It is important to look at the range of factors which contribute towards high risk situations. So too is it valuable to examine patterns of needle sharing behaviour between injectors. Analysis of the reported instances of needle sharing showed them to be closely related to patterns of sociability among injectors. Differences in patterns of sociability for men and women can be seen to influence sharing behaviour and also possibly the pathways of HIV infection.

Heterosexual sex and the risks of HIV transmission are the focus of chapter 5. These risks have been somewhat downplayed in relation to injectors because of the attention paid to the HIV associated risks of needle and syringe sharing. Nonetheless, the injectors in this study were sexually active which raised the possibility for HIV to be transmitted in this way.

Sexual activity and levels of condom use among injectors are discussed in terms of the broad range of factors which might influence the practice of safer sex and condom use. Perceptions of the risks of heterosexually acquiring HIV do have some influence on behaviour. However it is important to examine the dynamics of the sexual encounter in terms of the scope for safer sex and condom use. It is evident that men and women have different expectations of the sexual encounter and how it should be managed. These have implications for the practice of safer sex. Finally too, there are obvious differences between casual sexual encounters and long term relationships which raise completely different issues and problems regarding the practice of safer sex and condom use. In respect of sexual behaviour, drug injectors appeared little different from others living in the study area who did not use, or, inject drugs. Where relevant their accounts will be considered in discussing these issues.

Chapter 6 considers the connections between streetworking prostitution, injecting drug use and HIV infection. Since none of the men in the study claimed that they themselves prostituted, women are the exclusive focus of this chapter. The framework for discussing the HIV related risks of streetworking prostitution is provided by describing the conditions of work in the red light district in Glasgow. The pressures of financing an expensive and illegal drug habit are given particular attention. Condom use with clients is clearly an important part of any discussion of prostitution and HIV risks. The range of possible situations which might result in unsafe sexual encounters with clients, whether with the compliance of the prostitute or against her will, or beyond her control, are all considered in some detail. In respect of control, it appears that the degree to which a prostitute woman can assume dominance in negotiating sexual encounters with clients is linked positively to insistence on condom use.

The forthright stance adopted by prostitute women in insisting on condom use and protecting against possible HIV transmission with clients stands in stark contrast to their use in private, non-commercial relationships. It can be seen that the reasons prostitute women gave for not using them with their private partners were consonant with those held by heterosexuals in general.

The concluding chapter to this work begins by summarising the major findings of the study in terms of whether or not gender related behaviour differences place men, or, women injectors at greater risk of HIV infection. This follows with a consideration of the methodological implications of work of this kind, primarily in terms of the research relationships established with the people one studies and the influence this has on the process of data collection.

Attention then turns to the possible avenues for future research which became apparent during the course of this study. The final section of this chapter considers some of the theoretical implications for research similarly involved in examining processes of decision making and risk behaviour in the everyday context of people's lives.

CHAPTER 1. THE EPIDEMIC OF HIV AND AIDS: EPIDEMIOLOGICAL AND SOCIOLOGICAL PERSPECTIVES.

Introduction

It is a measure of the seriousness of the HIV/AIDS epidemic that even in the short space of time since the virus was discovered, a vast and burgeoning body of literature on the subject has emerged. This chapter will review a portion of this literature as it relates both to the epidemiology and sociology of HIV infection primarily amongst drug injectors. Both disciplines offer different, yet complementary perspectives on the problem. An overview of the pattern of HIV spread is provided by the work of epidemiologists. The sociology of HIV infection by contrast, is concerned with explaining the dynamics of HIV spread within given populations. This involves closer inspection of the behaviours which facilitate the transmission of HIV within a specific context.

First I will look at the global impact of HIV and AIDS especially within those geographic areas which have a high prevalence of HIV infection. Attention focusses specifically on the literature relating to those behaviours which carry a high risk of HIV infection for injectors. These are principally needle and syringe sharing and the practice of unprotected sex. The extent to which prostitution is a high risk behaviour is somewhat more controversial and this is reflected in the literature.

The Global Impact of HIV and AIDS

Cases of HIV infection and AIDS have now been reported the world over. Reports from the World Health Organisation (WHO) clearly show HIV infection as continuing to spread rapidly during the last decade. The WHO now estimate that by the year 2000 there will be close to 30 million adults with HIV and 10 million or more children will have been born with HIV. Cumulative totals of AIDS cases reported to the WHO as of 1 April 1991 were 345,000 from 162 countries and

territories. However this figure is acknowledged to under-represent the actual number of AIDS cases. It has been estimated that there may be as many as 1.5 million men, women and children in the world with AIDS (Answer, 1991a).

Even though HIV and AIDS are now prevalent worldwide, the pattern of spread remains highly variable both within and between populations. Three broad factors are thought to account for the variability. Firstly, the year in which the virus was introduced into an area clearly has an important bearing on the degree to which HIV infection is spread within a population. Differences in cumulative AIDS case rates are, at least in part, thought to be attributable to differences in the time when epidemic spread of the virus began (Sato et al, 1989). It is generally accepted, for example, that the HIV epidemic began in Europe approximately two years later than it did in the United States and that this is reflected in differences between the two areas in the number of AIDS cases.

Secondly, an accurate assessment of the spread of HIV and AIDS over time depends on the availability of complete and accurate global AIDS statistics. AIDS case detection and reporting are not however consistent across all countries and continents. In some industrialised countries it is estimated that approximately 80% of cases are detected and reported, whilst for some African nations this figure drops to about 10% (Chin and Mann, 1988).

The third, and perhaps most important, factor explaining the uneven distribution of HIV infection across different populations is that the majority of HIV infections reported arise out of voluntary human social behaviours, principally sexual intercourse and injecting drug use. These behaviours themselves vary within and across populations.

The different patterns of spread of HIV infections within different countries have led the World Health Organisation to create a classificatory schema for categorising different countries and different geographical regions. Pattern I type areas are primarily western industrialised nations where HIV is predominantly found amongst homosexual/bisexual men and injecting drug users. The numbers of people infected through heterosexual sex alone are still low. As men form the majority of those infected there are relatively small numbers of children with paediatric AIDS.

Pattern II type areas have a quite different epidemiology. These countries are primarily in Sub-Saharan Africa and some parts of the Caribbean. HIV is widespread throughout these areas and can exceed 25% in some urban areas (Sato et al, 1989). Transmission of HIV mostly occurs through unprotected heterosexual sex although a significant number of people in pattern II areas are still becoming infected through contaminated blood or blood products. Since there are approximately as many women as men who are HIV infected, there is high prevalence of paediatric AIDS.

Pattern III areas (which include North Africa, South East Asia and countries formerly in the Soviet Bloc) have reported few cases of HIV/AIDS to date. This may be a reflection of the comparatively late introduction of HIV infection in these areas. However low levels of HIV infection can change dramatically over a very short time, particularly if the recent sharp increases in the numbers becoming HIV infected in Bangkok and northern India are anything to go by (Sato et al, 1989). Changes over time are well illustrated by looking at pattern I/II areas, principally in Latin America. Whereas the virus was initially found in urban homosexual/bisexual men and injecting drug users in cities, in the last half of the 1980's an increasing number of infections have been heterosexually transmitted. As more women have become infected so there has also been an increase in cases of paediatric AIDS.

Latin America then is defined as being in transition from Pattern I to Pattern II and is now classified as having a separate epidemiologic pattern.

Injecting Drug Use and HIV Infection

In many of the developed countries the early 1980's saw an explosion in numbers of young people illicitly using injectable drugs (Stimson, 1987). In Britain, as in other European countries, the new drug users of the eighties were largely to be found in inner city areas characterised by widespread socio-economic deprivation (Pearson, 1987b, Stoneburner et al, 1990). Typically they were young males whose drug of first choice was heroin.

At the same time as injecting became an increasingly popular means of administering drugs in many of the inner cities, so too was HIV infection silently spreading within drug injecting populations. Data from various cities in North America and Europe indicate that HIV has been present in populations of drug injectors since 1977 in New York (Thomas et al, 1988), 1979 in Northern Italy (Tempesta and di Giannantonio, 1988) and 1983 in Edinburgh (Robertson et al, 1986). The rapidity with which HIV can spread once established within populations of drug injectors is well illustrated by the situation in New York City, Edinburgh and Milan. These cities have all experienced epidemic spread of the virus resulting in known seroprevalence rates of over 50% in tested injecting drug users (Des Jarlais et al, 1987). In Bangkok, Thailand, HIV seroprevalence rates shot from approximately 15.6% in 1988 to 42.7% in 1989 (Vanichseni et al, 1990). The same startling increases have been recently reported in Manipur, North India, an area bordering the Golden Triangle (Burma, Laos and Thailand) where large quantities of heroin are produced. Routine testing of injecting drug users through 1989 to 1990 in Manipur showed no known HIV infection in 1989. However by June 1990 the HIV seroprevalence rate was found to be 54% (Naik et al, 1991).

Even though HIV infection has the potential to spread rapidly within drug injecting populations its spread has not been geographically uniform. Britain is a case in point. Despite a large overall population of drug injectors, HIV seroprevalence is thought to be low in the majority of British cities. The notable exceptions to this are Edinburgh and, more recently, London.

Edinburgh has a large number of resident drug injectors who have tested HIV positive. Among known injectors the HIV seroprevalence rate is approximately 50%. The situation in Edinburgh is similar only to New York City (Des Jarlais and Friedman, 1990), Barcelona (Muga et al, 1990) and Milan in Northern Italy (Tempesta and Di Giannantonio, 1990).

The uneven distribution of HIV infection among drug injectors can be highlighted by comparing the contrasting fortunes of Edinburgh and Glasgow. Despite being approximately 50 miles apart these two cities have very marked differences in the prevalence of HIV infection. Both cities are estimated to have large populations of resident drug injectors. Glasgow has been recently estimated to have a population of approximately 10,000 drug injectors (Frischer, 1992b). Whilst over half of known Edinburgh injectors in general practice samples are HIV seropositive, only 1.4% of Glasgow resident drug injectors in a recent community study were found to have antibodies for HIV (Haw et al, 1991a). A number of possible explanations have been put forward to explain the differences in seroprevalence rates.

The date of introduction of HIV infection into local populations of drug injectors might go some way towards explaining differences in the numbers of people who are HIV infected. Whereas HIV infection seems to have been introduced in 1983 in Edinburgh, in Glasgow its earliest appearance is reportedly 1985 (Follett et al, 1986).

Differences in HIV rates between the two cities are likely also to be related to the frequency with which unsterile injecting equipment is used and the numbers of people involved. With regard to frequency of injecting, a Glasgow study has recently shown that those who inject more are also likely to share more (Frischer, 1992a). Research findings from a number of studies indicate a strong association between the frequency of needle and syringe sharing and HIV seropositivity (Des Jarlais et al, 1986, Marmor et al, 1987). Robertson and colleagues (1986) interviewed two general practice populations of injecting drug users in Glasgow and in Edinburgh as a means of comparing the behaviours of injectors in the two cities. On the basis of this they suggest that in Edinburgh higher numbers of injectors were often present when needles and syringes were shared than was the case in Glasgow. Gatherings of between ten and twenty injectors were apparently not uncommon in 1983. In addition to this they found an increased number of occasions where unsterile needles and syringes were used. This pattern of behaviour was not reported among Glasgow injectors, perhaps in part because Glasgow injectors did not appear to experience the same difficulties obtaining sterile injecting equipment as reportedly was the case in Edinburgh (Robertson, 1990). In passing it is noteworthy that this situation continues to obtain in New York City and New Jersey as a whole, where possession of injecting equipment remains an arrestable offence (Friedman et al, 1990a).

The above explanations as to why one city has high levels of HIV infection among drug injectors whilst another has not are not wholly adequate. If it were solely a matter of availability of sterile needles and syringes, for example, there would be little HIV infection among drug injectors in Italy where injecting equipment has been widely available for many years (Tempesta and Di Giannantonio, 1990). Further, in Glasgow, although needles and syringes can be obtained from selected pharmacies or from needle exchanges located in areas where large numbers of drug

injectors are known to live, this study found a good deal of needle sharing still occurring even within those areas.

Focussing on such issues as the frequency with which needles are shared and the numbers present on a sharing occasion, is clearly of considerable epidemiologic importance. However, it is of equal importance to explain what motivates and creates situations where risk taking behaviour takes place. This suggests the need for small scale studies which look in detail at local conditions for injectors, taking fully into account the social context and the dynamics created by their relationships with each other. Where the social dimensions of drug injectors' behaviour has been documented it has mostly been in studies which pre-date HIV and AIDS. The most recent of these arose in consequence of a dramatic increase in the availability and subsequent use of of heroin in the early 1980's. This includes two studies carried out in the north of England by Pearson (1987a) and Parker, Bakx and Newcombe (1988) and one study carried out in four cities in North America by Hanson, Breschner, Walters and Bovelle (1985). Notable earlier studies include work done by Preble and Casey (1969) which contradicted stereotypes of injectors as lacking purpose and meaning. Becker's study of 'Outsiders' (1963) although not about injectors but marihuana smokers was seminal in showing the importance of social context and the social meanings which marihuana users attached to their use of the drug.

A feature of all the above studies is how little specific attention is focussed on ways in which gender might differentially influence the experience of drug use for men and women. The exception to this is prostitution which is more likely to be used as a means of generating income by women than it is by men. Even in those studies which include data from men and women injectors, the experience of injecting drug use is most often treated as if gender played no part in mediating that experience. 'Taking care of business' (Preble and Casey 1969) for example, offers a view of

injecting drug use which by inference is about all injectors but which on closer inspection is exclusively male centred. The only major attempt to correct for the invisibility of women's experiences of injecting drug use is Rosenbaum's study of women on heroin (1981a). This study systematically explores an injecting drug using lifestyle from the point of view of women and in so doing gives the lie to characterisations of the lives of injectors as being uniformly experienced by men and women.

The following sections will concentrate on those behaviours known to be a high risk for transmitting HIV infection, namely, needle and syringe sharing, unprotected heterosexual sex and prostitution. Studies which have been able to show differences in the experiences of a drug injecting lifestyle for men and women will be highlighted.

Needle Sharing

Since it first became apparent that HIV was present in populations of drug injectors, numerous studies of HIV related risk behaviours have demonstrated a strong link between the shared use of unsterile injecting equipment and becoming HIV infected. These studies are geographically widespread and include the United States (Battjes et al, 1989, Chaisson et al, 1987), Italy (Rezza et al, 1989) and Scotland (Robertson et al, 1986). More recently studies in Thailand (Vanichseni et al, 1990) and North India (Naik et al, 1991) have again demonstrated the strong association between shared use of unsterile needles and HIV infection.

Examination of the relationship between needle sharing and HIV infection needs to take account of the social dimensions of drug injectors' behaviour. Only a handful of studies have systematically turned their attention to needle sharing as a social behaviour having social meaning for those concerned. This includes a San Francisco based study conducted long before HIV and AIDS was known about

(Howard and Borges, 1970). This work very clearly showed that needle sharing was a socially situated response to local circumstance and social ties between injectors.

Howard and Borges found that a large number of the injectors they interviewed were sharing injecting equipment. This was despite there being a high level of awareness of the risks of contracting blood borne infections, for example hepatitis B. The reasons given for sharing needles and syringes related not only to a lack of available clean equipment but more broadly to the social context of a drug injecting lifestyle. They found that sharing needles and syringes was culturally expected among injectors and on a personal level was expressive of close relationships or friendships. They also found that large numbers of injectors were using drugs in the company of others both because the injecting of drugs was viewed as a social occasion and because the presence of others conferred a sense of protection in case anything went wrong, like for instance, overdosing. Women were much more likely to inject in the company of others, the majority of whom did not in fact inject themselves but were injected by men.

More recently researchers in the United States (Friedman et al, 1990b, Des Jarlais et al, 1986) and in Amsterdam (Grund et al, 1991) have shown that needle and syringe sharing continues to have importance amongst drug injectors even if it occurs less frequently today than in the past.

Other work points also to the value of looking at patterns of interaction rather than individual risk behaviours. Friedman and his colleagues (1989) for example have found differences in the behaviour of new injectors compared to that of older, more experienced injectors. They found that younger, relatively inexperienced injectors were engaging in higher levels of risk behaviour between themselves than was the case amongst more experienced injectors. This has been reported by Stimson and

colleagues (1989) and, recently, by Grund and colleagues in their study of drug injectors in Amsterdam (1991). Despite this however, few of the recent initiates into injecting drug use were HIV positive. Friedman and his colleagues suggest that the explanation for this may lie in the social relations between injectors. They found that initiates into injecting drug use tended, at least at first, to inject (and share needles and syringes) with other initiates whose exposure to HIV at this time would be limited. However as these injectors become more experienced so they come into greater contact with a wider spectrum of injectors. As HIV is prevalent among the more experienced injectors, the likelihood of coming into contact with HIV infection increases as they become more immersed in the drug using subculture and extend their contacts with its members.

Where needle sharing has been looked at in some detail it is clearly not an indiscriminate activity. This has been found in numerous studies which show that most sharing, most of the time, is with people known to the borrower (Donoghoe et al, 1989a, Calsyn et al, 1989, Grund et al, 1991). Needle sharing is a social behaviour and such factors as who shares, with whom, and, how frequently are as likely to influence the direction of HIV spread as are issues of availability and cost of injecting equipment.

Drug injectors and the heterosexual spread of HIV infection

Drug injectors are thought to face their greatest risk of becoming HIV infected through the use of unsterile needles and syringes. To a degree however this is likely to be an artefact of the current practice of the American Centers for Disease Control and the British Public Health Laboratory Service to classify individuals under a single risk category even though multiple risk practices might be involved. Decisions as to the classification of cases where more than one risk factor are present are made on the basis of which factor was thought to most likely have resulted in infection (Bloor et al, 1991). Increasingly however it is recognized that

the risk of heterosexually transmitted HIV in Europe and North America is not insignificant, even though the relative risks are lower than through the shared use of unsterile needles and syringes (Cowan et al, 1989, Robertson and Skidmore, 1989).

The potential for heterosexual transmission of the virus is evident in a population which is predominantly heterosexually active and where raised levels of HIV have been identified (Des Jarlais et al, 1988). Perhaps the best evidence for this potential lies in the spread of HIV to heterosexuals with no known risk factor beyond sexual contact with someone whose behaviour is a high risk for HIV infection (Stoneburner et al, 1990, Brunet et al, 1987).

It has been suggested that differences in the likelihood of an individual becoming HIV positive as a result of coming into contact with the virus may be related to the presence of co-factors such as sexually transmitted diseases (Laga et al, 1990). The degree to which co-factors are influencing the transmission of HIV may go some considerable way towards explaining global variations in HIV spread.

Currently the only recommended means of preventing HIV transmission through sexual activity are either to avoid penetrative sex of any kind or to use a spermicidally lubricated condom. Drug injectors attending needle exchanges in England and Scotland have reported levels of sexual activity which are broadly the same as levels of sexual activity reported by young people in general. Stimson and colleagues found that 80% of injectors had been sexually active in the last three months (1988a). This approximately corresponds with figures reported on a random sample of the British population by Johnson and colleagues (1989) and those of Ford and Morgan in their study of heterosexual lifestyles of young people in one English city (1989). Levels of condom use among injectors have however consistently been found to be low (Haw et al, 1991b, Donoghoe et al, 1989b). Again this appears to be in keeping with low reported levels of condom use among

young people (Ford and Morgan, 1989) as well as the population in general (Potts and Short, 1989).

Heterosexual spread of HIV infection in North America and Europe appears to have a relatively distinctive pattern. Firstly the overwhelming majority of cases of heterosexually acquired HIV appear to have arisen as a result of sexual contact with an individual at risk of HIV, usually through injecting drug use (Shapiro et al, 1989, Norman et al, 1990). In New York city for example, of the 623 cases of heterosexually acquired HIV in women, 88% reported sexual contact with an injecting drug user and 10% reported sexual contact with bisexual men (Stoneburner et al, 1990). There is, as yet, little evidence to suggest the wider spread of infection (Chaisson et al, 1990).

Secondly, the available data on heterosexual transmission indicate that, proportionately, women may be at greater risk of acquiring the virus than men (Cohen et al, 1989, Stoneburner et al, 1990). Reports from Communicable Diseases Scotland Unit in 1990 would seem to be a case in point. Although there are cases of men acquiring the virus heterosexually in Scotland, their numbers remain small, (58 out of the total 1242 HIV positive men). Amongst HIV positive women however the situation is different, 96 out of 501 (19.2%) were infected heterosexually. The main transmission route is believed to be sexual contact with a partner whose behaviour is a risk for HIV transmission (Answer, 1990). Most often the partner of the infected person has been an injecting drug user. The most dramatic illustration of the disproportionate numbers of women who have become HIV infected as a result of heterosexual contact is afforded by 1989 figures from New York City. Of the total 630 people who became infected in consequence of heterosexual sexual contact with someone at risk of HIV, 623 were woman and just 7 were men (Stoneburner et al, 1990)

There are two possible explanations for this trend. The first is related to gender differences in the social structure of injecting drug use and the second appears to concern sex related differences in physiological susceptibility to the virus. With respect to the first point, it is widely accepted that the absolute majority of injectors are male (Frischer, 1992a). Furthermore the majority of these men have non-drug using girlfriends with whom they are sexually active (Robertson and Skidmore, 1989, Donoghoe et al, 1989b). The tendency for male drug injectors to have female partners who do not themselves inject drugs may play a significant part in predicting the likely direction of HIV spread from drug injectors to the general non-drug injecting heterosexual population. However it would appear that there are other factors influencing women's increased susceptibility to the virus. In the second instance there is some evidence, of which the New York data is the most dramatic (Stoneburner, 1990) that sexual transmission is more likely to occur from male to female than female to male (Padian, 1988, Nicolosi, 1990). This suggests that women are not only more likely to be exposed sexually to the virus, but that exposure may also be more likely to result in infection.

Women injecting drugs may be considered as doubly at risk of HIV, through drug use and also their sexual contacts which are predominantly with men also injecting drugs. This may be illustrated by reference to the situation in Glasgow where 54% of drug injectors identified as HIV antibody positive are women. Despite the fact that many more men than women are drug injectors, it is predominantly women who are HIV infected (Answer, 1991b).

Whilst attention has been drawn to the probable differences between men and women's experiences of HIV (Coxon and Carballo, 1989, Sato et al, 1989), few studies have systematically explored these differences. Relatively little is known for example, about the natural history of HIV infection in women (Chin, 1990) or indeed the special needs of women, particularly where childbirth is concerned

(Selwyn et al, 1990). Since the numbers of women with HIV infection are slowly but surely increasing, attention has begun to focus more specifically on HIV positive women. This shift in attention away from an almost exclusive concern with men may in fact reflect changes in the course of the HIV epidemic. The incidence of men with HIV began to level off in the mid 1980's whilst the incidence of women with HIV began to increase at about this time (Chin, 1990).

Indeed, in some areas where the prevalence of HIV amongst drug injectors is high, for instance New York City and Connecticut, HIV seroprevalence in men and women is similar, although more men than women are infected because there are higher absolute numbers of men injectors than women (Shapiro et al, 1989). In the United Kingdom women currently account for about one third of new cases in Scotland and one sixth of new cases in England, Wales and Northern Ireland (Norman et al, 1990). Importantly, four fifths of British HIV positive women are of reproductive age, which is similar to the situation in the United States where 85% of HIV positive women are of an age where reproduction is possible (Shapiro et al, 1989). This in itself raises a whole series of medical, social, moral and ethical issues which need to be addressed.

The majority of HIV positive women in Europe and North America are either themselves injecting drug users or have partners with a history of injecting drug use (Peckham and Newell, 1990). Female injectors are known to have a high rate of pregnancies, the majority of which are unplanned since regular contraceptive use is reportedly rare (Selwyn et al, 1990, Cohen et al, 1989). As the incidence of HIV infection among women increases so too we may expect an increase in the numbers of babies being born to these women. This is already happening in areas of high HIV seroprevalence; for example in the Bronx, New York City, HIV prevalence among women giving birth is 1 in 43 (Novick et al, 1989).

At an earlier stage in the epidemic it was estimated that the risk of an HIV infected mother giving birth to an HIV positive child was approximately 50%. On the basis of information from more recent studies these estimates have now been downwardly revised (Pizzo, 1985, Andiman et al, 1990). In France, for example, a prospective study of 117 infants showed only one third of infants as likely to have evidence of HIV/AIDS by eighteen months (Blanche et al, 1989). In New York City the current rate of perinatal transmission is reported to be 29% once the maternal antibodies have been replaced by the baby's own antibodies (Joseph, 1989). The most recently published finding from ten European centres (based on 600 children born to HIV infected mothers and followed up at least until eighteen months after birth) gives a transmission rate of just 13% (European Collaborative Study, 1991).

Even this comparatively low risk of passing on HIV infection to an unborn child may however be regarded as unacceptably high in some circles. The issue of childbirth is a highly sensitive one tightly bound with personal values, prevailing cultural expectations and social circumstances (Levine and Neveloff-Dubler, 1990, Arras, 1990). It cannot be expected that an HIV diagnosis will necessarily result in a woman terminating her pregnancy. This was demonstrated in a recent study which found that knowledge of HIV state did not consistently determine whether or not the woman decided to terminate the pregnancy or continue it to full term (Selwyn et al, 1990). This in fact is not unlike findings from work which reports on women who know that they carry a risk of transmitting genetic disability onto their offspring and have to consider whether or not they will go on to conceive or give birth (Parsons, 1990). Personal and\or social factors were similarly significant in determining the outcome for these women.

<u>The association between HIV infection, prostitution and drug injecting.</u>

Perhaps the first point to make here is that there is no consistent global pattern of association between prostitution and AIDS. In Sub-Saharan Africa prostitution

appears to have played a significant part in the spread of HIV infection (D'Costa et al, 1985, Piot et al, 1987). However, within Europe and North America a very different picture seems to have emerged in that prostitution does *not* appear to be playing a significant role in the transmission of HIV (Cohen, 1989, Chaisson et al, 1990). In fact early reports from the United States showed similar rates of HIV infection among prostitutes as for the total population in each area (MMWR, 1987). That prostitution in these areas does not appear to have played such a significant role in HIV transmission to date does not mean of course that this will always be the case. Recent reports from some North American cities of an association between the use of crack cocaine and high risk sexual behaviour clearly give considerable cause for concern (Golden et al, 1990, Weissman et al, 1990). Similarly, concern has also been expressed with respect to women who are prostituting in order to finance their injecting drug use. Data on the heterosexual spread of HIV infection suggests that unprotected sexual contact with individuals engaging in high risk activities (primarily injecting drug use and unprotected male homosexual intercourse) is a significant risk factor for HIV transmission (Des Jarlais et al, 1987, Stoneburner et al, 1990). The use of prostitution to finance a drug habit is disquieting since raised levels of HIV infection have been identified amongst female drug injecting prostitutes (Tirelli et al, 1989, Doerr et al, 1990).

Recent research carried out in a number of cities in the United Kingdom and elsewhere suggests that there is considerable overlap between female prostitution and injecting drug use. In London, Day and her colleagues found that 14% of their sample of female prostitutes were injecting drug users (1988). In Birmingham Kinnell (1989) found that 15% of the female prostitutes contacted were injecting drug users. Morgan Thomas and her colleagues in Edinburgh found that 28% of the female prostitutes they contacted self reported as injecting drug users (Morgan-Thomas et al, 1989).

The significance of the overlap between drug injecting and prostitution can only be assessed in terms of detailed information on such areas as the extent of HIV infection among prostitutes, the extent of needle and syringe sharing among prostitutes and the frequency of condom use between prostitutes, their clients and their non-paying partners. However data on these areas are only beginning to become available. There is a good deal of evidence from North America and Europe showing that prostitute women are using condoms with clients either all or most of the time (Ward et al, 1990, Padian, 1988, van den Hoek et al, 1990). It is also apparent that many prostitute women do not use condoms with private, non-paying partners (Day, 1988). These issues are looked at in greater detail in chapter six which concentrates specifically on the link between prostitution and HIV infection, the relationships prostitutes establish with clients and also their private non-paying partners.

The behaviours which spread HIV are primarily social. This places a premium not only on charting HIV related risk behaviours for epidemiological purposes but on understanding what motivates those behaviours in the first place. The value of a specifically ethnographic approach lies in its concentration on the processes of social action. The provision of a detailed in-depth understanding of behaviour in context can be especially useful in pinpointing patterns of behaviour as well as indicating how particular situations can lead to risks being taken. Ethnography has a clear role to play in informing our understanding as to why risk behaviour occurs and in what contexts. It is a necessary and important complement to the more broad-based approach of epidemiologic studies.

This chapter has sketched the outline of the epidemiological and related sociological literature as it concerns drug injectors and their risks of HIV infection. The issues raised here form the background to the empirical data to be presented in subsequent

chapters. The chapter which follows on from this one however details the methods used to collect the data used for this study.

CHAPTER 2. METHODS OF DATA COLLECTION: USING THE CONCEPT OF MEMBERSHIP AS AN ANALYTIC DEVICE

This chapter will begin by describing the study design and then go on to look at the look at the methodologies used to collect these data. The mix of methods used will be discussed in terms of their suitability for the different research settings where injectors were contacted. In addition this chapter will consider the degree to which data collection is influenced both by the research setting and the role the researcher is attributed or creates. The kind of relationship established between researcher and drug injector inevitably has consequences for the data collected. The means by which these data were analysed is presented in Appendix 1.

