THE DYNAMICS OF AIDS RISK AND GENDER RELATIONS AMONG INTRAVENOUS DRUG USERS IN NORTHERN VIETNAM

To you, Prof. Sjaak
With all my respect

Lam NT
28 April 2003

Nguyen Tran Lam
THE DYNAMICS OF AIDS RISK AND GENDER RELATIONS AMONG INTRAVENOUS DRUG USERS IN NORTHERN VIETNAM

Thesis submitted for Masters Degree
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Amsterdam, April 2003
To my love Phan Quynh Hoa
my daughter Nguyen Lam Quynh Huong
my son Nguyen Tran Bach
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Last but not least, I may risk a hackneyed gesture by numbering a long list of acknowledgments with a solemn thank-you to my informants in Hanoi and Quang Ninh, where the fieldwork was conducted. I admire them for their enthusiasm and cooperation.

That is why the thesis is written this way.

Nguyen Tran Lam
Abstract

Currently, the transmission of AIDS in Vietnam is mostly linked to drug injection. There is a potential of transmission of HIV from intravenous drug users (IDUs) to their heterosexual partners. Public health programs and intensive behavioral interventions have only limited success in the IDU population. HIV education programs focus on the personal responsibility model of risk in their risk-reduction messages, yet failing to address adequately other aspects of HIV risks in social contexts.

This paper examines the dynamics of AIDS risks (unsafe drug use and unsafe sex) and gender relations among IDUs. It is based on ethnographic fieldwork conducted in two urban areas of Hanoi and Quang Ninh, Northern Vietnam, over the period of more than three months, from August to November 2002. Fifty-six audio taped interviews (25 male IDUs and 31 female IDUs), four focus group discussions and three case studies were conducted. The qualitative interviews were conducted as a complement to participant observation. I examine the association between gender relations and HIV risk behaviors, with a focus on intimate relationships among IDUs. Three patterns of intimate relationships are analyzed, including: 1- IDUs in a heterosexual relationship with an IDU partner; 2- IDUs in a heterosexual relationship with a drug smoking partner; 3- IDUs in a heterosexual relationship with a non-drug-using partner. The analysis is based mainly on social theories of risk.

The findings show that intimate relationships play an important role in managing the AIDS risk among IDUs. The meanings of (non-)condom use and sexual relationships are discussed. Trust and love can be seen as solutions to dangers and uncertainties. In some cases, women could exert control over the use of condom in contrast with the stereotypic gender roles and the implied subordination of women. Care and responsibility confer different meanings in the drug scene and may be posited as a symbolic expression of risk management. There is a significant variability in the perceived effects of heroin on sexual experiences. The implications of these findings are discussed. In the concluding section, I suggest that HIV prevention should take into account the positive aspect of non-condom use in a loving, trusting relationship. For syringe sharing, I suggest a safer injecting training, including some necessary skills and information to be provided for IDUs in Northern Vietnam. It would also be advantageous to utilize aspects of IDUs' own subculture to change behaviour. Of key importance, intervention programs must pay attention to the specific context of their lives. Lastly, I suggest that ideological constructs regarding heterosexual relations mediate the impact of political and economy forces on IDUs' drug use and sexual decisions. In order to cope with the emerging epidemic effectively, there is a critical need for long-term and more comprehensive approaches that address the root causes of the epidemic, causes that are embedded in the structuring of politics, economy and gender relations.

Key words: injecting drug users, sex partners, sexual relationships, AIDS risk, syringe sharing, condom use.
**Abbreviations and some IDUs’ Argots Used in the Analysis**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AHRN</td>
<td>The Asian Harm Reduction Network</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial sex worker</td>
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<tr>
<td>FSW</td>
<td>Female sex workers</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HCMC</td>
<td>Ho Chi Minh City</td>
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<td>IDUs</td>
<td>Injecting drug users</td>
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<tr>
<td>IEC</td>
<td>Information-education-communication</td>
</tr>
<tr>
<td>MAP¹</td>
<td>Monitoring the AIDS Pandemic Network</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>SP</td>
<td>Sex partner</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Program on HIV/AIDS</td>
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<td>UNDCP</td>
<td>United Nations Drug Control Program</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Smoke | To smoke opium or heroin
Shoot | To inject
Black | Opium
White | Heroin
Meal | An injection/ a shot
Senphen | Seduxen and Pipolphen- two stimulants, often mixed up with heroin

¹ MAP: Monitoring the AIDS Pandemic Network. MAP is a collegial network of internationally recognized technical experts seeking to assess the status and trends of the global HIV/AIDS pandemic. MAP has more than 100 members in 40 countries.
CHAPTER 1
Introduction

In many of the developed countries in North America and Europe, the early 1980s saw an explosion in numbers of young people using illicit drugs. At the same time, HIV infection was silently spreading among drug injectors. In New York, HIV was found among drug injecting populations in 1977, respectively Italy in 1979 and Edinburgh in 1983 (McKeganey & Barnard 1992). About a decade later, many countries in Asia witnessed similar developments. In India, China, Myanmar and Thailand, HIV prevalence rates of over 40 percent among IDUs have been recorded for several years (MAP 2001).

In Vietnam, the results of sentinel surveillance (see appendix 4) show that the HIV epidemic is primarily associated with injecting drug use, primarily heroin and opium. The first case of HIV was recognized in December 1990. In 1993, there was a sharp increase of HIV infection among IDUs in the South (Long et al. 2000). In the North, there have been recent epidemics among IDUs over the last seven years. In some areas, the proportion of infection among IDUs is as high as 65% (Hien 2002).

Studies show that the rate of syringe sharing among IDUs in some urban cities is quite high (Tuan et al. 1999; Hien et al. 2000; Vinh 2002). This is one of the main reasons for the spread of HIV (Des Jarlais et al. 1986). Many studies show that syringe sharing among IDUs is socially situated (Hien et al. 2000; Rhodes 1997; Singer 1994) and it is more common when injecting with close friends or spouses (Vinh 2002; McKeganey & Barnard 1992).

IDUs not only share a syringe but also buy sex and sell sex. Nearly 25% of IDUs in Hanoi said they had bought sex in the past year, and most did not use a condom (MAP 2001). Another emerging problem is that commercial sex workers (CSWs) not only sell sex but also inject drugs. In sum, the AIDS epidemic in Vietnam is still at an early stage, predominantly situated among IDUs, yet there is a worrying potential for the wider spread of HIV. According to some epidemiologists and researchers, the epidemic seems to follow a similar evolution pattern as in Thailand, meaning that subsequent waves of HIV infection will follow shortly in CSWs and STD patients and consequently, into the population at large (Hien 2002; Elmer 2001).

To respond to the epidemic the HIV prevention program focuses on IEC work (information-education-communication). While harm reduction programs for
IDUs have been piloted, little is known about the impact of this approach on the spread of HIV among IDUs and on the drug use situation in Vietnam; in addition, there is a community backlash against needle exchange/distribution programs (Vu 2001). The epidemiological literature is silent on the prevalence of HIV among sexual partners of IDUs. HIV education merely focuses on the personal responsibility model of risk in their risk-reduction messages, failing to address adequately other aspects of HIV risks in social contexts. Little is known about the actual problems IDUs confront in their everyday lives.

Studies conducted elsewhere have indicated that in the time of AIDS, drug user-sex partner relationships are sculpted in a double risk: unsafe drug use and unsafe sex (Kane 1999; Sibthorpe 1992; Farmer 1996). Meanwhile, drugs and sex are highly interrelated (Iguchi 2001; McCoy et al. 1996; Miller & Neaigus 2001; Flom et al. 2001). There is variability in the effects of drug use on sexual performance and sexual history (Carlson 1999). Drug use and drug interdependence (i.e. depending on partners for a fix or sharing drugs) and sexual practices influence each other (Sherman & Latkin 2001).

But how do sexual relationships relate to risk-taking behaviours?

A focus on drug-related relationships seems especially relevant when HIV risk behaviors are increasingly seen less as an individual phenomenon and rather as socially embedded and hence highly sensitive to the context and nature of the relationships between people (Singer 1994; Sobo 1998; Rhodes 1997; Miller & Neaigus 2001). The interplay of social factors such as the distribution of power and control, particularly regarding the division of money and drugs between injecting couples, may influence the ways in which HIV risks are habitually managed (McKeganey & Barnard 1992; Barnard 1993). There are inconsistencies between sexual experiences and the stereotype of male dominance and control of women's sexual decision making (Carlson 1999). The perceived risks attached to both syringe sharing and condomless sex may be reduced (Barnard 1993). Injecting relationships have been found to have an equalizing influence on couples' drug consumption (Rhodes 1997). Emotional elements, such as love and trust, may play a key role in patterns of sexual and relationship risk management as well as HIV transmission (Rhodes & Cusick 2002; Sobo 1998; Wojcicki & Malala 2001). Furthermore, Rhodes and Quirk (1998) suggest that drug users' sexual relationships should act as key sites of risk management and behavior change.

My objective then is to unravel the association between sexual relationships and HIV risk behaviors among IDUs, with a focus on intimate relationships (whether conjugal or para-conjugal). By examining the situational contexts of risk-taking behaviors within IDUs' intimate heterosexual relationships, I attempt to get insight
into the dynamics of AIDS risk and gender relations among this population. Three patterns of intimate relationships among IDUs are analyzed, including: Pattern 1- IDUs in a heterosexual relationship with an IDU partner; Pattern 2- IDUs in a heterosexual relationship with a drug smoking partner; Pattern 3- IDUs in a heterosexual relationship with a non drug using partner. The analysis is based mainly on social theories of risks (Douglas & Wildavsky 1982; Douglas 1986; Douglas & Calvez 1990), which have been further developed by Rhodes (1997).

This thesis is an attempt to contribute to an interpretive anthropology of injecting drug users and their sex partners in the time of AIDS, based on ethnographic analysis. After describing a case story in this chapter, Chapter 2 offers a brief analysis of the social and cultural context of the AIDS epidemic in Vietnam, with an emphasis on drug abuse and prostitution. In Chapter 3, the methodology of this study is described. The next three chapters (4, 5, 6) present the findings of this study. In Chapter 4, I analyse some important parameters of the drug subculture, which is influential to the sexual relationships and risk behaviours among IDUs. Chapter 5 forms the core part of this paper, where I analyse characteristics of three patterns of intimate relationships among IDUs. Each pattern with its features, including the following themes: drug use practices, condom use, perceptions of risk, reducing and stopping drug use, managing AIDS risks and sexual relationships. Chapter 6 employs a case study approach in which the focus is on the life of two individuals, one female living with AIDS and one male IDU. The objective of the chapter is to broaden the view of looking at social contexts of AIDS risk and sexual relationships. In Chapter 7, I discuss the main issues emerging from this study, including: gender and power; care and responsibility; drugs and sexuality; stigma. In the last part of this chapter, I give some comments on the classification of “high-risk groups”. Chapter 8 is concerned with some implications for HIV prevention program. In the concluding part, Chapter 9, I suggest some practical approaches to deal with AIDS risks; and propose an orientation for AIDS research in the future.

The following case study foreshadows many of the issues that the rest of this paper will examine. This is a life story of a 32-year-old woman, named Ngan1, who began her drug career at the very time when AIDS came to Vietnam. For more than ten years, she was involved in different relationships with different types of sex partners: one with a drug injector, one with smoking partner, one with a non drug using man, and later with other IDUs. The reasons for the multiplicity were simple “first, for drug and, second, for love and sex”. The focus here is on the lived experience of a drug user. This section is fundamentally descriptive, and aims to explore the characteristics of AIDS risk and gender relations among IDUs.

1 All names in this thesis are pseudonyms.
A Story of a 32 Year Old Injecting Woman

At the beginning of the interview, Ngan told me candidly “I am not proud but I dare say to other drug users in Vietnam that I know a lot about drugs”. Ngan was born in 1970 in Hanoi. She grew up in a family making money by lode- a lottery business and joined the business with her parents since 1987. When she nearly finished eighth grade she had to quit school because “I knew to make money too early. The circumstances forced me to leave school”.

Ngan began to smoke opium in 1989, partly because “I got involved in a business with my mother. We smuggled narcotics from China to Vietnam”. During this time, opium was widely available in Vietnam, but heroin was scarce. In that year Ngan met Hung, a non- drug using taxi driver, who was unaware about her drug use. They got married in 1990 when the first HIV case was reported in Vietnam. One year later, they divorced, leaving their one-month-old son to stay with his grandparents: “we divorced partly because of serial conflicts with my husband and his parents...I lied them from the beginning. When they found out I was a heavy drug user they burst out into a rage and drove me out”. Feeling disappointed, Ngan continued to deepen her life into the drug scene.

Ngan met Cu in the autumn 1991 when they were both smoking opium. Cu was unemployed and lived in Haiduong, a small province 50 km from Hanoi. By that time Ngan could make money easily through her private transactions on narcotics. Every one or two weeks she went to see Cu in Hai Duong and they lived temporarily in a house shared with a young couple. One of them, Chu, was the owner of the house, which was also used as a shooting gallery. After a while, Cu moved unnoticed to injecting opium while Ngan was still smoking. It was during this period that some tensions arose between Ngan and Cu as a result of the difference in drug using habits between them. Ngan told me about the change in her feeling she experienced at the transition from smoking to injecting:

You know, even with him I feel sometimes hesitated [about my addiction status]... I was a novice smoker and he was a heavy smoker. I myself smoked black, but whenever I met him there, I did not want to reveal my smoking status. Until one day I saw him shoot with his friends. I felt sort of hate him very much and unpleasant [to see him shoot opium]...something dirty and depraving you know. By then I was in love with him for some months already. But this feeling disappeared when I began shooting like him. I did not feel unpleasant anymore. People say that those who smoke opium look clean. Even some of them who are compatible to drug, even look stronger than the ordinary people. But shooters were often said to be depraved.
Ngan was smoking for three years, from 1989 to 1991. During this period, her sexual desire seemed to reach high: “I think during the time I smoked black I enjoyed having sex with him very much”. Ngan and Cu did not use condoms because “by that time we did not know anything [about AIDS]”.

In May 1992, Ngan shifted to injecting opium because “I feel more exciting and get high faster than smoking”. Another reason was because “he brought me into the life”. Ngan started to get hooked on injecting opium: “from the beginning shooting black was cheap, but when I became addicted, it was very expensive because shooting black requires foreign narcotics which were also very expensive. For each meal [one injection] I play a double shot with a mix solution of three things: water opium and a pair of sen phen’.”

As their relationship developed, they began to increase the shared drug dose for each injection and, of course, they needed more money. But Ngan had “favorable conditions” for her addiction. She had money and time. The place they injected was far from Hanoi, therefore they could keep “the secret” to their parents and friends and that made her feel comfortable: “My parents simply knew that I went to Haiduong to meet my lover but they knew nothing about my addiction”. Different from other drug using women, Ngan rarely shared one syringe with Cu: “I could inject myself. Sometimes I had Chu [the house owner] to inject for me but in most cases I did not share with Cu. If we [Cu and I] play together, I have to wait when he finishes his shot. It is about two or three minutes but it is too long for me to wait. So I don’t like it”. Another reason was because of her fear to shoot with blunt needle: “if I shoot after him. I feel that the needle becomes very blunt. Even up to now I am still scared of blunt needle. It is painful, blood is stuck and becomes invisible”. She did not fear HIV because she did not know about it: “nobody knows about HIV then”. This is true. The number of HIV infections detected during 1991-1992 was less than 20. Although the First Medium Term Plan on HIV supported by the World Health Organization was on the way, young people like Ngan were unaware of the epidemic. Ngan’s fear of the blunt needle has helped her prevent the penetration of the virus. In December 1993, Ngan left Cu: “after two years of the relationship I started to feel tired of him. I did not know why. I felt it was a waste of time being with him in such a long time. In Hanoi I could enjoy the drug and I could partner with other men. No need to go there”.

The drug Ngan enjoyed was opium. It was the end of 1993. Ngan moved to smoking heroin in 1994 when this white powder substance was booming again in

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1 A pair of sen-phen in this case meant two ampoules of Pipolphen and Seduxen, the two “narcotics fellows of opium” that were available on the market long before the AIDS epidemic came to Vietnam.
Hanoi after disappearing many years in the Vietnamese market. "Nobody knew what it was, even people could not spell properly the word ‘heroin’". It was in the same year that the National AIDS Committee was upgraded to Government Office, chaired by a Deputy Prime Minister. It was striking that the time when Ngan shifted to smoking heroin was also a hallmark in the history of the AIDS epidemic in Vietnam: the number of HIV cumulative infections in 1994 was about 100 times higher than that of 1992 (MOH 2000).

The year 1995 saw a great loss in Ngan’s family. Her mother was arrested in May 1995 because of the involvement in smuggling narcotics. Her family business went bankrupt. Her father died one year after her mother’s arrest. Financial problems emerged. Ngan began working as a sex worker, after 6 years being in the drug scene. At that time the National AIDS Committee of Vietnam was five years old. The IEC work (information-education and communication) was still new to the public. Ngan did not understand much about HIV/AIDS but she always used a condom with casual clients in the street because she feared to be infected with sexually transmitted diseases. She explained:

"I am scared of benh xa hoi (sexually transmitted diseases), not of HIV because I don’t think that it [HIV] can be transmitted though this [sexual] route very much because when a man ejaculates, infection will occur when there are some abrasions in the woman’s [vagina]. For a healthy woman, it is rare to have infection through sexual route, only 30%, a little chance”

The concern about STDs has helped her to refuse having sex without condoms, even if she is paid extra money. This also helped her to maintain her health. Ngan is quite healthy after some years working as a sex worker. In addition, she did not like being looked down upon by others: “I don’t want to be a drug user under the public eyes. Please don’t laugh but even if I am a street girl I don’t want to see strange eyes staring at me because I still have my family, I was born and grew up in Hanoi. Wherever I go I may encounter acquaintances”.

In 1996, Ngan entered into a relationship with Vuong, a non-addict state officer. At first, Vuong was Ngan’s “casual client” but gradually he became “regular client” and then “private sex partner”. A bo [sex partner] like Vuong not only provides extra income but also emotional support and a promise of marriage. In addition, he increased Ngan’s social status among her peers by displaying her

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1 Before the 1990s, opium was the most popular illicit drug (black water opium in particular) followed by pharmaceuticals such as pethidine, morphine, promethazine and diazepam. Cocaine and marijuana was reportedly used in wealthier Vietnamese circles. Since the mid 1990s, significant and increasing use of heroin has re-emerged, which had largely disappeared from Vietnam after 1975 (AHRN)
desirability, as well as her capability to conform to cultural ideals regarding heterosexual relationships. The partnership with Vuong figuratively removes her from the realm of prostitution because she has a steady nonaddict partner in a socially acceptable relationship. Their love developed in the street and lasted for eight months. The break-up occurred due to the tensions embedded in the different lifestyles between the two partners. Ngan recalled:

He rented a room for me. After daily work hours or monthly business travels, he looked for me, either in the street or in the bars and we hang out together. After several months, I feel I am the one who loi dung [exploits] him. Our love is based on his money. Although he was very kind to me but I still felt something uncomfortable. He insisted on persuading me to stop drug use. He took me to many places for detoxification but no result. I didn’t like the way he persuaded me. To speak the truth when you are on drug, nothing is important to you but drugs. If I were responsible for myself I would have never been addicted and I wouldn’t bother others. I am like a ruly horse. Having sex partner or not is not important. I am still working and can support myself... The more he takes care of me, the more I feel disappointed. He could not understand me because he was not addict like me. I could not understand him either. We could not share enjoyment in sex. I always used condom with him. I didn’t know why. I think wearing or not wearing a condom is not important. The main thing is whether I like him or not. When I love someone dearly I can satisfy myself but if I don’t like someone I have to keep a condom for myself... at first he insisted on shagging without condom but I said to him "you know I am working as girl. You know well how can I keep [safe] in that environment. Condoms are ripped, breaking...sort of things. I myself am an addict and I don’t know whether I am suffered [infected] or not". He seemed scared when I said so, though I knew that he wanted [to shag without condom] very much...Later I avoided seeing him

From 1997 until I met her, Ngan has been involved in multi relationships with men, mostly with shooters. The shooting partners were "sort of addicted heavily like me more or less" and "the longest relationship lasted for one year". Serial unions with those shooting partners were summarized in her words: "We meet each other in the network, sometimes in the shooting galleries, or inviting for a shot...sometimes I have to ask a man to get some dope for me...In those situations I made acquaintance with these guys... then we rent a house and live together in this way we can also divert the public attention". As many others drug users who are isolated from the mainstream society, Ngan justified her multiple relationships with other drug users by the normative popularity of this phenomenon:
There are some women who are free from addiction but they still work as sex workers to feed their drug using men. If you notice you can see that, for example 10 women shooters and 10 men shooters, once they know each other they will cohabit anyways. Initially, the cohabitation starts with friendship, gradually [they] get closer and closer...lua gan rom bao gio cung ben (Vietnamese saying: straw near fire will catch sooner or later). For example, we [injecting women] or I never lived without men besides. People say what for? Drugs are accessible everywhere, and I can work [as prostitute] to support myself. Why should I live with men like that? First, for drug and, second, for love and sex.

Thus, drugs, love and sex are the main motivations for Ngan's involvement in serial companionships. However, her relationships with men are on and off. Remaining sexually monogamous is not always a viable option for an injecting prostitute like her because she must continue working as a girl to support her drug habit and because her men are often arrested in the middle of the relationship. The quest for a sex partner is significant and confers a layer of meanings. These connotations can only be fully understood in a broader picture. In the next chapter, I describe the social and cultural context of AIDS in Vietnam, which shapes the contours of sexual relationships among IDUs and their sex partners.
CHAPTER 2

The Socio-Cultural Context of AIDS in Vietnam

The first case of HIV in Vietnam was detected in December 1990 in Ho Chi Minh City. It was a young woman who was said to be infected by her sex partner—a foreigner. In 1991, no HIV case was reported. In 1992, 11 cases were reported. In 1993, the first AIDS patient was reported. One year later, the number of HIV cases rocketed to 1148, about one hundred times higher than that of 1992 (MOH 2000). By the end of 1996 and early 1997, there were an explosion of HIV epidemics among IDUs in Northern Vietnam (Hien 2002). Until July 2001, Vietnam, a country of 80 million inhabitants, reported a total of 29,924 HIV positive cases cumulatively; 60.1% of which were among IDUs, followed by FSWs (3.9%) and STD patients (2.2%). HIV infection has so far been reported mainly among men, who account for 84.6% of all reported cases. Of 5,784 reported AIDS cases, 3,123 have died (Hien 2002). If the extent of HIV infection among pregnant women (less than 1%) is used as an indicator of HIV’s penetration into the general populace, Vietnam is still in the early phase of the epidemic (MAP 2001). However, recent trends suggest a potentially uncontained spread of HIV/AIDS into the broader population (Elmer 2001).

The spread of AIDS in Vietnam has run along with economic development over the last 17 years. More than ten years after the war, in 1986, Vietnam launched economic reforms and entered the transition period to a market economy in 1990, which replaced the planned socialist economy and paved the way to an “open door policy”. Economic changes, industrialization and modernization undertaken over the last few years have brought in their wake not only increased living standards and poverty, as well as new lifestyles and behavioral patterns, but most significantly, new economic and social relations. This change has shaped the context for the rise of drug use, prostitution and AIDS in the country.

In Vietnam, the image of AIDS is socially sculpted in matuy [drugs] and maidam [prostitution]. Article 12 in the Ordinance on HIV/AIDS stated, “All acts of prostitution, intravenous drug use and other practices susceptible to HIV/AIDS transmission are strictly prohibited” (MOH 2000). While drug abuse and commercial sex are named as “social evils”, AIDS is socially constructed as a disease of IDUs and FSWs. There is a common belief that it is only or mainly IDUs and FSWs who are liable to get HIV. Indeed, the “social evils” label adhered

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1 While it could have been an imagined epidemic (Streefland 1998), it is evident that the number of IDUs infected sharply increased during this period.
to IDUs and FSWs has bad implications for HIV prevention. These negative moral overtones perpetuate the myth that syringe sharing and promiscuity are the “nature” of IDUs and FSWs.

Drug Abuse

Vietnam has a long history of wars and drug abuse. In the early 19th century, British opium began flooding into Vietnam via Southern China (AHRN). The Vietnamese monarch in 1820 outlawed opium, but this prohibition was not effective to prevent opium influx from China. The colonisation by the French (5-French colonialism 1873-1884) led to an establishment of an opium franchise, which brought large profits for the French administrators. During 1940s, opium was commonly used among the "Vietnamese elite" (AHRN). But since 1957, heroin and morphine became predominantly used by Vietnamese youth (Hien et al. 2000). The American war in 1960s and 1970s saw the emergence of heroin injection and smoking among American and South Vietnamese soldiers (AHRN). It was estimated that there were 500,000 drug abusers in Saigon (now Ho Chi Minh City) during the war (Thin et al. 1985, cited in Hien et al. 2000). By that time, both Americans and indigenous Southerners used opium and heroin. The American injectors were mainly soldiers and the Vietnamese injectors “tended to belong to the higher and middle classes” (Hien et al. 2000). US military personnel were seen as the main market for high-grade heroin in Saigon (Ford & Koetsawang 1991). This was due to the abundance of illicit drugs brought into Vietnam at that time. Vietnam is situated near the Golden Triangle, which straddles northern Burma, Thailand and Laos, where large quantities of heroin and opium are produced.

The recent HIV epidemics among young male IDUs in Northern Vietnam have been closely linked with the increased amount of heroin and opium smuggled into the country over the last six years. Drug trafficking rings are operational cross the border and throughout the country, with sophisticated scope and patterns. Drug smugglers are using more tricky methods in their illegal business, including transporting drugs by air, sea and via the postal system (VN News 2002). Drugs are trafficked into and within Vietnam by different routes, like a pendulum: from Lao, Cambodia to the central part and then to Ho Chi Minh City; from Southern China to Northern and North-western border provinces; from Northwest to Northeast; and from Northwest to Hanoi and from Hanoi to Ho Chi Minh City. In 2001, Vietnam uncovered 12,811 drug trafficking cases; an increase of 24.4 percent compared to 2000 (VN News 2002). These figures have shown that even though the anti-drug law is harsh, drug trafficking is still on the increase. It is likely that many drug users have recently shifted from smoking opium to injecting heroin as the result of the influx of heroin into Vietnam.
The exact number of drug users in Vietnam is unknown. In 2000, 185,000 drug addicts (about 0.24% of the population) were reported, but the real number is believed to be much higher. The majority of IDUs in Vietnam are males and young (Hien et al. 2000, Phi et al. 2000). Three quarters of drug users belong to the 18-35 age group; female users only account for 5.9% (Vu 2001). Heroin and opium are the commonest drugs used by IDUs. The use of other drugs, such as amphetamines and synthetic opiates has been reported (Vu 2001). In addition, local production of amphetamines has been described (Vu 2001).

The Law on Drug Prevention and Control 2000 states, “Matuy [drugs of all kinds] is a big threat to the society…and seriously affects social order and national security”. The following policies and measures to cope with drug abuse are cited: anti-drug information and education programs; eradication of opium cultivation; strengthened efforts against illicit production and trafficking; suppression of opium dens and drug injection locations; compulsory treatment of drug addicts. Harm reduction programs, emphasizing on peer education and syringe/needle exchange and condom distribution, met with many obstacles. It is believed among policy makers that the programs go against “anti-social evil campaigns”. For IDUs, the pressure to inject quickly because the pervasive fear of police arrest means that law enforcement can even worsen the problem by contributing to the shift from smoking to injecting drugs (Hien et al. 2000).

