THE DYNAMICS OF AIDS RISK AND GENDER RELATIONS

AMONG INTRAVENOUS DRUG USERS

IN NORTHERN VIETNAM

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To my love Phan Quynh Hoa

my daughter Nguyen Lam Quynh Huong

my son Nguyen Tran Bach
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Nguyen Tran Lam
Abstract

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

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

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

*Key words*: injecting drug users, sex partners, sexual relationships, AIDS risk, syringe sharing, condom use.

**Abbreviations and some IDUs’ Argots Used in the Analysis**

- **AHRN** The Asian Harm Reduction Network
- **AIDS** Acquired Immunodeficiency Syndrome
- **CSW** Commercial sex worker
- **FSW** Female sex workers
HIV  Human Immunodeficiency Virus

HCMC  Ho Chi Minh City

IDUs  Injecting drug users

IEC  Information-education-communication

MAP  Monitoring the AIDS Pandemic Network

MOH  Ministry of Health

SP  Sex partner

STD  Sexually Transmitted Disease

UNAIDS  The Joint United Nations Program on HIV/AIDS

UNDCP  United Nations Drug Control Program

UNDP  United Nations Development Program

WHO  World Health Organization
Smoke To smoke opium or heroin

Shoot To inject

Black Opium

White Heroin

Meal An injection/ a shot

Senphen  Seduxen and Pipolphen- two stimulants, often mixed up with heroin

CHAPTER 1

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

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

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

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

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

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

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

My objective then is to unravel the association between sexual relationships and HIV risk behaviors among IDUs, with a focus on intimate relationships (whether conjugal or para-conjugal). By examining the situational contexts of risk-taking behaviors within IDUs’ intimate heterosexual relationships, I attempt to get insight into the dynamics of AIDS risk and gender relations among this population. Three patterns of intimate relationships among IDUs are analyzed, including: Pattern 1- IDUs in a heterosexual relationship with an IDU partner; Pattern 2- IDUs in a heterosexual relationship with a drug smoking partner; Pattern 3- IDUs in a heterosexual relationship with a non drug using partner. The analysis is based mainly on social theories of risks (Douglas & Wildavsky 1982; Douglas 1986; Douglas & Calvez 1990), which have been further developed by Rhodes (1997).
This thesis is an attempt to contribute to an interpretive anthropology of injecting drug users and their sex partners in the time of AIDS, based on ethnographic analysis. After describing a case story in this chapter, Chapter 2 offers a brief analysis of the social and cultural context of the AIDS epidemic in Vietnam, with an emphasis on drug abuse and prostitution. In Chapter 3, the methodology of this study is described. The next three chapters (4,5,6) present the findings of this study. In Chapter 4, I analyse some important parameters of the drug subculture, which is influential to the sexual relationships and risk behaviours among IDUs.

Chapter 5 forms the core part of this paper, where I analyse characteristics of three patterns of intimate relationships among IDUs. Each pattern with its features, including the following themes: drug use practices, condom use, perceptions of risk, reducing and stopping drug use, managing AIDS risks and sexual relationships.

Chapter 6 employs a case study approach in which the focus is on the life of two individuals, one female living with AIDS and one male IDU. The objective of the chapter is to broaden the view of looking at social contexts of AIDS risk and sexual relationships. In Chapter 7, I discuss the main issues emerging from this study, including: gender and power; care and responsibility; drugs and sexuality; stigma. In the last part of this chapter, I give some comments on the classification of “high-risk groups”.

Chapter 8 is concerned with some implications for HIV prevention program. In the concluding part, Chapter 9, I suggest some practical approaches to deal with AIDS risks; and propose an orientation for AIDS research in the future.

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

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

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

Ngan met Cu in the autumn 1991 when they were both smoking opium. Cu was unemployed and lived in Haiduong, a small province 50 km from Hanoi. By that time Ngan could make money easily through her private transactions on narcotics. Every one or two weeks she went to see Cu in Hai Duong and they lived temporarily in a house shared with a young couple. One of them, Chu, was the owner of the house, which was also used as a shooting gallery. After a while, Cu moved unnoticed to injecting opium while Ngan was still smoking. It was during this period that some tensions arose between Ngan and Cu as a result of the difference in drug using habits between them. Ngan told me about the change in her feeling she experienced at the transition from smoking to injecting:
You know, even with him I feel sometimes hesitated [about my addiction status]...I was a novice smoker and he was a heavy smoker. I myself smoked black, but whenever I met him there, I did not want to reveal my smoking status. Until one day I saw him shoot with his friends. I felt sort of hate him very much and unpleasant [to see him shoot opium] ...something dirty and depraving you know. By then I was in love with him for some months already. But this feeling disappeared when I began shooting like him. I did not feel unpleasant anymore. People say that those who smoke opium look clean. Even some of them who are compatible to drug, even look stronger than the ordinary people. But shooters were often said to be depraved.

Ngan was smoking for three years, from 1989 to 1991. During this period, her sexual desire seemed to reach high: “I think during the time I smoked black I enjoyed having sex with him very much”. Ngan and Cu did not use condoms because “by that time we did not know anything [about AIDS]”.

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

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As their relationship developed, they began to increase the shared drug dose for each injection and, of course, they needed more money. But Ngan had “favorable conditions” for her addiction. She had money and time. The place they injected was far from Hanoi, therefore they could keep “the secret” to their parents and friends and that made her feel comfortable: “My parents simply knew that I went to Haiduong to meet my lover but they knew nothing about my addiction”.

Different from other drug using women, Ngan rarely shared one syringe with Cu: “I could inject myself. Sometimes I had Chu [the house owner] to inject for me but in most cases I did not share with Cu. If we [Cu and I] play together, I have to wait when he finishes his shot. It is about two or three minutes but it is too long for me to wait. So I don’t like it”. Another reason was because of her fear to shoot with blunt needle: “if I shoot after him. I feel that the needle becomes very blunt. Even up to now I am still scared of blunt needle. It is painful, blood is stuck and becomes invisible”. She did not fear HIV because she did not know about it: “nobody knows about HIV then”. This is true. The number of HIV infections detected during 1991-1992 was less than 20. Although the First Medium Term Plan on HIV supported by the World Health Organization was on the way, young people like Ngan were unaware of the epidemic. Ngan’s fear of the blunt needle has helped her prevent the penetration of the virus. In December 1993, Ngan left Cu: “after two years of the relationship I started to feel tired of him. I did not know why. I felt it was a waste of time being with him in such a long time. In Hanoi I could enjoy the drug and I could partner with other men. No need to go there”.