The Study Design

The data used to inform an understanding of gender differences in HIV risks among injectors were collected in the context of a more broad based research project funded by the ESRC. This was an ethnographic study designed to look at the HIV risks of young people living in an area of Glasgow where drug injecting since the early 1980's has become commonplace and which has raised levels of HIV infection among known injectors (McKeganey and Barnard, 1992). The principal researchers involved were Neil McKeganey and myself. Michael Bloor also had some involvement in collecting data from female streetworking prostitutes at a later stage in the study. Although there were points at which the researchers worked in pairs, all the data reported upon here were independently collected and analysed by myself.

Drug injectors were contacted initially in treatment settings. Whilst in themselves these offered fertile grounds for data collection, they also provided an excellent means of becoming familiar with the broad outlines of the drug injecting sub-culture in an unthreatening environment. The research plan was to move sequentially from

contacts with injectors in treatment settings to contacts with injectors in settings outwith of these institutions. The treatment agencies were all located within the area chosen for study in the north of the city. Many of the injectors contacted in treatment settings were resident in the local area. It was therefore unsurprising that some of the injectors contacted whilst in treatment were subsequently met during the second phase of the research. Many of these injectors then introduced the researchers to others injectors with whom no contact had previously been made. During the second phase of research contacts were also made with young people living in the area who were not actively involved in injecting drug use.

It was not originally envisaged that the research would move outside of the defined study area. However, during the course of the study it became apparent that there was some under-reporting of prostitution among the study sample. To counter for this the researchers jointly decided to attempt to contact prostitutes working in the red light district. Although both male and female prostitutes were contacted, this study only identified one male prostitute who was working to finance a drug injecting habit. It therefore appeared that the use of prostitution by male injectors was uncommon. The decision to concentrate on the female streetworking prostitutes was motivated by a concern to look at the HIV risks associated with the overlap between prostitution and injecting drug use.

The section which follows on from this looks at the factors which influenced the choice of a predominantly qualitative approach to data collection.

Qualitative Methods

Two main considerations influenced the decision to use a primarily qualitative rather than quantitative approach to data collection. The first was based on a pragmatic reasoning of what was likely to be feasible with drug injectors contacted in settings other than treatment centres. The second concerned the nature of the research itself

which set out to understand the social content and meaning of the risk behaviours injectors were involved in. By their nature survey methods are not particularly suited to these kinds of concerns.

Contacting drug injectors out of treatment settings was an important part of the study. It is estimated that only about one fifth of drug injectors come forward for treatment, (Stimson and Oppenheimer, 1982) which raises obvious questions as to whether or not those who do seek treatment can be said to be representative of drug injectors in general. Historically, treatment agencies are more likely to see older, male injectors who have been injecting for some time and for whom maintaining a drug injecting lifestyle may have become somewhat problematic. In general they have been much less successful at attracting females and also relatively inexperienced injectors (whether male or female) for whom drug injecting and its associated lifestyle may not be perceived as being particularly problematic.

Contacting drug injectors outside of treatment settings does however place limits on which data collection methods can be used. Whilst it might be possible to interview an injector at length and following a standardised format in the confines of a hospital ward this is clearly much less feasible in other settings such as the street or the red light district. It was with these limitations in mind that an informal and loosely structured research methodology was used.

The second and most important motive for using qualitative techniques concerned the purpose of the research itself. The explicit intention was to go some way towards not only answering questions as to the frequency with which needles were shared but why they were shared, even whilst the risks of HIV infection associated with this practice might be known. In essence these questions were concerned with exploring the meaning behind action rather than the charting of it. This implies gaining a deep, rather than a broad understanding of behaviour. The researcher is

involved in making sense of intention and motive within specific contexts. As Geertz points out meaning is, 'for a subject in a situation; it is about something that exists as part of a field; there are no simple elements of meaning' (1979:13). Behaviours that might otherwise be seen as inexplicable or irrational to the outsider might, once set in context be rendered intelligible and understandable.

Qualitative research proceeds on the assumption that it is possible to gain a deep, insightful understanding of another human group through some degree of participation in, and observation of, the lives of those humans. In distinction to survey research methods, it is the qualitative researcher, the fieldworker, who in a radical sense is the tool for research (Adler and Adler, 1987). It is she who must enter into discourse with her research subjects, listen to their words, watch their actions. Through careful attention to the details of their lives and the inevitable process by which these are then interpreted and made sense of through common sense judgements, perceptions and background knowledge; the researcher builds up an operational understanding of the behaviours studied. Participant observation is unlikely to provide the fieldworker with the same understanding or cultural authority of the native. However as Wax points out, it is because 'culture is a dynamic system maintained and modified by its members that participation is the most effective way to gain as near total a grasp of it as is possible for the alien' (1971:14).

A prerequisite of gaining such insights into the lives of others is access to those lives and the meanings attached to the behaviours then observed. In general terms, the accepted means by which the fieldworker's account is judged adequate rests implicitly upon the degree to which he or she can show a cultural competence and this in turn presupposes some form of membership of that group. Adler and Adler (1987) argue that the study of social life makes it incumbent upon researchers to take on some kind of membership role on the grounds that 'fieldwork is a

subjectivist methodology. It employs subjective means to study subjective phenomenon. If we want to get the closest to understanding the human actor in the human world we need to channel and marshal our efforts in this direction. To do so we must employ subjectivity, involvement and commitment' (1987:85) They add however, that in the same way that people participate as members of groups or associations with varying degrees of commitment, so too there are varying degrees of membership for the researcher from the most peripheral to the most active or most completely involved.

A major factor determining how involved it is possible, or desirable, for the researcher to be rests with the subjects of study. Research into the lives of injectors put clear limits on the kind of membership it was possible to achieve. Injecting drug use was the activity at the core of group membership and also at the centre of their identification with each other as members. The very illegality of their association with drugs made a clear demarcation between 'insider' and 'outsider' status. Membership of a drug injecting lifestyle was predicated upon participating in that activity. Without this involvement the only possible membership role was a peripheral one which, by its nature, precluded access to certain kinds of information and made the process of gaining trust that much more tenuous. In the circumstances, peripheral membership was the most appropriate and probably the most one could hope for without becoming an injector oneself. This much said, the role of the 'marginal native' (Frielich, 1970) afforded the researcher all the advantages of frequent and close interaction. Even without open access to the inner sanctum of complete membership it was possible to build up an understanding of the texture of injectors lives.

Clearly the success with which a researcher gains sufficient rapport with the group she intends to study has important consequences for the quality of the data collected. However, access is not a once and for all event which once granted is forever

secured. Like all social interaction, access has an ongoing dynamic with groups apt to relax or tighten the criteria for membership in different situations according to different rules. Even within groups, individuals may be more or less welcoming of each other and outsiders at various times. They may be more or less prepared to share confidences and be influenced by shifting group alliances. The interactions between the individuals one studies are dynamic, processual and highly sensitive to context. The researcher enters into this fluid, ever-changing situation and must accordingly negotiate and re-negotiate events and relationships and see how these place her in terms of the group and indeed how these affect the quality and type of data she collects. Wax, in her study of Japanese prisoners of war (1971) and Horowitz in her study of gang members (1986), comment reflectively on their changing relationships with their research subjects and the effect this had on the process of data collection.

In this chapter I will discuss the process by which these data were collected through an examination of the concept of membership, treating it as a topic rather than as a resource (Zimmerman and Pollner, 1970). I shall describe the various means by which data were collected and the settings they were collected in. Particular attention will be paid to the settings in which research was carried out since these had an important bearing on the drug injectors' perceptions of me and the role they saw me as playing as well as their management of social interaction with me and the information they were prepared to make available.

Participant observation perhaps more than other research methods implies a relationship between the researcher and the research subject in a specific context (Stanley and Wise, 1983). This is inevitably consequential for the data one collects. the resolution to this, as Emerson points out, lies not in 'restricting, cutting off or regularising field interactions but in trying to become sensitive to and perceptive of how one is perceived and treated by others.' (Emerson, 1981:365).

This next section begins with a brief description of the study area. It will then go on to outline the various research settings and consider the influence the setting had on the research process.

Data collection and Research Settings

The study took place in an area to the north west of Glasgow. It is an area which because of its markedly poor social and physical position shares much in common with many other British inner cities. Unemployment is endemic, in the 1981 census over 50% of 16-24 year olds were out of work. Where people were in work they were most likely to be earning a low income. The 1981 census found many households to be overcrowded. Numbers of single parents and large families were higher than the regional average. The housing in the area is generally recognised to be in a poor state of repair. In all it is a visually depressing area with long rows of featureless tenements some of which are boarded up and graffitied over (McKeganey and Barnard, 1992).

Drugs and drug use are common to this part of the city. Glasgow-wide this area has one of the highest concentrations of known drug injectors (Haw et al, 1991a). It has also been identified as having higher numbers of drug injectors who are HIV positive (D. Goldberg, personal communication). Drug injectors can be seen standing on the main shopping street waiting to buy or sell drugs. It is possible to find discarded needles and syringes in tenement stairwells. There are few people in the area who are not either related to someone who injects drugs or who do not know someone who injects drugs. Drugs and drug injectors are a feature of the life of the area.

The data were collected in a variety of different ways depending on the setting and the amount of time likely to be available for the purposes of research. Drug

injectors were contacted in 6 settings in or just outwith the study area. These were; a hospital drug and alcohol detoxification ward, a Church of Scotland residential drug detoxification unit, a pharmacy, a needle exchange, the streets in the local area and the red light district in the centre of Glasgow. It should be added that none of the people who agreed to be part of this research can be identified by name. Pseudonyms have been used throughout.

Additionally people who reportedly did not inject drugs were contacted in the settings of the local community centre and two schools in the area. Participant observation was used in the community centre. In the schools group discussions were used to generate data. Their views are incorporated into discussion on the HIV risks associated with heterosexual sex in chapter 5.

Neither of the detoxification units admitted more than four injectors at a time. In the hospital ward, injectors remained resident for two to three weeks. During that time they would be given a decreasing dose of a mixture of librium and methadone. The church run detoxification unit was more flexible about length of stay. Often residents would stay until a place at a residential rehabilitation unit was secured. Residents were not given any medication during their stay.

The needle exchange was situated just outwith of the study area. In the early days of the study it had great difficulties attracting injectors because of concerted opposition to its existence by local residents. However even though this situation no longer obtains, this particular needle exchange has never attracted high numbers of injectors. Possibly this relates to the positioning of the needle exchange just at the entrance to a hospital for infectious diseases on a busy main road running inbetween residential areas. The pharmacy on the other hand is in the middle of a residential area and sees large numbers of injectors, both from the immediate area

and beyond. At the time of this study the pharmacist reported sales of 3- 4,000 needles and syringes per month.

In the settings of the hospital detoxification ward and residential detoxification unit, it was possible to conduct open ended informally structured interviews which frequently lasted upwards of an hour. A total of eighteen drug injectors were interviewed in the hospital ward and nineteen in the voluntary detoxification unit over a period of six months. In the less structured setting of the voluntary detoxification unit it was also possible to take on the position of participant observer.

In the context of the needle exchange and pharmacy selling needles and syringes, research was necessarily a more compressed activity. The majority of drug injectors using these services were busy, purposeful people with limited time available. With this in mind a short, standardised questionnaire was used which could be expanded upon if the individual concerned had time and was willing to talk at greater length. A total of fifty drug injectors were interviewed in the needle exchange although many more were informally met during that time. A total of 35 injectors were interviewed in the pharmacy. Appendix II contains copies of schedules used and topic guides for semi-structured interviews. All the interviews reported upon here were conducted by myself.

Research in these settings went on over a period of about a year. At the same time drug injectors were also contacted in and around the streets in which they lived, or, in the case of those women who were prostituting, in the red light district. In these settings there was no scope for anything other than participant observation. For reasons of personal safety research in these locales was always conducted in mixed sex pairs. During these times no notes would be made and interaction took on the more commonplace character of casual, informal conversations between people. It

was only once away from the research setting that fieldnotes would be set down describing the content and quality of that interaction as accurately as possible.

Since female injectors are known to be fewer in number and generally less visible than their male counterparts, special efforts were made to contact them, even in preference to interviewing males. In treatment centres, for instance, women were interviewed in preference to men so these samples are slightly biased in favour of women (eleven out of eighteen interviewed in the hospital detoxification unit and ten out of eighteen interviewed in the residential detoxification unit). This was in anticipation of contacting fewer women in the local area, the chemist and the needle exchange, which in fact was borne out by subsequent fieldwork in these settings. Particularly in the context of the street (not the red light district) women were conspicuous by their absence. The public arena, at night at least, was almost entirely dominated by men injectors.

The setting within which one conducts research does have an influence on the type and quality of the data collected. Similarly it influences the kind of role it is possible for the researcher to adopt. Places such as the needle exchange, the street and residential detoxification unit are not neutral. They have a prevailing ideology encompassing norms of acceptable behaviour and indeed attitude. Zimmerman and Pollner note that 'the features of a setting attended to by its participants include among other things, its historical continuity, its structure of rules and the ascribed (or achieved) statuses of its participants' (1970:94). The research setting has an important influence on the way in which the researcher herself is perceived and so also the type and quality of the information she will be party to. Generally it was my experience that the more institutionalised the setting and the more the in-treatment individual was compelled to identify with the ideology of the setting, so the more I was identified as part of the setting, despite protestations to the contrary. Predictably, this meant that certain information was shielded from me. However,

meeting the same drug injectors away from the original setting often enabled me to ask questions relating to that time since the answers were no longer potentially negative in consequence for the respondent.

In-treatment settings

It was the hospital detoxification unit, and to a lesser extent, the voluntary residential detoxification unit, which most clearly illustrated the degree to which the flow of information was contingent upon the setting. Drug injectors in being admitted to these institutions are, at least temporarily, surrendering some of their control over their lives to those they are in the care of. The power they can exercise in these situations is largely that which is afforded by subversion.

Since access was mediated through the staff, there was a certain inevitability to the patient's perception of the researcher as having approximately the same status as staff members and in some sense being in collusion with the ideology of the setting itself. It is likely that the researcher will, to some extent, be identified with the staff if only because she is clearly not a patient. To expect otherwise would be, as Johnson points out, to overlook 'the importance of existing relationships of power within a given social setting' (1975:57). Issues of power and its hierarchical organisation cannot be ignored in settings such as these where an individual's continued presence is in large part dependent upon the good will of those she or he is in the care of (Bloor and McIntosh 1990, Des Jarlais et al, 1976).

What follows is an extract from an interview with a male drug injector whilst on the ward and de-toxifying from drugs. Inevitably the interview often touched on issues to do with drugs and the shared use of injecting equipment. Within this framework there was the scope for talking about current drug use or needle sharing whilst on the ward. Yet the subject was neither mentioned nor alluded to throughout the interview:

> He asked what the research was about and as soon as I mentioned needle sharing said,"oh no, I don't do any of that". He said that the last time he injected with someone else's needle was about 2 or 3 years ago... Harry had been on the ward 2 days and said he was being prescribed a methadone mixture at the moment. He wasn't very easy to talk to because he seemed so drowsy and was also quite irritable. He said he was depressed and wanted to leave the ward but also wanted to stay to try and prove his ma wrong. He kept casting me in the role of counsellor and was particularly anxious to know about HIV/AIDS, its history, its spread and its relation to him.
> (Hospital detoxification unit)

It later became clear to the ward staff that he and another in-patient had smuggled drugs and injecting equipment onto the ward and these were then used between them. As a result they were both discharged from the ward. When later I met Harry in his home environment he confirmed that he had in fact been using drugs at that time:

> "I'll tell you the truth, when I was in that ward, that time I spoke to you, I was usin' in there about 5 days running. I was jumpin' out the windae and away for ma Tems, I got ma works fae the chemist and I got back in. Then they began to notice me gone and so they questioned me, they couldnae prove anything but I just said, 'look, I'm gonnae pack ma things and leave because I don't think I'm ready for this, I don't think I can handle a life without drugs'."
> (Streetwork fieldnote)

The sensitivity surrounding certain kinds of information was again illustrated to me a week later when I spoke to a woman injector who had been on the ward at the same time as Harry and the other girl had been:

> In the week subsequent to Harry's discharge I spoke again with the woman who had originally reassured him that I was 'alright' to speak to. She told me that Harry had been discharged because they (the ward staff) thought he'd been using drugs. He'd been caught outside and so they asked him to leave. I asked her if in fact he had been using. "Aye, a bit, no' much." Later on, having just taken my leave of the staff in the staffroom, I spoke again with her, inadvertently repeating the question about Harry's suspected drug use. This time she said "No, they just thought he had."
> (Hospital de-toxification unit)

Even despite efforts to dissociate myself from the setting such as, for instance, not spending long periods of time talking privately to ward staff in the glass-fronted

office where I was easily observed by patients, and deliberately adopting a casual manner of speech and appearance, I was still seen as more a member of the group in authority than I was of theirs. This was probably inevitable given the nature of the situation, again to quote Johnson; 'Men of common sense view all knowledge as being use oriented, as being related to the personal interests and practical purposes of the knower' (1975:113). Insofar as the people I interviewed were concerned I was generally perceived as 'alright'. However, in the final analysis they most often identified me with the staff and in this regard information relating to their covert activities on the ward was concealed.

In the comparatively more relaxed atmosphere of the residential detoxification unit (run almost entirely by volunteers), interaction between myself and residents was correspondingly more informal and wide-ranging in scope. The ideology of the setting is primarily one of self help, residents are encouraged to see stopping drug use as a voluntaristic concern. Staff and volunteers were reluctant to actively police residents, preferring rather to provide a supportive atmosphere. Like the hospital, however, drug use by residents is not tolerated and results in their being asked to leave.

In the residential detoxification unit and also in the needle exchange it became part of the research bargain to take on the role of volunteer and de facto worker. In the case of the detoxification unit this meant that my role there effectively closed off the possibility of being party to information which would jeopardise the stay of the resident in question. As a volunteer, it was my duty to report any infraction of the rules of the unit. By taking on the role of volunteer I was constrained to act as one and align myself with the organisational running of the unit. In consequence it was often the case that the research role had to be downplayed in favour of that of the volunteer. It was not for example feasible for me to take residents away to a private part of the house in order to conduct an interview in private if there were no other

volunteers or members of staff present. Most often discussion was in the company of others (whether staff or residents) which meant that broaching sensitive subjects such as sexual activity was not easy or particularly productive. An additional problem was that the atmosphere of the place was so relaxed as to make directed conversation often difficult to sustain without its artificiality becoming apparent. The following field extracts are perhaps illustrative of the difficulties I experienced in reconciling two roles which often seemed to pull in opposing directions:

> I sat with Tim in the t.v. room. I found it difficult to get him to talk about anything to do with needle sharing and HIV risks etc. Partly this was because we had spoken on this before but also it was because the situation did not lend itself to such a discussion.
> (Residential detoxification unit)

and:

> I find that although the subject of drugs in general is one they can speak effortlessly about, the subject of AIDS and HIV-related risk behaviour most often draws a complete blank. Most of this morning was spent just sitting about, no-one talked very much, things felt very sluggish, everyone seemed pretty bored with things.
> (Residential detoxification unit).

The difficulties of trying to manage dual roles as a volunteer and as a researcher are evident in my fieldnotes and certainly affected the quality of data collected from this setting.

The main way in which my own sense of role uncertainty was overridden was to make additional visits on days when I was not working as a volunteer. Hammersley and Atkinson comment on the advantages to be had in changing role. 'Different roles within a setting can be exploited in order to get access to different kinds of data, as well as to acquire some sense of the various kinds of bias characteristic of each' (1983:97). Whilst there are advantages to be had from exploiting different roles there are situations in which these roles can potentially clash. In turn this can produce a good deal of anxiety for the researcher. Take as an example an occasion where I interviewed two male drug injectors on a day when I was not working as a

volunteer. Towards the close of the interview one lit up a hash joint which both they and I knew would result in expulsion if discovered. This was a difficult situation since silence could clearly be read as collusion with their infringement of the rules. At the same time however I was aware that at least part of the reason they were smoking it was to test me, to see which side of the fence I would fall into. In the interests of developing trust and hopefully, good data, I decided to elide my role as volunteer and chance discovery. In the event nothing happened and the episode passed off unnoticed. It was however illustrative of the tensions inherent in trying to maintain two roles simultaneously.

One advantage of interviewing residents who knew me as a volunteer was that of having already established a certain familiarity. However, as one might expect, this did not mean that they gave free access to every aspect of their lives I enquired about. Indeed Horowitz (1986) noted in her fieldwork with bikers that over time familiarity made fieldwork more, not less, difficult. The mere fact of 'getting on' with someone does not place any less of a premium on the value of managing certain kinds of information. This can be seen in the following account where I had interviewed a woman and subsequently discovered that she had omitted large parts of her biography:

> Anita and I had got on very well, she had spoken easily and at length about her life, even to the point where she'd shown me some poems she was writing to her boyfriend. However the staff worker at the unit just told me that Anita is in fact working as a prostitute although Anita had said she was not. It makes me wonder what kind of situation you'd have to be in before it would be okay for her to trust you with that kind of information.'
> (Residential detoxification unit)

In the hospital ward my role was seen as basically that of a counsellor as this most nearly explained to in-patients the anomaly of being somehow identified with the hospital whilst having no clearly defined role as nurse or doctor. This has similarly been reported by other researchers also working in institutionalised settings

(Cannon, 1989). In the residential detoxification unit my role was more clearly defined as one of the volunteers. Although in both instances my loyalties were assumed in the final instance to be aligned with the staff, I was perceived differently by research subjects in the two settings and this was in response to the organisational structures of the two research settings. There were occasions when the role I was attributed clearly did affect the nature of the interaction. As Jenkins points out; 'One negotiates an identity and this identity necessarily colours the rest of the research' (1984:161). The research identity one creates (or is attributed) does extend beyond the immediate setting. There is a point however when one's continual appearance across a range of settings does lend a certain fuzziness to the definition of that role which allows for its manipulation across a wide range of settings.

Contacting injectors out of treatment.

The drug injectors contacted in both the hospital and residential detoxification units in some senses represented a captive audience. Many indeed welcomed the opportunity to fill up their time by agreeing to talk to a researcher. This was not the case where injectors were met in any of the other settings of the needle exchange, the pharmacy, the street or the red light district. This held true even where I met the same injectors who had previously been contacted in a treatment setting. In the context of their daily lives drug injectors always appear active and purposeful. This is borne out by other observations of drug injectors like the now classic description by Preble and Casey of a drug using lifestyle: 'The heroin user walks with a fast purposeful stride as if he is late for an important appointment - indeed, he is. He is hustling (robbing or stealing), trying to sell stolen goods, avoiding the police, looking for a heroin dealer with a good bag (buying heroin), looking for a safe place to take the drug or looking for someone who beat (cheated) him - among other things. He is, in short, taking care of business...'(1969:2). Time is an important consideration for the drug injector looking to get everything

done so as she/he can get a fix. These are people in control of their lives, on their territory, who could and did exercise choices as to whether or not they would speak to a researcher.

Often drug injectors would come into the pharmacy or the needle exchange already in possession of drugs they intended to inject and were anxious to get sterile needles and syringes quickly for immediate use. It has been noted by other researchers that personal possession of drugs can itself be enough to precipitate withdrawal symptoms (Grund et al 1991, Wikler, 1973). This was borne out by this research. Constraints of time placed limits on what could be achieved in these settings as is apparent from the field extracts below:

> Katrina came in with Sam and her baby, I had wanted to have a talk with her but having just spent ages talking with Janey (another injector) I didn't feel I could absorb any more information. Unprompted by me however, Sam said "we've nae time for wee chats now, we've urgent business t'do."
> (Needle exchange)

and;

> I know Tam quite well from our street contacts and I thought that his being in the needle exchange might provide an opportunity to have a longer, more detailed conversation. When I asked him he tapped his trouser pocket to indicate he already had drugs he wanted to use saying "I cannae, I want to get away for ma hit the now."
> (Needle exchange)

The influence of the setting upon the process of data collection varied according to the role I was perceived to hold both in the needle exchange and the pharmacy. In the pharmacy access to drug injectors was partly controlled by the pharmacist and his staff. A certain amount of selectivity was apparent in the choice of whom I was to speak to, the following for instance were excluded; men perceived to be rough or difficult, individuals known to be shop-lifters (and therefore a hazard in the shop), or individuals too 'stoned' to have a conversation with:

> The woman I spoke to was barely conscious, clearly she'd only recently hit up since she was gouching heavily. Halfway through she

> completely nodded off and I had to gently tap her back to the here and now. It was an impossible situation, she was so stoned.'
> (Pharmacy)

The relationship between shop staff and drug injectors is generally perceived by both parties to be a good one. Drug injectors appreciate that this is one of the few places they can purchase injecting equipment in the north of the city. Additionally, the pharmacist will treat drug-related infections such as abscesses and often allows them to take injecting equipment on credit. There is a sense then in which the drug injectors have a social relationship with the pharmacist such that being asked by him to speak to a researcher is seen as 'helping Harry out'. This goodwill was often extended to the researcher whose interests were structured in terms of the immediate environment of the pharmacy:

> The pharmacist asked an injector who was buying needles if he would agree to speak to me. He said he was in a bit of a hurry but agreed to do it later, saying to me that the pharmacist was "brand new" (a Glasgow superlative) and he wanted to help out because he felt that the pharmacist had helped him.'
> (Pharmacy)

In the needle exchange it was much more a case of consciously creating a role which would be acceptable to the staff of the needle exchange and to myself as a researcher. This role evolved over time and represented a mid-way point between playing a useful role at the exchange as well as attending to the needs of the research. A similar role was negotiated by Power in researching a London needle exchange (1989). Taking on the role of a worker created an opportunity to approach drug injectors directly rather than relying upon the needle exchange staff, as had initially been the case. My dissatisfaction with this mediation can be sensed in the following field extracts:

> I did ask Margaret (receptionist at the exchange) if she'd look out for females living in the general area (so that I could speak to them). Two came in with a baby. One of them was 19 years old. However, although Margaret told me about them, she didn't actually go ahead and ask if I could speak to them because she felt they were pressed for time with the child there and because one was anxious to arrange a hepatitis test.
> (Needle exchange).

and;

> A woman previously registered at the exchange came in. I asked David (the charge nurse) if I could speak with her. He didn't want me to - "she's got a baby with her" was his explanation. I feel that while David is not anti-research he is very careful in screening whom I speak to and often it seems he would be happiest if I spoke to no-one.
> (Needle exchange)

The needle exchange staff, whilst having granted initial access to use the setting for the purposes of research were acting as gatekeepers to the drug injectors. This is understandable when one considers that the needle exchange had just faced down six months of vigilant protest by local people over its presence in the neighbourhood. In reparation the staff were understandably keen to provide a user-friendly service which was undemanding and non-judgemental.

It has been remarked that good ethnography is born of the space between familiarity and strangeness since it is with the former that one comes to know a society but it is with an essential strangeness, or marginality, that one retains the ability to comment upon the workings of that society (Powdermaker, 1966). As Hammersley and Atkinson comment however, 'marginality is not an easy position to maintain' (1983:100). The tendency is rather to increase one's involvement, whether out of a sense of insecurity or guilt arising out of being the slightly fraudulent 'uninvited guest' (Gans, 1983). Retaining what Agar describes as 'detached involvement' (1980) can, over time, become something of a strain in its own right. The insecurity engendered by having a detached, marginal role was relieved by taking on the role of worker at the needle exchange. Predictably however, it brought with it problems of another kind as my role became more associated with that of a worker than that of a researcher. My fieldnotes from this time are littered with references to a battle between the security offered by acting as an exchange worker and the sense of role insecurity engendered by being a researcher in this setting:

> I wanted to talk to him but thought maybe I should let him become familiar with the set-up here beforehand. In retrospect this seems a silly thing to have done since I might never see him again.
> (Needle exchange)

Another time I felt unable to refuse a request by the charge nurse that I have a student nurse present whilst I interviewed a drug injector:

> Since I am presently acting for Ian (charge nurse) I feel obliged to play down the research role in favour of the needle dispensing one. I am in the position of being his teacher and service provision the subject of the lesson.
> (Needle exchange)

Putative staff membership did probably result in the management of information, particularly regarding needle sharing. The ideology of the setting was explicitly directed towards preventing shared use of needles through the exchange of injecting equipment. Drug injectors using the exchange of course knew this. That some of them wished to downplay this aspect of their lives if they had engaged in it is apparent from the following fieldnote:

> I asked Tony when was the last time he'd shared his injecting equipment with anyone. He looked over at Jim (a fellow drug injector) who wasn't at this point really listening, "not that long ago, it was with Jim and Bill up at Jim's house, but I don't usually share my tools (injecting equipment) with anybody". I asked him to describe the situation. He again looked at Jim, who this time responded to him when Tony said again "it was with him, I used his, I don't usually share but that was desperado...I was up at Jim's, there was me, Bill and Jim." Jim said "no, you didn't, you used your own." Tony said, "no, don't you remember? It was up at your house..." He trailed off. Jim finished the conversation saying "No, you used your own."
> (Needle exchange)

A further example of the degree to which information was policed according to shifting criteria can be seen in the following conversation with Joe, a regular to the needle exchange:

> I managed to swing the conversation around to needle sharing and he said he didn't do that. Then I said I thought that people I spoke to in the needle exchange sometimes told me they didn't share because of where they were. I said I felt that sharing did still happen. At this Joe changed tack and said "Well...I did share the other night, I had

> to go and get a lend of works but I took them up the road and cleaned them first with hot water and then with bleach". I was very surprised when he told me this. It came suddenly and was told like in confession.
> (Needle exchange)

Even when meeting drug injectors out of any of the settings like the hospital or the pharmacy it was never entirely possible to avoid being cast in a therapeutic mould. This was partly because many contacts had initially been made in these various settings. Meeting the same drug injector in the context of her/his everyday life was not sufficient to dissociate me from the setting within which we had originally met:

> Neil (researcher) and I stood with Mick (a drug injector) sheltering from the wind in the doorway of a pub. A small guy known to Mick came over and looking over at us said "who'se are you then? Social workers?" Mick replied for us saying "no, needle exchange." "Oh" he replied, "D.C. then, drug counsellors." This explanation seemed to him to be adequate and he went off again.
> (Streetwork fieldnote)

Another possible explanation for why drug injectors assumed a therapeutic role for the researchers is grounded in a common sense understanding of purpose. What other means can one use to explain the presence of a non-drug injecting outsider clearly interested in drugs and the people taking them and seen in places where people are looking for, buying and taking drugs?