**Prostitution**

According to the law, prostitution is a serious “social evil”, which “badly affects social security” (Ordinance on HIV/AIDS). Prostitution is illegal and the law is tough. Article 117 of the Criminal Law stipulates that if one knows about one’s positive status [HIV/AIDS] but intentionally transmits the virus to another person, one will be put in jail for 1-3 years; if one intentionally transmits the virus to many people, one will be sentenced 3-7 years in prison. The law encourages monogamy yet discourages same sex marriage. Homosexuality is rarely reported. There is a denial of the existence of homosexuality at the community level, and shame ensues at the family level when a member is revealed to be involved in homosexual encounters (Carrier et al. 1992). Because homosexuals are seemingly ignored, prostitutes are referred to as women only. Prostitution is seriously stigmatized because “it violated traditional moral standards and caused bad consequences for families and society (Hong 1999).

In deed, the social norms are very strong. In traditional Vietnamese culture, sex before marriage is a rare occurrence, which would be severely sanctioned if revealed. Like prostitution, premarital sex is strongly stigmatized and considered by many as a depravation of Vietnamese culture. The purity of youth is often seen as a symbol of the purity of country and culture (Gammeltoft 2002). The
Government considers women’s traditional roles as mother and wife critical to the nation’s social and political stability (Feiling Go 2002). By and large, men are more socially acceptable than women to engage in extramarital relationships. Vietnamese culture tends to be sexually conservative. Marital infidelity is disapproved. Ladies and girls turn prudish when the topic of sex is initiated. Physical closeness is socially attentive. People are inhibited about making physical contact because it confers “romantic” meanings. Unlike Europeans, Vietnamese men and women are not accustomed to hugging or kissing each other in public. Husbands do not have the habit of kissing their wife when leaving home. Sexual intercourse is always a sensitive issue and rarely shown in feature films. Structural subordination of women is culturally reinforced in different ways. There is a cultural expectation of female passivity and/or naivety about sex. Women’s sexuality is generally accepted only within the confines of marriage, and most Vietnamese men prefer marrying women without a sexual past. Female virginity is highly appreciated by the community. Girls often worry about loss of virginity and pregnancy rather than being concerned about HIV/AIDS. Virginity is the first criterion for many men to select their life partner.

The predominant influence on Vietnamese culture came from Confucianism. The main aspects of Confucianism deal with how a quan tu- man of virtue- should live. This person should display the following virtues: generosity, moderation, politeness, reason, steadfastness, and trust. Individual achievement is de-emphasized, and the person’s primary responsibility is to the family and the society. In addition, Confucianism stresses filial piety and the subservience of women to, first, their fathers and later in life, their husbands (Penner & Anh 1977). Female good conduct was guided by two sets of principles: the three forms of submission (tarn tong) which forced women to submit themselves to their fathers when unmarried, to their husbands during married life and to their sons during widowhood, and the principle of four virtues (tu due) which included industriousness and skills (cong), reserved beauty (dung), proper speech (ngon) and proper moral conduct (hanh) (Wright & Ha 1995:26).

However, with the advent of the market economy and substantial changes in economic relations, including family ties, the traditional values have seemed to be faded out, resulting in the increase of prostitution with different scopes and nuances. Together with drug abuse, prostitution had been flourishing in the South during the Vietnam War. Ten years after “Doi moi” (the renovation process during the 1990s), the HIV prevalence reported in 1996 among sex worker population in the South was still low. In a cross-sectional study among 968 FSWs in Ho Chi Minh City, An Giang and Cantho during 1995-1996, HIV prevalence among FSWs was 5.2 % (Thuy et al. 1997). Over the years, the rate has been on the rise. Recently, 20% of the sex workers in Ho Chi Minh City were reported HIV positive (UN 2001).
Especially in nine Southern provinces bordering with Cambodia, prostitution has been increasing rapidly over the last ten years. During 1992-1993, about 20,000-25,000 Vietnamese women migrated to Cambodia to work in the sex sector (Tep & Ek 2000). There are some reasons for their migration. First, prostitution is illegal in Vietnam but allowed in Cambodia. Second, Cambodia is believed, among Vietnamese sex workers, to be more promising than Vietnam in terms of earning money by doing sex work. Third, most of them want to stay in Cambodia for a while to pay off a specific debt or earn money to send home (Schunter 2001). In my interviews with some Vietnamese sex workers living in Cambodia in 1999, a girl said “I feel safe here because people do not know what I am doing...here I can earn money more easily and quickly”. Many poor families are dependent upon the labor of their daughters in order to obtain an adequate income for their family to survive, or at least, the family does not have to support the girl. However, there is a high incidence of STD infection among these girls. In a study on STD treatment seeking behavior in border area Vietnam- Cambodia, prevalence of a STD was discovered in 1,269 out of about 4,000 cases (CARE 2000). There are no official figures of HIV infection rate among Vietnamese sex workers in Cambodia but it is believed to be as high as 40%.

Furthermore, these CSWs are highly mobile. Upon returning to Vietnam, many of them do not stay in their province but rather, they move to other localities, and of course, take the virus along with them. The transient lifestyle characteristics of CSWs may reflect their efforts to disguise their profession for fear of arrest, or to seek out fresh clientele (Elmer 2001). Clients of CSWs also worsen the situation because many of them are truck drivers and mobile construction workers. Their large trajectories fuel the supply and demand for commercial sex along major transportation routes, especially along the national highways (Beesey 1998). There is mounting evidence that many Vietnamese FSWs who return from Cambodia have migrated to the North. In a study among 261 sex workers in five Northern provinces, Hong found that sex workers were highly mobile. The sex workers come from 23 provinces and cities nationwide, more than 70% of them from rural areas. The main reasons for this mobility were poverty and unemployment. More importantly, about 60% of sex workers never used condoms when they had sex with their spouse and 85% never used condoms with their boy partners; in addition, many of them had drug-using husbands (Hong 1999).

The composition of CSWs has changed greatly since the advent of the market economy. Contrary to the image often portrayed in research papers and the mass media, prostitution in Vietnam is not limited to merely poor or uneducated rural girls, but many university students, fashion models and cinema actresses have become CSWs as well. A “temporary” engagement in the sex work can be posited as a legitimate means for economic advancement. A study in Thailand has also
shown that high level of education guarantees neither a high income nor impunity from being forced to become a CSW (Wait & Coughlan 1999). It is likely that these ambitious people want to make a fortune overnight, acquire a certain public status or “keep up with the Joneses”. Prostitution has become not only a means of survival but also, to some extent, a means of self-determination and career advancement. Monetization has become a sine-qua-non of promotion. There is a Vietnamese saying “if you have money you can buy a Fairy” (co tien mua tien cung duoc). Some girls have intentionally become fashion models; with their new identity, they can earn money more easily and quickly. These models or “elite CSWs” can gain USD 200 -1000 per night, which is 5 to 25 times the monthly salary of a state official. Recently, a ‘North-South call-girl ring’ (a pimp network specializing in coordinating model-CSWs throughout the country) has been uncovered (VnExpress 2002). Also, a study found the pimp network, in which out-of-school youth in rural areas were recruited to work in Hanoi selling trinkets and postcards on the streets in tourist areas. As they get older, the girls are often pressed into sex work with offers to work in bars as waitresses or cleaning staff (Elmer 2001).

In sum, in this chapter I have attempted to draw out some of the key social dimensions, which underline the specific nature of the pattern of HIV infection in Vietnam. Both the scale of drug abuse and commercial sex has provided a fertile context for the rapid transmission of HIV. The fact that commercial sex work has been increasing rapidly in recent years, both in scale and diversity, has reflected some erosion in the traditional values. Sex work is becoming more problematic because it is associated with drug use. This has fueled the spread of the AIDS epidemic predominant among IDUs. The mixing of drugs and sex in the time of AIDS should urgently get more attention.

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1 CSWs and sex price are both hierarchical. In Hanoi, for example, CSWs can be categorized into five groups, according to their operational styles: 1) CSWs working in brothels; 2) CSWs working as an occupation in dancing halls; 3) CSWs working as chay so in entertainment establishments (call girls who are controlled by mediators); 4) CSWs working in streets; and 5) CSWs working as sex-plus-service girls, operational in guesthouses and hotels. At the high end, CSWs working in dancing halls (sometimes are called high-class sex workers) can earn from USD 50 - 150 per sex visit, USD 200- 300 if overnight. At the low end, street or brothel FSWs (low class) are compensated for about USD 2-3 for a quick sex, USD 15-25 if overnight (GNP per capita in 2000 was USD 400). In general, the price depends on age, physical appearance, type and quality of sexual service and duration of sex plays.
CHAPTER 3
Methodology

Introduction

In Chapter 1, the objective of the study was presented. Chapter 2 described the socio-cultural context of the epidemic. I am now going to tell the reader about my research that aims to get more insights in specific processes of this larger problem. The research combines an exploratory and a descriptive approach. Emic views of IDUs and their SPs about AIDS risks and their relationships are analyzed from a cognitive-symbolic perspective. In addition, the social contexts and meanings of their risk-taking behaviors are carefully taken into account.

The Organisation of the Study

The Study setting

This study was conducted in Hanoi city and Quang Ninh province, Northern Vietnam.

Hanoi has a population of 2.8 million (2001). During the last few years, together with the economic development and urbanization, migration has become a burden, which complicates the increased unemployment rate. It is often said that earning a living in Hanoi is easier to other provinces. As a result, thousands of jobless people from other parts of the country rush here with a hope for a better life, among them many have become IDUs and CSWs. As reported, about 10,000 drug users are living in Hanoi. The number of CSWs is unknown.

The first HIV infection was reported in the city in 1993. In 1998, the number went up to 337 and by 30 June 2001, 2,879 cumulative HIV cases were reported, of which 76% were IDUs, 5% were FSWs and 2% were STD patients. Among IDUs, the HIV prevalence increased rapidly from 3.3% in 1998, 13.3% in 1999 and 17.5% in 2000. Among FSWs, HIV prevalence increased from 0.8% in 1997 to 3.8% in 1998, 6.5% in 1999 and 10% in 2000 (Hien 2002).

Quang Ninh has a population of one million. It is a tourist point with the two famous attractions known as HaLong Bay and Bai Chay Beach. This province is also famous in Asia for its coal mining industry. Together with Hanoi and Hai Phong, the three provinces form an industrial triangle zone in Northern Vietnam. Quang Ninh has a long border with China- the important source for trafficking
heroin to Vietnam. Chinese tourists often come to Bai Chay to enjoy the beach and to seek for CSWs.

Drug abuse and commercial sex have increased rapidly during the last few years. This has brought a rise in HIV infections. Quang Ninh is ranked the third province in Vietnam regarding the number of HIV cumulative cases per 10,000 inhabitants (MOH 2000). In a cross-sectional survey conducted in Quang Ninh among 602 IDUs, Hien (2002) found that IDUs are very young (99.2% are male and 57% are under 20 years old); have a high prevalence of HIV (32%), and high rate of needle sharing (50.7%).

The study definitions:

1. IDU A person who injects heroin, or injects heroin and other narcotic drugs
2. Smoker A person who smokes opium or heroin.
4. Sex partner (SP) A person who has vaginal intercourse with an active IDU of the opposite sex. SPs include: husbands or wives of IDUs; steady SPs; and FSWs. Those SPs who also inject drug are interviewed as IDUs.
5. Intimate relationships Long-term, primary, intimate, conjugal, or paraconjugal relationships, with at least some months of cohabitation and stability. In these relationships, at least one of them is an IDU.
6. CSW A person who provides sexual services, such as sexual penetration, oral sex or performance of masturbation for payment or reward.

The sampling

Based on rapport developed with a number of local IDUs and/or SPs from the first phase site visits of about two weeks, two active recruits (acted as “index participants”) helped me to identify other prospective participants by a snowball technique. Participants were also recruited with the assistance of two ex-addicts as outreach workers, one male IDU and one female CSW, who are familiar with the network of drug users and prostitutes in Hanoi. The two outreach workers were provided with a short training about the purpose of the study, criteria to select the participants and how to set up a proper appointment. Standard multiple-starting point “snowball sampling” outreach techniques (McCoyl996) were used in different locales to maximize the variation of subjects.

It was not very difficult to recruit IDUs. However, due to stigma towards women using drugs, it was difficult to recruit non-addict sex partners. To recognize injecting status, ‘fresh tracks’ and basic information about drug injection were tactfully checked during the initial minutes of the interviews. To assure SP status, recruitments were limited to individuals of whom the outreach workers had some
prior knowledge. In addition, some SPs were recruited through their IDU partners or individuals in the network.

The sample consisted of 75 individuals (53 in-depth interviewees, 3 case studies and 19 people participating in focus group discussions). No participants in in-depth interviews were included in FGDs. The composition of the sample is given in Table 1 below. Further characteristics of informants are described in Appendix 3. Most of the individuals in in-depth interviews and case studies (53 out of 56) described themselves as heterosexuals. Three women reported involving in bisexual relationships. Homosexuality was also mentioned in FGDs. The main style of intercourse is penetrative sex. However, oral and anal intercourse was also reported. The sample included: former and current IDUs and regular and irregular users of different narcotics.

Table 1- Composition of IDUs and SPs sample.

<table>
<thead>
<tr>
<th>Informants</th>
<th>In-depth interviews (n=53)</th>
<th>Case study (n=3)</th>
<th>FGDs (n=19)</th>
<th>Total (n=75)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>IDUs (incl. SPs who are IDUs)</td>
<td>21</td>
<td>22</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SPs (incl. smoker SPs and non-addict SPs)</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Data Collection Techniques

Primary and secondary data were collected over a period of three months, from 8 August 2002 to 3 November 2002. The methods used for primary data collection were: a) focused ethnographic interviews; b) focus group discussions; c) participant observation; and d) case study:

Focused ethnographic interviews

A total of 53 in-depth interviews were undertaken, of which 51 interviews were tape recorded with informed consent. Two informants in the sex partner sample (one female smoker and one male non-addict) did not agree to be recorded because of fear to be known by relatives and friends.

Each interview lasted between one and one and a half hours. In case of repeated interviews, respondents were encouraged to discuss the previous interview and their feelings about it, as a way of validating the data. Depending on the convenience for the interviews and the mutual agreement between the researcher and the informants, interviews were undertaken in informants’ homes, parks, roundabouts, slum areas etc. The purpose was to seek a convenient place with an
atmosphere favorable for openness.

The topics reviewed in the initial interviews served as an analytic frame of reference for the subsequent interviews. The interview protocol began with questions covering basic sociodemographic characteristics and drug use. Sexual relationships and sex-related issues were probed after that. Questions were asked in a non-standardized and conversational style.

The interviews were loosely structured, conducted with the assistance of the Question Guidelines. (see Appendix I). It seemed that interviews would provide richer information if the Question Guidelines were not put in front of the researcher. Lastly, informants were compensated with meals and/or gifts (equivalent to USD 4 for each) as a token of thanks for their time and contribution. I did not see any biases growing out of this compensation.

**Focus group discussions (FGDs)**

Four FGDs were conducted, with a total of 19 participants, each consisted of 4-7 informants. Because the sex topic is sensitive, two FGDs included only females and the other two with only males. Due to time limit and social condemnation towards women living with IDUs, it was impossible for me to recruit non-injecting SPs for FGDs. Each FGD lasted between one and one and a half hour. The selection criteria for FGD participants were the same as for individual interviews. The purpose of FGDs was to summarize and validate the findings collected from individual interviews. Different methods were used to stimulate discussions; for example, a vignette in which some situational contexts of IDUs’ sexual relations and risk behaviors were described by the researcher. The group was then asked if they recognized the situation and whether they had any comments.

**Participant observation**

Participant observation was divided into two phases and focused on the following themes: drug use, the social contexts of multiple relations and risk-taking behaviors, and argots/slang used by IDUs’ network members.

First phase participant observation was conducted during the start-up of the study (about ten days): I wore casual clothes and hung around with two outreach workers at the drug use sites where IDUs often congregated: parks, slum areas, roundabouts etc. Sometimes I went with the two outreach workers and sometimes I went alone. At the same time, I also developed rapport with two IDUs, one male and one female, who were living in my residential area. These two “index participants” were very helpful during the whole process of my fieldwork. They assisted me in recruiting informants, including making appointments,
crosschecking data, and facilitating FGDs.

Through the first phase observation on-site I was able to directly observe everyday life and interactions among IDUs. I also conducted initial short interviews randomly. I was sitting with them in teashops and several times in lo nghien (shooting galleries) with the purpose to make their acquaintance and witness drug life. As IDUs liked to talk about drug injection and craving rather than sexual issues, I have made use of this fact to adjust the order in the question guidelines for easier probing. In addition, during this phase I tried to interact, as much as I could, with “opinion leaders” in the network (individuals who were connected to many drug users and who were able to influence them in some way).

Second phase participant observation on-site was conducted during the remaining course of fieldwork, including observation in FGDs. I wrote field notes (either in the field or at home) to record day-to-day events and behaviors, overheard conversations and casual interviews. Field notes and interviews were revised everyday together with the two outreach workers or “index participants” to avoid missing data or misunderstanding of jargons used by IDUs. To complement the data collected during participant observation, I also conducted informal interviews with different key informants. During the fieldwork, I also visited a number of IDUs’ families, in order to understand more about the contexts of sexual relationships and drug use among IDUs and their SPs.

**Case studies**

I conducted three case studies (life stories): The three informants (two female and one male) were interviewed more than once to broaden the information and to better understand different social contexts of different patterns of sexual relationships. The selection criteria were the same as for IDUs and SPs. In addition, informants should a) be able to speak clearly and elucidate the dynamics of their drug life coherently; b) reside in different locations (for easier comparison

1. Key informants include:
   1. One staff from Hanoi AIDS Committee
   2. One staff from National AIDS Standing Bureau
   3. One staff from SHAPC, a local NGO
   4. One staff from Dong Da Hospital, Hanoi
   5. One staff from Rehabilitation Center, Hanoi
   6. One drug dealer
   7. One member of the After-detoxification Club
   8. Two pharmacists
   9. Three restaurant owners
   10. Five tea-shop owners
   11. Five service motorbike men
   12. Six parents of IDUs
and confirmation of data). Initially, I planned to recruit two non-injecting SPs but I
did not have enough time. However, Case 1 and Case 2 are the two in which two
female IDUs also are engaged in multiple sexual relationships. Through their
stories the portraits of different SPs were illustrated.

Secondary data collection:

In addition to the above-mentioned methods, the researcher also collected data on
the socio-demographic features of IDUs and their SPs. During each interview, I
also collected data on IDUs' network, drug injecting techniques, and sexual
orientation. Towards the end of the study I collected data on AIDS prevention and
intervention programs in Vietnam. Other methods that were applied:

- Interviews with health policy makers in Hanoi.
- Gathering and reviewing documents and reports.
- Literature review

Data Processing and Analysis

The preliminary phase of analysis began during the data collection period. 54
individual interviews were tape-recorded and transcribed verbatim in Vietnamese
where necessary. Data were organized and condensed according to the research
themes. The emerging themes were used in subsequent interviews and in the
FGDs. To avoid missing information, data were revised daily and weekly with the
assistance of two outreach workers. As a method of information review, every
night before going to bed I listened to the tape(s) that was recorded during the day,
taking notes and writing down the slang used by the informants.

The data were processed by hand. Each informant’s transcript was summarized in
a separate file on the computer. Then the data relating to research questions were
re-summarized in a data master sheet to ease analysis process.

Ethical Considerations

I was obedient to the following principles: 1) bearing responsibility of doing no
harm to the informants; 2) making conscious decisions on what to report and what
to decline to report, based on careful consideration of the ethical dimensions of
the impact of information on those who provide it, and the goals of the research; 3)
deciding how much to participate or not to participate in informants’ lives
(Bernard 1998). Prior to all interviews, informed consents were obtained, after a
clear explanation of the objectives, uses of the research, the rights of informants
and uses of tape-recorders and field notes.
Due to strong stigma towards IDUs and CSWs, maximal confidentiality was guaranteed through the concealment of identities and use of pseudonyms. In addition, anonymity for participants was preserved in field notes. Social distance between female informants and myself, as a male researcher, was kept as low as possible. At the end of interviews, informants who expressed a need for information, counseling or treatment were either professionally advised by the researcher or referred to quality services.

**Difficulties and Limitations**

The most difficulty in recruitment was setting up appointments with IDUs and/or SPs. Although my two “index participants” and outreach workers were very enthusiastic, many IDUs and SPs broke their promise for scheduled meetings, and in fact, it was very time-consuming. Because the topic was sensitive, it seemed that men were easier to meet than women. Usually, I had to give my mobile and home phone numbers to the two index participants, and to some IDUs who requested a means for contact. Then I had to reimburse them for the telephone call if they called me.

In Quang Ninh, it was very difficult to get in contact with SPs because when I arrived there, it was the time of a big anti-social evil campaign launched on the occasion of the National Day (2 September). Most of the IDUs were scared of being arrested by the local police and sent to a detoxification center. Consequently, I could only undertake in-depth interviews with male IDUs who often congregated on the crowded beach. Some men were willing to help me in contacting with their SPs. However, most of SPs refused to meet me because of the campaign.

It was not very difficult to recruit IDUs but it was very hard to find non-addict SPs, smoking SPs, and same-sex injecting partners. For non-addict SPs, especially females, the main reason was because of social stigma towards women living with IDUs. An IDU told me: “my wife said ‘tell Lam that I never give personal information to anyone but my husband. If I do, it means that I betray you’”. For smoking SPs, there were three reasons for difficult contact: a) the duration of shifting from smoking to injecting is usually short; b) because smoking and injecting overlapped at some point, the easiest way to contact smoking SPs and verify their smoking status was through their injecting SPs; c) most of them lived with IDU partners who were occasionally arrested by the police for their criminal offences or forcibly sent to a rehabilitation center or a detoxification facility for drug addiction or prostitution. As a result, I rarely got the chance to make contact with smoking SPs.

For most of the individual interviews and FGDs, incentives (cigarette, inviting for...
meal, gifts, etc.) were given to the informants. In some cases, however, they asked or even “conned” for cash. Knowing that giving money to IDUs is an act of “lending a hand” to the addiction, I still had to accept the situation. In some other cases, IDUs borrowed money from me and did not return.

The fieldwork was carried out in only three months. This short duration could possibly affect the quality of ethnographic techniques. It was time consuming to recruit the informants, especially the SP sample. Therefore the time for participant observation, which is a powerful tool for this kind of research, was very short. Although the majority of informants were cooperative, recall bias might occur, especially when describing past sexual activity and/or drug practices. In addition, information provided by SPs might create a different portrait of sexual relationships than IDUs or vice-versa. Lastly, FSWs were normally seen to be more openly in sex confiding. Non-prostitute women, however, were reluctant to talk about sexual experience with male outsiders.
CHAPTER 4

The Drug Scene as the Context of Sexual Relationships

In order to fully understand the characteristics of different patterns of intimate relationships among IDUs, it is critical to examine their relationships in the context of the drug subculture. In Vietnam, this subculture is labeled by drug users as “Canh nghien” [drug scene]. In this chapter, I analyze some important parameters of the drug scene, which affect the intimate relationships among drug users. First, I describe the relations of drug and money. Then I analyze different patterns of syringe sharing in contexts. After that I examine the association of drugs, sex work and condom use. Lastly, I explore the effects of drug use on sexual experience.

Drugs and money

Many drug users reported drug habits costing between VND 50,000 and VND 300,000 (USD 3.3-20) per day. This is an average figure because the price varies between regions. For example, according to some drug dealers in Quang Ninh, white powdered heroin in Quang Ninh is 9 times (at retail price) more expensive than in Hai Phong. A bag of heroin is often wrapped up in papers with different colors indicating the amount of drug. For retail sale, one bag costs VND 50,000 (USD 3.3), which is a minimum dose used by two injectors. Most of the drug users agree that their drug habit increasing in proportion to the amount they can afford to spend on it. The motto ‘co nhieu dung nhieu co it dung it’ [the more you have, the more you spend] is widely adapted by drug users as an excuse for their extravagance in spending money.

“Quay tien an thi kho, quay tien choi thi de” (It is difficult to make money for meals, but it is easy to make money for drug use) is another saying. It means that once you are in the scene you can think of many ways to earn money to serve your craving, and the more you get deeper in the life, the more flexible you become. Even the most sacred object can be sold to satisfy their desire for drug:

I am sorry but when you are on drug you will loose all your human personalities. Even the incense pot on the altar can be sold.

(14: Female injector, rehabilitation center)

1 During my interviews with IDUs in Quang Ninh, many report that they often go to Hai Phong to buy heroin (whole sale) and bring back to Quang Ninh and sell with more expensive price (retail sale). Bai Chay, Cam pha, Cai Dam and Gieng Day are the four “hot spots” for IDUs and CSWs in this province.
Money, which is always a “hot topic” for drug users, can play an important role in the maintenance of sexual relationships:

Now 100% of talks are about money, money and money all the time. Even money is coming in dreams. To be more frank, the reason of [drug users’] cohabitation is all money, that’s simple.

(7m: Male injector, Hanoi)

During the fieldwork, I could observe that drug users often pool money to have a shot. The pooling of money does not mean to be equal. Rather, those who have more money can share with those with less. When two injectors dica (go together for a shot), they often try their best to make sufficient money for a drug sharing. It is rare to see a drug user shooting while the other is craving. They explain that the witness of someone shooting while “the observer” is sick would be ‘impossible’ or ‘I could not bear it’:

Once I dica [go together] with someone, there are two things we do to together: get money and take a shot

(21m: Male injector, Hanoi)

The image of money and how to acquire it is always on the minds of drug users. A 24-year-old girl reported about her “money phobia”:

You know when I am sober it is different but when I’m sick I only think how to get money. In the past, for the same thing, I spend 10 but now I spend only 2 or 3. Now I feel sort of stingy you know...he only thing on my mind is how to accumulate enough money for a shoot.

(24f: Female injector, Hanoi)

The ways to make money are varied and sophisticated. They include: skillfully asking parents and relatives, borrowing from friends or acquaintances, deceiving relatives or friends, temporarily working as a drug dealer, working as a sex workers or prostitution mediators, stealing, gambling, and putting personal properties in pawnshops. However, the techniques to earn money are different among men and women. One of the most striking distinctions in terms of moneymaking styles among men and women is reflected in the saying “tao di an cap may di lam pho” (I [the man] go to steal and you [the woman] do prostitution). Many men tend to finance their drug use through criminal activities such as drug dealing, house breaking and robberies:

Every morning after we shoot he goes out with his band about 4 or 5 men. You know, they drive to the outskirt of Hanoi to ‘dap hop’ [break into a house]. You know, he can
As a strategy to feed the drug habit, it is also common for some male IDUs to seek injecting female sex workers for a temporary cohabitation:

Many men live on prostitutes. These men are so dependent on these women you know. They seem to lose their manly characteristics.

(12: Female injector, Hanoi)

Similarly, many women try to make the most of their relationships in more sophisticated ways. This “exploitation strategy” is labeled by drug users as dao mo [money digger], which is mostly found among the relationships between female IDUs and male non-addicts:

Those were the men who liked me. I do not love them but I think I am addicted so I should go to them and exploit them. And they go to me for another thing [sex]. They know that I sort of ‘money digger’ but they still accept that. Yes such things [relationships] are fast and temporary only...until one day I have to seek another man, something like that.

