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How to live with and despite addiction : Experiences of drug users in Vietnam

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THÈSE POUR OBTENIR LE GRADE DE DOCTEUR DE L'UNIVERSITÉ DE MONTPELLIER

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How to live with and despite addiction: Experiences of people who use drugs in Vietnam

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Le 2 juin 2020

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Table of contents

ACKNOWLEDGMENTS.....	5
ABSTRACT.....	6
RÉSUMÉ EN FRANÇAIS.....	7
ABBREVIATION.....	14
CHAPTER 1. INTRODUCTION.....	15
Overview of the chapters.....	17
Summary.....	19
PART 1.....	20
CHAPTER 2. THEORETICAL FRAMEWORK.....	20
The social constructionist approach and the meaning of normality.....	20
Overview of different conception models of addiction.....	21
1. Moral and medical models: Addiction as individual flaws.....	22
2. Sociological perspectives of drug use.....	25
Who is the drug user? Drug use from the individual perspective.....	29
1. Social learning theory.....	30
2. Theory of evolutionary behavior.....	31
3. Theory of choice.....	32
4. Drug users as active agents.....	32
5. Risk environment theory and the importance to contextualize the Neoliberal subject.....	34
Resources to deal with life hardships.....	36
1. Social capital.....	36
2. Cultural capital.....	41
Summary.....	44
CHAPTER 3. METHODS.....	46
Background of the study.....	46
Methods.....	48
1. The ethnographic work and our position in the field.....	48
2. In-depth interviews.....	56
Data treatment.....	58
1. The intersectional approach.....	58
2. Data analysis.....	58

Participants' characteristics	60
Summary	61
CHAPTER 4. THE SOCIAL CONSTRUCTION OF DRUG ADDICTION IN VIETNAM.....	62
Evolving social meanings of drugs and addiction in Vietnam	62
1. Overview of drug use in Vietnam: Drug issues are a big concern	62
2. Drug policies overtime: Competing messages about drug addiction	64
Socioeconomic context — Coming of age at Post-Renovation	70
1. Economic changes.....	70
2. Changes in social values.....	73
3. Socioeconomic particularities of Haiphong	74
Drug users: socio-demographic information and context of initiation to drug use	76
1. Socio-demographic information	76
2. Initiating heroin use in the 1990s and 2000s.....	78
3. Support for drug users: community-based peer groups.....	79
Summary	79
PART 2	81
CHAPTER 5. EXPERIENCES OF STIGMATIZATION IN DAILY LIFE	81
Concept of Stigmatization.....	82
Drug — related Stigmatization	84
Stigmatization and discrimination towards people who use drugs in Vietnam	88
Methadone maintenance treatment: global expansion and persisting ambivalence.....	90
Heroin use: from being discreditable to being discredited	93
Social Stigmatization towards people who use drugs	94
1. Stigma in the family: no rejection but mistrust and disrespect.....	94
2. Stigma in the neighborhood: avoidance, suspect or indifference.....	98
3. Stigmatization at workplace: Barriers to secure a socially approved job.....	100
Social and institutional stigmatisation in methadone treatment setting.....	101
Intra-group Stigmatization.....	107
Internalized stigmatization	113
Discussion.....	117
Summary	127
CHAPTER 6. NEGOTIATING DRUG-RELATED STIGMA AND DISCRIMINATION	128
Dramaturgical work and techniques of neutralization	129

Managing the discreditable information	132
1. Passing.....	133
2. Social avoidance.....	136
Managing external and internal tension.....	137
1. Social avoidance.....	137
2. Techniques of neutralization	139
Discussion.....	157
Summary	161
CHAPTER 7. LIVING WITH HIV IN THE ERA OF EXPANDED TREATMENT — THE BIOGRAPHICAL IMPACT OF HIV.....	163
HIV/AIDS in Vietnam	163
HIV and the biographical disruption framework	164
The diagnosis event	166
1. Initial reactions.....	166
2. Secret and disclosure	168
Adaptation phase.....	170
1. Uncertainty	170
2. “It’s all about your mind” — The key strategy to survive from AIDS.....	171
3. Other adjustments	172
Resources.....	174
Discussion.....	176
Summary	183
CHAPTER 8. CONCLUSION.....	185
Key findings and contributions related to PWID’s daily hardships.....	185
Key findings and contributions related to coping strategies	187
Key findings and contributions related to the social and cultural capital of PWID in Vietnam.....	188
Policy implication	192
Limitations	195
Future research.....	196
REFERENCES.....	198
APPENDICES	222
Appendix 1 — Informed consent form	222
Appendix 2 — Interview guides	230

First interviews..... 230
Second interviews..... 232
Appendix 3 — Published and submitted manuscripts..... 234

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ABSTRACT

Overcoming drug addiction has been proved to be realistic and common. However, it remains unclear how these people manage to do it, what facilitates and what hinders their efforts. This study seeks to understand the experiences of life with drug use with insights from Vietnam by investigating three specific questions: (1) What major hardships do people who inject drugs (PWID) encounter in their daily lives? (2) How do they cope with these challenges? (3) What resources (more specifically, what social and cultural capital) do they mobilize during this process? We employed ethnographic observation in peer support group offices for a total of 12 months and in-depth interviews with 62 drug-injecting individuals in Haiphong, a major port city in Northern Vietnam with a high burden of heroin addiction and HIV. About one third of participants were interviewed a second time a year after their first interviews. We found that stigma and living with HIV were the two major hardships that PWID in Vietnam encounter in their daily lives. Although participants actively sought to cope with these challenges and mobilized their available cultural knowledge and social resources, their efforts were most effective in reducing their negative feelings but had limited impact on changing their living situations. This limited impact relates to participants' broader disadvantages in terms of education and employability and a lack of supportive structural mechanisms. This study argues that the drug-related challenges of PWID in Vietnam are inseparable to broader structural factors. Thus, effective interventions must tackle broad social issues, instead of being limited to drug issues, to strengthen the existing support structure for PWID and improve the quality of life of PWID.

Keywords: people who inject drugs, stigma, coping, HIV, addiction

RÉSUMÉ EN FRANÇAIS

Aider les usagers de drogue à vaincre la toxicomanie est devenu la nouvelle stratégie antidrogue dans plusieurs pays en raison des preuves qui attestent que ce phénomène est possible et courant. Bien que les chercheurs s'accordent en général que les consommateurs de drogues pourraient éventuellement surmonter leurs problèmes de drogue. Cependant on ne sait toujours pas comment les usagers le font, ce qui facilite et ce qui entrave leurs efforts. Cette étude cherche à comprendre le quotidien des consommateurs de drogues au Vietnam avec trois questions spécifiques: (1) Quelles difficultés majeures rencontrent les usagers de drogues injectables (UDI) dans leur vie quotidienne? (2) Quelles sont leur stratégies pour faire face à ces défis ? (3) Quelles ressources (plus précisément, quel capital social et culturel) mobilisent-ils au cours de ce processus? Cette étude utilise l'observation ethnographique pendant 12 mois, auprès des groupes de soutien et des entretiens approfondis avec 62 UDI à Haiphong, une ville industrielle avec un taux élevé de la dépendance à l'héroïne et du VIH. Environ un tiers des participants a été réinterrogé après un an. Les résultats indiquent que les deux difficultés principales que les UDI au Vietnam ont rencontrées étaient la stigmatisation en lien avec l'usage de drogue et le stress causé par le quotidien avec le VIH.

Bien qu'ils aient cherché à relever ces défis et mobiliser leur capital culturel et leurs ressources sociales disponibles, leurs efforts étaient plus efficaces pour réduire leurs sentiments négatifs et moins pour changer leur situation. Cet impact limité est causé par leurs désavantages y compris un faible niveau d'éducation, une faible employabilité et un manque de mécanismes structurels d'aide. Cette étude soutient que les défis liés à la drogue des UDI au Vietnam sont inséparables des facteurs structurels plus larges. Ainsi, des interventions efficaces dans la lutte contre la toxicomanie doivent s'attaquer à de vastes problèmes sociaux pour renforcer la structure

de soutien existante pour les usagers de drogues et chercher à améliorer leur qualité de vie au lieu de se limiter uniquement aux problèmes de drogue.

Le **Chapitre 1** donne un aperçu de la thèse. Il met en évidence un manque de connaissances pour comprendre comment les personnes toxicomanes surmontent leur dépendance. Il expose les questions de recherche et présente la structure de la thèse. Dans ce chapitre, le premier auteur réfléchit à son point de vue initial et à l'évolution de son point de vue au cours de l'étude. Nous énonçons l'argument de la thèse et soulignons les implications politiques de cette étude. Cette recherche vise à élargir la compréhension actuelle des défis et des stratégies d'adaptation des personnes qui utilisent des drogues avec des informations provenant du Vietnam, un pays à revenu intermédiaire. Les résultats décrivent les personnes qui utilisent des drogues dans leur complexité et contrecarrent le stéréotype simpliste des consommateurs de drogue.

Dans le **Chapitre 2**, nous présentons différentes perspectives théoriques de la dépendance, des consommateurs de drogues et de leurs ressources. Nous adoptons l'approche constructionniste sociale pour comprendre les différents modèles de conception de la dépendance. Nous soutenons que la « drogue » et la « toxicomanie » sont deux constructions sociales, à la connotation variable, intégrées dans la hiérarchie sociale. La toxicomanie est un phénomène hybride étudié dans plusieurs disciplines. Les modèles moraux et médicaux considèrent la dépendance comme un défaut individuel enraciné dans la moralité, la personnalité ou les dispositions biologiques des usagers. Les perspectives sociologiques, en particulier les théories de la déviance sociale, affirment que la problématisation de la toxicomanie est, par nature, une lutte de pouvoir dans laquelle le groupe dominant mobilise son système normatif légitimé pour opprimer le groupe dominé. Ainsi, les perspectives sociologiques se concentrent

sur la question du pouvoir et du contexte social pour comprendre la signification sociale de la drogue et de la toxicomanie.

Les théories des sciences sociales qui étudient la consommation de drogues au niveau micro-économique perçoivent que l'usage de drogue est l'objet des mécanismes similaires à ceux de l'apprentissage et du choix. Ainsi, l'usage de drogues n'est pas pathologique, mais un comportement condamné par le système normatif actuel. Selon ces théories, les utilisateurs de drogues sont acteurs de leur choix, consciemment ou inconsciemment, en tenant compte des facteurs contextuels. Bien que ce discours néolibéral risque de laisser aux utilisateurs de drogues la responsabilité exclusive des problèmes concernant leur consommation et donc le soin de les surmonter seuls, il leur donne également du pouvoir. Le cadre environnemental des risques (Rhodes, 2002b) est utile pour reconnaître à la fois le rôle acteur des toxicomanes et les contraintes contextuelles dans lesquelles ils vivent.

Une étude des concepts de capital social et culturel montre que leur valeur dépend du contexte et qu'aucun capital n'est purement positif ou négatif. Néanmoins, posséder un capital social et culturel approprié pourrait apporter des avantages économiques et autres aux individus. L'éducation familiale joue un rôle important dans le capital culturel, mais l'éducation formelle contribue à ce processus. Dans le maintien du capital social, les individus doivent se conformer aux principes des échanges réciproques afin de cultiver la confiance mutuelle et de bénéficier du soutien des autres.

