A Qualitative Study on HIV Risk Among Injecting Drug Users in Vietnam: Reasons for Sharing Syringes and Needles

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SUMMARY

There is no doubt that both drug use and HIV/AIDS infection are now of a great concern in Vietnam. The country with a population of nearly 80 million people had an estimated 185,000 drug users in 2000 and claimed more than 40,000 HIV/AIDS cases as of September 2001. Sixty-six percents of these infected cases are among drug users. The cause for the HIV/AIDS progression is associated with unsafe drug injection, which is highlighted by a very high percentage of the sharing of syringes/needles among IDUs, ranging from 50% to 90%, according to a number of recently quantitative studies conducted in big cities and towns. Why do injecting drug users share syringes/needles? No information is documented in the country. This first-ever qualitative study strives to find answers for that question. The fact that the HIV/AIDS epidemic is still on the rise among IDUs also highlights the importance of this study.

The study was conducted in two urban districts of Hanoi city during three full months from August to October 2001. It uses two conceptual approaches in anthropology: contextualization and an emic and etic perspectives. In addition, it applies two theoretical perspectives in medical anthropology: transaction model and the cognitive and symbolic approach. These approaches and theories direct the study while investigating and analyzing findings.

Data collection techniques include in-depth interviews, FGDs and participant observation. These techniques ensure the acquisition of insights and in-depth information about drug injections and also allow for the cross checking of the data collected. The study population is active injecting drug users (IDUs). Thirty IDUs including six females are interviewed in-depth and four FGDs with 24 IDUs are conducted. All are selected by the snowball method from a shooting area (where drugs and injection items are sold and injection is practiced), two roundabouts, a large green park, a waste area (where people throw their waste), their own homes, and their peer homes where many of IDUs spend the night and inject. The in-depth interviews and FGDs also take place there. More importantly, the study observes drug injection practices of IDUs in their natural injection settings, especially in the shooting area. All in-depth interviews and FGDs are tape-recorded upon IDUs verbal consents while detailed fieldnotes are taken within the day after each of the participant observations. Each of the in-depth interviews lasts more than one hour, except for the last four sessions, which lasted 45 minutes since the similarities were found and their responses were consistent with the ones given by previous IDUs. Likewise, each of the FGDs also lasts more than one hour.

In-depth interviews are conducted with open-ended and unstructured questions. Topics covered include demographic characteristics, history and on-going practices of drug use with the focus on drug injection, drugs use and users’ pattern, drug availability, issues around syringes/needles, sharing or non-sharing of a syringe/needle, reasons for the sharing or non-sharing, whether or not a witness to other peers sharing syringes/needles, pooling of resources to acquire drugs and syringes/needles, money sources for the daily drug injection habits, social interactions with other peers, HIV/AIDS knowledge, and emic words used. FGDs cover similar topics, but are not as in depth.
Data is processed by hand. Thirty-four cassette-tapes are played and sometimes replayed for a careful note-taking. This work ensures the use of all key and related information for this thesis. Data is put into a data master sheet that is prepared beforehand with identified variables and themes, and additional notes for processing and analysis. Furthermore, whenever there are dialogues between interviewees and the author, and the group discussions provide valuable information that needed to be quoted for the thesis, verbatim transcription was made.

Analyzing the 30 in-depth interviewees, their mean age is 30.6 years old ranging from 17 to 47 years old (six are aged at over 38 while seven below 22 years old) and that 16/30 IDUs are now living on the streets. In addition, it also shows that their mean number of injection years is 2.8 years ranging from 3 months to 9 years. The mean number of daily injections is 2.6 ranging from one to five times. All 30/30 IDUs currently inject heroin, a half of which switches from either smoking or injecting opium. Data from 24 FGD participants show that their mean age is 30.5 years old ranging from 17 to 56 years old and that their mean number of injection years is 4.2 years ranging from one to ten years. All also currently inject heroin.

It is also noted that having an injection, an IDU needs a few things: heroin, a plastic disposable syringe/needle and an ampoule of distilled water or novocain solution (or sometimes just cooled boiled water). Some IDUs occasionally use seduxen and pipolphen when they have more money.

The pooling and sharing syringes/needles is very common among IDUs who participated in this study. From a quantitative perspective the study finds that all 30 in-depth interviewees and 24 FGDs participants pool money to jointly buy heroin and injection items. From the same perspective, nine among 30 in-depth interviewees have shared syringes/needles with various degrees: from “always” to “yes, but several times”. In addition, seven among 30 in-depth interviewees do not consider themselves as “people who have ever shared”, however, these IDUs tell that they have “kindly” given the drugs leftover in their “being-used” syringes/needles to their IDU close friends or even “just a peer”. Among these seven IDUs, one whose “being-used” syringe/needle is robbed by his IDU neighbor is included. In a broader sense, they can be considered as persons who share syringes/needles. Lastly, three among 30 in-depth interviewees also reported that they often frontload drugs between a new and an old syringe/needle, or two old syringes/needles. As result, it assumes that 16/30 IDUs in this study share syringes/needles while three others also are at risk for HIV/AIDS due to frontloading. In addition, among 24 in-depth interviewees who are asked whether or not they see other IDUs sharing syringes/needles, 21 IDUs strongly confirm that they have seen it in many places, especially in “the shooting area”.

This study makes the conclusion that there are five existing reasons, which are specified below, for IDUs in urban areas in Vietnam to share syringes/needles. Actually the following reasons drive IDUs to practice unsafe injection behaviors together, rather than as independent reasons.
First, there is a mutual trust among some special partners. This is most common and consequently challenges HIV/AIDS prevention work. These partnerships include husband and wife, sexual partners (most of partnerships are between a female sex worker and her male sexual partner), close friends, neighbors, and kin brothers. The sharing of a syringe/needle among them is usually a result of the pooling of resources to acquire heroin and other injection items, and symbolizes a bond in their hard lives of drug injection. This trust reason functions well and is perhaps stable for the first two partnerships listed regardless of factors relating to syringe/needle availability and accessibility, financial capacity, and knowledge and risk perception of HIV/AIDS infection.

This is definitely a big challenge for Vietnam since more and more female sex workers begin to inject heroin. If there is no timely and effective intervention, the HIV/AIDS prevention work will fail to prevent the epidemic from spreading to other populations with low risk behaviors in very near future.

Second, IDUs either do not have or lack money at the moment they are truly “hungry for drugs”, which are considered their “daily meals”. Therefore IDUs do not hesitate to ask for drugs leftover in a “being-used” syringe/needle from their friends or even from “just a peer”. Or, they just have enough money to buy a minimum drug dose for “cắm nghiêng” (just to overcome the craving status), but do not have any money left to acquire a new syringe/needle. This reason should be understood in their own context that is featured by the fact that many IDUs do not have jobs and stable incomes. More than 50% of them live on the streets and many IDUs get money by stealing small items like raincoats, motorbike helmets, construction materials and so on, and by gambling, selling sex and deceiving others.

Third, it is a drug use culture itself. Drug use is also considered a small society since there are the factors of profit, competition, territory, rules, reciprocity, deception, services, credit, drug divisions, pooling of resources, and so on. In this small society, IDUs are also subject to traps, many of which put them at risk for HIV/AIDS infections. The reason for drug use culture is identified with the robbery of a “being-used” syringe/needle, secret but contaminated syringe/needle exchange (the robbers will use it), and frontloading between a new and an old syringe/needle or two old syringes/needles, of which old ones are not cleaned properly.

Fourth, there is a lack of syringe/needle availability and accessibility. This also must be understood in accordance with emic points of view of IDUs because actually syringes/needles are very available, accessible and affordable for all IDUs without any limitations during the daytime. Law enforcements do not restrict any IDUs from possessing a syringe/needle. For many reasons, some IDUs inject at night when a syringe/needle is much less available, accessible and even less affordable. In addition, it is also very important to warn that IDUs share syringes/needles, for whatever reasons drugs are available for them, in some of the drug treatment centers, incarcerated camps and prisons. The lack of syringe/needle availability and accessibility is a valid reason coming from emic points of views of IDUs.
Fifth, it is undeniable that some IDUs interpret HIV/AIDS differently because of their incorrect knowledge and risk perception about the disease. They explain that their peers who use drugs for a long time are at risk for HIV/AIDS infection while those who just begin to use drugs are at no risk. They also consider blood as a contaminated and central problem of the HIV/AIDS transmission. With their own interpretation, therefore they jointly use syringes/needles in a different but definitely harmful way. Indeed they initiate their own way to prevent the disease incorrectly.

In addition, IDUs do not have a specific understanding about prevention measures during drug injection, therefore the frontloading between a new and an old syringe/needle, or two old syringes/needles is currently a reality.

The study finds no concrete data for IDUs to share syringes/needles because of social stigma or discrimination against them.

Lastly, this study also emphasizes that a lot of syringes/needles and glass ampoules are disposed improperly by IDUs. These injection items are seen in many places such as alleys, sidewalks, roundabouts, parks and public toilets. This definitely imposes a biohazard to community health.

The identified reasons for the sharing of syringes/needles are associated with socio-economic and cultural factors much more than it is a public health issue at this stage of the HIV/AIDS epidemic and its response. Besides, the HIV/AIDS epidemic is multi-dimensional and much more complicated than any other epidemics. Therefore, this study recommends that interventions in Vietnam targeting the population of IDUs to base on their emic points of view, peer approaches and user-friendly services. In addition, the interventions must include a component of counseling that cover both HIV/AIDS and socio-cultural issues.
Chapter 1: INTRODUCTION

Vietnam in Brief

Vietnam stretches along a 3200-kilometer section of the South East Asia, sharing borders with China, Laos and Cambodia, and is situated on the Pacific Ocean (Please see a map of Vietnam, annex 1 on page 79). The total land area of the country is approximately 331,114 square kilometers that are mainly mountains, high plateaus and jungles, of which the land for cultivation and living accounts only one fourth. There are two major river deltas that are the Red River Delta in the North and the Mekong Delta in the South.

Vietnam has a tropical climate with rainy and dry seasons. The country benefits from the climate but is also negatively impacted by it. Very often strong storms and large floods sweep across many provinces in the central and southern parts between June and October every year. These natural disasters often cause great losses of lives and property.

The country population was estimated at 77.7 million by 2000, of whom 24% live in urban areas. In the past the annual population growth rate was very high: nearly 3.0%. In contrast, last year the rate was 1.7%. The fertility rate was still high, 2.35 in 2000.

Vietnam is still poor. The percentage of the poor in 1998 was 37% as standardized by the international poverty line and the GDP per capita was 400 USD in 2000. Before the introduction of the renovation policy ("Đổi Mới") in 1986, the economy was subsidized and centralized. Inflation is high and there is a concern in daily life. Principal exports include crude oil, coals, sea products, woods, garments, textiles, footwear, coffee, rice and computer components while main imports are capital equipment, refined petroleum, steel, electronic equipments and fertilizers. Export products mainly go to Japan, China, Australia, Singapore, Taiwan, the EU and the United States of America. Trade deficit in the year 2000 was 1.1 billion USD (UNDP, 2000:1-2).

Health indicators have improved. Life expectancy at birth in 1999 was 68.3 years (70.1 for women and 66.6 for men). The under-five mortality rate was 42 per 1,000 in 2000.

Main religions in Vietnam include Buddhism, Cao Dai, Catholicism, Christianity and Taoism. The majority are Buddhists.

During the 20th century, Vietnam experienced two long and terrible wars. The first war for independence against France took nine years (also called Indochina war), beginning in 1945. The war was ended by the surrender of French soldiers at the "Diên Biên Phủ" battle, and by a sequential peace agreement signed in Geneva in 1954. The peace agreement terminated the French colonization in Indochina that began in 1858.
The second war (many Vietnamese called it the resistance war against American invasion while Americans called the Vietnam war) took place from the late 1950s until 1975. This war caused great losses on both sides. Vietnam suffered much more than America. Fallen, wounded and missing people, unexploded mines and bombs, consequences of Agent Orange sprayed by Americans during the war (still creating children born with defects), and war veterans are still problems for Vietnam.

Vietnam joined the United Nations in 1977, the Association of South East Asian Nations (ASEAN) in 1995, and normalized its diplomatic relation with the United States of America in May 1997. Vietnam is now well on the way of integrating itself into the world community.

Vietnam society is now in profound social and economical change because of “Đổi Mới” policy. This aims at developing a market economy that would stimulate production, and improve overall economic productivity. Since 1989, Vietnam has liberated economic policies even further and called for foreign investment and cooperation. This overall macro policy appears to be successful after enormous difficulties in the first years (1986 – 1991). Inflation was down from three digits to 5 – 10% in 1995 and foreign investment has increased nearly tenfold. The overall growth rate of the economy has been 8% over the last decade, making the country one of the fastest growing economies in the South East Asia region (NAC, 2000:7).

The market economy policy is improving the living standard for people but also causes negative changes in society, especially problems of illicit drug use (here refers to as drug use) during the last six years. Unsafe injecting drug use is determined to be the main cause fuelling HIV/AIDS infections in Vietnam.

The Problems: Drug Use and HIV/AIDS in Vietnam

The drug problem:

Vietnam has a long history of opium cultivation and smoking among ethnic minority groups in Northern mountainous areas. The use of the drug began to increase in lowland areas, especially in the North in the early 19th century when Britain brought opium to Southern China. Because opium use had a negative impact on the economy and society, the Vietnamese monarch outlawed the circulation and use of opium in 1820. Strict punishments were enforced for anyone who smuggled opium into the country. However, the situation changed when the French colonized Vietnam. The French established opium markets and took the monopoly of this business. Opium trade thus increased afterwards (AHRN, 2000).

Until the early 1990s, opium smoking practice was considered a symbol of the rich and was a cultural habit among hill tribe people. By 1945, it was estimated that about 2% of the entire population smoked opium, as well as 20% of the Vietnamese elites. Before 1954, only the rich and powerful people could enter opium-smoking galleries. It is also noted that opium plants in Northern mountainous areas are now being replaced by other crops as efforts made by the Government to combat drugs problems.
In the early 1970s, the South of Vietnam counted many drug users who chiefly used heroin. The majority were American and South Vietnamese soldiers. The use of heroin in the South disappeared when the war was over in 1975. In contrast, in the same period drug users were rarely found in the North of Vietnam, except for a number of ethnic minority people in mountainous areas and a small and hidden number of people in big cities smoked opium (AHRN, 2000).

The drug problem has been entirely different and has become a concern for the whole country since "Đối Mới" was introduced. The problem first began to arise in the South in the late 1980s. Old drug users returned to their former habits. However, their practice changed: they did not smoke heroin but injected opium. Not long after that young people in the North began to use drugs, first to "just try once" as many of them said, and then became addicted. Drug use began to boom in the North, during the years 1994 - 1996. Drug users in the North are much younger than their peers in the South. The majority of Southern drug users are old or pre-1975 drug addicts while their peers in the North are beginners. Seventy-four point five percent of 396 IDUs who have been infected with HIV in a 1999 study conducted in five Northern cities/provinces: Hanoi, Hai Phong, Thai Nguyen, Lang Son and Nghe An belonged to the age group of 19 - 29 (N.C Phi et al, 1999:231) while in Ho Chi Minh city their peers above 30 years old accounted for 90.8% or their mean age was 39 according to a study conducted among 1,519 drug users during three years: 1995, 1997 and 1998 (Ivan Wolffers & N.T Hien, 1999:149).

Many reports confirm that the majority of drug users in Vietnam are male. For instance, 99% of 520 drug users who were recruited by the snowball method in a cross-sectional study conducted in 1999 in Hai Phong city were male (D.A Tuan et al, 1999:243) and 98.7% of 472 IDUs in another study conducted in 5 Northern provinces/cities in 1999 were men (N.C Phi et al, 1999:231). However, this ratio in Ho Chi Minh City is a bit different as 9.8% of 1,519 drug users in the study conducted in 1995, 1997 and 1998 were female (Ivan Wolffers & N.T Hien, 1999:152). More recently, it has been indicated that the number of women, especially female CSWs beginning to use drugs is on the rise.

A recent UNAIDS publication estimated that by 2000 there were 185,000 drug users in the country (UNAIDS, 2001:13). Reportedly, the Vietnam National Drug Prevention and Control Program said that by the end of 1999 the nationwide number of drug addicts was 104,000 (Nhan Dan Newspaper, 22/11/2000). The program claimed that the reported number was accurate and reliable since personal details of every drug addict are available. The gap between the UN estimate and the country report is understandable since many drug users live hidden lives. There is also a difference between two concepts: a user and an addict.

The number of drug users also differs from one to another location. For example, in 1997 Ho Chi Minh City estimated 25,000 drug addicts in the city while one of the city drug rehabilitation centers had admitted 1,600 injecting drug users in 1996 alone (Ivan Wolffers & N.T Hien, 1999:150). Meanwhile Hanoi and Hai Phong reported 6,000 and 4,000 drug addicts respectively. In locations where economy, urbanization and
industrialization develop more rapidly, more drug users are reported. In border areas with China, Laos and Cambodia drugs problems are more complicated since drugs are trafficked across the borders.

Processed drugs for the Vietnamese market chiefly come from the Golden Triangle located in the adjacent area of Myanmar, Thailand, Laos and the Chinese province of Yunnan while a part of raw opium is transported to neighboring countries for processing. A study conducted at the border area between the Vietnamese province of Lao Cai and the Chinese province of Yunnan in 2000 reported that “the drugs that are transported from Vietnam to China are mainly in a raw form (dense or liquid opium) and after re-processing, these drugs are trafficked back to Vietnam” (V.M Hanh et al, 2000:10). Drugs are trafficked to Vietnam by all kinds of transportation means: land, water and air.

According to UNAIDS in Vietnam the majority of drug users use opium (UNAIDS, 2001:13) but other sources give a different picture. For example, 72% of 520 drug users in the 1999 Hai Phong study used heroin (D.A Tuan et al, 1999:243). Further, the study conducted among 396 IDUs with HIV (+) and 76 IDUs with HIV (-) in five cities/provinces including Hanoi, Hai Phong, Lang Son, Thai Nguyen and Nghe An in 1999, which is mentioned earlier in this part, concluded that 94.4% and 92.1% injected heroin respectively (N.C Phi et al, 1999:234). Recently, mass media also warns that some synthetic drugs are becoming available in the market and that the number of amphetamine users is on the rise. The drug market is continuously changing.

The percentage of drug injectors in Vietnam is not available (UNAIDS, 2001:13), however some previous studies indicate a high percentage. For example, the study among drug users in Hai Phong city in 1999 showed that 61% of 520 drug users injected (D.A Tuan et al, 1999:242). Another study among 297 drug users in Quang Ninh in 1998 also reported “nearly all the respondents injected heroin” (V.M Hanh et al, 1998). Additionally, the Provincial AIDS Committee of Quang Ninh claimed that almost 100% of 1,500 HIV/AIDS newly reported cases in 1998 injected heroin. HIV/AIDS infection outbreaks among drug users over the last decade, which will be discussed later in this chapter, can assume a high percentage of drug injectors. It is also warned that Ho Chi Minh City would observe a big shift from on-going heroin smoking among young drug users to injecting in the very near future.

Since the Government of Vietnam is actively concerned with the drug problem, both with the trade and the use, it has established a National Drug Prevention and Control Program. The implementation of the program began in 1993 with an institutional framework to involve multiple ministries and sectors. This program aims to a) provide policy directions on drug control and prevention issues; b) develop drug control and prevention legislation; c) implement and monitor opium crop substitution programs; d) control drug importation, production and sales; e) provide drug treatment services; and f) promote international cooperation in drug control. In December 2000 the National Assembly of Vietnam passed the first ever Law on Drug Control (VNA, 5/12/2000), which came into effect from June 1, 2001.
Vietnam currently has a total of 51 Government-run drug rehabilitation centers, of which 11 are separate for drug addicts only. The rest combine with social/educational support services for female sex workers. The relapse rate is very high, at 80–90% (UNAIDS, 2000:211).