The drug Ngan enjoyed was opium. It was the end of 1993. Ngan moved to smoking heroin in 1994 when this white powder substance was booming again in Hanoi after disappearing many years in the Vietnamese market. “Nobody knew what it was, even people could not spell properly the word ‘heroin’”. It was in the same year that the National AIDS Committee was upgraded to Government Office, chaired by a Deputy Prime Minister. It was striking that the time when Ngan shifted to smoking heroin was also a hallmark in the history of the AIDS epidemic in Vietnam: the number of HIV cumulative infections in 1994 was about 100 times higher than that of 1992 (MOH 2000).

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

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

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

In 1996, Ngan entered into a relationship with Vuong, a non-addict state officer. At first, Vuong was Ngan’s “casual client” but gradually he became “regular client” and then “private sex partner”. A *bo* [sex partner] like Vuong not only provides extra income but also emotional support and a promise of marriage. In addition, he increased Ngan’s social status among her peers by displaying her desirability, as well as her capability to conform to cultural ideals regarding heterosexual relationships. The partnership with Vuong figuratively removes her from the realm of prostitution because she has a steady nonaddict partner in a socially acceptable relationship. Their love developed in the street and lasted for eight months. The break-up occurred due to the tensions embedded in the different lifestyles between the two partners. Ngan recalled:
He rented a room for me. After daily work hours or monthly business travels, he looked for me, either in the street or in the bars and we hang out together. After several months, I feel I am the one who loi dung [exploits] him. Our love is based on his money. Although he was very kind to me but I still felt something uncomfortable. He insisted on persuading me to stop drug use. He took me to many places for detoxification but no result. I didn’t like the way he persuaded me. To speak the truth when you are on drug, nothing is important to you but drugs. If I were responsible for myself I would have never been addicted and I wouldn’t bother others. I am like a ruly horse. Having sex partner or not is not important. I am still working and can support myself... The more he takes care of me, the more I feel disappointed. He could not understand me because he was not addict like me. I could not understand him either. We could not share enjoyment in sex. I always used condom with him. I didn’t know why. I think wearing or not wearing a condom is not important. The main thing is whether I like him or not. When I love someone dearly I can satisfy myself but if I don’t like someone I have to keep a condom for myself...at first he insisted on shagging without condom but I said to him “you know I am working as girl... You know well how can I keep [safe] in that environment. Condoms are ripped, breaking...sort of things. I myself am an addict and I don’t know whether I am suffered [infected] or not”. He seemed scared when I said so, though I knew that he wanted [to shag without condom] very much...Later I avoided seeing him

From 1997 until I met her, Ngan has been involved in multi relationships with men, mostly with shooters. The shooting partners were “sort of addicted heavily like me more or less” and “the longest relationship lasted for one year”. Serial unions with those shooting partners were summarized in her words: “We meet each other in the network, sometimes in the shooting galleries, or inviting for a shot...sometimes I have to ask a man to get some dope for me...In those situations I made acquaintance with these guys... then we rent a house and live together-in this way we can also divert the public attention”. As many others drug users who are isolated from the mainstream society, Ngan justified her multiple relationships with other drug users by the normative popularity of this phenomenon:

There are some women who are free from addiction but they still work as sex workers to feed their drug using men. If you notice you can see that, for example 10 women shooters and 10 men shooters, once they know each other they will cohabit anyways. Initially, the cohabitation starts with friendship, gradually [they] get closer and closer...lua gan rom bao gio cung ben
(Vietnamese saying: straw near fire will catch sonner or later). For example, we injecting women] or I never lived without men besides. People say what for? Drugs are accessible everywhere, and I can work [as prostitute] to support myself. Why should I live with men like that? First, for drug and, second, for love and sex.

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

CHAPTER 2

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

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

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

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

The recent HIV epidemics among young male IDUs in Northern Vietnam have been closely linked with the increased amount of heroin and opium smuggled into the country over the last six years. Drug trafficking rings are operational cross the border and throughout the country, with sophisticated scope and patterns. Drug smugglers are using more tricky methods in their illegal business, including transporting drugs by air, sea and via the postal system (VN News 2002). Drugs are trafficked into and within Vietnam by different routes, like a pendulum: from Lao, Cambodia to the central part and then to Ho Chi Minh City; from Southern China to Northern and North-western border provinces; from Northwest to Northeast; and from Northwest to Hanoi and from Hanoi to Ho Chi Minh City. In 2001, Vietnam uncovered 12,811 drug
trafficking cases; an increase of 24.4 percent compared to 2000 (VN News 2002). These figures have shown that even though the anti-drug law is harsh, drug trafficking is still on the increase. It is likely that many drug users have recently shifted from smoking opium to injecting heroin as the result of the influx of heroin into Vietnam.

The exact number of drug users in Vietnam is unknown. In 2000, 185,000 drug addicts (about 0.24% of the population) were reported, but the real number is believed to be much higher. The majority of IDUs in Vietnam are males and young (Hien et al. 2000, Phi et al. 2000). Three quarters of drug users belong to the 18-35 age group; female users only account for 5.9% (Vu 2001). Heroin and opium are the commonest drugs used by IDUs. The use of other drugs, such as amphetamines and synthetic opiates has been reported (Vu 2001). In addition, local production of amphetamines has been described (Vu 2001).

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

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

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

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

However, with the advent of the market economy and substantial changes in economic relations, including family ties, the traditional values have seemed to be faded out, resulting in the increase of prostitution with different scopes and nuances. Together with drug abuse, prostitution had been flourishing in the South during the Vietnam War. Ten years after “Doi moi” (the renovation process during the 1990s), the HIV prevalence reported in 1996 among sex worker population in the South was still low. In a cross-sectional study among 968 FSWs in Ho Chi Minh City, An Giang and Cantho during 1995-1996, HIV prevalence among FSWs was 5.2 % (Thuy et al. 1997). Over the years, the rate has been on the rise. Recently, 20% of the sex workers in Ho Chi Minh City were reported HIV positive (UN 2001).