Full membership into the drug injecting sub-culture was never a realistic proposition. However a nominal membership could be achieved through association with and sponsorship by drug injectors. What evolved through time spent in the naturally fluid context of the streets was a basic acceptance on the part of some drug injectors, tolerance on the part of others and indifference from yet others. Any membership that might be achieved was always contingent upon the setting and would be defined by the drug injectors themselves, not the researchers. An individual might one day be accepting, even welcoming, of the researcher but be indifferent beyond extending a cursory greeting the next:

> Last time we saw Eddie he'd spent most of the evening walking around with us. This time he stopped barely long enough to say hello. He was preoccupied with his own thoughts and more or less ignored us.
> (Streetwork fieldnote)

The basic fact remained that we occupied different worlds and when the business of his or her world was pressing or sensitive, then access to that world was shielded or restricted and our marginality made apparent. As Giddens puts it we were accorded 'attached' or 'instrumental' membership which reaffirmed the status of being outsiders but which also allowed participation in a manner 'useful and agreeable' to those studied (1976:50). One gets a clear sense of this from the following conversation between a drug injector and the pharmacist:

> John mentioned seeing Neil (researcher) at the crossroads. "He was reading a paper, I didnae go up to him, you know he's a stranger, people don't know his face. He could be the polis or somethin'. I know he's not but they mightn't...I made eye contact but I didnae go over. If I had and people'd seen me talkin' to him they would've wanted to know who he was and all. It would be like the fuckin' French Inquisition... he's brand new, I mean, I know the guy and what he does but he's still a stranger."
> (Streetwork fieldnote)

It is worth noting that this conversation took place during the early days of fieldwork. As one might expect this suspicion was ameliorated by time and familiarity with our presence in the area.

One important means whereby membership could be extended to researchers was through the sponsorship of a local drug injector. The classic example in the ethnographic literature is that of 'Doc' whose sponsorship smoothed Whyte's passage into street corner society (1943). However sponsorship is unlikely to be straightforward in the context of research with drug injectors. Their lives were so characterised by uncertainty that one could never be sure of contacting any particular person at any particular time. Although field relationships did develop with individual injectors they are best characterised as erratic, unfixed and short lived. For example, one drug injector with whom a good deal of time was spent

went into a residential rehabilitation unit in England, another moved to Edinburgh after the death of her boyfriend and yet another began a prison sentence. Short lived and erratic though they were, they were enormously helpful in terms of increasing our acceptability amongst drug injectors previously unknown to us and allowing the observation of many drug related activities which would otherwise have been closed to us as outsiders.

Through prolonged periods of standing in doorways and walking about the housing scheme itself, one learnt a good deal of incidental information about injectors lives and the lives of their families and friends. One could say that they acted as teachers and as guardians although this could cut both ways in terms of being of benefit to the research. Some injectors took it upon themselves to protect us from harm or manipulation by other drug injectors, some others however would act as guardians of their sub-culture by guiding us away from certain types of information felt to be unsuitable for the ears of researchers:

> We were standing with a group of injectors when a girl came over to ask how to get the best effect out of the drugs she was injecting. Tony's reaction was to tell her not to talk about drugs and then made to walk away, indicating that we should go with him. It was crystal clear to us that he didn't want us standing there listening to drug talk. (Streetwork fieldnote)

Hammersley and Atkinston note in this respect that 'Gate keepers, sponsors and the like (indeed most of the people who act as sponsors to the research) will operate in terms of expectations about the ethnographer's identity and intentions' (1983:75). Instances of this kind were in themselves noteworthy as they indicated the boundaries between insider and outsider status as well as a concern to present a more sanitised version of a drug injecting lifestyle. Similar processes of impression management have been reported in the context of other ethnographic work in settings as diverse as Morocco (Rabinow, 1977), an internment camp for Japanese people in North America (Wax, 1971), and amongst British gypsies (Okely, 1983).

Contacting prostitutes

Contacting drug injecting women who prostituted presented the research with a different set of problems (Barnard, 1992). In the local area few women identified themselves as prostituting to finance a drug habit. One means of overcoming this was to contact women in the context of their work in the red light district. However, the casual interaction with injectors which had characterised fieldwork in the local area was simply not possible in the red light district. At night this area is unambiguously concerned with the buying and selling of sexual services. The women are there to make money and regard with suspicion anyone whose motives for being in the area are not clearly understood. This placed a premium on establishing a plausible explanation for being there as quickly as possible. The role which evolved was basically that of service provider. In this situation there was simply not the scope for any kind of membership role consonant with that held by the women. The most that one could hope for was a role which was not perceived as threatening and was in some way useful to them.

The researchers worked in pairs walking around the red light district. It was considered necessary for the research team to consist of both a male and a female. This would cut down on potential misidentification of the female (myself) as a prostitute and so also possible misidentification of the male researcher as a client looking to buy sex. It was also considered to be more secure for the researchers to work in pairs. Contacts with the prostitutes were initiated and largely sustained by myself.

Prostitute women were supplied with needles and syringes and assorted condoms if they wanted them. This incorporation of the role of service provider within the research role is not unique. Carey (1972) noted its particular value in researching deviant groups (in his case drug injectors) and more recently, Broadhead and Fox adopted a similar role in researching injectors in San Francisco. They note 'a *viable*

role is one that 'works' in that the research subjects accept it, it facilitates unobtrusive data gathering and the ethnographer is comfortable playing it' (1990:329, their emphasis). The important issue was to make sustained contact with prostituting women possible. Providing the women with condoms and injecting equipment did facilitate this contact. In total 208 streetworking women were contacted and it is probable that the incorporation of service provision within the research role did much to enhance the success of the research.

The provision of needles and syringes and condoms to the women gave purpose to our continued presence in the area and enabled the gradual build up of good working relationships with the women. It was important to establish a role acceptable to the women which made clear that we had no connection either with the police or the statutory agencies. The following field extract illustrates the scope for misidentification, at least in the early stages of research:

> Last night at about midnight we saw a girl who was clearly working. I began walking over to her and she immediately walked off really quickly. I called over to her but she didn't stop. Finally I said "Look, I'm not police or anything." She stopped then, clearly afraid. I told her who we were and where we were from and then I gave her needles and syringes and condoms. She was just starting work and was looking for someone to give her condoms because she didn't have any.
> (Red light district)

Further meetings with this woman were not difficult. It became apparent however that for this woman, and indeed many others, what appeared of importance was not what we were (researchers) but what we were not (police, social workers). The impression one received was that the women's assessment of 'good intention' (Johnson, 1975) was of more salience to them than explanations of the research role:

> Neil and I have been going around the red light district for just over a week now. At first when we approached the women they were reticent about us and clearly wondered who we were. Some women seemed reluctant to say they were injecting drugs even though we felt

> they probably were. However we have now spoken to about seventy women and word has spread. They don't seem entirely sure of what we do, describing us in vague terms like "fae the university". They don't seem to regard us as doing them any harm.
> (Red light district).

This tendency to assess the researcher more in personal terms than in terms of the aims and objectives of the research has been noted before in the context of other research work (Jenkins, 1984, Wax, 1971, Whyte, 1943, Johnson, 1975).

Adopting the role of service provider undoubtedly was an important facilitator of the research. However taking on the role of providing the women with the means to avoid HIV infection also increased the likelihood that at least some women would avoid discussing certain subjects in our company. It is probable that providing the women with the means to avoid risk taking behaviour did result in some under-reporting of risk activities. It is difficult to see how this could be avoided. However, the fact that some women did report risk behaviours suggests that they did not see the supply of injecting equipment and condoms as being tied to demonstrating a reduction of risk taking behaviour:

> A woman we had just given a needle and syringe to asked for another set for her boyfriend. I said that her set had been the last of them, "oh, well then" one said "it doesnae matter, we'll just use the one set."
> (Red light district)

It became apparent that the women were managing the flow of information both to the researchers and to other women. This pointed to the existence of a 'code of practice' operating amongst the women which judged certain behaviours to be unacceptable. The most important of these related specifically to working practices. Firstly there was an accepted price structure and it was generally understood that women should not undercut these prices. Secondly women should not accept client inducements to have sex without a condom, even if extra money was offered. Infringement of these norms was considered very poorly by other women:

> Susan said she was often asked by clients to agree to sex without a condom and if you refused the guy would drive off and later you'd see a woman getting into the car and you'd know she was doing it without a condom. She spoke of a girl "doin' it for fivers, without a condom, anything. The girls were cracking up over it, we told her but she didnae take any notice, so finally we told the vice and the vice drove her out o' this town saying to her; "if you're going to work at all, you should work properly."

Taking on the role of service provider did to a greater or lesser extent influence the women's perceptions of us and hence the type of information they were willing to impart. It is important to stress however that this was a small price to pay for the access afforded by taking on this role. Furthermore the information which the women sought to manage was itself revealing and a valuable source of information adding to an understanding of streetworking prostitution.

Conclusion

A great deal of time was spent with various people in all kinds of situations where friendships developed and secrets were shared. However, there were never any illusions as to the true nature of these relationships, either for the researchers or the drug injectors themselves. Complete acceptance never followed from identification with their lifestyle. As Weinburg and Williams (1972) noted in their research among deviants, what one is accorded is the status of a 'limbo member.' This is a role that involves the expectation of desertion whether in a crisis or simply because one's purpose as a researcher is effectively fulfilled. Douglas (1972) goes on to describe this tentative acceptance as a sufficient state for members to evaluate the trustworthiness of the researcher. This suggests that one can move from limbo membership to a more permanent state of membership. My field experiences however suggest that apart from going native, that is becoming a fully fledged drug injector, limbo membership was the most one could generally expect. However even given these limitations, it was possible to learn, as Giddens framed it, 'how to find one's way about' (1976:161) and in this way gain a deeper understanding of injectors' lives.

The collection of data from such varied settings as the hospital detoxification unit and the red light district was strong indication of the degree to which membership was provisional and defeasible. Membership was seen not as a given quantity inhering in individuals and in their relationships with each other. Rather it was better seen as having a certain fluidity, able to change over time and in different circumstances. This was as evident in the interactions between the researcher and the research subjects as it is more generally in social life. Recognising the determinants of membership was a valuable means of reflecting on the nature of the relationships established with the injectors in this study. It provided also a means of assessing the quality of the data collected across all the different settings.

The following chapter begins the argument that gender in exerting a powerful influence on behaviour affects the experience of a drug injecting lifestyle. In establishing the divergence between men and women's experiences of drug injecting the focus will be to show how gender in influencing behaviour also influences HIV risk-related behaviour.

CHAPTER 3: GENDER RELATED DIFFERENCES IN THE EXPERIENCE OF INJECTING DRUG USE

Introduction

This chapter will argue that gender as a centrally structuring feature of biography and social organisation inevitably affects the pattern and course of risk behaviour in general and drug injecting in particular. Although addiction to illegal and expensive drugs appears to create similar sorts of problems for injectors irrespective of sex, the response to these problems is to a large extent gender specific (Rosenbaum, 1981a). This seems largely in consequence of differing social structural pressures and circumstances confronting men and women.

If the influence of gender is such that a drug injecting lifestyle is not uniformly experienced by men and women so it may be supposed that gender differentially affects an injector's risk of HIV infection. Whilst injecting with unsterile injecting equipment and having unprotected sex are established risk practices irrespective of sex, the fact that a drug injecting lifestyle is experienced differently by male and female injectors suggests that exposure to HIV related risk might be of a qualitatively different order.

This chapter acts as a necessary precursor to the more substantive analysis to follow. It sets out to establish the distinctive influence of gender roles on behaviour in general terms and more specifically in the context of a drug injecting lifestyle. Injecting drug use, although a deviant activity, is nonetheless practised by individuals whose socialisation is into the dominant culture and whose values, expectations and norms of behaviour reflect this. As with society in general it can be expected that many of these will be gender distinct.

Moving on from this I will describe the social organisation of drug injectors and particularly, the influence of gender on behaviour. The notion of drug careers initially

expounded by Becker (1963) and taken up by Rosenbaum (1981a) in studying female drug use is a useful heuristic device for looking at differences in the ways men and women manage and experience a drug injecting lifestyle.

The data in this chapter are used descriptively to complement the existing literature on gender roles and drug careers. This chapter provides an important context for the forthcoming analyses of the influence of gender on HIV-related risk behaviour.

Gender roles and Injecting Drug Use

In all societies gender roles are socially ascribed from birth, with males and females being socialised differently according to the norms and behaviour expectations implicit in their sex roles. Gender as an ascribed status has been described as centrally structuring of identity in the orientation of the individual to the social world. (Prendergast and Prout, 1980).

The ideology of distinctive male and female roles is ubiquitous throughout society and is reflected in, or reflective of, the organisation of its economic, political and social institutions. The division of labour conventionally carves up the female domain as the household (private) and the male domain as the work place (public). Even in a situation where women are in the workplace they still tend to be defined primarily in terms of their familial context. It has been commented that female roles are definitively about 'being' (a good mother, a good wife, a good girl). Male roles, however, are about 'doing' (Chodorow, 1971, Rosenbaum, 1981a). The ideal female role is that of the passive dependent whereas the ideal male role is that of the active independent (Janeway, 1971). Females are brought up to be carers and nurturers, males to be providers and protectors. Gender socialisation thus moves along quite different paths for males and females, resulting not only in different behaviours but different attitudes and perceptions. Whatever happens in later life the sex roles learned in childhood remain pervasive influences in orienting our behaviour and attitude.

Drug injectors are not social isolates, they are part of the communities they grew up in and were socialised into. This may be especially the case among Glasgow injectors the great majority of whom are native to the city and have remained resident in the localities they were raised in (McKeganey and Barnard, 1992). Illicit drug use and its frequent association with criminal activity is generally viewed as deviant and anti-social behaviour. However, it would be a misperception to see drug injectors as having rejected all common cultural values. Rather it appears the case from this research and that of others that the majority of drug injectors hold what are in fact very conventional views on what constitutes appropriate male and female behaviour, as well as such other issues as marriage, abortion, religion, etc. (Miller et al, 1973, Suffet and Brotman, 1976). Male and female drug injectors appear to hold to a fairly orthodox interpretation of what constitutes acceptable gender related behaviour. This is reflected in their expectations of appropriate male and female behaviour. These may be judged as relating most directly to differences between the sexes generally rather than to differences consequential upon the experience of injecting drug use per se.

Drug Careers

Drug addiction has been characterised as a career passing through a series of stages from initiation to cessation (Becker, 1963, Rosenbaum, 198la, Pearson, 1987a). Drug use can be depicted as a series of stages from initial use to habitual (addicted) use and finally, cessation whether through detoxification and rehabilitation or through death. The notion of career conveys the dynamic inherent in a lifestyle which is physically, financially and emotionally exacting. It also provides a useful means of depicting the temporal dimension of injecting drug use. The forthcoming discussion divides into three stages of a drug injector's career; initiation into injecting drug use, absorption into and preoccupation with the lifestyle, and lastly burn-out, the point at which an injector might find it increasingly difficult to sustain that lifestyle. For the purposes of this discussion the representation of injecting drug use as a career is useful. However, it should not be inferred from this that

injecting drug use is inevitably experienced in this way. There is no necessary pattern to the way in which individuals experience and manage their involvement in injecting drug use.

Initiation.

Much of the research on injecting drug use in the 1960's and 1970's tended to portray differences in the behaviour of male and female injectors as being sex linked rather than gender-role linked (Ellinwood et al, 1966, Williams and Bates, 1970). Drug injecting women (most often asked in treatment) have been depicted as fatalistic, psychotic and more prone to depression than their male counterparts. (Suffet and Brotman, 1976, Martin and Martin, 1976). Their initiation into and involvement in drug use is often presented as being an individualised and psychiatric response to social stress. Men's drug use by contrast is apt to be described in more fully social terms relating to friendship networks, group norms and as a response to the contingencies of an often poor physical and social environment (Preble and Casey, 1969, Agar, 1973).

More recently however, research has pointed specifically to differences in the experience of injecting drug use for men and women, noting in particular the incompatability of normative expectations of the female gender role with that of the role of injector (Ettore, 1989, Cohen et al, 1989). In so far as initiation into injecting drug use is concerned it appears that young men and women are similarly socially motivated even though the route taken into addiction may be different. It is only once they have begun their career into addiction that gender differences in the response to addiction begin to become apparent. These relate to the increased stigma attached to female injecting drug use and the stresses attached to familial responsibilities (Mondanaro, 1990, ISDD, 1979, Maglin, 1974).

The data reported upon here and that of others (Parker et al, 1988, Pearson, 1987a, Morrison and Plant, 1990) support the view that initiation into injecting drug use is an event of social significance motivated by such things as curiosity and a desire to be like

others. This appears to hold true as much for women as for men. Men and women similarly report excitement over their involvement in drug use both because of the pharmacologically induced 'high' and the novelty of being involved in an active and illicit lifestyle fraught with danger (Feldman and Biernacki, 1988). There undoubtedly are individuals (both male and female) whose reasons for injecting drugs relate to some degree of psychiatric instability. However the processes by which a person becomes enmeshed in a drug injecting lifestyle seem more powerfully explained by looking to the social context within which the behaviour takes place (Morrison, 1991).

The early nineteen eighties saw an explosion in injecting drug use which was largely concentrated in the deprived inner cities (Stimson, 1987). The reasons why so many young people became involved in drug use may well be complexly related to factors of local availability as well as the markedly poor social and physical condition of these areas (Pearson, 1987b). Drugs serve not only to divert attention from the poverty of the landscape but also provide scope for a busy purposeful day in the round of raising money to buy drugs, finding drugs, finding a place to inject and finally enjoying the fruits of that labour. In the words of this drug injector:

> "It (the drug) prevents you from seeing." Seeing what I asked? "Seeing that your life is going nowhere, that you've got nothing to do." To this Tim added, "90% of drug users are unemployed, they've nae prospects, they're bored."
> (Drug detoxification unit).

Women interviewed in the study were as likely as their male counterparts to describe their initiation into injecting drug use in terms of it being an exciting and diverting experience. The following fieldnotes are indicative of this:

> She started injecting at 16. "It was through my boyfriend, he was using them and so were his friends... I was just dead, dead curious and they all looked so happy then because they didn't have a habit. So I started using and then somehow I got the habit. I didnae understand the consequences of using until I found I had a habit."
> (Needle exchange)

and;

> Anne described how first she'd tried heroin. She said she and her pal bought a £5 bag between them and smoked it. She'd done it because "everyone was talking about it and we wanted to try some."
> (Pharmacy)

In an area where drugs and injecting drug users are commonplace it is unsurprising that experimentation with different drugs and different means of administering them should reportedly also be common (Barnard and McKeganey, 1990). The majority of drug injectors who described their initiation into drug use did so in terms of its social significance, very few either began drug use alone or cited the use of drugs as being a response to psychological stress.

The road to injecting drug use and addiction should be seen as a graduated progression from recreational to habitual use, where drugs are used for their own sake, as an end in themselves. Initiation into injecting drug use relates importantly to the social world of the would-be initiate; ease of access to drugs and associating with people who use them or are prepared to take them clearly has a significant bearing on the likelihood of their being used:

> Shona said she'd first started using drugs with friends. "Everybody was doin' it, well no' everybody but people I knew. We were goin' wi' boys who said try them (tablets). I tried, liked them and continued".
> (Hospital detoxification unit)

The attraction of using drugs may be perceived by young people of either sex. However, on the evidence, more men than women become involved in both experimental and habitual drug use (Haw, 1985, Suffet and Brotman, 1976) which suggests differences in attitudes towards drugs and these in turn may relate more broadly to social mores of appropriate behaviour for males and females (Miller et al, 1973). In addition, it may be indicative of different patterns of socialization amongst men and women.

Among men group values are held in high esteem, to be 'one of the lads' is to belong (James, 1986). Membership however is conditional upon the demonstration of traditionally masculine traits of physical strength, endurance, bravado, sexual prowess, as well as solidarity and loyalty to each other in the face of trouble or danger (Coffield et al, 1986).

Feldman (1968) draws attention to the process by which young men can acquire status and prestige through demonstrating daring and toughness which includes the use of drugs. The peer group appears to play a central role in the socialisation of boys, it is thus unsurprising that the majority of those who become involved in injecting drug use should report having done so with a group of friends. Two factors are important in this situation, firstly; men can derive high social status from their willingness to take risks (Silman, 1987, Bellaby, 1990). Secondly, in a group situation it may be difficult for a man to refuse to participate for fear of being derided and perhaps excluded from group membership through his non-conformity.

Women do not appear to operate under the same constraints as men. They do not face the same pressure to prove themselves as men do. This may relate to the stability of sex role identity for women in that women 'are' whilst men 'do' (Chodorow, 1971). A woman's identity is fixed in terms of her expected role of mother and wife, a role which assumes dependence and passivity and in this sense eschews risk taking behaviour. Rosenbaum makes this point when she comments: 'Whereas men often derive high status positions because of their willingness to engage in risk, there are no such benefits for women, furthermore on a subjective level, women disdain the riskiness of a heroin lifestyle. It is not surprising that women derive no positive status from engaging in risk. The societal emphasis and expectations placed on *being* (a good mother, a good wife, a good girl) rather than *doing* and passivity rather than activity limit women's ability to receive or experience positive feelings from risk.' (1981a:50, her emphasis). Whilst men are constantly in the business of proving themselves and competing with other men in the process, the same is not true for women.

The peer group appears to be less significant for women than for men (Coffield et al, 1986). Women tend to have one or two 'best friends' with whom they spend a good deal of time, often in each other's houses (Prendergast and Prout, 1980). These relationships appear to become less significant as women enter into long term relationships with men and

focus their attention more on their partners and their children (Leonard 1980, Hendry et al, 1989). Differences in patterns of sociability are reflected in differences in the ways in which men and women become involved in and experience, drug injecting. The initiation of women into injecting drug use is, on the evidence, most often mediated by a male partner or female friend in a private setting (Suffet and Brotman, 1976, Cohen et al, 1989):

> Jean said she'd begun drug use "through a guy I met that was using. He was selling them so I moved in to stay wi' him. I stayed wi' him for 3 years. I was selling drugs then. I started off wi' speed, I snorted it a few times and then started injecting."
> (Residential detoxification unit)

Even where women began drug use in a group context their initiation was most often under the auspices of the male partner. Over half of those women asked said they had been initiated by their boyfriend or their husband, most of the remaining women cited initiation by a close female friend. Among the men just under half said they had begun drug use in the context of two or more male friends. These data are consistent with that reported by Parker et al, (1988) Rosenbaum (1981a), Suffet and Brotman (1976) and others.

Initiation into injecting drug use does not appear to be a uniform process for men and women but one demarcated by gender-related role expectations of both attitude and behaviour. The gender-specific nature of induction and involvement in injecting drug use may have a significant bearing on a man or a woman's risks of acquiring HIV infection. The empirical evidence for this assertion is demonstrated in later chapters. My purpose here has been to sketch the outlines of the influence gender exerts on men and women's involvement in injecting drug use.

The Life

Rosenbaum (1981a) describes the passage from initiation to addiction as being the 'honeymoon phase.' It is during this period that the use of drugs and the associated lifestyle can be enjoyed for its own sake without seeming too demanding. Addiction does not appear from drug injectors' accounts to be immediate upon initiation, rather it occurs

later when drug use has become habitual. Addiction becomes apparent once the drug is temporarily unavailable (Pearson, 1987a, Parker et al, 1988). Men and women reported experiencing the symptoms of 'flu or a heavy cold. When these symptoms were then described to an experienced, addicted drug injector the person concerned was told that they were now addicted since these were withdrawal symptoms which could only be alleviated by more drugs.

The following field extract shows the process by which many drug injectors came to see themselves as addicted:

> "See I injected it and next day I thought, aye, last night was good, it was really good. I did it again and I thought I wouldn't get into it bad but then one day I didnae have any and I started getting withdrawals but I didnae know what was happening. Ma pal told me that meant I was addicted, that I needed smack everyday, so that was me then".
> (Hospital detoxification unit)

The perception of oneself as addicted seems to be learned and marks the end of the honeymoon period. From here on whilst the drug may still be enjoyed, it is physically necessary if one is to avoid the discomfort of withdrawal symptoms.

Maintaining a drug habit requires money, time and energy. Drugs are expensive and few can afford to pay for them using legitimate means. This results in many injectors becoming involved in criminal activity of one kind or another so as to fund their habit. Drugs are not always readily available which often means that a good deal of time and energy is spent tracking them down. In addition, use of non-prescribed drugs is illegal which demands the constant vigilance of the injector not only from the forces of law and order but also from other drug injectors who could steal drugs without there being any possible recourse to the law. Finally, drug injecting is socially stigmatised by society and is generally viewed with hostility and suspicion.

Addicts, both male and female, are under constant pressure to meet the demands of their habit. However men and women's responses to addiction differ in consequence of differing social structural circumstances and pressures.

Financial pressures.

Addiction to illegal drugs can be extremely costly. Not only is heroin expensive but so too are illegally sold prescribed drugs like temazepam and Temgesic (buprenorphine) which have increasingly become the main drugs of choice by injectors in Glasgow (Sakol et al, 1989) The overwhelming majority of injectors interviewed in this study, as in other studies, were unemployed and therefore had no other legal income beyond state benefit (Parker et al, 1988, Morrison and Plant, 1990). Clearly this could hardly finance a drug habit. Crime in one form or another may be inevitable for many men and women drug injectors. The kinds of criminal activity entered into tend to be gender differentiated (Steffensmeier, 1983). Men are reportedly more likely to become involved in 'heavy' crimes (Inciardi, 1979, Ellinwood et al, 1966), such as burglary or assault. Women are more likely to be involved in non-violent crime of an income generating nature such as prostitution and shop-lifting (Maden et al, 1990, Datesman, 1985). In consequence of much greater involvement in these kinds of offences, together with an observed reluctance among the judiciary to penalise women by imprisonment, men are more likely to be incarcerated than are women and for longer periods (Parker et al, 1988, Ellinwood et al, 1966)

The use of prostitution as a means of finance is most commonly reported by women rather than by men. Prostitution can be a lucrative business enabling a woman to earn sums far in excess of any legitimate income open to her. Those women identifying themselves as prostitutes reported their involvement as being primarily motivated by economic considerations. It should be noted however, that by no means all women who inject inevitably use prostitution to finance their drug use. Many of the women in this study reported relying on shop-lifting and on borrowing small sums of money here and there. It

is possible however, that prostitution may become more likely the longer a woman injects. It is clear for example from the field extracts below that prostitution was a last option once alternative sources of income had dried up:

> "I was shop-liftin'' but then my face got too well known so then I had to start working down the town... you do it cos you have to, you've got to get the money and if there's no other way..."
> (Needle exchange)

and;

> Linda said she and her boyfriend had been dealing for 5 years, they'd been able to make good money and had "battered as much (heroin etc) as we wanted." Then he got caught with about a gramme of heroin and was now waiting to be sentenced. He expected 5-7 years. Since then the money had dried up, she'd become homeless and had had to come down the town to earn some money prostituting. She says she's still not used to this work and can't imagine doing it for years on end.
> (Red light district)

Elsewhere (Fields and Walters, 1985) it has been reported that drug injectors appear to retain a rough balance between their available income and the size of their habit. This runs counter to popular stereotypes of addiction as an uncontrollable escalation of drug consumption. However because prostitution is so financially lucrative women injectors who prostitute can potentially develop large and expensive drug habits making it necessary for them to work frequently and for longer hours. This scenario is even more likely when the woman is working not only to support her own habit but also that of her partner's.

<u>Time and place.</u>

Maintaining a drug habit is a full time occupation demanding energy, commitment and resourcefulness on the part of the injector. The now classic description by Preble and Casey (1969) of drug injectors as purposeful, active and resourceful in their pursuit of drugs rather than as passive, fatalistic victims is an enlightening depiction of the lives of male injectors, but it cannot be held as representative of the female injector. Rosenbaum comments: 'Women with children in our society are held responsible for their care; this is true for women in all categories - addicts as well as straights. Time inundation by heroin

prevents women from taking care of business, fulfilling what is seen by them, their peers and society as their main responsibility - their children. For this reason Preble and Casey can define men 'taking care of business' to be taking care of heroin-related activities, but when addicts who are mothers simply fulfil their responsibility to their heroin habit and neglect their children, they are seen as *not* taking care of business at all' (1981a: 59, her emphasis).

By actively working to service her own drug habit a woman is seen to reject her responsibilities to others. This is viewed as especially reprehensible where it concerns the care of children. In this study the majority of women had had at least one child. Some of these children had been taken into care or were being brought up by other family members, most often the grandparents. It was often the case that negative comment on women who injected drugs was allied to comment on their ability to parent:

> Phil said he wouldn't go out with a woman who used drugs. "I don't know why but I don't like to see a lassie usin' y'know, putting a needle in her arm. I don't think a lassie should do that. I suppose a man shouldn't either but somehow it's worse in a girl- aye, a girl with a wean. If she gets pregnant and she's usin'- alright if she stops, but to have a wean and still use, that's terrible. Everybody knows a junkie can't look after a wean."