Le **Chapitre 3** décrit le déroulement de cette recherche. Il fournit des informations sur la population, le rôle des intervenants auprès des pairs et des groupes de soutien entre pairs en tant qu'intervention clé de DRIVE. Ce chapitre comprend les réflexions de la chercheuse sur sa position vis-à-vis des participants et des travailleurs pairs. Dans ce chapitre, nous décrivons notre

travail ethnographique et la conception d'entretiens approfondis. Nous rapportons également sur notre approche d'analyse des données. Les caractéristiques démographiques de l'échantillon éclairent leurs positions sociales générales.

Le **Chapitre 4** décrit la construction sociale des problèmes de drogue au Vietnam et le contexte dans lequel nos participants ont commencé à consommer de la drogue. La consommation de drogues (l'opium jusqu'aux années 1990 et l'héroïne au cours de la période suivante) est passée dans les représentations d'une mauvaise habitude des personnes démodées des régimes féodaux et impériaux à un «mal social» menaçant, associé à d'autres vices de la culture occidentale, et au moment de cette recherche, l'usage de drogue a un statut multiple et ambigu. La réponse à la consommation de drogue est donc passée de la rééducation à la punition, à l'isolement et au traitement. La perception sociétale de la toxicomanie et des UDI est donc étroitement associée aux perceptions sociopolitiques actuelles.

Le début du XXI^e siècle a été témoin d'une lutte majeure entre les modèles de conception de la toxicomanie moral et médical au Vietnam. La définition officielle de la dépendance en tant que maladie chronique ne s'est pas traduite sans heurts dans les pratiques actuelles des prestataires de soins médicaux et des professionnels des affaires sociales et de la sécurité publique. L'arrivée de nouvelles drogues psychoactives a compliqué la situation car il n'existait aucun médicament efficace contre l'abus de ces drogues.

Nos participants consommateurs d'héroïne ont grandi à une époque donnée du pays. Après avoir survécu à la pauvreté de la décennie qui a précédé la rénovation pour entrer dans la soudaine richesse matérielle des années qui ont suivi la rénovation, ils ont été exposés à des changements radicaux dans le système de valeurs sociales. Les idéaux communistes dominants ont perdu de leur importance alors que le paradigme individualiste et matérialiste prévalait. Ils

ont également été exposés à l'évolution de la perception sociale des drogues et à l'évolution de la politique de lutte contre la toxicomanie. Au moment de cette étude, les personnes qui consommaient de l'héroïne constituaient une population vulnérable caractérisée par un faible niveau d'éducation, un statut socioéconomique bas et une mortalité élevée. Les organisations et réseaux à base communautaire, en tant que ressource pour les toxicomanes, ont été confrontés à des difficultés croissantes pour leur pérennité. Dans ce contexte, nous décrirons dans la prochaine partie les deux principaux problèmes liés à la stigmatisation et à l'infection par le VIH auxquels nos participants utilisateurs de drogues ont été confrontés dans leur vie quotidienne, ainsi que les stratégies et les ressources qu'ils ont mobilisées pour faire face à ces difficultés.

Dans le **Chapitre 5**, nous constatons que la stigmatisation est l'une des difficultés majeures auxquelles les UDI au Vietnam ont confronté. La stigmatisation de différents types s'est produite dans la plupart des contextes sociaux importants pour les individus, y compris la famille, le quartier et le lieu de travail. La stigmatisation publique ou promulguée s'exprime subtilement dans des interactions directes et quotidiennes par le biais de l'évitement social, de la méfiance et du manque de respect de la part des personnes entourant les usagers de drogues. La stigmatisation publique était centrée sur l'attente sociale néolibérale d'autonomie. La famille et la communauté s'attendaient à ce que les UDI gèrent leurs problèmes eux-mêmes tout en ignorant les défis structurels auxquels ils étaient confrontés, tels qu'une faible compétitivité sur le marché du travail, un accès au traitement contraignant et le rejet des employeurs potentiels. Le traitement à la méthadone, le seul traitement actuellement disponible dans le pays, entraînait une stigmatisation institutionnelle et interpersonnelle, limitant la capacité des participants à être autonomes, les forçant à choisir entre dépendance à l'héroïne et dépendance au traitement à la

méthadone. La stigmatisation internalisée nuit au bien-être des participants et entrave le développement de leurs réseaux sociaux.

Dans le **Chapitre 6**, notre analyse des techniques utilisées par les utilisateurs de drogues injectables au Vietnam pour gérer la stigmatisation liée à la drogue montre diverses stratégies d'adaptation axées sur les émotions. Ces stratégies ont permis de gérer les informations défaillantes, le sentiment de culpabilité et de honte et de négocier un statut social pour les individus. Au cours de ce processus, les participants ont mobilisé leurs ressources culturelles pour créer une image conforme aux valeurs essentielles de la société vietnamienne. Ce capital culturel incarné pourrait les aider à acquérir un statut social plus élevé au sein de leurs réseaux sociaux immédiats. Cependant, ils manquaient du capital culturel objectivé et institutionnalisé qui pourrait être plus utile pour des réseaux plus larges. Nous avons montré que les UDI et les non-usagers avaient les mêmes préoccupations, ce qui invalide la perception stéréotypée de l'UDI irresponsable et délibérément déviant.

L'absence de stratégies centrées sur les solutions signifie que les tactiques d'adaptation existantes des UDI pourraient n'avoir aucun impact significatif sur l'amélioration de leur situation. Alors que les membres de la famille et les usagers de drogues ne semblent pas aider les participants de l'étude à faire face à la stigmatisation, le rôle des mécanismes institutionnels qui fournissent un soutien aux UDI était invisible. Ainsi, nos participants n'étaient pas passifs face à la stigmatisation dans leur vie quotidienne. Cependant, l'efficacité de leurs stratégies de gestion de la stigmatisation a été limitée dans la réduction de leurs sentiments négatifs et dans la négociation de leur statut au sein des réseaux sociaux immédiats. Les participants manquaient de qualifications et de structures de soutien susceptibles de les aider à sortir de leur situation.

Nos données dans le **Chapitre 7** illustrent les expériences de personnes séropositives vivant avec le VIH au Vietnam, un contexte de revenu moyen-inférieur où le traitement antirétroviral a été étendu à l'ensemble du pays en moins de 10 ans. Différents facteurs déterminent les réactions des participants au diagnostic séropositif, notamment leurs attentes sociales en lien avec leur genre et l'âge, le lieu de leur diagnostic, qui implique le rôle du soutien par les pairs et les voies de transmission du VIH. Le diagnostic séropositif a incité les participants à repenser leur projet de vie et leur place qu'ils pensaient acquise. Les stratégies d'ajustement pour faire face à la maladie sont façonnées par la culture et reflètent la disponibilité historique du traitement au Vietnam. Les groupes de soutien familiaux et entre pairs, qui constituent les principales ressources permettant aux participants de faire face au fardeau émotionnel du VIH, sont essentiels pour l'efficacité de l'intervention contre le VIH.

ABBREVIATION

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
ATS	Amphetamine-type stimulants
CBO	Community-based organizations
DRIVE	Drug use and infections in Vietnam: ending the HIV epidemic among people who inject drugs in Haiphong, Vietnam
FSW	Female sex workers
HIV	Human immunodeficiency virus
INSERM	Institut National de la Santé et de la Recherche Médicale (French Institute of Health and Medical Research)
MSM	Men who have sex with men
PAC	Provincial AIDS Centre
PWID	People who inject drugs
SCDI	Centre for Supporting Community Initiatives for Development
UDI	Usagers de drogues injectables
VAAC	Vietnam Administration of AIDS Control

CHAPTER 1. INTRODUCTION

Supporting drug users to overcome drug addiction has become the new drug strategy in several countries like the United States or Britain with evidence showing that this phenomenon is realistic and common (Duke, 2013; Fleury et al., 2016; White et al., 2012). Longitudinal studies following alcoholic men and heroin users for decades since 1940s in the U.S report a percentage of remission from addiction to be as high as over 70% (Hser et al., 2015; Vaillant, 1988, 2003; Dan Waldorf & Biernacki, 1979). Half of the cases of nicotine, alcohol, cannabis, and cocaine dependence in the United States in 2001-2002 remitted approximately 26, 14, 6 and 5 years, respectively after dependence onset (Lopez-Quintero et al., 2011). One identified pattern is that as people grow older, the rate of remission increases (Heyman, 2013a). Although the studies above focus on drug use to measure recovery, growing opinions advocate for life quality as a better indicator of this phenomenon (National Academies of Sciences, 2016).

While scholars in general agree that drug users could eventually overcome their drug issues, it remains unclear how these people make it, what facilitates and what hinders their efforts (Kelly, 2017; National Academies of Sciences, 2016). The review of Heyman (2013b) shows that improvement in drug use is associated with better psychiatric and physical conditions, better family support, higher education and income and less judicial issues. Thus, understanding broad social, economic and political contexts is critical to understand drug use behaviors. However, existing studies that investigate the experiences of people who use drugs are far and few. This literature mostly focused in North America and Europe where the structural conditions are different than those in low- and middle-income countries. It also tends to focus on the individual, without adequate attention to the social context in which individuals are embedded.

This study seeks to understand the experiences of living with drug use with insights from Vietnam, a developing country in Asia-Pacific, with a sample of people who inject drugs (PWID). Assuming that humans have that natural tendency to live a good life, we investigate three questions:

1. What major hardships do PWID encounter in their daily lives?
2. How do they cope with these challenges?
3. What resources (more specifically, what social and cultural capital) do they mobilize during this process?

This study started with a clinical interest. As a clinical psychologist by training, the lead researcher has always been interested in resiliency and human agency, or how people cope with their challenges in life, how they can bounce back to their equilibrium after stress or despite stress. She started working in the addiction field since 2012, five years before this thesis started, as an addiction counseling trainer. Adopting the dominant viewpoint in medicine that addiction is a chronic, lasting brain disease, she perceived this condition to exist mainly, if not only, within the individual. Thus, as we initiated this study, we believed that no matter what life challenges were, solutions resided within the person. The sociological literature about addiction and insights from participants helped us to counteract this medicalized tendency and to gain a broader and more balanced view about the contextual, structural factors and human agency in drug issues.

This dissertation shows that stigma and living with HIV were the two major hardships that PWID in Vietnam encountered in their daily lives. Although they actively sought to cope with these challenges and mobilized their available cultural knowledge and social support, their efforts were most effective in reducing their negative feelings but had limited impact on changing their living situation. This related to their broader disadvantages in terms of education

and employability and a lack of supportive structural mechanisms. This study argues that the drug-related challenges of PWID in Vietnam were inseparable to broader structural factors. Thus, effective interventions must tackle broad social issues to strengthen the existing support structure for PWID and seek to improve their quality of life instead of being limited to drug issues.

Overview of the chapters

The dissertation consists of two parts. Part 1 provides the background and methods of this study. This part is consisted of three chapters. Chapter 2 describes important theoretical perspectives of addiction, people who use drugs and resources. This chapter outlines how the conception of addiction has evolved overtime and across disciplines. At the individual level, it presents how different theories consider the drug using behavior. Doing so, this chapter establishes my vantage point to examine drug use, addiction and people who use drugs. In this chapter, we also review the sociological concepts of social and cultural capital in the addiction literature.