Especially in nine Southern provinces bordering with Cambodia, prostitution has been increasing rapidly over the last ten years. During 1992-1993, about 20,000-25,000 Vietnamese women migrated to Cambodia to work in the sex sector (Tep & Ek 2000). There are some
reasons for their migration. First, prostitution is illegal in Vietnam but allowed in Cambodia. Second, Cambodia is believed, among Vietnamese sex workers, to be more promising than Vietnam in terms of earning money by doing sex work. Third, most of them want to stay in Cambodia for a while to pay off a specific debt or earn money to send home (Schunter 2001). In my interviews with some Vietnamese sex workers living in Cambodia in 1999, a girl said “I feel safe here because people do not know what I am doing…here I can earn money more easily and quickly”. Many poor families are dependent upon the labor of their daughters in order to obtain an adequate income for their family to survive, or at least, the family does not have to support the girl. However, there is a high incidence of STD infection among these girls. In a study on STD treatment seeking behavior in border area Vietnam- Cambodia, prevalence of a STD was discovered in 1,269 out of about 4,000 cases (CARE 2000). There are no official figures of HIV infection rate among Vietnamese sex workers in Cambodia but it is believed to be as high as 40%.

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

The composition of CSWs has changed greatly since the advent of the market economy. Contrary to the image often portrayed in research papers and the mass media, prostitution in Vietnam is not limited to merely poor or uneducated rural girls, but many university students, fashion models and cinema actresses have become CSWs as well. A “temporary” engagement in the sex work can be posited as a legitimate means for economic advancement. A study in
Thailand has also shown that high level of education guarantees neither a high income nor impunity from being forced to become a CSW (Wait & Coughlan 1999). It is likely that these ambitious people want to make a fortune overnight, acquire a certain public status or “keep up with the Joneses”. Prostitution has become not only a means of survival but also, to some extent, a means of self-determination and career advancement. Monetization has become a sine-qua-non of promotion. There is a Vietnamese saying “if you have money you can buy a Fairy” (co tien mua tien cung duoc). Some girls have intentionally become fashion models; with their new identity, they can earn money more easily and quickly. These models or “elite CSWs” can gain USD 200 -1000 per night, which is 5 to 25 times the monthly salary of a state official.

Recently, a ‘North-South call-girl ring’ (a pimp network specializing in coordinating model-CSWs throughout the country) has been uncovered (VnExpress 2002). Also, a study found the pimp network, in which out-of school youth in rural areas were recruited to work in Hanoi selling trinkets and postcards on the streets in tourist areas. As they get older, the girls are often pressed into sex work with offers to work in bars as waitresses or cleaning staff (Elmer 2001).

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

CHAPTER 3

Methodology
Introduction

In Chapter 1, the objective of the study was presented. Chapter 2 described the socio-cultural context of the epidemic. I am now going to tell the reader about my research that aims to get more insights in specific processes of this larger problem.

The research combines an exploratory and a descriptive approach. Emic views of IDUs and their SPs about AIDS risks and their relationships are analyzed from a cognitive-symbolic perspective. In addition, the social contexts and meanings of their risk-taking behaviors are carefully taken into account.

The Organisation of the Study

The Study setting

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

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

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

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

1. **IDU**

A person who injects heroin, or injects heroin and other narcotic drugs.

2. **Smoker**

A person who smokes opium or heroin.

3. **Non-addict**

A person who neither injects nor smokes a drug.

4. **Sex partner (SP)**

A person who has vaginal intercourse with an active IDU of the opposite sex. SPs include: husbands or wives of IDUs; steady SPs; and FSWs. Those SPs who also inject drug are interviewed as IDUs.

5. **Intimate relationships**
6. CSW

A person who provides sexual services, such as sexual penetration, oral sex or performance of masturbation.

The sampling

Based on rapport developed with a number of local IDUs and/or SPs from the first phase site visits of about two weeks, two active recruits (acted as “index participants”) helped me to identify other prospective participants by a snowball technique. Participants were also recruited with the assistance of two ex-addicts as outreach workers, one male IDU and one female CSW, who are familiar with the network of drug users and prostitutes in Hanoi. The two outreach workers were provided with a short training about the purpose of the study, criteria to select the participants and how to set up a proper appointment. Standard multiple-starting point “snowball sampling” outreach techniques (McCoy1996) were used in different locales to maximize the variation of subjects.

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

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

Table 1- Composition of IDUs and SPs sample.

<table>
<thead>
<tr>
<th>Informants</th>
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<tr>
<td>In-depth interviews</td>
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<tr>
<td>(n= 53)</td>
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</table>

Case study
(n=3)

FGDs

(n=19)

Total (n=75)

Male

Female

Male

Female

Male

Female

M&F
<table>
<thead>
<tr>
<th>IDUs</th>
<th>(incl. SPs who are IDUs)</th>
<th>SPs</th>
<th>(incl. smoker SPs and non-addict SPs)</th>
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<td>21</td>
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Data Collection Techniques

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

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

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

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

The interviews were loosely structured, conducted with the assistance of the Question Guidelines. (see Appendix 1). It seemed that interviews would provide richer information if the Question Guidelines were not put in front of the researcher. Lastly, informants were compensated with meals and/or gifts (equivalent to USD 4 for each) as a token of thanks for their time and contribution. I did not see any biases growing out of this compensation.
**Focus group discussions (FGDs)**

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

**Participant observation**

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

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

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

Second phase participant observation on-site was conducted during the remaining course of fieldwork, including observation in FGDs. I wrote field notes (either in the field or at home) to record day-to-day events and behaviors, overheard conversations and casual interviews. Field notes and interviews were revised everyday together with the two outreach workers or “index participants” to avoid missing data or misunderstanding of jargons used by IDUs. To complement the data collected during participant observation, I also conducted informal interviews with different key informants.

During the fieldwork, I also visited a number of IDUs’ families, in order to understand more about the contexts of sexual relationships and drug use among IDUs and their SPs.

Case studies
I conducted three case studies (life stories): The three informants (two female and one male) were interviewed more than once to broaden the information and to better understand different social contexts of different patterns of sexual relationships. The selection criteria were the same as for IDUs and SPs. In addition, informants should a) be able to speak clearly and elucidate the dynamics of their drug life coherently; b) reside in different locations (for easier comparison and confirmation of data). Initially, I planned to recruit two non-injecting SPs but I did not have enough time. However, Case 1 and Case 2 are the two in which two female IDUs also are engaged in multiple sexual relationships. Through their stories the portraits of different SPs were illustrated.

Secondary data collection:

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

- Interviewing health policy makers in Hanoi.

- Gathering and reviewing documents and reports.