Injecting drug use is deviant in our society. However, becoming involved in a deviant activity does not remove the very powerful influence of beliefs and attitudes inculcated from birth. Normative expectations of male and female roles are found as much amongst injectors as among others (Miller et al, 1973, Maglin, 1974). This can be seen in the social organisation of drug injectors which appears strongly centred around the concerns, activities and values of men. Maglin makes the point: 'The female drug addict is involved in a deviant sub-section of a male dominated deviant sub-culture' (1974:163). It is men who predominate in the network of distribution of drugs. Involvement in the distribution of drugs has high status in the drug world, in part because of the risk involved (File, 1976). Women tend towards dependant roles and access to drugs is frequently mediated by a male (File, 1976, Datesman, 1985).

Similarly women injectors are not judged by the same standards as men, even while these same men may themselves be injecting drugs (Cohen et al, 1989). Men injectors frequently expressed disapproval that a woman should be involved in injecting drug use. Women injectors were not unaware of their poor image and often indeed seemed to judge their behaviour in similarly disapproving terms:

> She then talked about people looking at her and thinking "oh she's a junkie, look at her." I want to get off, do what I'm supposed to do, be what I'm supposed to be.
> (Needle exchange)

Women injectors appear to be judged (indeed to judge themselves) as having transgressed societal mores of appropriate female behaviour in two important respects. Firstly, irrespective of whether or not a woman actually uses prostitution as a means of financing her drug habit, the implicit expectation is that she will do so at some point in her career (Rosenblum, 1975, Maglin, 1974). This point of view was often expressed by men injectors in this study. Women who inject are thus automatically stigmatised either because they do prostitute or because they are considered as likely to prostitute. Secondly, as drug injectors they are held to be rejecting of their central role as mothers and carers. In both respects drug injecting women are held to be in breach of their proper female role and are judged as having in some fundamental sense to have negated their womanhood. Small wonder then that so many woman injectors have a poor self image (Mondanaro, 1987, Rosenbaum, 1981a).

Women injectors tend to remain in the background both because they are socially stigmatised for their involvement in injecting drug use and because of the constraining definition of what constitutes appropriate female behaviour. Research on women in many societies has indicated the opposition between private and public domains (Gamarnikov et al, 1983). Women are most often found to occupy private (domestic) space and men the public arena (Imray and Middleton, 1983). This distinction has some resonance in looking at the division of labour between injecting couples and a more general attempt by many

women injectors to remain uninvolved in the general process of procuring drugs and its associated paraphernalia. In attempting to remain out of the public sphere, women emphasise their dependence on men and by extension, their vulnerability. This receives greater attention in chapter 4 on the shared use of injecting equipment and its associated HIV risks.

Burn out and coming off

Studies in the United States and in Britain suggest that drug addiction for many is not a lifetime career. Over ten years approximately a third of addicts can be expected to have given up drugs, others will have become casualties of their addiction and a minority will remain addicted to drugs (Stimson and Oppenheimer, 1982, Parker et al, 1988). In a London treatment based sample, 31% after ten years were judged to be no longer addicted (Stimson and Oppenheimer, 1982).

Addiction is a full time occupation which once habitual comes in time to be seen by many drug injectors, both male and female, as financially, physically and emotionally draining. The effects of drugs may be no less valued but the strains inherent in a lifestyle which is illegal, expensive and stigmatised, may come to be seen as increasingly burdensome for the injector. There are differences however in the ways these pressures are experienced and the avenues out of addiction which are likely to be utilised by men and women.

Women injectors are often reported as more likely to experience stress and anxiety than either their male counterparts or women not using drugs (Mondanaro, 1987). The following have been cited as areas of increased stress: responsibility for children; living alone; low income; partners that are likely to be using drugs; higher levels of depression and anxiety; lower levels of self esteem (Reed, 1987).

Women who inject and have children are in a precarious position, they have to balance the needs of their children (for clothes, food, etc.) against the needs of their own addiction.

Where financial resources are stretched, these needs may be in conflict with each other, sometimes the children lose out, sometimes the addiction does. Quite often too, women who inject will have used prostitution as a major source of finance. Women using these means have not only to face the stigma attaching to involvement in injecting drug use but also that attached to prostitution. The combination of some or all of these factors may go some way towards explaining how it is that women can experience a drug injecting lifestyle as extremely stressful. Even so a woman using drugs may be reluctant to approach drug treatment services for help either through fear of losing children to the statutory agencies or through a wish to avoid criticism of their lifestyle.

Male injectors seem to have different reasons for exhaustion with the lifestyle. As with women they may also find it increasingly 'dreary, pointless and glamourless' (Stimson and Oppenheimer, 1982). However the stress men associate with a drug injecting lifestyle may relate more to their involvement in criminal activity. Men frequently have a high incidence of convictions and in particular, institutionalization for offences. This situation does not obtain for women either because they are not involved to the same degree in crime, or, they are involved in less serious crimes which may only carry fines as punishment. The judiciary may also be reluctant to imprison them, particularly if they are mothers.

Male injectors in this study were frequently in and out of prison. Gerry was a case in point, in seven years of injecting use he reported having been charged with 21 offences.

> "Before the 8.8.88 the most I was out of that jail was 3 weeks in all the years I've been using drugs."
> (Streetwork fieldnotes).

Those men who reported being tired with the lifestyle, cited the irksome pressures both of having to constantly find new ways of earning sufficient money for drugs and the often inevitable consequence of a prison sentence for using criminal means to do so. The pressures associated with financing a drug habit are aptly shown from Mick's comments:

> "I'm using a tray (of Temgesics) a day, that's £35. I'm having to go into that town every day (shop-lifting), every day man, I hate that town. I nearly got the jail today. I had a load of T-shirts down ma front, had to dump them and run".
> (Streetwork fieldnotes).

Coming off

Having once decided that the costs of drug use outweigh the benefits, the next step may well be to get help with coming off drugs. However a number of studies have shown that treatment services are not used equally by men and women injectors. Even allowing for higher absolute numbers of male injectors, women are under-represented in drug treatment agencies (Mondanaro, 1987, McGregor and Ettore, 1987). Possible reasons for this might relate to a reluctance amongst women either to signal their drug using status for fear of condemnation, or for fear of having their children taken into care, or, a combination of the two.

A further consequence of this under-representation of women is that many drug agencies lacking the experience of women injectors may be unintentionally catering primarily for men. Recreational facilities tend to reflect men's leisure interests and very few treatment agencies offer childcare facilities to women (McGregor and Ettore, 1987, Jeffries, 1983). Glasgow for instance has no facilities for women who want, or have to have, their children with them whilst they come off drugs. There are in fact only a handful of mother and child units in the country. Women who want, or have, to be with their children may thus be discouraged from seeking or remaining in treatment. The following fieldnote is perhaps illustrative:

> I was talking to Sharon when the charge nurse came in saying "did the detox not work then?" She answered "no, the detox was alright but it was hard for ma wean 'cos it was the first time I'd been away fae him and I missed him so I had to leave."
> (Needle exchange)

In this case the woman concerned did at least have the option of leaving the child with people whom she trusted (her mother). For women who do not have that choice entering into treatment may be impossible. However there are obvious difficulties attached to

coming off drugs without the support offered by treatment agencies. Having to maintain responsibility for the welfare of children whilst in the midst of withdrawal from drugs and all the unpleasantness that this engenders may be extremely stressful.

An important part of remaining drug free seems to relate to the ability to change ones lifestyle, avoiding people who use drugs and attempting to break connections with drug use (Pearson,1987a). The degree to which this is achieved appears to be an important predictor of successfully breaking the habit (Stimson and Oppenheimer, 1982). For men this may necessitate breaking with their peer group, many of whom may be childhood friends. The difficulties associated with this were acknowledged by many men interviewed whilst in treatment:

> Simon told me he'd been off drugs for a year in the past, he'd spent all his time with his girlfriend (she doesn't use drugs) but he got bored with that. "I wanted men's company and so that's where I went and then I was right back into it again."
> (Residential detoxification unit)

Women are likely to experience similar difficulties. These may be made more acute where women are in relationships with men who were themselves injectors. Unless giving up drugs is a joint decision, or the relationship breaks up, remaining drug free might prove highly problematic in such an environment.

Conclusion

Where the effects of gender have been taken into account in the literature on injecting drug use it does appear that there are distinctive differences in their experiences. The data from this study confirm these differences which in large part appear to be in consequence of deeply held conventions as to what constitutes appropriate behaviour for men and women. These are as likely to influence the pattern and content of an injecting lifestyle as other walks of life.

In the following chapters it is further argued that gender, in influencing the experience of injecting drug use, might also have its part to play in HIV spread. Behaviours known to carry a risk of HIV infection, namely the sharing of injecting equipment, the practice of unsafe sex and, more contentiously, the use of prostitution are examined in terms of their interaction with gender and expectations of gender appropriate behaviour. The HIV risks associated with the practice of sharing needles and syringes form the focus of the next chapter.

CHAPTER 4: SHARE AND SHARE ALIKE? PATTERNS OF SHARING AMONG MEN AND WOMEN INJECTORS AND HIV RISKS.

Introduction

Contrary to many media presentations of drug injectors as incapable of changing behaviour or uninterested in their health and that of others, many injectors have made conscious efforts to reduce and in some cases eliminate their risks of HIV infection. However, it is apparent that some sharing persists even though knowledge of the risks is repeatedly found to be high among injectors in many European and North American cities (Becker and Joseph, 1988, Friedman et al, 1987, Blaxter, 1989). In the context of this research, needle sharing continued even though needles and syringes were locally available from a pharmacy and the nearby needle exchange.

This chapter has two related aims, firstly I will address the question of why it is that sharing continues in the face of the known risks it poses. Secondly, I will look at patterns of sharing of injecting equipment, considering in particular differences in the behaviour of men and women injectors. Whilst some sharing is undoubtedly in consequence of an absolute dearth of suitable injecting equipment, the notion of availability incorporates a wide range of possible situations of which a complete absence is merely the most clearcut. Further, it is apparent from this data that just to be in a situation where clean injecting equipment is unavailable does not determine that sharing will take place. There are still choices which can be, and are made by injectors as to whether or not to inject then, postpone drug use or follow some other course of action.

Levels of sharing are very likely to be influenced by the degree to which sterile needles and syringes are available (Calsyn et al, 1991, Stimson et al, 1988b).

Nonetheless it is apparent that the full picture is a good deal more complex since human agency also has its part to play, as do those underlying social factors which affect not only the choice, in the first instance, of whether or not to share, but, also the choice of whom to share with. Many recent research reports confirm the finding that where sharing does occur it is not generally an indiscriminate activity (Baxter and Schlecht, 1990, Haw et al, 1991b, Calsyn et al, 1991). The choice of who to borrow from is an important consideration with first preference usually for the needle and syringe of a partner, or family member with last preference being for that of a stranger's. Notions of social distance or closeness can clearly be seen in the data to be an important determinant of who shares with whom. When broken down it is possible to see how different patterns of sociability among males and females influence sharing behaviour and possibly also the pathways of HIV infection.

Sharing Considered

Perhaps the starting point for any discussion on needle sharing should be to emphasise the place of sharing both in the drug injecting sub-culture and its more general significance in the broader culture of which injectors are a part.

Over and over again in the course of the fieldwork it was demonstrated that the practice of giving and receiving and giving again was part of the social fabric of the area. Cups of sugar would pass from one house to another, cigarettes would be freely handed out and rounds of tea and biscuits bought. It often seemed the case that everything and anything could be shared. These were not one way transactions for it was soon apparent that as much as people gave so they also expected to receive. Implicit within the giving of gifts was the expectation of later return:

> I sat with Julie and the other young girls at the dancing class. One took out a cigarette, lit it and after taking a couple of puffs, passed it on to the girl next to her. This continued until the cigarette was finished off by the girl who'd initially supplied it. Later on, another

> girl produced a cigarette and a similar process was initiated. The girl who'd first supplied the cigarette went second.
> (Community Centre)

As might be expected such exchanges and the obligations implicit within them are not confined to the people studied here. The value of exchanges of goods and services, not for their own sake but for the sake of the relations they express or create between people has been seen to operate in many cultures, not least our own (Cheal,1988, Glassner and Loughlin, 1987). As Mauss wrote in 1925: 'To refuse to give, or to fail to invite, is like refusing to accept - the equivalent of a declaration of war; it is a refusal of friendship and intercourse'. (1967, 11 [1925]). Cheal makes essentially the same point when he writes that it is 'reciprocal expectations between persons that make social interaction possible.' (1988,11).

It would be surprising if by virtue of pursuing a deviant activity, in this case injecting illicit drugs, one could escape the influence of one's primary socialisation. In fact, injectors in respect of sharing behaviour appeared no different to the non-injectors that were contacted during this study. They similarly demonstrated a willingness to share out such things as cigarettes and sweets:

> 'We went back into the sitting room where Mandy shared out the last of her cigarettes with the others in there. She commented to me, "see it's funny, there's a lot of straight people who keep their fags to their selves saying they only smoke their own, but I cannae be bothered with that, most junkies, they're awful kind-hearted, well, generous with their fags."
> (Residential detoxification unit)

Drugs too could be the objects of exchange:

> As we walked over Annette was just taking her leave of Kate, thanking her again as she went. Kate explained that Annette was strung out (withdrawing) and short of five pounds. Kate had lent her this money. "I don't like to see someone strung out, mad eh?"
> (Red light district)

Lest this gives an overly rosy picture it is as well to balance this out by pointing to the existence of intimidation and violence as well as the predatory aspects of some injector's behaviour:

> Sam mentioned that there were a few people who wanted to 'jump him' (attack him). I asked him why. "Well a few times they've been strung out and asked me to go and score for them. So I said 'sure no problem', got the score and come back the other way. I ripped them off." Later he spoke about having been ripped off himself. He'd not been able to find a vein to inject into so he'd asked someone to do it for him. "I said, 'you gonnae come up this close and help me get a hit?' So he came, he was in the vein, the syringe had blood in it and he pulled it out and was away with it and ma kit (heroin). I shouted 'you cunt, I've got AIDS'. He came back then and gave me the rest of the hit. There's a few that do that nowadays, I've done it myself."
> (Hospital detoxification unit)

Clearly it is one thing to share cigarettes and even drugs, yet another to lend or borrow injecting equipment potentially infected with a life threatening virus. However, the value of evidencing the mundanity of giving and receiving of all kinds of goods and services is that it gives a context to the sharing of needles and syringes and makes it more readily explicable a practice.

There are other reasons compelling the continued practice of lending and borrowing of injecting equipment which relate more specifically to the peculiarities of being involved in a drug injecting lifestyle. From this and other studies (Grund et al, 1990, Friedman et al, 1990b), it is apparent that injectors have a shared understanding of the unpleasantness associated with drug withdrawals and appear to feel uncomfortable seeing others experience them. They understand the urgency with which people feel the need to inject again, whether to alleviate the discomfort of withdrawals or to feel the effects of the drugs. The practical expression of this may be no more than a voiced sympathy, or, probably more rarely, as was reported in the field extract above, might result in the provision of drugs. It may also result in the lending of injecting equipment where the person has drugs available but no means of injecting them:

> Joe spoke about responding to other people's requests for needles "I mean they're only 16p (for a 1 ml) set and if they need them..." His friend added, "Aye, if they need them, if they're rattlin' you know what its like." I wondered if they'd be willing to give these away late

> at night. "If it was late and I still had myself to see to then I'd say 'no, you can't have them.'"
> (Needle exchange)

It was evident from fieldwork that many injectors did feel a particular obligation to lend needles and syringes in this situation. At least part of this arose out of the harsh knowledge that this could be their own situation and in which case they too would not want to be refused the chance to inject and overcome withdrawals:

> "I would share even now-see if someone needed works and couldnae get a clean set they would use what was around and if somebody asked me, I would lend them because the situation might be the opposite next time and it might be me that needed them."
> (Residential detoxification unit)

and;

> "Aye, ma pals ask me sometimes. I give them then, I couldnae knock them back because I know they'd no' refuse me."
> (Needle exchange)

The framing of their responses in terms of needs which they might also have at some point in time is not dissimilar to the ways in which many blood donors reason their motives for contributing to the blood banks (Murray, 1991).

Availability

It has been argued that the reason why drug injectors share used needles and syringes is largely due to inadequate access to sterile injecting equipment (Power, 1988). Certainly this was the single most common reason cited by needle exchange attenders for having borrowed used needles and syringes from other injectors (Stimson et al, 1988a). However as Stimson and colleagues themselves point out there is reason to be cautious of making the interpretation that good availability equals the elimination of needle sharing. Italy is a case in point given the high reported levels of needle and syringe sharing (and HIV infection) among injectors, despite widespread availability of injecting equipment (Tempesta and Di Giannantonio, 1990). Certainly the ease with which injectors can access sterile injecting equipment must have an important influence on levels of sharing.

However, availability is not the whole of it; it cannot explain those instances where sharing takes place even despite clean needles and syringes being readily available; nor can it explain those cases where sharing does *not* take place in situations where sterile injecting equipment is unavailable. The use of someone else's unsterile needle and syringe is but one of a range of possible responses to a situation where drugs are available but injecting equipment is not. Even where the decision is taken to use another's needle and syringe, the risk of HIV transmission can still be eliminated through bleaching or boiling them, given access to these facilities.

In the following section I will illustrate these two case scenarios. Firstly the situation where drugs are available but sterile injecting equipment is not. Secondly the situation where needles and syringes are available yet needle sharing still occurs. The point is to demonstrate that the shared use of injecting equipment can not be adequately explained by reference to availability alone.

Being in prison, or in a residential detoxification\rehabilitation unit clearly puts limits on access to sterile needles and syringes. Injectors who wish to use drugs parenterally in these institutions but without risk of HIV infection, have to rely upon being able successfully to smuggle in sterile needles and syringes. Furthermore, if they want to be sure that they remain uncontaminated by anyone else they must keep them hidden lest others request or demand their use. The following field extracts are perhaps illustrative of how difficult this might be in practice:

> When in the jail he snorts Tems if he's going to use at all although he did give an instance of injecting when he had a clean set of tools. "A pal of mine, he heard I was in and gave me a couple of Tems. He offered me a loan of his own tools but I said 'no, you're alright, I'll just snort them'. When I got locked in I hit them then. See I didn't want to tell him because then maybe he'd ask for a use of them and then everyone'd be askin' to use them."
> (Pharmacy)

and;

> Ben described how he'd kept his works in the collar of his uniform shirt which he'd sewn down. The prison officer however cottoned onto this when he saw him pushing his tools up there. They then took him off and found his needle and syringe and six Temgesics.
> (Streetwork fieldnote)

Of those who had been in prison the majority reported the likelihood that they would have to inject with needles and syringes previously used by an unspecified number of people and that this was sufficient to deter them from injecting drugs in that situation:

> Sam talked about sharing in the jail but said he wouldn't do it "see me, I'd rather snort than do that. I've seen the same needle go round ten people." His cousin added, "there's a lot of things going down now, don't know who's using what in there."
> (Streetwork fieldnote)

This is not to downplay the significance of injecting drug use in prisons, often with injecting equipment reportedly used by large numbers of people (Kennedy et al, 1991, Turnbull et al, 1991, Dye and Isaacs 1991). The point, as I will go on to show is simply that non-availability of sterile injecting equipment is not a sufficient condition for sharing to take place. If it were just a case of availability one could predict that where clean needles and syringes were easily accessed then no sharing would take place. In an area which is served by a pharmacy and a needle exchange, needle availability would have to be judged as good. However, some sharing persists. Out of 134 interviewed in the needle exchange, the pharmacy and two residential detoxification units, 73 said they had shared in the last year and the majority of these reported having done so within the recent past. Some of the accounts given by injectors as to why they had shared do not easily square with notions of non-availability. For example whilst finding the pharmacy shut might reasonably be seen as a situation of non-availability, the occurrence of sharing during hours when the pharmacy was open and whilst in close proximity to it is not:

> Two young men said that the last few days they'd been using each other's needles and syringes. I asked why, was it because they didn't have the money to buy them? "Well that, and also like laziness, no' wantin' to go up the road and get some."
> (Needle exchange)

and;

> I asked Jim when was the last time he'd shared. "Yesterday, it was 9.30 in the morning when I scored and I didnae have a set on me, so I says to ma pal, 'you got a spare set?' He said 'no, but you can have these'. Jim gestured to his arm indicating to me that his pal had offered the set of works he was just finishing injecting with. I asked him why he'd not gone to the chemist, 'there's nae chemist in Bilton and I couldnae be arsed gointae Gordonston.' These two areas are adjacent to each other.
> (Needle exchange)

In illustrating that the sharing of needles and syringes is influenced but not determined by availability, it is clear that the notion of availability cannot adequately account for sharing behaviour. It offers a partial explanation which is limited by its exclusion of human agency and those social practices which underlie and give shape to situations within which sharing takes place.

Availability as an explanation may most closely resemble a 'first order construct' (Schutz, 1962). That is, a common sense interpretation of events taken at face value. Whilst it is true that sociology ultimately derives from commonsense constructs of the social world, the explanations it tries to give to behaviour are generally one step removed and can be termed 'second order constructs.' In other words an adequate explanation of sharing should be analytical and should also be able to account for variability in sharing behaviour. These issues are given more weight in Appendix 1.

The following section will look in closer detail at the fine mesh of individual and social practices which influence situations within which injecting takes place and the likelihood that unsterile injecting equipment will be used. Whilst some of these situations did not appear to be differently experienced in consequence of the gender of the injector, some situations clearly were. Where apposite these differences are highlighted.

For some people the risks associated with HIV infection were highly salient and they would avoid borrowing someone else's needle and syringe, even at the cost of having withdrawal symptoms. Although their numbers were small some individuals reported that they would never share in any circumstance:

> Jo had been talking about situations where sharing takes place, he added "but I'll never share. I can't stand that. I'd rather lie on ma bed strung out than do that, especially 'cos of ma wean. If I got somethin' and gave it to her, I'd do mysel' in."
> (Needle exchange)

and;

> "I don't share with anyone not even ma brothers. Even ma brother when he asks for a lend I say no. He says 'why, how come, you think I've got the virus or somethin'? I say 'no, Jim, you'll just have to get your own, I'll no' lend them.' "
> (Pharmacy)

At the other end of the spectrum there were those injectors for whom HIV infection was not obviously a salient concern. Again their numbers are small. In the majority of these cases sharing seemed to arise from a baseline understanding that the need to inject was more pressing than a concern with HIV infection. Comments such as "if there's a hit on it you'll just use what's there" or, "if you've got kit and you've not got a set you'll use anybody's," were often allied to reports of sharing:

> She habitually shares with her boyfriend, just changing the spike. I wondered if she thought he shared outside and if that concerned her. "Aye, there's been times when I'm sure he's had some. I don't really think about it (AIDS), if I'm strung out and I've got ma kit but no clean set of tools I'll use anybody's."
> (Hospital detoxification unit)

In some few instances the risks associated with sharing did not appear to enter into the equation at all:

> "Aye, well I have shared. You know I'll be full of it and the table will be just full of works. You'll come out of a gouch like and take the nearest ones to you and say to yersel' 'Aye, well they look like mine,' but how d'ye know? They might be anybody's an' then you just use them."
> (Needle exchange)

For the most part though, HIV was a salient concern and when needle sharing happened it was most often explained as being in response to situational factors. The borrowing of used needles and syringes was therefore not an everyday event but one which occurred when access to clean injecting equipment was judged to be difficult. The following section considers some of the factors which could impinge upon an injector's access to sterile needles and syringes. Broadly these relate to such situations as being imprisoned or resident in a detoxification or rehabilitation unit as well as those occasions when financial constraint might deter an injector from buying clean injecting equipment. Additionally attention focuses on the influence of gender on access to needles and syringes.

The most straightforward and most often cited reasons for needle sharing were those where clean injecting equipment was not readily available because either the pharmacy or the needle exchange was closed:

> He last shared a week and a half ago. It was about 10 pm and so the chemist was shut. "I went away up to ma house but I must've been full of it the night before because the spike was blocked. So I went to ma pal and used his, but I cleaned it with hot water and bleach and then with water again."
> (Needle exchange)

and;

> To explain the last occasion he'd shared James said, "well it was a rush job. I said to ma girlfriend (she doesn't use drugs) that I'd be out 5 minutes, ran to the chemist but it was closed, so I went to ma pal's and said 'gie me your tools' and he did. That's it."
> (Hospital detoxification unit)

Situations were reported when the pharmacy or needle exchange was open but was inconvenient to visit at the time. Most often it was the case that drugs were immediately available at a time when a clean needle and syringe was not. As this woman explained:

> "I was at ma pal's and ma spike blocked and rather than runnin' down to the chemist and losin' ma hit, I borrowed her spike...did I mind? Aye I minded because she's no' fussy about who lends her works."
> (Hospital detoxification unit)

The availability of sterile injecting equipment is most clearly constrained in institutional settings. Within the prison environment there seemed to be the least scope for retaining personal ownership of needles and syringes. Hierarchies of power, latent aggression and the expectation that needles and syringes would be shared, all appeared to mitigate against the possibility of retaining individual control of them.

Male injectors are much more likely to have spent time in prison than their female counterparts (Frischer, 1992a). In this study the majority of men injectors reported that they had been imprisoned in the recent past whilst only a minority of women injectors had been. This finding is reinforced by a recent study among injectors attending two needle exchange schemes in Glasgow (Kennedy et al, 1991). Furthermore of those women in this study who had been incarcerated, none reported that they themselves had injected drugs in prison and indeed stated that injecting drug use in women's prisons was uncommon:

> "Now and again people hit up but no' much. There's nae sharing in there. People snort or use their own works. It's no' like the men's prison. There's no' so much drugs as in there."
> (Hospital detoxification unit)

This clearly is an area where male injectors are at greater risk of HIV infection than are women. Firstly because men injectors are more likely to be imprisoned and secondly because once in jail they are more likely to have the opportunity to inject drugs than imprisoned women. The HIV risks associated with injecting drug use in prison are further increased when one considers that the numbers of people sharing the same injecting equipment are reportedly large (Kennedy et al,1991).

The shared use of needles and syringes in prison has received a great deal more attention than has the shared use of equipment in drug detoxification and rehabilitation units (Bloor et al, 1989). However it was made apparent in the course

of this study that injecting drug use did take place in these establishments and most often involved the shared use of injecting equipment. During the six months spent interviewing in two detoxification units, at least five people (three men and two women) were asked to leave upon discovery that they were injecting drugs whilst also receiving treatment on the ward for their addiction. Further instances of injecting drug use whilst undergoing treatment for drug addiction were reported by others:

> He said that whilst he'd been in the rehabilitation unit a guy had been in there with the virus. I asked if the guy had told him that himself. "Aye a set of works got brought in and he said 'listen guys, I'd like to use them but I've got the virus so I'll need t'go last.' I went first." I asked him if he'd brought the works in. "Aye it was me." (Needle exchange)

From the situations described above it is apparent that environmental factors (such as the pharmacy being shut or the respondent being in prison) played an important part in motivating the decision to share needles and syringes.

Borrowing of needles and syringes was also explained in terms of the costs of buying clean injecting equipment. As this injector commented:

> "See if someone has £25 and they're needing t'buy fags as well, well that makes it £26-27 and they'd rather use their spike again or use someone else's set than buy a new one." (Needle exchange)

In the main, injectors appreciate the increased availability of sterile needles and syringes and, within limits, they do not appear to mind having to buy them. The perceived benefits are generally considered to far outweigh the costs. Nonetheless there were those who resented having to buy them and for one reason or another did not use the needle exchange. They were more likely to ask others if they would lend their injecting equipment to them:

> I asked Janice if people often asked for a lend of her works. "Well, there's that wee Tam, he often comes up t'me and to ma pal and asks for a lend of ma tools. He never buys them, says he cannae afford them although if you're getting enough for a score deal (£20), I cannae see how you cannae afford a set of tools. I mean 39p, that's

> no' much is it? I say to him 'youse are gonnae have to start gettin' yersel' your own sets.' But he says 'well its alright fae you and Tina 'cos I know you, you don't share. I only get them fae you two 'cos youse are alright.'"
> (Residential detoxification unit)

Given the high financial costs associated with sustaining a drug habit it is unsurprising that there should be occasions where funding the money for drugs, let alone anything else, could be a difficult and time consuming task. This was amply illustrated on those occasions when injectors were observed begging for small change:

> Simon was standing outside the chemist asking people for money. He said he was looking for £2.50 so he could buy a Temgesic. From at least 2.30 to 4.20 pm Simon stood collecting coins. At 4 pm he came into the chemist and asked for a pound note for his change. He said he'd nearly made it and had only another 50p to go. I went out at 4.20 pm and saw him going up to his house so I presumed he'd made enough to score. Later on he gave me the thumbs up that he'd got what he wanted. By 6-ish I saw him again walking up and down the street looking to sort out his next hit.
> (Streetwork fieldnote)

Having painstakingly collected the money for the drugs he needed just at that time, it is difficult to imagine much enthusiasm for the additional time and effort it would take to collect the extra money needed for a new set of injecting equipment. In such situations the purchase of clean injecting equipment may be seen as something of a luxury which has to be foregone. This is not of course to suggest that all situations where finance is tight necessarily lead to sharing. Clearly choices can still be made, not the least of which might be to re-use an old needle and syringe. However, financial constraint was indicated in these data to have led to sharing in some instances.