In Chapter 3, we report the lead researcher's reflections regarding her background, personal interests and evolving understanding of drug addiction. It describes the parent study (DRIVE), our entry to the field and position vis-à-vis the participants. In this chapter, we explain the recruitment of study participants and its guiding approach. We also explain in detail our ethnographical field work and in-depth interviews as data collection methods. A step-by-step analysis is described. A table of participant characteristics belongs to this section.

Chapter 4 provides a contextual background of addiction in Vietnam. This section combines insights from the literature and from participants' accounts. First, it explains how the

meaning of drug addiction in the country has been socially constructed and with it, how drug policies have evolved and impacted people who use drugs overtime. Second, it describes the society of Haiphong in post-Reform years with its significant socioeconomic changes. As most participants came of age in this particular period, the chapter seeks to illuminate the complexities of their experiences in relation to social changes. In the third part, the chapter sketches a sociodemographic picture of people who use drugs in Vietnam as a population. Thus, it shows participants' relative position in the society, their physical and social burden. It describes how participants initiated drug use and how their drug use has gone from an innocent behavior to a deviant one. The development and struggles of peer support groups for drug users are also presented.

Part 2 addresses the research questions. This part is consisted of three chapters, covering the themes of stigma and living with HIV as the two major hardships in participants' daily lives. For each theme, we describe the challenging situation that participants were in, then the strategies they employed to cope with it. We highlight the cultural capital and social support that helped participants in their coping.

Chapters 5 and 6 cover the stigma theme. Chapter 5 describes participants' experiences of stigma. Basing on the conceptual frameworks of Link & Phelan (2001) and Fraser et al. (2017), we describe the different types of stigma that participants encountered, namely, social stigma, internalized stigma and institutional stigma. Institutionalized stigma expresses most clearly in the context of methadone clinics as the most frequented healthcare service of participants. We highlight the social norms of stigmatizing expressions to show that the meaning of drug use as a deviant behavior is inseparable to the regime in power.

Chapter 6 utilizes Goffman (1975)'s theory of dramaturgical work and Sykes & Matza (1957)'s techniques of neutralization to analyze the strategies participants employed to deal with stigma, when it was discreditable or discredited. We describe the cultural content of these strategies and highlight their relative impact in changing participants' situation.

In Chapter 7, we present the experiences of living with HIV and how participants dealt with HIV-related stress. Biographical disruption theory is the guiding framework for this analysis. We describe participants' reactions to the positive diagnosis, their subsequent adjustments of life expectations and coping strategies. We show how social support and family support were available to participants and how their coping was embedded in the social and historical context of treatment in Vietnam.

The final chapter provides a discussion of research findings. It discusses some policy implications and suggests directions for future research among people who use drugs in Vietnam.

Summary

This chapter provides an overview of the dissertation. It indicates the knowledge gap to understand how people who use drugs could overcome their drug-related challenges. It sets out the research questions and presents the structure of the dissertation. In this chapter, we reflect on our position, point of view and how our viewpoint has evolved over the course of the study. We state the thesis argument and highlight the policy implications of this study. In general, this research seeks to extend current understandings of the challenges and coping strategies of people who use drugs with insight from Vietnam, a middle-income country. Findings describe people who use drugs in their complexities and counteract the simplistic stereotype of drug users.

PART 1

CHAPTER 2. THEORETICAL FRAMEWORK

Drug use has always been present in human life. Ample evidence indicate the existence of fermented beverages since the Middle Ages in Greek and Latin societies (Horton, 1943; Villard, 1988). Opium, tobacco, marijuana and other drugs were also found in ancient Egypt and throughout human history (Delcourt, 2016; Horton, 1943; Villard, 1988).

Drug use is the use of a psychoactive substance. This substance could be legal like alcohol, tobacco or medications or illegal like heroin, methamphetamine, cocaine, etc. Drug use spectrum encompasses occasional, regular or daily use of different intensities such as use, misuse, abuse, dependence (physical state) and addiction (physical and mental states) (DSM-IV, 1994). Drug use has been associated with severe individual and social consequences such as violence, crimes, family disturbances, human rights violation, health issues and mortality (United Nations Office on Drugs and Crime, 2016). Medically, the extreme degree of drug use—addiction—is characterized by a set of physical symptoms such as physical withdrawal, tolerance—the need for markedly increased amounts to achieve the desired effect, and psychological ones including drug craving, loss of control over drug consumption and disengagement from important social, occupational or recreational activities due to drug use (Hasin et al., 2013).

The social constructionist approach and the meaning of normality

In this study, we adopt the social constructionist approach to understand the drug issues. Social constructionism denies the absolute truth and posits that humans could only understand

the world indirectly through a meaning system shared among people and carried in language (Berger & Luckmann, 1967). What is considered to be legitimate is only legitimate in a given symbolic universe or a socio-historical context. A symbolic universe is stable but not static. It might change as it confronts with new meanings coming from other symbolic universes (Berger & Luckmann, 1967). Adding to social constructionism, the theory of class struggle argues that the mainstream value is the normative system of the dominant class. As the dominant class comes and goes, the normative system in power changes too.

Considering the issue of what is normal and what is pathological in medicine, Canguilhem (2013) states that there is no solid line between these two categories. The normal might be understood as a statistical means or an ideal type. In the first case, the pathological is just the variations of the normal and as the pathological outnumbers the normal, it can become the new norm. In the second case, a given environment might dictate a given hierarchy of possible life forms and the normal happens to be on the top of this hierarchy. In other environments, what used to be defined as the pathological might prove to be more adaptive and become the new normal. Given the arbitrary nature of the normal and the pathological, Canguilhem proposes to consider what is normal and what is pathological in the relationship between the individual and its environment. From this vantage point, we will provide an overview of different conception models to prove that drug addiction is socially constructed and bounded.

Overview of different conception models of addiction

Our society's understanding of drugs and addiction has evolved over the past three hundred years, together with social movements and technological advances, however, not uniformly and not at the same pace everywhere. Addiction has evolved from being a moral issue

to a personality disorder, then a biomedical condition or a social problem. Etiological theories aiming to explain drug use and addiction are multiple and span across disciplines, namely pharmacological, medical, psychological and sociological perspectives. These models of conceptions co-exist in all societies at different degrees.

1. Moral and medical models: Addiction as individual flaws

1.1. Addiction as a moral failing

Addiction literature suggests that the notion might appear since the late 18th century when alcohol drinking was a common practice in American and European societies and drunkenness was seen first as a bad habit (S. Earnshaw, 2014; Levine, 1978). The view of addiction as a moral failing relates closely with the mainstream values in societies at the time. Drinking in the late 18th century was considered to be under the individual's control; thus, individuals assume the total responsibility for their drunkenness or excessive alcohol consumption (Levine, 1978).

The moral views of addiction were founded on the stereotype of drug users as irresponsible, lazy and self-indulgent people (S. Earnshaw, 2014; Levine, 1978). Alcoholics were blamed for neglecting their family and religious duties for their overdrinking (Levine, 1978). Moreover, the feelings of loneliness and self-despair that stereotypical alcoholics expressed were associated with a loss of faith in God (S. Earnshaw, 2014). These characteristics were all heavy sins in Christianity (S. Earnshaw, 2014), and therefore, justified social isolation and harsh treatment towards alcoholics.

Addiction and alcoholism in particular also interfered with the dominant virtues of self-control, autonomy and productivity in the Industrial Revolution in North America and Europe (Berridge, Walke & Mold, 2014; Earnshaw, 2014; Seddon, 2009). With time, the struggle of

individuals to overcome the habit became more visible. Addiction was called the “disease of the will” or “disease of the mind” that made people unable to drink moderately.

Despite being challenged by other addiction models since the early 19th century, the moral views of addiction continued to be prevalent and legitimized punitive policies towards drug users (Berridge et al., 2014; Levine, 1978; Moskalewicz & Herczyńska, 2014; Seddon, 2009; Weiner & White, 2001). In the early 19th century, people who got addicted to drugs were locked up in rehabilitation centers far from the neighborhood (Levine, 1978). The wars on drugs in many countries that have claimed numerous lives, suggested this harmful perspective was still dominant in today societies (Jauffret-Roustide & Granier, 2017).

1.2. Addiction as a medical condition

In the first medical explanations of addiction, the focus switched from one’s own responsibility to the harmful effects of the substance and individual biological defects (Levine, 1978). In the United States, this change happened in the 1920s within the context of alcoholics coming together into mutual support associations, with Alcoholic Anonymous as the most influential association (Levine, 1978). Alcoholics claimed their helplessness and surrendered under the power of alcoholism as a medical condition.

Studies among drug users in the 20th century reported a high prevalence of psychiatric conditions and suggested that addiction was a psychiatric disorder. In this perspective, people who used drugs and eventually became addicted were patients of psychological and personality blemishes (D. Waldorf & Reinerman, 1975). Addiction treatment at that time was essentially psychoanalytic and professionals kept looking for the underlying causes in the personality of patients (D. Waldorf & Reinerman, 1975). However, no evidence has confirmed this direction of causality between addiction and such personality traits (Clark, 2011). Numerous longitudinal

studies in the latter part of the 20th century introduced the concept of addiction as a chronic disease and emphasized the necessity of long-term treatment.

The medical model of addiction reached its zenith in the last years of the 20th century with major breakthroughs in addiction research thanks to advances in animal experimentations and brain imaging techniques (Koob & Volkow, 2010; Leshner, 1997; Volkow et al., 2012; Volkow & Li, 2004). For the first time in the history, it is evident that repeated drug exposure changes the brain and hinders its capacity to resist the temptation to use drugs. Drug consumption was proved to “hijack” the reward system in the mid-brain by usurping the person’s dopamine regulation (Koob & Volkow, 2010; Volkow & Li, 2004) and to impair the prefrontal cortex, responsible to our rational judgments (Goldstein & Volkow, 2011). The brain disease model, based on these discoveries, has been greatly influential and contributed to considerable changes in drug policies and drug interventions (Volkow & Koob, 2015).

Both medical and social scientists, however, have recently challenged the brain disease model of addiction (S. H. Ahmed, Lenoir, & Guillem, 2013; J. Davies, 2017; Fenton & Wiers, 2016; Fraser et al., 2017; Heather et al., 2017; Heyman, 2013a; Levy, 2013; Lewis, 2017; Suissa, 2008). Its opponents pointed out several flaws of this claim, including the studies’ cross-sectional design that could not allow to establish a causal link between brain changes and the persistence of drug use (Fraser et al., 2014; Levy, 2013; Lewis, 2017). Lewis (2017), for instance, argued that neuroplasticity—the ability of the brain to change itself—was the most notable brain capacity, therefore brain changes in drug exposure did not inevitably lead to a brain disease, especially when the extent to which drug-related changes were different from changes happened in other human acts was not clarified. Others criticized the model to be deterministic and simplistic for overlooking the abundant data of ex-addicts who stop using drugs without any

treatment (S. H. Ahmed et al., 2013; Heyman, 2013b; Lewis, 2017). S. Fraser et al. (2014) disapproved the biomedical model for ignoring the important role of social factors in individuals' experiences of drugs and the individual agency in controlling one's consumption. Scholars have warned against medicalization in general and the medicalization of drug issues in particular, pointing that the over-investment in pharmacological research might restrict or prevent funding for sociocultural interventions which might be more effective (Conrad, 1992; Goode & Ben-Yehuda, 1994; Levy, 2013). Although advocates of the model claim that positing addiction as a physiological disease relieves drug-related stigma, evidence does not appear to support it (Meurk et al., 2014). Scholars have recently questioned the conception of addiction as a problem and urged people to rethink the issue with addiction as an unavoidable part of our current social functioning (Fraser et al., 2017).