(17f: Female injector, Hanoi)

Some female drug users, who had to work as a sex worker to feed their drug habit, have different “schemes” to deceive their clients. As described by a 23-year-old girl how she and her sex partner deceived a client:

He [client] and I agree the price of VND 200,000 [for a quick sex]. Then I rent a guesthouse where I often go. As we [he and I] are in the room, I pretend to forget something and go down to take it...of course; my husband is waiting for me at the base already. You know I should ask him [client] to give me money in advance, see...he has to pay the room rent as well.

(11f: Female injector, Hanoi)

When in great need, money is usually associated with risk acceptance, whether sharing a syringe or unprotected sex, provided that they can get “hot money”.

When money is abundant and you are not sick, it is Ok to walk 1 or 2 km to buy do [works: syringe]...but when I am sick, I beg my friends any [syringe] for a temporary shot just as they finish the shot. This is exactly the same way when I am prostituting. When I am well [not sick]- I still have cash in my pocket—it means that I only agree to go [with clients] when condom is there. But when I am sick, it
Syringe Sharing: Patterns in Context

Syringe sharing is a frequent and normative activity in the drug scene, which is applied by drug users as a means to cope with the immediacy of their craving. Syringe sharing has been described as one of the highest risk practices in the spread of HIV infection because potentially infected syringes are utilized in the process of sharing drugs.

Patterns of syringe sharing and the situational contexts attached vary between geographic locations. First, I give a description of different techniques of syringe sharing, and then I move to the patterns and contexts.

Syringe sharing techniques:

Grund et al (1996) mention the following techniques in other countries: frontloading, reversed frontloading, backloading, storage syringe, sharing from the cooker, and sharing a load. In Hanoi and Quang Ninh where I conducted this study, 'frontloading' and 'sharing a load' were the two common practices applied by the drug users.

Front loading (sharing a load but different needles)

This technique is most common practice by IDUs in Hanoi and Quang Ninh. It works like this: the needle is removed from the hub of a 'receptive' syringe; its plunger is pulled back. The needle of the 'donor syringe' is then inserted through the hub at the front of the 'receptor' syringe, and a part of the solution squirted in. This technique can only be used when the receptor syringe has a detachable needle.

Sharing a load (sharing a load plus sharing needle)

The practice works as follow: after dissolving, the liquefied drug is drawn into one syringe. The first injector injects himself with part or half of the contents of this syringe, and then the second injector injects the remaining contents, including the 'flag' (the blood drawn into the syringe to see if the needle is in the vein) of the first user.

1 Hereinafter syringe sharing should be understood as to both syringe and needle sharing.
The following field note describes a sharing episode in which this technique was taken by an injecting couple in Hanoi:

The couple starts to prepare a shot. The man holds a small pack of white powdered heroin wrapped in tinfoil, takes out the plunger from his 3ml detachable syringe and pours the white stuff in to the barrel on his right hand. He takes a tube of distilled water and breaks the tip of the tube. He carefully puts the needle into the tube, and by pulling the plunger gradually, he draws the solution into the barrel. When the calibration on the barrel indicates number1, he begins to shake up the syringe so that the powder stuff is dissolved completely. The woman is rolling her sleeve and making a fist for the shot from him. The man pumps up her veins. He looks carefully at her arm and then sticks in the needle. While he pushes and pulls the plunger a little, a small amount of blood immediately runs into the syringe. Then he pushes the plunger gradually and pumps the mixture into her vein. He is pumping halfway when he stops. He pulls out the needle from her arm and immediately pumps the remaining mixture into his veins on his left hand. He fires a cigarette, sticks the filter to the bloody place where he has just injected and continues smoking. I asked: "what for?" he said "not to waste [the blood]". The whole process took place in about seven minutes.

(Fieldnote in Hanoi)

Patterns in Context

Syringe sharing events occur in many contexts. I suggest ten patterns of syringe sharing with the contexts attached (Matrix 1)

1. Sharing between primary sexual partners and spouses. Most injectors (42 out of 47) in an intimate relationship with a heterosexual injector report sharing. The great majority of the sharing we identify throughout this study is between primary sexual partners or between husbands and wives. It is evident that sharing syringe occurs on a basis of trust individuals place upon each other. Many injectors believe that by limiting their sharing to their sex partner they can somewhat minimize the risk of infection. Trust here refers to a sense of security in this relationship:

   We don’t fear anything [being infected with HIV through sexual route] once we have lived together, let alone sharing.

   (17m: Male injector, Hanoi)

   Once we are spouses, no need to avoid it [sharing]

   (8m: Male injector, Quang Ninh)
Spousal sharing is safe. Nothing to worry about when you are husband and wife

(18f: Female injector, Hanoi)

2. **Sharing between (close/best) friends.** This pattern is most likely to be found among men and occurs when two IDU pool money to buy drug for a shot, but there is only one syringe. In this context, the person who is “more trusted” (expectedly non-infected) or “more respected” (having more money) would have “more power” and thereby injecting first. The second person then reuses the syringe of the first person. This means that the second person would risk the chance of possible infection if the first person were positive. This action is labeled by drug users as *chat nhuong nhin* [giving in nature]. The word “trust” in this context, which implies “cleanliness” or “HIV negativity”, is synonymous with the degree of one’s risk assessment and judgment of their friendship in a sense that “because he is clean so I accept to shoot after him”:

Sometimes I shared but he [the person I shared with] should be the one I believe, or he is a beginner or novice injector.

(9m: Male injector, Quang Ninh)

Sometimes I shared with my friends who never play [inject] after anyone

(15m: Male injector, Quang Ninh)

Sometimes I shared but he [the person I shared with] should be the one I believe, or he is a beginner or novice injector.

(9m: Male injector, Quang Ninh)

Sometimes I shared with my friends who never play [inject] after anyone

(15m: Male injector, Quang Ninh)

In many cases, after I shot I gave my syringe to them [my friends]

(19m: Male injector, Hanoi)

3. **Sharing between two seronegative injectors after return from rehabilitation center.** This pattern commonly occurs between two IDUs who meet while they are in rehabilitation centers or detoxification establishments. Most of the respondents in this study spent sometime in these centers at least once. The following fieldnote explains this sharing pattern:

Sharing occurs when two IDUs, who are known to each other, in rehabilitation center, believe that they are free from HIV (because of negative test undertaken as a procedure of detoxification). This makes the two injectors feel safe and they will possibly share one syringe on return to the community. In this case the sharing may take place when syringe is unavailable or when one person lends/borrows his or her syringe to/from another. However, it is possible that both of them are still in the window period2, which is unknown to them.

(Fieldnote from focus group discussions)

4. **Sharing between two seropositive injectors.** This pattern is very common among
HIV/AIDS carriers:

After I got infected with HIV I often shared with my friends who were also infected...if syringes are not there, we play in turn [sharing one syringe]

(22m: Male injector, Hanoi)

5. *Sharing between one positive and one negative injector.* This is perhaps the most worrying case in which the positive person-being trusted by the negative person- unknowingly passes the syringe to the latter, who does not know that the lender is infected:

I shared with him only once. He did not know that he was infected. It means that I believed him and he never thought that he was infected. In that case [there was no syringe] we would think " both of us are not infected and he would say to me "let take mine [syringe] for a hit"...That's it in the case of no way out for a shot. So [I] have to use his syringe although he did not want to...later he died in PS prison camp.

(25f: Female injector, Hanoi)

6. *Sharing in institutions.* In this case, several people, even hundreds of people, share one syringe as a result of syringe scarcity in these establishments. This has posed to the possibility of serial anonymous infections occurring between groups of IDUs and has to be seen as a situation of very high risk:

In prisons they share much more than outside (community). Hundreds of men share one [syringe]. You know to have a mui thuc [a shot] we resort to different styles of van vo [tricks]. It's so hard there [in prison]

(16m: Male injector, Hanoi)
Matrix 1- Ten Patterns of Sharing Syringes and Needles in Contexts

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Context</th>
<th>Need to inject</th>
<th>Craving</th>
<th>Syringe scarcity</th>
<th>Trust</th>
<th>Lack of money</th>
<th>Carelessness</th>
<th>Lack of AIDS knowledge</th>
<th>Confusion</th>
<th>Revenge</th>
<th>Lending/Borrowing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sex partners &amp; Spouses</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>No</td>
<td>Not necessary</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Close friends</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Sometimes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Two negative IDUs (post-detox)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Two positive IDUs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>One positive &amp; One negative</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Not necessary</td>
<td>No</td>
<td>Not necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Institutional (rehabilitation/detoxification/prison)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
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<td>7</td>
<td>Shooting gallery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Dead-end</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>No</td>
<td>Not necessary</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Accidental</td>
<td>Yes</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Not necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Non-accidental</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Not necessary</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

- the belief that a fellow/partner is free from HIV
- confusing to use an infected person's syringe
I would rather detox at home than going there [detoxification center]. You know one syringe is passed on to unknown number of people.

(9m: Male injector, Quang Ninh)

7. Anonymous sharing in shooting gallery. Five respondents report that they used to inject in shooting galleries where prepared syringes with drugs were available on sale. These syringes possibly were not sterilized and used by different people. In this case “trust” is not important. The need to inject, craving and syringe scarcity prevail. This has to be seen as a situation of high risk:

The first time I had a shot in a shooting gallery. There you can buy as many drugs as you can. Syringes with drugs inside were ready on sale. I was not sure whether those syringes were sterilized or not.

(18m: Male injector, Hanoi)

8. “Dead-end” sharing. I want to term this pattern as “dead-end” because perhaps this is the most striking sharing pattern in which people implement the injections after collecting or begging for several syringes from strangers when they are about to finish the shot or when they have thrown away. Invoking these IDUs is a way of talking about drug use, which is considered to be dirty and desperate facets of behavior. These junkies are characterized by their willingness to share other people’s used equipment (“trust” does not play a role anymore) and their apparently insatiable drug habits:

The poor guy started to collect syringes, which were recently used and abandoned by other shooter. He picked one, two, three syringes. He was patient to collect. He went on picking more syringes, about 30 or 40 [syringes] I think. It was fresh syringes cos I still saw blood inside [those syringes]. Then he began to pour the remaining contents of all 40 syringes into his [syringe]. After he shot he continued to pick syringes for the next shot. The moment when he finished his picking work [to have enough drugs for the previous shot] was also the moment when the next craving arrived.

(7f: Female injector, Quang Ninh)

I drove into a small lane with many teashops on either side. Just as I stopped and locked my motorbike, 4-5 young women turn up and say to me: please come in, we watch out the motorbike for you. Just as I nearly finish the shot—only about 0.2ml solution left, a girl said: “don’t finish it, please, give me the remaining [drug]!” I pull back my syringe, and immediately the girl grasps it from me...blood remnants are clearly seen in the space between the hub and the plunger. She pumps the remaining solution into her own syringe and holds it...she collects residual drugs from 4 or
5 men like that and she will pump into her veins...I asked her "have a fever or allergy, cause you use 4-5 different types of blood?" and she says "no", and he continued to give his comments: "such kinds of prostitutes who have become sort of cheap and ugly...nobody [client] wants to fuck them so they run out of money all the time. So they always practice begging or grasping any polite man...waiting for the remaining drug stuck [in the barrel]...days by days...hundreds of people in Xomlius. Now they move to Ngouynh.
(17m: Male injector, Hanoi)

9. Accidental sharing. In case of positive-negative couples, some sharing may occur inadvertently as a result of confusingly using the infected person's syringe. This confusion is partly resulted from the mutual trust between the two:

It is the case of a person infected living with a noninfected. Very often the infected store their own syringe in a separate place after marking it [syringe] in a certain way. However they often mix up.
(21m: Male injector, Hanoi)

10. Non-accidental sharing. Sometimes, a positive person intentionally substitutes his or her infected syringe with a small trick so that a negative person is unknowingly infected. In this case the latter misplaces trust on the former. The reasons for this intentional infection are explained by some drug users as “revenge”, “because of conflicts” or “I want you to become infected like me so that you have to ‘stick’ your life to mine”. As reported by the two injectors:

I know some people who used to stay in rehabilitation centers for some time...they were infected you know. But when they returned to the community, they even shared [intentionally] with close friends who never shared in the past. The positive person insisted on inviting the other to share until one day [the invitee] was infected.
(8m: Male injector, Quang Ninh)

My friend confided: “it was because of men who passed the virus to me. Therefore now I also do the same way [infect them intentionally]”
(20f: Female injector, Hanoi)

Drugs, Sex Work and Condom Use

The majority (21 out of 24) of female injectors became sex workers after addicting to a drug. The main reason for their involvement in sex work is to finance their own or their partner’s drug habit. This also shows the economic relation between drug use and sex:

[Lam: how do drugs and sex relate to each other?] It is an
economic relation. As for me, I became addicted and then I had to work as girl [sex worker]...to earn money to support myself first [drug habit] and also support my sex partner.

(12f: Female injector, Hanoi)

In focus group discussions among injecting women, it is clear that one of the main reasons for them to get deeper into the drug life is the need to have a shot before going to work.

Taking a hit before going to work is a must [to enhance health]. Going to work in craving status is okay but it is sort of uncomfortable feeling. Yes, anyways, [I] should have a shot before going to work. It is important to have sufficient dose first...everybody does the same.

(23f: Female injector, Hanoi)

These drug injecting prostitutes live in two separate contexts: life in the street where strangers may become their casual or regular clients and life at home where private sex partners or spouses provide some sort of security to them. Casual clients can be considered as one-off sexual encounters. A regular client is someone who pays for sex after a short introductory period and the couple is usually involved in a sexual relationship for a limited time. A male sex partner is considered to be more of a long-term partner who supposedly has a vested interest in the physical and emotional well being of his companion. At some point, however, the relationships between injecting prostitutes and their sex partners are situated in the fuzzy middle where love, sex, risks and money are blurred in people's attempts to find what they desire.

In street life, the condom is represented as a habitual and integral part of their work. The great majority of the injecting women reported insisting on the use of condoms with both casual and regular clients:

Very often we [drug users] don't use condom when we have decided to live with each other. But for clients, even regular clients we always use condom.

(20f: Female injector, Hanoi)

In some contexts, women use their power to force men to use a condom, without threatening the sex-for-money exchanges in which they engage:

I have a disease [pretending] and I think you [client] should use it [condom]. It is better to use a condom. It will keep safe for both of us.

(9f: Female injector, Hanoi)

You know well that the disease [AIDS] is overwhelming...If you want to keep safe for yourself you have to keep safe for
me as well. If every man is like you [don’t want to use condom], will I be alive?

(3f: Female injector, rehabilitation center)

Using a condom is to keep safe for others first. Our occupation is sex work. You are my client. You have to keep safe for yourself because you still have wife and children. For us [sex workers], we are not sure ourselves [about being infected or not]. Maybe today is no problems [not infected] but what about tomorrow’s [HIV] test? So you should know that. Don’t exchange a spontaneous minute now for a regret later

(18f: Female injector, Hanoi)

Condoms are often used when injecting women have sex with their one-off sexual encounters or even regular clients, but condoms are dispensed with once the couple decides to cohabit. The transition from regular clients to private sex partners is often “marked” by the decision of the woman whether to use condom or not:

We [injecting prostitute women] use condom only with [casual] clients...but once we [the client and I] have determined to live with each other we never use it.

(12f: Female injector, Hanoi)

I still use condom with regular clients, except the case when [I] feel that we [the client and I] will sort of decide to live together...then I would not think about it [using condom]...if he and I meet each other for that purpose [having sex on the street] I still force him to wear condom. [Lam: what is the difference inherent in these relationships then?] It is different of course. If you come to me frequently, [I] see you as my regular client only. But if you live with me...it is different, because very often when we begin to live together we rent a house. Therefore we stay together all day long, except the time I spend in the street [for sex work]. If regular clients want to partner with me...I have to investigate something [to find out what kind of man he is]

(19f: Female injector, Hanoi)

What is interesting about this extract is that the young woman did not mention how long the “transition” lasted. This would mean that the “boundary” between these two periods- two patterns of relationship- are blurred and unclearly demarcated, and that sometimes during this period, she would not use condom with that man.

The Interplay of Drugs and Sex

Previous studies mention pharmacological and physiological effects of drugs by showing that opioids, and especially heroin, make sex difficult, “uncomfortable”,
repress libido (Rhodes 1998, McKeganey 1992). While this is true in general, our data show that the matter is much more complicated.

Among the world of drug users, drugs are viewed as the first priority, whereas sex ranks the second. According to two injectors in Hanoi:

For a normal person, sex is the most favorite pleasure. But for drug users it is only a minor thing. That’s paradoxical. (16m: Male injector, Hanoi)

As for me, sex cannot compare with drug because addicts are always guided by drug. Drug and sex cannot be in balance (22f: Female injector, Hanoi)

Most of IDUs in this study said that their sexual demand and the frequency to have sex decreased over time, as they got deeper into the drug life:

We have sex less than before, from the beginning it was frequent. But later when [we] play heavy it [sex] was not necessary. (17m: Male injector, Hanoi)

In general, women seem to have a more “positive attitude” than men towards sexual life. While women are more likely to report about the pleasure they have with sex partners during a sex act rather than a loss of interest in sex, men, on the contrary, usually complain about their sex life: “I had sex for the sake of it”, “It was my duty rather than pleasure”, “I felt irritable...I could not erect”, “I felt painful and unable to ejaculate”, “it was a compulsory sex”, “it took long like a century”.

Drug users differ in their sex life. In the drug use subculture, “juniors” are defined as novice injectors or amateurs who have a history of a few months (usually from one to three months) after shifting to injecting pattern. “Seniors” are experienced injectors who have involved in injecting life for at least five to seven months. Juniors and seniors bear distinct features in terms of the timing to have sex, sexual desire and feeling during a sexual episode.

Some male juniors report that they prefer having sex right after the injection with the condition that the drug dose should be used at a low level:

[Amateurs] liked to shag [have sex] right after the shot. But the hit should be done in a way that you don’t get too high (22m: Male injector, Hanoi)

In contrast, most of seniors (both females and males) do not want to have sex right after the injection:
It is very rare to find someone to have desire for sex right after a shot

(1f: Female injector, rehabilitation center)

Among the exceptions, however, four IDUs said that they want to have sex right after a shot:

As for me I like fucking after a hit, right away. I had to do masturbation for my husband [to stimulate his ejection].

(19f: Female injector, Hanoi)

After shooting, the need for sex is higher than [the one I had] when I was nonaddict

(10m: Male injector, Quang Ninh)

One female injector explained that she wanted to have sex right after the shot in the condition that the drug dose should be low:

If we play moderate [inject with a low dose] we can fuck right after the shot. After fucking we take another shot and want to go to bed.

(2f: Female injector, rehabilitation center)

Both male and female seniors report that they want to have sex when the craving comes up, provided that this craving lasts rather long, normally from 3 to 10 hours; or when they are in post-detox period. Subsequently, women want to have a quick sex, which means that ejaculation should be implemented in a quick manner:

For example when I shoot moderately I never think about sex, but when I stop shooting for a while, I always think about it. That’s strange... having sex when craving makes me feel comfortable and also to forget about drug

(14m: Male injector, Hanoi)

If I have a shot in the morning and I don’t shoot during the rest of the day... it is clear that during the time intervals from afternoon until night, at some moments I want to have sex. But that sex demand exists only in my mind. It is not as urgent as demand for drug. If demand for drug is, say 70%, the demand for sex is only 30%. However sex desire appears intermittently. After a while it may be disappear. But if I have a man beside at that moments and he wants to fuck I would often say “Listen I am so craving. I don’t want to fuck right now”. However if we still have sex then, I feel sort of enjoyable anyways, provided that it [ejaculation] should be fast. If he takes long I feel sort of uncomfortable.

(16f: Female injector, Hanoi)

When female seniors feel “rather full of drug”, they like long sex:
Most of us [female seniors] like long sex. Only long sex can produce good feeling. If sex [ejaculation] is done fast I can't manage to realize what kind of enjoyment it was
(20f: Female injector, Hanoi)

When I am in noncraving status, it takes long to have an orgasm
(4f: HIV female injector, rehabilitation center)
CHAPTER 5

Different Patterns of Intimate Relationships among Injecting Drug Users

In this chapter, I describe different patterns of intimate relationships among IDUs. Analytically, we can make the following categories of:

Pattern 1- IDUs in a heterosexual relationship with an IDU;
Pattern 2- IDUs in a heterosexual relationship with a drug smoker; and
Pattern 3- IDUs in a heterosexual relationship with a non-addict.

Matrix 2- Parameters for analysis in three relationship patterns

<table>
<thead>
<tr>
<th>IDU-IDU Relationship</th>
<th>IDU-Smoker Relationship</th>
<th>IDU-Nonaddict Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons of cohabitation</td>
<td>The difference between smoking and injecting</td>
<td>Partnering</td>
</tr>
<tr>
<td>Injecting practices</td>
<td>Switching between smoking and injecting</td>
<td>Non-disclosure and the &quot;double life&quot;</td>
</tr>
<tr>
<td>Condom use</td>
<td>Sex and condom use</td>
<td>Condom use</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>Reducing and stopping drug use</td>
<td>Managing relationship</td>
</tr>
<tr>
<td>Reducing and stopping drug use</td>
<td>Managing relationships.</td>
<td></td>
</tr>
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<td>Managing relationships.</td>
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Each of these relationship types has different characteristics. Based on the problems emerging from the study, I shall focus my analysis on key parameters in each pattern respectively (Matrix 2).

Characteristics of IDU-IDU Relationships

This type of relationship is the most prevalent among IDUs. The majority of sexual relationships between a drug injector and a sex partner will, in the long run, shift to this pattern. However, this is also the most "risky relationship" because couples have to cope with two potential risks simultaneously: unsafe drug use and unprotected sex. In this chapter, I analyse the following themes: the reasons of cohabitation; injecting practices; condom use; risk assessment; reducing and stopping drug use; and managing relationships.
Reasons of cohabitation

These relationships are considered as advantageous by most IDUs because of the shared commonalities and mutual understanding. Such relationships are viewed as "we are in the same boat", or "we both share a special affinity". Sharing the same injecting habit is highlighted as the most important element:

The majority of shooters live with shooter cos they have many things in common...we are in the same boat [we both inject] so it is easy for us to sympathize with each other

(17m: Male injector, Hanoi)

A common habit of injecting seems to be a necessary condition for the formation of IDUs-IDUs relationships. In the drug subculture, once men and women are known to each other, they often start their love affair by a close friendship, which is often "marked by a shot" or a drug sharing. The amount of time between the first moments they meet until the decision to live together is usually short:

It is quick for shooter play [partner] with shooter, you see?...playing with nonaddict is difficult.

(24f: Female injector, Hanoi)

While seeking a sex partner, many Vietnamese women value manliness. But female IDUs see it as less important than having the same injecting style:

He is sort of having the same interest [with me] to use drug...he is well...manly: caring, loving, considerate. We [female IDUs-CSWs] often lack love you know. Even whoever we live with we never care about financial issues or something. It means that we covet for love...we want to live with those who are compatible in terms of personality or who can understand our sadness and know how to encourage us emotionally.

(9f: Female injector, Hanoi)

Most relationship patterns, in the end, lead to IDU-IDU pattern. Being in this relationship, people don't have to explain or hide anything. They feel mutually understood. Indeed, although during the course of their drug life some female IDUs intermittently partner with a non-addict man, but that kind of "discordant relationship" often exist only once. After living with a non-addict for a while, injecting females often go on seeking other injecting males, as they prefer to do so:

I like living with a shooter after all...we feel comfortable in those relationships because sometimes we can confide and share intimate feelings at night...you know we can't sleep. So [male IDUs] have many things in common [with me].

(13f: Female injector, Hanoi)
Injecting practices: “The Dynamics of the Shooting Meal”

Most injecting couples do not seem to care much about the possible infection caused by sharing. Often, the significance of their relationship usually outweighs the risks of sharing:

Once being a husband and wife...having had sex already...so sharing or not sharing are the same.

(19m: Male injector, Hanoi)

Taking two or three shots per day is a common and normative activity. The need of injecting is so important for IDUs and their SPs that they call a shot as bua (meal). They take meals in different ways. The majority of injecting respondents say that they use two patterns of drug injection “it depends [on the availability of syringe], sometimes we use separate syringes and sometimes we share one”. However, even in the case of using two syringes, accidental sharing may occur, especially at night when syringes are reused. By marking the injecting paraphernalia after use, drug users believe that they use their own one. But if the syringes are put in the wrong place and their craving comes, they can’t make sure that they use the right syringe or not. In another context, when reusing two separate syringes is not the habit and the injecting event occurs at night, when the second syringe can’t be bought, it is common that a couple shares one syringe, with a simply rinsing with water. All the time, a variety of uncertainties are constantly haunting the minds of injecting couples:

...cos we live together, you know all sort of things....shooting, being sick...many things may happen and you never know [the risks]...for example scratches during a shot or something like that.

(22m: Male injector, Hanoi)

Shooting at home is considered to be “safer” than shooting outdoors. Our data suggest that syringe sharing is not confined to a sexual relationship, with 9 out of 22 of the male partners and 6 out of 24 of the female partners sharing outside of their current relationship. Men seem to share outside more frequently than women. During my interviews with female IDUs, I observed that many women feel uncertain about the sharing behaviors of their male SPs, which might occur outside the home:

He and I share at home all the time...but of course I am not sure [whether he shares or not] when he is out.

(20f: Female injector, Hanoi)
Reducing and withdrawing drug use

Almost all injecting interviewees see attempts to stop injection is a difficult problem associated with their dyad relationships. Stopping drug use when both partners were injectors was described as “nearly impossible”, “very hard” or “never works”. The only possibility, dependent on specific contexts, is to reduce the number of daily meals. However, this is still very challenging:

I was living with a man. He played [injected] VND 100,000 (USD 7) per day, but I played VND 200,000 (USD 14). We were playing together for several days. Then he told me to reduce to the same level as his. But no way! Impossible! Cos once drug enters your body you have your own cu (standard level). If the dose is not enough for a shot, then craving comes very fast. This makes you feel very uncomfortable.

(2£: Female positive, rehabilitation center)

[Stopping drug use] is almost impossible. If there were something more addictive than heroin but harmless...[in that case] I think I can stop drug use altogether.

(20m: Male injector, Hanoi)

When two injectors live together they often inject several times a day. Depending on the level of addiction, the amount of money available, and other circumstances, the number of meals will vary. The dose for each meal is reported by IDUs as “it is cu-standard level”- it is unchangeable”. In a relationship, one person may be more heavily addicted than the other. As they cohabit and routinely inject at the same time, one partner may influence the amount the other uses to a certain level. The first point to note is that it is common to hear injecting couples talking about their drug use to be increasing rather than decreasing. The motto “the more you have the more you spend” is widely spread in these relationships:

Two shooters living together... they have to accept [to be abstinent] only in case money is not there.... But most of them cannot control themselves. Even one after one [shot] is a normal thing.

(24f: Female injector, Hanoi)

The following female injector talked about how she increased her dose when she partnered with a senior shooter:

It [drug dose] is always increasing while [I am] living with a person who is more addicted [Lam: if he shoots more than you, what about drug division? Is it equal?] He takes the bigger portion of course! [Lam: so, how can you increase your drug use?]...cos he shoots more than me (he shoots 5 times per day and I shoot 3 times per day).you know he is shooting in front of me. This forced me to shoot with him...sort of
ngua nghe (unbearable feeling) That’s natural how I increase. He has his level [of dose], I have mine. If his dose is divided to me, he can’t bear it. If he uses 50 [VND 50,000] and he plays 150, we will buy 200 to play together. But then I have to buy an additional 50 pack to play my portion. And he had his cu [level] 150 already; he does not want to reduce his dose.