- Literature review
Data Processing and Analysis

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

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

Ethical Considerations

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

Difficulties and Limitations

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

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

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

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

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

The Drug Scene as the Context of Sexual Relationships

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

Drugs and money

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

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

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

(14: Female injector, rehabilitation center)

Money, which is always a “hot topic” for drug users, can play an important role in the maintenance of sexual relationships:
Now 100% of talks are about money, money and money all the time. Even money is coming in dreams. To be more frank, the reason of [drug users’] cohabitation is all money, that's simple.

(7m: Male injector, Hanoi)

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

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

(21m: Male injector, Hanoi)

The image of money and how to acquire it is always on the minds of drug users. A 24-year-old girl reported about her “money phobia”:
You know when I am sober it is different but when I’m sick I only think how to get money. In the past, for the same thing, I spent 10 but now I spend only 2 or 3. Now I feel sort of stingy you know...he only thing on my mind is how to accumulate enough money for a shoot.

(24f: Female injector, Hanoi)

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

Every morning after we shoot he goes out with his band about 4 or 5 men. You know, they drive to the outskirt of Hanoi to ‘dap hop’ [break into a house]. You know. he can earn more than me. Sometimes VND 1 million (USD70) sometimes 2 million (USD 130) per day.

(21f: Female injector, Hanoi)
As a strategy to feed the drug habit, it is also common for some male IDUs to seek injecting female sex workers for a temporary cohabitation:

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

(12: Female injector, Hanoi)

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

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

(17f: Female injector, Hanoi)
Some female drug users, who had to work as a sex worker to feed their drug habit, have different "schemes" to deceive their clients. As described by a 23-year-old girl how she and her sex partner deceived a client:

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

(11f: Female injector, Hanoi)

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

When money is abundant and you are not sick, it is Ok to walk 1 or 2 km to buy do [works: syringe]...but when I am sick, I beg my friends any [syringe] for a temporary shot just as they finish the shot. This is exactly the same way when I am prostituting. When I am well [not sick] I still have cash in my pocket-it means that I only agree to go [with clients] when condom is there. But when I am
Syringe sharing is a frequent and normative activity in the drug scene, which is applied by drug users as a means to cope with the immediacy of their craving. Syringe sharing has been described as one of the highest risk practices in the spread of HIV infection because potentially infected syringes are utilized in the process of sharing drugs.

Patterns of syringe sharing and the situational contexts attached vary between geographic locations. First, I give a description of different techniques of syringe sharing, and then I move to the patterns and contexts.
Grund et al (1996) mention the following techniques in other countries: frontloading, reversed frontloading, backloading, storage syringe, sharing from the cooker, and sharing a load. In Hanoi and Quang Ninh where I conducted this study, ‘frontloading’ and ‘sharing a load’ were the two common practices applied by the drug users.

**Front loading** (sharing a load but different needles)

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

**Sharing a load** (sharing a load plus sharing needle)

The practice works as follow: after dissolving, the liquefied drug is drawn into one syringe. The first injector injects himself with part or half of the contents of this syringe, and then the second injector injects the remaining contents, including the ‘flag’ (the blood drawn into the syringe to see if the needle is in the vein) of the first user.
The following field note describes a sharing episode in which this technique was taken by an injecting couple in Hanoi:

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

(Fieldnote in Hanoi)

Patterns in Context

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

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

(17m: Male injector, Hanoi)

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

(8m: Male injector, Quang Ninh)

Spousal sharing is safe. Nothing to worry about when you are husband and wife

(18f: Female injector, Hanoi)
2. Sharing between (close/best) friends. This pattern is most likely to be found among men and occurs when two IDU pool money to buy drug for a shot, but there is only one syringe. In this context, the person who is “more trusted” (expectedly non-infected) or “more respected” (having more money) would have “more power” and thereby injecting first. The second person then reuses the syringe of the first person. This means that the second person would risk the chance of possible infection if the first person were positive. This action is labeled by drug users as chat nhuong nhin [giving in nature]. The word “trust” in this context, which implies “cleanliness” or “HIV negativity”, is synonymous with the degree of one’s risk assessment and judgment of their friendship in a sense that “because he is clean so I accept to shoot after him”:

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

(9m: Male injector, Quang Ninh)

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

(15m: Male injector, Quang Ninh)

In many cases, after I shot I gave my syringe to them [my friends]
3. Sharing between two seronegative injectors after return from rehabilitation center. This pattern commonly occurs between two IDUs who meet while they are in rehabilitation centers or detoxification establishments. Most of the respondents in this study spent sometime in these centers at least once. The following fieldnote explains this sharing pattern:

Sharing occurs when two IDUs, who are known to each other, in rehabilitation center, believe that they are free from HIV (because of negative test undertaken as a procedure of detoxification). This makes the two injectors feel safe and they will possibly share one syringe on return to the community. In this case the sharing may take place when syringe is unavailable or when one person lends/borrows his or her syringe to/from another. However, it is possible that both of them are still in the window period\(^2\), which is unknown to them.

(Fieldnote from focus group discussions)

4. Sharing between two seropositive injectors. This pattern is very common among HIV/AIDS carriers:
After I got infected with HIV I often shared with my friends who were also infected ...if syringes are not there, we play in turn [sharing one syringe]

(22m: Male injector, Hanoi)

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

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

(25f: Female injector, Hanoi)

6. Sharing in institutions. In this case, several people, even hundreds of people, share one syringe as a result of syringe scarcity in these establishments. This has posed to the possibility of serial anonymous infections occurring between groups of IDUs and has to be seen as a situation of very high risk:
In prisons they share much more than outside (community). Hundreds of men share one syringe. You know to have a mui thuoc [a shot] we resort to different styles of van vo [tricks]. It's so hard there [in prison]

(16m: Male injector, Hanoi)

Matrix 1- Ten Patterns of Sharing Syringes and Needles in Contexts

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Context</th>
<th>Need to Inject</th>
</tr>
</thead>
</table>
Craving

Syringe scarcity

Trust

Lack of money

Careless

Lack of AIDS knowledge
Confusion

Revenge

Lending/

Borrowing

1

Sex partners

&Spouses

Yes

Yes
THE DYNAMICS OF AIDS RISK AND GENDER RELATIONS Part 1

Written by Nguyen Tran Lam
Friday, 04 April 2003 00:00 - Last Updated Monday, 20 December 2010 22:48

Not necessary

Yes

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

No

Not necessary

2

Close friends

Yes
| Yes | Yes | Yes | Yes | Yes | Yes | Not necessary | Sometimes | No | Yes | 3 | Two negative IDUs | (post-detox) |
Two positive IDUs
Yes