In summary, the drug problem in Vietnam is a growing concern and it changes over time as well, including changes in the market, its use and user patterns. First, heroin is probably overtaking the opium market because areas for opium plants in Northern mountainous provinces have shrunk due to the increasing replacement of other crops. Besides, opium-smoking galleries have disappeared under continuous police raids and heroin is smuggled more into the country as well. Second, drug users switch from smoking opium to injecting heroin. Third, young people from every social class in urban areas get involved in using drugs.

The HIV/AIDS problem:

Vietnam has two kinds of HIV/AIDS data collecting sources: the passive and active surveillance systems. For the passive surveillance, HIV/AIDS cases are reported systematically from all health facilities of 61 provinces/cities throughout the country (counseling rooms, hospitals, clinics, laboratories, blood transfusion centers, etc). HIV/AIDS testing used to be made compulsory for some high-risk groups (migrant workers who returned home from abroad, boat people who returned from refugee camps, IDUs, CSWs, hotel workers, foreign seamen and some groups of foreigners who entered Vietnam) until 1995. However, it is now voluntary for all people who want to know whether or not they are infected with HIV. Still, the test is compulsory for those who visit or are referred to hospitals/clinics if doctors suspect that their visitors or referred patients may suffer from HIV/AIDS. In such cases doctors have the rights to adopt HIV/AIDS compulsory tests for a confirmed diagnosis. Pre- and post-test counseling services are made available in the country but do not work well since there is lack of trained staff to do counseling professionally.

The National Institute of Hygiene and Epidemiology has set up active surveillance (or HIV sentinel surveillance) to monitor HIV/AIDS among six groups on an annual basis. The groups include IDUs, CSWs and STI patients (representatives of groups with high-risk behaviors) and antenatal women, military recruits and TB patients (groups with low-risk behaviors). The testing is unlinked anonymous. The active surveillance was first conducted in 1994 in eight provinces/cities, expanded to 12 in 1995, and now takes place in 20 provinces/cities. Unlike the passive surveillance, which responds to the demands of hospitals/clinics' clients, the active surveillance is a routine epidemiology survey. These surveys are conducted by provincial centers of preventative medicine or hygiene and epidemiology during only a certain month of the year.

The first case of HIV infection in Vietnam was documented in 1990 and according to a September 2001 update; the total 41,030 HIV cases have been reported from the passive surveillance system. Among all these reported cases, the group of injecting drug users accounts for 65.7%, 86.2% are male, and 77.7% are under 40 years old. HIV/AIDS infections have been reported from all 61 provinces/cities across the country (NASB, 9/2001).
Nationwide data in the table below from the active surveillance shows HIV/AIDS trends among IDUs over time:

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>No provinces:</td>
<td>7 (*)</td>
<td>11 (*)</td>
<td>19 (*)</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
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<tr>
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<td>14.81%</td>
<td>9.4%</td>
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<td>1.2%</td>
<td>4.66%</td>
<td>5.34%</td>
<td>12.50%</td>
<td>16.0%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Range:</td>
<td>0 - 33.7%</td>
<td>0 - 43.59%</td>
<td>0 - 50.77%</td>
<td>0 - 68.59%</td>
<td>0 - 81.82%</td>
<td>0 - 75.8%</td>
<td>1.9 - 70.4%</td>
</tr>
</tbody>
</table>

Source: The National AIDS Standing Bureau of Vietnam (NASB)¹

Some large HIV/AIDS outbreaks have occurred among IDUs over the last decade. For example during the period 1993 – 1996, HIV outbreaks were mainly among old IDUs in Ho Chi Minh City (in the southern part), and Nha Trang and Da Nang (in the central part) while the epidemic was negligible in the North. However, since the end of 1996 HIV/AIDS has affected young IDUs in the North. Lang Son province, which shares its border with China, was the first to report HIV outbreaks among young IDUs in the North. From 1996 to 2000, 641 people, almost all IDUs, had been infected with HIV in the province. Next, Quang Ninh, which shares its borders with China, Lang Son and Hai Phong, reported only 2 HIV cases before 1996, but since 1997 HIV infection has raised among young IDUs. As of May 2000, 2,587 HIV cases had been notified in the province, of which 80.8% were IDUs. Recently, Hai Phong and Hanoi also have experienced similar epidemics beginning in 1998 and in 1999 respectively. As of May 2000 more than 2,840 HIV/AIDS positive cases – again mainly as IDUs – had been confirmed in these two cities. The 1999 annual sentinel surveillance data revealed that HIV/AIDS prevalence rates among IDUs ranged from 12.0% to 32.5% in these four locations (NAC, 2000).

International and national experts have estimated that by the year 2005 the number of HIV/AIDS infected people in Vietnam would be 250,000 (VNA, 5/4/2001). This estimate has been accepted as the corner stone to deal with the HIV/AIDS epidemic in the country.

The Harm Reduction Program is a component of the National AIDS Program, which began in 1990. It targets both IDUs and CSWs and is carried out in 28 big cities and provincial towns. The program composes of a peer approach, distribution and exchange of syringes and needles, and condoms are provided as well. The harm reduction was initiated and piloted in Hanoi and Ho Chi Minh City in 1993. Currently there are 49 groups of peer educators for IDUs with 500 peer educators for both IDUs and CSWs (separated numbers are not available). The groups are run and supervised by various organizations at the local level including provincial AIDS committees, preventive medicine centers, youth unions and international NGOs. International agencies and NGOs (like WHO, UNDCP, UNAIDS, GTZ, SCF/UK) have funded most of these peer education groups through short-term projects of one to three years’ duration. Challenges for harm reduction include: (1) how to sustain the program in the long run due to the lack of governmental financial commitment following the withdrawal of funds by international donors; (2) the majority of peer educators for IDUs, especially peer educators in central and southern provinces, are working with older drug users. Those peer educators have insufficient knowledge of the social network of younger users, so it
is more difficult to approach the young peers; (3) the current peer educator/IDU ratio is too low, for example 1/300 in Ba Ria Vung Tau province and 1/500 in Ho Chi Minh city. This low ratio results in insufficient coverage and inadequate and irregular services. In other words the harm reduction program is less responsive to users' needs and to the rapidly changing drug use situation; lastly, the number of needles and syringes distributed per IDU is far below the projected needs to be effective. For example, Da Nang city distributes only around 300 needles and syringes to about 200 IDUs per month. The percentage of a safe injecting practice is increasing, but not very much (Vu Trang, 2001:23-24).

It is clear that the HIV/AIDS epidemic in Vietnam is associated with unsafe drug injection and is still on the rise. It continues to infect IDUs meanwhile there is a lack of effective interventions among this population.

**Justification for the Study**

Although the National AIDS Standing Bureau (NASB) and other international organizations have been considering IDUs as a priority target population for years (NAC & UNAIDS, 1998:25), the population is still hit severely. Nationwide data on the sharing of syringes/needles is not available but findings, which are below, from six recent quantitative studies conducted in major cities assume that the percentage of the sharing of syringes/needles is very high.

First, the study conducted over three years: 1995, 1997 and 1998 in Ho Chi Minh city among 1,519 IDUs reported that 50.9% of the respondents have shared syringes/needles “often” and 38.5% “sometimes” (Ivan Wolffers & N.T Hien 1999:153).

Second, the baseline survey conducted in 1998 at 11 wards of five cities/provinces namely Hanoi, Hai Phong, Lang Son, Thai Nguyen and Nghe An before carrying out a small-scale harm reduction project showed that 71.5% of 452 IDUs have shared syringes/needles (L.N Yen & N.T Khanh, 1999:40).

Third, the baseline survey conducted in 1998 in Quang Ninh province before interventions revealed that 93% of 297 drug users (nearly all as injectors) have shared syringes/needles (Hanh V.M et al, 1998).

Fourth, the baseline survey conducted in 1998 in Lao Cai province among IDUs before interventions reported that 38.38% of the respondents in Lao Cai town and 70.75% in Cam Duong town have shared syringes/needles (Lao Cai PAC, 1999:457).

Fifth, the study conducted in five Northern provinces including Hanoi, Hai Phong, Lang Son, Thai Nguyen and Nghe An in 1999 stated that 96% of 396 IDUs with HIV (+) and nearly 50% of 76 IDUs with HIV (-) have shared syringes/needles (N.C Phi et al, 1999:234).

Sixth, the study conducted in between March and May 1999 in Hai Phong city reported that 68% of 319 IDUs have shared syringes/needles (Tuan D.A et al, 1999:246).
All except one study above were presented at the Second National Scientific Conference on HIV/AIDS from December 9 – 11, 1999 in Ho Chi Minh City. Detailed descriptions and findings of the studies were included in the conference proceedings. From a quantitative methodology it is difficult for the studies above to answer a question as to why IDUs in Vietnam share syringes/needles. In actuality, the studies did not even focus on it. Answers to the question of the reasons for sharing are not available in any other reports, either.

Therefore, it is important and useful to conduct a qualitative study on drug injection to answer the necessary question above which will fill the gap. Currently there is only the availability of percentage data of the sharing among IDUs from quantitative studies.

This qualitative study has been conducted over the three full months from August through October 2001 to reach two specific objectives: 1) to identify reasons why injecting drug users share syringes/needles; and 2) to describe the contexts of HIV infection risks regarding injecting practices.

This study is also designed to get insights of the sharing of syringes/needles among IDUs in the Vietnamese context for that the National AIDS Program would adopt for further prevention interventions among this “difficult-to-reach” population.

**Analytical and Conceptual Framework**

Many studies conducted in Western countries report a wide range of reasons for injecting drug users to share injection equipment. For example, an Amsterdam cohort study among IDUs concludes that: “the problems associated with syringe use no longer seems to concern availability of syringes/needles or lack of knowledge on AIDS; if a needle is shared, it is more the result of the lifestyle of IDUs and an unfavorable or an insecure environment” (Ameijden, 1994:123). Another study in the Euregion Maas-Rhein also reports that 42.0% of the injection drug users share syringes with their sexual partners and 47.8% with their friends (Franken & Kaplan, 1997:161). Likewise, a study among Asian Drug Users in San Francisco tells that: “the most commonly cited reasons for sharing needles were having trust in the needle-sharing partner (44% of men and 60% of women, not statistically significant) or not having their own or enough clean needles available for use (50%). Although 54% of IDUs cited one or more reasons for worrying about the risks of sharing needles, 46% stated that they did not worry, primarily because they trusted the people that they shared equipment with (50%) or because they did not know much about HIV (31% of males and 50% of females, not statistically significant) or because they did not care about the risks involved (12%). Also, 23% of IDUs said that they were so desperate to shoot up that they didn’t care about the risks” (Nemoto et al, 2000:132). Or another study in the United States of America also concludes that: “After limited changes in the Massachusetts syringe prescription law that intended to increase access to sterile syringes, the arrest, prosecution, conviction and incarceration of IDUs for syringe possession continued. These law enforcement activities may have contributed to the multi-person use of syringes and the transmission of HIV and other blood-born infections. Retaining drug paraphernalia and syringe prescription laws in Massachusetts may
diminish the chance that IDUs will carry and use sterile syringes and therefore may contribute to HIV transmission” (Case. Pet al, 1998: S75).

It is also inferred that reasons for sharing injection equipment are different from one to another cultural context. In addition, the sharing reflects the diversity of the drug culture itself and the change of the drug market over time.

Why do injecting drug users in Vietnam share syringes/needles? As noted earlier, no information is documented. After consulting with a number of experts who work with HIV/AIDS and the drug problem in the country, and reviewing a variety of available literature, an analytical framework for it has been developed (Please see annex 2 on page 80).

The first reasons for sharing syringes/needles is probably for the pooling of resources because it would be cheaper and more practical for IDUs to inject by buying drugs and injection equipment together, instead of independently. Next, the unique drug culture itself is also perhaps a reason. Explanation for this may include the meanings and symbolism of the sharing, group identity and peer pressure. The next reason would be related to the perception of HIV risk. It is believed that the risk perception would be very likely to play a crucial role in controlling their injecting behaviors. Their risk perceptions are often influenced and enhanced by IEC campaigns and harm reduction programs. The next reason would be a social stigma. Family, non-drug user friends and the community probably keep their eyes on IDUs at every turn, so it would be difficult for IDUs to carry drugs and injection equipment in their pockets or bring them home. Hence, they may gather somewhere underground to inject together. The next reason would be related to an enforcement of law. Drug use is prohibited, and police and drug prevention and control program usually bust the drug trafficking networks and shooting galleries. Officials then detain and/or arrest drug users for administrative fines or for compulsory drug rehabilitation programs. Therefore, IDUs would not dare to carry paraphernalia thus resorting to inject in places where peer pressure may dominate. In such circumstances IDUs would be subject to share. Additionally, if the law prohibits pharmacies from selling paraphernalia for IDUs, it would affect their injecting practice, too. The last reason would be a scarcity of syringes and needles. Obviously if this is the case, IDUs would opt to share.

All or only some of the possible reasons above are true in Vietnam or not? Or are there any other reasons? So far we do not know.

Besides the main question of the study “why IDUs in Vietnam share syringes/needles”, the study also looks into some other questions concerning drug use. These should include where do IDUs get money from for their daily injection habits? How do they clean and dispose syringes/needles? What are slang words to be used among IDUs? And so forth.

This study uses two conceptual approaches in anthropology, which include: contextualization, and the emic and etic perspectives. In addition, it also applies two theoretical perspectives in medical anthropology:
transactionalist model, and the cognitive and symbolic approach. These approaches and theories direct the study while investigating and analyzing the findings. What do these terms mean? Please look at the following borrowed elaborations that are written in a manual: “Applied Health Research – Anthropology of Health and Health Care” (Anita Hardon et al, 1995:1 – 21).

The contextualization: it is an anthropological approach that gains understanding of a certain subject by studying it in its context. In human language words derive their meaning from the sentence in which they are used, and the meaning of a sentence is also dependent on the sentences around it. In a similar way, people’s ideas and practices can only be understood when viewed in context. The anthropological approach is, therefore, often the opposite of what is practiced in natural sciences. The object of research is not ‘dissected’ or reduced to smaller entities, it is broadened by the inclusion of its relevant context. The biologist studies the quality of water by taking one drop and placing it under a microscope, looking for microbes. The anthropologist is likely to study how people use water in everyday life, who collects it, who uses it, for what purpose, etc.

The emic and etic perspectives: the anthropologists’ emphasis on understanding and studying culture in context usually implies trying to discover how people view their own situation and how they solve their problems. This we call the emic approach. It can be contrasted with the etic approach, which is based on ideas that outsiders, policy makers and health workers included, have about a particular group. It has frequently been the case that development projects have failed because they do not take the community’s own ideas and preferences into account. Anthropological research focusing on the emic point of view may help to correct this shortsightedness.

The transactionalist model: in the transactionalist perspective, culture is also seen as the outcome of competition, but in this case at a more individual level. In their attempts to reap maximum profit, enterprising individuals negotiate, become brokers, do ‘business’ and, in doing so, recreate and change society, including conditions of health and health care. This perspective can be applied to both health workers and their clients. The activities of health workers may be motivated by profit-making considerations and patients may use health services to further their individual interests.

The cognitive and symbolic perspective: other anthropologists emphasize the importance of the cognitive and symbolic aspects of culture. This view has proved to be particularly useful and productive in medical anthropology. Questions such as: what is illness, how do people explain and label illness, how do they choose between various curative alternatives, and how communicate with health practitioners may be usefully addressed from a cognitive/symbolic point of view.

In this study, a working definition to call someone as an injecting drug user is mentioned in sampling procedures of chapter 2, but a definition of the sharing of a syringe/needle is borrowed as follows:
"The use by two or more people of the same needle and syringe for the injection of drug. It is a major route for the transmission of blood-borne viruses such as HIV, hepatitis B and C among injection drug users. Also used imprecisely as a term to refer to the shared use of any injecting equipment (e.g. spoons, water containers, filters)" (UNODCCP, 2000:47).

For some other necessary terms in drug use that would be useful for common understanding, please refer to annex 3 on pages 81 and 82.

How is this thesis structured in next chapters? In chapter two, I will discuss about methodology giving reasons about the choice of study type, and mainly describing data collection techniques and sampling procedures. In addition I also list variables and themes, describe about data processing and analysis, and consider ethical issues in research. In chapter three, I will discuss issues regarding syringes/needles in order to find whether the issues make IDUs to share or not. In chapter four I will discuss some reasons for sharing a syringe/needle and at the same time I also will describe contexts influencing IDUs to share. In chapter five, I will describe some existing kinds of deception in the world of drug use that put IDUs at risk of HIV/AIDS infections unintentionally. In chapter six, I will discuss about another possibility regarding IDUs’ current knowledge and risk perception to see whether it is a reason for sharing or not. Based on findings and the previous chapters discussions, chapter seven will conclude on reasons for sharing a syringe/needle before making some recommendations for further HIV/AIDS prevention interventions among the population of IDUs.
CHAPTER 2: METHODOLOGY

Study Type

Little is known about drug injecting practices in Vietnam, especially about emic points of view and contexts in which injecting drug users share syringes/needles. Besides, the study wishes to answer a “why” question, which are to discover reasons for the sharing of syringes/needles. Finally, drug use, in nature, is illegal and originates from many complicated socio-economic problems in many countries, of which Vietnam is included, therefore talking about it and HIV/AIDS infection as well is a sensitive topic for injecting drug users to disclose. For all these reasons, and also because time and other resources are limited, an exploratory type of study was done.

The study is conducted in the capital city of Hanoi, exactly in the two urban districts of Ba Dinh and Hai Ba Trung (seven urban and four rural districts in total; Please see two districts maps, annexes 4 and 5 on pages 83 and 84). This city with a 2.672 million population (source: Census, April 1999, Vietnamese General Statistic Office) is selected because of its growing concern on drug use and HIV/AIDS infection. In addition, the city is chosen for logistical reasons my residence makes it easier for my three-month participant observations. HIV/AIDS cumulative reported cases in the city have been increasing rapidly over the past few years (see table below). Of the cumulative number, 70.93% are injecting drug users. The male infected accounts for 94.1% and the age group of 20 – 29 for 69.6%.

<table>
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<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>19</td>
<td>30</td>
<td>337</td>
<td>1,032</td>
<td>1,847</td>
<td>2,879</td>
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Source: The Hanoi City AIDS Bureau

The city also claimed that there were 8,700 reported drug addicts by September 2001 meanwhile the estimated number would be between 15,000 and 17,000. The percentage of drug injectors is not available (source: Hanoi City Bureau for Drugs Prevention and Control Program, 9/2001).

Data Collection Techniques

This study applies three data collection techniques: in-depth interview, focus group discussion (FGD) and participant observation. The techniques allow me to systematically collect information about drugs injecting practices and about the injection settings as well. Since the study topic is difficult and sensitive, and involves the stigmatized group, appropriate techniques are selected to investigate. More importantly, the techniques are able to gain insights and in-depth information regarding injecting drug behaviors and serve as different sources of information to complement and cross check each other, thus validating findings.

All the in-depth interviews and FGDs of the study are tape-recorded, after the respondents give their verbal consent. Detailed fieldnotes of participant observations are recorded and notes from the working day is done within the day when I get home, of which below is an example:
A note of daily finished tasks:

At 9:00am have met I13 [I(1,2,..): Interviewee numerically coded] at a roundabout (appointment made after yesterday in-depth interview with him). We drank tea at a stall at the roundabout. Waited while I13 was calling his peer. At 09:10am I13 introduced a new IDU. Three drank some tea more and I paid money for drinks. At 09:20am I took the new IDU on my motorbike to another place for in-depth interview. We talked together on the way.

At 09:40am I began the interview with him at a small green park nearby a large lake. It ended at 11:00am. This man is coded as I14.

At 11:30am I14 and me met I13 again at the roundabout. I took both I13 & I14 to "the shooting area" on my motorbike after expressing that I wanted to follow them to observe injecting practices inside the area and they agreed accordingly. On the way I13 & I had to wait for I14 who called at a market to sell a spare part of a luxury motorbike that both of them stole before.