Differences in the take-up rate by men and women injectors of services offered by the needle exchanges in England and Wales are an indication that access to clean needles and syringes is not just a question of availability (Stimson et al, 1988b, Hart et al, 1989). Typically needle exchange attenders were older than average and tended also to be male. In this study the average age of injectors was younger (88%

were between the ages of 15 and 25) which reflects the overall younger population of injectors in Glasgow, (Haw et al, 1991b). However the majority of needle exchange attenders were male. Numerous women claimed to find it embarrassing and awkward to use the services of either the needle exchanges or the pharmacy. Men by contrast rarely claimed to have any such difficulties. Of 44 men and women injectors who were asked, 23 of 30 women said they disliked or avoided having to buy or exchange injecting equipment, only 2 men claimed to have similar reservations. The following three field extracts perhaps capture the tenor of the women's disquiet at having to indicate that they injected drugs:

> Anne said she found it difficult to buy works but couldn't really explain why. She described a recent situation, "I was away wi' ma pal in Gordonshill. She said t'me 'here am I, I've got ma Tems and no works and I cannae go in and get any.' I tried to talk her into it but she wouldnae go, instead I had to. It wasnae easy for me either you know - ma face was that red."
> (Hospital detoxification unit)

and;

> I asked John if he'd ever been asked to buy needles for girls. "Aye its happened a few times. I'll gie' you an example of a few weeks back, a lassie asked me to get her a set of works. She was standing outside the shop and she asked me because she knew the woman in the shop and didn't wantae get them fae her. See, I know her too but I don't mind so much. There's a lot of girls that say that:'see her, I know her, I cannae get them fae her.' "
> (Hospital detoxification unit)

and;

> When I asked Jane if she ever found it embarrassing to buy works from the pharmacy she replied, "it's funny you should ask that. Up until 8 months ago I would stand by the railings, you know, near the chemist, and wait until someone I knew came down the street. Sometimes I'd be standing there half an hour but I wouldn't go in there. Then finally one day I came out the Post Office and I just flew across the road. I don't know, I must've been strung out, but I went in. I had a bright red face the first time but I just said 'a set of blue and orange 2 ml syringes.' It was alright after that." One of the other ward residents asked her if she'd go in there with other customers in the shop. "No, you kiddin'? I'd never go in there when it was full, nae way. The only way I'd go in is when its empty."
> (Residential detoxification unit)

These women and others found it difficult to have to publicly acknowledge their injecting drug use, whether to the shop assistants or more generally to other customers in the shop. The relatively poor take-up rate of the needle exchange services by female injectors is perhaps related to the fact that the needle exchange provides a service which is specifically for injectors. Being seen either entering or leaving the premises leads inevitably to a fairly obvious interpretation. The range of possible reasons for being in the pharmacy is of course much wider. Furthermore female injectors may be more reticent about using the needle exchange out of a fear of official Home Office notification of their injecting drug use. In particular, women with children may fear that official discovery of their injecting drug use will result in them being judged as unfit, or unable, to parent properly. Certainly there were male attenders of the needle exchange who collected injecting equipment for female injectors who would not attend.

Clearly not all women reported difficulties buying or exchanging needles and syringes. Furthermore over time women may find it easier to confront and manage the situation. They may also be thrown on their own resources more through circumstance as in the following field extract:

> I asked Michelle about buying needles and syringes. "We broke up just now for 2 months so I had to buy ma own then, but even when we was goin' out wi' each other more often than not he'd be buyin' them. I don't know, I don't like buyin' them much."
> (Needle exchange)

The data strongly suggest that women, to a much greater degree than men, are socially inhibited from securing independent access to sterile needles and syringes. Access to clean needles and syringes frequently appeared to have been mediated by a third party, whether it be a sexual partner or friend, or just an acquaintance. Whilst this dependency might not, of itself, predict sharing it is evident that these women were in a more tenuous position than they would be if they were independently securing sterile injecting equipment. To be reliant on others for

access to needles and syringes is to be more subject to the vagaries of circumstance and the good will of others. In such a situation the possibility of having to share must become that much more of a likelihood.

So far sharing has been discussed in terms of the availability of sterile injecting equipment. It has been shown that availability is a necessary but not a sufficient condition to prevent situations where needles and syringes are shared. Where relevant, attention has been drawn to ways in which access to needles and syringes might differ for men and women injectors. Given differences in male and female experiences of injecting drug use and its attendant lifestyle it is perhaps unsurprising that these should also influence the practice of injecting itself.

In this next section attention shifts from looking at the conditions which might create, or contribute to a situation where sharing takes place, to looking at the dynamics of *who* shares with *whom*. These data quite clearly indicate that sharing is seldom a random activity, most frequently it was reported between people known to each other. In the majority of cases sharing was reported between people who had some relationship to each other; as brother or sister or sexual partner or friend. Only in very few cases was sharing reported to occur between strangers.

As will be shown, patterns of sharing do most clearly resemble patterns of sociability between injectors. This itself is further testimony to the fact that sharing is a socially embedded behaviour which is responsive to the many rights and obligations often implicitly held by people in their relationships with each other. These data show that patterns of sociability are quite strikingly demarcated by gender. The ramifications of this in terms of HIV risks for men and women form an important part of this discussion.

Patterns of sociability: their influence on sharing behaviour

Sharing as a social behaviour usually implies, or is expressive of social ties between people and is therefore generally attributed with social meaning. The obligations within friendships can make it difficult to refuse requests to lend injecting equipment. So also may it be socially awkward to refuse offers from others to borrow their needle and syringe or, in the event of borrowing, to take steps to protect oneself against possible HIV transmission. The difficulties injectors might have in negotiating such situations can perhaps be sensed in the following field extract:

> Anya asked if she could have an extra needle and syringe for her friend. "See, she borrowed ma works this afternoon, she's clean y'know, she got the test and it came back clear but still. I took ma hit, then she took hers, that was the last hit. See I can't really bleach them in front of her can I? It'll offend her, y'know, she's ma pal, so its hard, she'll look at me funny if I get the bleach out, so I just put them (the needle and syringe) in the drawer, left them like that."
> (Red light district)

The woman describing the above situation clearly felt it was one which required a degree of sensitivity. She was prepared, or felt obliged, to lend her needle and syringe but was unhappy about using it again without being able first to sterilise it. This she avoided doing because of the perceived negative connotations of her behaviour in so far as her friend was concerned.

Turning down the offer of someone else's needle and syringe was also viewed by some as a delicate affair because refusal could be taken to imply a broad range of negative sentiments about the relationship in question. Between friends it could be taken to mean that the other person was dirty or possibly HIV infected. Between sexual partners it could imply a lack of trust and the unwelcome assertion of separateness. The evident care with which this issue was dealt with by the injectors in the following field extracts illustrates a clearcut understanding of the potential ramifications of refusing to share with a friend. It is noteworthy in both cases that

the person refusing to borrow felt the need to articulate a reason for refusing. In the case of the second field extract the injector appears to use the fact of being a parent to legitimise not sharing. In both cases great play is made of a *general* concern to avoid HIV infection rather than it having any personal bearing on the person offering to lend his or her needle and syringe:

> In response to my question as to whether or not she shared, Kate said, "I don't share ma works, no' with anybody - see I've been where I've no' had any works of ma own and I've asked Carla and she's said she's none but said 'I've only got these but they're used, you can have one of them if you want' but I've said 'nothing against you Carla (you know with her being up the town an' all that) but I'd rather mash it down and snort it,' and that's what I've done, mashed it right down in front of her and snorted it, 'nothin' wrong wi'you Carla but I wouldnae use them after my ma, ma granny or anybody.'"
> (Needle exchange)

and;

> Mick described a recent situation where he'd not had any clean injecting equipment of his own and had refused the offer of someone else's. "One of ma pals said 'you think there's something wrong wi me? You've known me all ma life.' I said no, I didnae think that but I felt I wanted to be careful. I said 'its only 'cos of ma son, he's all I've got, I've got to be careful.'"
> (Needle exchange)

Sharing is a social act which most often occurs between people who know each other (Sheehan et al, 1988). Analysis of the occasions where sharing took place broadly confirms these patterns of sociability. This can be seen in the table below which classifies the cases of sharing reported by injectors to the researcher.

Table 1	Relationship of borrower to lender on last occasion unsterile injecting equipment was used. n = 73 reporting sharing in the last year.		
	Male respondents n=31	Female respondents n=42	Total (73)
Family members	2	4	6
Sexual partner	4	16	20
Sexual partner + male	1	2	3
Sexual partner + female	2	2	4
Female friends		8	8
Male friends	18		18
Mixed sex friends		3	3
Male acquaintance	2		2
Female acquaintance		0	0
Group sharing		3	3
Sharer unspecified	2	4	6

It is immediately apparent that where sharing does occur it is most often with people with whom there is some degree of relationship, whether family, partner or close friend. This finding is mirrored by recently reported figures from an ongoing study of 500 injectors in Glasgow (Frischer, 1992a). These data also show that it was men, not women, who were most likely to borrow needles and syringes from

than one other person's needle and syringe in the last 6 months. Similar patterns of sharing were evident in this study.

The majority of women in this study reported having male partners who injected drugs. Whilst some of these women did not inject drugs with the same needles as their partner, most of them did, either when the need arose or habitually. They were also most likely to report that this sharing was exclusively with their partner. Comments like those listed below were typically heard when women were discussing their sharing behaviour:

> "I might use ma boyfriend's works sometimes and he mine, but we'll no' use anyone's outside."
> (Needle exchange)

> I asked her how many times she'd shared in the past 4 weeks. "Oh, I don't know how many times. See I use ma boyfriend's most of the time." I asked her if she used anyone else's, "you kiddin, I'm seven months pregnant."
> (Needle exchange)

> Before now she got her works from the pharmacy. Her boyfriend used to buy the one set between them up until September when he found out he had the virus. Since then she's tried to use her own but has used his when she's been "pure full o'it" or they're just had the one set between them.
> (Needle exchange)

It is interesting to note that women who were asked about sharing did not often view the behaviour as worthy of comment if it involved their partner. However it was often considered in terms of the associated HIV risks if it involved people outside of that relationship.

Again, data from the first year of a Glasgow study of 500 injectors complement these data in respect of gender differences in sharing patterns. Whereas 42.7% of females reported sharing with their regular sex partner only 20.7% of males reported doing so. The biggest single explanation for this difference must relate to

the fact that so few male injectors have partners who inject drugs themselves (Frischer, 1992a).

The incidence of sharing with friends was most marked among male injectors. Those women who reported sharing with another woman were most often single and unattached. Usually they described the person they shared with as being a 'best pal.' Some men also reported sharing with a best friend but in the main they had a wider network of friendships. Other studies have found broader peer relationships to be more a feature of male friendships than female friendships.

Research on the lives of young men and women clearly shows the strong influence of gender on friendship patterns (Coffield et al, 1986, James, 1986). Up until the point at which men and women begin to have serious long term relationships and particularly once children are born, men tend to socialise primarily with men whilst women tend to spend most of their time with women. Friendship patterns tend to shift somewhat once couples are formed and families are begun. Friendships may retain their importance but after a time often become less dominant, as other, familial, concerns compete for attention, particularly amongst women (Leonard, 1980).

These patterns of sociability are as much in evidence among young men and women who inject drugs as among those who do not. Indeed it may be that there are certain features of a drug injecting lifestyle which reinforce gender boundaries. The division of labour between many injecting couples and the greater stigmatisation of female injectors relative to males may be of particular influence in this regard.

The tendency among men injectors to share with other men may indicate two things. Firstly, since men injectors are not in the main in sexual relationships with women injectors they may be spending more time with other men injectors, particularly

when attending to the needs of their drug habit. Secondly, even where men are in relationships with women who also inject drugs the division of labour may be such that it falls to the man to secure money for drugs, the drugs themselves and injecting equipment both for themselves and their partners. Quite often this work will be done with another man, whether for security or company. Both drugs and needles may be shared in this context.

Analysing the data on sharing points to a number of interesting differences in patterns of sharing among men and women. It is apparent that women injectors are not sharing widely but with their partners, or if they are without one, with a best (female) friend. When women borrow needles and syringes it is less likely to be from a relative stranger than is the case among men injectors.

However, those women who report sharing habitually with their partners are, just by virtue of the frequency with which they use another person's needle, taking very high risks in so far HIV is concerned. It is after all an article of faith to assume that one's partner does not borrow other people's equipment when out of one's own company. Work by Mulleady and Sherr (1989) shows the fragility of this notion. There are difficulties however, with characterising these women as high risk takers, since their risk taking is in the context of a relationship. This is somewhat different to the more conventional understanding of risk taking. The indiscriminate borrowing of needles and syringes from large numbers of people is a closer approximation of the classic high risk scenario. This, on the evidence, would have to be viewed as more likely among men than women. The literature on risk taking behaviour as it relates to men and women (irrespective of whether or not they inject drugs) suggests that women are generally averse to risk taking behaviours (Rosenbaum 1981a, Silman, 1987). It is somewhat paradoxical therefore that they should, as a consequence of having a relationship with a partner also using drugs, be in a situation where they are taking high risks.

Conclusion

The purpose of this chapter has been to demonstrate that the sharing of injecting equipment occurs not merely in response to a lack of sterile needles and syringes but more broadly relates to the social situations in which injectors find themselves. Whilst many of these situations may be experienced no differently by men and women injectors, some are particularly likely to be experienced by men rather than by women or by women rather than by men.

Availability evidently does have an important part to play in the creation of some of the situations where needle sharing takes place. However, this can only be part of the explanation as there were situations where sterile injecting equipment was available and sharing still took place and vice versa. A review of the reported instances of sharing showed it to be highly situationally variable. Environmental, personal, financial and social factors could all play an important part in motivating the decision as to whether or not to share needles and syringes.

It was evident from the data that there were instances when sharing occurred not out of any difficulties associated with availability but for personal or social reasons. Habitual needle sharing between sexual partners was one case in point. Whilst the complex of factors which went to make up situations where sharing might take place were important considerations, so too was it important to look at who shared with whom and the possible consequences of this.

Analysing patterns of sharing between injectors highlights sharing as rarely being an indiscriminate activity but one which frequently follows patterns of sociability quite closely. The gender distinct nature of much of this social activity and its reflection in sharing patterns suggests that the risks of HIV infection, in respect of needle sharing, are differently focussed for men and women. The particular tendency for

women injectors to be in relationships with men injectors and also to share with them is one area in which women are clearly at higher risk than their male counterparts. This particular issue is taken up again in the following chapter which looks at men and women injectors' sexual relationships and the associated HIV risks.

CHAPTER 5: IN THE NAME OF LOVE: HETEROSEXUAL SEX AND THE RISKS OF HIV

Introduction

A good deal of attention has focused upon the HIV associated risks of using unsterile needles and syringes. By contrast comparatively little attention has been paid to the risks of injectors' heterosexually acquiring the virus from their sexual partners. Since the majority of drug injectors report being heterosexually active there clearly is the potential for sexual transmission to take place, especially since raised levels of HIV have been identified amongst this population.

This chapter will address the related issues of heterosexual transmission of the virus and the practice of safer sex, particularly with regard to the use of condoms. These issues are not neatly demarcated by gender. However, behaviours which appear to put men at greater risk of HIV than women and vice versa are pointed out throughout the chapter. Sexual activity and levels of condom use among those drug injectors contacted form the initial focus. This provides a frame of reference for discussing the range of reasons which might impinge upon sexual practice and condom use. Broadly four main areas are considered as being influential, these are, perceptions of risk of heterosexually acquiring the virus, the processes leading up to the sexual encounter, notions of gender appropriate behaviour and, long term relationships. These areas will be discussed in terms of drug injectors and also, those others not injecting drugs. This provides a broader perspective on sexual behaviour and attitudes among young people living in the study area and well illustrates how issues relating to sex and safer sex were no more easily spoken about, or dealt with, or resolved, by drug injectors than they were by those not injecting drugs.

Sexual activity and levels of condom use

Safer sex generally refers to the use of condoms as a means of protecting against the exchange of body fluids which might be infected with HIV. Clearly the best protection against HIV would be to avoid sex altogether and failing that to avoid penetrative sex. However to expect this degree of behaviour change is unrealistic just because sexual expression is generally regarded as so fundamental a feature of human relationships. The majority of men and women drug injectors in this study were sexually active. It is worth noting that the use of drugs like Temgesic does not appear to repress libido in the same way as heroin is reputed to do. Indeed those few who reported being sexually inactive tended to explain it in terms of a specific addiction to heroin:

> "With the junk, sex is the last thing on your mind."
> (Needle exchange)

and;

> "Tae tell ye the truth, smack takes over fae sex, it's smack ye love".
> (Needle exchange)

and;

> "I don't bother wi' sex, I just get ma hit, go to ma house, get ma sleep, wake up and have ma hit, like that".
> (Needle exchange)

Contrary to popular stereotypes of drug injectors as deviant in every respect, including the realm of sexual behaviour, the great majority of those interviewed in this study were apparently sexually conservative. A similar finding has recently been reported in a study of drug injectors and their sexual partners in New York City (Kane, 1991). Most commonly the injectors in this study were in long term sexual relationships with one partner, only a minority self-identified as homosexual or lesbian. Again only very small numbers reported having had many casual sexual contacts:

> "Aye, well I'm very promiscuous and I have slept with women who are HIV positive without a condom". He later estimated having slept with about 9 women in the last two weeks.
> (Needle exchange)

and;

> 'Tom said he'd slept with a good few women, some drug injectors, some he felt had the virus. "That's what I'm afraid of, in case I catch it through the thingummy...the willie, the penis...I just cannae resist they women".
> (Residential detoxification unit)

Clearly, even a few such individuals have the potential to generate epidemic spread, it is however important to recognize that only a minority, most often men, reported large numbers of sexual contacts. These findings are in general accordance with those reported by Donoghoe and colleagues (1989b) on the sexual behaviour of clients attending needle exchanges in England and Scotland.

Despite health educationalist's efforts to encourage heterosexuals to avoid penetrative sex, it is apparent that other sexual practices, such as for example, mutual masturbation, if they happen at all, are not generally regarded as substitutes for penetration. Indeed they appear to be seen as a part of the process leading up to penetration, which act for many people is what defines sexual intercourse (Kent et al, 1990).

It was found that over 80% of men interviewed had non drug injecting sexual partners. Undoubtedly part of the explanation for this resides in simple arithmetic, there are very many more men injecting drugs than there are women who do so. A recently reported figure shows a ratio of 2.6 males to 1 female drug injector in Glasgow (Frischer, 1992b). It can however also be explained by reference to an oft stated preference for women not injecting drugs:

> Tam said he wouldn't go out with a girl who was using drugs. "I don't know why but I don't like to see a girl using, you know puttin' a needle in her arm, I don't think a girl should do that. I suppose a man shouldnae either, but somehow its worse in a girl, aye, a girl wi' a wean."
> (Needle exchange)

The commonest explanation for the stated preference for women not using drugs was moral in character and centred on the inappropriateness of drug use by a woman.

It is pragmatic to use condoms as a means of protecting against the exchange of body fluids which may be HIV infected. Condoms do provide a practical and relatively effective means of guarding against HIV infection. There are however, a number of objections to their use which clearly illustrate the dangers of regarding the condom as unproblematical. The main objections to condoms are well known, people generally report them to be clumsy, messy and unreliable as contraceptive measures, as well as being embarrassing and difficult to negotiate. The problems associated with condom use pre-date the advent of HIV infection (Wellings, 1988).

A particular objection often raised by men is that condoms are desensitising, a feeling articulated by this male drug injector who claimed to have large numbers of sexual contacts:

> "D'ye want me to carry condoms wi' me? You'd be as well havin' sex wi' a tea cosy on." I quizzed James further over his saying that he worried about his sexual contacts with women he felt were 'dodgy'. What did that worry mean in practice? "After it (sexual intercourse) you're like that for a wee while: 'Jeez what have I fuckin' done?'". He ended by saying that he felt that sex with a condom was a waste of time, "better off reading a book."
> (Residential detoxification unit)

A factor influencing use of condoms which may be more specific to drug users than others relates to the effects of some of the drugs used. The injected use of temazepam is a case in point as this is often associated with lack of control and awareness (Klee et al, 1990). Some of the people interviewed said that they had felt too 'stoned' to think about anything very much:

> I asked Kate if she'd used condoms with her last sexual partner "No, we were both too full of it (drugged)."
> (Hospital detoxification unit).

It is evident that condoms remain generally unpopular, as this non-drug injecting man commented:

> "There's 15 reasons why people won't use them, at least 15 reasons, one reason and that just discourages them altogether, from things like buying them to wearing them, anything, and I don't think there is enough done by the government to promote it, maybe it's not a good thing to promote but it is good, it's not sort of the done thing." (Community centre)

The unpopularity of condoms, whether for purposes of preventing conception or to prevent possible transmission of the virus is well demonstrated in the table below. Out of a total of 123 sexually active drug injecting men and women interviewed in both the chemist and the needle exchange, only 26% reported the use of condoms on at least an occasional basis. A telephone interviewing survey carried out in London and Central Scotland in 1990 reports broadly similar figures on condom use. Levels of condom use among drug injectors are generally consistent with those reported by this randomly selected sample (McQueen et al, 1990a, 1990b).

Table 2: Condom use among injectors interviewed in the pharmacy and the needle exchange

Needle exchange	Using condoms
n = 40	15 (37%)
Pharmacy	
n = 83	18 (21%)
n = 123	32 (26%)

A small minority reported consistently using condoms. The rationale for their use was most often cited to be out of a specific concern to avoid HIV infection rather than for purposes of avoiding conception:

> 'I'm careful, I always carry a condom. I have one on me the now 'cos you never know. He said he didn't have a girlfriend at the moment but of the last three partners, two had been injectors.'

(Needle exchange)

and;

> "Ma boyfriend who hits up and me always use condoms 'cos I wouldnae know if he had slept around or used someone else's tools." (Pharmacy)

Others did report use of condoms but inconsistently, depending on whether or not they were available at the time:

> I asked him if he thought that he might be at risk of HIV through his sexual contacts: "I use condoms, well not every time right enough. If I don't have any on me then I'll do without them. I'm no' bothered about usin' one though. I don't like them but I use them." (Needle exchange)

Despite repeated campaigns stressing the importance of condom use it is apparent that they remain problematic. To understand the reasons behind the low up-take rate of condoms it is important to place the issue within the context of the social relations of which they are a part. Precisely because the use of condoms is a social act and has social meaning it should be credited as being more than a simple mechanical procedure (Weinstein and Goebel, 1979).

Perceptions of Risk

A first step towards preventing risk behaviour is to inform people of the risks involved in the behaviours one wishes to change. Successive health education campaigns since 1987 have stressed the risks of heterosexual transmission of the virus. However research into the effects of these campaigns suggest very little behaviour change, indeed many heterosexuals appear unconvinced that they might themselves be at risk of HIV infection via heterosexual sex (Macdonald and Smith, 1990, Nutbeam et al, 1989). This appears to hold true as much among drug injectors as among the general population. (Donoghoe et al, 1989b, Klee, 1990). The following field extracts are illustrative of the range of responses given:

> "Aye I do worry (about sexual transmission of the virus), but I've heard that it's difficult for a guy to get it fae a lassie." (Needle exchange)

and;

> In reply to my question as to whether or not he used condoms, John answered "I've nae need of them, I've been tested and I'm negative." The charge nurse then asked about his partner "I've just the one bird and she's nae junkie."
> (Needle exchange)

and;

> Neil (researcher) asked if he would use condoms, he shook his head; "nah, I'd know if the bird was sleepin' around."
> (Pharmacy)

Furthermore during the course of the fieldwork it was often demonstrated that the risks of sexual transmission were not considered anything like as serious as the risks of infection through sharing used needles and syringes:

> Each time I bring up the subject of condoms and unprotected sex I draw a blank. They seem to see the issue as totally unrelated to them."
> (Residential detoxification unit)

It became apparent during the course of this study that most people found it difficult to sustain an image of themselves as potentially infected and therefore a risk to other people. More commonly they saw themselves as at risk from others. In consequence sexual transmission of the virus was discussed by them in terms of the likelihood that they would become infected. This may be partially in consequence of successive health education campaigns which have tended to emphasise the risk of becoming infected rather than the risk of passing infection onto others. This is somewhat ironic given the large numbers of men whose sexual partners were most often women not using drugs:

> "No you can't really get it that way can you? I mean maybe if I had a girlfriend who was usin' I might be worried but apart from that, I'm no' worried."
> (Needle exchange)

Some men had partners who did not know of their drug use. This was also found in a New York Study (Kane, 1991). Clearly this is a piece of information which is relevant to the injector's partner in assessing personal risks of HIV infection and

might have been instrumental in deciding on the value of using condoms. Being in possession of the facts is yet more relevant where a potential partner has the virus:

> Tina described the first time she and Tim (HIV positive) got together. "I don't drink really but that night I was steamin' (drunk). Well that night we slept wi' each other and we didnae use a condom or anything. Then next day I heard he had a hospital appointment and then I twigged. He wasnae steamin' he knew what he was doin' and he had the virus and he didnae even tell me. That really hurt me."
> (Streetwork fieldnote)

The fact of the other person's HIV seropositivity might not in the event be the deciding factor in terms of whether or not barrier protection is used or even if sexual intercourse takes place. However, it is information that is of significance to the other person. Nonetheless, contacts with people who had HIV or other infections which could be sexually transmitted illustrated the very real interactional difficulties which could arise in consequence of their health status:

> Tracey talked about her ex-boyfriend saying she still likes him but doesn't know what to do if she goes out with him again because of her hepatitis. "I mean how can I ask him to use a condom, say I don't want to get pregnant? I don't want him to know about this hep. but I don't want him to get it."
> (Residential detoxification unit)

Suggesting the use of a condom might itself be interpreted as indicating either one's own HIV sero-status or suspecting it in the potential sexual partner. Clearly this can create problems:

> "One lassie she said to me 'you'll need to wear one o' them' but after I think she felt bad, like her conscience was guilty that she thought she might get something off me, but I said; 'no, you're right, you're right to be careful.'"
> (Needle exchange)

A central tenet of the health education campaigns has been to communicate the message that a person with asymptomatic HIV infection looks exactly the same as anybody else. It was evident however from the way in which HIV infection was spoken about that many thought you could tell if someone was HIV infected from their physical appearance:

> I asked him if he knew anyone who was HIV positive and he said he didn't. At this point he started asking me about the symptoms of HIV/AIDS and began pinching his face, asking me if I thought he looked thin and unhealthy.'
> (Hospital detoxification unit)

and;

> "You can tell someone's got the virus, know how you can tell? Their faces and bodies are dead, dead thin, pure wasted, but around here (she slapped her thigh) they're like that (big), that's the only place they don't lose it. That's how you can tell if someone's got the virus."
> (Needle exchange)

At the time of fieldwork none of the injectors in the study who had tested HIV positive were symptomatic. The tendency of people to associate HIV infection with an unhealthy or unkempt appearance has also been reported in another study in Glasgow (Kitzinger, 1990). The problem is that if physical attraction is at least partly defined in terms of appearances (of which presumably 'cleanliness' is a component part), then the issue of whether or not the potential sexual partner is HIV infected has already been discounted. Following through the logic of this assessment there is then no obvious need to use a condom. This much seems clear from these schoolboys' evaluations of whether or not to use a condom:

> I asked if they would insist on condom use, the girls were unanimous, the boys less certain all shaking their heads. So I asked: "You wouldn't wear one then?" "Nah, no' if I'd been goin' with her a while". "Depends if she was boggin".
> (School)

It appears then that a large part of the decision as to whether or not safer sex is even worth considering is premised on evaluating the appearance of the person one is sexually interested in.

The overall impression received from contacts with people not injecting drugs was a certainty that they would be able to detect if someone was injecting drugs before becoming either sexually or emotionally involved with them. It is however noteworthy that in this study many of the woman who began injecting in the context of a sexual relationship did not initially know that their partners' were injecting

drug users. Similarly in Kane's study in New York City (1991) most sex partners did not know that their partner was injecting drugs until well after the relationship was established.

Negotiating the sexual encounter and safer sex

Efforts to encourage widespread use of condoms are hampered in this society by the fact that issues of sex and sexuality have all the trappings of a taboo subject (Mittag, 1991). Only rarely is sex a subject of conversation in any meaningful sense, most often issues relating to it are swathed in ambiguity, awkwardness and uncertainty. This perhaps explains the paucity of our vocabulary for expressing these concerns in ways which are not themselves charged with sexual meaning or innuendo, or so oblique as to lose all meaning. One consequence of this observed cultural reticence to raise the subject of sex and discuss it frankly is that little is specifically known about sexual behaviour. From the point of view of health educationalists this creates the obvious difficulty of targeting appropriate strategies aimed at changing behaviours.

The difficulties associated with raising the subject of sex as a matter for open discussion were well demonstrated during fieldwork. Whilst the risks of HIV transmission through shared needles were frequently discussed in detail and at length, the risks of sexual transmission were relatively rarely discussed and never in great detail. Men and women alike often mentioned being embarrassed to talk in depth about sexual matters finding it difficult to discuss the subject without awkwardness. This was well illustrated during group discussions with young people at the schools:

> "So", I probed,"what other way can you get the virus apart from sharing needles/blood?" A coy answer from one girl, "through sleeping with someone". A ripple of embarrassed laughter spread through the group. "How can you protect yourself?" I asked. Again a certain coyness and one boy in saying "condoms" provoked much laughter.'
> (School)

This same awkwardness and embarrassment was apparent in all of the settings where people were contacted. It should be added perhaps that the researcher, often without realising it, colluded in a number of ways with this reticence to discuss issues of this kind. For example, in retrospect it seems that there was a degree to which an unwarranted sensitivity was brought to bear on the research situation, such that the subject of sex was not probed further if the person concerned seemed uncomfortable with the subject. Additionally the subject of sex was often ruled out of bounds by the nature of the situation. Discussions of heterosexual risks of HIV infection are for example conspicuously absent from contacts with drug injectors in public settings. It would seem that the researcher and her subjects adhered to a mutual understanding of the appropriateness of certain settings for certain subjects. The issue of when, where and how to address potentially sensitive subjects has surfaced in other research work such as is reported by Stimson and his colleagues (1988a).