Yes

Yes

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

One positive &
One negative

Yes

Yes

Yes

Not necessary

Yes

Not necessary

Not necessary

Not necessary

Not necessary

Yes
<table>
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<tr>
<th>Institutional</th>
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<td>(rehabilitation/detoxification/prison)</td>
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<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
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<td>Not necessary</td>
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<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
Shooting gallery

Yes

Yes

Yes

Not necessary

Yes

Yes

Yes

Not necessary
THE DYNAMICS OF AIDS RISK AND GENDER RELATIONS Part 1

Written by Nguyen Tran Lam
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Yes

8

Dead-end

Yes

Yes

Yes

No

Yes

Yes

Yes

Not necessary
Not necessary

Yes

Yes

Not necessary

Yes

Not necessary

Yes
Yes

Not necessary

Yes

10

Non-accidental

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary

Not necessary
a- the belief that a fellow/partner is free from HIV

b- confusing to use an infected person’s syringe

I would rather detox at home than going there [detoxification center]. You know one syringe is passed on to unknown number of people.

(9m: Male injector, Quang Ninh)
7. **Anonymous sharing in shooting gallery.** Five respondents report that they used to inject in shooting galleries where prepared syringes with drugs were available on sale. These syringes possibly were not sterilized and used by different people. In this case “trust” is not important. The need to inject, craving and syringe scarcity prevail. This has to be seen as a situation of high risk:

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

(18m: Male injector, Hanoi)

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

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

( 7f: Female injector, Quang Ninh)

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

(17m: Male injector, Hanoi)

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

It is the case of a person infected living with a noninfected. Very often the infected store their
own syringe in a separate place after marking it [syringe] in a certain way. However they often mix up.

(21m: Male injector, Hanoi)

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

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

(8m: Male injector, Quang Ninh)

My friend confided: “it was because of men who passed the virus to me. Therefore now I also do the same way [infect them intentionally]”

(20f: Female injector, Hanoi)
Drugs, Sex Work and Condom Use

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

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

(12f: Female injector, Hanoi)

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

Taking a hit before going to work is a must [to enhance health]. Going to work in craving status is okay but it is sort of uncomfortable feeling. Yes, anyways, [I] should have a shot before going to work. It is important to have sufficient dose first...everybody does the same.
These drug injecting prostitutes live in two separate contexts: life in the street where strangers may become their casual or regular clients and life at home where private sex partners or spouses provide some sort of security to them. Casual clients can be considered as one-off sexual encounters. A regular client is someone who pays for sex after a short introductory period and the couple is usually involved in a sexual relationship for a limited time. A male sex partner is considered to be more of a long-term partner who supposedly has a vested interest in the physical and emotional well being of his companion. At some point, however, the relationships between injecting prostitutes and their sex partners are situated in the fuzzy middle where love, sex, risks and money are blurred in people's attempts to find what they desire.

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

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

(20f: Female injector, Hanoi)
In some contexts, women use their power to force men to use a condom, without threatening the sex-for-money exchanges in which they engage:

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

(9f: Female injector, Hanoi)

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

(3f: Female injector, rehabilitation center)

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

(18f: Female injector, Hanoi)
Condoms are often used when injecting women have sex with their one-off sexual encounters or even regular clients, but condoms are dispensed with once the couple decides to cohabit. The transition from regular clients to private sex partners is often “marked” by the decision of the woman whether to use condom or not:

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

(12f: Female injector, Hanoi)

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

(19f: Female injector, Hanoi)

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

The Interplay of Drugs and Sex

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

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

For a normal person, sex is the most favorite pleasure. But for drug users it is only a minor thing. That’s paradoxical.

(16m: Male injector, Hanoi)
As for me, sex cannot compare with drug because addicts are always guided by drug. Drug and sex cannot be in balance

(22f: Female injector, Hanoi)

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

We have sex less than before, from the beginning it was frequent. But later when [we] play heavy [sex] was not necessary.

(17m: Male injector, Hanoi)

In general, women seem to have a more “positive attitude” than men towards sexual life. While women are more likely to report about the pleasure they have with sex partners during a sex act rather than a loss of interest in sex, men, on the contrary, usually complain about their sex life: “I had sex for the sake of it”, “It was my duty rather than pleasure”, “I felt irritable...I could not erect”, “I felt painful and unable to ejaculate”, “it was a compulsory sex”, “it took long like a century”. 
Drug users differ in their sex life. In the drug use subculture, “juniors” are defined as novice injectors or amateurs who have a history of a few months (usually from one to three months) after shifting to injecting pattern. “Seniors” are experienced injectors who have involved in injecting life for at least five to seven months. Juniors and seniors bear distinct features in terms of the timing to have sex, sexual desire and feeling during a sexual episode.

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

[Amateurs] liked to *shag* [have sex] right after the *shot*. But the *hit* should be done in a way that you don’t get too high

(22m: Male injector, Hanoi)

In contrast, most of seniors (both females and males) do not want to have sex right after the injection:

It is very rare to find someone to have desire for sex right after a shot
Among the exceptions, however, four IDUs said that they want to have sex right after a shot:

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

(19f: Female injector, Hanoi)

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

(10m: Male injector, Quang Ninh)

One female injector explained that she wanted to have sex right after the shot in the condition that the drug dose should be low:
If we *play moderate* [inject with a low dose] we can fuck right after the shot. After fucking we take another shot and want to go to bed.

(2f: Female injector, rehabilitation center)

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

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

(14m: Male injector, Hanoi)

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

(16f: Female injector, Hanoi)

When female seniors feel "rather full of drug", they like long sex:

Most of us [female seniors] like long sex. Only long sex can produce good feeling. If sex [ejaculation] is done fast I can’t manage to realize what kind of enjoyment it was.

(20f: Female injector, Hanoi)

When I am in noncraving status, it takes long to have an orgasm

(4f: HIV female injector, rehabilitation center)
In this chapter, I describe different patterns of intimate relationships among IDUs. Analytically, we can make the following categories of:

Pattern 1- IDUs in a heterosexual relationship with an IDU;

Pattern 2- IDUs in a heterosexual relationship with a drug smoker; and

Pattern 3- IDUs in a heterosexual relationship with a non-addict.
Matrix 2- Parameters for analysis in three relationship patterns

IDU- IDU Relationship

IDU-Smoker Relationship

IDU-Nonaddict Relationship

Reasons of cohabitation

The difference between smoking and injecting

Partnering

Injecting practices

Switching between smoking and injecting
Non-disclosure and the “double life”

Condom use

Sex and condom use

Condom use

Risk assessment

Reducing and stopping drug use

Reducing and stopping drug use

Managing relationship

Managing relationships.
Each of these relationship types has different characteristics. Based on the problems emerging from the study, I shall focus my analysis on key parameters in each pattern respectively (Matrix 2).