We arrived at "the shooting area" at around 12:15pm. After leaving my motorbike and bag, which kept my cassette recorder, blank cassette tapes, batteries and ballpoint pen at a residence area nearby, we walked to "the shooting area". I followed I13 & I14 entering "the shooting area" (more detail about the observation is described in another note). We stayed there for 35 minutes. At around 13:00pm three of us left "the shooting area" on my motorbike. I invited two guys to have lunch with me.

At 13:30pm we had lunch together. I paid for our lunch.

At 14:30pm I took two men back to the roundabout and returned home afterwards

At 16:00pm I got home and jotted down some important notes for today's observations. After dinner at 08:00pm I checked the tape to ensure the quality for a while. It is good. Now I begin to write down in detail what I saw and heard during my observation at "the shooting area" this afternoon.
REMIND: tomorrow meet 113 & 114 again at the roundabout at 9:30am

In collecting data, I always played the role of an outsider, who seems to know nothing about drug use and HIV/AIDS. I expressed my wish to learn from the users and listen to their insiders' perspective. At the same time, I tried to act as an insider who tried to get involved and understand the daily lives of IDUs, by dressing somewhat as a street living person and hanging out with IDUs. I also paid special attention to their contexts and natural injection settings.

Sites at which I first encountered potential interviewees or FGD participants are defined as the selection places. It is necessarily noted because the interview/FGD sessions may take place at others. Additionally, most of the study participant selection and interview places have something in common for IDUs: the ability to see the police coming, easily able to run away, and able sleep there without complaint. These places are public places and safe havens.

During the interviews, the FGDs and participant observations I did not ask their names (except when they voluntarily told me) and concrete contact addresses.

During my data collection, I also met some difficulties such as: several missed interview appointments (including previous interviewees who promised to introduce a new IDU to me, and some potential interviewees as well) and because of late arrival or no-shows. The organization of FGDs groups is also time-consuming because it is not easy to meet six or eight IDUs at the same time. In addition during the discussions, some IDUs talk more than others. Some in-depth interviewees also borrow me some money (not so much) but failed to return to borrowed amount. Anyway, most respondents were willing to participate.

All in-depth interviewees and FGD participants in this study also received money as an incentive rewarding for their time and cooperation.

In-depth interviews: are conducted at different places that are suggested by either the selected interviewees or me. The final choice of places for each of the interviews is mutually agreed upon on the basis that all the following are ensured: no interruption by any other people including their peers and family members, a private dialogue only between the IDU and me (so that no one can hear the discussion), not too much noise for the talk and tape recording, a favorable atmosphere for the interviewee to talk naturally, openly and honestly. For those IDUs who were selected at sites far from the agreed places for the interviews I would take them there by my motorbike.

In fact all in-depth interviews of this study were conducted at the following places, which strictly meet the conditions above: three IDU homes (interviewed with six IDUs), an area where people throw their waste
(with four), one small green park nearby the side of a big lake (with eight), one roundabout (with two), two lakesides (with four), a river bank (with one), three large green parks (with four), and a small green park at a street corner (with one). Regarding three IDU homes: first, I interviewed individually with three IDUs at a room of an IDU’s rented house (one among three interviewed IDUs lives with his family there) since three are familiar with each other; second, I interviewed an IDU at his house where he lives alone, and his peer afterwards. His house is often a place for their gathering to inject; last, I interviewed an IDU in his attic of his house where he lives with his family.

Located in the districts of Ba Dinh and Hai Ba Trung, all the interviewed places above are also meeting points for many of the interviewees to gather, inject drugs and spend the night. In addition, many improperly disposed syringes/needles are seen on the grounds.

Informal chats between the selected interviewees and me often started in-depth interviews. The interviews are done with the majority of open-ended and un-structured questions covering different topics like: demographic characteristics; their history and on-going practices of drug use, especially injection; drugs use and users’ pattern; drug availability; issues around syringes/needles and whether they share it or not; reasons for sharing or not; whether or not they see their peers sharing syringes/needles; the pooling of resources to acquire drugs and syringes/needles; financial sources for daily injections; social interactions with other peers, HIV/AIDS knowledge; emic words used among IDUs; family and police attitudes towards their injection behaviors, etc.

I also use some necessary interviewing skills for further investigations and for the encouragement of IDUs to be natural, open, and honest when participating. For example, I did the sequence of questions appropriately and sometimes asked stupid or curious questions for the exploration and repeated questions for the verification of the consistency of the previous information as well. Further, the interviews sometimes subjectively lead to other discussions such as regarding their personal life and family stories, their successes and failures in the past, education, work and their wishes for the future. While interviews were taking place, many of them also smoked cigarettes, drank teas or soft drinks, and ate crackers or sweets that are paid for by me. Additionally, four out of 30 in-depth interviewees even injected during the interviews.

For the first 26 in-depth interviews it lasted from one hour to maximum one hour and half but for the last four sessions it took 45 minutes since the data needed from the interviewees were sufficient and consistent with the previous ones. In-depth interviews are conducted at different hours of the day depending on the availability of interviewees, ranging from 9:00am to 6:00pm.

Focus group discussions (FGDs): were conducted at a roundabout (with two groups), at a small green park at a street corner (with one group) and at a large green park (with one group). Similar to a part of the in-depth interview description above, the places are suggested by either the selected FGD participants or me,
and finally agreed by both sides. The criteria for the selection were the same as the in-depth interview ones and for those IDUs who were selected at sites far from the agreed places for the interviews I would take them there by my motorbike.

The participants and I sat on the ground in a circle and informal chats always began the discussions. Indeed the participants themselves created FGDs with my help. My role in the FGDs was to stimulate and support the discussions. I introduced myself and asked participants to do the same. In addition, I explained about the purpose of the FGDs and the kind of information needed, and reminded the participants that there would be no ‘right’ or ‘wrong’ answers. During the discussions, I formulated questions and encouraged the participants to actively share information and express their views.

The discussed topics included: history and on-going practices of drug use, especially injection; drug use and users’ pattern; drug availability; issues around syringes/needles and whether they share or not; reasons for sharing or not; whether or not they see their peers sharing syringes/needles; the pooling of resources to acquire drugs and syringes/needles; social interactions with other peers, HIV/AIDS knowledge; and emic words used among IDUs. In addition, very brief information about ages, the years in which they began to use drugs and switch from smoking to injecting were collected from all the participants.

One among the 24 FGD participants injected during the discussion and the duration of each FGD lasted from 50 minutes to a bit more than one hour. All the discussions took place in the afternoon at the later stage of the study, two during the last two weeks of the second month and the rest during the third month.

Participant observations: are considered as an important tool in this study because I wanted to understand the context of what IDUs say in the in-depth interviews and FGDs, and to further investigate this topic, which is difficult and lacks of specific data. As said earlier, it is also essential for cross checking and evaluating data obtained from the in-depth interviews and FGDs. This data collection technique moves through three phases: descriptive, focused and selective observations, and was continuous work throughout the whole period of the study. The technique focus is to investigate, face to face, the way IDUs prepare and inject drugs; whether or not IDUs share syringes/needles in reality; the context in which IDUs share syringes/needles, and to interpret reasons for sharing; how to get and clean a syringe/needle; daily pooling of resources; and emic words communicated among IDUs. In addition, I also collected some artifacts for the report that were thrown away after use (Please see annex 6 on pages 85 and 86).

The participant observations were conducted at different places, especially at “the shooting area”, where the most valuable and reliable data on unsafe injection practices are caught. “The shooting area” is located within the two urban districts at which the study was conducted. Since “the shooting area” is also near the city center, drug users in the city are easily accessible in terms of distance. They can go there by either “motorbike taxi” or scheduled buses during the daytime, or even on feet. It is “open” all the day and is
frequented by many drug users. The rush hours for “the shooting area” are in the early morning when city people do morning exercises, at noon and in the late afternoon.

Actually “the shooting area” is previously an empty land area but was occupied by “ready to take the risk” or “head stubborn” people approximately ten years ago. It became a slum area since then. No one can go in or go out “the shooting area” by any other ways other than by its only entrance and exit through a dead-end alley. Just opposite and around the entrance there are several tea stalls, “motorbike taxi” services (this is different with the “motorbike taxi” mentioned in the previous paragraph, which transfers IDUs to the entrance and exit of “the shooting area”), and drug brokers. These tea stalls are regarded as transit points for those who really want to take a short rest or to re-think whether or not to go in the dead-end alley now or later. Of course “motorbike taxi” services here mean the offer of “safe” rides for new comers or someone who does not want to take a possible risk of being arrested by police, especially when leaving “the shooting area” with drugs. Moreover, if one does not really want go in “the shooting area” to buy drugs, she/he could get it from drug brokers who are always around there. Next to the dead-end alley is a police point that works to limit drug users from going in and out “the shooting area”, especially from taking drugs when leaving. The alley is rather narrow (just walk or ride a bike or motorbike at a slow speed) and not long, perhaps 200 – 300 meters. Along this dead-end alley there are often some people who squat and probably keep watch. Perhaps they are persons of an alert system.

I entered “the shooting area”, with the only purpose for conducting participant observation on unsafe drugs injecting practices, four times. Four IDUs who were previously interviewed in depth and frequent “the shooting area” were asked to guide me. Upon the understanding of the entry purpose they agreed to be guides. In fact they facilitated and stayed inside “the shooting area” with me during each period of participant observation. Four participant observations in “the shooting area” were done within one week during the third week of the August. The first time I followed both 113 and 114 going in at noon soon after completing the in-depth interview with 114. I had been inside there and did participant observation for 35 minutes. The second time I followed both 113 and 115 and the participant observation lasted 40 minutes at noon. 115 was interviewed in-depth soon after my second participant observation. The third time I followed both 115 and 116 after interviewing the latter. This time it had been done in the late afternoon for 45 minutes. The last time I once again followed 113 and stayed there for 30 minutes in the early afternoon after hanging out with this guide person.

As seen by my sketch of “the shooting area” (Please see annex 7 on page 87), sale of heroin, and sale of syringes/needles, distilled water, novocain solution, seduxen, pipolphen and cigarettes, and drug injection practices are done outdoor. Again, that is why it should be called with “the shooting area” (in contrast, if it is inside a house that is often called with a shooting gallery). In fact there is only one person to sell heroin but several to sell the injecting items mentioned above. The distance between the first point that the heroin sale person stands and the second point that the injecting items sale persons squat is less than ten meters. IDUs should pay money first and then get heroin quickly from the sale person who stands just at the edge of
the alley before continuing to move approximately ten meters forward to possibly buy some of the injecting items from other sales persons who squat in the alley. After passing by the second point, IDUs again should go around ten meters or even a bit further to find a space for drugs injections. IDUs often inject in small spaces behind small huts or beneath tumbled brick walls and bushes that they call “safe”. In general IDUs should inject promptly.

During four participant observations, I usually squatted next to IDUs together with the guide men, and observed their drug injecting practices and listening to their talks. Except for the guide men, other IDUs did not know about my presence, being a non-drug user. Clearly, in such circumstances I only can participate as a bystander or a spectator regardless of some discussions with them.

Addition to “the shooting area” I also observed in an area where people throw their waste, two roundabouts, tea stalls in front of “the shooting area”, and some others. In terms of the participation level and time for these observations, I could talk, interact and hang out more with IDUs at different hours of the day. I did observations on both IDUs who previously participated in the study and who did not. In total I saw 17 IDUs (13/30 in-depth interviewees and four out of 24 FGD participants), face to face, injecting drugs either during or after the interviews/FGDs. I also observed their daily activities outside of their drug injections.

**Sampling Procedures**

The study population was active injecting drug users (here refers to injecting drug users or IDUs) in the city of Hanoi. The steps for sampling are very simple. First, I gave a briefing about the study at the National AIDS Standing Bureau (NASB) and later at the Hanoi City AIDS Bureau for their endorsement and support. Second, I approached a health station at the community level, which is in the district of Ba Dinh and was introduced by the city bureau. Third, at that community a health worker of the station took me to meet four injecting drug users, who were later not selected as study units of this study, but I talked with them hung out a bit. I also did a pre-test on the sampling method (when developing the study protocol, I proposed to recruit in-depth interviewees and FGD participants with the full-time help of some peer educators). One of these four IDUs introduced to me the first interviewee who is considered the beginning of the snowball method in selecting next IDUs. Previous study participants helped me build the trust and meet with new ones.

Explicitly, all IDUs of this study are selected by the snowball technique or by the convenience sampling method in other words. Mathematically, 30 IDUs were interviewed in-depth and 24 participated in four FGDs.

This study makes no exception for demographic selection, however, the criteria were enforced including: a) being introduced by an IDU who previously has been interviewed or had participated in FGDs of this study; b) currently injecting drugs (self-identified and it is subject to be asked by me to show any proof on the
body that indicates an active drug injection); c) willing to be interviewed in-depth or to participate in FGDs for at least one to maximum one hour and half; d) at present living in the city of Hanoi.

In fact I did detect proof of injections on the limbs of all IDUs. All confirm their active drug injections besides the verbal confirmations given by their peers. Proof was traced in a proper manner. In addition, as mentioned in the previous part, I myself did see 13/30 in-depth interviewees and four out of 24 FGD participants injecting heroin.

Although the snowball technique is applied for the selection of the participants, the selected study units come from different categories that draw a diverse picture of drugs use. Look at the following data:

For the in-depth interviewees:

Four IDUs are recruited from “the shooting area”, 13 from two roundabouts, seven from an area where people throw their waste, four from their own homes, and two from their peer homes.

Six female IDUs involved in the interviews, of which three have their husbands who also use drugs (additionally, two used to collaborate with their husbands to sell drugs by retail, and one is deceiving male sex clients for money by pretending to be a street female sex worker), and one poses as a street sex worker and is cohabiting with a male sexual partner who also uses drugs.

15 are married however eight of them are currently either divorced, or separated, or live with the second wife after a divorce (one case), or widow (one case). In addition, several others usually quarrel with their wives.

Two kin brothers and one conjugal couple (a husband and a wife) are included among the in-depth interviewees.

Mean age: 30.6 years old with the range: 17 - 47 years old (six are over 38 while seven are below 22 years old), and median age: 29 years old.

16 are residents in the district of Ba Dinh while four in the district of Hai Ba Trung, three in the district of Dong Da, one in each of the two urban districts of Hoan Kiem and Thanh Xuan.
Five IDUs are not registered as Hanoi residents however they have lived there for a long time, 12 years for three persons, ten years for one, and three years for one. In addition, of which four are living on the streets in the district of Ba Dinh and one is living with his family in a rented house in the district of Ba Dinh.

Regardless of registered or non-registered residents, a total of 16/30 IDUs are currently living on the streets of the two districts of Ba Dinh and Hai Ba Trung.

21/30 have been injecting for at least one year or much more. Or in other words, the mean number of injection years: 2.8 years with the range as from three months to ≈ 9 years, median number of injection years: 2.5 years.

Mean number of daily injections: 2.6 with the range: 1 - 5, the top record of the number of injections within a day: 11.

All 30/30 inject heroin, of which one half switched from opium.

For the FGDs:

Five IDUs are recruited from “the shooting area”, 18 from two roundabouts and one from a large green park (in the two districts of Ba Dinh and Hai Ba Trung).

Four female IDUs participate in the discussions, of whom two together with their “husbands” (also inject) participate in the FGDs, one is a street sex worker and the other is believed to do so.

Mean age: 30.5 years old with the range: 17 - 56, median age: 30.

Number of years for which they have been injecting: range 1 - 10 years, mean: 4.2 years, median: 3 years.

All 24/24 inject heroin.

For further background information about 30 in-depth interviewees and emic words used, please see annexes 8, 9, 10 and 11 on pages 88 - 92.
It is also noted that sites from that the selection of all IDUs in this study belong to the two urban districts of Ba Dinh and Hai Ba Trung.

**Study Variables and Themes**

As mentioned earlier, many different open-ended and unstructured questions were asked during more than one hour, for most of the cases, of each of in-depth interviews. As results, a lot of valuable data was collected. The variables and themes that follow the study manage to focus and collect from each respondent since the beginning:

**Variables:**

a) Age, sex, education, marital status and where to spend the night;

b) Number of years for which he/she has been using drugs;

c) Number of years for which he/she has been injecting drugs;

d) Number of daily injections;

e) What kinds of drugs he/she has used before and is using now;

f) Places he/she often injects at present;

g) Whether he/she has ever shared syringes/needles, with whom if yes;

h) Whether he/she pools money to acquire drugs and syringes/needles;

i) Whether he/she has ever put other peers at risk of HIV/AIDS infections by letting them re-use his/her contaminated syringe/needle;

j) Whether he/she has ever seen their peers sharing syringes/needles;

k) Issues around syringes/needles including availability, accessibility, price, how to clean for re-use if they have, and disposal;

**Themes:**

a) How to earn money now, especially financial sources for maintaining the use of drugs;

b) Reasons for him/her to start using drugs;

c) Reasons for him/her to shift from smoking to injecting, if applicable;

d) Reasons for him/her to share or not share syringes/needles;
e) Reasons for him/her to pool money to acquire drugs and syringes/needles; and how to prepare and divide drugs as well;

f) In what circumstances for him/her to put other peers at risk of HIV/AIDS infections by letting them re-use his/her contaminated syringe/needle;

g) Describe the cases he/she has ever seen their peers sharing syringes/needles;

h) How to clean a syringe/needle for re-use if they have, and disposal;

i) HIV/AIDS knowledge;

j) Emic words used among IDUs.

Some other themes for the study were discovered and added during the data collection. For example, some stories are about a deception in the world of drug use that puts IDUs at risk of HIV/AIDS infection, and frontloading between a new and an old syringe/needle or two old syringes/needles. Some of the variables and themes above that directly contribute to the achievement of the study objectives are applied to the FGDs.

**Data Processing and Analysis**

In fact, data processing and analysis in this study is an ongoing process and the preliminary analysis identifies key variables and central themes for further analysis. Data are also processed by hand because of some considerations. First, it is clear that all variables and themes would not be identified prior to analysis. Second, the information collected from 30 in-depth interviews and four FGDs with 24 participants are huge and diverse. Many questions were asked in the open-ended and un-structured manner and interviews also dealt with other aspects like personal life stories. Lastly, computer software for data processing and analysis in Vietnamese language is not yet available.

Also because of different tape-recorded information, more than one hour of each interview and FGD, and the limitation of resources, verbatim transcription was not possible. However, all 34 cassette-tapes as outputs of the interviews and discussions were played and sometimes replayed for carefully note-taking. This work ensured the use of all key and related information for this report. Data were put into a data master sheet that was prepared beforehand with the columns of identified variables and themes, and additional notes for processing and analysis. Further, whenever dialogues between interviewees and me during the group discussions providing valuable information needed to be quoted for the report, verbatim transcription was made.

The last note is that the quality of recording is very good since the voices of the interviewees, the FGD participants and me are very clear.
Ethical Considerations

It is entirely voluntary for IDUs to participate in the study. In fact verbal consent from all the study participants are made prior to the in-depth interviews and FGDs.

I hereby reconfirm that the confidentiality for all IDUs who participate in the study is definitely assured. Identifiable names of IDUs as well as geographic locations are not written down in any reports except for the code to be used for easier communication. Findings from the study are used for the purpose of the reduction of drug related harms on health only.