2. Sociological perspectives of drug use

Sociological perspectives, based on the theory of social constructionism (Berger & Luckmann, 1967), stress on the social context to understanding drug use and addiction. These perspectives look at the phenomenon from both the societal perspective of the large context and the individual perspective of drug use (Adrian, 2003). From the societal point of view, drug use and social treatment of drug use are seen as expressions of multiple social issues and conflicts. From the individual angle, drug use behavior is considered in its interaction with the social environment. Thus, the boundary among the different medical terms of drug misuse, drug abuse or addiction is unclear from a sociological perspective. In this report, we will use them interchangeably but we will avoid the terms "addiction" or "addict" whenever possible.

These societal-level theories prominently postulate that drug use is a social deviance, based on the fact that it infringes mainstream social norms. The oppositional theories, most

notably the theories of Weber and Marx, are most popular in this kind (Adrian, 2003). These theories posit that the dominant groups in a society impose social norms and these norms tend to maintain these groups' domination. Depending on which normative system is in power, a phenomenon would be qualified as deviant or not (Becker, 1963). As classes or groups of conflicting interests permanently oppose each other, whether or not a phenomenon is socially deviant depends on each regime of domination (Ogien, 2012). An example of these theories is the earlier example of alcoholism as social deviance in Industrial Revolution when it interfered with labor productivity—the norm imposed by the employers.

The oppositional theories have served numerous studies of drug-related policies as social control of drug use. White (1979), studying American chemical prohibition, found that drug prohibition policies were not to protect people from the drugs' harmful effects but to oppress the minority groups who use those drugs. Policies that prohibit the drugs in question immediately turn users into criminals as they violate laws by the mere fact of using. In the American history, opium was associated with immigrant Chinese, cocaine with Blacks, marijuana with Spanish-speaking population (White, 1979). Their using populations were supposed to possess a criminal or violent culture. In France, the Laws of 1970 were criticized for using the criminalization of drug use to repress the May 1968 social revolution of rebel youths (Bisiou, 2016; Zafiroopoulos & Pinell, 1982).

Political and social treatment of drug use has always been unequal vis-à-vis different populations. Since the early days of alcoholism as a social issue, excessive drinking was deviant only if it happened among poor people; those with property could drink as much as they wanted without being discriminated (Levine, 1978). Drug users are publicly depicted as being unemployed, criminal, violent or no education while the common drug use among other

functioning taxpayers is neglected (Lutz, 2017). Facing the same issue of opioid addiction, for example, citizens of wealthy classes receive medical care while those of popular classes are more likely to be criminalized (Garriott & Raikhel, 2015; Jauffret-Roustide & Granier, 2017). An analysis of popular discourses shows that the media tends to portray methamphetamine users of upper-middle class as people doing drugs to cope with social pressure; while it associates users of lower income classes with recreational purposes (McKenna, 2011). This differential treatment seeks to maintain existing social class division.

The ambiguous dichotomy of “good” and “bad” drugs at the basis of drug prohibition laws is likely to come from a desire to maintain the social order and economic profits, rather than from a public health perspective (Bisiou, 2016; Seddon, 2010). Since the first international agreement on drug traffic and drug use in 1909, governments have adopted numerous interventions to fight against drugs (Bisiou, 2016; Yvorel, 2016). These efforts, however, seem to go without a rationalized distinction between legal and illegal drugs (Bisiou, 2016; Nguyễn Thị Phương Hoa, 2006; Seddon, 2010; United Nations Office on Drugs and Crime, 2013). The main reason why some substances are more dangerous than others is their association with crime but recent studies have challenged the causality between drugs and crime (Stevens, 2007). Additionally, tobacco and alcohol continue to be legal and widely available despite being the global leading risk factors of death thanks to the financial benefits governments get from their production (Bisiou, 2016; World Health Organization, 2009).

Drugs could be seen as physical products and drug use behaviors as social behaviors (Robin Room, 2005). As physical products, drugs carry with them symbolic values. The consumption of drugs, thus, serves to affirm or enhance the individual status. For example, methamphetamine users are seen as “stylish” or “higher class” among female sex workers in

Vietnam, compared to the degraded and “more addicted” heroin users (Ho et al., 2013). The symbolic meaning of drugs varies in line with social changes. One example is cigarette smoking, popular and in style in the past, but now stigmatized in some countries (Peretti-Watel et al., 2014).

The social meaning of drugs is inseparable from social realities (Glasser, 2012; Raikhel, 2016). The ethnographic work of Raikhel (2016) describes the different significations of alcohol and heroin as rising from the particular politico-historical context of the country at the time. When alcohol is familiar, heroin represents alien, foreign forces. Thus, heroin users are more stigmatized and isolated. Using drugs might lead to different outcomes, as alcohol consumption in two Mayan communities leads to violence in the patriarchal society but stupor in a more equal one (Glasser, 2012).

The close links between medicine and drug policies or the medicalization of drug use are seen as an attempt to ensure social cohesion (Conrad, 1992). Medical declarations about the dangerousness of the drugs in question justify prohibition laws (Vrecko, 2010; White, 1979; Zafiroopoulos & Pinell, 1982). The political notion of “forced care” to prevent social consequences of certain drugs mobilizes the medical system as a tool to control the population using those drugs (Bisiou, 2016). The arguments of Levy (2013) towards the brain disease model of addiction show how the attempt of putting responsibility on the person and blaming him or her would make us neglect other social and environmental factors, therefore would continue to reproduce drug use as a social deviance.

Social science studies, especially anthropological works, indicate that drug use is an expression of the underlying societal issues rather than a problem in itself. Raikhel (2016) reports on a rise in alcohol-related deaths during Russia’s crisis of socialism in the late 1980s.

Bourgois (2003) shows how economic oppression and disparity in access to education and work have prevented immigrants in New York to live a conventional life and pushed them into drugs and clandestine economy. Furthermore, Garcia (2010) describes how cultural dispossession and historical conflicts with mainstream society contribute much to endure drug use in Hispanic population in New Mexico. Studies of drug perceptions also reveal that the use of a specific drug is closely related to the problems of societies at the time (Jauffret-Roustide, 2009). For examples, the use of hallucinogens in 1960s reflected the willingness to change the current social state, while cocaine in 1990s was linked to the social concern of performance and conventionality (Jauffret-Roustide, 2009). Scholars accuse capitalism and the consumerist culture for facilitating drug use and addiction by promoting instant gratification and material consumption (Alexander, 2008; Brugvin, 2010; Couteron, 2012; Suissa, 2008, 2013). Some authors have gone so far to call modern societies “addictogenic” (Couteron, 2012; Obradovic, 2015).

Who is the drug user? Drug use from the individual perspective

Micro-level theories seek to understand the emergence, the persistence, the cessation of as well as the resistance to drug use from the individual’s perspective. The social processes between individuals and groups that underlie different aspects of the behavior are investigated. These studies contribute importantly to illuminating the phenomenon in its complexity. Sociological theories of drug use from the individual’s perspective are inspired by neighboring disciplines such as social psychology, psychodynamics, anthropology or economics. The theories below contribute to our social constructionist approach to better understand the person who uses drugs.

1. Social learning theory

The social learning theory posits that individuals learn to use drugs in the same way as they learn other behaviors, deviant or not. In this perspective, a behavior is acquired via imitation and modeling and under social conditioning. Quantitative and qualitative data on the contagion effects of drug use support this theory (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979; Ali, Amialchuk, & Dwyer, 2011; Becker, 1963; Fowler & Christakis, 2008; Keenan et al., 2015; Valdez, Neaigus, & Kaplan, 2008). Ali et al. (2011) found that a 10% increase in the proportion of close friends who use marijuana leads to a 5% increase of the probability that an adolescent chooses to use marijuana. Fowler & Christakis (2008) detected positive association between smoking cessation by a member of one's close social network and decreases in his or her chances of smoking.

Using drugs becomes an almost natural behavior when one grows up in an environment where drug consumption is normative and lived by the members of his or her family and social networks (Valdez et al., 2008). In these environments, offering drugs is a gesture of friendship and hospitality, rather than an act of bad intention (Faupel, 1987). In marginalized and economically precarious neighborhood, adolescents tend to look up to drug dealers as successful models and engage in drug traffic to build a decent life (Philippe Bourgois, 2003). A study with non-drinking students in a university where the majority of their peers drink reveals it could be physically and mentally hard to resist the pressure to drink (Herman-Kinney & Kinney, 2013).

From a more developmental aspect, Levy (2006) argues that the skills one uses to resist drug temptation are the same skills built in childhood that help individuals to delay gratification. The sharpness of the skills depends largely on how encouraging to the behavior the environment

is. Not delaying rewards could be merely a learned response from a milieu where one's possession could be taken away at any moment.

Social learning theorists consider this learning process a dual determinism where individuals are both products and producers of their environment (Bandura, 1999). People always employ strategies to create the situations they want and to adapt to the environment in a proactive manner (Bandura, 1999). From this perspective, if a social environment could provide reinforcement for non-drug activities and/or punishment for drug use, individuals can unlearn their drug use behavior. As human brain is capable in organizing itself to adapt to new environmental stimuli, humans can learn and unlearn a behavior, even though addiction is among the most challenging behaviors to change (Lewis, 2017). Social learning approach is popular in addiction treatment.

2. Theory of evolutionary behavior

The theory of evolutionary behavior posits that humans (and other organisms) are by nature evolutionary as they develop physiological, psychological and cultural alternatives based on environmental conditions (D. S. Wilson, 2005). The theory suggests humans have innate desire to eliminate negative emotions and enhance positive ones, which explains the drug-seeking behaviors (Pharo, 2010, 2011). Combining the theory of evolutionary behavior with social constructivism, Burrell & Jaffe (1999) posit that drug use results from individuals' tacit and possibly unconscious calculation between “the bad and the worse”:

“When a person reports ‘I don’t know why I use substances’ or ‘I just ended up using’ without apparent volition or plan, an evolutionary constructivist perspective assumes that he is still making choice and knows more than he can tell.” (p. 55)

Burrell & Jaffe (1999) also suggest that individuals might have different experiences with drugs overtime as the meanings of drugs to them change. Drugs might be important and helpful to people sometimes (e.g. to lift them out of depression), while at other times, they are of less significance (e.g. as people find non-drug rewards).