Characteristics of IDU-IDU Relationships

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

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

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

(17m: Male injector, Hanoi)

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

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

(24f: Female injector, Hanoi)
While seeking a sex partner, many Vietnamese women value manliness. But female IDUs see it as less important than having the same injecting style:

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

(9f: Female injector, Hanoi)

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

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

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

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

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

(19m: Male injector, Hanoi)

Taking two or three shots per day is a common and normative activity. The need of injecting is so important for IDUs and their SPs that they call a shot as bua (meal). They take meals in different ways. The majority of injecting respondents say that they use two patterns of drug injection “it depends [on the availability of syringe], sometimes we use separate syringes and sometimes we share one”. However, even in the case of using two syringes, accidental sharing may occur, especially at night when syringes are reused. By marking the injecting paraphernalia after use, drug users believe that they use their own one. But if the syringes are put in the wrong place and their craving comes, they can’t make sure that they use the right syringe or not. In another context, when reusing two separate syringes is not the habit and the injecting event occurs at night, when the second syringe can’t be bought, it is common that a couple shares one syringe, with a simply rinsing with water. All the time, a variety of uncertainties are constantly haunting the minds of injecting couples:
...cos we live together, you know all sort of things....shooting, being sick...many things may happen and you never know [the risks]...for example scratches during a shot or something like that.

(22m: Male injector, Hanoi)

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

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

(20f: Female injector, Hanoi)

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

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

(2f: Female positive, rehabilitation center)

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

(20m: Male injector, Hanoi)

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

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

(24f: Female injector, Hanoi)

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

It [drug dose] is always increasing while [I am] living with a person who is more addicted [Lam: if he shoots more than you, what about drug division? Is it equal?] He takes the bigger portion of course! [Lam: so, how can you increase your drug use?...cos he shoots more than me (he shoots 5 times per day and I shoot 3 times per day). you know he is shooting in front of me. This forced me to shoot with him...sort of ngua nghe (unbearable feeling) That’s natural how I increase. He has his level [of dose], I have mine. If his dose is divided to me, he can’t bear it. If he uses50 [VND 50,000] and he plays 150, we
will buy 200 to play together. But then I have to buy an additional 50 pack to play my portion. And he had his cu [level] 150 already; he does not want to reduce his dose.

(3f: Female positive, rehabilitation center)

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

We often talk with each other [about reducing and stopping drug use]. However, once we have the same blood [both are injectors], at the maximum level, we can only keep [drug use] at an average level. We know that we should stop at a specific level...because sometimes we don’t have any money...from the beginning we had different injecting habits, at different times of the day. Then I tried to be abstinent sometimes by skipping one or two meals myself. After several times doing like that I got used to his schedule
Efforts to reduce or stop drug use may be inhibited by being in a relationship with an injecting partner (Rhodes and Quirk 1998). On the other hand, our data suggest that a partner in an injecting relationship may reduce his or her drug use in some specific contexts, especially when the couple concern about the possibility of not being able to earn money anymore or when they want to have children:

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

(18f: Female injector, Hanoi)

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

(21m: Male injector, Hanoi)
Although injecting couples can reduce drug use when both of them worry about money running out, this may change again when the couple has money again or if they have to cope with a difficulty. In such contexts, it is likely for the couple to resume the increase:

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

(11f: Female injector, Hanoi)

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

(19m: Male injector, Hanoi)

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

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

(14f: Female injector, Hanoi)

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

(8f: Female injector, Hanoi)

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

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

(22f: Female injector, Hanoi)

Condom Use

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

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

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

(14m: Male injector, Hanoi)

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

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

(15f: Female injector, Hanoi)

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

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

(17f: Female injector, Hanoi)

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

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

(16m: Male injector, Hanoi)

Trust is even used as a means of existence, a means of survival:
We don’t use condom because we trust each other. In order to survive, [we] should trust each other. That’s it.

(18m: Male injector, Hanoi)

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

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

(23f: Female injector, Hanoi)

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

(18f: Female injector, Hanoi)

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

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

(16m: Male injector, Hanoi)

Risk Assessment

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

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

(21m: Male injector, Hanoi)

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

(9f: Female injector, Hanoi)

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

2. Uncertainty about the risks of sexual transmission;

3. Uncertainty about sex partners’ sharing or having sex with outsiders.

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

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

(17m: Male injector, Hanoi)

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

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

(20m: Male injector, Hanoi)

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

Interestingly, 12 out of 56 respondents report that in case of a positive- negative couple, cutting (pinching by nail) the teat of a condom before ejaculation can prevent the transmission from the positive person to the negative one. They reason that such a “gentle pinching” can prevent abrasions, which may occur during a sexual episode:
You know during the whole time of sexual intercourse- it is a long time- pinching a bit off the teat of condom just before ejaculation...this duration is too short. The time of contact [between penis and vagina] is too short. Not enough [time] to be infected. [Lam: so, that pinching can minimize the infection?]. Yes, a lot.

(2f: Female, rehabilitation center)

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

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

(10f: Female injector, Hanoi)

The uncertainty about sex partner’s having unprotected sex with outsiders comes to the fore when a couple wants to have children. One man describes his consideration about his wife’s going for a test:
I also asked my wife [a sex worker] in what cases she did not use condom [with clients]...in the future if [we] want to have children, [I] have to consider [whether she is infected or not]...a test is necessary [for her] then.

(22m: Male injector, Hanoi)

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

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

(1f: Female injector, rehabilitation center)

Some seropositive IDUs feel confident that they could “guess” their positivity status by recalling past risk related contexts they engaged in. As a HIV positive female reported:
Very often, we always look back into the past, go against the time when and why [we] were infected...trying to remember whether the sex partner [I] had shared with or had sex with was infected or not. By recalling those moments I will know [when and why I was infected]...in specific contexts of each person...they can know the reasons for infection by recalling the past...for example, I can confirm, of course not 100%, but rather precisely the duration of time I got infected

(6f: HIV Female injector, rehabilitation center)

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

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

(4f: HIV Female positive, rehabilitation center)

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

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

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

(12f: Female injector, Hanoi)

I have the feeling that our cohabitation is something like ...a place to go in and go out. It is no problems if I leave her and vice versa. For example, if we are apart, it is even more difficult for her to seek a decent man [after me].
Some female IDUs said that they do not consider their relationships with male injectors as “love”. They rather define them as situational or spontaneous cohabitation, often fraught with lies and doubts. Comparing their current relationships with a true love, they highlight the negative impacts of drug use posed on the meaning of their relationship:

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

(18f: Female injector, Hanoi)

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

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

(24f: Female injector, Hanoi)

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

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

(22m: Male injector, Hanoi)

While money is always short, many men don’t want their partners to work as a sex worker. As a
man asserted:
I would rather die because of my wife but I never accept her as a prostitute.