The sharing of syringes and needles put IDUs at risk for HIV/AIDS infection. Therefore after the data collection work was completed, I told them how to prevent them from becoming infected. Since it is not easy to meet them all again, these health education briefings reached about 25% of all those who were interviewed.
CHAPTER 3: SYRINGES AND NEEDLES

In many developed countries laws prohibit any individuals from buying and carrying a syringe/needle if they do not have a doctor’s prescription. For example in the United States of America “legal impediments to the sale and distribution of syringes exist in every state: 47 states have drug paraphernalia statutes, eight states have syringe prescription statutes, and 23 states have pharmacy regulations or practices guidelines. The Mail Order Drug Paraphernalia Act permits federal enforcement against individuals who knowingly sell or distribute syringes to IDUs. Congress has prohibited the use of federal funds for syringe exchange programs” (Gostin, 1998:S60). In contrast, it is not illegal for anyone throughout Vietnam to buy and carry syringes/needles regardless of having or not having a doctor’s prescription. In Vietnam a syringe/needle is one of many medical products that may require certain conditions for those who can sell it. However, so far no case has been reported or publicized because of a syringe/needle being sold outside of pharmacy stores. Besides, there are not any reports documenting police arrests of someone because of their possession of syringes/needles without a doctor’s prescription.

In this chapter I do not intend to compare and justify the difference in laws on syringes/needles, but will discuss the issues of syringes/needles: availability and accessibility, how to clean and dispose, and price and specification. The discussion helps us understand whether these issues cause the sharing of syringes/needles among IDUs or not. I especially will reflect emic points of view of IDUs and contextualize the issues.

Availability and Accessibility

All IDUs including in-depth interviewees and FGD participants in this study confidently said that it was so easy for them to buy a syringe/needle in many places, like these two statements: “So easy to buy like a bundle of vegetables in market” (I18) and “It is so easy to buy, syringes/needles are at everywhere” (I23). The places that IDUs cited the most are pharmacy stores along streets, in front of hospitals and in residence areas, as is illustrated in the dialogue below:

R: How do you prepare for drug injection? (R: Researcher)

I1: I go to [pharmacy stores in front of] hospitals, or to pharmacy stores to buy a “xi” (a syringe/needle) and an ampoule of “nốvô” (novocain solution).

Pharmacy stores are visible everywhere in the city since their big signs are numerous and always catch our eyes. I continued to tell me this “Whoever you are, whether you have a motorbike or not you can easily buy. Go to any pharmacy stores and just ask for a “xi”. Immediately salespersons behind the counters will give you one plus an ampoule of either distilled water or “nốvô” [novocain
solution”. I went to an IDU-familiar address of a pharmacy store in a street by following the tip. I even made an order and easily got a syringe/needle plus an ampoule of novocain while I was seated on my motorbike stopping at the edge of a street. It cost one thousand VND5 for everything. During the in-depth interviews and FGDs whenever I asked any IDUs for a concrete address of a pharmacy store that they often went to, it is not difficult for them to tell.

FGDs also discussed a question about syringes/needles issues. All four discussions agreed very quickly that syringes/needles are very available and accessible to IDUs. In addition, the discussions confirmed that there is no discrimination against any IDUs who counter pharmacy stores to buy syringes/needles: “Pharmacy stores do trade so they must sell. They always look forward to customers” FGD (I).

If one has money and goes to pharmacy stores, definitely he/she will get a syringe/needle without any difficulty. However, when being asked in-depth about whether IDUs always could buy syringes/needles at any time from any pharmacy store, they replied that most of the stores close in the late evening, between 8:00pm and 9:00pm, and that pharmacy stores, which are open all the day thanks to their good locations in busy areas in front of big hospitals, are often far from places where IDUs spend the night and inject. Therefore, pharmacy stores are indeed not accessible for IDUs at night. For example, some said that IDUs even had money to take a “motorbike taxi” ride but “it takes a long time” or “we are lazy”, so they failed to go there to buy syringes/needles at that time. In that case IDUs who inject at night and do not have any syringes/needles in advance challenge a difficult consideration: to share a syringe/needle or not. As I13 who spends the night everyday at a roundabout said: “At night it is impossible to buy [syringes/needles] except you go to [a confidential hospital]”. Exploring this topic further, I13 told me:

I13: At night it is impossible to buy syringes/needles so they [other IDUs] share.

R: Have you ever seen such a sharing?

I13: At night? A couple of nights ago I saw some sharing right at [a confidential roundabout where I13 spends the night everyday]

R: Why didn’t they inject during the daytime but at night?

I13: Because they stayed up late and injected at night. Whenever they have money they will inject.

R: It is impossible to buy [syringes/needles], isn’t it?
Il3: Truly it is still possible at night. However, they don't have any vehicles or money to go to selling places, so they shared. Two and three shared one single syringe/needle. During the daytime, it is rare.

R: Why didn't they buy syringes/needles when going to buy drugs?

Il3: They bought drugs at late afternoon and kept it but they found it difficult to sleep. They met friends and invited each other [to use drugs]. The host didn't have syringes/needles but his friend had one, which he hid under bushes. "I have a syringe/needle" [one said]. Looking for water is easy. There is a night tea stall in a street nearby. Ask for a glass of "nuoc loc" (cool boiled water) you can exceed your need [for dissolving drugs].

Syringes/needles are very available and accessible to IDUs at pharmacy stores during the daytime, but it is not true at night from emic points of view. The above-mentioned statements about the availability and accessibility of syringes/needles at pharmacy stores during the daytime are justifiable and understandable. Vietnam is now moving towards a market economy and therefore more and more products are becoming available and accessible to any customers, of which syringes/needles are included. In addition, the relation between the buyers and sellers is on this basis: the better price and the better service, the more clients come. The context also facilitates the syringes/needles accessibility to IDUs since the city life provides more freedom and pharmacy business is controlled by the pluralism. In that situation IDUs can have more choices to go to any pharmacy stores that they like. Besides, relatives, friends and neighbors keep less of an eye out on IDUs compared with their rural counterparts. However, it is undeniable that pharmacy stores do not consider IDUs as their priority target clients. Syringes/needles are not the only pharmacy stores' goods to be sold. Therefore, most of the pharmacies are not open to serve this marginalized group at night.

The second syringe/needle selling place is within "the shooting area". This place is in the open-air and is well-known by every IDU in this study and many of their peers as well. It is probably a unique one because IDUs can buy syringes/needles and some other injection items right after getting a heroin package in "the shooting area". IDUs are supposed to inject afterwards rather than to take drugs with them when leaving. They would be at risk of being arrested by police if they did so.

Below is evidence of my participant observation regarding how IDUs get syringes/needles in "the shooting area":

At around 12:15pm I followed Il3 & Il4 entering "the shooting area" through a dead-end alley. Three of us joined other drug
users to come in. Il3 and Il4 walked ahead while I kept a very short distance behind. I just walked around for ten minutes first and saw a woman, who was standing at the right edge of the alley, and selling packages that were kept inside a used box of "vina" [a popular brandname of cigarette in Vietnam] for around five people. Customers gave money first and in return the woman handed over little packages. Il3 went through the same scenario and took the task of buying drug. At that moment Il3 moved forward and leaving Il4 and me behind a bit. Il3 approached closer, giving money to the woman. Very quickly she rewarded a little package to him. It took only some seconds to do the transaction.

Three of us passed the woman. Right after that Il3 asked me "Please give us three thousand [VND] for syringes/needles". He passed this amount of money to Il4. This time Il4 took the lead. Less than ten meters further and right in the middle of a cross of the alley were squatting three other women. They were selling something. At the moment Il4 stopped and was asking a sales woman, another man appeared and asking Il3 whether he wanted to pool money to buy a "phen" [an ampoule of pipolphen] with him or not. Just saying a few words with Il4, Il3 turned to the man and nodded. The man gave to Il3 five thousand and again Il3 gave that money to Il4. When Il4 and the woman were exchanging, I saw three women selling plastic disposable syringes/needles, distilled water, novocain, pipolphen and cigarettes. It is noted that at that moment I didn't see three women selling seduxen but many IDUs affirmed later that they were doing so and I got a used ampoule of seduxen as an artifact from "the shooting area". Three women were keeping injection items in their hands and bags. After paying the money three of us and the man continued to move further, around 10 meters on the left to find a space for injections. While walking I asked Il3 very quietly but loudly enough for the confirmation: "What did he [Il4] buy and how much?". He replied to me in the same manner: "[Il4] bought two "xi" and two "vina". It cost three thousand [VND] and "phen" cost ten thousand. Today we will use pipolphen instead of water [an ampoule of distilled water] or "nővő" as usual". He continued to add: "If you bought a "xi" and a water or "nővő" here it would cost one thousand and half, and it
would cost two thousand for the same plus one “vina”. I bought heroin, a thirty thousand package”.

Many IDUs told that syringes/needles and other injection items in “the shooting area” were sold even at night or “24/24 hours”. However, some IDUs also revealed that syringes/needles sometimes might not be sold at night because of some reasons. First, syringes/needles sometimes would run out at late afternoon or evening, therefore the sellers cannot order them in a timely fashion or get syringes/needles immediately for that night. Second, the sellers sometimes do not serve very late, like this statement: “Sometimes, it is too late to buy syringes/needles there” (I19).

A few tea stalls and grocery shops nearby places where IDUs often inject sometimes sell syringes/needles. Only a few among in-depth interviewees have ever bought syringes/needles there. Both the sellers and buyers are usually similar to each other. For example, IDUs buy cigarettes, drink teas or are around there daily. In addition, these tea stalls and grocery shops often close very late at night. These stalls/shops often charge more for syringes/needles than pharmacy stores do. These places just serve as back-ups in case IDUs cannot buy syringes/needles from pharmacies.

Lastly, with regard to the availability of syringes/needles, there is the issue about some particular places where drug users are forced to stay for different reasons. In these places drugs are somehow made available underground meanwhile syringes/needles are definitely difficult to obtain and injections are very strictly prohibited. As a consequence the sharing of a syringe/needle is unavoidable there. IDUs in this study told some stories regarding their sharing due to no availability of syringes/needles in some of drug treatment centers, incarcerated camps and prisons where they used to stay. An in-depth interviewee who has ever shared a syringe/needle in an incarcerated camp (this man has been in prison for 3 years, from 1997 – 8/2000) told us this:

Ill: I even still injected drugs inside [a confidential camp], usually with “black” [opium]. Their [his cellmates] relatives came to see and bringing some gifts “just help them have funs” [his cellmates].

R: You said you had ever shared there. Where were syringes/needles from?

Ill: Went to the camp’s health station and stole one when we were sick or visited the station. They injected and threw the syringe/needle into a bin. We took one for use. Tens used one. The condition was not permitted there. We cannot buy [syringes/needles] even though we have money, therefore we have to
Of course syringes/needles are very available at every pharmacy store [outside].

In summary, syringes/needles are very available and accessible during the daytime in the city. IDUs easily can get it from many pharmacies along the streets, in front of hospitals and residence areas, and even from "the shooting area". In addition, IDUs also can buy it from a few of the tea stalls and grocery shops. However, because of many different reasons, which include "couldn't find money during the daytime on that day", "go gambling or return from gambling at night", "difficult to sleep", "previous injections during the daytime didn't make him get "high"", "working at night", and so on, IDUs inject at night when their access to syringes/needles is still difficult. In addition, syringes/needles are definitely not available and accessible within some centers where IDUs are forced to stay while drugs are somehow made available. These entire realities make IDUs, more or less, share a syringe/needle.

**How to Clean and Dispose**

If a syringe/needle is not cleaned properly, it obviously will harm any IDUs who re-use it. In a broader sense, the re-use of an unclean syringe/needle also means sharing it. Frontloading between a new and an old syringe/needle as well as between two old syringes/needles put IDUs at risk for HIV/AIDS infections, again if the old one is not clean. Therefore, it is necessary to discuss the way IDUs clean syringes/needles for re-use. It is also important to raise the issue about how IDUs dispose their used syringes/needles. The justification is that, to some extent, the more available improperly disposed syringes/needles, the more likely IDUs re-use them. Last but not least, if used syringes/needles are thrown wherever IDUs like, this improper disposal definitely imposes a biohazard to our community. Now let us see what IDUs are practicing in reality through stories told by IDUs themselves in this study and through my observation as well.

R: Please tell me about how your sharing is?

Il7: Put [drugs] into a single syringe/needle and share it. Like this, draw water and then dividing into two [parts]. Push a half into an ampoule of "nővő". One ampoule of "nővő" often contains either one "phân" (miniliter) and six "ly" (one tenth miniliter) or two "phân". If one "phân" and six ["ly"] each would have eight "đen" (one tenth miniliter), and if two "phân" each would have one "phân". Push one "phân" into that [used] ampoule of "nővő". After injecting, one reuses that "xi". Just resin it for invisible blood.

R: Clean by what?
I17: Water.

R: Where is it from?

I17: Sometimes I ask for “nuóc lọc” (cool boiled water) and sometimes get it from other peers who also buy drugs and an ampoule of “nôvô” or distilled water. Draw it. Some may inject with much water while some with little. With one thirty [thousand VND] package [of heroin] some only use some “đêm” (one tenth miniliter) of water. In that case there would be around one or more than one “phân” [water or “nôvô”]. So ask for it and use for cleaning. If blood is invisible it would be fine.

R: Have you ever shared like that?

I17: Yes.

In addition, below is a thick description about the way an IDU cleaned his syringe/needle, which is a note of my participant observation in a roundabout. Is his cleaning proper or not? Let us go through the following.

This afternoon I hang out with some IDUs in a roundabout. When talking with an IDU whose age is below 30 years old, by chance, I did an observation on the way he cleaned his syringe/needle. It was around 3:00pm then.

Talking for a while, he took a little white paper package out of his chest pocket. Perhaps it was invisible from any other directions since both of us squatted on the ground and faced a stone bench just in front of us. He opened the package. There was a little white powder on the small square-size white paper. I asked him:

“What is it?”


The man divided the amount of heroin into two parts by carefully, using a razor, the brand name of which is CROMA (made in Germany). He told me after I asked about the amount of heroin in the little package: “I bought a thirty thousand [VND] package and just
injected one third a couple of hours ago”. He stopped for a while to open a nylon plastic package, which contained a used syringe/needle and continuing: “Now I want to inject one more time because the previous injection didn’t make me “phá” (“high”). The rest is for the next use this evening”.

After the completion of injection with three times of “kich” or “hôi” (jacking), he rinsed his syringe/needle with a little amount of distilled water left in the ampoule, less than one milliliter. At that moment I even saw that his syringe/needle was still in red. He put it back to the original nylon package and wrapping it with a piece of a newspaper. Definitely the syringe/needle was not cleaned. I asked him:

“Why do you wrap it?”

“I still use it”. He answered.

“Why?” I continued to ask in a curious but intentional manner.

He said: “It is still sharp, so I don’t have to buy a new one”.

I asked: “Have you ever brought a syringe/needle, which you have used before or like this one [the one he has kept inside the piece of newspaper], with you so as to divide drugs when you pool money with your peers?”

“Yes, sometimes”.

It is obvious that once an IDU resins a syringe/needle he/she or someone will re-use it. No one can be sure that he/she will not reuse it to frontload drugs with his/her peer’s syringe/needle when pooling money. In that case it puts IDUs at risk for HIV/AIDS infection. I will continue to discuss the importance of this issue in the part of frontloading in the chapter 4.

During this study I had not seen any bleach or disinfectant solution that IDUs should use to clean their syringes/needles. Only a few mentioned that they disinfect their syringes/needles with boiling water that is not easy for IDUs who live on the streets to have.

Disposal of syringes/needles is also a concern. IDUs in this study told a long list of places where they inject and throw their used syringes/needles, of which many places are cited with specific addresses. The places they inject and throw their used syringes/needles away are the same. The list includes open-air grounds in
“the shooting area”, from large to small green parks, roundabouts, lanes or alleys in residence areas, pavements of quiet streets, sides of lakes or ponds, under fly-over, under bridges, areas where people throw their wastes, public toilets, and so forth. It is true that many used syringes/needles are seen on the grounds of all these places.

R: Where can someone usually buy drugs?

II3: There must be many different places, but we may not know all. Once it is known they will go to buy, and inject at any places that are “convenient” since injection is easy. It looks as if we make water. Just open up and roll down [trousers] they can inject at once. No one can see.

R: What about the used syringe/needle? Where do they dispose it?

II3: Just throw it at the place we have just injected?

R: In that case people will know it is an injection place, how can you do it?

II3: Generally speaking, if people know let it be. How we can know to do.

Since used syringes/needles are visible on many grounds, health workers once again have to face with another problem: reuse among IDUs.

II1: There are also some people who want to spend their one thousand [VND] to buy cigarettes and drinks, and they also think that they have already acquired the disease [HIV/AIDS] [rather than buy a syringe/needle]. Therefore they pick up used syringes/needles that have been thrown in alleys [in “the shooting area”] to reuse.

I also realize that IDUs never cap the used needles before throwing them away. Therefore, it definitely risks the health of people who unintentionally step over it. In many of the places above, I myself see a huge number of used syringes/needles but no one cares about it. In addition to the improper disposal of used syringes/needles, used ampoules of distilled water, novocain solution, sexuden, pipolphen are also thrown away and easily seen on the grounds of the same places. It definitely requires us to find an appropriate way to solve the problem.
burglary, deception, sex work, gambling, and income from labor or dependence on family members. Age and “where to spend the night” variables are associated very closely with the way IDUs get money.

Ten out of 20 in-depth interviewees whose ages are below 33 years old admitted very frankly that they usually stole items from either streets/markets or their families (one female sex worker is included while one IDU who does steal is excluded because of his age of 36). In addition, nine among these ten IDUs are now living on the streets. The stolen items include bikes, home appliances, motor helmets, raincoats, spare parts of motorbike, construction materials, fruits, cloths, and so on. Money acquired from these items usually provides IDUs with only one to a few injections; therefore they have to keep stealing for their “incomes”. Like other IDUs in this study, II4 frankly told me about his “income generating” strategy (during my fieldwork period he was arrested by police when he was stealing in the streets).

II4: I frankly tell you that this career [drug injection habit] is never honest. Honesty is possible unless I am not addicted.

R: When stealing something you are not afraid of the risk of being arrested, are you?

II4: It is subject to be arrested. I must endure.

R: Have you ever been captured?

II4: Sure.

R: How did you do then?

II4: Just ask for their forgiveness. Generally speaking, for a raincoat they [people who captured him] didn’t think it was worth taking me to the authority or a ward, but something bigger maybe...

I did my observation on II3 and II4. It is true that they frankly told me how they can get money for their drug injection habit. Below is a fieldnote relating to their burglary:

At 11:30am I finished my in-depth interview with II4. I took II4 back to the roundabout where I met him and II3 early this morning. II4 and I met II3 again there. Upon their agreement I took both II3 & II4 to “the shooting area” where they go back and forth several times a day and where I hope to be able to do my observation on drug injections.
I took them on my motorbike to "the shooting area". On the way, both I13 & I14 told me "You stop nearby [a confidential market] because we need to sell this motorbike spare part". It is a small made-of-rubber spare part of a "made in Italy" luxury motorbike that they stole before. I13 and I waited around ten minutes when I14 went to the market to sell the spare part.

Before I14 got on my motorbike again he said to I13 "I have sold it for thirty five thousand [VND]". I13 responded to I14 by nodding his head, and said "O.K and let's go".

At around 12:15pm I followed I13 and I14 entering "the shooting area" where I saw them using that amount of money to buy a little package of heroin and a half of pipolphen ampoule, which is shared with another peer. Heroin and pipolphen definitely cost $35,000 VND in total besides I13 also asked me for three thousand VND to buy two syringes/needles and two “vina” cigarettes.

Continuously, out of nineteen IDUs who do not steal, five get money by gambling; one female IDU sells sex and sometimes steals as well; one couple (husband and wife) deceives male sex clients by pretending as a female sex worker; besides some IDUs also tell lies to get money from their peers and their families.

R: How much money have you just pooled?

I18: Fifteen thousand (VND) from an amount of money that I got for my breakfast and for some food I was supposed to buy for my family's dinner today.

R: Really. How much money did your parents give to you?

I18: Twenty two thousand [VND]

R: You spent fifteen thousand for drug, didn’t you?

I18: Yes.

R: What else did you buy?

I18: I spent for "motortaxi" ride, "xi", cigarette and drinks.

Nine among ten IDUs whose ages are equally or over 33 years old (as noted before, one IDU at the age of 36 steals) get money by working or they get it from their family members. When being asked all the middle
R: Where do you get money from for your injection habit?