3. Theory of choice

The theory of choice complements the theory of evolutionary behavior; however, it focuses more on rationality. This theory draws its legitimacy on two facts: first, the proportion of people dependent on substances in real life is much less important to this proportion of animals under laboratory conditions; two, many people quit drugs at certain points in their lives, despite their past drug use severity (S. H. Ahmed et al., 2013; Heyman, 2013b). Researchers suppose that when drugs are not the only choice, which is the difference between real life and animal experimentations, more people would choose non-drug rewards (S. H. Ahmed et al., 2013). Moving from past drug consumption to non-drug activities would thus, be more likely. People usually stop using drugs when they adopt new roles and responsibilities more gratifying to drugs, such as a new job, getting married or becoming parents (Heyman, 2013b; Keenan et al., 2015). These above theories illuminate what is called the *akrasia* dilemma where different systems of reasoning collide and where it seems like individuals opt for immediate gain rather than better-perceived long-term benefits. From this perspective, although drug users cannot provide a rational reason for the use of drugs, they do what best serves their most urgent needs, consciously or unconsciously, given the social knowledge they dispose.

4. Drug users as active agents

While drug users are considered deviants – those are believed to deliberately disregard social norms, investigations among drug users of different social positions demonstrate the

opposite. Drug dealers and drug users in Bourgois's study internalize the same American virtues of self-reliance and autonomy (Philippe Bourgois, 1998; Philippe Bourgois et al., 2013). They take full responsibility for their social disadvantages without blaming the social structure. Young users who sell ecstasy in a study in France only aim to be economically independent from their parents (Panunzi-Roger, 2001). In their natural milieu, drug users are purposeful individuals who pursue a meaningful life and achieve greatly in their own way (D. Waldorf & Reinerman, 1975).

People take drugs mainly to overcome physical and mental limitations to fulfill their social roles. A large number of patients under drug treatment are professionals and the estimated prevalence of drug-using professionals not in treatment is important too (Antunes Lima, 2017). Professionals use drugs to cope with various factors, ranging from physically harsh working conditions (Antunes Lima, 2017; Keenan et al., 2015) to fear of losing their jobs and their social status (Antunes Lima, 2017; Lutz, 2017). They use drugs to "fit in" with the surrounding environment (Lutz, 2017; White, 1996). Drug use, from this standpoint, is just a proxy of underlying tension within the individual-society relationship.

The stereotyped image of drug users as physically and mentally sick, homeless, criminal people coming from poor, dysfunctional families does not match the complex reality of drug use. Sociological studies depict different types of drug users and different phases in the course of drug use (Antunes Lima, 2017; Boeri, 2004; Faupel, 1987; Lutz, 2017; Radcliffe & Stevens, 2008; Zufferey, 2010). Faupel (1987) describes four stages of drug use career, based on the association of drug availability and life structure—from the occasional user to the street junkie. M. W. Boeri (2004), based on the combination of social roles and control over drug use, identifies nine categories of drug users—from controlled occasional users to relapsing addict. Both authors underline that these stages are not necessarily linear and drug users can come and

go from one stage to another within a certain period (Boeri, 2004; Faupel, 1987). Their life stories illustrate that not all drug users will end up losing control over their consumption and their lives and that many are functioning just like any “straight” person (Boeri, 2004; Zufferey, 2010).

5. Risk environment theory and the importance to contextualize the Neoliberal subject

The important role of individuals in managing their medical issues is gaining popularity in medical and political discourse about drugs and addiction, notably in harm reduction (Moore & Fraser, 2006; Rhodes, 2009). This perspective underlines the individual responsibility in starting, enduring and quitting drugs. Not only this perspective cannot explain many health disparities for ignoring the structural conditions that shape the outcomes of individual efforts, but it also facilitates righteous blame on individuals (Moore & Fraser, 2006; Rhodes, 2009). Scholars argue that social issues are materialized on the individuals and express in their everyday practice (Duff, 2007). However, people who use drugs embrace the neoliberal perspective as it makes them feel they are “equal to other citizens” (Moore & Fraser, 2006). One useful approach to reconcile this conflict is Rhodes (2002)’s “risk environment” framework that emphasizes environmental forces in shaping individual issues.

The “risk environment” framework theorizes that four types of environments: physical, social, political and economic ones at micro and macro levels, interact among them and with the individual to define drug-related harms (Rhodes, 2002a). It straightforwardly aims to act. By identifying the environmental determinants and the ways they shape the lives of people who use drugs, we can create “enabling environments” that facilitate health improvement.

Within nearly two decades, studies have applied the “risk environment” framework to illuminate the contextual factors that affect health behaviors. Notable works include the review

of Strathdee et al. (2010) that calculate HIV prevalence would reduce by 30% to 43% if unmet needs for HIV prevention and treatment programs reduce by 60%. Studies also illuminate the moral ambivalence regarding assisted injection caused by harm reduction message and the insider's belief (Guisse et al., 2018) or the environmental factors that contribute to overdose risk (McLean, 2016).

Collins, Boyd, Cooper, & McNeil (2019) recently expand the "risk environment" framework by adding an intersectional perspective in which they argue environmental factors would combine with different social positions (e.g. gender, race, ability or class) to produce different effects on individuals. For example, gender inequity put female drug users at a more disadvantaged position than their male counterparts in benefiting from harm reduction policy (Boyd et al., 2018). Black people who inject drugs are more likely to have adverse HIV-related outcomes and more likely to live in states with harsher drug policies (H. L. F. Cooper et al., 2016). While acknowledging the environmental determinants that shape individuals' risks, the framework does not ignore the agentic role of individuals in acting upon their living environments (Collins et al., 2019).

In this study, we consider addiction not to be a medical or moral issue but a consumption behavior that happens to be condemned by the mainstream society. We perceive drug users as actors working towards while being constrained by their living environments. We pay attention to the roles of their social positions in defining the environmental effects and the effectiveness of their coping. For each theme of stigma and living with HIV, we will first describe the situation drug users were experiencing, then the strategies and resources they mobilized to deal with such challenges. Finally, we will describe what constrained or facilitated the efficacy of their efforts.

Resources to deal with life hardships

To understand how people who use drugs deal with their eventual drug-related hardships, we explore the different types of capital participants might possess. Capital is a notion first used in economic theory. Bourdieu (1986b) argues that economic capital alone cannot explain the sophistication and complexity of social distribution and social exchanges. Bourdieu (1986b) proposes three forms of capital including economic, social and cultural capital that are convertible into each other. These concepts have helped to explore different social phenomena such as health inequity (Chang et al., 2016), acculturation outcomes of immigrants (Erel, 2010), stigma management (Reich, 2018), academic outcomes (Jack, 2016) or digital living (Ollier-Malaterre et al., 2019). In the field of addiction, Cloud & Granfield (2008) propose the recovery capital framework to explain the phenomenon of drug-dependent individuals who are able to maintain a drug-free life without treatment. The framework lists four domains: physical, human, social and cultural capital. As our participants seemed to have similar material possession and financial capacity (physical capital), and as human capital overlaps to a great extent with cultural capital (Cloud & Granfield, 2008), we focus our investigation to social and cultural capital. In what follows, we will provide an overview of the two concepts and their roles in drug-related issues.

1. Social capital

Social capital is considered to be the primary source of capital as other types of capital are built up through one's relationships with others and made available to him/her through these relationships (Bourdieu, 2013; Zschau et al., 2015). This classic concept of social sciences has become widely popular in recent years. The origin of the term has been traced back to the early times of sociology in late 19th, early 20th centuries (Macinko & Starfield, 2001; Portes, 1998).

According to Portes (1998), the new attractiveness of the concept comes to its potentiality as a new and less costly solution to social issues (Portes, 1998).

Definitions of social capital are multiple, however, quite similar (Adler & Kwon, 2002). These different definitions differ by their focus on substance, sources or effects of social capital, on the interpersonal relationships, the structure of relations among actors within a collectivity or both types of linkages (Adler & Kwon, 2002). We employ their definition in this study: “*Social capital is the goodwill available to individuals or groups. Its source lies in the structure and content of the actor's social relations. Its effects flow from the information, influence, and solidarity it makes available to the actor*” (Adler & Kwon, 2002). Bourdieu, in his analysis of the concept, suggests that the volume of social capital a person possesses depends on the network's size and at the same time, on the volume of capital each of its members possesses. Social capital is convertible to economic capital and vice versa (Bourdieu, 1986a). The benefits from social networks could bring financial benefits to the social capital owner; conversely, time and money given out could be favors or gifts that serve to maintain social relationships (Bourdieu, 1986a).

Social capital is not the immediate result of social acts but requires maintenance through continuous investment of network members in terms of time and efforts (Bourdieu, 2013). In this perspective, individuals are not passive beneficiaries of the existing social capital but they actively build their social asset by conforming to the norms of exchanges (Bourdieu, 1986a; Ferlander, 2007; Portes, 1998). Indeed, it is challenging to maintain relationships in cases of unbalanced giving and receiving. Adler & Kwon (2002) explicitly point out that people make resources available to others with expectations of return. Four motivations for people to do so include *value introjection* (people internalize norms and feel an obligation to behave in such

ways), *bounded solidarity* (mechanism among people of the same community and of the same fate), *reciprocity exchanges* (the collectivity might repay the individual in the form of status or honor), and *enforceable trust* (because of powerful community obligations of repayment).

Different forms of social networks produce different types of social capital. Social networks differ by the ties' directions (horizontal vs. vertical), ties' strength (strong vs. weak) or ties' formality (formal vs. informal). They are classified into bonding, bridging and linking networks (Ferlander, 2007). Horizontal ties refer to relationships among people of equivalent status and social power such as family, friends, neighbors or voluntary associations. Vertical ties involve connections among people at different hierarchical positions, thus, people of different social power, for example, between employees and employers, citizens and civil servants. *Bonding network* consists of horizontal ties as it links people of certain similar characteristics such as age, ethnicity or geographic areas. Bonding networks tend to consist of informal, strong ties and produce mainly emotional and instrumental support. Both bridging and linking networks are weak ties and involve people of different characteristics. However, bridging networks are more horizontal with people of similar social status while linking networks are more vertical. Bridging and linking networks generate more informational support (Ferlander, 2007; Macinko & Starfield, 2001). Granovetter (1973) proves that weak ties are not less important than strong ties and in many instances, they are critical for mobility opportunity.

Social capital could also be analyzed at individual or collective levels (Ferlander, 2007). Research on individual-level social capital focuses on the social support resulting from interpersonal social connections; research on collective-level social capital considers the cohesiveness and reciprocal norms of exchange in a community (Ferlander, 2007). However, the

definition of collective-level social capital has been criticized for its logical circularity whereas “social capital is simultaneously a cause and an effect” (Portes, 1998).

Studies in substance misuse and HIV tend to emphasize the importance of bonding networks such as family and friends (Best et al., 2008; Bischof et al., 2000; Booth et al., 1992; Chen, 2006; Laudet & White, 2008). Family could provide participants with various support such as childcare (A. J. Gunn et al., 2018; Haritavorn, 2016), food, housing and costs for medical care (Tomori et al., 2014). However, while drug users could get access to high-bonding and bridging networks of drug treatment programs or family and friends, they have few opportunities to create linking networks at work or in social activities due to their lack of financial and cultural resources (Boeri et al., 2016). This undermines their engagement in the mainstream society. Under such circumstances, bonding networks seem to be their only option for social capital (Ferlander, 2007). This is also the case in resource-limited settings where public welfare is unavailable and people living with HIV must rely on their informal networks to get the assistance they need (Dageid & Duckert, 2008).