(16m: Male injector, Hanoi)

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

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

(10f: Female injector, Hanoi)

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

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

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

(19m: Male injector, Hanoi)

The great majority of individuals in injecting relationships said that they do have quarrels or conflicts but that it is not easy for them to break their relationships. In most cases, their relationships are temporarily discontinued as a result of being arrested by the police for their criminal activities (mostly involved by men) or being sent to rehabilitation centers for a compulsory detoxification. They seldom terminated their relationships by themselves.
Sometimes we [injecting couples] have quarrels or get angry at each other. But to say good-bye is very difficult.

(23f: Female injector, Hanoi)

We don’t quarrels, no conflicts cos we don’t share money. She has her money and I have mine.

(21m: Male injector, Hanoi)

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

I feel something untruthful between us …our relationships [with male IDUs] go nowhere…life is full of obstacles… so he went his way and I avoided seeing him.

(8f: Female injector, Hanoi)
Some male IDUs, who are incapable of making money, cohabit with female injecting prostitutes not because of love but because of the money the woman earns from her sex job. In this case, injecting prostitutes often complain about the instability of their relationships. The most frequently cited reasons for the break-up are financial issues:

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

(25f: Female injector, Hanoi)

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

(13f: Female injector, Hanoi)

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

The difference between smoking and injecting patterns

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

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

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

(Fieldnote in Hanoi and Quang Ninh)

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

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

(14f: Female injector, Hanoi)

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

(18f: Female injector, Hanoi)
Injectors seem to be sympathetic to smokers, rather than the other way round. This can be explained by the fact that because injectors have undergone “smoking period”, it is easier for them to share feelings with smokers:

[Is it unpleasant for a shooter witness a smoker inhaling?] No. It’s normal. It is their [smokers’] habit. They [smokers] do not want to change so [injectors] should not force them to change. Don’t force them to do something they dislike.

(15m: Male injector, Quang Ninh)

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

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

(19m: Male injector, Hanoi)

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

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

1. As the smoking dose increases over time, more money is needed. Initial injections require a small dose and less money compared to smoking. Injecting seems to be cheaper than smoking at the onset of addiction (when drug users get deeper into addiction, injecting becomes even more expensive than smoking, especially for those who use ‘poly drugs’). This economic reason is the most frequently mentioned by the informants.

2. Smokers shift to an injecting pattern to overcome their cravings [chong va]. It is a situational solution or a strategy to cope with the immediacy of drug desire.

3. Injecting makes them get high faster and reach more “rush” than smoking.

4. The ‘aftermath durability’ after injecting is longer than smoking. This ‘durable effect’ of injection makes drug users feel more satisfied.

5. As smoking takes more time to have an effect than injecting, many smokers decide to inject to get high immediately.
6. Taking an injection is more ‘convenient’ than smoking, which requires a group of people and a comfortable place.

7. Drug users assume that it is easier to withdraw drug use while injecting than when smoking. Consequently, smokers who intend to stop drug use may “try” to switch to an injection pattern. In most cases, once they inject they will not be able to smoke again.

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

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

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

(7f: Female injector, Quang Ninh)
Many smokers move from oral to intravenous use whilst in a sexual relationship with an injector. It is very difficult in such a case to sustain smoking status overtime:

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

(12m: Male injector, Hanoi)

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

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

(20f: Female injector, Hanoi)
In some cases, smoking partners themselves ask their shooting partner “for a try” and this trial then becomes the hallmark for a smoker to go deeper into drug life:

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

(24f: Female injector, Hanoi)

Few smokers can maintain their oral pattern for a long time. Those who can may be divided into three categories:

1. Smokers who never engage in a sexual relationship. They are fearful of being infected if they shift to injecting; their fear of fatal overdose which is often caused by heroin (note*); their fear of being stigmatized by society; and their phobia of seeing a needle (for women).

2. Smokers in a relationship with a nonaddict. Such smokers can sustain their smoking pattern because they still can earn money legally or may be financially supported by their nonaddict partners.
3. Smokers in a relationship with an injector. Such smokers can control themselves or are positively influenced by their injecting partners. One female injector reported:

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

(10f: Female injector, Hanoi)

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

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

(7f: Male injector, Hanoi)

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

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

I left him because after a while I saw him sort of incompatible to me. In addition, he had his wife and I did not want to continue [this relationship]...he is much older than me so we have different attitudes...I am still a playgirl. I like group funs. But he is different. Therefore the tensions [between us] arise. When my friends come he feels sort of unpleasant...although he did not forbid [my friends’ visits] but I don’t like living like that. After we said good-bye to each other, I shifted to shooting again.
Basiclly, IDU-smoker relationships have similar features as IDU-IDU relationships with respect to sexual issues. One minor difference is that women smokers in IDU-smoker relationships seem to have a higher and more frequent sexual desire than women injectors. Some women smokers report that smoking opium enhances their sexual desire, which then is so strong that they do not care about using condom:

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

(3f: Female injector, rehabilitation center)

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

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

(16m: Male injector, Hanoi)

Characteristics of IDU-Nonaddict Relationships

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

Partnering

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

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

(12f: Female injector, Hanoi)

Although she loved me but I did not care. All I need is money from her. You know beautiful or ugly are not important

(10m: Male injector, Quang Ninh)

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

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

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

(18f: Female injector, Hanoi)

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

When I partnered with nonaddicts...in many cases it is difficult to say. He insisted on persuading me to stop [drug use] and that I should change...that sort of things you know. I don’t like that. I would rather live with a shooter...sometimes having a deep talks at night, you know that [IDUs often experience broken nights]...it feels good...many things in common [with IDU partners].