(3f: Female positive, rehabilitation center)

It also occurs that the senior injector will decrease the number of meals while the junior continues to maintain his or her level of drug injection. It is common to hear the sentence “it is easier for shooters to speak to shooters”, which means that it is most likely for a person to reduce his or her drug use as a result of the cohabitation. IDUs reason that injectors could understand injectors better than smokers and nonaddicts. This is an advantageous feature of injecting relationships because the senior may reduce his or her meals to the same level as the junior’s. This is called “the equalizing pattern of drug use” (Rhodes and Quirk 1998). The following case illustrates this:

We often talk with each other [about reducing and stopping drug use]. However, once we have the same blood [both are injectors], at the maximum level, we can only keep [drug use] at an average level. We know that we should stop at a specific level...because sometimes we don’t have any money...from the beginning we had different injecting habits, at different times of the day. Then I tried to be abstinent sometimes by skipping one or two meals myself. After several times doing like that I got used to his schedule.

(16f: Female injector, Hanoi)

Efforts to reduce or stop drug use may be inhibited by being in a relationship with an injecting partner (Rhodes and Quirk 1998). On the other hand, our data suggest that a partner in an injecting relationship may reduce his or her drug use in some specific contexts, especially when the couple concern about the possibility of not being able to earn money anymore or when they want to have children:

Even if both are heavy shooters, it is possible to keep [injecting drug] at a controlled level. As for me, for example...first I worry about physical deterioration. Second about financial matters. I think this way: if today I shoot [a lot] like that, what about tomorrow? If the weather is bad. By thinking like that, I could keep [slow down number of injections]. But of course there should be some influence from the other person [my partner]. If I am on my own, I sort of the more [drugs] the better. There should be two persons always.

(18f: Female injector, Hanoi)

We think about our newborn, we advised each other to reduce
together, and in practice, we have reduced [number of daily injection] considerably.

(2lm: Male injector, Hanoi)

Although injecting couples can reduce drug use when both of them worry about money running out, this may change again when the couple has money again or if they have to cope with a difficulty. In such contexts, it is likely for the couple to resume the increase:

If we have money, we increase the number of meals. However we don't increase the dose [of each shot].

(llf: Female injector, Hanoi)

[Is it possible if both of you commit to stop?] Maybe...it is likely to happen because it is OK if everything is going smoothly. But if something wrong...it is easy to look for something [drug] to relieve.

(19m: Male injector, Hanoi)

Backsliding to the old level usually occurs when one partner tends to be "weakened":

We tried to stop once, it was very hard. In that situation you know I sort of played a trick on him to see whether he would sit up or not. With that thought, I asked him " want to play some?" he said, with an assertive voice " are you mad? We have said [that we would stop] already." I sit up and snorted...I swear with you that he could never lie there still to bear the craving. Sit up at once! It was very difficult. We have experienced that. Both shooters made a common effort. Extremely difficult. Will could not win the self.

(14f: Female injector, Hanoi)

That day I proposed to stop. We were locked ourselves out and we asked an old woman to provide some minor care. You know each [of us] with a blanket lying all day in the room...I looked terrible like a ghost...he felt sorry for me and he said " forget it. No need to be miserable like that". You know we both stood up immediately and rushed to buy drug...you know three days we locked ourselves out...

(8f: Female injector, Hanoi)

If a senior partners with a junior, the senior will have more chance to reduce their drug use; if a junior partners with a senior, the junior would be likely increasing his or her dose. This "two-way effect" is exemplified by a female shooter:

They [the seniors] don't have time to persuade me [the junior]. If they do [have time] it were empty words. In case
if I go with the junior... for example I shoot three times per day morning, noon, and evening. But he shoots twice morning and evening. So until noon he did not shoot. In that case, it is possible that I respect him, I am afraid that I don't have enough money, or may be since he did not shoot at noon, therefore I did not have opportunity to shoot noon meal. Thus I could contain myself and such a way of decreasing my dose. But if I go with the seniors, I would plan to shoot in the morning and at noon. But till noon, he had shot twice. That made me have a bit [a shot]

(22f: Female injector, Hanoi)

Condom Use

Risk of exposure to HIV among IDUs and their SPs is partly derived from sharing; risk from not using condom makes the double risk more serious. Indeed, 47/47 (100%) IDUs in this study reported inconsistent condom use with their heterosexual partners. The reasons for this inconsistency vary, depending on the context of their relationships. It is clear that the frequency of condom nonuse is much higher than that of condom use.

In the context of injecting relationships, unprotected sex is deemed acceptable:

We have sex normally... once we live together, if one of us gets the disease, we should accept it. Living with each other means accepting anything, which may come. Having had sex one time already... it [risk] is unavoidable

(14m: Male injector, Hanoi)

Our data suggest that not using a condom within an intimate relationship is synonymous with love and trust. IDUs trust a sex partner because they believe that he or she has safe behaviors and therefore nonthreatening, including as a potential source of disease. Most of IDUs say that they may use condom “several times” at the onset of their cohabitation. However, as their relationship develops, the tendency of dispensing with condom becomes clearer. In the context of this relationship, the perceived “risks” of not using condoms do not seem to outweigh the perceived “benefits” of expressions of love and trust. Indeed, most of IDUs appreciate their love, which they often relate to a mutual responsibility for each other’s well being:

It is said that lovers don’t care much [about risk]... it is true. We love each other because of love so we don’t have to think about it [condom]. If something wrong [being HIV positive] we should be responsible for each other... if he [my partner] happens to share [syringe] or something like that, even I get infected [from him] or something [smack the lips]... nothing to regret. Yes, I accept [being infected]

(15f: Female injector, Hanoi)
Women, perhaps more than men, subscribe to what might be described as the ideology of romantic love such that they often represent themselves as having thrown in their lot with their male partners and are ready to face life’s trials together:

We don’t use condom...once we loved each other, [we] don’t think anything you know. If [he or I] has HIV, [we] accept all.

(17f: Female injector, Hanoi)

Trust is signified by the duration of the relationship and vice versa, the duration of relationship is rationalized as a test to reaffirm their mutual trust and attachment:

Previously we used condom. But now we don’t. We have lived with each other for 10 years now.

(16m: Male injector, Hanoi)

Trust is even used as a means of existence, a means of survival:

We don’t use condom because we trust each other. In order to survive, [we] should trust each other. That’s it.

(18m: Male injector, Hanoi)

Quite often, a steady couple does not have access to two syringes when to share. Sharing a syringe, with the inherent risk of infecting one another, makes it easier to dispense with a condom:

For shooting partners, sometimes we buy two new syringes...shooting...and marking for the next shot. But sometimes we can’t buy [syringe] at night so we reuse...sharing requires rinsing by boiled water. Therefore I don’t keep [safe] [by allowing him to enter me without condom]...

(23f: Female injector, Hanoi)

The introduction of condom use becomes more problematic when it relates to the issue of contraception. For some couples, condom use (albeit inconsistent) was equated more with contraception than with protection from HIV. Some other female injectors also told me that because of a pregnancy scare, they sometimes used condom with their partner. However, it is a common knowledge among IDUs that when a woman is on drugs, it is very difficult for her to have a baby. The explanations given by most of the injecting females are “drug made me loose period” or “it [infertility] was because of drug”. As a result, of 24 female IDUs, 7 said that they did an abortion more than once. The following statement is representative of female injectors’ view:
When we have sex we don’t think about the disease [AIDS]. We sometimes think about pregnancy but let it be [no need to use condom]. We are both injectors so it is difficult to be pregnant

(18f: Female injector, Hanoi)

Similarly, many men are not concerned about sexual risk of pregnancy or infection. Their risk perceptions are often reinforced by a lack of a feeling of responsibility for their sex partner:

[When do you use condom?] Now and then...when [we] feel safe [difficult to be pregnant], we don’t use. Usually [we] calculate the [safe] days. Often my wife calculates her period, I don’t know. Let her do it. We both decide not to use it, neither of us proposed to use it.

(16m: Male injector, Hanoi)

Risk Assessment

Many IDUs seem to be unconvinced they may themselves be at risk of HIV infection. They believe that if they become infected they can prolong their life for five years, seven years or even longer. It is this perception that put them and their injecting partners open to the potential of HIV infection:

[We] also suggested to use condom but...smacking the lip...let it be [no need to use condom]- if death comes we go together...ten years [if AIDS] to a death. No worry. That’s it.

(21m: Male injector, Hanoi)

I think if something [HIV] happens both of us will suffer [HIV]. Life or death is a matter of three years or so. Maybe a drug shock comes and you will die...not to say the century disease [AIDS] it takes 5-7 years until you die...but if you know how to keep your health you can live up to 10-15 years. It is normal.

(9f: Female injector, Hanoi)

Many IDUs have vague knowledge about the combined risks of unsafe drug use and unprotected sex. The uncertainty is the ramifications of lacking both biomedical knowledge and source of proper information. Our data suggest three kinds of uncertainty:

1. Uncertainty about possible risks in sharing events;
2. Uncertainty about the risks of sexual transmission;
3. Uncertainty about sex partners’ sharing or having sex with outsiders.
1. Uncertainty about possible risks in sharing events. This uncertainty is associated with the safety in drug injecting behaviors. Since accidents may occur during a shooting event (as mentioned earlier, such as risks in frontloading events or mistakenly using another person’s syringe), even those who use separate syringes still doubt about the effectiveness of their risk management. This is the most important problem of IDUs in this study:

Sometimes we share one syringe and sometimes we use two syringes...infected or not infected... I am not sure.

(17m: Male injector, Hanoi)

2. Uncertainty about the risks of sexual transmission. The risk of sexual transmission is not considered as serious as the risk caused by sharing syringes. 100% of respondents in this study assert that syringe sharing is the most dangerous and quickest way to get HIV infection. They say that 70 up to 90 percent of all infected cases resulted from sharing. In contrast, most of them affirm that the probability of the infection by sexual intercourse is “only 30%”. Indeed, IDUs seem to be unconvinced that they may themselves be at risk of HIV infection via heterosexual sex. During the interviews I could feel the confidence in their tone when they mentioned these figures. The information came from the mass media, television or from lessons learnt in rehabilitation centers:

Infecting by this sexual route is rare, very rare...most of us 90% have been infected via injecting route

(20m: Male injector, Hanoi)

In addition, the negative effects of injecting a drug were mentioned more than those of unprotected sex. References to vein degeneration and collapse, overdose, the fear of blunt needle, the pain associated with withdrawal were frequent. This predominant perception not only results in a careless attitude to prevent possible risks during a sex episode but also facilitates promiscuity. Of 56 depth interviews, 47 respondents (27 females and 20 males) mention that if abrasions (caused by contacts between penis and vagina) could be avoided during a sexual event, HIV infection would not occur.

Interestingly, 12 out of 56 respondents report that in case of a positive-negative couple, cutting (pinching by nail) the teat of a condom before ejaculation can prevent the transmission from the positive person to the negative one. They reason that such a “gentle pinching” can prevent abrasions, which may occur during a sexual episode:

You know during the whole time of sexual intercourse- it is a long time- pinching a bit off the teat of condom just before ejaculation...this duration is too short. The time of contact [between penis and vagina] is too short. Not enough [time] to
be infected. [Lam: so, that pinching can minimize the infection?]. Yes, a lot.

(2f: Female, rehabilitation center)

3. Uncertainty about sex partners’ sharing or having sex with outsiders. This uncertainty was mostly reported by women. While women often put their trust in a male sex partner, they still feel uncertain about the possibility of men sharing outside the home or having sex with other women. In this sense, trust is relative because it is accompanied by uncertainty and doubt. As one woman said:

We use separate syringes and we don’t share...it is of small probability for an infection. So I am not afraid of being infected by this way [injecting]. However, I am only afraid that my sex partners are promiscuous. It is possible to be infected by sexual route...but 80% not infected by sexual route. By a woman’s sensitivity I think none of my four sex partners has shared syringe or had sex with outsiders

(10f: Female injector, Hanoi)

The uncertainty about sex partner’s having unprotected sex with outsiders comes to the fore when a couple wants to have children. One man describes his consideration about his wife’s going for a test:

I also asked my wife [a sex worker] in what cases she did not use condom [with clients]...in the future if [we] want to have children, [I] have to consider [whether she is infected or not]...a test is necessary [for her] then.

(22m: Male injector, Hanoi)

The great majority of drug users hesitated whether to go for a HIV test or not. Although sharing a syringe and not using a condom are common, only few injectors feel that they ought to be tested:

I never shared syringe. However, I am not sure cos there were people who were detected positive after one year sent here (rehabilitation center)... very often window period lasted from three to six months. But I am not sure...I think that in order to make sure [that I am negative] I should have some tests here and more tests on return to the community

(1f: Female injector, rehabilitation center)

Some seropositive IDUs feel confident that they could “guess” their positivity status by recalling past risk related contexts they engaged in. As a HIV positive female reported:

Very often, we always look back into the past, go against the time when and why [we] were infected...trying to remember whether the sex partner [I] had shared with or had sex with
was infected or not. By recalling those moments I will know [when and why I was infected]...in specific contexts of each person...they can know the reasons for infection by recalling the past...for example, I can confirm, of course not 100%, but rather precisely the duration of time I got infected

(6f: HIV Female injector, rehabilitation center)

While seropositives are well aware of their health status, all four HIV positive drug injectors I interviewed continued to inject. However, they are acutely aware of the risks they may pose to others:

I was living with a man after he escaped from prison...sometimes we shoot indoor sometimes outdoor. But we don’t share. We use two syringes. I was infected before he lived with me. I kept safe for him in any risky aspects. In general I kept telling him about the risks. Anyways I was such a person [infected] I don’t want to do this or that [harm] to others. We used condom all the time. I was the person who proposed to do that [wearing condom]

(4f: HIV Female positive, rehabilitation center)

I never mistakenly put my syringe in the wrong place. I used to live with a [negative] man but I was always aware of it. I was always the person who prepared the syringe and threw it away after use. I never mix up putting the syringe...because I am positive

(5f: Female positive, rehabilitation center)

Managing Relationships

Some IDUs describe their relationships as “provisional” or “momentary”, meaning that the forming as well as the breaking of such relationships will occur easily:

I did partner with some men shooters but it was sort of momentary relationships you know, cos no future, no direction...so we did not intend to maintain our relationships for long. We loved each other but we did not see the future...[we] felt that when we like each other we can go together. When [we] dislike each other...let say good bye

(12f: Female injector, Hanoi)

I have the feeling that our cohabitation is something like ...a place to go in and go out. It is no problems if I leave her and vice versa. For example, if we are apart, it is even more difficult for her to seek a decent man [after me].

(20m: Male injector, Hanoi)

Some female IDUs said that they do not consider they relationships with male
Injectors as “love”. They rather define them as situational or spontaneous cohabitation, often fraught with lies and doubts. Comparing their current relationships with a true love, they highlight the negative impacts of drug use posed on the meaning of their relationship:

I think that what drug is like is exactly what our love is like. It is fast...shooting...getting high...awake and nothing left. It is not a love. It is sort of temporary sentiment, for example perhaps we have some commonalities and we like each other...[Lam: but I think it is still a love] you never know how people tell lies when they become addicted. So I think it is rare to have a true love or a beautiful love because the drug itself has guided our minds. It [drug] is number one in me. I am desperate for it and so love ranks the second.

(18f: Female injector, Hanoi)

Women often hide their way of living as a sex worker even to their sex partners. Many injecting prostitutes feel uncomfortable whilst being referred to as a con pho [sex worker]:

I never forbid him to have relations with other women, provided that we respect each other.... I think that I am a play girl [injector] and I also work as a girl [prostitute]...clearly my SPs knows [that I am a prostitute] but on the contrary they never went to my workplace. They never saw me go with a client. I hide [my occupation] in that way [Lam: Why should you hide it?] both of us never talk about my job...I neither told him what I was doing...sort of "superficial hiding" only. What I need is that they don't open their mouth saying that I am a con pho [sex worker].

(24f: Female injector, Hanoi)

Some men do not seem to care about their sex partner’s outdoor occupation:

She is working in a karaoke parlor. I am a shooter...with respect to her work, I don’t ask her but I still know that...provided that we love each other. That’s all.

(22m: Male injector, Hanoi)

While money is always short, many men don’t want their partners to work as a sex worker. As a man asserted:

I would rather die because of my wife but I never accept her as a prostitute.

(16m: Male injector, Hanoi)

In the drug scene, where “night is day and day is night”, drug users have to rely on
each other to manage their drug use. At the time of my fieldwork, most of female IDUs were working as sex workers in order to finance their own, and sometimes their sex partners’ injecting habits. Meanwhile, the majority of male IDUs tend to make money through criminal activities, such as drug dealing, stealing, house breaking and robberies. Very often, however, women seem to earn more than men. Even so, women expressed their feelings of interdependence in their relationships:

Until the end of the day, we are in the same boat [IDUs] so we rely on each other. But mostly he relies on me rather than I rely on him...but this market [prostitution work] is not stable. We [sex workers] can’t fix money. Sometimes a lot sometimes nothing. When I earn good money, he doesn’t have to care but sometimes I earn nothing, for example on rainy days you know...then he has to take care [of money].

(10f: Female injector, Hanoi)

To maintain this work, most of female injectors report that they need to inject before going to work, usually in the evening. Many of them explain that they do not want at all go to work in craving status. In the context when the amount of drug is not sufficient and the woman has to go to work anyway, the male partner often has to “give in” a portion of drug to the woman. This act of “concession” [chat nhuong nhin] has become an argot described by IDUs as an act of generosity and a way of caring for each other.

The notion of joint responsibility is expressed in the avoidance of HIV risks and by looking ahead for a better future:

A couple, a husband and a wife should know how to keep [safe] for each other...for example, avoiding shagging with others...[if we] want to have a good future, [both of us] should try to keep [the relationship] secured [free from risks]. Otherwise, it depends...I can’t forbid that. It is difficult

(19m: Male injector, Hanoi)

The great majority of individuals in injecting relationships said that they do have quarrels or conflicts but that it is not easy for them to break their relationships. In most cases, their relationships are temporarily discontinued as a result of being arrested by the police for their criminal activities (mostly involved by men) or being sent to rehabilitation centers for a compulsory detoxification. They seldom terminated their relationships by themselves.

Sometimes we [injecting couples] have quarrels or get angry at each other. But to say good-bye is very difficult.

(23f: Female injector, Hanoi)

We don’t quarrels, no conflicts cos we don’t share money. She
has her money and I have mine. (2lm: Male injector, Hanoi)

But, four female injectors said that their relationships were broken due to difficulties resulting from untruthful love or the life itself:

I feel something untruthful between us ...our relationships [with male IDUs] go nowhere...life is full of obstacles... so he went his way and I avoided seeing him. (8f: Female injector, Hanoi)

Some male IDUs, who are incapable of making money, cohabit with female injecting prostitutes not because of love but because of the money the woman earns from her sex job. In this case, injecting prostitutes often complain about the instability of their relationships. The most frequently cited reasons for the break-up are financial issues:

They [male shooters] often put us on scale you know...sort of calculator you know. If they find that I can earn enough money for both [to shoot], they will continue to stay [with me]...if they find that sometimes I can not earn enough, they get bored...then [we have] quarrel...then [we] say good bye. (25f: Female injector, Hanoi)

We [injecting prostitutes] live with IDUs...it is rare to meet someone having a kind heart. They often rely on us for drugs. I mean unemployed IDUs often live like that. I saw many couples who said good-bye today and the next day I saw that man living with another girl. Otherwise he would die craving because he did not have any talent or jobs...he did not dare to steal so he had to seek another partner [IDU-FSW]...cling to her for drug (13f: Female injector, Hanoi)

Characteristics of IDU- Smoker Relationships

During the fieldwork, I often saw IDUs living with heterosexual injecting partners but rarely saw IDUs living with drug smokers. Focus group discussions confirm that IDU- smoker relationship pattern is less common than other patterns, such as IDU-IDU, IDU-nonaddict and smoker- nonaddict relationships. Below, I describe main features of IDU-smoker relationships. First, I describe the difference between smoking and injecting practices. Then, I analyse the switching between these two patterns: This may help us to understand why this pattern is rare, and to design appropriate interventions.

The difference between smoking and injecting patterns
In general, smoking is more a social event than injecting. The following fieldnote and extracts illustrate briefly about the differences of these practices:

**Smoking:** often requires the participation of two, three or more people. Smoking is often conducted indoors. Smokers sit in circle like a "round table" and chat. Respondents say smoking together in group makes fun. Usually, a smoking episode takes more time than an injecting episode. According to respondents, to smoke, there should be some refreshments, fruits and cigarettes, which enhance the feeling and get high faster.

**Injecting:** can be practiced by one, two or a group of people. Injecting can be conducted indoors or outdoors. In an injecting event, shooters prepare drugs and paraphernalia, take a hit, and get high in a shorter time than smoking. Some IDUs complete the whole process of injection in two or three minutes. During a shot people also chat but not much and they do not sit in a circle like smokers do. Often, they take a cigarette as soon as they pull back the needle from the syringe [right after finishing the shot]. Then they lie down immediately (if injecting outdoors), still chatting but not in a "round table" like smoking.

(Fieldnote in Hanoi and Quang Ninh)

Within a couple’s context, the differences seem to be clearer in terms of timing and feeling:

When we both played drug, while I was still smoking... very long...you know, he took a shot, finished it and lay down in a minute...That made me hurriedly want to finish it [the inhaling]. But the more I expected to be faster the more impossible it turned out to be...cos smoking requires a long time, which would produce better feeling.

(14f: Female injector, Hanoi)

When I knew that he was a shooter I hated it [the action of shooting] I felt sort of dirty and slovenly. I felt unpleasant seeing him shoot. I was in love with him for eight months by then...that feeling lost when I began shooting black (injecting liquefied opium).

(18f: Female injector, Hanoi)

Injectors seem to be sympathetic to smokers, rather than the other way round. This can be explained by the fact that because injectors have undergone "smoking period", it is easier for them to share feelings with smokers:

[Is it unpleasant for a shooter witness a smoker inhaling?] No. It's normal. It is their [smokers'] habit. They [smokers] do not want to change so [injectors] should not force them to
change. Don’t force them to do something they dislike.
(15m: Male injector, Quang Ninh)

Because of differences between smoking and injecting, it is very difficult for smoke-injector couples to reduce or stop their drug use. In most cases, it may lead to tensions between the couples:

Shooters and smokers are all addicts but these two things are quite different. Cos if you never know the feeling of a shot, for example, you may say [to me] “stop shooting, let smoke together” maybe I listen then. But if you know that once I shot I could not smoke anymore, you would never say so.
(19m: Male injector, Hanoi)

Switching between smoking and injecting patterns

Of 56 drug users I contacted, 53 had shifted from smoking to injecting (onwards transition). The drugs they used for both smoking and injecting were either liquefied opium or powdered heroin. Very often, the transition process is very short, from one month to six months. According to some respondents, on the average, six or seven months after having shifted to injecting, drug users could not change to smoking again. At the time of the study, only 3 out of 56 drug users still stayed on their oral habit.

Why do most of drug users switch from oral use to intravenous use? The following accounts were most frequently cited:

1. As the smoking dose increases over time, more money is needed. Initial injections require a small dose and less money compared to smoking. Injecting seems to be cheaper than smoking at the onset of addiction (when drug users get deeper into addiction, injecting becomes even more expensive than smoking, especially for those who use ‘poly drugs’). This economic reason is the most frequently mentioned by the informants.
2. Smokers shift to an injecting pattern to overcome their cravings [chong va]. It is a situational solution or a strategy to cope with the immediacy of drug desire.
3. Injecting makes them get high faster and reach more “rush” than smoking.
4. The ‘aftermath durability’ after injecting is longer than smoking. This ‘durable effect’ of injection makes drug users feel more satisfied.
5. As smoking takes more time to have an effect than injecting, many smokers decide to inject to get high immediately.
6. Taking an injection is more ‘convenient’ than smoking, which requires a group of people and a comfortable place.
7. Drug users assume that it is easier to withdraw drug use while injecting than when smoking. Consequently, smokers who intend to stop drug use may “try” to switch to an injection pattern. In most cases, once they inject they will not be
able to smoke again.

8. Living in a network of drug users, it is easy for a smoker to shift to injecting as a result of peer influence/peer pressure or curiosity.

The moments that marks the “leap” is often well remembered by drug users:

I shifted to injecting cos it is said that it is easier to withdraw while being in injecting status than smoking. That day I was very sick [for smoking]. I could not wait for silver foil to be prepared...and silver foil was not there you know. So I thought I should cut off the foil paper from the cigarette packet. But it would take long. So I thought to myself “that’s all right...let have a shot to chong va [satisfy immediate craving by shooting with any dose of drug available]”...you know the first time you smoke you feel unpleasant. But the first time you shoot you feel sort of exciting.

(7f: Female injector, Quang Ninh)

Many smokers move from oral to intravenous use whilst in a sexual relationship with an injector. It is very difficult in such a case to sustain smoking status overtime:

Until the end of the day I think that a smoker will begin to shoot...anyways. It is very hard to keep it [maintain smoking status]

(12m: Male injector, Hanoi)

Often, the smoker is pulled into injecting by the injector. This drag- in effect is so common that drug users label it as dua vao doi [bring into shooting lifestyle]:

When we met each other, we were both smokers. Later when I got used to shooting, I brought him into the [injecting] life with me. You know, many times he tried to persuade me...many times he brought me to detox centers...that sort of things. But of no result [for me]. At last he started shooting.

(20f: Female injector, Hanoi)

In some cases, smoking partners themselves ask their shooting partner “for a try” and this trial then becomes the hallmark for a smoker to go deeper into drug life:

He [my smoking partner] asked me [the shooter] for a try [to shoot]. After that trial, he felt good ...then he insisted giving up smoking, by all means, not smoked anymore and began to shoot from that time...because you know shooting always makes you feel immediate high

(24f: Female injector, Hanoi)

Few smokers can maintain their oral pattern for a long time. Those who can may be divided into three categories:
1. Smokers who never engage in a sexual relationship. They are fearful of being infected if they shift to injecting; their fear of fatal overdose which is often caused by heroin (note*); their fear of being stigmatized by society; and their phobia of seeing a needle (for women).

2. Smokers in a relationship with a nonaddict. Such smokers can sustain their smoking pattern because they still can earn money legally or may be financially supported by their nonaddict partners.

3. Smokers in a relationship with an injector. Such smokers can control themselves or are positively influenced by their injecting partners. One female injector reported:

   He [a smoker] also advised me to shift to smoking to avoid the disease [AIDS]. I was obedient to his advice. You know he was smoking for a long time but he did not move to shooting because he said that he was afraid of fatal overdose and that for him, shooting looked terrible, something depraving.

   (10f: Female injector, Hanoi)

One smoker wife could maintain her smoking style because her injecting partner did not allow her to use needles:

   I don't allow her to shoot. I only allow her to smoke in order to relieve her pain.

   (7f: Male injector, Hanoi)

   I intended to shoot but he did not allow me to do that. I did not move to shooting cos I sort of respect him.

   (ls: Female smoker, Hanoi)

It is rare to find relationships in which shooters alter their pattern from injecting to smoking (reverse transition). Our data in focus group discussions suggests that novice injectors sometimes can maintain both patterns (smoking and injecting) simultaneously. These individuals are called “mix-up users”. If a mix-up user smokes, the amount of drug needed to get high should be higher (usually three or four times) in comparison with the amount used for injecting. According to mix-up users, during this time their demand for an injection is not yet high. Therefore they can possibly shift to smoking.