I24: Each person in my family gives me a little and I fast from food in order to meet my injection habit.

R: Can you tell me more specifically?

I24: My brothers and sisters sometimes give money to my mother. But she is old enough and loves me so she gives me a part of that money [laughing]. For example my brothers and sisters give her two hundred [two hundred thousand VND]. But she is old so she doesn’t spend so much, only fifty [fifty thousand VND]. She gives me the rest, one hundred and fifty [one hundred and fifty thousand VND]. I keep and spend it for some-day drug use.

Sharing: An important question is does the issue of money itself play any role in driving IDUs to share syringes/needles? Definitely it does. IDUs have different reasons for their sharing of syringes/needles.

First, IDUs told that at the moment they need to inject immediately (they are craving) but they had little money in their hands that is only enough for “câm nghi’en” (overcoming a craving status). No money left is for syringe/needles and IDUs cannot find any more meanwhile they cannot delay “bự chích” (a “scheduled” injection or “meal”) any longer. Therefore, they share syringes/needles. Look at a story below from one of the in-depth interviewees:

R: I want to ask you a question that is surely not harmful to you at all. Have you ever shared syringes/needles since you began to inject?

Il5: [Silent for a while] Yes.

R: In what circumstances?

Il5: The incident is due to the fact that I had no money left on that day and it happened at night as well. Two brothers [i.e. Il5 and his peer] had only one “xi”, so we shared.

R: How long ago?
I15: Around half a year ago?

R: Does it happen often or not?

I15: No. "often" is not, just a couple of times.

R: Please tell me your reasons "why" and how that situation was?

I15: We had only fifty thousand [VND] on that day. Two brothers went to buy drugs [in "the shooting area"]. After buying drugs, we had no money left to buy syrines/needles. Unfortunately it happened at night and how we could do...

R: What was the time then?

I15: It was between 1:00am and 2:00am. Luckily my friend had a syringe/needle in his pocket. So we put drugs into the syringe/needle and shared it.

R: Was his syringe/needle new or old?

I15: A new one.

R: Why was the syringe/needle ready in his pocket?

I15: He kept it for just in case.

R: Whose money on that day?

I15: We both pooled that amount of money to buy drugs but the syringe/needle was his.

R: How did you prepare the drug?

I15: Disolved it with water, drew two "phan" (milliliter) and then I injected it into his vein. I used the syringe/needle to inject into his vein. Push it until one "phan" left. Took it out and then it was my turn.

R: Why did you share at that moment?

I15: At that moment I had no money left to buy a "xi" therefore I was induced to do so.
R: Why didn’t you inject for yourself first but for him?

Il5: It was his syringe/needle so I did for him first.

R: You aren’t afraid, are you?

A: I was “vật” (hungry of drugs) at that moment.

The second reason for sharing is that some IDUs do not have any money for their drug injection habits that are needed on a daily basis and they depend so much on drugs. How do they solve this situation? They kept asking for drugs from their drug injection friends, and even any other peers both inside and outside “the shooting area”. However, they often asked someone in “the shooting area” more often since the area is visited by many IDUs and it is also a place where IDUs are supposed to inject after buying drugs. Below is a story representing similar stories told by IDUs. A young in-depth interviewee told me he had given a smaller half of his drug in a syringe that he was using to his older drug injection peer in “the shooting area”.

Il8: Yesterday I also gave drug. His body was shivering then.

R: How much drug did you give?

Il8: He is as old as my father. Goosebumps appeared on his limbs... He was shaking and all goosebumps appeared. He was sweating as if he had a bath. He said “I am too “vật quá” (hungry of drug), “con” (son or means Il8) give “bố” (father or me) just a bit. You cut down on [your dose]... he didn’t have any “có xi có xiếc” (syringes/needles or something like that)... you keep “dâm” (injecting) and just cut down two [or] three “vạch” (one tenth milliliter) for father (him). “Bố” (father or me) bench my knees down in front of “con”, and so on. There were many people for whom he didn’t ask but me. I had to pool because I didn’t have much money. Anyway I left a smaller half for that man at that moment.

R: Did you get “phê” (“high”) then?

Il8: Not at all. I left a bit less than half.

R: Did he inject immediately?

Il8: Yes immediately.

Similar stories were often told by IDUs. Please refer to two other stories below:
I17: Have you ever been asked by someone to give your drugs left in your syringe/needle that you are using?

I17: Yes

R: Is it very often?

I17: No. It takes a long time to have one. Just "sometimes".

R: You mean you have given your drug left in your "being-used" syringe/needle, haven’t you?

I17: Yes. Suppose I have one “phân” of water [and drug] in my syringe/needle. I shake and beginning to “chôì” [inject]. When I am piercing he sees me and saying: “I am “vât quá” (so hungry for drugs) please leave three, some “đem” (one tenth milliliter) for me”.

And:

I25: I mean (coughing) when I am injecting like this he appears and says “I am “vât quá” (very hungry for drugs), please give me a little”. But I say: “I have already injected into my body and now there is blood inside the syringe/needle”. However he says: “Though blood, I still “chôì” (inject)”. That is why I left two “đem” (one tenth milliliter).

In summary, when being asked a question “why do you share syringes/needles?” many IDUs responded in a short and decisive manner “I did not have any money at that moment”. My analysis put their short answer in their own context to have a deeper understanding. IDUs depend so much on drugs. They even call it as a “būa” (“meal”). They travel back and forth to “the shooting area” several times a day. The first time is very early in the morning: they just wake up and go if they have money in their hand (they often should prepare a readiness for it since the prior afternoon or evening). An IDU often requires an injection at least from one “chông vât” (overcoming a craving status) to three or four times (to get “high”) a day. Each IDU often spends from thirty to fifty thousand VND per day for their “modest” demand of heroin injection excluding money for their transportation back and forth to “the shooting area” (also several times a day), and for other injecting items and basic food for survival. I see that IDUs do not even eat fast food, go “on and off” or have a very simple food for their daily life. They do not care about their hygiene, clothes, and so on. All money they get is just for their heroin injection rather than any other needs. Meanwhile the majority of IDUs do not have jobs and consequently they do not have stable incomes, and many of them live on the
streets as well. Therefore “At that moment I had no money left to buy a “xi” so I was induced to do so (to share a syringe/needle)” or “Though blood, I still “choi” (inject) with a used and contaminated syringe/needle)” is challenging IDUs themselves and HIV/AIDS prevention work.

Pooling Money

“Chung tiền” (pooling money) in Vietnamese language means more than two people contributing their money jointly buy something that they need. Practically there should be at least two prerequisite factors for that people rely on to decide whether or not to pool money: (1) people can use the goods together; (2) the goods must be dividable for individual use. In discussing about the pooling of money in drug use, let us look at an intertwined relation among the goods, the buyer and the seller for that a decision to pool money usually will be made.

For the goods: it is an object for which the buyer would think about before making a decision on their pooling. Factors regarding the goods should include:

- The goods must be, of course, necessary for the buyer’s demand otherwise they will not buy it;
- Either the goods can be divided for individual use or the buyers who pool money can use it together;
- The goods may be much cheaper if the buyers buy it with a higher quantity;
- It is often difficult to keep or store longer for next or continuous use because of its illegal status and its nature (melting, quality loss, and so on).

For the buyer: it is a person who decides whether or not to pool money to jointly buy the goods. Therefore the buyer often relies on factors relating to his/her financial capacity, culture and responsibility. Specifically, these factors include:

- Whether or not the buyer has enough money to buy the goods with the fixed price or the fixed package;
- Whether the buyer can easily find other people to pool money with or not;
- How to keep the pot (pooled money) safe;
- How to guarantee getting a fair share,
In case others know the buyer easily affords the whole package of the goods, the buyer may be afraid that other IDUs will ask for his/her donation meanwhile an excuse for the refusal is impossible;

- Whether it is beneficial to the buyer’s spirit if the pooling of money with others to buy and use the goods together;

- Whether the pooling brings him/her any risks regarding legal responsibility and health.

For the seller: it is a person who make a decision to sell the goods with the purpose of maximizing their profit but reducing their costs as much as possible. The seller often considers the quantity of the goods that should be packaged for retail sales.

As mentioned earlier, pooling money is very common among all 30/30 IDUs who were interviewed in-depth in this study, and so is it for the FGDs participants. Most of IDUs pool money to buy heroin, while some also buy other items like syringes/needles, distilled water, novocain solution, cigarettes and drinks. The pooling of an IDU’s money to buy drugs has just appeared within two and three years ago according to the FGD (II).

At present there are two fixed prices, which are the most popular, for heroin packages sold in “the shooting area”. The smallest package in a small piece of the white paper costs thirty thousand VND while the bigger package in some different color papers is fifty thousand VND (Please see annex 6 on pages 85 and 86). Some IDUs evaluated that the amount of heroin in the package of fifty thousand VND nearly doubles in comparison to that in the package of thirty thousand VND. So it can assume that the price would be a bit cheaper in the package of fifty thousand VND. Additionally, two other small transparent nylon bags with much more heroin are also present in the market; however, heroin dealers only sell these two bags to a very limited number of clients. A bag with a half “phan” (one “phan” means one centimeter long) heroin costs 120,000 VND while the bigger heroin bag (one “phan”) costs 220,000 VND. Clearly one “phan” heroin bag is sold at a cheaper price in comparison to the bag with a half “phan” heroin. In addition IDUs reported that the price of heroin has increased from six years ago. Some said the heroin amount of the present fifty thousand VND package is perhaps similar to that of the past twenty thousand VND package. Anyway it is somewhat right since inflation has been a reality over the past years in Vietnam. The exchange rate went from 10,000 up to 15,000 VND per USD in 1995 and 2001 respectively.

No IDU in this study can use a heroin dose of fifty thousand VND for a single injection because this high dose may risk their lives. There is evidence that some IDUs who have injected with this high dose by dividing by two within one-hour interval have experienced overdose shocks but luckily survived.
Usually two IDUs pool their money to buy either a thirty thousand or fifty thousand VND package of heroin, or sometimes three IDUs do the same to buy a fifty thousand VND package of heroin. Besides, it also happens that three IDUs also pool money to buy the thirty thousand VND package or four to buy the fifty thousand VND package. However this is the case when IDUs fail to find money more and obviously this shared amount of heroin just helps them temporarily overcome their craving for heroin.

R: When pooling, which package of heroin do you often buy?

I7: Fifty thousand [ VND] for three people

Besides the amount of money paid for heroin, in fact IDUs also have to spend some more money for their transportation costs. If one has “plenty of” money, the drug injector can go to “the shooting area” by “motorbike taxi”, which costs from five to ten thousand VND for an individual’s returned travel depending on the departure place or even on the changes of the market services. If one has less money the drug injector can go there by buses, which are only available during the daytime. This costs two thousand VND for a returned ticket from any departure places. If one cannot afford for these kinds of transportation means the drug injector has to go there on feet, which is a reality for many IDUs.

IDUs usually go together to buy drugs when pooling their money. This is considered as a precautionary measure against money loss since their peer may disappear if one just gives money and waits, which is discussed in the chapter 5.

IDUs have some specific reasons to pool their money to buy heroin:

1) The first reason for pooling money, which is most commonly expressed by many IDUs, is due to their money shortages to buy the whole package with the fixed price mentioned above.

R: How much money do you spend for drug for a day at present?

I7: At present I only spend [ from] thirty thousand, [ to] fifty thousand [ VND].

R: In that case you have no reason to pool money with others to buy drug, don’t you?

I7: I ask [ tell] you this when I have only ten thousand or fifteen thousand and I can’t find more, so I have to pool.

And:

R: Have you ever pooled money to buy drugs?
I28: For “bữa trưa” (“lunch meal”) I have to pool because I don’t have enough money by that time. [But] for “bữa chiều” (“dinner meal”) I have [enough] money [so I don’t have to pool].

2) The second reason for pooling money is that some IDUs are in “co-ownership” of an amount of money that they get from their burglary. This reason is especially more popular for many of the IDUs who are young and living on the streets. I13 and I14 who have their daily lives on the streets frankly tell me that they steal something every day for then they have money to buy heroin (note: in this part they are viewed from another perspective regarding their reason for the pooling):

I13: Both of us [I13 and I14] stole a pair of scaffolding for construction work and sold it for eighty five thousand [VND]. Our work was divided, each stole one. We bought a fifty [thousand VND package of heroin]. We went together and injected right there [“the shooting area”].

And:

R: What time did you get up this morning?

I14: We both got up at 4:00 or 4:15am. By “đi chộ” (stealing) we had sixty thousand [VND]. A “motorcycle” ride charged us seven thousand [VND]. We both bought a five [fifty thousand VND] package and two “xi” [Two ampoules of distilled water or novocain solution] [charged with] three thousand [VND].

3) The third reason for pooling money is that the amount of heroin sold in the fixed package is higher than IDUs’ needed doses since they have just begun to inject. However, only a few IDUs reason it for pooling their money to buy heroin.

R: Did you pool money yesterday?

I26: Yes. Frankly I have just begun [to inject] so I cannot use the whole thirty thousand [VND] package. For smoking I can but for injecting it is impossible.

4) The next reason for pooling money is safety and avoidance of a risk of being arrested and robbed. IDUs do not want to keep heroin in their pocket even though they can afford to buy a large amount of heroin. Some tell that they do not manage to use heroin properly if the drug is always available in their own pockets. In addition, IDUs also tell that they do not want to keep heroin in their pockets for their next uses
because it is an illegal drug that may easily put them at risk for being arrested by police and because heroin is easy to spoil if it gets wet as well.

5) When IDUs pool money to buy heroin they also use it as a reciprocity strategy. If they contribute a good share this may help them get the drug if they do not have any money left or do not have enough money to buy a needed dose of heroin in the future. In that situation they can ask for a free injection from their close peers or for a higher amount of money from their peers to pool. That is a just cause for which heroin is divided into the same amounts even though one may pool less than the other does. In fact, by contributing a higher amount of money when pooling but while getting the same amount of heroin, they buy credit for the future. This kind of pooling and heroin division is often applicable for those who consider themselves as close friends and know each other well. In contrast, IDUs will divide heroin on the basis of "pool more get more" for other relations.

R: How much money does each pool?

I7: One pools twenty thousand, the other ten thousand and one twenty thousand [VND]. One who has more money should pool more. This time reciprocates the previous time.

R: How do you divide drug?

I7: It is the same for everyone

R: One who has pooled ten thousand gets the same with the one with twenty thousand, why is that?

I7: We should rely on each other to survive because sometimes they have money less but we have more.

6) Many of IDUs tell that they pool money to buy heroin without sociable purposes. Rather, they pool money to buy heroin with their practical purposes. I have heard and seen several times about how IDUs find a person to pool money to buy heroin in "the shooting area". They call each other rather loudly "Chung di" (Let's pool), or "Ai chung khong" (Who wants to pool?). Indeed, it is not difficult for IDUs to find their peers both outside and inside "the shooting area" to pool money to buy heroin. For example, one in-depth interviewee said to me:

R: Do you often pool money with strangers or acquaintances?

I18: To pool with an acquaintance you have to wait until the next year harvest of ripe tangerine.

Or:
R: Do you closely socialize with them [I1, I2, I3]?

I7: No. I don’t. Just a bit socialization. I don’t have any close relations with them. I just pool money with them when I don’t have enough money.

Sharing: Does the pooling of money itself put IDUs at risk for HIV/AIDS infection? Yes, it does. Let us look at a story below told by an in-depth interviewee:

I19: This morning I had to share [a syringe/needle].

R: Why?

I19: Because I had only fifteen thousand [VND] when I pooled money to buy drug. I had only fifteen thousand.

R: Why didn’t you find more money rather than only fifteen thousand to pool?

I19: I had only fifteen thousand and another man had thirty thousand [VND]. I had to be precautionous so I said to him in advance “Well please offer me a syringe/needle”. His name is [confidential], and perhaps his home is in [confidential]. He has to move from one to another gamble place. He loses gambling so he has to move. He said he had thirty thousand left. Didn’t worry. His exact statement is “You don’t have to worry about the issue of “xi”. Look at me. I have to spend a lot of money to buy drugs but I don’t mind about it”.

R: You mean before both of you pooled money he did say so, didn’t he?

I19: I mean I didn’t have enough money and I had to be cautious by asking him so. When drug was already bought but he said: “I didn’t have any money left, either. Well let’s share. I don’t have any diseases”. Well the situation is that money has been pooled and drug has been bought. Should I say “I won’t inject” or just let him [inject]… or how. It is an embarrassing situation at that moment. In fact in my mind I don’t want to share at all. I don’t know you have a disease or you don’t, but I don’t like to share. Well it has happened. It is a reason for this morning case.
R: Where is a syringe/needle from?

I19: That man has.

R: Is it new or old?

I19: He said it was new.

R: Did you see him tearing the package?

I19: I didn’t see him tearing but he said it was new.

**Frontloading**

The division of heroin in the form of solution is a common practice in this study (a reason given will follow), or more concretely I should say it is a daily practice among most IDUs. The practice has been described and considered a risk for HIV/AIDS infection by previous investigations in different parts of the world. The practice is termed as frontloading, and also known as backloading. All IDUs in this study frontload heroin solution between two syringes/needles or, in other words, the drug is divided by frontloading.

So what is a frontloading? In reply to this question, I borrow a short but clear description about it written by a Dutch researcher who did a study among IDUs in Rotterdam, the Netherlands nearly ten years ago. It reads: “The practice involves a special technique using two syringes. When sharing by frontloading, heroin is prepared on one spoon and then drawn in one syringe (A). From the second syringe (B) the needle is removed and the plunger is drawn back and by spouting a part of the solution from syringe A through the hub of syringe B, the drugs are divided. In this way the drugs can be divided into two or more equal parts” (Jean-Paul C. Grund, 1993:150).

Why do IDUs divide drugs by frontloading? This study finds a number of reasons for IDUs to do so. First, two IDUs usually (maximum three or four, but rarely) pool money to buy a thirty or fifty thousand VND heroin package (the two most common packages) and need an immediate injection afterwards; therefore they then divide the drug (except they intend to share a single syringe/needle and the pooling is done between one injector and the other smoker). Second, IDUs also tell that the division of heroin in the form of solution ensures the equality between those who pool money, and avoid the loss or waste of the drug during the steps of division as the amount of heroin solution to be divided is so small – each IDU often needs from a half to one milliliter.

R: When pooling do you divide drug in the form of powder or solution?

I21: Solution.
R: Why is that?

I21: Because it is more equal.

The equality is considered as an important reason since there is additional evidence to support it. Some IDUs say that sometimes they see their peers exchanging "heavy and light words" about the inequality during the drug division. Lastly, in case one who has heroin wants to offer it in the form of solution to his/her peers, they do not want to share a single syringe/needle, and the drug needs to be divided, too.

In comparison with the frontloading, which was commonly seen among IDUs in the city of Rotterdam (Jean-Paul C. Grund, 1993:150), my study finds the frontloading steps a bit different. Heroin is dissolved in a syringe/needle rather than on one spoon and then drawn into one syringe. In addition, IDUs in the city of Hanoi dissolve heroin in a simpler way: they just put heroin into a syringe, draw either two milliliters of distilled water or novocain solution (the most common), or seduxen or pipolphen (much less common) before thoroughly shaking it. On the other hand, IDUs in the city of Rotterdam mix lemon and water with heroin before boiling it on a spoon. A note below from my participant observation in "the shooting area" describes a representative situation in which heroin is shared by frontloading between a man and a woman whose ages are below thirty. They do not know each other but meet in "the shooting area" and pool money to buy a thirty thousand VND heroin package. Their frontloading is done between a new and an old syringe/needle (Please see annex 13 on page 94) that has put the man at risk for HIV/AIDS infection.

This is the third time I have done my participant observation on injection practice in "the shooting area" with the guidance of I15 & I16. It was around 4:00pm then and I15 and I16 have just finished their injection after they pooled money to buy a thirty thousand package of heroin. We all squatted on the ground together with nearly ten other IDUs. At that moment I saw a young man and a young woman coming in. I thought I should focus my observation on these two people since they were squatting just in front of me on the same ground.