Social capital is not purely positive nor purely negative, or in other words, its effects come “with costs and risks” (Adler & Kwon, 2002). The positive side of social capital lies in its provision of social control, parental and kin support and network-mediated benefits (Portes, 1998). The social control function is activated through one's bonds with traditional institutions (family, school, church...). These institutions encourage socially accepted behaviors and discourage deviant pursuits through monitoring and goal direction (Moos, 2007). Family support exists in multiple forms: emotional safeguard, parental efforts and money to enhance children's physical and cultural development, job finding, etc. (Portes, 1998). Network-mediated benefits come from extra-familial others as exemplified by a group of former students of an elite school

with explicit purpose of concentrating social capital to benefit its members (Bourdieu, 2013). Network-mediated benefits are mainly in terms of information or finance, but can also be tangible (Portes, 1998; Stablein, 2011).

The same good things about social capital could create barriers to the individuals themselves or others (Philippe Bourgois et al., 2013; Cloud & Granfield, 2008; A. Gunn & Guarino, 2016; Portes, 1998; Stablein, 2011; Tomori et al., 2014). While high cohesion in some groups is necessary for emotional support, it could become oppressive and restrict individual freedom. The social ties among homeless youth and young adults could provide them with affective support and safety, but at the same time, increase homelessness, facilitate substance use and increase the risk of sexual exploitation (Stablein, 2011). The family could be a major source of emotional support, financial assistance and ongoing care for drug users, but critics from family members could also make drug users stressed or hurt (Tomori et al., 2014). The harsh social control over drug use reproduces community stigmatization towards drug users (A. Gunn & Guarino, 2016). The norm of reciprocity could make successful entrepreneurs targets of excess claim for support from their community/kin members and reduce their chances of further development (Portes, 1998). Additionally, group solidarity could hinder individual ambitions to live up to the norms of mainstream society (Portes, 1998). These both sides of social capital require careful examination of how social capital contributes to the recovery process, especially when various other factors might mediate its so-called causal effect to individual outcomes (Mouw, 2006).

Different forms of capital do not exist and function separately but interdependently. Lower economic capital could entail lower social capital and cultural capital and vice versa (Bourdieu, 1986a). A lack of social activities could be due to money and time constraints

conditioned by low socioeconomic status among drug users (Boeri et al., 2016). On the other hand, the lack of cultural knowledge undermined the capacity of Puerto Rican immigrants in the U.S. to succeed socially (Philippe Bourgois et al., 2013). On a positive note, peer support in the homeless milieu helps individuals learn essential skills for surviving on the street and accordingly, integrate better in the culture of the street (Stablein, 2011).

2. Cultural capital

The concept of cultural capital has been theorized most prominently by Bourdieu (1986a), as the cultural knowledge that one possesses. As stated, all the forms of capital strongly are interrelated. Similar to social capital, cultural capital is convertible into economic incentives. It also needs economic investment to grow. Moreover, being embedded in appropriate social relationships could facilitate the growing of individual's cultural capital, and conversely, people with appropriate cultural capital could establish social relationships more easily.

It takes time to accumulate cultural capital and that the amount and quality of cultural capital is proportional to the time devoted to acquiring it (Bourdieu, 1986a). Bourdieu stresses that the domestic transmission as the exclusive way to cultivate one's cultural capital. The differential cultural capital is an outcome of social inequality as only wealthy families could afford to take time from work and invest financial resources in their children's education. At its turn, cultural capital could also reproduce social inequality as students with more cultural capital will better meet academic requirements and thus, have better chances to succeed in life (Bourdieu, 1986a). Family education is important because it also raises individuals' awareness and motivation to do necessary tasks (Ollier-Malaterre et al., 2019, p.). However, empirical evidences that students of disadvantaged family background could develop valuable academic

skills if they have benefited from appropriate education have challenged Bourdieu's negligence of school in the cultivation of cultural capital (Jack, 2016).

Cultural capital is intimately linked to the concepts of habitus and field. A person's habitus shapes her cultural capital. It is her beliefs, assumptions and manners that result from her historical, spatial and interpersonal socialization given to her through her social origin, defined by class, race and gender (Bourdieu, 1986b). Habitus is not static, nor deterministic. It shapes and is reshaped by individual's actions. One's cultural resources depend on his/her habitus. When such cultural traits are valued, they become cultural capital and can be exchanged for other types of capital like economic gains or social status (Bourdieu, 1986a).

Cultural capital is also linked to the concept of field. A field is a specific context with power struggles and regulations (Bourdieu & Wacquant 2007). Only in a specific field that specific cultural resources can become cultural capital, since they are valued. The value of cultural capital is however relative. Specific skills might be more appreciated and yield more profits in contexts where they are scarce. Hence, not only the dominant class has cultural capital (or the high-culture), but people of minority groups also possess their own cultural capital, valued in their specific subcultures (S. Davies & Rizk, 2018). Moreover, some lifestyles of minority groups might become fashionable and get adopted by the dominant class (Klein, 2009). The context-dependent value of cultural resources expresses clearly in the case of migrants. For example, the Puerto Rican peasants in Bourgois (2003)'s work lose their respect on them just after a night as the new context does not appreciate their cultural knowledge.

Cultural capital is classified into three types: the embodied, the objectified and the institutionalized ones (Bourdieu, 1986a). The embodied cultural capital is the form of knowledge that resides within the person. It includes her appearance, her manners, what she says and the

way she says it. The embodied cultural capital takes time to acquire and cannot be easily transmitted. The objectified cultural capital is one's material possessions that reveal who the person is. A fine-art collection, for example, could signify how sophisticated the owner is. The objectified cultural capital exists only in relation to the embodied cultural capital or the ability to "consume" cultural goods. The institutionalized cultural capital is objectified and could be the possession of diplomas, titles, acknowledged by an institution. Qualifications or institutionalized cultural capital may be most directly converted into economic capital in case of job application, however, not necessarily straightforward. Recent works comparing the role of qualifications in the contexts of France and Britain have expanded Bourdieu's analysis (Brown et al., 2016). Brown (2016) argues that as the middle class expands, more people are getting higher education; thus, qualifications have somehow lost their scarcity. In such context, behavioral competence or "talent", what the job market looks for, becomes the focus of achievement (Brown et al., 2016).

Studies also stress on the agentic role of the individual in cultivating their own cultural capital. The migrants in Erel (2010)'s study actively added new skills, qualifications or knowledge into their cultural capital package, negotiated the value of their cultural capital in the host country or exchanged their newly acquired cultural traits in their country of origin. This finding goes against the simplistic approach that an individual's cultural capital could only fit or not fit the host culture (Erel, 2010). This agentic role also expresses in individuals' intention to acquire valuable cultural capital, such as qualifications (Brown et al., 2016).

Cultural capital is a valuable currency in the field of substance abuse. In the context of peer relationships, substance use could be a cultural asset that helps individuals to gain social status and benefit from social resources, for example, smoking for young women (Haines et al., 2009), or drinking for students (Herman-Kinney & Kinney, 2013). In the medical field, drug

users could mobilize their valued cultural resources in their interactions with healthcare providers in exchange for better care (Chang et al., 2016). Such cultural capital includes the desire to take care of their health or some medical knowledge (Chang et al., 2016).

The theory of cultural capital is sensitive to power struggles as cultural traits are valued only in specific fields. The dominant group in that field dictates which cultural skills and knowledge would be right and valuable, and thus, disadvantage those without such resources. In hierarchical relations, those with power could decide on the acceptance or valuation of specific cultural capital that their interlocutors offer (Chang et al., 2016; Erel, 2010). For example, medical providers will decide which cultural characteristics are appropriate in their interactions with drug-using patients and can refuse to acknowledge the cultural capital of these patients, despite the latter's efforts to communicate it (Chang et al., 2016). Drug-using patients who have the right cultural capital are more likely to benefit from healthcare services (Chang et al., 2016).

Summary

In the above section, we have outlined different theoretical perspectives of addiction, people who use drugs and resources. We adopt the social constructionist approach to understand the different conception models of addiction. We argue that drugs and addiction are both social constructs, embedded in social hierarchy. Addiction is a hybrid phenomenon studied by different disciplines. The moral and medical models consider addiction to be an individual flaw that roots in their morality, their personality or their biological dispositions. Sociological perspectives, especially theories of social deviance posit that the problematization of addiction is, in its essence, a power struggle where the dominant group mobilizes its legitimized normative system to oppress the dominated group. Thus, sociological perspectives focus on the question of power and social context to understand the social meaning of drugs and addiction.

The social learning theory and the theory of choice posit that the drug use behavior follows the same mechanisms to other behaviors. Using drugs is not pathological but a behavior that happens to be condemned by the current normative system. These theories consider drug-using individuals to be active agents who make choice, consciously or unconsciously, based on their consideration of contextual factors. Although such neoliberal discourse risks putting on drug-using individuals the full responsibility to overcome their issues, it also empowers them. The risk environmental framework is useful to acknowledge both the agentic role of drug users and the contextual constraints they live in.

An investigation of the social and cultural capital concepts shows that their value is context-dependent and no capital is purely positive or negative. Still, possessing appropriate social and cultural capital could bring economic and other rewards to individuals. Family upbringing plays an important role in cultivating cultural capital but formal education contributes to this process. In maintaining social capital, individuals must conform to the principles of reciprocal exchanges to cultivate mutual trust and benefit from the support of other people.

CHAPTER 3. METHODS

Background of the study

This study belongs to the qualitative research component of DRIVE (*DRug use and Infections in ViEtnam: ending the HIV epidemic among people who inject drugs in Haiphong, Vietnam*) — a five-year intervention study to reduce HIV incidence among PWID in Haiphong. Over four respondent-driven sampling rounds, the study recruited nearly 6000 PWID in Haiphong and maintained two HIV — positive and negative cohorts of 800 to 900 participants each. DRIVE was the first study in Vietnam that involved the community-based organizations into their research design and other research works.