It is very hard for a shooter to shift to smoking. But even when a shooter succeeds to switch to oral use, it would be very difficult for him to maintain smoking over time. Our data shows that only few smokers can sustain their oral habit for a long time. After a while (reportedly from 3 months to two years), most smokers backslide to their old injecting habit. As a 28 year old woman explains about her relapse to
injecting habit after two years staying in oral pattern while living with her smoking partner:

I left him because after a while I saw him sort of incompatible to me. In addition, he had his wife and I did not want to continue [this relationship]...he is much older than me so we have different attitudes...I am still a playgirl. I like group funs. But he is different. Therefore the tensions [between us] arise. When my friends come he feels sort of unpleasant...although he did not forbid [my friends’ visits] but I don’t like living like that. After we said good-bye to each other, I shifted to shooting again.

(15f: Female injector, Hanoi)

Sex and condom

Basically, IDU-smoker relationships have similar features as IDU-IDU relationships with respect to sexual issues. One minor difference is that women smokers in IDU-smoker relationships seem to have a higher and more frequent sexual desire than women injectors. Some women smokers report that smoking opium enhances their sexual desire, which then is so strong that they do not care about using condom:

We were living together for two years. Both were smoking black. He shifted to shoot first and later I did the same. We did not use condom because, to be more frankly, playing black [smoking opium] made me feel much more excited [than when I injected opium].

(3f: Female injector, rehabilitation center)

It is possible that because of this higher desire among smokers, shooters have to work to achieve sexual harmony. This “balance management” is often implemented by male injecting partners who have to pretend to have the same feeling “to make her happy”. Sex is then described in functional terms as “duty” or “shagging for the sake of it”:

As she [my smoking partner] requested to have sex, I had to please her in that way...or sometimes I feel that because of responsibility that I have to do that [have sex], otherwise she would think that I don’t fancy her anymore. But in fact I didn’t.

(16m: Male injector, Hanoi)

Characteristics of IDU-Nonaddict Relationships

During the course of their drug life, both male and female IDUs may involve in a relationship with a non-using sex partner. Although this relationship pattern is often short-lived, it has some special features differentiated from the said patterns. In this
section, the following themes are analyzed: partnering; nondisclosure and the “double-
life”; reducing and stopping drug use; and managing relationships.

Partnering

It was more common to find injecting women living with nonaddict men than
injecting men living with nonaddict women. Injectors who live with nonaddict
partners are mostly novices (or juniors). As they get deeper into the drug scene they
tend to partner with drug users rather than nonaddicts. Our data shows that
“seniors” often have one-off relationships with a non-addict partner in the course of
their drug career. In most cases, after a while, an IDU and their nonusing partners
cannot get along. The break-ups often arise from everyday lifestyle differences.

IDUs often live with non-addict partners not because of love but because of money:

For example, I live with a non-addict man but on the
conditions that he should have money...because I am not
stupid and I am not a novice injector.
(12f: Female injector, Hanoi)

Although she loved me but I did not care. All I need is money
from her. You know beautiful or ugly are not important
(10m: Male injector, Quang Ninh)

Usually, female injectors meet their nonaddict partners when they are on street
work. This kind of relationships develops from a casual client to a regular client and
then a private sex partner, at the expense of the man’s money. I also observed that
the way females describe the transition of such a partnership is often signaled by the
terms “he liked me” rather than “I liked him”.

Injecting prostitute women view their nonaddict partners as a ‘passer by’, which
means that this kind of relationship is usually short-lived:

I used to partner with a nonaddict man. But it was not like
this [my current relationship with a male injector]. He was
sort of passer-by you know. Nothing left in me.
(18f: Female injector, Hanoi)

Our data suggests that the main reasons for the fragility of IDU-nonaddict
relationships are the differences rooted in drug use. This has made some injecting
women compare their relationships with nonaddict men and injecting men to show
the difficulties of living with nonaddicts:

When I partnered with nonaddicts...in many cases it is
difficult to say. He insisted on persuading me to stop [drug
use] and that I should change...that sort of things you know.
I don’t like that. I would rather live with a
Female injectors express their wish to have a steady partner who is not addicted to a drug. However, the fear of being looked down by the prospective partner has made them avoid partnering with nonaddict men:

I think hard sometimes [about whether partnering with a nonaddict]. But I feel [I am] sort of bad thing for him. So it is better not [to partner with him] I may do harm to him. Inferiority complex is always in me. I have a lot of good friends who are not addicted but I avoid meeting them when they want to come to me cos I feel I have changed. I am living another life

(1lf: Female injector, Hanoi)

The sentence “I am living another life” was frequently used during interviews with IDUs. It is embedded in the notion that the life drug users are living is “abnormal”, versus the “normal life” that nonaddicts or “ordinary people” are living.

The difficulty of partnering with a nonaddict, which was often signaled by expressions like “incompatible” or “having only few things in common”, came to the fore:

It [partnering with nonaddicts] is very rare. [I] felt that they were not compatible to me...something coercive. It is difficult.

(20f: Female injector, Hanoi)

Some women talked about the difference between men’s attitudes towards partnering with female injectors and women’s attitudes towards partnering with male injectors. According to them, it is more likely for women to accept a male injector than for men to accept a female injector. This gender difference was confirmed in focus group discussions with both male and female IDUs who ever had partnered with a nonaddict. One female injector explained as follows:

Life is always like that. We [female injectors] are more likely to accept a male shooter than men to accept a female injector cos it is very difficult for women injectors to live with nonaddict men. We have high self-respect...anything can make our self-esteem injured. I feel sort of being insulted [while living with nonaddict men]. That kind of relationships [female injectors- nonaddict men] never last long. On the contrary, nonaddict women who live with men shooters are more likely sympathetic. Women often show more sympathy than men. This makes a man think about the way to do to be a good place for women to turn to.
Nondisclosure and the “double-life”

When IDUs partner with a nonaddict, they often hide their injecting status. This nondisclosure is a strategy to manage their relationships with nonaddicts. Usually, IDUs reason that the disclosure will create problems in the relationship or that nonaddict partners will not accept their drug use. In some cases, the reason for nondisclosure is in fear of the stigma inherently attached to them:

If he were also a drug user like me, I would not hide [my addiction status]...but I always determine in my mind that the life I am living now is condemned by the whole society. I myself cannot be suited in that [pure society]...By my instinct I did not tell him the truth from the first time I met him.

(2f: Female injector, rehabilitation center)

Among male injectors, the strategic nondisclosure is fraught with difficulties and tensions as how to maintain the relationships while trying to hide the truth of their drug use. In many cases, nondisclosure fails because the male IDUs lose sexual desire, lack sexual arousal or can’t ejaculate as a result of using heroin:

If I don’t shoot I feel that I come out [ejaculate] very fast...but if I shoot...it seemed to break the ejaculation, even it [penis] does not erect and I don’t want to fuck. However, in order to hide it [my drug habit] I still tried to have sex with her. She seemed to doubt but I have to think of some ways to justify for the lie...something like “I feel tired today so it is a bit long for the ejaculation”.

(14m: Male injector, Quang Ninh)

Regarding sexual desire...once you shoot you never care. But in order to maintain our relationship and meet her sexual demand I have to please her...In that way we can get along.

(19m: Male injector, Hanoi)

Drinking wine before going out with lovers has become a technique applied by male injectors as an excuse for delayed ejaculation:

You know every time I go with her I don’t forget to take a sip of wine. That makes me feel at ease when I talk with her and that makes her sympathize with me if I come out long.

(7m: Male injector, Quang Ninh)

Wherein injectors live a “double-life”, tensions arise. IDUs wish to have sympathy from their nonaddict partners. But their demand is never met because most of nonaddicts often “feel terrible” or “I can not accept watching her/him shooting”.

(25f: Female injector, Hanoi)
Sexual life is even more problematic. Many female injectors report that their sexual need is not satisfied by their nonaddict partners. So, the complexity of the drug-sex conflicts leads to tensions. The following extracts are illustrative of this “double difference”:

For sex matters, he couldn’t meet my demand. On the contrary, he treated me very well. Another thing incompatible is that because he does not use drug, I can’t ask him to go and buy some drugs for me when I feel sick. Then I had to go and buy myself. And when I couldn’t shoot myself, I had to have others to shoot for me. Therefore sometimes I feel sort of difficult to say [to him] because my sex partner is a nonuser. For example, sometimes at night he was looking for me and he went to my place [streetsexwork] to pick me home. Even I did not yet have a shot then but I had to go home with him. And when we arrived...it was already the time of my craving but he insisted on having sex. I felt very annoyed then and I did not want to fuck at all. As always, I should find drugs first.

(3f: Female injector, rehabilitation center)

He took great care of me. But when we were having sex, I felt that he made me feel uncomfortable. I want to seek for a person who can share commonalities with my drug use. Second, in sex life they [nonaddict men] should meet my demand for sex. I don’t want if they [have sex] too fast.

(16f: Female injector, Hanoi)

I am an addict and he is not. When sleeping I feel sort of unpleasant. Until I shoot...he stares at me...I don’t agree at all. When having sex after a shot ...[sex] desire is quite high. It means that [I] want my sex partner to have a long sex with me. If he sort of wants to fuck fast I want to drive him out

(15f: Female injector, Hanoi)

The demand to have long sex a few hours after injecting was rationalized by female injectors as a tactic to maintain sexual harmony:

Normally I have a shot every three or four hours per day...but about two or three hours after the shot I want to have sex...that is more enjoyable...but on the condition that I have shot a medium dose only...not a high dose...but I don’t like having sex right after the shot...

(24f: Female injector, Hanoi)

If this demand is not met by the nonaddict partner, the woman will feel uncomfortable and this may create conflicts between the two partners. These sex-related conflicts intensify over time, and are complicated by drug-related contradictions and other lifestyle differences. The disadvantages then seem to
outweigh the benefits, certainly when nonaddict men do not sympathize with their injecting partner’s drug use or do not know proper sex:

To be frank, I can earn VND 500,000- 700,000 (USD35- 45) per day. VND 100,000 per person [client]. Thus, I met [had sex] five to seven men everyday. What for do I need more sex [with nonaddict] ? There is only thing that he [nonaddict partner] can bring to me: that is love. But he couldn’t do that. Regarding sex, he could not bring [satisfy my need] either cos he was not using [drug] so how could he understand me? Perhaps since I was addict, I did not understand him well. On the contrary I also thought that he didn’t meet my demand for sex. So, what for do I need him? I would rather go to work so that I can have money everyday and I don’t have to wait for him...that’s simple.

(9f: Female injector, Hanoi)

(after his ejaculation) I still did not know what was the feeling of sex...not reaching climax yet

(20f: Female injector, Hanoi)

The great majority of male injectors report consistent condom use with sex workers while not using condom with their non-using partners. Dispensing with condoms in their relationships with nonaddict partners is labeled as “I don’t like it” or “it is not real”, to justify their risk behaviors:

I always use condom with sex workers but I don’t use condom with my sex partner, say 100%...because I don’t like it. It is not real.

(19m: Male injector, Hanoi)

For men, appeals to love, respect and sexual pleasure were commonplace forms of excuse making for their condom nonuse:

You see once we love each other, using condom means nothing to enjoy and perhaps if I do use, she may think that I look down on her.

(13m: Male injector, Quang Ninh)

Trust is another excuse. Trust here means, “We believe we are free from HIV”. As a man reported:

We don’t use condom cos we are very trustful to each other. She also trusted me. Sometimes [we] calculate the [safe] days [to avoid pregnancy]

(8m: Male injector, Quang Ninh)

In comparison to men, injecting women describe their non-condom use in a more sentimental manner. Again, the main reason for rejecting a condom is love and trust:
I told him everything about my past and so did he. We love each other and and we trust each other. We don’t use condom. Neither of us proposed to use it.

(10f: Female injector, Hanoi)

Many injecting men don’t seem to feel responsible for their non-using lovers in terms of pregnancy and HIV prevention:

We did not use condom 100%. She did not say anything [about condom use] and I did not understand why. You see, once I kissed and fondled her, she felt sort of up to the sky. So, fuck up with the condom. I don’t know when she is on period. She did abortion five times. Fucking is just fucking. That’s it.

(14m: Male injector, Quang Ninh)

Most of men [shooters] are not responsible for women. Once you are immersed in the play you will often forget. Perhaps you can realize something sometimes but you can’t concentrate [your minds] all the time.

(12m: Male injector, Quang Ninh)

Some male injectors based their condom use on their relative risk assessment:

If I was infected I would keep safe for her. But I am sure that I am not. So, no need to use condom.

(9m: Male injector, Quang Ninh)

I don’t intend to use condom because I can assure you that I don’t share syringe and I don’t go to sex workers either. Since I became addicted, I did not fancy girls anymore [sex workers]. Previously I often played [frequent sex workers] but now I rarely do.

(15m: Male injector, Quang Ninh)

Most of the non-using female partners appear to have fragile negotiation skills:


(10m: Male injector, Quang Ninh)

In contrast to the majority of men, injecting women seem to feel more responsible in preventing risks of HIV infection for their nonaddict partners:

He did not mention about it [using condom] but I myself want to keep safe for him. I think that AIDS can come to me at any time because I am a shooter. So I told him to use condom and he agreed.
Injecting women (most of whom were also working as sex workers) report consistent condom use with their casual clients and dispensing with condom use while in a relationship with a private sex partner. Yet some injecting women report consistent condom use after a casual client has become their private partner. The reason to use a condom in this context lies in the social stigma toward drug using women:

I met him when he was a client. Later we lived with each other but I still used condom with him because I did not like it. I don't know why. For many male IDUs, I never use condom. But for those sex partners who used to be my clients and who met me in that environment [street work]...they came to me for a sex and I came to them for money, I always used condom with them.

(11f: Female injector, Hanoi)

The transition from condom non-use to condom use is often marked by the moment when injecting partners reveal their drug use. While nondisclosing about one's drug use status is often synonymous with condom nonuse, disclosing about injecting status may lead to the initiation of using a condom:

For some months I did not tell him that I was a drug user and we did not use condom. After a while I myself felt sort of complex inferiority, so I told him to use condom. Because... anyway he knew that I was addicted, and later he found that I was a shooter...he did not say anything but, after I disclosed the truth and he also saw me shoot several times... from that time I saw a condom in his purse. It meant that he began to think about it [using condom]. Gradually, we had less sex and if we did, both he and I proposed to use condom.

(3f: Female, rehabilitation center)

When I smoked black she did not say anything. But later when she found out that I was a shooter, she initiated to use it [condom]

(12m: Male injector, Quang Ninh)

Reducing and stopping drug use

Our findings show that the possibility of reducing or stopping drug use among those in IDU-nonaddict relationships is higher than those in IDU-IDU and IDU-smokers relationships. None of injectors in this study could reduce or stop their drug use permanently. However, injecting women appear to be easier to be persuaded by nonaddict men than injecting men by nonaddict women in reducing or stopping drug use. In some cases, the persuasion can be effective, based on the following conditions:
First, the person who persuades should never have been involved in drug use:

Common psychology is like this: if you have never played but I do, you can persuade me [to reduce or stop].

(7f: Female injector, Quang Ninh)

Second, the nonaddict partner should be “a good shelter” for the drug user. Women often express their wish to have a nonaddict lover with a stable job:

It is very difficult for two IDUs to stop. In order to be effective, it should be a drug user and a nonuser. [Injectors] should find a nonaddict. For example, [that nonaddict partner] has a certain thing fundamental...job for instance. This is the pedal or the foundation [for me] to step on. In this circumstance I may accept [to stop drug use]

(12f: Female injector, Hanoi)

Third, the nonaddict partner should have a good understanding about drug use so that they can sympathize with their injecting partners:

An injector and a nonaddict can never have a serious talk about this [reducing or stopping drug use]. Nonaddicts can only theoretically advise [me] to stop but they can’t sympathize [with me] in my drug use and they can’t persuade me [effectively] because they are non-addicted so they don’t know about the ways to inject less or how to reduce the dose or number of daily shot so as to stop gradually.

(24f: Female injector, Hanoi)

Many nonaddicts advised me...but this kind of advice...I just listen only but in fact I don’t keep it in mind cos they don’t understand me. They just say, “stop it”...cos injectors [like me] have high self-respect. We [injectors] often feel discontented with many things. For example, if the advice is given in inappropriate context, we are ready to turn down everything...let it be

(1f: Female injector, rehabilitation center)

Lastly, our data shows that injecting women seem to be more likely than men to be persuaded by their nonaddict partners:

He takes care of me but he controls the money. He reduced my drug dose by reducing the amount of money he allowed me to spend for a shot: from VND 50,000 to VND 30,000 per day. After [street] work, I gave all money to him. I only kept VND 50,000 for myself. I just keep that for my fifties (a bag of heroin which costs VND 50,000). During one year I did not increase my dose, I just kept drug use at a low level...I loved him and respected the way he lived. That’s why I obeyed
him.  

(25f: Female injector, Hanoi)

He said: “I love you...but there are only two ways: either you should stop drug use or our relationship will go to the end”. He also took me to some home-based detoxification centers with a hope that I could say good-bye to heroin. But at last I could not overcome myself...after that he left me saying nothing.

(20f: Female injector, Hanoi)

Managing Relationships

Managing a relationship between an injector and a nonuser is considered to be very difficult. The success of this relationship sustainability depends partly on the ability of the injecting partner to reduce or stop drug use:

[Lam: IDU- nonaddict relationships can’t exist long and you can’t maintain your relationship?] Yeah, it is very difficult. Our relationship may exist if I can overcome [craving] and I can say goodbye with drugs. But if I continue to shoot, I think nobody wants to partner with a person like me

(10f: Female injector, Hanoi)

For male injectors, maintaining a relationship with a nonusing lover by taking advantage of her was justified as mot mui ten trung hai muc dich [an arrow with two goals]. These men try to get as much as they can from the relationship. This was rationalized by them as a “strategy” to feed their drug habit use and to satisfy their sexual needs simultaneously:

We have sex six times per week. At the same time I still maintain our relationship and love, provided that I have money. I borrow money from her and go for a shot. After that I go home and sleep with her.

(14m: Male injector, Quang Ninh)

IDU-nonaddict relationships seem to be easily broken due to tensions and contradictions arising from different lifestyles. Our data illustrate that the conflicts between them are mostly rooted in the stigma that the society places on drug users as a whole, particularly on women using drugs:

That nonaddict man never cursed me but he knows the place where I work [street sex work] and he often went to that place to take me home. I felt very uncomfortable cos people may think that “she is chan dat [deceived] by him or she works to feed that guy, nothing else. She is a drug injector and she is stupid”...something like that. This annoyance led to contradictions. He did not have sympathy in sexual
matters. He was also incompatible to me in terms of drug lifestyle. In addition, when we were near each other I had to be dependent on him. It did not mean that I lived on him but I felt something coercive.

(23f: Female injector, Hanoi)

In some cases, the break-up may not occur because of the “manliness ideology”, which is embedded in the minds of nonaddict women. Manliness is configured as a reason for some women to maintain their relationship with injecting partners. The following extract and fieldnote illustrate this point:

When I insisted asking my [nonaddict] wife about the reasons why she did not leave me, she said, “I still live with you only because you have not yet lost your manly characteristics”

(21m: Male injector, Hanoi)

In general, nonaddict women get tired of injecting men (and this may result in the relationship break up) when the men have lost their manly idiosyncrasies. In this case the women don’t want to stay in this relationship any more. A man, regardless of injecting or nonusing, should have a position/job in the society or at least some “power” in the family (e.g., he still is a breadwinner in the family). Otherwise, nonaddict women may abandon their injecting husband. A man shooter said “If your words are still valid, she still loves you, even she accepts to support you, provide money for you...whether they [nonaddict women] leave you or not depends on you...I am sure”. Many women say good-bye to their injecting husband, not because he is a drug addict but because he has lost his manliness.

(Fieldnote from FGDs)

Most men do not show any concern if their relationship with a nonaddict lover breaks up. While female injectors describe their relationships with nonaddict partners in a sentimental manner, male injectors describe their relationship management in a more practical way, showing less responsibility:

I don’t fear anything, neither the break up [of our relationship]...if, for example she were infected with HIV, I would say goodbye to her

(12m: Male injector, Quang Ninh)
CHAPTER 6
The Two Extended Case Studies

The cases of Chau and Chung, together with the life story of Ngan presented in Chapter 1, illustrate various ways IDUs manage their everyday lives, which are fraught with drug desire, risks, uncertainties and disease. Like Ngan, Chau has entered into different relationships with a number of men. For her, this is “normal”, as many IDUs will explore such options before settling on one partner. Each relationship has been of varying intensity and duration. Again, sharing syringes and not using condoms has become a normative feature of Chau’s relationships. As a result, she got infected with HIV without knowing the real cause. For Chung, there is something different. He is not promiscuous. He knows how to restrain his drug habit and he does not share syringes with his partner. He has a job and he is looking forward for a better life. In sum, these two stories help us to get more insights into the social contexts of AIDS risk and complex relationships IDUs have to confront. Furthermore, there are a number of issues inherent in their stories. Poverty, family break-ups, migration, employment, peer pressure are all negative factors which influence their lives. Paying close attention to the dilemmas faced by IDUs may lead one to a better understanding about the social construction of AIDS.

Case 1: Chau

Chau was born in 1980 in Nghe An, a rural province in the central part of Vietnam. She has one younger sister. Her parents divorced when she was ten. After finishing the ninth grade she had to give up school because “my family was poor and my parents did not pay any attention to my study”. When Chau was 18, she fell in love the first time with Ngu. Both of them were opium smokers. But they soon divorced, because “he beats me up frequently”. With the invitation of her friends and the attractiveness of the urban life, Chau decided to move to Hanoi with a hope to find a job. There she shared the room with three addicted friends in a cheap rent-house. As other drug users, she impressed me by talking about the way in which she became immersed in the drug life:

I began to smoke black [opium] in 1998. I was a heavy opium smoker when I began to inject white [heroin] one year later. I shifted to injection because after a long time of smoking, I seemed to get the “saturation status” which means that I did not feel good or get high anymore. Only heroin injection can make me feel good. I gradually increased the quantity of drug... from VND 50,000 (3.3 USD) to VND 300,000 (20 USD) per
day. Then I decided to shift to injection. It is cheaper and quicker to get high.

To “feed the high”, Chau had to think of different tactics to make money:

For shooters [IDUs], we have various ways to earn money: working as a girl [sex worker], you know... when you become an addict, you don’t care anything but money... I also steal things or deceive different people... any way you can think of to get money, anything you can change into cash to satisfy your craving. I deceive all my acquaintances, relatives and friends who are not aware of my addiction, with all possible reasons: I need money to come back to my native village, go to hospital for health check up... I know that friends often show their sympathy when I say I have a disease so they would give me money if I say so. For the men who like me (and they do not know that I am on drug), I can exploit them as well, asking them for money you know, all sort of things... I also go to the parks to steal belongings of young couples, at the moment when they are fondling each other... When I was pregnant, I even practiced selling illicit drug because I knew that the law does not punish pregnant women...

In 1999, Chau met Tuan, the second man after her husband. Tuan was a heavy injector, just returned from prison. “He has a talent to earn money. I think I could bank on him to satisfy my craving for drug, that’s why I liked him... there was no love from me”. Tuan made money by “dap hop” (breaking into houses). They were living together for four months when Tuan was arrested because of a robbery. Tuan hit more heavily than Chau. From the beginning they used two syringes but then they shared one: “we shoot to each other... he takes 10 dem (1cc) and I take 5 dem (0.5cc)¹. After a while I sort of increased my dose”. During the daytime they rarely met each other “He and I pursue different ways to earn money, we meet only at night. I often go to work [street prostitution] at 7 pm, but I hit and sleep during the day, I return from work at about 11pm, we play one [shot] and go to bed”. When Tuan is out, Chau also shared with her peers at home: “I also share with my peers... sometimes the drug is prepared in one syringe. After my friend finished the shot, I would remove the needle, shake off the barrel until no blood is left, then I put back the needle [to the barrel] and shoot.”

At that time Chau was 19 and Tuan was 25. Although Tuan was more heavily addicted than Chau, both of them were novice injectors in the drug scene. They both seemed to enjoy their sexual life. As Chau explained how heroin and sex went together:

...very often, 30 minutes after the hit, we have sex... but

¹The calibration on the syringe
with the condition that we play temperate [inject with a medium dose] and at the same time it should be our intention to have sex... then we can fuck right after the hit... If you take high dose, you can’t have sex right after the shot. Very often the injection makes your nerve sort of powerless so you want to sleep after that. But if you do something [having sex] right after the shot, you will be awake. Therefore after the fuck we have the need to take another shot so that we can get into sleep. Usually, we take a shot, fuck after that and then hit another shot: these three actions occur within one hour, continuously.

...When I’m sick I have a desire to have sex. The more you’re sick, the more you want to have sex, even when I have become a heavy shooter...very often, when the craving comes, I don’t have a desire for sex at once, but when I have suffered from the craving for 2-3 hours then the desire for sex will arise as well. Normally if I am full of it [drug] I am not interested in having sex with my partner or lover...in that context having sex is some kind of formality, nothing is orgasm...If you are in a normal state, your orgasm may need a longer time to be reached, but if you are in a sick [craving status], you will reach orgasm very quickly. By then you need something fast [quick sex] you know...if you have reached orgasm, nothing to be cared...

...Sometimes the weather is bad, rainy...I don’t have guests [clients], even if you have money but sometimes at night you can’t get the stuff [heroin] somewhere...sometimes you have been craving for the whole day...but even so sometimes in the day you still want to have sex...when you are on drug, sick is a normal thing...even when I am in detoxification period of one or two weeks, my need for sex is quite high. If my demand for sex is satisfied then, drug craving will be relieved for a while, I mean during the sex act only...right after that you miss the drug at once...

Chau did not use a condom with Tuan: “Once we love each other, we don’t use condom. Fucking without condom is normal for lovers or cohabiting couples. If I propose to use it, he may look down on me. He may think that I don’t love him truly, or consider him as a bad man [infected]. On the contrary, if he suggests to use one I would think so too”. According to Chau, dispensing with a condom is also synonymous with sharing a syringe: “We use one syringe and share, it means that once we are not afraid of unprotected sex so we share”.

Chau and Tuan were living together for six months when Tuan was arrested and sent to a detoxification center in the South. In the summer 1999, Chau entered the third relationship with Cuong, a drug smoker. Although they had different drug using styles, Chau seemed to “sympathize” with Cuong: “I think that I have experienced
that period [smoking] already. Of course, injection is quick and smoking is long but it is no problem”. After two months, Cuong began to shoot as a result of the cohabitation with Chau. But for Chau, the shift from smoking to shooting is quite conventional: “...it is easier for a shooter to drag a smoker partner into injection more than a smoker to drag a shooter into smoking, because shooting produces more high and more directly absorbed into blood than smoking...once you have shifted from smoking to injecting, you don’t want to smoke anymore and even if you do smoke, you don’t feel high anymore...

Two months after Cuong was sent to prison for his involvement in a robbery, Chau met with Chu, a nonaddict, and lived with him for one year. Chau decided to hide her drug use with Chu right from the beginning. She explained about the motive for her concealment:

“You know we [drug addicts] are condemned by the entire society...even when I sit somewhere in a public place I can hear the condemnation from the crowd...therefore I feel afraid of disclosing my addiction status...they will not accept me...but there are some people who seem to be willing to help me even when I disclose but I don’t want to tell them the truth anyway... because I have fooled myself by shooting the fucking stuff so I am scared that I will not be able to stop...therefore I have to lie... when you are on drug, you become small-minded and selfish.”