Soon after their arrival the man and the woman began to divide their drug. The man took his syringes/needle out of his pocket while the woman was holding a syringe/needle in her hand. The man's syringe/needle was definitely new but the woman's syringe/needle was perhaps old because I didn't see her tearing off a nylon package then. They were syringes/needles with three milliliters volume size. The man pulled the plunger out of his syringe and then opened a white paper package, which was
definitely a thirty thousand VND heroin dose as the white color of the paper told the quantity of the package. While his left hand was holding the syringe his right hand emptied all heroin into it. After that he put the plunger back. While he was using the plunger to pulverize heroin a bit, the woman kept watching. The man began to draw out a novocain solution, but he didn’t forget to look how much it should be in his syringe. He drew two milliliters and then shook it well. Then he looked at the woman and said “Done”. Immediately the woman removed the needle from her syringe and then drew her plunger back. She also looked how far it should be, which was one milliliter. The woman nodded as a signal “ready” to the man. While holding his syringe/needle up he slowly freed air from it and later once again looked how much the solution in his syringe. After that he carefully inserted his needle in the woman’s syringe whereas she was holding her syringe in a lower position. The man pushed his plunger forwards slowly while keeping his eyes on the milliliter indicators on the barrel of his syringe. This ensured how much he should put over. The woman also looked interested in this drug division, too. Definitely I saw the man’s needle touching the drug, which was ready in the woman’s syringe. I also saw the drug in the woman’s syringe becoming red a bit at that moment. The red color was truly visible. Before the man stopped pushing the plunger, he said to the woman in an obvious and quiet manner “You are satisfied”. Both the man and the woman looked very quickly at their syringes as a comparison. They said nothing and stood up. All took around five minutes to complete. The woman moved forward a bit further and facing a direction that prevented other peers from watching her injection. She opened her trousers up, rolled it down a bit and injected, definitely, into her groin vein. Meanwhile the man did the same but stood right at the place he and the woman had just divided the drug.

Although IDUs have been asked, I do not see or hear anyone backloading. It is not practiced because all IDUs are using removable needles (fixed needles are imported, rare and often used for insulin injection) and the backloading may require a considerably more skilled hand than frontloading.
In summary, the frontloading in drug injection is of our interest since it matters for the risk of HIV/AIDS infection. This study finds that the frontloading is often done between either two old syringes or one new and one old syringe/needle. As discussed in the chapter 3, the old one is usually cleaned improperly meanwhile many IDUs do not know this kind of practice puts them at risk for HIV/AIDS infection. For a few IDUs who know about this risk I will discuss further in the chapter 6.

**Mutual Trust Among Special Partners**

In fact this study finds that some special partnerships induce IDUs to share syringes/needles. These partnerships include: husband and wife, sexual partners (often between a female sex worker and a man), close friends, IDUs neighbors and kin brothers. The sharing of syringes/needles among these kinds of partnerships was shared by many IDUs since they see it face to face in many places where injection practices are done, especially in “the shooting area”. On two occasions, I also saw the sharing of a single syringe/needle between: a husband and wife, and two sexual partners (a young female sex worker and a young man). I even saw it right away during my first participant observation in “the shooting area”.

I saw a young conjugal couple (a husband and wife) sharing a syringe/needle just before I interviewed them in-depth in an empty house in a large green park. The couple had just begun to live on the street for three weeks. With the help of the husband, the woman was deceiving male sex clients for money by pretending as a female sex worker. Both of them are very young, but have been using heroin for more than five years. They had been injecting heroin for more than three months.

The participant observation took place at noon then. I selected I29 (wife) and I30 (husband) from a roundabout with the introduction of a previous in-depth interviewee. Before taking this couple to a large green park that is some kilometers away from the roundabout for the in-depth interview, I saw I29 bending down to take a syringe/needle that was hidden under grasses, tiny trees and flowers behind a stone bench. We all went together on my motorbike. When we were in an empty house in a large park, I30 opened a thirty thousand VND package of heroin, a half of which was used before, and put it into the syringe/needle. He mixed the drug with two milliliters of distilled water and injected for the woman first. It was not easy for the man to locate a vein on the back of her left hand to pump since it took around five minutes. Like all other IDUs, he didn’t clean an injection spot on her skin before injecting. He pumped half of the drug. Immediately after the injection, he used the same syringe/needle for the woman to pump the drug left into his vein in the left arm. It was not easy
for himself either. It took him around five minutes to locate his vein.

After that I interviewed I29 and I30 individually. Both of them have told me their just causes for the sharing of the syringe/needle when I asked a direct question about their reasons for sharing.

Look at an explanation given by the wife:

R: Why don’t each of you use a separate syringe/needle?

I29: Actually he [her husband] said to me right at the beginning: “As a husband and wife we don’t need to [use a personal syringe/needle]. Suppose we have...[HIV/AIDS infection] we as husband and wife cannot avoid it anyway”. That is why I ignore it and still keep sharing. Because we avoid this thing but we won’t be able to avoid that thing. As a husband and wife shall we stay away from each other? We have to accept it.

Look at an explanation from the husband:

R: Why do you both share a syringe/needle?

I30: Generally speaking there aren’t any reasons at all. I tell you that the sharing or non-sharing is useless because we as a husband and wife must continue to have sexual intercourse. Therefore, if one has already acquired the disease [HIV/AIDS], the other still gets it regardless of the sharing or non-sharing. So the sharing or non-sharing is the same. Being as two men or two women they should use [syringes/needles] separately. If one doesn’t have sexual intercourse with each other, they should use [syringes/needles] separately.

Actually below is what I saw the sharing of a syringe/needle taking place during my first participant observation in “the shooting area”. This happened between a female sex worker and a young man.

It is the first time for me to follow I13 and I14 entering “the shooting area” with the only purpose to observe IDUs injection practices. It was at noon then.
The space I observed IDUs injection is around ten meters from the left turn from the intersection of the dead-end alley where syringes/needles, an ampoule of pipolphen and cigarette are sold. The space is actually small and surrounded by bushes and trees. On the ground there are many used syringes/needles, used pieces of paper that packaged heroin, used ampoules of distilled waters, novocain, pipolphen... There were seven IDUs then. They were busy preparing drugs and injecting. At that moment one young man and one woman came in. They sat down and prepared heroin immediately. They dissolved a thirty thousand VND package of heroin with an ampoule of novocain solution in a single syringe. The woman did it. Right after that, both stood up together. The young man streched out his left arm and ready for woman to inject. It was not difficult for the young woman to locate his vein and inject. She didn’t clean the spot of injection on his skin. She pumped a half of two milliliters of the drug and took it out. It perhaps took less than two minutes for the woman to inject for the man. After that the woman opened her trousers up and easily located “mã” (a fixed spot along a vein that IDUs always insert their needle) on her groin right vein. She used the same syringe/needle even without a little effort to remove a bit of blood in the needle by splashing it as some IDUs may do. She herself pumped the drug left to her vein. Likewise, she did so quickly. Just after their injection both left.

When they left two guys I13 and I14 told me that they cohabit while the woman is a sex worker.

The sharing between sexual partners (often between a female sex worker and a man) is very common since many in-depth interviewees and FGD participants told me similarities when I did a cross check. Below is an example:

R: Have you ever seen someone sharing syringes/needles?

I13: I definitely see it but the sharing often happens between a pair of a young man and a young woman who are sexual partners. I have seen it a couple of times rather than just once. Sexual partners or female sex workers and their male partners share
I have witnessed such sharing. They cohabit with someone in the roundabout (where I live and overnight). It is true two persons share one syringe/needle. I have seen it.

R: Why don’t they use a syringe/needle separately?

I13: I don’t know for that. They have an exceeding amount of money to buy new syringes/needles. They have an exceeding amount of money to use it separately. Perhaps they don’t like [to use it separately]. I don’t know.

Discussion about sharing is also among FGD topics. One IDU participating in FGD (I) told me he shared a syringe/needle only with ones who are his close friends or who he knows very well.

R: Have you ever seen someone sharing syringes/needles?

FGD(I): I myself even share rather than talk about others.

R: What circumstances do you share?

FGD(I): I don’t have a syringe/needle and a person who I share is truly trusted. That is my very close friend or a friend who I know very well and who has just used drug. It is not true for me to share a syringe/needle with everyone. That is a friend who I know very well and have a close relation.

A similar story told by I20 about his sharing of a syringe/needle. This sometimes happens between him and another man who is his neighbor. They live in the same street thus knowing each other well. In addition, they often pooled money to buy heroin.

R: Why do you share?

I20: Well. I have to understand about people who give me drugs [drugs left in a “being-used” syringe/needle]. For example, a friend of mine lives near my house, when the man began to use drugs and he injects daily together with me. That is it. In general only people who get along well with each other give drugs. Well I understand partly [about the donor] so I am not scared as much. Moreover, at the moment of a drug craving, I truly say that “Well I don’t care”.

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An in-depth interviewee told me this about the sharing of a syringe/needle between two kin brothers. This also happens in “the shooting area”:

Il6: One more story about the sharing. It is about two twin brothers whose house is on the street of [confidential]. They are two twin brothers. My god, “Just buy one [syringe/needle]”. “Why do we have to waste money”. “Why do we have to waste money”. They are called brothers [a pseudonym] at [confidential] of the street of [confidential]. They are twins. “Why do we have to waste money”. “Just buy one”.

R: Have you seen them sharing?

Il6: Not long ago in this place [“the shooting area”]. The twins have only one [syringe/needle]. They inject exactly like this: draw four milliliters, two for me. Finish it and taking the syringes/needle out. Two left is yours. Never buy two [syringes/needles]. Saved money to buy other things: drinks and cigarettes.

In summary, this study finds that a mutual trust among partners is dangerous for IDUs since it leads to sharing syringes/needles. The sharing happens widely and even daily since I saw it face to face twice, many in-depth interviewees and FGD participants do so and they see their peers sharing as well. Why is that? These special partnerships mean their bonds are more important than the disease. Even if they have money and they can easily access easily syringes/needles, but they keep sharing. The sharing demonstrates their close ties and symbolism. In addition, I think it may be related to the way IDUs see and translate HIV/AIDS infection into something far away rather than a real problem for themselves. Further discussion about IDUs’ knowledge, risk perception and prevention of HIV/AIDS will be in the chapter 6.
Chapter 5: DECEPTION IN THE WORLD OF DRUG USE

"Lừa bịp" (deception) in Vietnamese language means taking property away (heroin and money in this case) from someone without one’s consent. People who lose their property often do not realize their losses at that moment or may realize it, but cannot do anything rather than they have to accept it. Under law, people who lose their property (which should be valuable or worth being reported) can bring the case to the court against people who have taken their property after they failed to get it back.

The world of drug use also can be seen as the outcome of competition. Individuals who are involved in drug problems because of their financial profit or drug addiction attempt to reap maximum profit by deceiving. The deception in the world of drug use is a daily reality that causes drug users to lose either financially, medically, or both. In doing so, the deceivers put other IDUs and even themselves at risk for HIV/AIDS infections.

Fraudulent Heroin

Nearly all IDUs in this study reveal that they have bought fake heroin at least one to several times during their on-going drug use. It especially happens with young heroin users with a few drug use experiences, but there is also no exception for IDUs with more experiences. It also often happens when police aggressively raid areas where heroin is sold. In general, persons who sell pure heroin (real heroin dealers) will retreat or evacuate quickly at the moment of the raids. In contrast, the raids are good chances for some guys who dare to deceive heroin users to earn money. Imitation heroin sellers will be present right at the places where real heroin dealers often stand and sell the drug. By standing there, fake heroin sellers will be able to deceive more easily and usual drug users will come there, asking for heroin. Only at the time the buyers use the drug, do they realize that it is not the real drug. Can the users find out who are sellers of fraudulent heroin? It is always a difficult task and the buyers must accept the reality that they have been deceived. No one in this study states that his or her health is harmed by imitation heroin, but money is definitely lost.

I24 revealed his experience with forged heroin during a talk between us:

R: Have you ever bought a forged drug?

I24: If there is a police raid [on “the shooting area”] it would be possible. I bought forged heroin once.

R: Much much was your package then?

I24: Fifty [thousand VND] package

R: Please tell me about your story.
On that day there was a police raid so real heroin sellers have run away. That is why another person stood and was selling heroin there. I thought it was a real heroin seller so I bought it. But I was wrong.

Most of the incidents of fake heroin are at the moment when there are police raids, especially when drug users do not have any information about the sellers. Rather, heroin sellers remember the faces of heroin buyers so that they can minimize their risk for being arrested by police. That is why during the police raids drug users find it difficult to buy heroin in places where they do not buy drugs daily. In that case drug users must ask their peers to buy heroin on their behalf. In addition, drug users hardly remember heroin sellers since they take “shifts” (“the shooting area” is open all the day). Drug users also have to follow a “ruler” that is described above when they buy heroin everyday: just go to a given or usual “meeting point” to buy heroin by following a few steps: quietly stand in “a queue”, pay money first and then get heroin in a few seconds, and leave immediately. Therefore, drug users cannot warn each other about who are sellers of pure or impure heroin. Heroin sellers have the power to control the transaction rather than heroin users.

In addition, “the shooting area” is an open-air and unclaimed area, so heroin is sold at unknown addresses along the dead-end alley. If the deceived go back they cannot claim the fake heroin. Besides, heroin is an illegal drug and the deceived perhaps should keep quiet rather than report. IDUs in this study also tell that it is very difficult to know whether the quality of the drug until one uses it. In that case if heroin is not real, it often means that it is difficult to dissolve or becomes cloudy when mixing it with water or novocain. Besides, another indicator that can help but is too late is that IDUs will not get “high” as usual after the injection.

During my discussions with IDUs I also learned that some of them want to express their drug use experiences by sharing that they are able to recognize whether or not the drug is “ngon” (very good) depending on the kind of feeling they get after their injection. If the smell they get after injections is similar to longan or a fresh fruit scent, or if the “high” lasts for a long time, the quality of drug must be “ngon”.

IDUs in this study also complain about the quantity of drugs they get by comparing one drug-selling place with another. “The shooting area” is evaluated by all IDUs in this study as the only place providing a good, stable and competitive price in comparison with any other places. Besides, drugs are also available and accessible since it is opened all the day. For all these reasons IDUs give it a metaphor name “supermarket” or sometimes call it a flower festival market during the Tet (the new year festival).

Deceived by Peers when IDUs Pool Money

Another kind of deception among IDUs themselves is also common. Simply I can describe it like this: two IDUs meet and “trust” each other. They agree to jointly pool money to buy heroin (sometimes including other injection kits). One gives his money to the other with the purpose of buying heroin together, and wait at a given point. One waits one hour, three hours and five hours, and continues to wait, but the man who
kept the money does not come back. Actually the man has used his peer’s money to buy heroin and inject it all. Some stories given below represent many experiences of other IDUs who have been deceived:

R: Have you ever been deceived by your peers when you pooled money to buy drugs?

II9: One man has spent my money. His name is H. His house is [confidential]. I only know that his house is [confidential]. He sat on a bench over there...

When meeting him I said that I had had only thirty thousand left. At that moment he took out his money that was ninety thousand. He said “I have just “choi” (injected) but I know that you haven’t [injected yet]. Let’s pool money to buy drugs”. Then he separated his thirty thousand and saying: “Fifty thousand is for drugs and ten thousand for a motorbike ride, in sum it is sixty thousand”. He continued: “This is my thirty thousand and that is your thirty thousand”. He kept the money separately from his own. It sounds clear and “fair play”. At the time he left was 12:20[pm]. I had awaited for him until 1:30[pm], but hadn’t seen him at all. Fuck him, I went to a motortaxi driver over there and asked him. But he said he didn’t know. The driver who I met gave him a ride. The man had already returned but the driver said he didn’t know. Next time, which I had to wait until around 2:10[pm], I came back and asked the driver again. This time the driver said that the man had got off at a bus station a long time ago [nearby a roundabout where I am interviewing II9]. It is near (confidential bridge). Returning from “the shooting area” so he must had followed [confidential road]. He had got there so the driver was back to this place. I thought the driver got back here so he also returned here. Waited and waited for a long time but I haven’t seen him. Waited until 2:10[pm] I said to myself he must have spent my money. There was no misunderstanding and I should not wait more. It was true that during those days strict control over “the shooting area” was being launched. Fuck him. I came into a shop over there and there was a knife that was as long as this [he used his hand to describe]. Fuck him. I took the knife immediately and went to his house to find him. Fuck him I didn’t find him. On that day if I found him he would have died. However, I met him some
days later when I was sitting at a tea stall over there. At the moment I saw him I immediately took a pestle, which belongs to the stall and is used for breaking ices, to beat him for more than ten times. So he ran away. He came back with a shoulder pole to fight against me. But people tried to stop us. That is over. On that day my feet slipped so I fell down and was hurt, but I had beaten him a lot. He was fortunate. If I met him on the day before I would have chopped just once so he would have died. My body shook because of drug inadequateness (craving). Because of money inadequateness people pool money to buy drugs but it seems a fate. Money is often lost. If I have enough money I have no reason to pool money with anyone.

Or:

R: Have you ever been deceived by your peers when you pool money with them?

I7: I have been deceived many times. I was deceived by my true acquaintance last week.

R: Who is it?

I7: A friend of mine who lives on my street. I gave money to him because I thought we were a brother and a sister, or friends. He ran away. When I met him the day after, he said he had been arrested by police. He told a lie. If I met him on that day I would have killed him by a knife but it was the day after so I forgave it.

R: Why is that?

I7: I am honest and trust friends.

Many IDUs are deceived by this way, therefore they usually go together to buy heroin. Only at the moment two cannot pay their separate money to heroin sellers, money from them are pooled. They also keep going side by side until the drug is divided fairly. It seems that many IDUs do not trust each other when pooling money to buy heroin, but among some special partners, trust exists for sharing syringes/needles. I have discussed about pooling money and trust in chapter 4.
Secret but Deadly Syringe/Needle Exchange

The most harmful deception for IDUs in this study regarding health is a secret but deadly exchange of a syringe/needle with pure heroin with another contaminated one. For whatever reasons, to have heroin or anything else, IDUs will be at risk for HIV/AIDS infection either intentionally or unintentionally. It is because both the person who deceives and the other who is deceived can get infected with HIV/AIDS. In order to understand this kind of deception, look at two stories that will follow representing of many similarities told by IDUs in this study.

The first story is told by an in-depth interviewee (I15) who frequents “the shooting area” at least two or three times a day since I encountered him very often when I was around the area. He also shares during the interview that he injects at least three or four times a day and he usually buys heroin and injects in “the shooting area”. He tells the story when I asked him whether he has ever been deceived by someone with regard to drug use.

I15: “Ho” (they) [some deceivers] deceive other peers by helping someone to inject there [“the shooting area”]. “Minh” (our) veins are invisible, so “we” couldn’t “dành” (inject). “We” ask for a help. “We” give a syringe/needle that already contains “our” dissolved drugs to “them” and asking for “their” injection help. “They” immediately exchange it with another syringe/needle, which is “theirs”. “They” will inject for “us”. “We” are being injected but feel nothing. “We” think it might be not be pure heroin. The drug has been injected into the body but “we” feel nothing. Actually the man who gives the injection has exchanged “our” “xi” (a syringe/needle) of good drug with “their” forged one. “Their” syringe/needle also has water and it looks as if it is the same. “They” have exchanged the syringes/needles at the moment “we” don’t pay any attention at all. Well it is a kind of the deception there.

R: You says “they”. How many are “they”?

I15: There are a couple of men. “They” deceive people who are new comers.

R: Do “they” keep “their” ready drugs in “their” pockets.

I15: “They” don’t have any drugs at all. That is only “nơ vô” (novocain solution).
R: The syringe/needle is new, isn’t it?