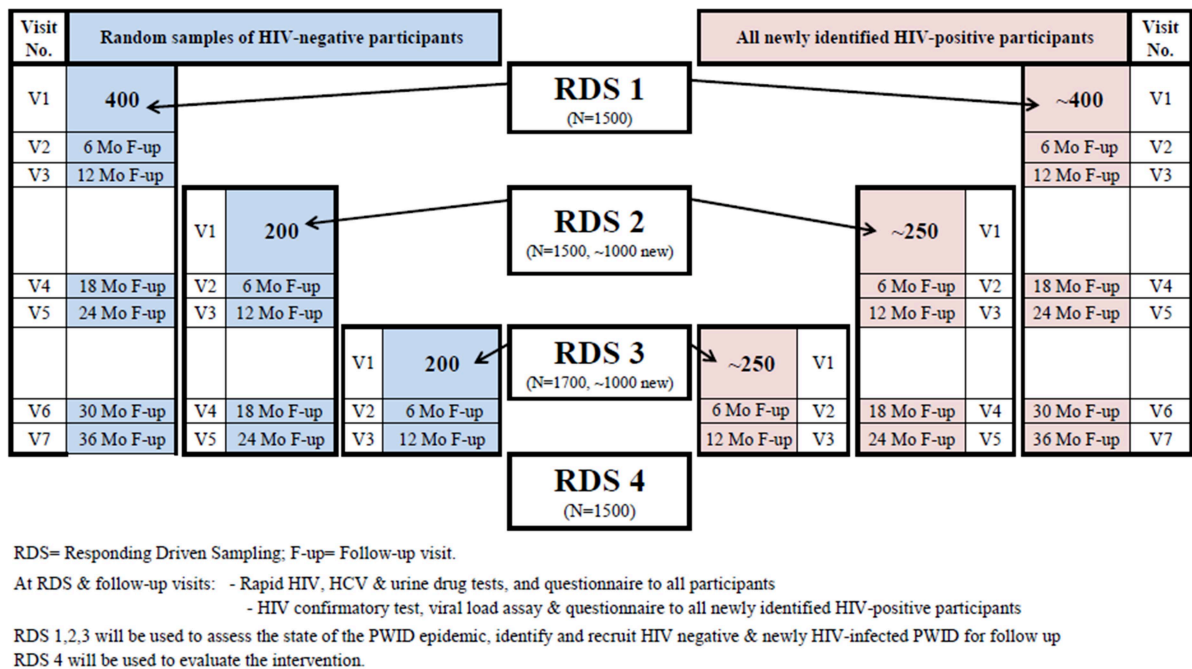


Figure 1. DRIVE study implementation

Peer support groups or community-based groups of drug users were key in the study intervention (Hammett et al., 2018a). DRIVE employed a community-based approach of

respondent-driven sampling to recruit participants, starting from the “seeds” that peer outreach workers picked from their acquaintance. Peer outreach workers acted as system navigators, helping participants to access HIV and methadone treatment and to deal with administrative requirements. The collaboration with Haiphong Provincial AIDS Center (PAC) has facilitated this process. From two peer support groups for PWID and PLWH in Haiphong downtown — Friendship’s Arms and Light House, the network grew to include 30 peer groups covering different parts of the province within two years.

Peer outreach workers were not only transporters of intervention but also the intervention. Through their case management with participants, participants received social support, treatment adherence assistance and harm reduction information. Each peer outreach worker was in charge of 30 to 50 clients whom they would check in with at least once a month. Peer outreach workers maintained contact with clients' families and in most cases, their clients' peer networks.

The DRIVE study team include researchers from France (INSERM 1058), the United States and Vietnam. The team from Vietnam included three stakeholders: Haiphong University of Medicine and Pharmacy, Hanoi Medical University and Center for Supporting Community Initiatives for Development (SCDI) — a Vietnamese non-governmental organization. Moreover, the study closely collaborates with the Vietnam Administration of AIDS Control (VAAC) — the central agency under Vietnam Ministry of Health in charge of HIV and drug interventions. Through VAAC, the study receives good support from Haiphong PAC.

Methods

1. The ethnographic work and our position in the field

Getting to know the peer outreach workers

We got to know the DRIVE study team in 2014 when we were invited to join their discussion of the findings of their pilot study and to prepare for the new proposal. It was the first time we met the peer outreach workers. In the meeting then, some segregation existed between the two groups of researchers and peer outreach workers. Although the men of the peer group were more distant to me, the women reached me out. Their friendliness helped me to feel more comfortable around them. We met again in another meeting the next year and started working together in the summer of 2016 as Hanoi Medical University team was in charge of a qualitative study to inform the new DRIVE project. Peer outreach workers helped us to invite participants of the pilot study to interviews and discussions. They joined the discussions too. Thus, before our fieldwork officially started in the summer of 2017, we had known the peer outreach workers group. We were, however, in the position of people from the investigator team, who were distant to them.

When the first author came back to Haiphong in the summer of 2017, together with a colleague, we spent most of our time working with peer outreach workers to select and invite participants for interviews. We followed the peer workers to participants' home to verify the addresses participants provided. We got behind them on their motorbike in a speed race on the highway to rescue overdosed cases. We had lunch and tea with each other every day at the research site. Between June 2017 and January 2018, she stayed in Haiphong for about ten days a month.

The data collection process at DRIVE consisted of eight steps, including 1) welcoming the participants, 2) checking fingerprints, 3) explaining the consent form, 4) checking injection marks and urinalysis, 5) getting blood samples, 6 & 7) conducting questionnaire-based interviews and 8) collecting contact information. Participants were more relaxed at Desk 1 — the reception and Desk 4 — the injection mark checking and urinalysis as peer outreach workers were in charge of these steps. They talked more, whether with the peer workers or among themselves. As the exchanges at Desk 4 were more informative, we spent most of our time there. The conversation was about participants' drug use practices, family status and mutual acquaintances. This gave us the opportunity to select potential participants for interviews based on diverse criteria of sex, age and family status.

While waiting for participants, the peer workers and we chatted about various things. We told them about our research project and gave them copies of the informed-consent form (Appendix 1). They seemed interested in our proposal. Some said that they would refer us to people who had “well recovered”, meaning having stayed abstinent for a long time. Some offered us to interview them. In the consent form, the lead researcher stated her position to be a student. Since then, we felt like they perceived us differently, less like people from the research team and more like students. When peer workers had some free time, we watched them playing games on their mobile phones, joking with each other and discussing cases or their own treatments.



Picture 1. *DRIVE* research site — Friendship's Arms' Office — from the outside. Two peer outreach workers were watching vehicles. The reception desk was right behind them.



Picture 2. Desk 2 — Registration and reimbursement.



Picture 3. *Desk 3 (in front) — explanation of the informed consent by a staff. Desk 4 (in the back) — checking injection marks and urinalysis by peer workers.*

After this period, we came back to Haiphong from September throughout December 2018, mostly to do interviews. This time, we worked at the SCDI office as the rooms at the DRIVE research sites were busy. Thus, we were able to better understand how SCDI staffs worked as the focal point among peer outreach workers, participants, Haiphong PAC and the legal system. Below is a part of our notes taken from our conversation with Thanh, the SCDI regional coordinator over our morning coffee.

December 2018, 7:45 am, in a coffee shop next to SCDI office

Thanh told me that the process of sending drug users to compulsory rehab was not transparent. On top of that was the ignorance of the drug users' families. The police might persuade the family to sign all kind of agreement to send the guys away. They even agreed to sign blank paper. Drug users would go to a drug court to accomplish the process. However, in one case, the person was not informed about the decision for his rehab. No one had called him to attend the drug court at all. Thanh needed to work with a lawyer to counteract on this kind of decision. This showed that at the grass-root level, laws were manipulated and drug users' rights were not respected. Drug users felt like they could not resist the power from the government/police and let them do what they wanted.

Another issue was a high prevalence (50-70%) of MMT patients continued to do heroin in An Lao (a district of Haiphong). Patients kept asking to be tapered off and at the same time they used heroin. In my opinion, it was okay if we considered the principle of harm reduction. Thanh thought that this inefficiency resulted from a high turnover rate of MMT physicians, due to low salary. In Thuy Nguyen (another district), the police sneaked in MMT clinics and tested patients and arrested them. This made drug users hate MMT clinics.

Getting to know the participants

With the introduction of peer outreach workers, we got to visit some “hotspots” where drug traffic was most active in Haiphong. During these visits, we established a good relationship with the family of a participant whom we visited every time we came to the city. This

opportunity helped us to understand the concerns of participants' parents and their family dynamics. The lead researcher also had the privilege to live for two weeks at the home of L., a peer outreach worker, in a rural village to do our interviews with informants living nearby. As L. distributed clean syringes for a Global Fund project, we got to meet her clients. With L., we had lunch and spent the evenings together. On the one hand, we were thrilled at the opportunity to enter the daily life of people. On the other hand, we had to manage our feeling of discomfort when living in a stranger's home and in a different cultural atmosphere. Most of the time, L. was out of the house while we were doing interviews and only came home around meal time. However, in rare occasions when she was home, we informed the informants about her presence in another room, probably within eardrops. We ended these interviews early and asked participants to come back the following day to continue the conversation.

Like other peer outreach workers, L. perceived the lead researcher as a student and introduced her to her own clients as such. We understood that for this reason she insisted the researcher to stay at her home instead of in a hotel, "*so you could save your money.*" As a result of this introduction, our informants were patient with our ignorance and said things like, "*As you are doing research, you need to know such and such in order to tell others.*"



Picture 4. *L. 's house where we conducted our interviews*

Participant observation of the development of drug and HIV policies

Prior to this study and throughout the length of this Ph.D., the lead researcher has been an active member of the Vietnam — HIV Addiction Technology Transfer Center at Hanoi Medical University. In this position, she has an insider understanding of the development of drug and HIV policies. She has attended frequent meetings with the VAAC, managers and clinicians in methadone and HIV programs. She has also clinically supervised methadone counselors in several Northern provinces. Below are some of our notes from a meeting among Hanoi PAC, methadone professionals and Hanoi Medical University:

Hanoi Provincial AIDS Center started the day with the presentation on the current situation of Hanoi methadone programs. The speaker provided conflicting discourses. On the one hand, she criticized the two articles in Decree 96 that required patients with positive urinalysis with non-opioid drugs to be kicked out of MMT. According to the harm reduction principles, these two articles were counterproductive. On the other hand, since the police criticized MMT programs to be a harbor for addicts who wanted to avoid compulsory rehabilitation and since the rates of dropouts, of concurrent heroin use and of low methadone doses were high, she suggested we should screen patients for their motivations. She argued that when getting into MMT was challenging and the screening process was strict, dropout rate was much lower. The reason for high dropout rates was supposed to be the motivation of the patients. In this sense, her discourse was not at all about harm reduction.

Since patients often cited time conflict with work to be a reason of dropout, the speaker criticized them to pick “unsuitable” jobs that required them to work at long shifts and did not allow them to come to the clinics. This discourse indicates that the medical system and its providers did not seem to recognize the structural barriers that methadone patients were encountering.

2. In-depth interviews

This study belongs to DRIVE's qualitative study component that inquires barriers to care, changing drug scenes and drug norms or impact of policy changes in Haiphong. This study aims to understand the daily hardships of participants and how they deal with such challenges. We integrated this question of interest in the interviews on other topics. Thus, this analysis drew

from the accounts of 62 participants. Among them, 16 were interviewed twice, with one year of interval, one person was interviewed three times, also at one year of interval.

We constructed a list of potential participants from the ones we met at the research site and from the recommendations of peer outreach workers. We selected participants for other sub-studies from DRIVE's database to ensure a variety of factors including sex, age, family status, HIV, methadone and antiretroviral treatment statuses. While many of these participants were out of reach at that moment (e.g. running away from home, traveling for work, etc.), no one declined our proposal. Interviews were conducted at various locations: at the research site, in our hotel rooms, at SCDI office and at L.'s home. We ensured the confidentiality of our participants. All interviews were audio-recorded. Before the interviews, participants read and signed the informed-consent form. They received 200,000 VND (~ 8 euros) at the end of each interview.

The guide for baseline interviews aimed to be comprehensive. It was informed by the recovery capital framework (Hennessy, 2017) and covered the experiences of drug use, childhood, family relationships, social networks and future plan. The second interviews were conducted after we had identified salient themes in the first round data. Second interviews were thus, more focused to explore the salient themes in greater details, as instructed by Glaser & Strauss (1967).