Chau also thought of another plan if the hiding with Chu would not succeed “if it fails [and he discovers my addiction], I would drag him into shooting with me”. This plan is based on her experience living with other men: “There are some men who are not influenced by my ‘pulling’ [dragging him into injecting habit] and they still persuade me to withdraw...maybe from the beginning they still give me money and also during that time they persuade me but if I remain the same, they will feel tired and say good bye to me...except the case for men who love me truly, they have to accept the situation [by continuing to live with me]”. But Chau did not succeed in pulling Chu into the life with her. When Chu found out that Chau was using drugs heavily, he began to use a condom with her. However, Chu still showed his kindness by persuading Chau to withdraw “He helped me a lot, so I felt I loved him truly and from that time I did not want to loi dung [exploit] anymore...however he will never be able to help me to stop...even parents, the most sacred relation can’t help me withdraw...so nothing can stop me”.

In April 2001, Chau was found to be infected with HIV. The test was confirmed after one week of her stay in Bavi rehabilitation center. She recalled:

I think I got the virus because of sharing rather than playing no condom”...When I was working girl [CSW] I did use condom most of the time. But there was the time when we
gathered in T. commune for shooting. We were all sort of heavy shooters and that time policemen launched campaigns to arrest many addicts and drug dealers...that’s why white [heroin] became very scarce. We had to go to shooting galleries where black [liquefied opium] was readily prepared in syringes for sale. You know, that were all used syringes... they simply cleaned the syringes by water and pump in the stuff [opium] for us...we were all so sick [craving] that we did not think anything, and after the shot we gave the used syringes back to them. They then do simple cleaning again and prepare drug for others...

With regret, she told me how she understood about AIDS before being infected: “When I was a novice shooter, I was not aware of SIDA [AIDS]. I saw AIDS people on TV, at their last stage, with rashes, ulcers...Then I went to Hanoi and shared [syringe] with my peers. They looked healthy and I thought to myself: ‘nothing to be worried about’...now I know what it is…”

Case 2: Chung

“Since the day I began using drug, I have lost a lot of things. First I lost my own human dignity. Second I lost respect from others”.

Chung was 29 years old when I met him. Different from Ngan and Chau, Chung had a decent job: he is a freelance painter. Chung can earn USD 100 a month with his painting job. Like Ngan and Chau, he was brought into the drug scene when he was young. After finishing 10th grade, he had to abandon his study in school because “my family faced a lot of difficulties. We did not have any money to save my mother’s cancer. My father died one year after my mother’s funeral. I was very small then. I have three brothers. All of them can live on their own but they all are involved in gambling”. Chung began his drug career as a heroin smoker in 1996. The reason for his involvement in the drug scene was “I began to use drugs and that is simple because my brothers were using drugs too. They were sort of hardened shooters, OK? And I would hang around them. They often shoot in the attic and socialize there you know. And I just sort of curious want to know what they were doing. So I started shooting with them”.

In 1999, about the time Chung returned from rehabilitation center, Chung met Thi at a binge in a karaoke parlor where Thi was working as a bargirl. Thi liked Chung because of his painting talent and manual skills “I am good at painting. All of my previous relationships originated from my drawing capacity. In addition, I am sort of skillful person. I can repair TV and motorbikes, all those things in the house. That’s what a woman needs from a man”. He decided to live with Thi after some consideration
To rate myself, I think I am not a pure person who has a healthy lifestyle. In general, I don’t care what kind of girl she is. The main thing is we love each other. That’s all. I know that she is using the white [heroin]. But I am addicting myself so she is similar. I should accept my addiction and its consequences.

From the beginning both Chung and Thi hide their addiction status. Until one day Chung could not tell lies anymore because Thi saw him inject with his friends. But they already feel committed to each other, and thus try and go ahead, live with it. They went on living together and had sex normally as before as if nothing had happened. Thi remained a bargirl. It seemed that both of them could predict what would happen. They have already gotten “in too deep”. For them risk is something fearful at the beginning, but readily acceptable later. The cohabitation is equivalent with the inherent risks. Risks require sympathy. With these rules they maintained their cohabitation:

In general, she is similar to me from the beginning when I met her and then I lived with her and had sex with her, I sometimes scared [about HIV risk]... But when we got married officially [we] don’t care. Each person should have sympathy to another. May be she thinks something but she does not say. So do I. Later both of us agreed that we don’t mention the past. We live in the present. Once we are as a husband and a wife, we should keep safe for each other.

About one week later, Thi revealed her habit of “chasing the dragon”[smoking heroin] and “sometimes preferring a shoot”. Chung described his cohabitation:

We rarely have meals together. The house is a place to sleep only. She and I pursue different goals. I am sort of self-indulgent. Let it be… It is no problems whether we live together or say good-bye. It is difficult to maintain a normal life, provided that each of us feels no obstacles in emotional life. Set it free. I spend what I can gain. So does she. It all depends on myself: If I want to have a good life, I have to restrict drug use. Otherwise I have to accept a depraved life even it can lead to a young death… So does she. She is sort of similar to me. One should be responsible for oneself. No other ways.

With that mandate, they compromise their cohabitation and pursue their responsibilities independently. Time spent together is short and unpredictable. They often meet each other at night when Thi returns from work. It is habitual that Chung goes out to buy drugs and two syringes. Then they take a shot and go to bed. Sometimes they have sex and sometimes they use condom “when [we] feel dangerous [she is on period] we use a condom. Otherwise [we] calculate [the safe] days to have sex. Often, both of us suggest using”. Although they are scared of AIDS, they went on having sex without condom because “if one of us gets the
disease [AIDS] we have to accept it. No other ways. You know having sex no condom, sharing...all kinds of risks”.

Different from many IDUs, Chung can control his drug use. As he goes to work everyday, he decided not to inject frequently because “if you shoot daily, you will increase the dose and you never know”. He does not want to be a “professional drug user” because he still has to work and he is scared of being vilified by other people. But taking drugs is something unavoidable. He said he could not stop it. So he has to manage a special habit of using drug “I sort of playing moderate [inject with medium dose regularly]... I don’t shoot to a level, as I want. In this way I can balance myself. I usually shoot a small dose but I think to myself ‘it is enough’”. In this way he can balance himself in some way. But this “balance” is never complete, as he needs something more- that is sex: “it’s always a combination between drugs and sex, I should say. Anytime when I shoot, sex is involved somewhere. I don’t know why but may be it’s the high. It seems like you need the sex to bring the high down. The high itself makes you just want to have sex”. Chung also wants to have sex during his “abstinent days”: “as you know I don’t shoot daily because sometimes I have to go to other provinces. So during these trips I am very busy and I have to stop using drugs temporarily. But I still need sex. I am sure about this feeling. It’s like sex makes you forget about drugs and makes you feel comfortable”. In this context, drugs and sex seem to have a positive relationship, which helps Chung to “balance the hardships”.

Previously Chung used to have multiple relationships with different prostitutes but now he is loyal to his wife. He does not have any intimate relationships with other women anymore. He does not need to have sex outside because for him “it is not my need. My wife is enough. I still work and I have money. No need to partner with girls. It is a waste of time. Sometimes involvement in such relationships burdens you more, pulls you more into the drug life. The best way is that da trot thi phai tret [now that you had accepted you had to begin], I am still able to play it erratically [inject infrequently]...partnering is useless”.

Chung and Thi live together for three years but they don’t have any children. For Chung, thinking about having a child is something ambiguous. It does not mean that Chung and Thi don’t want to have a child. In fact, they do: “you get married and you settle down. That is still a marriage life. You have a family when you have a child”. In his sense, a couple without children is not called a family. But it is not simple to have a child in his context. Having a child requires a lot of things and may complicate their life: “I feel scared when I think about that [having a child]. If I have children I should change myself. I should work harder. Having a child is something to tie you up. Therefore I am not in a hurry. [She]’s still on the pill. We have not thought about it yet. My wife is working as a karaoke girl you know. Sometimes I ask her in what cases she uses condom...later if [we] want to have
children [I] should consider [whether she is infected or not]”. On one hand, Chung is concerned about the possibility that his wife may be infected. On the other hand, risk is something acceptable to him: “once you are deepened [in the drug scene] you should know how to cope with every kind of unluckiness. It is inevitable. You should have a strong will. Because you have decided to live with her, you should accept something unpredictable. She is sort of like you. No different”. Chung is not concerned about the break-up of their relationship because “we are still free. [We] don’t have children yet. Let it be. We don’t quarrel because we each have our own money”. Thus, Chung appreciates a relationship in which they are independent of one another and they don’t have to be burdened with childcare responsibilities. This is perhaps one of the ways to manage his cohabitation with Thi.
CHAPTER 7
Discussion

The drug scene, which interacts with sexual relationships among IDUs, is accompanied by a kaleidoscope of folklore and argot, and a distinct set of rituals and rules around the acquisition and use of illicit drugs (see also Singer & Baer 1995; Grund et al. 1996). The drug scene is also the arena in which IDUs' daily lives unfold, with a constant movement and hassle between drug-related social connections (cf. Kane & Mason 1992). The desire to get high, the scarcity of drugs and the secrecy required are three important parameters guiding IDUs' behaviours.

Living in secrecy and being ostracized by the mainstream society, drug users need to develop trusting relationships in which they cooperate in the struggle to acquire scarce drugs. In order to survive, drug users have become mutually dependent for fulfilling basic human needs, but at the same time they play tricks on each other. Therefore they live under constant pressures; managing their drug and sexual habits as well as relationships, while trying to cope with the police and constantly estimating whether other drug users are a threat or a source of companionship. To satisfy the desire to get high, IDUs have to face a multitude of risks, of which sharing a syringe and not using a condom - the two ingredients of AIDS risks- are the most important (Freeman et al. 1994; Sibthorpe 1992; Farmer et al. 1996).

Syringe Sharing

Sharing [syringes and needles] is an integral part in the daily lives of IDUs in this study. It does not mean a "social bond" between two injectors (Conviser & Rutledge 1988). Rather, it seems to be a normative feature of drug users' social relationships (e.g. McKegancy & Barnard 1992; Schiller 1994). The traditional view that sharing reflects a culturally entrenched ritual has been expanded to acknowledge a pragmatic response of IDUs to the restricted availability of needles and syringes (Celentano et al., cited in Carlson 1999:267). As Connors (1992:597) notes:

Sharing drug injection equipment can be seen as a form of 'life insurance' among people with scarce resources if it helps to maintain a relationship with someone who can be called on in time of need.
I found ten patterns of sharing situated in different contexts. Sharing within intimate relationships is the commonest type. “Front loading” and “sharing a load” are the main techniques applied by IDUs. Sharing can be accidental or intentional, individual or multi-person, and anonymous or overt.

Reasons for sharing vary. In general, the immediate desire to get high and the unavailability of sterile syringes at the moment of sharing are the main one. Among close relationships, trust-the belief that a fellow is disease-free and thereby non-threatening - is the primary sufficient condition for sharing. In other contexts, the following reasons were mostly cited: lack of AIDS knowledge, lack of money right before a sharing event, having the same positive status, confusion, revenge. Carelessness has emerged as an important factor for sharing decision. Although 100% of the drug users in this study can name the two modes of HIV transmission (sharing a syringe and not using a condom), they can't consciously control their behaviors. At the same time, they don't care about the consequences of those careless actions. The majority of our respondents were sent to rehabilitation centers at least once, where they are provided with basic knowledge about HIV prevention, during a period of three months. In spite of this, many drug users continue to share. During FGDs, some IDUs say that carelessness has become some kind of personality or "kieu choi" [play style].

Sharing is gendered in character. Men are more likely to share outside the home (in a group), whereas women are more likely to share indoors. In addition, some studies show that female injecting partners of male IDUs may be more likely to be the receptive partner in a syringe event (Barnard 1993) and thus may be at greater risk of becoming infected with HIV by engaging in this behaviour (Grund et al. 1996). This is not confirmed in this study. Many women can inject themselves and many women inject after their male partner.

Sharing has some important functions. Often new relationships are initiated through sharing and existing ones are re-established. Some IDUs say when they are in withdrawal, they miss their sharing partner (whether the partner is male or female). Through sharing, the two persons renew and reinforce their common bond. Sharing is often found to be an important part of socialising. Sharing which is accompanied by other recreational activities helps to bring drug users together.

Sharing has several symbolic meanings. First, in a sharing event, the roles of donor and receptor are mostly determined by who furnishes the most money, carries a sterile syringe or possesses greater shooting skills. Often, those who have money and/or drugs have more power and hence, are the donors. In addition, the reciprocal character of sharing leads to mutual obligations resulting in more structural relationships. In addition to drugs, IDUs also share other commodities such as food and money. They care for each other in different ways (e.g., pooling to buy drugs;
providing a friend in hunt a place to sleep; doing artificial respiration when one is overdosed; giving a tiny portion of drug to a partner before she goes to sex work). In a broader sense, as Grund et al. (1996:698-699) observed:

Syringe sharing is considered as a symbolic expression of an elemental interaction pattern of reciprocal exchanges of valued items among group’s members, which provide a practical and emotional balance to daily hardship.

Sexual Partnerships

Sexual expression is a fundamental feature of human relationships. The majority of IDUs in this study is no different in this respect. Many of them are sexually active and have at least one sexual partner. The searching out of intimate relationships among IDUs does not mean to be indiscriminate, but rather, rational. It provides a sense of security in the drug scene characterised by uncertainty. Seeking for a SP to live is also a means to escape social isolation. By and large, female IDUs are more likely to have a SP who is a drug user and to be living with another than male IDUs.

The drug scene brings IDUs and their SPs together. Shooting galleries are good for having a fun [a shot]. Besides selling drugs, drug dealers also provide an opportunity for IDUs to meet. By offering a homeless friend a place to live, by asking someone to buy a bag of heroin, by pooling money to have a shot, a new relationship is established. Having a sexual relationship between IDUs is thus significantly associated with engaging in drug using practices. In addition, IDUs may meet their SPs in other situations: in karaoke parlours, at sex work, in detoxification or rehabilitation centers.

The conditions of partner choice are often affected by drugs and money. Trading sex for drugs not only enhances risk for HIV infection but also increases number of SPs among the majority of women. Through sex work, women meet their clients who may become their “casual”, “regular” or “private sex partners”. Meanwhile, male IDUs, whose main job is often stealing or drug dealing, decide to seek drug-using prostitutes to cohabit. Some men who are incapable of earning money by these ways try to deceive [nonaddict] women to live on.

Selecting a SP is gendered in character. For women, manly characteristics, such as generous, caring, steadfast, are still important and appreciated. The meaning of manliness is beyond the scope of this study, however it is worth emphasising that manliness, as embedded in the traditional sexual culture, plays a very important part among Vietnamese women. During my interviews with drug users, especially with women, I observe that the phrase “co tinh dan ong” [manliness] was repeatedly cited. Manliness is an important criterion that many women use when seeking for their partners. For men, the selection for a sex partner seems to be more superficial
and materialistic. Often, they are interested in the money of the woman, her appearance, and whether she shares a similar attitude in recreational activities.

When a drug injector and his/her sex partner feel that they are compatible, a new relationship begins. If the sex partner also uses drugs (whether injects or smokes), the couple would rent a house to live, enjoy their drug habits, and have sex. In case the sex partner is a non-user, the place to have sex often occurs outdoors: in hotels, guesthouses, cafes or karaoke parlours. In most cases, there is a high rate of changing sex partners. Depending on patterns of relationships, the conditions for this partner change vary: being arrested, violence over financial issues, conflicts in sex and/or drug habits, being discovered about one’s addiction. In the following sections, I discuss some specific features of each relationship type.

**IDU-IDU Relationships**

Having the same injecting habit is viewed as the most important element in forming and regulating the cohabitation between two IDUs. IDUs see their partner’s acceptance of drug use to be crucial in preventing relationship problems. This pattern of relationship is viewed as “safer” and “simpler” than other ones because IDUs don’t have to hide or to lie about drug use and consequently, they don’t have to deal with the risks associated with the failure to keep “the secret”. Because of this advantage, this pattern is the most prevalent among IDUs. Other types of relationships among IDUs, in the long run, will shift to this pattern.

Sharing a syringe and dispensing with a condom are the most salient risks in this relationship. These two behaviours are very frequent and seem to be a “norm” among injecting couples. Sharing occurs on a basis of trust between two injecting partners. Trust here communicates a sense of relative security of a shared destiny. Trust is used as a means of risk survival. Such a tenuous relationship also entails risky sex. Sharing a syringe makes it easier to reject a condom because sharing (even once) implies getting an infection. So, “no need to be prudent”. For IDUs in this relationship, sharing or not sharing, using a condom or dispensing with it - these are not important choices. Risk is a relative concern in this context. Furthermore, IDUs must weigh the risks posed by AIDS against the benefits they receive from condomless sex and sharing. Taking such risks may therefore be felt as acceptable. The force of emotions in risk decision-making is highlighted here. The acknowledgement of AIDS risk challenges all patterns of uncertainties inherent in this relationship: uncertainty about risks in sharing events; uncertainty about risks of sexually transmitted infections and uncertainty about a sex partner’s sharing or having sex with outsiders.

Using a condom may be viewed as a risk itself because condoms hinder the development of meaningful relationships (Rosenthal et al. 1998). In the context of these relationships, a condom is used erratically at the beginning of the cohabitation.
As the relationship becomes "stronger" or more "meaningful", the tendency to reject a condom becomes apparent. Often, neither partner suggests condom use because they fear that such a proposal will denote infidelity on their part or suspicion of the other. Transitions towards unprotected sex thus help define or demonstrate relationships as both intimate and secure (Rhodes & Cusick 2000).

What we observe in these relationships are actions to prevent them from being broken. Love, trust, intimacy and loyalty are inadequate elements for a strategy to manage the relationship. IDUs and their sex partners have to work out other pragmatic tactics. First, there is a division of labour between the two partners in this relationship. Often, female IDUs have to prostitute in order to finance their own, and sometimes their sex partners' injecting habits. To maintain a sex job, female injectors need to inject before going to work, usually in the evening. Many of them explain that they do not want to go to work in a craving status. In this context, if the amount of drug is insufficient for both, the male partner often has to "give in" some portion of drug to the woman before she leaves the home. This act of "concession" has become an argot described by IDUs as an act of generosity and a way of caring. While the concession can be viewed as a means of managing the relationship, this has put the woman at a heightened risk because this situation occurs repeatedly. Meanwhile, most of the male IDUs tend to make money through criminal activities such as drug dealing, stealing, house breaking and robbing. Interestingly, these "jobs" are expected and admired by female injectors in the drug scene. If men can't work illegally, the relationship seems to be more difficult to manage and it can lead to a break-up due to conflicts derived from financial issues.

Second, hiding one's occupation as a sex worker has become a way of managing the relationship. Some female injectors even keep "this secret" from their injecting partner. The reason for this concealment is sculpted in the strong stigma of the society in general, and of the men in particular, towards women on drugs. Although this tactic seems to be fragile and this hiding is merely "superficial", it reflects the women's strong desire to be respected by the society.

In sum, the IDU-IDU relationship is notorious for its two most prevalent AIDS risks: sharing syringes and dispensing with condoms. These two behaviours are not simply a physical act; it is a symbolic act of great significance. Sharing is a product of trust and necessity. Not using a condom is a product of trust and a denotation of a true love. Especially among women, the pervasive idealisation of a romantic love is still of prime importance. However, risks and uncertainties often outweigh trust and love. This makes IDUs and their sex partners discontented with their hard life. Some IDUs say that their ongoing relationship is not considered as "love", but is simply a "spontaneous", "provisional" or "momentary" cohabitation. By comparing their ongoing relationship with a true love, they highlight the negative effects of drug use on the meaning of their relationship.
IDU-Smoker Relationships

In this type of relationship, IDUs and their sex partners have to face with a difference of two distinct types of drug-using patterns: injecting and smoking. In general, injecting procedures are simpler than smoking ones. An injection is said to get high faster and more “directly” (via vein) than a smoke (through mouth). While this difference may lead to some minor conflicts at the onset of their cohabitation, couples tend to acknowledge the reality, mark in practice the difference in their drug use, and work to negotiate their relationship in some ways. Everyday routines and rules are established to mitigate the potentially negative effects that a partner’s behaviors may actually have on a relationship (e.g., by setting an independent schedule between the two partners). Injectors seem to be more sympathetic to share the “feeling of difference” than their smoking partners because injectors “have just gone through” the smoking process. In contrast, some smokers cannot sympathize with their injecting partner because the feeling of shooting a drug into the vein is still new to them and therefore makes them feel uncomfortable watching the partner inject. This may force smokers to switch to injecting so as to have a “drug use harmony” with their partners.

IDUs and their partner not only have to work towards a harmony in drug use but also a harmony in sexual life. Our data shows that smokers often have higher sexual desire than injectors. Specifically, female smokers frequently report having high sexual desire during the smoking period. On the one hand, this high desire may lead to dispensing with condoms. On the other hand, the difference in sexual interest between injectors and smokers will “force” some IDUs to manage their sexual life with their smoking SPs by pretending to be “normal”. This can be seen as a key feature of relationship risk management made complicated by drug use (cf. Rhodes & Quirk 1998).

The social organisation of this relationship pattern is influenced by two processes: “onwards transition” (a move from smoking to injecting identity) and “reverse transition” (injecting to smoking). For some IDUs, the act of injecting is operated as a “risk boundary”. The smoking and injecting identities are not mutually exclusive, there is slippage and there are crossovers between them. In fact, many smokers can’t maintain their oral use for long and reflexively decide to “pass” this boundary to intravenous use. But more commonly, they are “pulled into” injecting as a result of being in this relationship. The motives for this onwards transition lie in the relationship itself. It is possibly a desire to feel close and similar to their partner or a wish to have an equal share of drugs (MacRae & Aalto 2000). This also means that IDU-smoker relationship pattern tends to shift to IDU-IDU type as a result of the smoking partner’s change in pattern of drug use. In other cases, however, some smokers can be positively influenced by their injecting partner so that they may sustain the oral habit for a long time. Furthermore, some novice injectors can return.
to oral use (reverse transition) as a result of the cohabitation with smoking SPs (although the likelihood of the success is very slim). Thus, changing pattern of drug use (from smoking to injecting) may lead to changing pattern of relationship (from IDU-smoking to IDU-IDU type); conversely, the relationship also has impact on the chance to change behaviours (from injecting to smoking).

IDU-Nonaddict Relationships

In the course of their drug career, an IDU may engage in relationships with a nonaddict partner. Female IDUs tend to live with nonaddict men more than male IDUs living with nonaddict women. This can be explained by the fact that there are many more men than women who inject. Further, our data suggests that it is more likely for nonaddict women than nonaddict men to accept an injecting partner. This gender difference in choosing a partner is rooted in the stigma men often attach to addict women. In some cases, even male IDUs defame their female counterparts. This stigma among men seems to contradict with the fact that some female IDUs still want to seek for a nonaddict man. For some of these women, the searching for such a relationship denotes an emotional need. For others, engaging in a relationship with a nonaddict man can be viewed as a means to earn money and to form socially appropriate relationships. Similarly, young injecting men often see money is the most important motivation in their search for nonaddict girls. To achieve these goals, both male and female IDUs have to hide their identity as a drug addict, right at the formation of the relationship. But maintaining a non-disclosure strategy is more problematic because, at the same time, IDUs have to struggle with differences arising from two distinct lifestyles. Many male IDUs face a difficulty of hiding their addiction while pretending to have a “normal” sex life. In contrast, female IDUs complain that their sexual need is not satisfied and that their drug demand is not met and neither sympathised by the nonaddict partner. Usually, the “double difference” is seldom acknowledged and rarely discussed openly by either partner. This “closeness” also exerts influence on the initiation of condom use. In general, nonaddict partners are constantly assessing the risk of HIV. When they are not sure about their partners’ level of addiction (whether recreational use or smoking a drug), they may agree to have sex without a condom. During this phase of the relationship, the drug-using partner may have shifted to intravenous use but the nonaddict is possibly unaware. When nonaddicts find that their partner injects, rather than smokes, their concern for HIV rises. In general, when “hiding tactics” used by the injecting partners are still effective, the nonaddict partner may agree to dispense with condoms. As IDU-nonaddict relationships are usually short-lived and nonaddict partners may be involved in other sexual relationships after the break-up with injecting partners, this poses to the possibility of cross-transmission among IDUs and their nonaddict partners, and subsequently from these nonusing individuals to the populace.

Most studies examining variations in condom use between casual and regular/private
sex partners reveal that safe sex practices decline markedly based on familiarity with the partner (Darke et al. 1990; Sherman & Latkin 2001; Wojcicki & Malala 2001; Pickering et al. 1993; Schoepf 1992; Wawer et al. 1996). These authors show that, for women, condom is often used with “casual partners”, but not with “regular” or “private partners”. However, data from IDU-nonaddict relationships in this study reveal that, in some cases, injecting women refuse condomless sex even when a [nonaddict] casual client has become their private sex partner. The reason for this denial is rooted in the social condemnation toward addict women as a whole. In this context, the woman is said to feel degraded or losing dignity because the man comes to her for the sake of penetrating her- thereby she is like a “sex tool”, rather than love. This also implies that she is “an addict” and thus “dirty”, and he is “a nonaddict” and thus “clean”. Her insistence on condom use does not mean that she wants to keep safe for someone she loves. Rather, it can be seen as the resistance against the stigma inherently residing in the man’s thought.

Our data shows that the possibility of reducing or stopping drug use for an IDU in this relationship is higher than the case in the previous relationship patterns. Injecting women seem to be easier to be persuaded by male partners than injecting men by female partners. While stopping is viewed as very challenging, the success of persuading an IDU to reduce gradually or temporarily “fix” at a low level of drug use should be considered as a promising intervention among IDU-nonaddict relationships. This finding mirrors other studies where this type of relationship was found to be protective against participation in drug use risk practices (cf., Miller & Neaigus 2001)

In sum, being in this relationship, IDUs and their nonaddict partner are constantly in the process of struggling with their differences associated with drug use and sex. The management of drug and sex conflicts is located in and affected by the management of the relationship. This type of relationship is thus viewed by drug users to be particularly difficult to manage, since these conflicts never end. The “double life” is felt to introduce uncertainty and mistrust between partners even if drug users have disclosed their addiction status. Due to all these obstacles, this relationship pattern can be considered as the most fragile in comparison with the two above mentioned ones.

The Meaning of AIDS Risk and Intimate Relationships

People who share a syringe and forgo condom use are often said to be “in denial” about AIDS risk. Though, the term “denial” hides more than it reveals: it constructs AIDS-related risk-taking as a self-evident, individual level, “micro-social problem” (Singer et al. 1992)- a problem without macro-level correlates or causes (Sobo 1998). My exploration of denial’s mechanisms reveals that IDUs’ denial of their risks for AIDS and their related practice of syringe sharing and condomless sex has “a level of meaning and cause beyond the narrow confines of immediate experience”
Of course, once one is aware of risk, risk avoidance is matter of choice (Douglas 1986). But the idea of a high-risk lifestyle can be seen as an accepted norm in the drug scene (see also Douglas & Calvez 1990). In fact, many IDUs have thrown in their lot with their partner. Even if they are aware of AIDS risk, they don’t seem to avoid them. Choosing risky behaviors is something normalized in the drug scene. There are different reasons that encourage IDUs to take risks either by sharing or having condomless sex with multiple partners. First, IDUs’ risk perceptions are often fraught with myriads of uncertainties inherently residing in a situational complexity attached to accounts of drug and sexual behaviors. There is always a contradiction between safe sex and safe drug use. IDUs often give themselves and their SPs more leeway around issues of safety when it comes to their discussions of sexual practices, than with their drug using practices. The risks of sexual transmission are not considered as serious as the risks of infection through sharing syringes (cf., Kane 1999; Sibthorpe 1992; Rhodes 1997). While sharing is attached more with physical pleasures, non-condom use is attached more with emotional meanings. Furthermore, perceptions of acceptable risk were said to shift in keeping with the length of relationships and expressions of commitment. As Kane (1999) notes:

Sex partners might choose to continue ignoring their risk or choose to transform their understanding of risk so that they feel more comfortable with it, personalising public health information so that it fits their situation, protecting themselves in some ways, but not adhering to any absolutes.