The view that sexual behaviour is a private, personal concern appears culturally embedded in our society. The fact that issues concerning sex do not appear to be raised often for discussion even between sexual partners further suggests the extraordinary status of sex in our society. Sex clearly is treated as something to be negotiated with care and due caution. Recognizing the delicacy and complexity of the processes involved in the negotiation of the sexual encounter is an essential part of understanding the many influences which cut across the seemingly straightforward injunction of health educationalists to use condoms.

The term 'negotiation of safer sex' has been much used in recent years to help foster an awareness of the preventable risks of HIV infection in sexual encounters. However for many the term bears little relationship to the realities of sexual experience in which the negotiation of any kind of sex, let alone the use of

condoms, might be considered a hazardous, uncertain and potentially fraught business (Barnard and McKeganey, 1990, Brooks-Gunn and Fursternberg, 1990).

Although there has been little systematic work in this area, it appears that ambiguity is an important feature of the process leading up to sexual relations between heterosexuals (Kent et al, 1990). This does present certain difficulties in so far as the introduction of safer sex practices are concerned. The problem is that negotiating safer sex requires a degree of explicitness which may actually be in opposition to the whole tenor of the proceedings. Research by Kent and colleagues suggests that the lead up to sexual relations is an incremental process signposted by mutually understood, even if non-verbal, signals representing a gradual move towards a situation where agreement to sexual relations is taken to be consensual. By avoiding making explicit statements of sexual intent both parties may be able to avoid potential embarrassment or discomfort should the advances of either be rejected. Physical signs such as switching off the light or locking the door are often used to represent the wish to take things one step further. If the other person consents to this turn of events this may then be read as agreement to have sex. The overriding impression is that of a progressive move towards a situation where sex 'becomes' the agenda, even if this is never explicitly acknowledged by those involved. It is almost as if a necessary fiction is created such that the actual consummation of the sex act although frequently represented as a spontaneous, unportended event can be seen analytically as the result of a protracted, careful and subtle process of negotiation.

The point at which it is decided between two people that they will have sexual relations appears to mark the end of the negotiating process, consummation may follow on very quickly from this point. In terms of the structure of the process it would appear that it is only really in the compressed space between agreement and consummation that the issue of safer sex could be introduced. This itself creates a

number of problems. The deliberate ambiguity which characterizes the lead up to the sexual encounter by its nature does not allow for explicit recognition of intent; discussing safer sex at this point would be to place the cart before the horse. However to raise the issue once it is agreed that sex is on the agenda may not be particularly easy either, this much is apparent from the following fieldnotes

> He thinks he may have the virus (although earlier on he'd said he didn't think so) because he's slept around. I asked if he knew how many partners he'd had. "Oh millions and I never used a condom. When you're in the bedroom you're not thinking about a condom, only one thing on your mind then."
> (Hospital detoxification unit)

and;

> "See sometimes you don't just go wi' your bird, sometimes you get into other women and practically all the birds here are junkie birds and you want to go right away (and have sexual intercourse) but you're not really thinking about a condom then, just getting it away."
> (Needle exchange)

and;

> "I'm no sayin' that I wouldn't sleep wi' him without something (a condom) because that jus' happens."
> (Residential detoxification unit)

These fieldnotes demonstrate firstly the degree to which sex is seen as a spontaneous act. Secondly and relatedly, the movement from negotiating the sexual encounter to consummation is apparently very compressed leaving little or no space for the issue of condom use to be decided upon.

Women bargaining from a position of weakness?

Men and women do not appear to enter equally into the process of negotiating the sexual encounter which therefore also compromises the weaker party's ability to negotiate safer sex. Traditional gender related expectations of behaviour place the onus upon men to take the lead in initiating sexual relationships between men and women (Jackson, 1982, Richardson, 1990). In this society at least, it would appear that male dominance is a feature of the ideological heterosexual relationship. This can effectively place limits on the woman's potential to negotiate with her partner

over the issue of safer sex (Holland et al, 1990a). Given societal expectations of female passivity and additionally, the expectation that a woman should not profess to know too much about sex (James, 1986), it can be seen that a woman might feel unable to raise the issue of condom use without inviting negative comment (Pollack, 1985). This seems apparent in the following field extract, even though the woman is asking for condoms, her whole manner suggests real difficulty in insisting on their use:

> I asked Jenna if she worried about getting HIV through sexual relations. "I do, that's how I'm gettin' condoms fae you" (she whispered this to me, her boyfriend was nearby and she didn't want him to hear). "He doesnae want tae use them but I think he should because like I says to him, 'I don't know who youse are with and if youse are sharin' their tools and sleepin' wi' girls, I've got tae protect ma health, think of myself.'"
> (Needle exchange)

In the context of a cultural expectation of female naivete about sex it might be considered inappropriate for her to be in possession of condoms (Scott, 1987). Certainly the schoolchildren in this study were sensitive to these issues. Despite a greater professed willingness to use condoms prophylactically relative to the males, the females were sensitive to comments which they foresaw as likely if they were found to be carrying condoms.

> The girls all said they'd be embarrassed to carry a condom and said their friends would think they were a slag if they found out they were carrying one.'
> (School)

Not surprisingly, this same reticence to carry condoms was also noted among female drug injectors:

> Neil asked if she'd consider using a condom with her next partner. She seemed unsure. He gave her a hypothetical situation - at a party and wanting to have sex with a man she'd met there. "In that situation, aye." She then went on to say that they were horrible things and she wouldn't carry them on her.'
> (Hospital detoxification unit)

It was interesting to note that many of the schoolboys saw it as the responsibility of women to carry condoms. This attitude may relate to the expectation that women should take charge of contraception to avoid falling pregnant. The problem arising however, is that women are also supposed to be the guardians of their own morality defending their honour against the onslaught of male desire (Horowitz, 1981). A woman who is seen to be sexually available risks losing her reputation and being labelled a 'slag' or a 'whore' (James, 1986, Holland et al, 1990b). Clearly the inclination of women to carry condoms must be compromised where they stand to be so poorly judged for doing so.

Currently the thrust of a good deal of health education has been to encourage men and women alike to carry condoms routinely so that they are prepared for situations where sex might take place. However it was apparent from this study and others (Abrams et al, 1990) that women, although more prepared to *use* a condom were not prepared to *carry* them for fear of adverse social comment for doing so.

<u>Condom use in long term relationships</u>

It could be argued that much of what has been said thus far is largely relevant either to new or casual sexual encounters. In making this case there is the assumption that sex the second or third time with the same person will be a less uncertain and delicate affair. Clearly there are differences between casual sexual encounters and more long term arrangements which are likely to have some effect on sexual practices and condom use. Condom use may in fact be more, rather than less, problematic.

There are particular problems associated with encouraging the introduction of safer sex practices into long term relationships. Condom use, if it occurs at all, is most often at the start of a relationship. Once it is established that the relationship will continue it is common that the woman goes on to the pill (Holland et al, 1990a).

The condom appears to be seen as a temporary measure associated more with the one off sexual encounter than stable long term relationships. Liebow reports a similar finding in his pre-Aids and (pre-pill) study of street corner boys (1967). They were also reluctant to use condoms in their long term relationships even though they were quite prepared to use them for one-off sexual encounters. This woman commented:

> "There's got to be a time when you get together if you are close and condoms will go out the windae, you know what I mean, that you are not prepared for what is gonnae happen."
> (Residential detoxification unit)

There is a degree to which a woman's use of the pill can be taken as signifying commitment or seriousness to the relationship (Kent et al, 1990). This seems borne out by the following field extract:

> I asked Joanne if she used condoms with her boyfriend. "No, I'm gettin' married in a month. I used condoms at first but no' now."
> (They have been going out for a year).
> (Pharmacy)

From this woman's response it is apparent that condom use was considered inappropriate at this stage of the relationship. It may well be that the point at which a relationship appears to take on a more stable character is also the point at which condoms are rejected in favour of a less obtrusive form of contraception. The introduction of condom use into an already established relationship may be still more problematic, particularly if other means of contraception are being used:

> James has a regular girlfriend. She doesn't use drugs but she knows he does. I asked him if he worried about sexual transmission. He looked surprised at this and said no. I asked if she wanted him to use condoms "no, she doesnae need to, she's on the pill."
> (Pharmacy)

In this situation it may be very difficult for the partner not to suspect the motives of the other for suggesting the use of barrier protection. The social ramifications of

suggesting condom use may be considerable, introducing an element of distrust and uncertainty into the relationship.

Recent work analysing communication between partners indicates that certain topics are held to be taboo in close relationships. In essence these topics can be seen as potentially threatening the status of the relationship. Broadly these subjects relate to sexual history, current sexual activity outwith of the relationship and discussing the current state of the relationship (Baxter and Wilmot, 1985). Broaching the subject of condom use and more generally, safer sex, can raise issues which may have remained submerged precisely because they are sensitive and potentially de-stabilising of the relationship (Perlmutter-Bowen and Michel-Johnson, 1989, Kane, 1991). It is, for example, interesting to note in the following field extract the difficulties this man clearly envisages would occur if he were to suggest use of condoms in his long term relationship, even while he recognized the risks of sexual transmission of the virus:

> "If I have sex wi' a girl I don't know I use condoms. Ma girlfriend doesnae use, no, I don't use condoms wi' her. That would be difficult."
> (Pharmacy)

A major obstacle to the use of condoms in the context of long term relationships appears closely related to socially constructed notions of intimacy. Condom use seems on the evidence, to run counter to ideas of physical and emotional closeness, creating a barrier between the couple which may be seen to be as much symbolic as physical. Generally, relationships are assumed to be about increasing closeness in both emotional and physical terms. To introduce condom use into this scenario may be difficult because it seems to create distance rather than reduce it (Gillman and Feldman, 1991).

Women, more than men appeared to subscribe to what might be described as the ideology of romantic love. They often represented themselves as having thrown in their lot with their partners and were ready to face life's trials together:

> I asked Jane if she worried at all about AIDS. She was emphatic that she didn't. She injects with the same needle as her boyfriend. "It doesnae matter, he'll no' share outside and nor will I." I asked if she and her boyfriend used a condom; "no, never, there's nae point, what he gets I'll get and same wi' me for him."
> (Residential detoxification unit)

and, in the case of a woman whose boyfriend was HIV positive:

> "The doctor used to sit and say 'you'll have to use them (condoms) because there's nae use you getting it'...but I'd just say 'och I think I'll be alright' or, 'if it happens, it happens. The two of us have got to stay together. I know that sounds weird."
> (Residential detoxification unit)

It is illustrative in this regard to compare differences in the attitudes of the male and female schoolchildren contacted in this study. When asked what their attitude would be if they discovered their partner to be injecting drugs there were quite marked gender differences in response. The boys were inclined to be hardline, comments like "sling em", "out the windae" or "I'd set about her" were frequently made. The girls however were much less dogmatic and tended to be more concerned with the nature of the relationship established and the personal attributes of their partner. Many said that the fact of a partner injecting drugs would not necessarily mean an end to the relationship. In general the girls were more conciliatory, often saying they would "gie them a chance" to come off drugs. They saw themselves as first trying to help their partner rather than giving up on the relationship. These differences in attitude between males and females are perhaps indicative of general differences in the expectations men and women have of relationships.

In the particular case of one's partner being HIV positive it seemed that the non-use of condoms could be a statement of commitment on the part of the other:

> I wondered if being in a relationship with Lenny made it difficult for her to use protection. "You do take chances you know. When it started I fell in love wi' him, and I thought this is forever and ever and so I didn't think about him wi' the virus and all that much."
> (Streetwork fieldnote)

The whole issue of safer sex and condom use is clearly at odds with a woman actively seeking to get pregnant. The following fieldnote is apposite in this regard:

> "My boyfriend is usin' (drugs) in the prison just now and I know he's sharin'. No he wouldnae let me use condoms cause he wants to have a wean (child) by me."
> (Pharmacy)

Although aware of her boyfriend's risk behaviour and the consequences this might have for her, this woman felt unable to protect herself against sexual transmission because of her boyfriend's injunction that she get pregnant. More broadly however, women injectors are stigmatised for their involvement in drug use and are seen to be in breach of their proper social role as mothers and carers. For many woman injectors, having a child and becoming a mother is one way in which they can aspire to traditional expectations of appropriate female behaviour. Becoming pregnant may, in these terms, come to assume greater importance than using a condom to avoid possible HIV transmission (Mitchell, 1988).

Conclusion

Condom use remains unpopular in the general population even despite strong advocation of their use to protect against potential HIV transmission. Drug injectors on the whole were similarly ill-disposed towards condoms citing the same objections to them as have been voiced more generally by people.

In the first place many injectors did not perceive themselves to be at risk of HIV through heterosexual sex relative to the HIV risks associated with needle and syringe sharing. This may be a response to health education campaigns which emphasised the risks of injectors contracting HIV through sharing unsterile injecting equipment. Rather less attention has focussed on injectors' risks of contracting or

spreading HIV through unprotected heterosexual sex. In this respect it is notable that the majority of health education campaigns have focussed on protecting against the risks of contracting HIV infection rather than passing it on. Most of the male injectors in this study had non-injecting partners and judged the risks of contracting HIV from them to be negligible. The potential risk that they posed to their partners was not a prominent part of their calculations. A further factor mitigating against condom use was the generally held perception that HIV infection was symptomatic and hence visible. Such signs as thinness and poor health could be taken as indicative of HIV infection. By inference a healthy looking person was unlikely to have HIV thereby rendering the use of a condom unnecessary.

The low take up rate of condoms among injectors, and others, needs also to be explained in terms of the dynamics of the sexual encounter. The use of condoms was variously regarded as socially awkward, interruptive and embarrassing. Very few injectors, in this study at least, were sanguine about their use. Two features of the negotiation of sexual encounters appeared to pose particular problems for the introduction of a condom in the situation. Firstly, use of a condom requires a degree of explicitness about sexual intent. Secondly, sex is very often represented as being an unportended, spontaneous event. Introducing a condom into the proceedings might be viewed as crudely setting the agenda in a situation which would otherwise be deliberately left ambiguous.

Introducing condom use into long term relationships was no less likely to be problematic. Condoms, if indeed they were used, were most likely to be used at the start of the relationship and then for contraceptive purposes. The use of condoms as barrier protection against possible HIV transmission could be seen as challenging the emotional fabric of the relationship.

The fact that the majority of women injectors were in sexual relationships with men who themselves injected suggests that they are at increased risk of heterosexual transmission. Beyond this there appear to be gender related behaviour expectations implicit in the ways in which men and women approach and manage sexual encounters. Men are expected to take the lead in sexual interactions, by inference if a condom is to be used it should be suggested by the man and so also should he be responsible for its supply. Expectations of female passivity and modesty do not encourage women to assert the desire for them to be used or to provide them. Traditional expectations of male dominance in sexual relations (and other spheres) make it that much harder for women to incorporate requests for safer sex into the process of negotiating the sexual encounter.

This situation is somewhat different for women working as prostitutes who appear to view condom use with clients in quite different terms. This is taken up in greater detail in the following chapter where the nature of the relationship between drug injecting, prostitution and risks for HIV infection are considered.

CHAPTER 6: STREETWORKING PROSTITUTION: THE RISKS OF HIV INFECTION

Introduction

Women who inject are much more likely to use prostitution as a means of financing a drug habit than are men injectors. This chapter will look at the relationship between injecting drug use, prostitution and HIV risks. The initial focus of this chapter will be to consider the greater likelihood that women rather than men will enter prostitution to fund a drug injecting habit. Once a woman is involved in prostitution she may become more and more financially dependent upon it to support her drug use. Providing an insight into the conditions of work for prostitutes, particularly those with drug habits links importantly with a consideration of the HIV risk behaviours associated with prostitution. Of particular note in this regard is the use of condoms with clients and consideration of the range of factors which might influence their use in commercial sexual encounters. The degree to which prostitute women are able to control the transaction is shown to bear importantly on their insistence that condoms be used. This is contrasted with the women's attitudes towards condom use in private, non-commercial relationships. Finally the risk that needles and syringes will be shared in the context of the red light district is considered.

The great majority of the field extracts used come from fieldwork in the red light district, therefore only those fieldnotes taken in other settings will be indicated.

A Woman's Hustle.

Addiction to illicit drugs is an expensive business. Even though Glasgow injectors are now more likely to make illicit use of prescribed drugs such as buprenorphine (Temgesic) and temazepam rather than heroin (Sakol et al, 1989) their frequent, sustained use can still create a good deal of financial pressure for the injector. The

majority of drug injectors in this study, as in others (Parker et al, 1988, Pearson, 1987b) were unemployed and lacking in either trained skills or qualifications. The main source of finance for many therefore lay in involvement in criminal activity. However, as was noted in chapter 3, there are notable differences in the ways male and female injectors become involved in criminal activity. These seem in large part linked to sex roles and the expectations of behaviour implicit within them (Rosenbaum, 1981b).

Whereas males are more likely to become involved in 'heavy' crimes such as burglary or assault (File, 1976, Ellinwood et al, 1966), women are predominantly involved in non-violent acquisitive crimes which provide a quick cash turnover (Datesman, 1985, James et al, 1979). The crimes women are most likely to become involved in are drug dealing (usually with a male partner), shop-lifting and prostitution. Often prostitution was represented by the women as being the last available but least attractive option.

Prostitution is a highly stigmatised activity which in itself may be sufficient to deter a woman from entering into it. This is despite the fact that it offers a relatively reliable means of regularly earning quite substantial sums of money. However, for many drug injecting women the pressures of funding an expensive habit and perhaps also those of meeting the clothing and feeding needs of children, may eventually override considerations of stigma and illegality.

Conditions of Work for Streetworking Prostitutes

The main red light area in Glasgow is situated in a part of the city which is mostly made up of offices. It is not a residential district and by night there are few amenities within the immediate area. At the time of this study for instance there were no local commercial outlets for sterile injecting equipment although there was

a prostitute drop-in centre. This supplies condoms and recently has begun to operate also as a needle exchange too.

Prostitute women can be seen working from as early as 5 p.m. until as late as 5 a.m. the next morning, although the time when trade is busiest is between about 9 p.m. and 1 a.m. The women tend to stand alone or in pairs on the streets whilst potential clients either drive by or walk along looking at the women. There is not usually any shortage of men looking to buy the services the women have on offer.

It is important to note that as much as potential customers are looking to buy so prostitutes make choices as to which client they will or will not provide sexual services to. Furthermore they are discriminating in terms of which services they are prepared to provide. So too are women discerning about the places they will take their clients. Some women will work in the nearby alleyways, others will only conduct business with men inside cars or in the confines of their own private accommodation. Whilst it is certainly the case that the women are there to make money this does not mean they are not discerning. This is scarcely surprising given the obvious dangers of getting into cars with strange men who for the most part are likely to be physically stronger than them. The decision as to whether or not to get into a car has to be made quickly because of the illegality of soliciting. Women have to make snap decisions on the basis of minimal clues such as whether or not they like the 'look' of the client. It is a measure of the women's potential vulnerability that their intuitive skills were in most cases all they had to go on. That these are not by any means foolproof can be seen in the two fieldnotes below:

> Tina told me how she'd been attacked the other night. She'd gone with a man in a car, he'd attacked her in the car park. She was surprised at the attack. "I always check them out and if they're dodgy I go 'oh no dodgy' and I don't go wi' them but this one he seemed dead plausible, y'know normal looking, quiet kind of guy, but when he was having sex he just started strangling me and biting ma neck." She said she'd become really scared and fought him off managing to get out of the motor and run away from him.

and:

> Kate described being 2 storeys up in a car park when the punter had turned on her with a shotgun. She'd jumped out of the car park, "when you've a shotgun stuffed down your mouth you've nae choice have you? She'd broken both her legs from the fall, he'd punched her all over and also bit one of her nipples off. It seems a miracle to me that she survived. Kate thought it was probably because she had taken temazepam so she was relaxed in the fall.

The women were discriminating in their choice of clients and which sexual services they would or would not provide. Some women would only provide vaginal sex, some only oral sex. None of the women reported that they would have anal sex. The following field extract gives the lie to popular conceptions of prostituting women being led entirely by consumer demand:

> While we talked a car drew up. Sally walked over to him but told us to wait because she didn't think she'd be going away with him and indeed she came back saying "he wanted sex." I asked her why she doesn't do sex (she does oral sex only). "I don't like it, all different men in you." Neil wondered if this was because of AIDS. "No, I've never done it."

Even so brief a description of the conditions of work for streetworking female prostitutes links importantly with the forthcoming discussion of the HIV risks associated with prostitution. The illegality of soliciting places a premium on the speedy negotiation of the encounter so that prostitute and client can avoid attracting police attention. This necessarily restricts the amount of time that can be spent negotiating safer sex and, importantly, weighing up the potential personal risks of getting into the car.

It is apparent from looking at the working practices of prostitutes that there is a good deal of variability not only in what services clients want but also what services woman are prepared to provide. This further emphasises how prostitutes differ one from another and how in turn their risks for HIV infection are individually variable. These depend not only on such factors as whether or not a woman injects but also

on the types of services she provides and whether or not she is willing, or able, to secure client compliance to use a condom.

I will now turn to a consideration of the financial value of prostitution and how this influences a woman's drug injecting habit.

Lucrative returns.

Women who become involved in prostitution quickly find themselves earning sums of money far in excess of any they could legitimately expect to earn. The fieldnote below is apt illustration of this earning power:

> Tracy exampled the kind of money she was making. "I got £100 the other night for gieing a guy a hand job (masturbation). Monday to Wednesday I made £450." She added that it did vary quite a bit.

The money may in itself be incentive to continue working as a prostitute. One consequence of this increase in cash flow is that many women find their drug habit increasing in proportion to the amount they can afford to spend on it. This process can perhaps be glimpsed at through a comment made by one woman injector who prostituted:

> When Lindy commented that she'd made a good bit of money last night I asked if that meant she'd had money left over for the next day (I suppose I was thinking she wouldn't have to work every night if she did well on certain nights). At this she just shrugged and said, "the more money you make, the more you spend, you just get a bigger habit that's all."

It was not infrequently the case that women reported drug habits costing between £100 and £300 per day. This relationship between the money available for drugs as proportionate to the size of an individual drug habit has been commented upon elsewhere (Fields and Walters, 1985). The relative speed with which women could earn tidy sums of money may be evident from this fieldnote:

> Paula (who has a heroin habit) said she was looking to make £90 so she could get away and score before coming back out again. She and her pal had earned £45 and £30 in the last hour. I puzzled, wasn't

> heroin usually about £80 a gramme? " Aye it is but we need money for taxi fares and that, fags..you know."

A prostituting woman is liable to develop a heavy and expensive habit. In turn this may necessitate that she work longer hours and more frequently to make sufficient money to pay for the drugs she needs. The quantitative data collected in this study tend to support this argument. Not only were drug injecting women in the absolute majority (59% of all prostitutes contacted over a six month period were injecting drug users) but they worked for longer periods of time and more frequently. The finding that 59% of the 208 prostitute women contacted were injectors stands in contrast to figures from London, Birmingham and Edinburgh (Day et al, 1988, Kinnell, 1989, Morgan Thomas et al, 1989), where the proportions of women prostituting to fund a drug habit are significantly lower (14%, 15% and 28% respectively). Those women who prostituted but did not use injectable drugs were observed less frequently and reported working shorter hours. Many indeed said they only worked when there were bills to be paid or because occasions like birthdays and Christmas were coming up:

> In passing one of the women not using drugs said she was only out working twice a week. "Sometimes I might not be out for 5 weeks - it depends if I'm heavy wi' bills or not."

Women may also be prostituting to finance their partner's drug habit, even though they may not be using drugs themselves:

> Jane told us she worked to support her man who uses drugs. "It was either that or the jail for him and I wanted to keep him out. I mean I knew he was a junkie when I started wi'him so I knew what I was takin' on, I love him to bits, it had to be done."

The data indicate however that this was not a common occurrence among non-drug injecting prostitutes in Glasgow. Indeed only 2 of the total 208 women contacted reported this to be their situation. It has been reported as more typical in other British cities (Kinnell, 1989, McLeod, 1982). More usually women reported themselves as working to finance their own habit and often also that of their

partners. Where women worked to service two drug habits they were clearly under increased pressure to work longer hours, particularly as some women reported that their partners ceased to earn money themselves:

> "Many's the time I've rushed back with enough to get Bill squared up, in the end he gave up shop-lifting and stayed in his bed the whole time. In the end I said 'tae fuck with this, I'm away working my arse off and he's in bed'. So I said, 'you're strung out now, right, so you can stay strung out because that's me and you can find me at ma Dad's, so I left.'"
> (Needle exchange).

It is possible to see how once a woman begins prostituting as a solution to the problem of funding an expensive habit she might find it difficult to give up that source of income. The speed with which relatively large sums of money can be made can lead a woman into developing a stable but high dose injecting habit which necessitates the continued use of prostitution as a means of meeting the expense involved.

Prostitution however produces its own pressures. Many women reported it to be increasingly exacting, both mentally and physically. Yet the money is so compelling as to make an exit from it difficult if the woman is to sustain her drug habit. Indeed, from many of the womens' accounts it appeared the case that they saw the cessation of prostitution as contingent upon the cessation of their drug use:

> Wendy described herself as completely fed-up with working the town. "I'm gettin' out of here. I cannae be doin' wi' this, it's doin' ma nut in, I'm gonnae get a de-tox, stop using and get a life for mysel'."

Women who reported periods of time when they did not prostitute were likely to add that during this time they had not been injecting drugs:

> Last night we met a woman who'd been off drugs for the last five years. Then she began 'dabbling' again and has subsequently developed a heavy habit which, she explained, is why she's started to prostitute again.

The pressure of having to fund an expensive and illicit drug habit by illegal, stigmatised and potentially dangerous means can also be seen as having an important bearing on a prostituting woman's risks of HIV infection. Having provided the context within which these risks may be situated, they will be considered in terms of condom use with clients and the control women have in their transactions with clients.

Condom use with clients.

Currently the sole recommended barrier against heterosexual transmission of HIV infection is the use of a condom combined with spermicidal lubricant (Hearst and Hulley, 1988, Stein, 1990). Although public health initiatives to encourage use of condoms among heterosexuals have not proved entirely successful, their uptake among prostitutes is reportedly high (Day et al, 1988, Padian, 1988). All of the women spoken to in this study reported insisting on the use of condoms with clients. The main cited motive for condom use was to protect against possible HIV transmission. Condom use was represented as being an habitual and integral part of the women's work. In addition to a generally stated preference for vaginal sex with spermicidally lubricated condoms, many women also used extra protection such as spermicidal sponges and virucidal creams:

> Anita added, I know I'm a junkie bird an' all that but I'm really clean, I always use condoms and C-film and sponges an' that". She very matter of factly said yes men did try to break condoms. "Oh aye, they try and do it as they get them on but you usually tipple before they get in you."

However, as this fieldnote shows, although the women saw condom use as part and parcel of the work, this attitude did not appear to be universally shared by their clients. This has also been found in other studies (Kinnell, 1989, van den Hoek et al, 1989). The majority of women who were asked said that clients would often request sex without a condom and would be prepared to pay extra for this service:

> We asked Sandra if she was ever asked to have sex without a condom "you get asked every night for it without a condom, some guys'll

> offer £200 without one in a hotel... no, no they're no' usual but I mean there's no-one type of guy. I mean they could be really rich or just regular kinds of guy, like just out the dancin' and wantin' a bit of business, but when you go to get the condom they're goin' 'oh no, turn it up, I'm no' wearing one o' them.'"

and;

> Cindy says she gets asked about 3 times a week to have sex without a condom, sometimes they'll offer £100 or so, and sometimes they'll not offer anything extra.

Although none of the women reported that they themselves would have sex with a client without a condom, they frequently pointed out that there were women who would provide this service. Non-drug injecting prostitutes tended to point the accusatory finger at the drug injectors:

> "It's the junkies that's doin' it, all the junkies." She recounted being attacked recently in a car by a guy wanting sex without a condom, "he goes to me, 'your pal done me without one.' I says, 'ma pal? Oh you must be kiddin' me on.'"

An important point to note is that once a woman has refused the client's request to have sex without a condom it is not usual that he will then comply with the prostitute's conditions. Rather it appears that the client's wish to have sex without a condom is not a negotiable demand:

> Mick (researcher) asked if you could negotiate with a client to wear a condom but she said no, they just asked somebody else, they didn't agree to wearing one. "They just keep on asking until they get one that'll do it without a condom."

Judging from the frequency with which the women said they got asked for sex without a condom and their reports that clients continue to look until they find a woman to accede to their requests, it would seem that some women, at least occasionally, are providing unsafe sex. The following fieldnote is an apt illustration of this:

> Linda said she'd been picked up by a punter last night and when she refused to do it without a condom he said he frequently got sex without one. "I says to him 'if that's the case how come you've picked me up?' He wasnae kiddin' either 'cos he pointed out the girl, knew her name and everythin' he said that she'd said to him 'want to gie me somethin' extra and I'll do you without a condom.'"