Il5: Never. It is “their” old syringe/needle. “They” never use new ones because “they” are deceiving.

The second story is told in response to my question that is made after I have heard the deception from Il5. Both Il5 and Il6 frequent “the shooting area” daily and have a long history of drug use. Indeed I do a cross check.

R: Is there anyone deceiving by their exchange of a forged drug syringe with the good drug one?

Il6: There is a case like this, right now. There is a man who always squats on shooting grounds (“in the shooting area”) in order to inject. For those who can inject by themselves, it doesn’t matter but it is a matter for those who cannot. He always holds a newspaper that wraps a syringe/needle inside. In his pockets there are several different kinds of syringes/needles. He looks at “you” who are in troubles with injections and looks for a help. He sees “you” holding a syringe/needle with five “phân” (milliliter), or ten “phân” or fifteen “phân” for instance [when telling, he makes an assumption about different syringes/needles]. “Uh, uh, give me “your” syringe/needle, “brother” (meaning the deceiver) inject for “you”. At that moment he has already known what kind of syringe/needle “you” are having. “Your” drug that has been dissolved is absolutely good. “You” give the syringe/needle to him for an injection help. Deception! Deception! When “you” are giving him “your” syringe/needle he pretends to put the newspaper down and at that moment he has already exchanged it with another syringe/needle. His syringe/needle is not harmful but not good either. It contains distilled water only. Well. It is happening right now and inside “the shooting area”.

... 

Il6: When being injected, only senior drug users with experiences can know whether good drugs are being injected or not. For many men who are new addicts or have just shifted into injection, the deceiver injects “nuóc lặ” (unboiled water which gives a meaning of unclean water) or distilled water they cannot know. In some
R: Suppose that you are injecting like this and one man comes and says “Well, today I haven’t had any drugs yet. Please give me your drug leftover”. Do you give it to him? Or have you ever given drug like that to others?

I9: No. I haven’t.

R: I mean you give the amount of drug left in your syringe/needle that you are using.

I19: I haven’t. [silent for a while]. Well, I may have once. Exactly I haven’t given it to him. On that day I came to ask him to inject for me. I had already dissolved drugs. It was ready in a syringe/needle. I had already put drug into the syringe/needle. I said: “Go with me and inject for me, please”. He said: “Yes”. He came with me to help me inject. He injected a half and then he took the syringe/needle out and ran away immediately. Fuck that man. He injected for me a half, a bigger half. He was craving drugs then. He took the syringe/needle out and ran away. I thought he was too hungry for drugs so it would be fine. That was the only time. Truly I hadn’t experienced any like that before. If he asked me in advance I would have agreed. But he didn’t ask me. I asked him to inject for me but there was still a half. He took the syringe/needle out and then ran away. I couldn’t find him then.

R: Who is he on that day? Your friend or someone else?

I9: My friend.

R: Your friend? Did you meet him later?

I9: Yes.

R: What happened then?

I9: When I met him, he said “I was so hungry for drug] on that day. I was afraid that you wouldn’t give me [your drug]. Therefore I ran away”. That was the only time.

R: Where did you inject on that day?

R: You had already prepared drugs before calling him for help, hadn’t you?

I9: Yes. It was ready before I called him.

R: Is he your neighbour or where was he then?

I9: His house is next to mine.

R: You did ask him for injection help. Why didn’t you inject by yourself?

I9: It was true that injection into my veins was difficult then. I found it rather difficult to inject during the previous injection. The veins were missing when I tried to locate them. I found it difficult then. This time I thought “Well, it’d be better to ask for his help”. That is why I called him. He took the syringe/needle and then injected for me. He injected for me. He pumped half, but there was still half. He took the syringes/needle out very suddenly and ran away. Fuck him.

R: Was there anyone else present at home then?

I9: There was no one but two of us at home then.

I9’s story is echoed by the FGD(II) when the similar question was put into the air: whether anyone in the group had been asked by their peers to give drugs left in the syringes/needles, which he/she has injected at that moment. Although only a single voice responded quickly and shortly to the question, it is the same with what happened to I9.

FGD(II): “Some days ago right here (in a roundabout where the FGD is being done). Some days ago right here there was one man who was injecting into his arm. Blood stuck everywhere. Veins were invisible. He [another IDU] robbed the syringe/needle with a lot of blood from the man and running away”.

Definitely IDUs who robbed the “being-used” syringe/needle will use it. So they are willing to be at risk for HIV/AIDS infection rather having to bear their craving. In summary, drug use is also a small society in which there is a daily deception. Each IDU has one’s own strategy for competition in order to have heroin or money. In doing so, they ignore or accept a reality that they put their peer or even themselves at risk for HIV/AIDS infection by re-using a contaminated syringe/needle.
Chapter 6: DRUG USE AND HIV/AIDS

All IDUs were asked about HIV/AIDS during in-depth interviews and FGDs. Since HIV/AIDS education in Vietnam is done widely and continuously it is not surprising to hear from IDUs that they all get information about the disease and prevention measures from a variety of communication channels including TV, radio, newspapers, posters, booklets, leaflets, and HIV/AIDS lessons at schools, drug treatment centers and even prisons. Annual World AIDS Day - December 1 campaigns also contribute to increase their understanding about the disease. In addition, a few IDUs told that peer educators of harm reduction projects in the city also approached and talked with them about HIV/AIDS. Exactly how do they understand the disease, perceive the risk of infection, and prevent it? Does their knowledge about HIV/AIDS and perceived risk play any role in sharing a syringe/needle during their daily drug injections? This chapter will address these questions.

Knowledge About HIV/AIDS and Risk

Whenever being asked about HIV/AIDS, all IDUs expressed that the disease is not unfamiliar to them. In addition, they also told me that everyone knows about HIV/AIDS and they are not exceptions. All IDUs in this study demonstrated a basic understanding about the disease. For example, one in-depth interviewee talked about HIV/AIDS when I interviewed him:

R: How is HIV/AIDS transmitted?

I20: It is transmitted via blood mode, syringes/needles mode. If one doesn’t clean syringes/needles well and sharing it they will be... [infected]. The blood mode is the easiest way to transmit. Next it is sexual mode. I understand about these things.

R: Where do you get information?

I20: Well. I hear from TV and radio.

A female IDU also reasoned her refusal to share a syringe/needle because she usually heard about HIV/AIDS through mass media. She understood why someone gets AIDS. It is due to the sharing of a syringe/needle. She said the following:

R: Why don’t you share a syringe/needle with someone?

I7: You see TV often talks about SIDA (AIDS). Getting SIDA is due to the sharing of syringes/needles. I have to be careful. Though I unfortunately get involved in drug use I have to keep away from the disease. I am still young.
It is the fact that in response to HIV/AIDS, Vietnamese mass media usually portrays drug users as people with HIV/AIDS or vice versa, drug use means HIV/AIDS. In addition, the disease also means dirty or deviance as well. All IDUs heard about the disease, however they did not understand it deeply. Upon these messages some IDUs translated the disease in their own ways. They perceived the risk of HIV/AIDS incorrectly although they understood that IDUs probably get the disease. They thought that the disease only comes from their peers who have been using drugs for a long time as this man said:

R: What is SIDA? What scares you about SIDA (AIDS)?

I27: I am scared only of someone who has been injecting drugs for a long time. If I share syringes/needles with them I am afraid that I would be infected.

Meanwhile some IDUs regarded their peers who look clean or are new users as non-infected persons. This incorrect perception of the risk ensures that they will ask for drugs from these peer’s used syringes/needles or to share a syringe/needle with them without any hesitations.

R: Have you ever asked someone to give drugs left in their being-used syringes/needles to you?

I17: Myself? Yes. I asked my close friends only, close friends only since they look clean. But for those who look... [unclean] surely I won’t [ask].

In addition, there is a fact that some IDUs did not consider they were at risk of HIV/AIDS. They ignored the risk of the disease even someone warned them of the risk when they were sharing a syringe/needle. An in-depth interviewee told me what she saw and interacted with a man and a woman in a roundabout:

R: Have you ever seen a man and a woman sharing a syringe/needle in this roundabout?

I28: Yes. Once.

R: Please tell me about it.

I28: Two persons [a man and a woman] used only one “xi” to inject. They even didn’t divide their drug into any other container. The man injected for the woman first and then he injected for himself. They didn’t divide their drug into any other containers.

R: In your opinion why did they share like that?
I28: I warned them about [the risk] but they reacted that they were not scared [of the disease] at all. "Why do you share like that". They even reacted: "It doesn’t matter at all. There is no good reason to buy two "xi"". They said so.

One couple (a husband and wife) participating in a focus group discussion told me that they did not perceive that they are at risk of HIV/AIDS if they share a syringe/needle. They were not scared about HIV/AIDS but scared about a fever that they may get from sharing:

FGD (II): We as a husband and wife aren’t scared of the disease. But we are scared of blood because only a bit of blood left in a syringe/needle causes a fever for us. The injection with other people’s blood causes a fever.

Similarly, a FGD also discussed about their HIV/AIDS misperceptions. They were concerned more about a fever that they may get from sharing rather than HIV/AIDS. They did not perceive that they were at risk of HIV/AIDS infection if they share a syringe/needle.

FGD(IV): If the first sharing of a syringe/needle doesn’t cause a fever it means it doesn’t matter. Therefore they trust each other and begin to share a syringe/needle.

It is a reality that IDUs did not have a deep understanding since information provided is often general and lacks concrete messages. In addition HIV/AIDS education programs targeting this group are sometimes not consistent and is limited. Therefore, they misperceived about the risk of HIV/AIDS infection. How to change their behavior is still a challenge.

Prevention

With the knowledge about HIV/AIDS and risk of infection in mind some IDUs initiated their own way to protect themselves from getting the disease. In considering blood as a contaminated and central problem of the HIV/AIDS transmission, they tried to make sure that blood does not go much into a syringe, which will be shared, when the needle is in the vein.

R: Have you ever asked someone to give their drugs to you?

I17: Yes. I even shared the syringes/needle. However I try to make sure that the blood “họi báo” (just come out) at the moment the needle is in the vein. You should be skillful to ensure that a bit of blood just comes out at the tip of the needle. Just see a bit
of red, pump immediately. And remove the needle and remove the blood from the needle by splashing (without cleaning).

Like I17, two sexual partners (a man and a female sex worker) use prevention methods from HIV/AIDS in their own way when they were sharing a syringe/needle. After injecting for himself the man removed the needle from the shared syringe/needle, and the blood from it by splashing, and then continued to inject for his sexual partner.

R: Have you ever seen someone sharing a syringe/needle? Have you seen two persons sharing only one syringe/needle?


R: Female or male friend?

I23: It is my female friend (a sex worker) who “cắp bó” (cohabits) with a man. Two share a syringe/needle. They have one syringe/needle containing two “phận” (milliliters) of drug. Pump one “phận” for the man. Take it out and remove the blood from the needle by splashing the needle. Fix the needle back and continue to inject for my female friend. In general there are a lot [of people sharing a syringe/needle]. I see so many [people sharing a syringe/needle].

I asked IDUs in detail about the frontloading between two syringes/needles so as to identify their risk behaviors. However, many of them did not realize that they were at risk of HIV/AIDS infection when their frontloading is done between a new and an old syringe/needle or two old syringes. That is except for some IDUs who are middle aged using drug for a long time and who also has heard so much about HIV/AIDS. Therefore, they knew how to prevent HIV/AIDS risk during the frontloading. They always insisted that the frontloading must be done between only two new syringes/needles or that the drug must be dissolved in a new syringe/needle and then dividing it into their used but clean ampoule of distilled water or novocain solution. The person who owned the old syringe/needle can draw their drugs from the ampoule.

R: When you pool money and inject together with others, how do you divide drug? How can you prepare and divide drug?

I28: Put drug into “xi mới” (a new syringe/needle) and then we also put it over to the other new syringe/needle. We inject individually. Fair division. Drug is not divided between one new and one old syringe/needle. All are new.
R: Have you ever divided drug by one new and one old syringe/needle?

I28: No. I am also afraid of the disease [HIV/AIDS]

R: Have you ever divided drug by one new and one old syringe/needle but the old one is yours?

I28: No. If I know all are new we will divide so. If I don’t know I will put drug over to an ampoule of distilled water. [used but clean one].

**What Can Be Done**

It may surprise us when hearing an IDU to tell about what he can do in regard with HIV/AIDS. He knew well about the disease and was scared of it as well. However, he shared a syringe/needle with his peers a couple of times. He always remembered his sharing events with some information: when and with whom. From his words, we may not assume what he can do if his peers who he shared a syringe/needle with get infected with HIV/AIDS.

R: Have you ever shared a syringe/needle before?

FGD(III): Three times

R: You remember so well even about the number!

FGD(III): Not really [laughing]. Because I am scared, I am scared about with whom I share. Whenever I share I have to remember. “Share with whom” I have to remember in order to see whether they have problems or not (HIV/AIDS). If they have I can find the way.

In summary, all IDUs understand basically about HIV/AIDS: how it can be transmitted, and how to avoid it. In general they knew the sharing of a syringe/needle puts them at risk of HIV/AIDS infection but some also misperceive the risk of HIV/AIDS infection. IDUs interpreted the disease differently: who among IDUs are more likely to be infected and who are not. Upon their own interpretation, they initiate their own way to prevent the disease incorrectly and are unprepared for their potential future infection.
Chapter 7: CONCLUSION AND RECOMMENDATION

There is no doubt that both drug use and HIV/AIDS infection are now of a great concern in Vietnam and the fact is that the HIV/AIDS epidemic is still on the rise among IDUs. The country with a population of nearly 80 million people estimated 185,000 drug users in 2000 and claimed more than 40,000 HIV/AIDS cases as of September 2001. Sixty-six percent of these infected cases are among drug users. The cause for the HIV/AIDS progression is correlated with unsafe drug injection, which is highlighted by a very high percentage of syringe/needle sharing among IDUs, ranging from 50% to 90%, according to a number of recently quantitative studies conducted in big cities and towns. Why do injecting drug users share syringes/needles? No information is documented in the country. This first-ever qualitative study strives to find answers for that question.

By analyzing responses from 30 in-depth interviewees and 24 FGD participants, and especially fieldnotes from participant observations, this study makes a conclusion that there are five existing reasons for IDUs in urban areas in Vietnam to share syringes/needles (Please also see annex 14 on page 95). Actually the reasons together drive IDUs to practice unsafe injection behaviors rather than they do independently. These reasons are specified below:

First, there is a mutual trust among some special partners. This is most common and challenges HIV/AIDS prevention work. These partnerships, which are listed in the order of sharing frequency, include husband and wife, sexual partners (most partnerships are between a female sex worker and her male sexual partner), close friends, neighbors, and kin brothers. The sharing of a syringe/needle among them is usually a result of pooling of resources to acquire heroin and other injection items, and symbolizes the bonds in their hard lives of drug injection. This reason functions well and is perhaps static for the first two partnerships regardless of an existence or non-existence of factors: syringe/needle availability and accessibility, financial capacity, and knowledge and risk perception of HIV/AIDS infection. For example, a husband reasoned his sharing of a syringe/needle with his wife: "Generally speaking there aren't any reasons at all. I tell you this: sharing or non-sharing is useless because we as a husband and wife must continue to have sexual intercourse. Therefore, if one has already acquired the disease [HIV/AIDS], the other still gets it regardless of sharing or non-sharing. So sharing or non-sharing is the same" (I30).

This is definitely a big challenge for Vietnam since more and more female sex workers begin to inject heroin. If there is no timely and effective intervention the HIV/AIDS prevention work will fail to prevent the epidemic from spreading to other populations with low risk behaviors in very near future.

Second, IDUs either do not have or lack money at the moment they are truly hungry for drugs, which is considered their "bữa" ("daily meals"). Therefore IDUs do not hesitate to ask for drugs left in a
“being-used” syringe/needle from their friends or even “just a peer”. Or they just have enough money to buy a minimum drug dose for “cảm nghiện” (just to overcome the craving status), but do not have any money left to acquire a new syringe/needle: “He is as old as my father. Goosebumps appeared on his limbs... He was shaking and all goosebumps appeared. He was sweating as if he had a bath. He said “I am too “vật quá” (hungry for drug or craving), you give me just a bit. You cut down on [your dose]... He didn’t have any syringe/needle or something like that... You keep injecting and just cut down two [or] three “vạch” (one tenth milliliter) for me. I bend my knees down in front of you”, and so on. There were many people for whom he didn’t ask but me. I had to pool because I didn’t have so much money. Anyway I left a smaller half for that man at that moment” (II8). This reason should be understood in their own context that is featured by the fact that many IDUs do not have jobs and stable incomes. More than 50% of them live on the streets and many of IDUs get money by stealing small items like raincoats, motorbike helmets, construction materials and so on, and by gambling, selling sex and deceiving others as well.

Third, it is a drug use culture itself. Drug use is also considered a small society since there are the motivating factors of profit, competition, territory, rules, reciprocity, deception, services, credit, drug divisions, pooling of resources, and so on. In this small society, IDUs are also subject to getting trapped, many of which put them at risk of IllV AIDS infections. The reason for the drug use culture is identified with the robbery of a “being-used” syringe/needle, secret but contaminated syringe/needle exchange (the robbers will use it), and a frontloading between a new and an old syringe/needle or two old syringes/needles, of which old ones are not cleaned properly.

Fourth, there is a lack of syringe/needle availability and accessibility. This also must be understood in accordance with emic points of view of IDUs because actually syringes/needles are very available, accessible and affordable for all IDUs without any limitations during the daytime. Law enforcements do not restrict any IDUs from possessing a syringe/needle. For many reasons some IDUs inject at night when a syringe/needle is much less available, accessible and even less affordable. In addition, it is also very important to warn that IDUs share a syringe/needle, for whatever reasons drugs are available for them, in some of drug treatment centers, incarcerated camps and prisons. The lack of syringe/needle availability and accessibility is a plausible reason coming from emic points of views of IDUs.

Fifth, it is undeniable that some IDUs interpret the disease differently because of their incorrect knowledge and risk perception about HIV/AIDS. They explain that their peers who use drugs for a long time are at risk of HIV/AIDS infection while those who begin to use drugs are at no risk. Besides, they also consider blood as a contaminated and central problem of the HIV/AIDS transmission. Therefore, they jointly use a syringe/needle in a different but definitely harmful way. Indeed they initiate their own way to prevent the disease: “I even shared the syringe/needle. However I try to make sure that
the blood “hồi báo” (just come out) at the moment the needle is in the vein. You should be skillful to ensure that a bit of blood just comes out at the tip of the needle. Just see a bit of red, pump immediately. And remove the needle and remove the blood from the needle by splashing (without cleaning)” (117).

In addition, IDUs do not have a specific understanding about prevention measures during drug injection, therefore a frontloading between a new and an old syringe/needle, or two old syringes/needle is currently a reality.

The study also finds no evidence for IDUs to share a syringe/needle because of social stigma or discrimination against them.

Lastly, this study also emphasizes that a lot of syringes/needles and glass ampoules are disposed improperly by IDUs. These injection items are seen in many places such as alleys, street pavements, roundabouts, parks and public toilets. Definitely it imposes a biohazard to the community’s health.

Clearly, the identified reasons for the sharing of a syringe/needle are associated with socio-economic and cultural factors much more than it is a public health issue at this stage of the HIV/AIDS epidemic and its response. Besides, the HIV/AIDS epidemic is multi-dimensional and much more complicated than any other epidemics. Therefore, this study recommends that interventions in Vietnam targeting the population of IDUs base their programs on emic points of view, peer approaches and friendly-users services. Interventions also need pragmatism. These recommendations are made to organizations running and financing harm reduction programs in Vietnam such as provincial AIDS committees, preventive medicine centers, youth unions, women’s unions, and National AIDS Standing Bureau (NASB), Vietnam-based international agencies and NGOs working with HIV/AIDS.