Second, AIDS risk is often left to chance once multiple choices and risk reduction attempts have been made. While IDUs and their SPs try to manage AIDS risk and their relationships in their own ways to prevent the infection and the break-up of their relationship, this endeavor often entails many obstacles. In the event of risk management being overly complex or impossible (e.g., a female partner has to agree to have condomless sex to show her fidelity; a couple has to share one syringe because the second one can’t be bought at night), it is then inevitable that recourse is made to alternative solutions of risk acceptability, destiny and chance.

Third, feeling secure in an intimate relationship is often a denotation of trust - a belief that one’s partner is disease-free and thereby “safe enough”. Trust, which is usually accompanied by love and intimacy, makes possible a sense of security and safety for both self and the relationship (Rhodes & Cusick 2000). Trust is the main reason given by IDUs as a justification for their risk acceptability and fatalism. In IDU-IDU pattern, trust is expressed by a mutual agreement to share one syringe. In all three patterns, trust is represented by consent to have sex without condoms. Choosing condomless sex is a prime expression of the trust that love is culturally
constructed as entailing (Sobo1998)

Fourth, dispensing with a condom is a means to define the relationship as "intimate" and "committed". This gives explanations to the fact that female injecting partners tend to use condoms with their clients at work; however, they tend to forgo the usage with male partners at home because condoms signal a distance that is inappropriate in the context of intimate relationships. Since trust, love and intimacy play such an important role, broaching the subject of condom use may be a violation of these elements and thereby brings suspicion and disequilibria to the sexual relationship (cf. Wojcicki & Malala 2001).

Yet our findings show that the process of managing relationships is contradictory. The crux of this contradiction is the fragility of trust, which is often accompanied by doubt. Risks, dangers and uncertainties are something out there. In IDU-IDU pattern, for example, suspecting one’s partner to share syringe outside or to have condomless sex outside is somehow inevitable. In IDU- nonaddict relationships, mistrust occurs when IDUs reveal their drug habit. Furthermore, love is not always a "true love". There is also another type of love in the drug scene, that is the so-called “exploited love" [tinh yeu loi dung]. This often occurs in case of IDU-nonaddict relationships in which an IDU seeks for a nonaddict to cohabit for some purposes. For example, an addict woman may prolong her attachment to her partner if he is willing to take care of her through economic support as well as an expression of love. In Quang Ninh, I also talked with some male IDUs who viewed partnering with rich girls as a tactic to make money to feed their drug habit. In this type of love, a condom is given more chance to be rejected because “the scheme” should be maintained over time.

Thus, in the context of intimate relationships among IDUs, the meaning of AIDS risk and relationships interact with each other. AIDS risk, characterised by syringe sharing and condom denial, is an important determinant of relationship status. It is impossible to understand intimate relationships without mentioning the symbolic denotations that AIDS risk confers. Although trust, love and intimacy are sometimes confounded by the elements of doubts and uncertainties, AIDS risk should be re-configured as one aspect of relationship security, and not merely as a matter of self-protection. Finally, it is also necessary to recognise that knowledge of AIDS risk must be incorporated into the complex emotional and personal aspects of people’s lives.
CHAPTER 8

Implications for HIV prevention

In this chapter, I want to make a number of general points arising out of this study, which have a bearing on efforts to change IDUs’ risk behaviour patterns. I shall look more critically at some of the implications for HIV risk-reduction interventions in relation to gender and power, care and responsibility, drugs and sexuality, and social stigma. In the final section I shall make some comments on the typology of high-risk groups.

Gender and power

The literature on heterosexuality among IDUs generally ignores economic self-sufficiency among women while preferring to discuss behaviors deemed deviant or immoral (such as risky, premarital or non-monogamous sex). It is clear in this study that many women can support themselves and their male partners, albeit via sex work. Most women seem to have a firm sense of agency and consider themselves financially independent from men. Often, those men who depend on women for money are forced by circumstance to ignore the infidelities of and risks for their female partners while engaging in commercial sex. In this case, women don’t assume a subordinate role vis-à-vis these men and have considerable control over sexual decision-making and use of condoms. This implies that they are breadwinners so they have more power and assertion in sexual negotiation. This can be seen as social change accompanied by changes in the conceptions of sexuality and gender. The influence of Confucianism on women’s passive roles has become less valid in this context. Therefore, HIV prevention program should not always be based on a normative gender model of hierarchical gender relations and role expectations as it is commonly portrayed in contemporary studies about AIDS. Such generalized models often contradict with real life experiences, at least in the case of IDUs presented here. It is also critical to examine why some women apparently exercise control in their sexual decision making while others do not. As Klee (1996:167) notes:

There is danger here that, in an effort metaphorically to ‘rescue’ female drug users from ‘blame’ for their own circumstances, we collude in their disempowerment through an implicit assumption that they have no power and control over their lives.

Care and responsibility
IDUs are often blamed for their low self-esteem, high-risk lifestyle, and lack of care and responsibility for themselves. This is not always the truth. Our data shows that many IDUs don’t label themselves as such. In fact they have different ways to care for themselves and for others (e.g., taking risk-reduction measures in their own ways; taking care of one’s children when one is arrested; educating peers to inject safely; providing a homeless friend a place to live; providing first aid when a fellow IDU gets an overdose). Some other forms of care may be viewed by health officials as “negative”, such as: pooling money to buy drugs, lending injecting equipments to a close friend, assisting a friend with collapsed veins. Thus, in the drug scene, care and responsibility confer different meanings and may be considered as a symbolic expression of risk management. Responsible behaviors for the self and for others should be emphasized as the means to curb the spread of the AIDS epidemic. As Hassin (1994:397) has also suggested:

Interventionists need to engage the IV drug users’ ‘good selves’ in their discourse on responsibility. To do this, they must give credence to existing responsible behaviors, even if token gestures.

Given that so many IDUs have multiple relationships, there is a possibility for HIV strategy designers to build on existing identities (injecting, smoking or non-using) to encourage responsible drug injecting and/or sexual practices, rather than to bank on the ritualized slogans “don’t share” and “practice safe sex behaviors”.

Drugs and sexuality

In general, drugs and sex are highly interrelated (Iguchi et al. 2001; McCoy et al. 1996; Miller & Neaguis 2001; Flom et al. 2001; Rhodes et al. 1996). Drug use is associated with trading sex for drugs/money and often means unsafe sex (Iguchi et al. 2001; Latkin et al. 1994; Brummelhuis & Herdt 1995). Couples using heroin use opiates together to enhance sex (Lex 1990). Further to this, our data suggests that there is tremendous variability in the perceived effects of heroin on sexual experience. Some IDUs reported a positive relationship between heroin, other stimulating drugs, and sexual pleasure and performance. Some female smokers also report that smoking enhanced their sexual desire. In contrast, other IDUs confirm negative relationship between heroin and sexuality. While some male juniors prefer having sex right after the injection, seniors don’t. In addition, women seem to have a more positive attitude than men with respect to sexual pleasure. Thus, this variability may be a result of the physiological effects of the drugs, length of drug use, and/or other factors. The point is that the relationship between drug use and sexual experience is highly variable. This variability should be integrated into HIV risk-reduction counselling. As Carlson (1999: 71) points out:

“A ‘one size fits all’ safer sex intervention is unlikely to meet individual needs
satisfactorily, given the [above mentioned] variability in experiences”.

An experienced heroin injector may not respond to the message “always use condom” because sexuality for him is likely unimportant. Attention should be paid to situate the variability in sexual history as well as history of drug use, specifically with respect to the effects of drug use on sexual experience. NGOs and self-help organisations may reconsider such kind of work.

Social stigma

A common trope in the discourse of AIDS is that IDUs and FSWs are often presented as “vectors” or “bridging populations” of disease transmission. Because risk is defined on the basis of occupational description, being an IDU or a sex worker is synonymous with “high risk groups” or “social evils”. The chain of infection is often configured as IDU-sex partner-populace or FSW-client-wife and therefore perpetuate the negative image of these groups at risk. IDUs and FSWs have become the diseased other and responsible for AIDS in society while clients of FSWs are absolved of responsibility. As Schiller et al. (1994: 1344) point out:

This tendency [to distance the “high risk groups” from the “general population”] has acted as cross-purposes to public health goals, facilitating public definitions of the HIV epidemic as a problem which concerns others, not oneself and one’s own ‘group’

As a result, many women attempt to distance themselves from the stigmatised “sex worker” identity. In fact, they don’t situate themselves within this category. The account of “I have to work as girl [sex worker] to support myself” is partly a reflection of the felt stigma, to borrow the term of Jacoby (1994). The stigma is so strong that many female IDUs even conceal their occupation as a sex worker to their male injecting partners – the “secret” deemed unnecessary to keep among members of the drug scene. It is therefore unwise for the society to support tapping into the already existing and inappropriate negative stereotypes of risky sexual partners, such as “con diem” [the prostitute] or “thang nghien” [the junkie]. Instead, preventing stigma and discrimination towards IDUs and CSWs (and people with HIV/AIDS) should be put as an important component of the HIV prevention in Vietnam. A multidisciplinary approach is needed to reduce stigmatising attitudes, at least in the short term. Mass media campaigns on stigma, a combination of providing information and coping skill acquisition are examples of this approach. For a long-term strategy, a change in the law and public policy should be considered so that they censure this stigma rather than sanction it.

About the typology of high risk groups
The epidemiological statistics are silent on the prevalence of sex partners of IDUs. This is perhaps because the category “sex partners” of an IDU is too problematic in AIDS discourse. As Schiller (1992: 243) notes, IDUs commonly are “described as having ‘sex partner’ rather than lovers or spouses”. Indeed, during interviews, most IDUs avoided mentioning the words “người yêu” [lover]. Instead, they often refer to “bạn tình”, “bồ” or “ca” [sex partner]. Also, as Kane (1999) has emphasized, sex partner of a drug injector is not a natural category, it is not a social group, nor is it necessary a part of an individual’s identity. In fact, many people are the sex partners of IDUs and do not know it. From an epidemiological perspective, smoking and injecting sex partners of IDUs are in the same AIDS-related risk group. But from ethnographical perspective, the behaviour of these sex partners should be understood from the perspective of the drug culture. Novice smokers or even novice injectors are not considered by their peers as “addicts”. Needless to say, this makes prevention efforts targeted to people at risk very difficult and, as Herdt (1992:13) indicates, the notion of sex partner varies across cultures and can be the source of significant error in research design. Selection bias may occur if a clear definition of sex partner is not given. In her study among sex partners of IDUs in the USA, Kane (1999:302-303) suggests:

The categories of ‘sex partners’, ‘IV drug users’ and ‘general public’ can not be clearly separated in practice...there are limits to the usefulness of elaborating risk group typologies as a long term strategy and goal of AIDS research and prevention.
CHAPTER 9

Conclusion

As research on AIDS has developed, greater sensitivity to the complex process of the negotiation of AIDS risk and relationships between men and women has yielded new insights that contrast with prevailing views. Indeed, many IDUs share syringes not only because of syringe unavailability or drug scarcity but also because sharing is an expression of trust. Many women don’t use condom not because they lack negotiation skills but because the nonuse of condom is a denotation of love and attachment. It is emotional need that’s at stake (rather than financial gains) are important motivations for having unsafe sex among IDUs. Messages of prevention stress the use of condom in sexual relationships, but do not take into account the positive aspect of non-condom use in a loving, trusting union (Sobo 1993; Ratliff 1999). Beyond that, consistent condom use requires not only information dissemination and condom availability as well as negotiation skills but, as Ratliff (1999:91) suggests, “changes in the basic perceptions of sex and love in society”.

HIV prevention program merely emphasizes the risks of sharing syringes and telling IDUs to stop this behavior. This is inadequate. Instead, peer education, harm reduction and syringe exchange programs should be integrated with safer injecting training. Based on training techniques developed by Stern (cited in Grund et al. 1996), my own observations, and the Vietnamese context, I suggest the following pragmatic skills and information be provided for IDUs:

1. Applying safety and hygiene precautions for each and every step of the drug preparation and injection sequence.
2. Presenting all information in positive terms (“try it this way”), rather than negative ones (“don’t do that”).
3. Explaining that frontloading per se is not risky behavior, but that this can only be done safely with sterile/sterilized syringes.
4. Teaching IDUs how to clean injecting equipment before and after each use, which do not cost extra time, or disrupt injecting satisfaction, and permit re-use by same individual.
5. Providing additional information on: preventing hepatitis, HIV and other infectious diseases; locating and rotating veins; distinguishing between veins and arteries, safe use of tourniquets, and abscess prevention.
6. Teaching needle re-sharpening and encouraging IDUs to retain at least one set until a new one can be acquired.

Furthermore, there is an advantage to utilize aspects of IDUs’ own culture to change
behavior (McKeganey & Barnard 1992). Intervention programs that target this group must take into account the specific context of their lives; programs designed for ideal-type or generic IDU will be of little help (Sobo 1993).

Health promotion campaigns focus on IEC (information-education-communication) and encourage individuals to make healthy choices, with the assumption that risks are systematically calculated by individuals. Harm reduction, peer education, syringe exchange, and safe sex promotion programs are based mainly on theories of health behaviour which view risk perception and behaviour change to be product of individual decision making. Because they are theories of cognition, these theories are largely unable to conceptualise risk as being the product of social actions (Douglas & Wildavsky 1982). It is social interactions, rather than individuals, that do “a large part of the perceptual coding on risks” (Douglas 1986). In this study, we have seen how intimate relationships have impact on risk behaviors and vice versa. Therefore, we cannot underestimate the role of sexual relationships in risk decision-making. As Rhodes & Quirk (1998) suggest:

> Relationships are themselves a form of risk management made complicated by drug use...viewing social relationships as the unit of analysis makes considerable advances over individual paradigms.

The findings of this study are preliminary and mostly appropriate to intimate heterosexual relationships among injecting drug users. I have not analyzed characteristics of bisexual and homosexual relationships among IDUs. Carlson (1999) suggests that describing and analyzing the models for negotiating and constructing relationships of various kinds is an important topic for future research. But perhaps more importantly, I have neither described how other factors other than sexual relationships influence behaviours among IDUs (e.g., networks, poverty, inequality). Finally, I suggest that ideological constructs regarding heterosexual relations mediate the impact of political and economy forces, albeit indirect and sophisticated, on IDUs’ drug use and sexual decisions. In order to cope with the emerging epidemic effectively, there is a critical need for long-term and more comprehensive approaches that address the root causes of the epidemic, causes that are embedded in the structuring of class, politics, economy and gender relations in contemporary Vietnamese society.
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Wait, W. N. & Coughlan, J.E. 1999 The Socio-Economic Backgrounds and Knowledge of STDs of a Sample of Bangkok Thai CSWs Who Work With Foreign Men. 7th International Conference on Thai Studies, University of Amsterdam (4-8 July 1999).


## Contexts of Syringe Sharing

1. Tell me how do you prepare for a shot?
2. Who do you often share drug with? Why? 3. Please describe the steps in a sharing event with your SP?
3. What do you need for the sharing event?
4. Do you often borrow from or lend works to your partner? In what circumstances?
5. How do you clean the works?
6. Do you perceive yourself at risk for HIV?
7. Do you reuse your own syringe?
8. Are you afraid of being arrested by the police? How do you manage that?
9. How much money do you spend a day for drugs?
10. Where do you get money?
11. Where do you get drugs and syringe?
12. Does your SP help you in financial issues?
13. If you don't have enough money for a shot, what do you do?
14. With whom do you often pool money to buy drugs? In what circumstances?

## Contexts of Condom Use

1. Tell me about your SP? How does the relationship develop?
2. How long is your relationship?
3. Do you patronize CSW?
4. Do you use condom then? Why?
5. Does your SP suggest using condom? How? And what happen then?
6. Have you ever shot during of after having sex?
7. How do you feel then? What do you think your SP feels then? Do you think heroin makes sex difficult?
8. Are you afraid to get AIDS? Why?
9. Do you think you or your SP is at risk of HIV/AIDS?
10. What is the difference between sharing drug and not using condom?
11. Before having sex, do you intend to use condom?
12. Do you think that beauty or dirtiness are important for using condom or not?
13. Do you or your SP have STD?
14. What are you most afraid of?
15. Do you feel you should be responsible for her/his health?
16. What do you think is a ‘serious’ relationship?
17. If your SP is HIV positive, what is important for you then?
18. Do you trust your SP?
19. How often do you have sex?
20. What do you think of using/or not using condom?
21. When and where and with whom do you use and not use? Why?
22. How do you feel when you have sex? Any obstacles for enjoyment?
23. What do you think your SP feels?
24. Do you really love your SP?

## Relation between Risk Behaviours and Sexual Relationships

1. Do you think syringe sharing is risky?
2. What does the sharing event mean to you?
3. How do you share drugs?
4. If you are sick but have no drugs around, how do you feel?
5. Can you reduce or stop drug use? Why and why not? What do you think the best solution for withdrawal?
6. If one stays on and one come off, what do you think?
7. In what case may the relationship collapse?
8. Can your SP help you reduce drug use?
9. Have you ever seen anyone or any couple who tried to stop? Tell me in details if you have.
10. In what conditions do you think you can reduce or stop drug use?
11. Do you think it is effective if you both commit to come off?
12. What are your criteria to select SP?
13. What do you expect her/him to be?
14. Regarding AIDS, sex or drugs do you think is more risky?
15. Why do you continue to risk your life?
16. What are important factors, which maintain your relationships?
17. How is the relationship important for you?
18. What is the basis for your relationship?
19. What is the most important for you in this relationship?
20. Are you afraid of losing your SP? Breaking the relationships?
21. Do you want to maintain the relationship? Why?
22. How do you do to maintain the relationship?
23. What do you want from your SP?
24. What do you do have in common?
25. Who is responsible for earning money? Taking care of children?
26. Can you tell me about the conflicts which may arise? What are the reasons?
27. Do you and your SP live in harmony?
28. Do you feel comfortable to live with her/him?
29. Do you think that you or your SP may have been infected?
30. When you are on drugs, what is the most/less important for you in this relationship?

### For IDU-non addict relationships

31. What are the consequences of (non) disclosure?
32. Do you want to protect her/him from harm?
33. If you lie, how can you maintain overtime?
34. If you cannot stop drug use, what will happen?
### Appendix 3- Characteristics of the Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Women (n=31)</th>
<th>Men (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>24.2</td>
<td>27.5</td>
</tr>
<tr>
<td>EDUCATION (number of years attending school)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>6-9</td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td>&gt;=10</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>INCOME (six months prior to interview)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Unemployed</td>
<td>28</td>
<td>17</td>
</tr>
<tr>
<td>- Prostitution only</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>- Illegal sources (theft, pimping, drug dealing, deceiving)</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>RESIDENCE (six months prior to interview)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Lives with sexual partner</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>- Lives with own kin</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>- No stable residence</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>- In the rehabilitation/detoxification</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- In prison</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>MEDICAL HISTORY</td>
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<td></td>
</tr>
<tr>
<td>- Reported STDs</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>- Reported HIV +</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>DRUG USE</td>
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<tr>
<td>- Mean age of first drug use</td>
<td>22.1</td>
<td>19.3</td>
</tr>
<tr>
<td>- Mean age of first IV use</td>
<td>25.4</td>
<td>23.8</td>
</tr>
<tr>
<td>- Currently injecting heroin</td>
<td>20</td>
<td>64</td>
</tr>
<tr>
<td>- Currently smoke heroin</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>- In detoxification</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>- Ever injected liquefied opium</td>
<td>28</td>
<td>90</td>
</tr>
<tr>
<td>- Ever injected heroin+ other narcotic drugs</td>
<td>12</td>
<td>38</td>
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<tr>
<td>SEXUAL RELATIONSHIP PATTERNS (six months prior to interview)</td>
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</tr>
<tr>
<td>- Live with IDU sex partner</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>- Live with smoker sex partner</td>
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<td>- Live with nonaddict sex partner</td>
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<tr>
<td>- No partner</td>
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## Appendix 4- HIV Sentinel Prevalence among Target Groups 1994-2000

<table>
<thead>
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<th></th>
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<tr>
<td><strong>IDUs</strong></td>
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<tr>
<td>- North R.</td>
<td>0.25</td>
<td>0.36</td>
<td>2.17</td>
<td>5.1</td>
<td>7.97</td>
<td>14.78</td>
<td>17.70</td>
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<tr>
<td>- Central R.</td>
<td>14.52</td>
<td>7.8</td>
<td>25.37</td>
<td>41.27</td>
<td>57.12</td>
<td>50.80</td>
<td>25.63</td>
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<tr>
<td><strong>Total</strong></td>
<td>18.25</td>
<td>14.81</td>
<td>9.40</td>
<td>13.35</td>
<td>16.92</td>
<td>20.5</td>
<td>22.10</td>
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<td><strong>CSWs</strong></td>
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<tr>
<td>- North R.</td>
<td>0</td>
<td>0</td>
<td>0.12</td>
<td>0.11</td>
<td>0.77</td>
<td>2.25</td>
<td>4.05</td>
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<tr>
<td>- Central R.</td>
<td>0.78</td>
<td>0</td>
<td>0.32</td>
<td>0.42</td>
<td>0.80</td>
<td>0.69</td>
<td>0.74</td>
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<tr>
<td>- South R.</td>
<td>0.88</td>
<td>2.18</td>
<td>1.69</td>
<td>2.85</td>
<td>4.10</td>
<td>6.42</td>
<td>5.87</td>
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<tr>
<td><strong>Total</strong></td>
<td>0.59</td>
<td>1.03</td>
<td>0.90</td>
<td>2.60</td>
<td>2.44</td>
<td>3.77</td>
<td>4.30</td>
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<tr>
<td><strong>STDs</strong></td>
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<td></td>
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<tr>
<td>- North R.</td>
<td>0.10</td>
<td>0.06</td>
<td>0.14</td>
<td>0.08</td>
<td>0.52</td>
<td>1.35</td>
<td>1.12</td>
</tr>
<tr>
<td>- Central R.</td>
<td>0.27</td>
<td>0.12</td>
<td>0.29</td>
<td>0</td>
<td>0.36</td>
<td>0.83</td>
<td>0.18</td>
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<tr>
<td>- South R.</td>
<td>0.68</td>
<td>1.06</td>
<td>0.70</td>
<td>1.47</td>
<td>1.82</td>
<td>2.52</td>
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<tr>
<td><strong>Total</strong></td>
<td>0.46</td>
<td>0.34</td>
<td>0.38</td>
<td>0.60</td>
<td>0.94</td>
<td>1.64</td>
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<tr>
<td><strong>Prenatal women</strong></td>
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<tr>
<td>- North R.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.05</td>
<td>0.01</td>
<td>0.25</td>
</tr>
<tr>
<td>- Central R.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.03</td>
<td>0.03</td>
<td>0.09</td>
<td>0.05</td>
</tr>
<tr>
<td>- South R.</td>
<td>0.03</td>
<td>0.19</td>
<td>0.11</td>
<td>0.24</td>
<td>0.14</td>
<td>0.15</td>
<td>0.22</td>
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<tr>
<td><strong>Total</strong></td>
<td>0.02</td>
<td>0.07</td>
<td>0.04</td>
<td>0.12</td>
<td>0.08</td>
<td>0.08</td>
<td>0.19</td>
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<tr>
<td><strong>Military Recruits</strong></td>
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<tr>
<td>- North R.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.28</td>
<td>0.26</td>
<td>0.65</td>
<td>1.06</td>
</tr>
<tr>
<td>- Central R.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.02</td>
<td>0.05</td>
<td>0.08</td>
</tr>
<tr>
<td>- South R.</td>
<td>0</td>
<td>0.13</td>
<td>0.13</td>
<td>0.09</td>
<td>0.12</td>
<td>0.41</td>
<td>1.57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0.03</td>
<td>0.04</td>
<td>0.13</td>
<td>0.15</td>
<td>0.41</td>
<td>0.96</td>
</tr>
</tbody>
</table>


Note: The main source of data on HIV/AIDS comes from Sub-Committee of HIV/AIDS surveillance, National Institute of Hygiene & Epidemiology. HIV Sentinel surveillance was set up in VN in 1994. Up to now it has expanded to 20 provinces. Populations monitored are STD patients, CSWs/ massage girls, IDUs (which are called 'high risk groups'); TB patients, prenatal attendees and military recruits (which are called 'low risk groups'). 1-2 sentinel sites are selected for each sentinel population in each sentinel province. The cross sectional surveys are repeated every six months (March and September) for CSWs, IDU and STD clinic attendees and every year for other groups. Before 1995, HIV testing was compulsory but since 1995 HIV testing was voluntary. As with any other country in the absence of systematic screening for HIV, the actual number of cases of HIV infection in Vietnam is thought to be much higher than the number of officially reported cases. As of September 2001, there has been 41,030 cases of HIV of which 65.7% are IDUs; 4000 AIDS cases. The estimated number is about 200,000 (UNAIDS).
Appendix 5- Some Important Findings Worldwide

Below are some important findings extracted from many studies worldwide relative to drugs, sex and AIDS.

A- Network

1. Douglas 1990: [drug addicts, the prostitutes] are so isolated that they do not have to develop a justification in the eyes of their fellows, their opinions are less stable; they are neither risk-averse nor risk taking, but idiosyncratic.
2. Iguchi 2001: the risk corresponding to prostitutes resulted not from increased sexual activity but from sexual activity with certain individuals, specifically IDUs with more ties to high risk networks.
3. Latkin 1994: network characteristics of size and density are associated with sexual risk behavior.
4. Miller and Paone 1998: social network characteristics, particularly social isolation, may be independently associated with HIV risk and deserve increased attention (p.774).
5. Miller and Neaigus 2001: The influence of higher-order causal level factors, particularly the influence of network and social and economic structural factors are a principal underlying cause of the current differential HIV incidence rates between men and women who use drugs (p.974).
6. Neaigus et al 2001: network approach provides a basis for deepening our understanding of the relationship between injecting drug use and HIV risk and could increase our ability to prevent the further spread of HIV among IDUs as well as their sex partners (p.221).
7. Neaigus et al 2001: Injection drug users’ risk networks, as conduits of influence, can also be used to promote risk reduction among couples (dyads) who are drug using and/or sexual partners, among groups of friends and close associates who are members of IDUs’ personal drug and sexual risk networks and, through socio-metric diffusion, to large numbers of drug users (p.225).