The unpopularity of condoms in the general population and among men in particular, has been well documented (Wellings, 1988, McQueen et al, 1990a). Condoms are claimed by many to reduce sensitivity and the overall pleasure of sex. These considerations may be enough for clients to try to avoid their use, instead they may try and employ other means of reducing the risks associated with the sexual encounter. Prostitute women reported clients making assessments of the likelihood that they had HIV on the basis of how 'clean' they looked and also whether or not they injected drugs. As this woman commented:

> "It's no' us that's needing testing or educating, it's them, the men, they're the one's askin' for it without a condom, you can't believe some of the things they ask you, like they'll say to you they want it without a condom and you say you don't do it without one, then they'll say 'but you look clean to me.' I say to them 'how, you think you come with AIDS stamped on your forehead? You cannae see it on a person.' Then they'll say 'but I'm clean' and again you say 'but how do I know you're clean?'" She also said that some men said she was too old to have AIDS which made her laugh.

The likelihood of a male client contacting a drug injecting prostitute in the red light district is extremely high both because they constitute the majority and because they work more frequently and for longer hours than their non-drug injecting counterparts. The inability of clients to distinguish between those women who inject and those who do not was often commented upon by the women:

> Anita said she'd just done business with a client who'd wanted to be sure she wasn't using drugs (she does). "He checked and checked and double checked ma arms for track marks." In the end he believed her when she said she didn't inject drugs.

From the women's accounts it would seem that some clients, and indeed some of the non-drug injecting women, believe the red light area to be spatially divided into discrete areas worked by women who inject drugs and those women who do not. Fieldwork experience showed however that reliance on spatial distinction was no measure of whether or not a woman used drugs:

> Mandy (a drug injector) said she worked up at the top (north end) of the red light district. "You get a better class of punter 'cos they don't think you get junkies up here". She said that a punter had

> asked her how you could recognize a junkie. "I said 'I don't know how you can tell', and me a junkie too."

Client reliance on external cues such as physical appearance or location can only be viewed as a wholly inadequate means of minimising the risks perceived to be associated with prostitution. This much was expressed by a prostituting woman who herself does not take drugs:

> "Punters say to me they can tell a woman who's using but they cannae tell. Especially now there's women using different drugs like Temgesic, and I reckon they make a bird look really straight."

Despite having spoken to approximately two thirds of estimated numbers of street working women, only two have said that they had themselves provided a client with sex without a condom. This and other observational data, suggest that a 'code of practice' operates among streetworking prostitutes. Firstly a woman should not undercut an accepted price structure for sexual services to clients and secondly she should not have sex without insisting on the use of a condom. This code of practice appears to operate more widely than among Glasgow streetworking prostitutes as it has been reported by researchers in England and in North America (Lawrinson, 1991, Shedlin, 1990). The strength of these prescriptions was often demonstrated during the fieldwork period, women would constantly refer to them and pointed out other women whom they felt were in breach of these norms:

> We were standing with a group of women when one began telling Anna about a woman she knows has sex with clients without a condom. She was clearly disgusted by her. "See that wee Jane doin' it for fivers and without a condom I caught her in the act, she couldnae deny it." I asked how she'd caught her. "Well see, no' bein' rude or nothin', a punter stopped me and said he wanted to come in ma mouth and I said 'oh get t'fuck, I'm no' doin' any of that' and then I came up here to talk to Anna and I sees wee Jane gettin' out the same motor so I says to her 'you've just done business without a condom and you've done him a gam' (oral sex) and she was like that (embarrassed). She pulled a reddy (red face). I was gonnae batter fuck out of her but her man was standin' across the road and I thought he might batter into me so I left it"

Relations between prostitute women who injected and those who did not were often strained if not openly antagonistic. Many of the non-injecting prostitute women

claimed that it was the injectors who provided sex without a condom and for less than the accepted price. These accusations may just reflect the hostility which many non-injecting prostitute women expressed towards injectors. However it is also the case that injectors do share a pressing need to inject at regular intervals, if they are to avoid the unpleasantness associated with withdrawal from drugs. A woman who has begun to withdraw but does not have sufficient money to buy drugs may well be tempted by the offer of extra money for sex without a condom:

> Sally talked about experiencing withdrawal symptoms the other night; "and there was this guy driving all around this town trying to get someone to do it without a condom. He was offering £100 for it. It's the first time I've ever really thought about it, you know I was like that (she gestured to show how bad she'd felt) but I just ended up saying 'oh no, I can't do that.' In the end he got another lassie to do it."

The unpleasantness associated with drug withdrawals is common to all injectors. However, they may be especially unwelcome in the specific context of work in which women are competing with other women to attract men to buy sexual services from them. Some women claimed to find it very difficult to concentrate on work when they were suffering withdrawals:

> First thing Jane said to me was that she was 'strung out'. "I cannae work when I'm strung out, I've been down here since half six and I've done nothing (it was 11.30 p.m.)."

Even where a woman was not experiencing withdrawal symptoms she might still feel under a good deal of pressure to earn money, whether for her own drug habit or for her partner's and possibly also for other things such as child care or debts or court fines. Fieldwork experience suggested that even though women who were not injecting drugs might also have debts and the such like to meet, there was not the same urgency as that observed among women working to service one (often two) drug habits. This was expressed by a woman describing the difference between drug injecting prostitutes and non-drug injecting prostitutes:

> "A lot of junkies have got to be wider (streetwise) because the whole time they've got a customer they're thinking about a hit and the more

> money they get the more heroin they get. That's always in the mind, how to make more money, more money."
> (Residential detoxification unit)

It would clearly be untenable to suggest either that it is *only* drug injecting prostitutes or that it is *all* drug injecting prostitutes who provide clients with unsafe sex. However, given the kinds of pressures faced by prostitutes who are drug dependent it is at least likely that some will have acceded to client requests for unsafe sex in return for higher payment. In such cases there is a risk that HIV infection could be sexually transmitted.

Controlling the transaction

Where the use of condoms has been examined situationally it is apparent that very often the issue of whether or not a condom will be used is determined by who is in control of the situation (Stein 1990). For example as was noted in preceding chapter, in the traditional formulation of heterosexual, non-commercial, sexual relations there is an expectation that the power balance will be weighted in favour of the male (Richardson, 1989). This reportedly makes it difficult for many women to insist on the use of condoms (Holland et al, 1990a). In prostitute/client encounters the situation is reversed, prostitutes seek to manage and control the interaction from beginning to end and part of this is the insistence that clients use condoms.

In many senses the prostitute/client relationship is exactly opposite to normative expectations of male/female sexual relationships. It is pre-eminently and overtly a business transaction, women describe what they do as 'business', when clients approach they ask them if they are 'looking for business.' Whether drug injecting or not, prostitute woman seek to manage their interactions with clients as completely as possible. At the outset the women determine the price, the services on offer and the place where sex will take place. Once agreed, the women insists on payment before the provision of sexual services. The assertive stance adopted by the women is demonstrable from the following fieldnote:

> We stood with a group of three non-drug injecting prostitutes when a man approached on foot making a bee-line for Irene. He asked her for sex, shaking her head she flatly replied that she didn't do sex outside. He then said he had a car. Looking straight at him Irene said "well, it's £10 for sex in a motor." He agreed the price and with that Irene walked away with him. Throughout this it was very clear that Irene was in control of the transaction of business, making plain her terms and conditions and seemingly inflexible in the application of those conditions.

It is noteworthy that in determining the terms of business there is the complete absence of any emotional input. The explicit agenda is agreement on the terms of the transaction. In asserting these terms the woman takes charge of the situation. This can be contrasted to non-commercial sexual encounters which, as I have indicated in chapter 5, appears (at least at the outset) to be deliberately left ambiguous with both parties avoiding explicit articulation of the desire for sex to take place.

The controlling stance adopted by the women in their relations with clients creates the conditions for insistence upon condom use by placing it as integral to the process of negotiation between prostitute and client. This is illustrated in the fieldnote below where a prostitute is engaged in negotiating with a client:

> I was standing talking with a prostitute woman when a man slowly walked past. Seeing this the woman turned round and asked him if he was looking for business. He didn't appear to speak much English but he clearly was and asked about prices. "Aye, well its £10 in a motor and £25 in a flat." He said he had no car to which she replied; "it'll have to be in a lane then." He then asked "with or without Durex?". She didn't understand at first, then she said "oh no it'll have to with Durex, unless you wank yersel off and I'll let you have a feel o' me for £15." He replied "I want to fuck but I don't really like Durex." In response the woman said "well you got to wear one if you fuck, if you'll no wear a Durex then I'm no' doin' any business wi' you. None of the lassies will do it. It's too dangerous, you should mind that by the way."

The establishment of directive relations with clients and being able to insist upon condom use seem to be linked. This linkage seems further confirmed when considering the reasons for the relatively low levels of condom use among Glasgow

streetworking rent boys. A major difference between Glasgow rent boys and Glasgow streetworking female prostitutes lies in the difficulties reported by the former in being assertive in their dealings with clients (Bloor et al, 1990, Barnard et al, 1990). In particular it is noteworthy that Glasgow rent boys do not on the whole assert that it is a business transaction by determining the price and demanding payment before providing their services.

It may be partly in response to the many dangers inherent in prostitution, together with a recognition of their own vulnerability that encourages women to assert control over the transaction. The women do not so much negotiate with clients as create the conditions for their compliance. This is not to say that clients do not attempt to subvert those conditions. This has similarly been found in a study of streetworking prostitutes by Lawrinson (1991). The fragility of these notions of control over clients are exposed by the women's accounts of client violence directed at them. Women reported being raped by clients, thrown out of moving cars and threatened with weapons whilst in cars. Clearly a woman's ability to insist upon condom use is much reduced in a situation where the client refuses and threatens with violence or intimidation:

> Susan said men asked for sex without condoms frequently. "Some get aggressive if you say you don't do that." Tanya added that earlier in the week an oldish man tried to force her into giving him oral sex without a condom. "When I says no, he started trying to force ma head down there, so I shouted out and two lassies came down the alley and chased him."

Another factor influencing the degree to which a woman can maintain control over the transaction relates to the quantity and type of drug a woman might have taken.

Many women report prostitution to be a stressful occupation, clients can be dangerous, police can arrest them and no woman could fail to be aware of the stigma attached to the work. Women often reported that their response to these

pressures was to try and numb the experience by making sure they had injected drugs both before and after work, as these two women report:

> "Working in the streets puts a lot of pressure on your mind because of what you're doing... A lot of times I'd a hit before I went to ma work so I didnae think about it and then after I left ma work I'd have a hit."
> (Residential detoxification unit)

and;

> "It's no' easy money, it's quick money but it takes a lot of bottle. Your head's wasted with it, that's what used to stop me from working. I just couldnae handle it."
> (Residential detoxification unit)

The use of drugs not only as an end in themselves but also to numb the experience of prostitution sometimes resulted in women working whilst clearly not in full control of themselves. Misuse of temazepam is a particular case in point as it is especially associated with lack of control and awareness (Klee et al, 1990). One has to wonder at the chances of negotiating any kind of safe sex whilst heavily intoxicated with drugs. The following is a case in point:

> We saw Anna, a woman we know to be injecting. She staggered across the road barely able to walk and then collapsed in the doorway. Mick (researcher) and I walked over to see if she had hurt herself or if she was about to overdose, she certainly looked close to it, but she pulled herself up and lurched across the road again, presumably to look for business.

It would be unfair to suggest that this is typical of all drug injecting prostitutes. However the potential for this type of situation clearly exists where women who inject have adequate finance and access to drugs whilst working in a stressful occupation.

Condom use with private sexual partners

Many studies have shown that drug injecting women are most likely to have partners who are also injectors whereas the obverse is true for men injectors (Cohen et al, 1989, Donoghoe et al, 1989b, Sheehan et al, 1988). This study was no different, almost without exception the partners of drug injecting prostitute women

were themselves injecting drug users. These women are thus at risk of heterosexually acquiring or transmitting the virus from or to their partners.

Even though it is widely accepted that condoms are a relatively effective barrier against HIV infection, they remain generally unpopular at least in the context of non-commercial sexual encounters. The cited obstacles to their use are largely social. To suggest the use of a condom is not a neutral activity, on the contrary it is one invested with social meanings and significance which neither party may wish to convey to the other (Weinstein and Goebel, 1979, Kent et al, 1990). Prostitute women appear to attach specific significance to their use in their private relationships which relates to their use of them for commercial sex. They reported a reluctance to use them in their private sexual relationships seeing their non-use as an important, even essential means of differentiating between the two:

> Jenna said she didn't think many women would want to use condoms with their private partners. "I think they think to themselves, well I don't want to do it if it feels like I'm still working, I felt like that with ma boyfriend. I didnae want to use a condom.. Mostly girls that don't use condoms it's because they've got that at the back of their mind about working the town."
> (Residential detoxification unit)

When asked whether or not they used condoms with their private partners the majority of women replied in the negative. This finding is in keeping with studies elsewhere (Cohen, 1989, Hooykaas et al, 1989, van den Hoek et al, 1988).

The distinction between condom use in commercial sexual transactions and in private sexual relationships is noteworthy. Whereas condoms were mundanely regarded as integral to their work as prostitutes, and specifically as a means of avoiding possible infection, few women even considered their use with private partners. Where condoms had been used, women were apt to describe the occasion as atypical, as "a one off" and "for a laugh." It is worth noting that the majority of prostitutes were in long standing relationships with their partners. As was noted in

the preceding chapter condom use was less likely in these contexts. Where women wanted to protect against conception they would be more likely to use the contraceptive pill. The following fieldnotes are illustrative of the women's attitudes to condom use with their boyfriends or husbands. These appear in keeping with attitudes towards them voiced by heterosexuals in general:

> "No, I've nae need to (use them). I know I've no' got the virus and I know he's no' got it, so what would be the point?"

and;

> "No, we've never used them. I could do I suppose, safer I suppose in the long run, but we don't."

and;

> "No, I've never used condoms. A couple of times out of curiosity, y'know." Another girl added "once we did it for a laugh. I wouldnae though."

Unprotected sex with a private partner who is also an injecting drug user might expose a woman to greater risk of HIV infection than that posed by the client (Ward et al, 1990, Rosenberg and Weiner, 1988).

Injecting drug use and risks for HIV

It was evident from the fieldwork that although some women would inject only before and after their work, others were injecting during the course of the evening. Drugs were for sale in the red light district itself and money was being made to buy them with. However, as previously noted, the red light district is situated in a primarily commercial setting and during the fieldwork period (1989-90) there were no local facilities for buying or exchanging sterile injecting equipment. It was not uncommon for women to report that something had happened during the course of the evening to render their injecting equipment useless. For example the needle might have snapped or the syringe blocked. In the event of this happening a woman has one of two options, either she foregoes injecting at that point in time or she takes a risk and uses someone else's needle and syringe. It has already been

mentioned that many of the women actively sought to numb their awareness of their work and additionally reported finding it difficult to work whilst experiencing withdrawal symptoms. For the majority of women foregoing drugs was not an option. By taking drugs orally or intranasally a woman could avoid the risks of using someone else's injecting equipment. However these methods of administration appear unpopular among Glasgow injectors who report their preference to inject drugs wherever possible.

In the red light district a woman wishing to inject but lacking a needle and syringe will have to borrow a set, most likely from another woman also working there:

> We asked three women we were speaking to if they were ever asked to lend needles and syringes. "Oh aye, like that lassie the other night goin' round askin' everyone if they'll lend her a set. She even asked me but I said I don't carry any on me. I mean she asked me and I'm a stranger. She was askin' everyone, she could've used someones that's got AIDS."

In much the same way as the woman spoke of others having unprotected sex with clients but not themselves so too was there a reluctance to admit to asking for anyone else's used needle and syringe. Women also reported that men would ask to use their needle and syringe:

> As I approached a woman whom I thought to be working a guy came over, obviously intending to speak to her. I thought he was a client so I walked on by. Still within earshot I heard him ask her something about needles. When he left I enquired if he'd been asking for a loan of her works. "Aye, I gave them him". Had she minded? "No, I didnae mind". I wondered if she expected to hit up again tonight. Her answer was vague and seemed unthinking. "Well if I can get the money together, aye". I tried to find out if she had an extra set on her to enable her to inject but she just said she had some at her house, adding; "they're shot though".

Two inferences can be made from this fieldnote. Firstly the woman did not see anything remarkable in giving her needle and syringe away which does suggest a certain casualness regarding the use of another's equipment. Secondly, had this woman earned sufficient money to inject again that night she might well have had to

use someone else's equipment as, by her own admission, she had given away her only functioning set.

Of course needle sharing is an intrinsically risky activity whether or not it happens in the red light district. However the specifics of the situation encountered late at night in an area where at the time of this study there was no local availability of sterile injecting equipment, combined with a preference or need to inject to counteract withdrawals or the pressures of prostitution, could be sufficient inducement for a woman to take the risk of using someone else's injecting equipment. The risks involved in using someone else's injecting equipment might actually be higher in the context of an area populated by women coming from different parts of the city, some of which will have higher HIV seroprevalence rates than others.

Conclusion

Prostitution although lucrative is a hazardous business. The risks of HIV infection are one aspect of those hazards. By asserting control over the transaction with clients the women were often able to determine their terms and conditions, including the negotiation of safer sex. There are however a number of factors which compromise the women's control of the transaction. Unsafe sex might occur in consequence of client coercion or intimidation or through a decision to take up offers of extra financial remuneration for sex without a condom. A woman might not be in full charge of her senses either through excessive drug use or use of drugs which impair her judgement. In these circumstances she may not be able to negotiate very much at all.

Additional HIV related risks refer to the specifics of a situation where women injectors are prostituting primarily to buy drugs in an area where sterile injecting equipment was unavailable. Finally, one has to consider the risks of unprotected

sex with husbands or boyfriends of whom the majority are themselves injecting drug users. Considered together with the evidence on HIV transmission between female prostitutes and clients, it would seem that contrary to widespread media reports, it is prostitute women whom are most in jeopardy of contracting HIV infection, be it through their private sexual relations or their injecting drug use. Since HIV positive women are widely practising safer commercial sex, the danger of infection to clients is small unless they attempt to rape, intimidate or bribe the women into unsafe sex.

CHAPTER 7: CONCLUSION: METHODOLOGICAL, RESEARCH AND THEORETICAL IMPLICATIONS

There are four dimensions to this concluding chapter. In the first instance I will provide a brief summary of the major research findings of this study. The HIV related risks of needle and syringe sharing, heterosexual sex and streetworking prostitution will be summarised in terms of whether or not gender-related behaviour differences place women, or men injectors, at greater risk of HIV infection. Following on from this I shall consider the methodological implications arising from this work. Thirdly, during the course of this research a number of issues worthy of further research became apparent. These are briefly outlined here. Lastly, perhaps most importantly, the theoretical underpinning's of this work are considered in terms of their relevance to other work similarly concerned with evaluating risk behaviour.

Summarising HIV risks for men and women injectors

Close consideration of injecting drug users gives the lie to characterisations of injecting drug use as uniformly experienced by men and women. Men and women enter by different pathways into an injecting drug using lifestyle and their experiences of a drug injecting lifestyle are quite clearly demarcated by gender. Differences in the orientation of men and women towards injecting drug use are reflected in those behaviours which carry a risk of HIV transmission. Examining patterns of HIV spread *within* populations of drug injectors is valuable not only in its own terms, but also in terms of what it says about the potential direction of HIV spread more widely in the general population.

In highlighting differences in the behaviours of men and women injectors it became apparent that although there were ways in which men were at increased risk of infection it was women injectors who appeared to be most at risk of HIV. This

finding is supported by figures from Communicable Diseases (Scotland) Unit which show proportionately higher rates of infection among women injectors in Glasgow (Answer, 1991a). This is further underlined by the consideration that men injectors outnumber women injectors by 2.6 to 1 (Frischer, 1992b) Before considering the ways in which the behaviour of women injectors might place them at higher risk of HIV infection attention shall first focus on the situation for men.

Two particular trends are noteworthy among men injectors. Firstly, men are more likely to commit arrestable crimes and be sentenced for them than are women. They are therefore more frequently imprisoned than are women. Once inside prison they are more likely to come into contact with injectable drugs and, if they do inject, will be highly likely to have to use an unsterile needle and syringe. Other research on the numbers of men using the same needle and syringe whilst in prison has shown that the numbers of people involved can be high. Clearly this is one very obvious way in which HIV could potentially be transmitted to large numbers of people.

Secondly, in analysing patterns of sociability amongst injectors it became apparent that friendship patterns were quite different between men and women. Young unattached men and women both tended towards single sex grouping. However whilst young women tended to have one or two 'best friends', young men were more likely to have a wider peer group. Contact with the peer group continued to be important even where men were involved in relationships with women. On the other hand, women's contacts with their female friends tended to be somewhat overshadowed by their relationships with men, particularly once they had children. Differences in the patterning of friendships for men and women were reflected in the pattern of needle sharing emerging from injector's descriptions of situations within which they had most recently shared injecting equipment. Men were more likely to instance having shared in the company of two or more men friends.

Men injectors appear on the basis of these data to be more likely to share injecting equipment in high risk situations. Injecting in prison poses the obvious question as to how many people might have used the needle and syringe previously. Making shared use of injecting equipment in a group situation raises similar kinds of questions. As these behaviours are more likely to be found among men injectors it seems that in this respect they are at higher risk of HIV.

The classic high risk scenario is one where an unsterile needle and syringe is used by large numbers of people. This was not commonly reported by women injectors. On the contrary women were more likely to report using a needle and syringe which had been used by one other person, usually someone well known to them. In the majority of cases women injectors had boyfriends who were themselves injecting drugs. Some of these women reported not using the needle and syringe of their partner, they were however few in number. Most of the women used the needle and syringe of their partner either habitually or, less frequently, when the need arose. This is quite a different situation to that among men injectors since the overwhelming majority were not in relationships with women who used or injected drugs.

Those women who reported sharing habitually with partners were clearly taking high risks, just because of the frequency with which they used unsterile needles and syringes. The degree to which such sharing was exclusively between partners must be something of an unknown quantity, even perhaps to those concerned. Certainly in some cases it was evident that there had been some needle sharing with people outside the relationship which suggests the fragility of risk reduction strategies dependent on an equivalent commitment from both partners.

It is of course the case that both partners are at risk of HIV transmission where needles and syringes are shared between them. However, given that the majority of women are in relationships with injectors whereas the same is not true among the men, one would have to conclude that in this respect women are at higher risk of HIV.

At least part of the reason why so few men injectors had partners who injected drugs related to societal expectations of appropriate behaviour for women. Drug injecting men often disparaged women injectors claiming to find injecting drug use unacceptable in a woman. Some men framed their objections to having a relationship with a woman injector in terms of the economic difficulties in sustaining two drug habits. Others argued that a woman who injected would inevitably become a prostitute, some few argued that this would increase their personal risk of HIV infection. In the main though they appealed to a more general sense of the moral impropriety of a woman injecting drugs.

This is indicative of a more pervasive difference in the experience of injecting drug use for men and women. Women are more heavily stigmatised for their involvement in an injecting drug using lifestyle than are men. The explanation for this appears embedded in societal expectations of gender appropriate behaviour. Women's roles are defined primarily in relational terms, they are supposed to be carers and nurturers, whether mothers or wives. This role carries within it the expectation of passivity in contrast to the male role which is defined by activity, assertiveness and independence. Boys and men are encouraged to take risks and are judged positively for doing so. This is not the case for girls and women whose socialisation teaches them to eschew risk taking behaviour. A woman who injects drugs is at odds with these behaviour expectations since she is seen to be actively involved in satisfying her own needs rather than those of others.

No women so socialised could fail to be aware of the low esteem she would be held in having once transgressed these norms of behaviour. It may be partly in response to this that drug injecting women have partners' who themselves are injectors. Beyond this however, the weight of the stigma attaching to female drug use does not encourage them to make public their drug use. In their reluctance to indicate that they had a drug habit many women reported not buying or exchanging their own injecting equipment but relying on others (often boyfriends or husbands) to do so. In so doing they were dependent on others and hence more vulnerable than if they secured their own injecting equipment. The stigma attaching to female drug use might then be characterised as potentially contributing to higher levels of risk behaviour among women injectors.

Similarly in the sphere of sex and the negotiation of sexual encounters, expectations of behaviour appropriate to a woman appear to be out of kilter with the assertive and also explicit stance consistent with negotiating safer sexual practices. To a degree men and women are equally disadvantaged in this respect since both are primarily socialised into a culture which on the whole shies away from frank discussion of sexual matters. However, this situation is further exacerbated by expectations of male dominance and female modesty. In sexual matters at least, women are not expected to take the lead over men. If they do so they risk being negatively labelled as sexually loose and available. Given an existing power balance in favour of men it may be extremely difficult for a woman to assert her desire that a condom be used. Similarly it was the case that women reported a reluctance to carry condoms. This appeared to be in response to the negative social comment which attaches to women apparently prepared for sexual intercourse.

In this study condoms were reported as being rarely used both by men and women in non-commercial sexual encounters. A variety of reasons were given to explain their unpopularity. The main reason cited by men for not using condoms was that

they did not see themselves at risk of sexual transmission, particularly if their partner did not use drugs. This of course begs the question as to the risk they posed to their partners which, presumably, was not part of their calculations. For women injectors in sexual relationships with men who injected and with whom they had shared needles and syringes, the use of condoms might seem a rather redundant gesture.

The use of condoms in long term relationships raises a different set of issues to their use in casual sexual encounters. Socially constructed notions of emotional intimacy and physical closeness may appear to be at odds with the use of condoms because they create a barrier which can be seen as much in symbolic as in physical terms.

The social ramifications of introducing or sustaining condom use in relationships may be considerable, potentially creating distrust or uncertainty between people and raising issues which might be considered better left unsaid. A good example of this is instanced by the use of condoms by prostituting women in their non-commercial, private relationships. Having a sexual relationship with a drug injector where condoms are not used probably places a women at greater risk than she faces in her commercial sexual encounters where condoms are used. However the need to make clear the distinction between personal and commercial sex might be sufficient to rule out the use of condoms in private relationships.

Women who want to become pregnant inevitably have to expose themselves to mischance. The positive personal and social value which accrues from motherhood may be that much more acutely appreciated by drug injecting women aware of their poor social status. It may, in fact, be more of a salient concern than consideration of the associated HIV risks.

In this study the possible HIV risks associated with injecting drug use and prostitution exclusively concerned women. None of the men injectors interviewed reported the use of prostitution to finance their drug habit. All the prostituting women injectors contacted worked the streets in the city's main red light district. The preponderance of women injectors working the streets rather than other locales such as massage and sauna parlours appears to be related to their drug use. Women report that sauna managers are averse to employing known injectors and would check job applicants for track marks and other tell-tale signs of injecting drug use. Furthermore the chaotic lifestyle associated with a drug habit militates against working regular hours.

The association between prostitution and HIV risk is still uncertain in Europe and North America. There are however concerns over findings of raised levels of HIV among drug injecting prostitutes. In practical terms the risks of HIV transmission should be negligible provided that barrier protection is consistently and successfully used with clients. The prostituting women in this study (whether injecting or not) reported habitual condom use with clients. Nonetheless, fieldwork experience indicated the potential for unsafe sex to occur. This could be with the consent of the prostitute, or accidental (through condom failure), or as the consequence of client subversion of the prostitute's wishes.

Although it proved almost impossible to obtain self reported data on the provision of sexual services without a condom, a good deal of indirect evidence suggested that it did occur at least on an occasional basis. Offers of financial reward for unprotected sex were commonly reported by the women. Anecdotal evidence suggested that these offers were more likely to be taken up by those women who were injectors. Prostitute women with drug habits to support often appeared to feel a greater and more immediate pressure to earn money than was apparent among those prostituting women who did not take drugs. This is also reflected by

differences in their working patterns. Prostitute women who injected worked longer hours and more frequently than their non-injecting counterparts. The pressure to earn sufficient money to cover their drug costs and avoid withdrawals may have been exacerbated where women were also working to support the drug habit of their partner.

Even where women are consistently using condoms there remains the danger that they will accidentally tear or rip. Sexual practices such as vaginal or anal sex may be more likely to result in this. Unfortunately it is precisely these activities which carry most risk of HIV transmission. In addition to this, prostitutes reported that some clients would attempt to remove or break condoms during penetrative sex.

All prostitute women are similarly constrained by the illegality of soliciting and the effect this has on their working practices. When clients express interest in a woman she has only limited time available to make decisions about the relative safety of going alone to what are oftentimes dark and deserted places. Dangerous, violent men are an occupational hazard of prostitution. Many women reported physical assault including rape from clients. The scope for insisting on condom use in these situations must be seen as highly circumscribed.

In negotiating the terms and conditions of the commercial sexual encounter women take an assertive, business-like stance. This has the added advantage of aiding them in insisting on condom use as an integral feature of the service being negotiated. Women who prostitute whilst not fully mentally aware are not in an especially good position to negotiate the sexual encounter. Excessive use of drugs, or use of drugs like temazepam which have a marked effect on mental awareness, are two such scenarios within which it is difficult to imagine any kind of negotiation, including that of safer sex.

This study indicated a marked discrepancy between the forthright negotiating stance adopted by women in commercial contacts with clients compared to ways in which private sexual relationships were reportedly framed and managed. The majority of prostitute women in this study conceived of their relationships with boyfriends or husbands in terms consonant with heterosexuals in general. This was reflected in their attitudes towards condom use with partners. Indeed as was noted earlier, some women framed their objections to condom use in terms of their use for commercial sexual encounters.

Injecting with unsterile needles and syringes and having unprotected sex are activities which carry a risk of HIV whether they involve men or women. However, because these are behaviours which are pre-eminently social and so also influenced by people, time and place, it is perhaps unsurprising that the pattern of HIV spread is not uniform. Gender influences behaviour, this influence does not cease because of addiction to drugs. Men and women are socialised according to different role expectations, the effects of this socialisation are ubiquitous and extremely influential. This is reflected in men and women's experience of an injecting drug using lifestyle and its associated HIV risks. The influence of gender on behaviours which are a risk for HIV has been shown in the areas of needle and syringe sharing, heterosexual sex with private partners and the use of prostitution by female injectors.