In this sense, harm reduction programs in Vietnam should still continue, but should also consider the concrete suggestions that follow. First, incorporate emic points of view of IDUs when developing and implementing HIV/AIDS prevention projects for this group. Getting them involved in all stages of intervention is also important. Second, set up friendly-users rooms for IDUs. These rooms should be run by community-based organizations and located in areas that are accessible to IDUs after they get drugs. Syringes/needles should be sold in the rooms at low prices and biohazard boxes should be made available for injection kits disposal. These rooms also should provide IDUs with other skills: safe drug injection skills, first aid (to save lives from drug injection shocks due to overdose), how to dispose syringes/needles properly. In addition, counseling about HIV/AIDS and other drug-related harms, and appropriate IEC materials regarding HIV/AIDS and drug use also should be made available in these rooms for IDUs. Together with the availability of these friendly-users rooms, drug injections in public areas must be strictly prohibited by law enforcement.
NOTES:

* Some provinces were not able to carry out sentinel surveillance among all six groups

1 A Government agency assists the Prime Minister to execute the National AIDS Program in Vietnam

2 It is a street junction at which traffic circulates in one direction around a central island. This island is large enough for trees, flowers, grasses, footpaths, stone benches, a fountain, some statues and even some small spaces for sports like badminton and morning exercises

3 It is described in the part of participant observations

4 It is an only place, according to participants of this study and my observation, IDUs can buy drugs and at the same time are supposed to inject at once afterwards. Generally speaking, it is rather difficult for IDUs to take drugs with him when leaving. The study participants often mentioned this area during the interviews and discussions, and calling it with an identifiable name but because of the confidentiality throughout this thesis it is called with a name “the shooting area”. In other drugs selling places it is contrary that IDUs are requested to take drugs with them and inject outside.

5 Vietnam currency: 1.0 Dfl equals to 6,000 VND

6 It is an action that an IDU draws back between one and two milliliters of blood from his/her vein to the syringe at the moment the heroin solution has just been pushed into the vein, and just after that the user pushes back the blood into his/her vein. This may repeat one to several times. In their belief this action makes sure all heroin in the in their syringe is pushed into the vein, thus making him/her easily get “high”. Many IDUs in this study believe and do so. In addition, a syringe/needle used by IDUs who often do “jacking” is not easy to clean, so it increases chances for HIV/AIDS infections if it is reused or used for frontloading.

7 115 uses a word of “nọ” that means they, their and them. These words here imply someone as deceivers.

8 115 uses a word of “minh” that means we, our and us. These words here imply someone as IDUs.
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Peter, J Brown


UNAIDS


UNAIDS


UNDP


UNODCCP & the Commonwealth of Health and Aged Care, Australia


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Vu Trang


VNA


VNA

ANNEX I: Map of Vietnam

Map of Vietnam

Study site
ANNEX 2:

Analytical Framework: Assumed Reasons for Sharing Syringes and Needles among IDUs in Vietnam

1. Pooling of resources
   - Emotional reasons
   - Peer pressure
   - Group identity
   - Meanings and symbolism of sharing
   - Togetherness and socialized activities
   - Influence of IEC campaigns and harm reduction

2. Drug culture
   - Acquiring syringes, needles and drugs
   - Practical and cheaper
   - Difficult to socialize with non-drug use friends
   - Scarcity of syringes and needles
   - Poor accessibility of syringes and needles
   - Poor availability of syringes and needles

3. HIV risk perception
   - Knowledge of HIV infection
   - Family
   - Community
   - Non-IDU friends

4. Social stigma
   - Illegality (drug law enforcement)

5. Illegality (drug law enforcement)
ANNEX 3: Some Necessary Terms in Drug Use

Below are some terms in drug use that would be useful for common understanding. These terms are defined and described in the publication of the United Nations Office for Drug Control and Crime Prevention: “Demand Reduction: A Glossary of Terms” (some terms are re-quoted from the WHO Lexicon of Alcohol and Drug Terms), which came out in 2000.

Illicit (or illegal) drug: “A drug listed in the schedules to the international drug control convention can only be called an illicit (or illegal) drug if its origin was illicit. If the origin is licit, then the drug itself is not illicit but only its production, sale, or use in particular circumstances. The drugs listed in the schedules to the various drug control conventions are under control and their use for solely medical or scientific purposes is licit”.

Drug addiction (addict): “One of the oldest and most commonly used terms to describe and explain the phenomenon of long-standing drug use. In some professional circles it has been replaced by the term ‘drug dependence’. According to the WHO Lexicon of Alcohol and Drug Terms, addiction is defined as the repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronologically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntary ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

By indicators of ‘addiction’ have traditionally been thought to be tolerance and experience of a withdrawal syndrome, i.e. it is often equated with physical dependence. More recently, some drug researchers have suggested that ‘compulsion to use drugs is a more central indicator of addiction. Addiction is otherwise regarded by the self-help or ‘recovery’ movement as a discrete disease, a debilitating and progressive disorder rooted in the pharmacological effects of the drug for which the only cure is total abstinence. This view is most notably associated with the ‘self-help’ or ‘recovery’ movement, e.g. Narcotic Anonymous and Alcoholics Anonymous. In 1960s the WHO recommended that the term ‘addiction’ be abandoned in favor of dependence, which can exist in various degrees of severity as opposed to an ‘all or nothing’ disease entity”.

Administration (or method) of drug use: “According to the WHO Lexicon of Alcohol and Drug Terms, administration is defined as ‘the route or mode of administration, i.e. the way in which a substance is introduced into the body, such as oral ingestion, intravenous (IV), subcutaneous, or intra-muscular injection, inhalation, smoking, or absorption through skin or mucosal surface, such as the gums, rectum,
or genitalia. The manner of administration has a critical effect on the speed and intensity of drug effects and hence, on the degree of intoxication, nature of risk exposure and dependence liability. It can also have a major influence on the nature and severity of undesirable effects and consequences, including body organ damage (e.g. lungs, veins) and infection transmission (e.g. HIV, hepatitis). Thus, smoking a drug may predispose the user to respiratory problem, while injecting it in other injecting equipment may increase the risk of blood-borne viruses such as HIV or hepatitis.

**Injection equipment**: "The paraphernalia used for drug injection. This can include such items as a needle and syringe, a spoon for mixing, some water or acid for dissolving powdered drugs, filter material to draw the solution through when filling the syringe (e.g. piece of cigarette filter, cotton wool, paper), an alcohol swab to clean the injection site, and a tourniquet". /.
ANNEX 4: Map of the Urban District of Ba Dinh
Map of the Urban District of Hai Ba Trung
ANNEX 6: Artifacts

The white color is for a thirty thousand VND package of heroin and all other colors are for a fifty thousand VND package of heroin.

A two-milliliter ampoule of novocain solution 2% and a two-milliliter ampoule of distilled water.
A two-milliliter ampoule of pipolphen (Hungary) and a two-milliliter ampoule of seduxen (China)
ANNEX 7: “The Shooting Area”, Located in a Slum Area, is a Dead-End Alley With Only One Entrance and Exit
**ANNEX 8:**

**Background Information of 30 In-depth Interviewees**

<table>
<thead>
<tr>
<th>Code</th>
<th>Age &amp; Sex</th>
<th>Marital status</th>
<th>Spend the night</th>
<th>Residence</th>
<th>How to get money</th>
<th>No of injection Per day &amp; Year</th>
<th>Share or not</th>
<th>See the sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1</td>
<td>47 M</td>
<td>Divorced but marries &amp; lives with the second wife &amp; 2 children</td>
<td>Family</td>
<td>12 years</td>
<td>From his wife</td>
<td>1 (1995)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>I2</td>
<td>31 F</td>
<td>Divorced (2 husbands &amp; one child)</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Self labor</td>
<td>2 (1999)</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>I3</td>
<td>32 F</td>
<td>Unmarried but cohabiting</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>From her boy friend</td>
<td>3 (1999)</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>I4</td>
<td>26 M</td>
<td>Unmarried</td>
<td>Family</td>
<td>Hanoi</td>
<td>Family &amp; self labor</td>
<td>2 (1999)</td>
<td>Yes*</td>
<td>N/A</td>
</tr>
<tr>
<td>I5</td>
<td>30 M</td>
<td>Married, not have a child yet</td>
<td>Family</td>
<td>Hanoi</td>
<td>Family &amp; self labor</td>
<td>2 (1997)</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>I6</td>
<td>26 M</td>
<td>Live with wife &amp; one child</td>
<td>Family</td>
<td>Hanoi</td>
<td>Gambling &amp; self labor</td>
<td>1 (1996)</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>I7</td>
<td>21 F</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Boy friend</td>
<td>2 (2001)</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>I8</td>
<td>22 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>3 (1997)</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>I9</td>
<td>33 M</td>
<td>Live with wife &amp; one child</td>
<td>Family</td>
<td>Hanoi</td>
<td>Family and self labor</td>
<td>2 (1997)</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>I10</td>
<td>31 M</td>
<td>Divorced (wife &amp; one child)</td>
<td>Live alone in a house</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>2 (1998)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>I11</td>
<td>31 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Gambling</td>
<td>2 (1997)</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>I12</td>
<td>17 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>2 (2001)</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>I13</td>
<td>29 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>2 (2000)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>I14</td>
<td>22 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>3 (2000)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>I15</td>
<td>36 M</td>
<td>Divorced (wife &amp; 2 children)</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>3-4 (1996)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>I16</td>
<td>45 M</td>
<td>Live with wife &amp; 2 daughters</td>
<td>Family</td>
<td>Hanoi</td>
<td>Driver</td>
<td>2 (1999)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>I17</td>
<td>27 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>4 (1997)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>I18</td>
<td>19 M</td>
<td>Unmarried</td>
<td>Family</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>1 (1999)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>I19</td>
<td>43 M</td>
<td>Live with wife &amp; 2 daughters</td>
<td>Family</td>
<td>Hanoi</td>
<td>Construction worker</td>
<td>5 (2001)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>I20</td>
<td>46 M</td>
<td>Separated (wife &amp; children)</td>
<td>Live with his mother</td>
<td>Hanoi</td>
<td>Tennis teacher</td>
<td>2 (2001)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>I21</td>
<td>33 M</td>
<td>Live with wife &amp; 2 children</td>
<td>Family</td>
<td>Hanoi</td>
<td>Gambling &amp; family</td>
<td>3 (1997)</td>
<td>Yes</td>
<td>Don't pay attention</td>
</tr>
<tr>
<td>I22</td>
<td>17 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>3 (2001)</td>
<td>Frontloading</td>
<td>Yes</td>
</tr>
<tr>
<td>I23</td>
<td>27 F</td>
<td>Unmarried but cohabiting</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary &amp; sex work</td>
<td>3 (2000)</td>
<td>Frontloading</td>
<td>Yes</td>
</tr>
<tr>
<td>I24</td>
<td>47 M</td>
<td>Divorced (wife &amp; 3 daughters)</td>
<td>Live with his daughters and mother</td>
<td>Hanoi</td>
<td>Family</td>
<td>2 (1999)</td>
<td>Frontloading</td>
<td>Yes</td>
</tr>
<tr>
<td>I25</td>
<td>46 M</td>
<td>Divorced (wife &amp; 2 children)</td>
<td>Live alone in a house</td>
<td>Hanoi</td>
<td>Gambling and family</td>
<td>3 (2001)</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>I26</td>
<td>19 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Burglary</td>
<td>2 (2001)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>I27</td>
<td>25 M</td>
<td>Unmarried</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Gambling</td>
<td>3 (2000)</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>I28</td>
<td>38 F</td>
<td>Widow</td>
<td>Family (with children)</td>
<td>Hanoi</td>
<td>Self labor</td>
<td>3-4 (1993)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>I29</td>
<td>26 F</td>
<td>Live with husband (one child)</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Pretend as a sex worker</td>
<td>3 (2001)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I30</td>
<td>26 M</td>
<td>Live with wife (one child)</td>
<td>On the streets</td>
<td>Hanoi</td>
<td>Get involved deception</td>
<td>3 (2001)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Yes*: give drugs left in their being-used syringes/needles to their drug injecting peers
ANNEX 9: Transition between Opium and Heroin Use among 30 In-depth Interviewees
ANNEX 10:

Number of In-depth Interviewees Beginning to Inject Drugs by Year

Year

Number

'93 '94 '95 '96 '97 '98 '99 '00 '01
ANNEX 11: Emic Words Used Among IDUs

Below are emic words used by Vietnamese IDUs. These words were recorded during this study. For Vietnamese non-drug users, it is difficult or even impossible for them to understand the meanings of them if no explanations are given. In addition, many words must be contextualized so that the non-drug users can understand.

<table>
<thead>
<tr>
<th>#</th>
<th>Emic words in Vietnamese</th>
<th>Similar meanings or explanations in English</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ven công</td>
<td>“Drainage pipe” veins (often call big ones like neck, groin and elbow veins)</td>
</tr>
<tr>
<td>2.</td>
<td>Ven chính</td>
<td>Main vein (means big vein)</td>
</tr>
<tr>
<td>3.</td>
<td>Ven tăm</td>
<td>“Tooth pick” (as small as a tooth pick) veins (often called small ones like veins on the back of hands)</td>
</tr>
<tr>
<td>4.</td>
<td>Ven lửa</td>
<td>“Flame” vein (means artery). Because some IDUs insert the needle incorrectly (in the artery). This especially may happen when IDUs are in a hurry because police are coming. At that moment IDUs feel hot in their body though only a bit of drug is injected</td>
</tr>
<tr>
<td>5.</td>
<td>Ven chìm</td>
<td>Invisible vein (hidden vein). It is difficult for IDUs to locate the vein</td>
</tr>
<tr>
<td>6.</td>
<td>Hà ven</td>
<td>“Wormeaten” vein (wormeaten sweet potato) as consequences of unclean and frequent injections or the needle is out of the vein many times</td>
</tr>
<tr>
<td>7.</td>
<td>Bào</td>
<td>Blood comes out of the tip of the needle to indicate it is ready in the vein for pumping the drug</td>
</tr>
<tr>
<td>8.</td>
<td>Kích</td>
<td>“Jacking”: before taking out the syringe/needle, IDUs draw one or two milliliters of blood back into the syringe. It is their belief that it ensures the entire use of the drug that is left in the syringe/needle. IDUs often repeat two or three times</td>
</tr>
<tr>
<td>9.</td>
<td>Hồi</td>
<td>“Jacking”</td>
</tr>
<tr>
<td>10.</td>
<td>Phế</td>
<td>“High”: feelings IDUs get after injecting a sufficient drug dose</td>
</tr>
<tr>
<td>11.</td>
<td>Căn</td>
<td>Feelings IDUs get after a bit of an overdose is injected</td>
</tr>
<tr>
<td>12.</td>
<td>Dyu</td>
<td>Feel sleepy due to the use of seduxen with drugs (heroin or opium)</td>
</tr>
<tr>
<td>13.</td>
<td>Vật</td>
<td>Hard feelings caused by lack of drugs. It requires an immediate injection</td>
</tr>
<tr>
<td>14.</td>
<td>Đói</td>
<td>Hunger for drugs or lack of drugs, or craving. It requires an injection soon</td>
</tr>
<tr>
<td>15.</td>
<td>Mà</td>
<td>An injection spot that is created by repeating the needle insertion at the same point. By having this created injection spot, IDUs can locate the vein much easier and quicker</td>
</tr>
<tr>
<td>16.</td>
<td>Cây mà</td>
<td>To create an injection spot by repeating the needle insertion at the same point. It often takes two-week continuous injection</td>
</tr>
<tr>
<td>17.</td>
<td>Nuôi mà</td>
<td>To create an injection spot by repeating the needle insertion at the same point. It</td>
</tr>
<tr>
<td>Number</td>
<td>Vietnamese Word</td>
<td>English Translation</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>18.</td>
<td>Cặp</td>
<td>A pair (often means a pair of an ampoule of seduxen and an ampoule of pipolphen)</td>
</tr>
<tr>
<td>19.</td>
<td>Tếp</td>
<td>An amount of heroin packaged in a very small plastic tube (reused string for soft drink). It was a former way for heroin package before. However heroin is now packaged in small pieces of paper</td>
</tr>
<tr>
<td>20.</td>
<td>Xi</td>
<td>Syringe and needle</td>
</tr>
<tr>
<td>21.</td>
<td>Xen phen</td>
<td>Seduxen and Pipolphen</td>
</tr>
<tr>
<td>22.</td>
<td>Nơ vô</td>
<td>Novocain solution 3%</td>
</tr>
<tr>
<td>23.</td>
<td>Đấm</td>
<td>Inject</td>
</tr>
<tr>
<td>24.</td>
<td>Đánh</td>
<td>Inject</td>
</tr>
<tr>
<td>25.</td>
<td>Chọt</td>
<td>Inject</td>
</tr>
<tr>
<td>26.</td>
<td>Chốc</td>
<td>Inject</td>
</tr>
<tr>
<td>27.</td>
<td>Choác</td>
<td>Inject</td>
</tr>
<tr>
<td>28.</td>
<td>Phích</td>
<td>Inject</td>
</tr>
<tr>
<td>29.</td>
<td>Tọa</td>
<td>Inject</td>
</tr>
<tr>
<td>30.</td>
<td>Thuốc ngon</td>
<td>Good drug</td>
</tr>
<tr>
<td>31.</td>
<td>Thuốc đàm</td>
<td>“Salty” or “sweet” (means good drug)</td>
</tr>
<tr>
<td>32.</td>
<td>Thuốc nhất</td>
<td>“Not salty” or “not sweet” (means not good quality drug)</td>
</tr>
<tr>
<td>33.</td>
<td>Thuốc đen</td>
<td>“Black” drug (means opium)</td>
</tr>
<tr>
<td>34.</td>
<td>Thuốc trắng</td>
<td>“White” drug (means heroin)</td>
</tr>
<tr>
<td>35.</td>
<td>Sủng</td>
<td>“Gun” (means syringe and needle)</td>
</tr>
<tr>
<td>36.</td>
<td>Den, Dem, Vạch, Lý</td>
<td>One tenth milliliter</td>
</tr>
<tr>
<td>37.</td>
<td>Đi chợ</td>
<td>“Go to market” (means stealing)</td>
</tr>
<tr>
<td>38.</td>
<td>Quay</td>
<td>To steal</td>
</tr>
<tr>
<td>39.</td>
<td>Cáo cầu</td>
<td>Borrow money with no intention to return the borrowed amount back</td>
</tr>
<tr>
<td>40.</td>
<td>Đường thủy</td>
<td>“Water way” (means Injection)</td>
</tr>
<tr>
<td>41.</td>
<td>Đường bộ</td>
<td>“Land way” (means smoking)</td>
</tr>
<tr>
<td>42.</td>
<td>Bữa</td>
<td>“Meal”. IDUs demand drug injection like meals (breakfast, lunch, dinner). It also implies that they heavily depend on drugs</td>
</tr>
<tr>
<td>43.</td>
<td>Cá mèn nghĩ</td>
<td>A mimimum dose of drug to overcome a “craving” status</td>
</tr>
</tbody>
</table>
ANNEX 12:

Three syringes/needles with different volumes of 1 ml, 3 ml, and 5 ml
(Product of a Vietnam and South Korean Joint Venture Company)
ANNEX 13:

Frontloading between a new and old syringe/needle
ANNEX 14: Identified Reasons for IDUs in Vietnam to Share Syringes and Needles

- Robbery of a being-used syringe/needle
- Secret but contaminated syringe/needle exchange
- Deception in the world of drugs use
- Husband/wife, sexual partners, close friends, neighbors, and kin brothers
- Mutual trusts of some special partners
- IDUs share syringes & needles
- At night
- At some of drug treatment centers, incarcerated camps and prisons
- Pooling of resources
- Syringes & needles are not available and accessible
- Lack of money
- HIV/AIDS knowledge and risk perception
- Incorrect prevention measures
- Wrong definition of risk behavior persons
- Don't have money to buy heroin and a new syringe/needle
- Live on the streets, no jobs, and no incomes
- Have money to buy a minimum heroin dose but don't have money to buy a new syringe/needle