B. Drug Use

2. Dennis et al 2001: drug use is associated with trading sex for drugs/ money and trading drugs/ money for sex, thereby increasing number of SPs (p.189).
3. Dennis 2001: substance users are likely to share drugs and have sex with people from social networks (p.189).
4. Dennis et al 2001: use of drugs before or during sex prolongs male erection, allow women to ignore a lack of vaginal fluids or pain, and may lead to increased genital abrasions (p.189).
5. Gossop: men are more likely to use heroin by injection and women are more likely to inhale/ smoke heroin (chasing the dragon).
7. Lex 1990: heroin use increase stress and hamper coping effort.
McKeganey et al 1995: Even in situations where drug injectors may have modified their behavior in the direction of lower levels of reported sharing, a propensity to share may remain (p.1253)

Perlman 1999: doing shotgun: a form of drug use which has close ties to sexual behavior

C. Drug Users and Sex Partners

Baker 1994: female are more likely to have injecting drug sex partner

Bell: drug users engage in risky sexual behavior than in risky injection behavior

Douglas and Calvez 1990: among them [populations at risk], the idea of high risk lifestyle is an accepted norm (p. 461); [drug addicts, the prostitutes] are so isolated that they do not have to develop a justification in the eyes of their fellows, their opinions are less stable; they are neither risk-averse nor risk taking, but idiosyncratic (p.462)

Erickson 1997: sex partners (SP) of IDUs are at high risk of HIV.

For female sex partners of IDUs, reducing number of SPs per se may not confer adequate protection from HIV.

Freeman 1994: female are more likely than males to report injecting with a SP

Freeman 1994: female IDUs are at greater risk for HIV as a result of involvement with drug using SP than because of risky needle practice.

Freeman 1994: female IDUs are more likely than males to be daily users of crack cocaine and more likely to report poor health.

Gossop: women are more likely to have a SP who is a drug user and to be living with another than men.

Iguchi et al 2001: sex within the context of a monogamous relationship has also been associated with increased seroconversion risk in women when the partner is known to be HIV positive (p.175)

Iguchi et al 2001: trading sex for drugs or money by women has been reported as a risk factor for HIV infection and has been assumed to be largely a function of the increased number of SPs among such women (p.176)

Iguchi et al 2001: the risk corresponding to prostitution resulted not from increased sexual activity but from sexual activity with certain individuals- specifically IDUs with more ties to high-risk networks (p.176)

Iguchi 2001: women with multiple SPs are at greater risk for HIV infection than women with few or only one SP.

Kall 1994: among IDUs, HIV positivity increases whereas the proportion of noninjecting SPs decreases with the duration of drug using career.

Latkin 1994: a significant minority of males having multiple SPs and exchange money or drugs for sex

Latkin 1994: alcohol is significantly associated with multiple SPs, exchange money or drugs for sex.

Lex 1990: partners experience stressful events; Participation in mates' family life reshapes behavior.

Lex 1990: the couples using heroin used opiates together to enhance sex.

Lex 1990: the male's role is less responsible and attracted less respect than that of abstinent male.
20 Margolis 1998: partner’s injection drug user status, sexual orientation and age are important.
21 McKeganey & Barnard 1992: Attention should be paid to the significance prostitutes attach to the use of the condom as a means of distinguishing between client sexual encounters and private sexual relations (p.88)
22 Miller and Neaigus 2001: The character and dynamics of relationships with sex partners is an important determinant of risk, both for engaging in risk behaviors and for doing so with high-risk partners (p.974).
23 Miller and Neaigus 2001: Injectors-non injector relationships has been found to be protective against participation in drug use risk practices (p.969)
24 Newmeyer et al 1989: changing sexual practices of IDUs is more difficult than changing their needle using behaviors. (p.174)
25 Rhodes 1996: there is a high level of sexual mixing between IDUs and non IDUs.
26 Rhodes 1996: social context plays an important role in the production of sexual risk behavior
27 Schiller 1992: IDUs are commonly described as having ‘sexual partners’, rather than lovers or spouses (p.243) and ‘the practice of reducing spouses and long term mates of IDUs to SPs is culturally distancing’ (p.243)
28 Schoepf 2001: [Research on AIDS] shows how structural and corporeal violence result in social suffering and contribute to risk of AIDS, and demonstrates the key role of power and inequality in determining the health of populations (p.354)
29 Singer 1994: Behaviors sometimes said to symbolize group identity may be far more practical and far less symbolic and group-affirming than the literature sometimes implies (p.1323)
30 Wallace 1993: women are at high risk for contracting AIDS from injecting drug use or from sexual contact with addicts.

D. Condom Use

1 Darke 1990: majority of opioid users never use condom with regular partner.
2 Dennis et al 2001: Use of drugs before or during sex may diminish an individual’s judgment about who to have sex with and/or whether to use latex contraceptives (p.189)
3 Erickson 1997: barriers to condom use are self-related and partner-related; women lack knowledge about sexual transmission of AIDS.
4 Farmer 1995: Sexism weakens women’s ability to negotiate safe sexual encounters (p.19)
5 Foucault 1972: there are no relations of power without resistances. The latter (resistances) are all the more real and effective because they are formed right at the point where relations of power are exercised (p.142).
6 Freeman 1994: condom use is rare among IDUs, particularly among those with one partner.
7 Iguchi et al 2001: women with only one sex partner (especially in committed relationships) also tend to use condoms less frequently, possibly confounding the protective effects of monogamy (p.175); not liking condoms was a common reason for not using.
8 Iguchi et al 2001: monogamy-focused interventions may be counter-productive for female SPs of IDUs if they do not simultaneously attend to the difficulties inherent in maintaining condom use in monogamous relationships (184).

9 Kall 1994: condom use is low among IDUs but higher among HIV positive IDUs.

10 Kerrigan et al 2001: barriers to condom use include the development of trust and intimacy between partners; financial attachment; issues relating to exchange partner patterns.

11 Margolis 1998: IDUs with multiple SPs who trade sex for money were the most likely to use condom.

12 Margolis 1998: those with one partner are least likely to use condom.

13 Sherman 2001: characteristics associated with consistent condom use include HIV positive drug user; not living with SPs, not being financially interdependent.

14 Sherman 2001: low use of condom with main partner than with casual and exchange partners.

15 Wojcicki & Malala 2001: No matter how accessible condoms are to a sex worker, as long as she still decides to bargain for more money for unsafe sex, public health education programs that focus on education and condom access will be unsuccessful (p.102).

16 Wojcicki & Malala 2001: condom use may be a violation of trust and intimacy and brings an element of disequilibria to the sexual relationship (p.100); many women viewed the possibility not to use condom as a chance to make more money (p.109); those women who do not use condom get the most clients (p.109); although women complained about poverty and difficulties with clients, they do take advantage of clients’ desires to have unsafe sex by raising the price for condomless sex. Bargaining is part of a power struggle between sex workers and clients- and part of this power struggle involves the use of condom and price (p.110); some sex workers will use condoms with clients but not with boyfriends so as to make a separation between work and pleasure (p.111).

E. Sexually Transmitted Diseases

1 Dennis et al 2001: drug use is linked to increased rates of STDs and increased STD are linked to AIDS (p.188).

F. Prevention

1 Clatts and Mutchler 1989: a tendency to focus on particular behavioral patterns of American “high risk” groups may direct our attention away from other possible factors of the etiology and spread of the disease (p.112).

2 Darke 1990: focus on sexual risk-taking behavior of IDU.

3 Darke 1990: opiate treatment is associated with lower levels of risky injecting practices; there is no association between treatment and safer sexual practices.

4 Dennis et al 2001: female groups selling sex for drugs or money contact with many people and they need very different interventions than the other groups who have one SP (p.202).

5 Dennis et al 2001: HIV interventions should target specific subgroups (p. 187).

6 Dennis 2001: interventions should acknowledge the steps they have taken but check
on their effectiveness. If they recognize and use information on early attempts to change, outreach workers may help motivate drug users to enter more formal substance abuse treatment (p.202)

7. Douglas and Calvez 1990: the best protection for the victims of plague will be a community that already has taken social justice to heart (462)

8. Erickson 1997: AIDS risk reduction intervention should focus on barrier to condom use.

9. Farmer 1995: In societies where the female has a weaker hand, effective methods of prevention have a better chance of working if the woman does not have to rely on either the consent or the willingness of her partner (p.19)

10. Grund 1991: HIV prevention is more effective if IDUs are organized to help themselves and their peers, rather than reduce risk behavior.

11. Grund 1996: Sharing of drugs sanctions a common lifestyle and strengthens mutual ties; merely emphasizing the risks of sharing syringes in HIV education for IDUs is plainly inadequate. High priority must be given to educating drug injectors on those drug-sharing techniques, which potentially allow for viral transmission. However, merely telling IDUs to stop sharing drugs is unlikely to work; education could be well integrated with safer injecting training (p.699)

12. Iguchi et al 2001: For female SPs of IDUS, reducing number of sex partners per se may not confer adequate protection from HIV. For women in committed relationships with IDUs, interventions should address contextual factors in relationships that elevate risk and complicate prevention (p. 175)

13. Iguchi et al 2001: develop strategy to include partners in risk reduction interventions and address relationship issues, including threats of violence, that may constitute obstacles to change (p.183)

14. Iguchi et al 2001: for women in long term, committed sexual relationships with single IDUs, emphasis should be placed on dealing with difficulties of initiating and maintaining condom use (p.183)

15. Iguchi et al 2001: risk reduction messages must be tailored to different populations based on the source of their exposure to HIV (p.184)

16. Iguchi et al 2001: to change behavior in steady relationship, the following should be addressed: gender roles, relationship dynamics, issue of power, the degree of leverage a woman has over her partner’s condom use, the meanings of condom use (trust, intimacy, desire to have children), the potential for domestic violence, and motivation for change on the part of both partners (p. 183)

17. Kane and Mason 1992: A fuller grasp of the contexts of risk behaviors must lead one to the conclusion that information and education while crucial are insufficient in and of themselves as policy tools in the struggle against AIDS (p. 220)

18. Kane and Mason 2001: The culture is key: if you change the culture (rules, codes, values, habits) of IVDUs organized into social networks, you will also change the networks of HIV risk (p.462)

19. Kerrigan et al 2001: social exchange of some form was implicit in almost all relationship types, indicating the need to further measure such exchange patterns and their influence on condom use.

20. Kerrigan et al 2001: the possibility of adapting Thai 100% condom program should be considered: refine educational messages regarding condom use and engage sex
workers in participatory discussions related to the risks of HIV/STI infection associated with regular partnerships and protective strategies specific to these relationships (p.236).

21 Lewis 1990: continued aggressive culturally sensitive outreach sexual risk reduction strategies are needed.

22 McKeganey et al 1995: Services working with IDUs need to focus not only upon actual sharing behavior but also upon the preparedness to share (p.1253).

23 McKeganey & Barnard 1992: Such measures [eradicating prostitution] are likely to increase HIV-related risk behavior by forcing prostitutes into increasingly covert styles of working, and out of contact with helping agencies; it is important to develop street-based agencies that have a non-threatening style of working and which are accessible to male and female prostitutes; providing condoms and sterile injecting equipment, health check-ups, advice on HIV reduction and referral to specialist services. Outreach work should be extended to include prostitutes and clients as part of a dual strategy aimed at risk reduction (pp.87-88).

24 Miller 2001: future research should focus on higher-order casual level factors (dyadic relationship, network, structural levels).

25 Neaigus 2001: future research should develop network approach- to prevent HIV among IDUs and SPs.

26 Neaigus 2001: targeting opinion leaders.

27 Parker 2001: the study of ‘structural violence’ considers the interactive or synergistic effects of social factors such as poverty and economic exploitation, gender power, sexual oppression, racism, and social exclusion (pp.168-169).

28 Parker 2001: structural interventions have come to the fore. For example, there are attempts to change the employment options for sex workers or improve the logistics of condom availability and distribution, with the ultimate goal of altering the structural conditions that may impede or facilitate the adoption of safer sex (p.172).

29 Parker 2001: HIV/AIDS prevention must be understood as part of a broader process of social transformation aimed not merely at the reduction of risk but at the redress of the social and economic inequality and injustice (p.172).

30 Perlman et al 1999: it is necessary to develop and evaluate comprehensive risk reduction interventions which take into consideration the relationships between interpersonal and sexual behaviors and specific forms of drug use (p.1441).

31 Rhodes 1996: interventions should target social relationships as agents of social network and community change.

32 Schiller et al 1994: Effective prevention requires examination of the contexts of ‘risky behaviors’ as well as the implementation of efforts to encourage behavior change at the individual level (p.1344).

33 Schilling et al 2000: in a certain stage of the HIV pandemic, outreach may be a relatively weak strategy, given the nature of drug abuse itself, the myriad problems exhibited by long time infection drug users, adverse social and community influences, and the limitation of available health and social services (p.311).

34 Sherman 2001: HIV prevention program focus on the benefits, such as trust and a sense of security, and risks of not using condoms in primary relationships.

35 Schoepf 1998: In order to stop the epidemic, effective STD treatment, condom access, social support for risk reduction, and broad socio-economic change are
needed (p.237)
36 Tortu: prevention target at women should address differences in behavioral risk patterns.
37 Wojcicki & Malala 2001: Public health programs should emphasize reducing the stigma and discrimination that sex workers face (p.102)

G. The Politics of AIDS/Sex/Drugs

1. Singer 1994: AIDS has exposed the hidden vulnerabilities in the human condition as it has moved along the fault lines of our society and become a metaphor for understanding that society (p.1321)
2. Wojcicki & Malala 2001: Public health publications should desist from emphasizing the ‘powerlessness’ of sex workers and their victim-hood. These characterizations are not only inaccurate but also fraught with sexism and negative symbolism (p.116).
Appendix 6- A Glossary of Terms

**Detoxification:** The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimizes the symptoms of withdrawal and risk of harm. While the term 'detoxification' literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, i.e. withdrawal and any associated physical and mental health problems. Detoxification is undertaken with a degree of supervision. Typically, the individual is clinically intoxicated or already in withdrawal at the outset of detoxification. Detoxification may involve the administration of medication. When it does, the medication given is usually a drug that shows cross-tolerance and cross-dependence to the substance(s) taken by the patient. The dose is calculated to relieve the withdrawal syndrome without inducing intoxication, and is gradually tapered off as the patient recovers.

**Harm reduction:** refers to policies or programs that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The aim is to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle sharing among IDUs. Harm reduction typically involves establishing a hierarchy of risk behaviours and involves individuals or communities working to find a position on the hierarchy, which is acceptable to them while reducing harms or risk of harms.

**Heroin:** A widely used opiate. It has the chemical names diacetylmorphine or diamorphine. It comes in different forms: heroin brown; heroin white; heroin pink and homebake heroin. *Heroin white:* When white, heroin is typically in the form of the water-soluble salt diamorphine hydrochloride and is suitable for injection. White heroin has tended to originate from South East Asia and is referred to as “Chinese heroin” or “China white”. Purity is often graded, e.g. “number 4”.

**Narcotic drug:** a chemical agent that can induce stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics.

**Needle exchange:** Provision to reduce the transmission of infectious diseases by the repeated use and sharing of needles in order to reduce the transmission of blood-borne viruses. The concept involves the provision of clean needles in exchange for used needles, which are then safely disposed of. In practice, an “exchange” is not always required and clean injecting equipment is provided on demand, sometimes for a small payment.

**Opiate:** one of a group of alkaloids derived from the opium poppy with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression. The term opiate excludes synthetic opioids such as heroin and methadone.

**Opioid:** the generic term applied to alkaloids from the opium poppy, their synthetic
analogue, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The most commonly used opioids (such as morphine, heroin, methadone) produce analgesia, mood changes, respiratory depression, drowsiness, psychomotor retardation, slurred speech, impaired concentration or memory, and impaired judgment.

**Opium:** The crude mixture obtained by the air drying of the juice which oozes from incisions made in the ripened seedpod capsule of the opium poppy, *Papaver somniferum*. It contains a number of important alkaloids such as morphine, codeine, and papaverine. For non-medical use, either by smoking or eating, the raw opium is boiled in water for several hours, strained to remove insoluble materials, then evaporated into a sticky paste referred to as prepared opium. When prepared opium is smoked in a pipe, combustion is incomplete and about half the starting material is left stuck to the walls of the pipe as a black, dry, granular residue known as dross opium. Heroin is a semi-synthetic modification of opium. There is evidence that where programs have tried to eradicate opium use, this has been replaced by more readily injectable opioids such as heroin resulting in increased transmission of HIV and hepatitis.

**Outreach:** A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Peer (or indigenous) outreach projects use current and former members of the target groups (such as IDUs) as volunteers and paid staff.

**Overdose:** the use of any drug in such an amount that acute adverse physical or mental effects are produced. Overdose may produce transient or lasting effects, or death. A fatal overdose from heroin occurs as consequence of central nervous system suppression of respiratory function. This action is frequently associated with the combined use of other central nervous system depressants, notably alcohol and benzodiazepines.

**Peer education:** the use of same age or same background educators to convey educational messages to a target group. Different methods have been employed for the selection of peers but mostly rely on the judgments of members of the relevant peer group. Peer educators work by endorsing 'healthy' norm, beliefs ands behaviours within their own peer group or 'community', and challenging those, which are 'unhealthy'.

**Rehabilitation:** the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning, and social well-being. Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. In encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training and work experience. There is an expectation of social reintegration into the wider community.
Risk reduction: describes policies or programs that focus on reducing the risk of harm from alcohol or other drug use. Risk reduction strategies have some practical advantages in that risky behaviours are usually more immediate and easier to objectively measure than harms, particularly those harms that have a low prevalence. For example, it may be more practical to measure reduced sharing of needles and other injecting equipment than induces of harm such as the incidence of HIV.

Syringe/needle sharing: The use by two or more people of the same needle and syringe for the injection of drugs. A major route for the transmission of blood-borne viruses such as HIV, hepatitis B and hepatitis C among IDUs.

Withdrawal: A term used to refer to either the individual symptoms of, or the overall state (or syndrome), which may result when a person ceases use of a particular psychoactive drug upon which they have become dependent or after a period of repeated exposure. The level of central nervous system arousal and the accompanying mood state is usually directly opposite to the direct action of the drug. Thus withdrawal from central nervous system depressants typically involves increased anxiety and heightened arousal level (increased heart rate, blood pressure and perspiration). Withdrawal from central nervous system stimulants involves reduced arousal, lethargy and depression. Withdrawal states and symptoms exist in degrees as a direct consequence of the frequency, intensity and recency of drug use. Withdrawal or 'rebound' phenomena have been demonstrated after relatively brief periods of heavy drug use for a wide range of drug types and are not experienced exclusively by severely dependent individuals. Withdrawal states are thought to occur principally as a consequence of a process of neuroadaptation, however, it is also well documented that intense desires for a drug are sometimes accompanied by signs and symptoms suggestive of withdrawal symptoms. The withdrawal syndrome has cognitive and behavioural elements as well as those, which are purely physiological. The duration of withdrawal symptoms varies according to drug type and extent of prior use. For some commonly used drugs such as alcohol, withdrawal symptoms are most severe between 24 and 72 hours after ceasing use but less severe withdrawal-like phenomena may be experienced for weeks or even months after withdrawal.
Appendix 6- Slang Used by the Informants

Below I cite some local terms, which are widely used in the drug scene. These argots are used by IDUs to deflect the police and other people. Carefully examining the use of this language can provide insight into how IDUs construct models of their world.

**********

Anh em Peers; close friends
Anh xăm hội Senior peer
Bánh bao To cover expenses for someone; to support; to feed.
Bì A meal; a shot; an injection; a hit.
Bảo kê Men in attendance
Bộ bích 1. Boyfriend; girlfriend; mistress; 2. Partnering
Bạo 1. Condom; 2. see bánh bao
Bộ đội Men of good virtues; manly; playboys
Bặp vào To be immersed in drug addiction
Bi A metal or plastic ring or a small glass ball fixed to the penis for sex stimulation or pleasure
Bồ lộc Curbing expenses (often implying rural SWs who save money by engaging in sex work)
Bo, tiền bo Tip (extra money clients give a SW)
Bon lên Secretly bring illicit drugs to rehabilitation/detoxication centers or prisons
Bệnh xăm hội STDs
Bế 1. Getting too high 2. Hyperexcitability
Bỉ đính Being infected with HIV
Cái kiếm Make money
Công máu A mixing up of different types of blood. This occurs when a person uses serial used syringes simultaneously.
Cũ Standard (means: using drugs moderately)
Cài mà Repeatedly inject at the same point. The purpose is to locate the vein more easily.
Cây mà See cài mà
Cảnh nghiên Being in the drug scene
Cám Make a deposit (put stealing properties in pawnshop)
Căn Get high; euphoria; coma
Ca Peer; close friend.
Cô tuổi Senior IDUs; hardened IDUs
Cặp sen phen A couple of ampoules (Seduxen and Pipolphen) often mixed up with heroin when inject.
Cặp bó To partner; to cohabit
Cặp kè See cặp bó
Cặp ca See cặp bó
Cải tay bo Individual detoxification
Cave Female sex workers; CSWs
Chăn đắt To decoy; to mediate prostitution
Chơi amato
1. Junior drug users; novices; 2. using drugs for recreation
Chơi cho dâ
Inject with exceeding dose; get too high
Chích
To inject
Chơi trần
Have sex without condoms
Chơi
1. To inject; to beat up, to take a hit; 2. To have sex
Chạy nă
Being tracked down by police
Chạy sô
A prostitution pattern in which CSWs are supervised/mediated by mediators
Chủng vă
To take any drug dose available to overcome craving
Chất nhường nhin
A concession; giving in; letting someone to inject first or giving one's partner a portion of drug while one is abstinent
Chợ
Market. Means: engaging in illegal activities
Chợ bán Ankara
See chợ
Cùng mẫu nghiên
Having the same drug habit
Cự
Opportunity
Cúc 50
A unit bag of heroin which costs VND 50,000
Con nghiên
A drug user
Cô quay
To deceive
Cuồng
Withdrawal aftermath. A syndrome which may includes muscles aches, gooseflesh, muscle or abdominal cramps
Dem
Calibration on a syringe
Đình
See tỷ đính
Đánh
See chích
Độc
Dolargan
Đâm
See chích
Đạo mò
To take opportunity to “exploit” a partner. A
Đô
Injecting equipment
Đồ hâm
Refreshments used for smoking a drug
Đưa vào dôi
Pull someone into drug addiction
Đính (bệnh)
To be infected with HIV
Đi
1. Get high; 2. To smoke
Đâm mê
To addict
Đô bền nghiên
Addiction durability
Đen
Opium
Đi chô
To go to sex work; to prostitute
Đi làm
See đi chô
Đi không [bao]
To have sex without condom
Đi nhanh
To have quick sex
Đi phổ
To frequent CSWs
Đính
See chích
Đói thuốc
To be sicky; to desire for drug
Đi cạ
To partner; to make friend with
Đi khách
See đi làm
Gạch
See đin
Hớp
1. Shooting gallery; 2. Brothel
Gái sân
CSWs who work in dancing halls.
Hôn
To partner/fall in love with someone in rehabilitation/detoxification
<table>
<thead>
<tr>
<th>Vietnamese</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hút</td>
<td>To smoke</td>
</tr>
<tr>
<td>Khách</td>
<td>Client; customer</td>
</tr>
<tr>
<td>Khách xin</td>
<td>Rich client</td>
</tr>
<tr>
<td>Không nghe phó nói chuyên, không nghe nghiên trình bày</td>
<td>Don’t listen to CSWs, don’t listen to IDUs. A saying in the drug scene. Meaning: don’t trust CSWs and IDUs because they often tell lies and deceive.</td>
</tr>
<tr>
<td>Khuyên</td>
<td>See bì</td>
</tr>
<tr>
<td>Lâu bất nghiên</td>
<td>1. Temporary withdrawal. Refer to IDUs who withdraw temporarily. These IDUs are not considered as real addicts; 2. A duration in which a person has addicted to a drug without knowing</td>
</tr>
<tr>
<td>Làm luật</td>
<td>A bribery; to bribe; money CSWs give to gatekeepers</td>
</tr>
<tr>
<td>Làm một cái</td>
<td>See choi</td>
</tr>
<tr>
<td>Lò</td>
<td>Shooting gallery</td>
</tr>
<tr>
<td>Lính trạng</td>
<td>See bọ đói</td>
</tr>
<tr>
<td>Máu bão</td>
<td>The blood drawn into the syringe to see if the needle is in the vein</td>
</tr>
<tr>
<td>Máu mất</td>
<td>Senior/ hardened/ experienced IDUs</td>
</tr>
<tr>
<td>Máu nghiên</td>
<td>See cùng máu nghiên</td>
</tr>
<tr>
<td>Mô</td>
<td>A mine. Meaning: a [rich] person who can be made use of.</td>
</tr>
<tr>
<td>Móm</td>
<td>To run out of money</td>
</tr>
<tr>
<td>Mật chất</td>
<td>To lose good characteristics/ values</td>
</tr>
<tr>
<td>Mũi</td>
<td>See bìra</td>
</tr>
<tr>
<td>Nóng</td>
<td>Novocain</td>
</tr>
<tr>
<td>Chăn dint</td>
<td>1. Pimp; 2. to mediate CSWs; 3. To deceive</td>
</tr>
<tr>
<td>Ngú phê</td>
<td>Get high; Drug induced stupor; euphoria</td>
</tr>
<tr>
<td>Ngú nghĩa</td>
<td>Drag in effect: a drug user is influenced by another to inject</td>
</tr>
<tr>
<td>Nó</td>
<td>To be full of drug</td>
</tr>
<tr>
<td>Nuôi mả</td>
<td>See cài mả</td>
</tr>
<tr>
<td>Oái</td>
<td>Tired; craving</td>
</tr>
<tr>
<td>Phố</td>
<td>Bad behaviour; mediocre; awkward</td>
</tr>
<tr>
<td>Phân</td>
<td>See dem</td>
</tr>
<tr>
<td>Phê</td>
<td>A sense of well-being/ euphoria</td>
</tr>
<tr>
<td>Phở</td>
<td>See cave</td>
</tr>
<tr>
<td>Quây</td>
<td>Round-up; seize (by police)</td>
</tr>
<tr>
<td>Quay tiền</td>
<td>To make money</td>
</tr>
<tr>
<td>Quay tiền ăn thì khó</td>
<td>It is difficult to make money for meals but it is easy to make money for a drug habit. A saying in the drug scene. Meaning: IDUs can make money by any way possible. Some say that IDUs are given luck by the God so they can make money easily.</td>
</tr>
<tr>
<td>Quay tiền nghiên thì dễ</td>
<td></td>
</tr>
<tr>
<td>Rán mả</td>
<td>See máu mả</td>
</tr>
<tr>
<td>Rơi bọ</td>
<td>Muscle cramps (after withdrawal)</td>
</tr>
<tr>
<td>Rít</td>
<td>See hút</td>
</tr>
<tr>
<td>Sốc</td>
<td>Overdose</td>
</tr>
<tr>
<td>Sen phen</td>
<td>See Cáp sen phen</td>
</tr>
<tr>
<td>Sống họn phân</td>
<td>1. A lifestyle in which one looks down on others; 2. A respected lifestyle</td>
</tr>
<tr>
<td>Siêu thị (thuốc)</td>
<td>Supermarket. Meaning: A place to buy drugs</td>
</tr>
</tbody>
</table>
Lucky
Policemen
Number of stays in rehabilitation centers/prisons
To have a quick sex
The period in which a person begins to addict to a drug
See làm luật
See den
Heroin
Seduxen and Pipolphen
See thuốc trắng
To bind. Meaning: to bribe policemen
Desperate for drug injection; sicky
See dem
To deceive; deceit
See vả
Female sex partner
The area where IDUs congregate
Syringe
To ask for money deceptively
To make money
See lô