(20f: Female injector, Hanoi)
Female injectors express their wish to have a steady partner who is not addicted to a drug. However, the fear of being looked down by the prospective partner has made them avoid partnering with nonaddict men:

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

(11f: Female injector, Hanoi)

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

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

It [partnering with nonaddicts] is very rare. [I] felt that they were not compatible to me...something coercive. It is difficult.
Some women talked about the difference between men’s attitudes towards partnering with female injectors and women’s attitudes towards partnering with male injectors. According to them, it is more likely for women to accept a male injector than for men to accept a female injector. This gender difference was confirmed in focus group discussions with both male and female IDUs who ever had partnered with a nonaddict. One female injector explained as follows:

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

(25f: Female injector, Hanoi)

Nondisclosure and the “double-life”

When IDUs partner with a nonaddict, they often hide their injecting status. This nondisclosure is a strategy to manage their relationships with nonaddicts. Usually, IDUs reason that the disclosure will create problems in the relationship or that nonaddict partners will not accept their drug use. In some cases, the reason for nondisclosure is in fear of the stigma inherently
If he were also a drug user like me, I would not hide [my addiction status]...but I always determine in my mind that the life I am living now is condemned by the whole society. I myself cannot be suited in that [pure society]...By my instinct I did not tell him the truth from the first time I met him.

(2f: Female injector, rehabilitation center)

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

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

(14m: Male injector, Quang Ninh)
Regarding sexual desire...once you shoot you never care. But in order to maintain our relationship and meet her sexual demand I have to please her...In that way we can get along.

(19m: Male injector, Hanoi)

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

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

(7m: Male injector, Quang Ninh)

Wherein injectors live a “double-life”, tensions arise. IDUs wish to have sympathy from their nonaddict partners. But their demand is never met because most of nonaddicts often “feel terrible” or “I can not accept watching her/him shooting”. Sexual life is even more problematic. Many female injectors report that their sexual need is not satisfied by their nonaddict partners. So, the complexity of the drug-sex conflicts leads to tensions. The following extracts are illustrative of this “double difference”:
For sex matters, he couldn’t meet my demand. On the contrary, he treated me very well. Another thing incompatible is that because he does not use drug, I can’t ask him to go and buy some drugs for me when I feel sick. Then I had to go and buy myself. And when I couldn’t shoot myself, I had to have others to shoot for me. Therefore sometimes I feel sort of difficult to say [to him] because my sex partner is a nonuser. For example, sometimes at night he was looking for me and he went to my place [streetsexwork] to pick me home. Even I did not yet have a shot then but I had to go home with him. And when we arrived...it was already the time of my craving but he insisted on having sex. I felt very annoyed then and I did not want to fuck at all. As always, I should find drugs first.

(3f: Female injector, rehabilitation center)

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

(16f: Female injector, Hanoi)

I am an addict and he is not. When sleeping I feel sort of unpleasant. Until I shoot...he stares at me...I don’t agree at all. When having sex after a shot...[sex] desire is quite high. It means that [I] want my sex partner to have a long sex with me. If he sort of wants to fuck fast I want to drive him out
The demand to have long sex a few hours after injecting was rationalized by female injectors as a tactic to maintain sexual harmony:

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

(24f: Female injector, Hanoi)

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

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

(9f: Female injector, Hanoi)

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

(20f: Female injector, Hanoi)

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

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

( 19m: Male injector, Hanoi)
For men, appeals to love, respect and sexual pleasure were commonplace forms of excuse making for their condom nonuse:

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

(13m: Male injector, Quang Ninh)

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

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

(8m: Male injector, Quang Ninh)

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

(10f: Female injector, Hanoi)

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

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

(14m: Male injector, Quang Ninh)

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

(12m: Male injector, Quang Ninh)
Some male injectors based their condom use on their relative risk assessment:

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

(9m: Male injector, Quang Ninh)

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

(15m: Male injector, Quang Ninh)

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

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

He did not mention about it [using condom] but I myself want to keep safe for him. I think that AIDS can come to me at any time because I am a shooter. So I told him to use condom and he agreed.

Injecting women (most of whom were also working as sex workers) report consistent condom use with their casual clients and dispensing with condom use while in a relationship with a private sex partner. Yet some injecting women report consistent condom use after a casual client has become their private partner. The reason to use a condom in this context lies in the social stigma toward drug using women:

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

(14f: Female injector, Hanoi)

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

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

(3f: Female, rehabilitation center)

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

Our findings show that the possibility of reducing or stopping drug use among those in IDU-nonaddict relationships is higher than those in IDU-IDU and IDU-smokers relationships. None of injectors in this study could reduce or stop their drug use permanently. However, injecting women appear to be easier to be persuaded by nonaddict men than injecting men by nonaddict women in reducing or stopping drug use. In some cases, the persuasion can be effective, based on the following conditions:

First, the person who persuade should never have been involved in drug use:

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

(7f: Female injector, Quang Ninh)
Second, the nonaddict partner should be “a good shelter” for the drug user. Women often express their wish to have a nonaddict lover with a stable job:

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

(12f: Female injector, Hanoi)

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

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

(24f: Female injector, Hanoi)
Many nonaddicts advised me...but this kind of advice...I just listen only but in fact I don’t keep it in mind cos they don’t understand me. They just say, “ stop it”...cos injectors [like me] have high self-respect. We [injectors] often feel discontented with many things. For example, if the advice is given in inappropriate context, we are ready to turn down everything...let it be

(1f: Female injector, rehabilitation center)

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

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

(25f: Female injector, Hanoi)

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

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

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

(10f: Female injector, Hanoi)

For male injectors, maintaining a relationship with a nonusing lover by taking advantage of her was justified as mot mui ten trung hai muc dich [an arrow with two goals]. These men try to get as much as they can from the relationship. This was rationalized by them as a “strategy” to feed their drug habit use and to satisfy their sexual needs simultaneously:
We have sex six times per week. At the same time I still maintain our relationship and love, provided that I have money. I borrow money from her and go for a shot. After that I go home and sleep with her.

(14m: Male injector, Quang Ninh)

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

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

(23f: Female injector, Hanoi)

In some cases, the break-up may not occur because of the “manliness ideology”, which is embedded in the minds of nonaddict women. Manliness is configured as a reason for some women to maintain their relationship with injecting partners. The following extract and fieldnote illustrate this point:
When I insisted asking my [nonaddict] wife about the reasons why she did not leave me, she said, “I still live with you only because you have not yet lost your manly characteristics”

(21m: Male injector, Hanoi)

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

(Fieldnote from FGDs)

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

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