Differences in the HIV related behaviour of men and women injectors raise the implicit question as to whether these result in men or women being at greater risk of HIV. On the basis of this study women injectors appear more likely to come into contact with HIV infection. It is somewhat ironic that the behaviours which place women at higher risk of HIV relative to men injectors do not, contrary to popular stereotypes, come as a result of wild and reckless behaviour. Rather they

appear primarily to derive from the socio-structural circumstances of injecting women and the influence these have on their attitudes and behaviours.

Having summarised the study results, consideration is given to the methodological implications of this work. Following on from this possible avenues for future research will be identified. Finally I will conclude with an assessment of the theoretical implications arising from this study.

Methodological Implications

It is perhaps predictable that the methods chosen at the design stage of a research project should be influenced and modified by practical experience of their use in field research. Each research project throws up different problems the resolution of which have implications for other research projects. In this section I will consider three of the most salient methodological implications which presented themselves during the course of this research.

The first of these implications concerns the assumption often made in ethnographic research that having secured access to the study population it is a relatively straightforward step to obtaining access to information usually privy to group members. This feeds directly into the second point to be made. In social relations there is generally the expectation that sensitive subjects can only be broached with the advent of sufficiently close and trusting relationships. However this is not necessarily the case, at least in so far as research relationships are concerned. On the contrary, discussion of sensitive issues for the purposes of research may be hampered by the development of closer, more seemingly personal ties. The third issue concerns in particular the problems of conducting research on hard-to-reach populations.

Securing access to the study population is clearly a crucial first step in ethnographic research. However access is not a once and for all event. There is in fact no necessary reason to suppose that establishing contact with the people one studies will lead to the provision of information usually restricted to group members.

The assumption implicit in qualitative research is that over time the researcher will gain sufficient trust and acceptance from group members to be able to pass as a member and enjoy its attendant privileges, particularly as regards access to information. This research indicated that membership did not have a fixed quality rather it was fluid and elastic. The criteria for exclusion or inclusion as a member were apt to change in response to contingencies of time, place and person. A key feature of drug injectors' identification with each other was their involvement in a drug injecting lifestyle. However the influence of other factors such as age, class and personal familiarity had an important role to play in influencing the criteria for including or excluding people in certain kinds of situations. In practice this meant that information was not freely available to all, but shielded or modified according to circumstance. Unsurprisingly this was also the case for the researcher whom in being accorded peripheral membership status had to expect greater restrictions on what could and could not be heard or observed.

The management of information remained a feature of interaction throughout fieldwork. At least a part of the reason for this lay in the fact that the study population were engaged in an illegal and stigmatised lifestyle which placed a premium on the careful guardianship of information which could be used to their detriment.

Whilst good research relations did facilitate the collection of good quality data there were limits to the data it was possible to collect through reliance on this means. Not the least of this was because shifts in the criteria for exclusion or inclusion

were contextually related to perceptions of the researcher and her role and the value attributed to the information sought.

There were a number of ways in which it was possible to exploit or extend the limitations of the membership role accorded the researcher. Examination of those situations within which it became apparent that information was being shielded became interesting in their own right. They allowed critical reflection on the ways in which the researcher was perceived and the onus placed on certain kinds of information in certain situations. In itself the decision to limit the flow of information could be a revealing source of data. It was for example illuminating that injectors interviewed in the hospital detoxification ward withheld information relating to their drug use whilst on the ward until later. Quite apart from anything else it was a clear indication of the role attributed to the researcher which, despite assurances to the contrary, was not viewed neutrally.

A strategy used in circumstances where the research subject was apparently managing information was to challenge the account given on the basis of a display of appropriate 'insider' knowledge. This could and did result in some injectors altering their accounts of certain situations. Where this was not possible it was sometimes valuable to relate anonymously an account given by one injector to one or more others. This was a useful means of assessing the likely validity of the account and furthermore supplementing it with the interpretations given by other injectors. A means of countering for the influence of the setting was to request the same information from the same person in another context. Differences in the accounts given often bore an interesting relationship to the structure of the setting indicating the degree to which information was context bound.

The development of good, amicable relationships with the people we study is probably a first necessary step towards the collection of data relating to the lives of

those people. It is however an act of faith to suppose that this of itself will lead to the provision of all kinds of information. What seems to happen is that research subjects trust the researcher to a degree and will extend some degree of membership with its attendant privileges. They are aware of the limitations of the contact between themselves and the researcher and appear to retain a clear sense of the boundaries. So even whilst membership can be awarded it can be taken away and this may be especially likely where issues that are seen as sensitive are touched upon. Insight into the lives of others often appears to come not merely from that which they are willing to show but from what they want to hide from view. In accepting the limits of the position researchers often come to occupy in the lives of those they study, it is also possible to exploit and use it in ways which throw further light on the subject of enquiry and help deepen our understanding of the complex layering of social lives.

In social research there is the expectation that the most sensitive or 'true' details of a person's life will be forthcoming once the research relationship is sufficiently deep and trusting. However this is not necessarily the case. On the contrary in the context of this research it became in some cases increasingly difficult as contact increased to make research enquiries into sensitive areas of a person's life. Enquiries into sexual lives for instance were often more easily managed at the outset when the relationship was most clearly a research one.

Pollner and Emerson (1983) note that fieldworkers should try to establish research relationships which are a combination of both distance and rapport. However in trading on personal relationships to collect data it is not always easy for researchers to maintain the distance implied in the research role. This may be especially the case if research subjects are actively involved in establishing a personal rather than a professional relationship. In practice, maintaining distance and rapport is often something of a juggling act.

One means of retaining the distinction between a professional role and a more personal relationship might be to avoid letting the relationship take on the trappings of an alliance, chiefly in terms of limiting the reciprocal flow of personal information which characterises close friendships. Retaining an essential distance with the research subject might be especially important when requesting sensitive details which relate to sexual lifestyles.

Researchers might consider ways in which that distance could be formalised at points where it is thought that the personal relationships established with research subjects might impinge upon the divulgence of more sensitive kinds of information. It might for instance be valuable to include the use of a formal research schedule as a means of re-stating the primacy of the research relationship. Additionally it might be useful to attempt to collect sensitive data in a formal setting, again to emphasise the research role. A further strategy might be to collect sensitive data at the beginning of the research relationship before the development of a more personal relationship.

The third and last methodological implication arising from this research concerns the difficulties associated with research on hard-to-reach populations. The prevalence of HIV and AIDS among drug injectors, a notoriously difficult population to contact, provides compelling reasons for trying to go beyond these difficulties.

In the context of this study access to injecting drug users was much facilitated by establishing initial contacts within treatment settings. These contacts were further developed when injectors were contacted again on their home territory. From there on it was a case of being introduced by these injectors to others with whom no contact had previously been made. However, establishing contacts with women

who prostituted and were prepared to self-report earning money in this way was less straightforward. Research in the study area suggested that there was a good deal of under-reporting of prostitution. To counter this, a decision was made by the researchers to work in mixed sex pairs as a means of contacting women directly in the red light district. This at least would overcome obvious difficulties on reliance on self-report data.

There still remained the problem of establishing contact with the women during their working hours. At night the red light district is unambiguously concerned with the buying and selling of sexual services. This placed obvious limits on the range of plausible reasons for being in the area without raising the suspicions of the streetworking women. It was in recognition of this, combined with the need to make sustained contact with the women, that prompted inclusion of a service provider role within the research role.

Research on streetworking prostitutes would probably have been a good deal less successful had contact with the women been framed purely in research terms. Perhaps the single most important lesson to be drawn from the experience of this particular aspect of the research is the place of flexibility and pragmatism in research design (Leviton, 1989). Thorny issues of access and establishing research relations with prostitutes were in large part resolved by the inclusion of a service-provider role. Beyond these academic concerns however there were good ethical reasons for providing the women with the means to avoid HIV transmission. In itself this was an important factor motivating the decision to conduct research in this manner.

Identifying future research

A striking feature of research into the area of injecting drug use and relatedly, the field of HIV and AIDS, is that so little attention has focussed on women's

experiences of either. Most often injecting drug use is treated as being undifferentiated by gender and so too the HIV risks associated with it. What little work that has been done looking specifically at the influence of gender on these behaviours suggests that there are marked differences in the experience of a drug injecting lifestyle. As a general point then there is good case for more research which explores the influence and impact of gender on behaviour. In particular, research should concentrate on the association between female injecting drug use and HIV risks since they appear at increased risk relative to their male counterparts. At minimum it seems important to look in detail at the relationship between gender roles and expectations of gender appropriate behaviour with the experience of a drug injecting lifestyle. Such an examination would highlight the ways in which women injectors are particularly at risk of HIV infection through their behaviours.

Although not a topic which is gender specific, this research did find evidence of injecting drug use taking place during the time that both men and women were in-patients at hospital and residential de-toxification units. Whilst attention has been paid to the HIV risks associated with injecting drugs in prison and remand centres virtually none has focussed on the situation in de-toxification units and rehabilitation centres. Given that the scope for use of sterile needles and syringes and access to means of sterilising them is probably as limited as it is in prisons there is clearly reason for concern that HIV could be spread in these settings.

As has already been noted, the HIV risk behaviours of women injectors do not, on closer inspection easily conform to generally held ideas of high risk behaviour. Women injectors appear to be most at risk from behaviours which arise in consequence of their relationships with men who inject. This suggests the value of assessing HIV risk behaviours between injecting couples. Such factors as the division of labour between couples and the emotional and social content of these

relationships may all have their part to play in the patterning of HIV risk behaviours.

Examination of the division of labour between injecting couples might indicate gender-based differences in behaviour which are also HIV risk-related. For example, where it is primarily the responsibility of the male partner to secure money, drugs and injecting equipment there may be an increased chance of some drug use and perhaps also needle sharing taking place outside of that relationship, particularly since many male injectors reported that these activities were usually in the company of one or more male friends. On the other hand, injecting women in the domestic context might also occasionally use drugs and share needles with other women in similar circumstances. Given the high reported levels of needle sharing between injecting couples it is clearly of some importance to assess the degree to which needle sharing between couples is in fact as exclusive as was often claimed.

With injecting couples it may also be of value to look at injecting practices. It has been reported for example, that many women are reluctant or unable to inject themselves (Howard and Borges, 1970). If this is the case between couples who share injecting equipment then there may well emerge a consistent pattern of risk behaviour prejudicing whoever it is who gets second use of the needle and syringe. Similarly there may be other aspects of injecting practices between individuals which are differentially risky. Research could focus on the exact details of the sharing event to pin-point social practices which might be particularly likely to result in HIV transmission (Stimson, 1991).

More generally it would be useful to look at the range of specific reasons given by injecting couples for using unsterile needles and syringes between them. Belief in the good health of the other is likely to be an important influence as may a concern to cut down on the cost of drug use by buying one set of needles and syringes

between two. It may however also be the case that an expectation of trust between partners might inhibit risk reducing behaviour since insisting on clean needles and syringes could be seen as questioning the very fabric of the relationship. In much the same way as condom use in long term relationships can be viewed as problematic so may it be interactionally very difficult to insist on sterile needles and syringes being used.

The risks of heterosexually transmitting HIV between injectors have been somewhat overshadowed by the risks associated with needle and syringe sharing. However, these risks are clearly not insignificant as is shown by the increased numbers of people in North America and Europe who appear to have been heterosexually infected. Indeed Ronald and colleagues claim that heterosexual transmission is now the most common cause of HIV spread among injectors resident in one part of Edinburgh (1992).

Drug injectors do not appear very different in their sexual behaviours from those others who do not inject drugs. They report similar experiences in the negotiation of sexual encounters, similar attitudes towards condoms and similar problems with their use. Like others in the general population they are aware of the risks associated with having unprotected sex which suggests that the problem is more strongly related to social and interactional difficulties in negotiating sex and condom use. Detailed research into the ways in which sex is negotiated between men and women would at least go some of the way towards identifying just exactly where these difficulties lie. In this respect, exploring the role and function of ambiguity in sexual encounters appears of particular importance.

Cloaking sexual intentions by retaining an essential ambiguity until the point where sex is about to take place appears to run counter to the kind of frankness required for raising and negotiating safer sex and condom use. These issues need to be seen

as gender distinct. Men and women are clearly under different social pressures and have different expectations of their sexual roles which in turn relates to notions of power in relationships and has an important bearing on the process of sexual negotiation.

These issues are rather differently focussed for women working as prostitutes and involved in negotiating commercial sexual encounters with clients. Nonetheless it should be borne in mind that the sexual relationship is always a strategic relationship involving the exercise of specific techniques of power. The exercise of power is intrinsic to the dynamics of the sexual encounter, whether more generally between men and women or specifically between prostitutes and their clients.

Whilst a good deal of research has concentrated on risk behaviour amongst prostitutes very little attention has focussed on the factors influencing the working practices of prostitutes and so also the conditions which contribute to an unsafe commercial sexual encounter. There are a variety of factors which could potentially create a situation where unsafe sex takes place. Some of these might involve the prostitute voluntarily, others might ensure her participation through coercion. Examination of these requires close attention to the social and legal context within which prostitution takes place as well as the economics of prostitution. In particular it is valuable to look at the dynamics of the prostitute\client relationship in terms of the ways that prostitute women seek strategically to manage the encounter.

The negotiation of safer sex appears from this work to be related to the directive stance adopted by prostitute women in their relations with clients. This suggests that further research might consider in greater detail the structure of the negotiating process between prostitute and client and the range of factors which impinge upon that process. In so far as prostitutes who inject drugs are concerned this might also

include the use of drugs like temazepam which when injected have a quite marked effect on awareness and control. Use of drugs of this kind may significantly impair a women's ability to negotiate with clients.

Theoretical implications

The concern of this study has been to show gender differences in the experience of injecting drug use and so also differences in behaviours which are a risk for HIV infection. However it was in examining the contexts within which risk behaviour took place and the various accounts provided to explain risk behaviour that the paucity of most theories used to account for these behaviours became apparent. This final section will challenge the assumptions made about human behaviour which underpin these theories, namely, that behaviour is rational, calculated and individually motivated. It will argue that behaviour should not be seen in abstraction but as profoundly influenced by social circumstance and the relationships established with others.

Theories on decision making, and by extension on risk taking behaviour, often appear to be rooted in an economic model of human behaviour which is based on a rationalist appraisal of the costs and benefits of any particular course of action. A risk behaviour can be defined as one which has potentially different outcomes which may be more or less favourable for the individual. Three main assumptions are often implicit within theories of risk behaviour, firstly, that an individual will calculate the cost and benefit of risk behaviour before acting. Secondly, that in the event of making a calculation, the individual will opt for minimal cost and maximum benefit i.e. the least risky course of action. Thirdly, there is the assumption that decisions are individually motivated rather than influenced by others. In short, risk behaviours are often assumed to be calculated, rational and directed by individual concerns.

In the context of HIV and AIDS, numerous studies have demonstrated high levels of knowledge of HIV transmission risks among different sections of the population, including those most at risk of contracting the disease (Joseph et al, 1987, Ginzberg et al, 1986, Strunin, 1991). It is similarly evident from many studies that risk behaviours persist even despite high levels of knowledge (Valdiserri et al, 1987, Stimson et al, 1988b, Haw et al, 1991b). The assumption that the provision of information will of itself bring about changes in behaviour is a questionable one. The evidence seems to point rather more to large changes in knowledge, small changes in attitudes and little change in behaviour (Bartlett, 1981).

The persistence of risk taking behaviour cannot be adequately explained by relating it to the degree to which the population is educated into those risks. Where risk taking continues the logical conclusion to this line of reasoning must be that people have either misconstrued the message or are acting irrationally. The focus of future health education campaigns then becomes one of identifying and correcting 'biases in thinking' which might prevent people from acting rationally (Slovic et al, 1981). The point must surely be that the decisions that people make are as coloured by personal, moral and social concerns as by evaluations of the relative risks attached to any particular behaviour (Douglas, 1986, Lee, 1981).

Perhaps the biggest difficulty with prevailing models of health behaviour is their inherently abstract and decontextualised character. They assume that decisions are made on the basis of purely objective criteria which are not affected by social context. The situations within which people act and the subjective influences or constraints on their behaviour are rarely satisfactorily incorporated into the model. Of particular importance in this respect is the influence exerted by other people. With respect to HIV risk related activities for example it is clearly the case that these all involve at least one other person. As Bloor and colleagues note, the

relational dimensions of risk behaviour must be central to any analysis of that behaviour (1991).

A further problem is the tendency of many theories of health behaviour to take the individual as their focus of concern. Risk taking is most often conceived of as a property of the individual, hence the characterisation of individuals as being either high or low risk takers. In the context of HIV and AIDS, high risk takers are those who frequently engage in activities like unprotected sex and\or the shared use of equipment. Whilst there are undoubtedly some individuals who frequently take high risks and those who go to great lengths to avoid them, it seems a mistake to consider risk taking as an individual propensity. This is best illustrated by reference to those individuals who fall neither into the high risk nor into the low risk category, but who more or less frequently do take risks.

It is when risk behaviour is evaluated in context and with reference to the values attaching to those very behaviours, that it is perhaps most apparent how decisions about risk taking are situationally determined and so influenced by other people and circumstances. Risk considered in abstraction from context can assume uniform value, either a behaviour carries a risk or it does not. However, precisely because risk behaviour does not exist in a vacuum but is influenced by people and events it is rarely considered in these terms. Take for example the practice of making shared use of unsterile injecting equipment. From the point of view of the observer, the outsider, the practice is, regardless of circumstance, an activity which carries a risk of HIV infection. However the injector may not view risk objectively as having a uniform value but on the contrary as varying according to different situations and circumstances. In this sense it is of some value to place the perspective of the risk taker, the injector at the centre of enquiry. Rather than assuming that calculations of risk are pre-eminently salient for the injector it becomes possible to see how other concerns, whether personal, social or financial, might be equally or more

salient. It may even be the case that an assessment of the risk involved is not taken into consideration. This is not the equivalent of behaving irrationally for, as Douglas and Wildavsky comment, 'the exercise of rational choice must include a selection of focus, weighting of values and editing of problems. Thinking about how to choose between risks, subjective values must take priority' (1982:73).

Prohaska and colleagues comment on a tendency among people generally to evaluate risk subjectively on the basis of personal circumstance rather than treating it as if it had an absolute value as some risk analysts might contend. They found in a study of self-perceived risks of adults in the general population that two major risk activities were not significantly associated with perceptions of higher risk. These were engaging in anal intercourse and not using a condom. However having multiple sexual partners and not knowing about one's partners sexual history were considered high risk activities. To explain this apparent anomaly they note that whereas the latter two practices are high risk factors under any conditions; 'the risks of engaging in anal intercourse and of not using a condom are determined situationally. For example, people may perceive that it is unnecessary to use a condom or to avoid anal intercourse if they believe that their relationship is monogamous or that their sexual partner previously was celibate' (1990:391).

Perceptions of risk and its salience in people's lives can be seen not as having a fixed quantity but as responsive to circumstance and therefore capable of change (Bellaby, 1990). Close empirical inspection of risk taking behaviour amongst injectors clearly indicated how far removed it was from a model of behaviour where action was predicated on a rational probabilistic evaluation of the costs and benefits attaching that behaviour. Risk taking should be seen in context and from the perspective of the actor rather than the observer. From the latter's point of view considerations of risk are uncomplicated by human relations, differing circumstances and pressures and individual dispositions. However, from the actor's

perspective it is precisely this interweaving of considerations which influences the way in which risk is perceived and the priority it is given in the course of her or his daily life.

Theories of decision making and relatedly risk taking behaviour have in the main failed to take adequate account of the degree to which behaviour is coloured by the subjectively experienced reality of the person concerned. Undoubtedly taking account of these many influences on behaviour much complicates the picture. Nonetheless, if the test of a good theory is its ability to describe the social reality it studies, such influences have also to be incorporated and accounted for.

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APPENDIX I: ANALYSING QUALITATIVE RESEARCH

ANALYSING QUALITATIVE RESEARCH

It has not been common practice for qualitative researchers to provide insight into the processes by which their data were analysed as opposed to the processes of their collection. Qualitative research, because it does not often have clearly defined parameters of study, hypotheses and a standard instrument, can appear to be unsystematic. Worst of all charges is that the whole endeavour may be based on little more than a series of hunches the researcher has, strung together by a series of anecdotes supplied by the research subjects. In shying away from making qualitative research procedures and analyses explicit, researchers leave themselves open precisely to these charges. This is regrettable, whilst it is perhaps more difficult to make explicit the processes of inductive research it is no less important to do so.

The form of data collected in qualitative research is most often the utterances of research subjects from interviews and conversations, together with the recorded observations of the researchers. It is data rich in detail and often wide ranging in subject. Consequently there is most often a great deal of it to be analysed. Furthermore the form of the data does not lend itself to computations as does quantitatively collected data which can be pre-coded and given numerical values. The analysis of qualitatively collected data then lies largely in systematically (and most often manually) going through all the data, indexing and categorising according to subject matter. To provide a specific example of this process, I will evidence the way in which the data were analysed for chapter 4 on the sharing of needles and syringes by injectors.

In the first instance data collected from all research sites were searched exhaustively for all reported instances of needle sharing, whether needles were lent or borrowed. Additionally it was noted where injectors reported that they did not

share injecting equipment together with the reasons given for this. From this it was found that 65 reported not borrowing used injecting equipment in the last year (a minority reported neither borrowing nor lending needles and syringes), 73 reported having borrowed unsterile needles and syringes at least once in the recent past.

Having ascertained the numbers of respondents sharing needles and syringes the next step was to categorize all reported instances of such sharing. Whilst it was clearly of value to know the relative frequency with which people shared needles and syringes, the major issue was to examine the complex of social and interpersonal factors influencing and giving shape to the practice itself. These were categorised according to the range of reasons given for sharing as well as the social relationships between sharers and respondents.

Sharing events were critically examined in light of the proposition that the availability of sterile needles and syringes is an important determinant of whether or not sharing occurs. Two opposite case scenarios demonstrated the limitations of using the notion of availability to explain the occurrence of sharing. Firstly, situations where sharing took place even despite the availability of clean needles and syringes, and secondly, situations where needle sharing did not occur when sterile injecting equipment was unavailable.

Field extracts were used throughout to evidence the insufficiency of arguing that availability alone can account for sharing behaviour. They were also used to show the importance of other, social, factors and the place of human agency in any analysis of sharing. These data were used both illustratively and analytically. Take for example the use of data to demonstrate individual variations in behaviour; a person might share in some situations but avoid doing so in others. Attention to the scope for individual variability in sharing behaviour is important because it forms an understanding which goes beyond a generalised distinction between those who share

and those who do not. Rather it indicates the influence of local circumstances in motivating the decision of whether or not to share each time such a situation potentially arises.

Analysis of the reported cases of needle sharing showed quite clearly the degree to which its occurrence was heavily influenced by situational factors. One obvious example of this might be where the injector is in prison, in possession of injectable drugs but lacking access to sterile injecting equipment. The individual concerned might decide to take the risk and share even though ordinarily he would avoid such action. Another example might be one where a person has drugs and decides to use the needle and syringe of another on the basis that the other person 'never usually shares' or has only been injecting drugs for a short while (and might therefore be presumed unlikely to have come into contact with the virus). Environmental, social and financial factors, among others, could all be seen to influence decisions over whether or not to act in ways that carried a risk of HIV transmission. It was this interplay of subjectively evaluated criteria which made it difficult to argue for an individualised propensity to share as if it were a trait characteristic of the person concerned. Needle sharing can be seen as arising out of a fluid situation where priorities change and individual needs are continually open to re-assessment in light of those changes.

One means of assessing the strength of this interpretation of needle sharing behaviour is to examine the deviant cases. These are those accounts of needle sharing which do not appear to accord easily with the main argument presented. The degree to which an explanation of the behaviour in question is sufficient (rather than just necessary) is dependent on the deviant cases. Through a process of continual refinement of the argument (such as through incorporating qualifications to the main argument or a more narrow definition of the behaviour to be explained), the argument moves from necessary to the sufficient causes. In the following

section I will example two deviant cases and illustrate how they can be reconciled with the main argument.

In the latter half of chapter 4 it was argued that women injectors were most likely to share needles and syringes with their partners' or female best friends. In the study however, three women reported that they had shared with male friends with whom they were not in a sexual relationship. Two of the women did not have either a boyfriend or husband at the time. In terms of the main argument it was shown that women who were in sexual relationships tended to act with their partner, as an economic unit, whether this meant a domestic division of labour or that both would actively be involved in sharing money and drugs. Where women are acting independently, as these two women were, their situation is inevitably a good deal more fluid and open to ad hoc arrangements. The third woman had a partner who was at that time serving a prison sentence, the onus was therefore also upon her to meet her drug and other needs.

All three women were independent. Securing money for drugs and the drugs themselves is likely to require movement out of the domestic context, whether to the city centre or to other schemes in the city. This kind of wide ranging movement may be as likely to involve other males as other females. It may actually be even more likely to involve mixed sex pairings if other women friends have child care commitments which prevent them from moving too far away from their local area.

It was less usual for women to report having shared with male friends. However, the relative infrequency of it happening is not adequate reason to discount it from the analysis. It should still be explicable in terms of the central argument, adding to rather than detracting from its strength.

The second deviant case concerns four cases where women reported having shared with their partner and one other person too. In three of these cases the sharing was between the woman, her partner and one of his family members (a sister or a brother). It is perhaps noteworthy that this sharing concerned members of the man's family rather than from the woman's side. The fact that this sharing was between people who had close social\familial ties is consistent with the general finding that the sharing of needles and syringes is most often between relations or close friends.

The fourth woman reported that if she shared injecting equipment it was exclusively with her boyfriend. However, on this occasion she had been in a situation away from him when drugs were available but a sterile needle and syringe was not. She took the decision to use her friend's injecting equipment justifying her actions with the comment that her friend had only just begun injecting and therefore posed no risk to her. This illustrates again the degree to which decision making is sensitive to context. Whilst claiming she never usually shared outside of her relationship with her boyfriend on this one occasion she decided she would. Presumably also the decision to do so was influenced by an assessment of her friend's probable risk to her.

Each of the above cases do in some way deviate from the central argument in Chapter 4 that there are discernible patterns to sharing behaviour. It is predictable that not all cases should fit neatly into the general scheme of things. Where human agency has its part to play idiosyncratic behaviour can be expected. However, closer inspection shows these cases can be explained in terms which do not undermine the interpretation made of the data on sharing in this study. Rather, analysis of the deviant cases provides a basis for extending and qualifying the original argument.

The analysis of qualitatively collected data clearly requires quite a different set of procedures from data which is collected quantitatively. It is still of equal importance however to demonstrate adherence to the same principles of good research practice. In arguing for any interpretation of social reality it should be demonstrable that it accords with the data. In turn this makes it attendant upon researchers to ensure that data is rigourously and exhaustively examined.

APPENDIX II: FORMATS USED FOR SEMI-STRUCTURED INTERVIEWS IN TREATMENT SETTINGS, THE PHARMACY AND THE NEEDLE EXCHANGE.

Topic Guide: Used for Informal Interviews in Residential

Detoxification Units.

General

How long using drugs? What age used? How did use start? Describe first injecting occasion, how many others present? Did it feel different to be injecting than before? Injecting how many times a day? Ever filter drugs? How often injecting with another person? Where do you travel to get drugs?
Would they consider snorting instead of injecting?
Rip offs etc-ways to avoid them.

Friendship and Family Relationships

Many friends also drug users? People you used to go to school with?
Inject with different people or same one/s?
Anyone else in family injecting drugs?
Family tolerant of drug use?
Possible to keep works in the house?

Risks: needle sharing

Last time shared needles - describe - how many people present?
Lend works out? Re-use?
List kinds of situation in which sharing happens.
How needles cleaned, getting works from where?
Know about needle exchange? Ever visited it?
Partner injecting? Sharing works with him\her?
Embarrassed about buying works - ever asked anyone to
buy them because of this?

Risks: sex

Regular partner - how long relationship?
Any others? How many?
Attitude to use of condoms - contraception in general?
Working as a prostitute, experience of such work, how got into such work. How much money can be made.

HIV/AIDS

Had test? Why yes\no, i.e. motive?
Know anyone HIV positive? Think you are at risk of AIDS?
Ever shared with someone HIV positive - at time or later on?
Think that people not using treat drug users differently now, i.e. because of fear of virus?

Any friends changed injecting behaviour?

a) less injecting, b) less sharing?

Do you talk about it amongst yourselves?

Contact with services

Relationship with GP - family doctor?

Possible to be seen for other problems?

Ever been in prison - how long sentence?

What for? Using while in Prison?

Injecting? How supplied? Much sharing in there?

Anyone in there HIV positive?

Topic Guide: Questions in needle exchange and pharmacy

Sex of Interviewee:

Interview Place:

Date of Birth:

Interviewer:

1. Do you think that selling needles and syringes is a good idea?

2. How long have you been injecting?

3. Would you consider stopping injecting and snorting/smoking instead?

4. Are you worried about HIV/AIDS?

5. Do you think that you will be able to avoid HIV/AIDS?

6. Can you tell me whether you clean your works and if so, how?

7. Can you tell me when you last used someone else's works or lent yours to someone else?

8. Do you know anyone who has HIV/AIDS?

9. Do you worry at all about contracting HIV/AIDS sexually if so, do you use condoms?

General observations