Table 1 — Topics of first interviews

- 1) Drug use history
 - Initiation to drugs and subsequent events
 - Reactions from family and community
 - Trajectory of a drug user
 - Attempts to quit drugs
- 2) Childhood
- 3) Experiences with HIV
- 4) Relationships with family, friends and neighborhood
- 5) Experiences with peer support groups
- 6) Projections of future, hopes & concerns

Data treatment

1. The intersectional approach

Intersectionality has emerged as an important analytical framework in the 1980s from the feminist and anti-racist movements (McCall, 2005). The framework traditionally focuses on the convergence of gender, race and class and questions the foundation of taken-for-granted social beliefs and traditions. Intersectionality illuminates how the interaction between different axes of inequality (e.g. race, gender, gender orientation, incarceration history) affects the substance abuse risks and stigma towards PLWH and people using substances (A. J. Gunn et al., 2018; Mereish & Bradford, 2014; Monteiro et al., 2013; Smye et al., 2011).

McCall (2005) discusses three intersectionality approaches: the anticategorical complexity, the intracategorical complexity and the intercategorical complexity. The first and second approaches generally perceive social life as “irreducibly complex.” For them, linguistic categories themselves are biased and cannot reflect the nature of experiences. While acknowledging their argument, McCall highlights the usefulness of provisional categories in investigating the influential factors to social experiences, provided that researchers are critical of the category development process. The intercategorical complexity approach allows researchers to compare different categorical groups and investigate different inequality configurations. We found the third approach useful to investigate how different social processes including gender, age or residency influence the living experiences of people who use drugs in Vietnam.

2. Data analysis

Data analysis started right at the interviews. After each interview, we wrote a brief summary by themes and noted questions to be clarified in next interviews. We also noted our observations not only from fieldworks but also from the meetings concerning drug addiction and

stigma we attended. Before coding, we listened to the audiotape of the interviews to immerse ourselves in participants’ stories again and to capture the emotional nuances invisible on transcripts (Ayache & Dumez, 2011). We conducted both inductive and deductive coding. We started with line-by-line coding to allow themes to emerge and to prevent pre-defined ideas from narrowing the scope of data (Charmaz, 2006). After ten cases when no new theme was found, we grouped codes into larger categories such as values, social contexts, drug use history, addiction stigma, HIV as a haunting image, protecting identity, social support, etc. We then applied this coding frame onto other interviews. As we searched for theoretical frameworks that would illuminate our findings, we developed a deductive coding scheme based on the theoretical framework of each theme. For example: information and tension management (Goffman, 2009), techniques of neutralization (Sykes & Matza, 1957) for the stigma coping strategies; diagnosis and adjustment to HIV infection (Bury, 1982) for the experiences of living with HIV. We conducted memo-writing in parallel with coding and throughout the analysis (Corbin & Strauss, 2014). Constant comparison was employed within each transcript and across cases.

Table 2. Example of open coding

Experiences of living with HIV	Labelling
Yeah, I’m afraid that if I die early ... They are too young; they haven’t had a direction for their lives, for their future.	Early death Worry about children
If only they had been grown up, had been 18, 20 years old, they had been able to direct their lives, I would not have worried. But they are too young now.	Worry about children
I try to live positively; to do well in treatment, to do good to my kids, to my family and to the society. I’ll do what I can.	Taking care of self Taking care of children Caring about family Living positively Helping others

After the first interviews, we employed theoretical sampling to recruit more participants whose insights might illuminate the existing analysis. For example, as we realized there were too few women and too few HIV-infected people living in the inner city in the initial sample to understand the intersectional stigma of addiction, sex, HIV and residency, we recruited 13 more women and 21 more HIV-infected drug users from the interviews our team did earlier with DRIVE participants on other topics. We also recruited transcripts of focus group discussions with methadone and non-methadone participants to understand the stigmatization in methadone settings.

Participants' characteristics

Attributes	n = 62
Age	
<30	4
30–39	24
40–49	28
>=50	6
Sex	
Male	43
Female	19
Education	
Primary and middle school	23
High school	8
College	3
No information	28
Residency	
Inner city	45
Rural districts	17
Marital status	

Married/Cohabited	29
Single	20
Divorced/Separated/Widowed	13
Occupation	
Unemployed	16
Odds jobs	18
Relatively stable jobs	28
HIV status	
Positive	35
Negative	27
Currently under methadone treatment	
Yes	38
No	24

Summary

The chapter above describes the conduct of this research. It provides information about the population base, the role of peer outreach workers and peer support groups as the key intervention of DRIVE. This chapter includes our reflections about our position vis-à-vis participants and peer workers. In this chapter, we describe our ethnographical fieldwork and the design of in-depth interviews. We also report on our data analysis approach. The demographic characteristics of the sample illuminate their general social positions.

CHAPTER 4. THE SOCIAL CONSTRUCTION OF DRUG ADDICTION IN VIETNAM

This chapter seeks to answer two questions of how drugs and addiction have been socially constructed in Vietnam and who are the people who use drugs. To answer these questions, we describe the country's changing societal perception of drugs overtime, including drug-related political environment, socioeconomic evolution since 1986 and socio-demographic characteristics of the drug-using population. This background information is important as it illuminates the social position of drug users and how participants' drug issues relate to their other life dimensions. This chapter comes from our literature review and from participants' narratives of their childhood and young adulthood. In this chapter, we argue that the current social meaning of drugs and addiction is ambivalent and still evolving. It is translated into competing political and medical discourses and into unfavorable practices towards drug users. We also argue that the use of drugs is much related to distinct social phenomena in the Vietnam's context.

Evolving social meanings of drugs and addiction in Vietnam

1. Overview of drug use in Vietnam: Drug issues are a big concern

Vietnam, being located close to the “Golden Triangle” region — one of the two extensive opium-producing areas of Asia — and with a long coastline, has always had their drug issues unsettle. As of January 2017, the number of illicit drug users known by the Government is 210,751, so 0.66% of the country's adult population (Ministry of Health, 2018). This number, however, probably underestimates the actual magnitude of the situation as it mainly includes opiate users and not users of other drugs (Ray, 2008; T. Vuong et al., 2012).

Vietnam has a long history with drug use including opium and its derivative — heroin (V. T. Nguyen & Scannapieco, 2008; Windle, 2012). Since mid-2000s, methamphetamine has

emerged as the new drug of concern (Ministry of Health, 2018). The bloom of opium production and consumption started in the early 19th century, during the French Colonization period, with the migration of Chinese opium farmers into Northern mountainous regions of Vietnam (Windle, 2012). According to Windle (2012), the French colonial government, at the time, in order to finance their heavy military power, promoted and regulated opium use as a legal activity. Thus, the prevalence of opium smokers during this period went as high as 50% among Vietnamese elite (Windle, 2012). Opium consumption only decreased as the Vietnamese Government took over the power (Windle, 2012).

After the country adopted a market-oriented economic model in the early 1990s, Vietnam's drug market changed. Heroin, smuggled into goods, came to Vietnam around the same time through trading with neighboring countries and quickly replaced opium to be the drug of choice (Giang et al., 2013). Although Vietnam was no longer an opium production area since mid-1990s, its long coastline made it a preferred transportation route for illicit drugs from China and the Golden Triangle to international markets (Windle, 2015). As a consequence, the number of heroin addicts in the country rocketed within just a few years (V. T. Nguyen & Scannapieco, 2008; Windle, 2012).

Heroin use started decreasing in prevalence over the last decade but remains the primary substance of abuse with more than 70% of users (Ministry of Health, 2018; Ministry of Labor, Invalids and Social Affairs, 2015). In parallel, amphetamine-type stimulants (ATS), especially methamphetamine, have rapidly increased (Ministry of Health, 2018; United Nations Office on Drugs and Crime, 2012). Official data estimate ATS users account for between 60% and 80% of all drug users in Southern provinces (Ministry of Health, 2018). First ATS use was reported in the late 1990s and associated with young people coming from affluent families (United Nations

Office on Drugs and Crime, 2012). However, a longitudinal study among community injection drug users in Haiphong reports an increase in methamphetamine use from 25% at the baseline to 40% at 24-month follow-up (Duong Thi et al., 2017). Intravenous injection is the preferred route of heroin administration (V. T. Nguyen & Scannapieco, 2008) and smoking is the principal route of ATS use (United Nations Office on Drugs and Crime, 2012).

The drug-associated burden for individual and societal health and well-being is considerable. 34% of all new HIV cases reported in the first six months of 2016 are likely to be injection drug users (Vietnam Administration of AIDS Center, 2016). They also are disproportionately affected by hepatitis B and C (Clatts et al., 2010; Huy et al., 2014), and depression (Esposito et al., 2009). The mortality among injection drug users is 13-fold higher than the general population and mainly due to AIDS and drug overdose (Quan et al., 2011). Financial problems due to large expenses for drugs make drug users economically dependent and deplete their family economy (V. T. Nguyen & Scannapieco, 2008). This contributes to frequent conflicts between individuals and their entourage (Ministry of Health, 2012). Drug trafficking and trading is a major reason for drug users to be imprisoned (V. T. Nguyen & Scannapieco, 2008).

2. Drug policies overtime: Competing messages about drug addiction

Vietnam is among the countries of toughest drug policies, both for ideological and economic reasons (T. H. Khuat et al., 2012a; V. T. Nguyen & Scannapieco, 2008; Windle, 2015). Vietnam's Declaration of Independence in August 1945 clearly stated that opium had been a means that colonists used to destroy Vietnamese race; thus, it called for a collective effort to end opium (and alcohol) consumption in the country (Ho Chi Minh, 1945). Addicts were at

the time seen as bourgeois people of the old regime with an outdated mind who needed to be educated (Ministry of Social Welfare, 1958).

Official documents of the Vietnamese Government during the 1940s reveal that opium used to be a valuable product of exchange with China and East European countries (Ministry of Finance, 1947a, 1947b). Only since mid-1950s, concerns about opium addicts and plans to eradicate opium addiction started to appear in formal correspondence (Ministry of Social Welfare, 1959, 1958). As the ban on opium encountered objection from opium farmers and ethnic minorities with an opium-smoking tradition, the Government allowed some ethnic groups in Northern mountainous regions to produce opium for personal use (Windle, 2012). Moreover, with opium's high monetary value, its cultivation for export was still maintained, although reduced in size (Windle, 2012).

The fight against opium became fierce after the Renovation in 1986, when Vietnam opened the door to market economy and international trading (T. Vuong et al., 2012; Windle, 2012). Different approaches including replacing opium by other food crops and other development projects to support former opium producers have been implemented, although with little success (Windle, 2012). In 2008, Vietnam became one of the rare countries that downsized opium production to almost zero (V. T. Nguyen & Scannapieco, 2008; Windle, 2012). A high level of political authority and law enforcement got credit for this achievement. This victory in the “war on opium” promoted Vietnam's international image and facilitated the country's economic cooperation in the West (Luong, 2006; T. Vuong et al., 2012; Windle, 2012).

Law enforcement has been the main strategy to deal with the drug situation since the arrival of heroin into Vietnam (T. Vuong et al., 2012; Windle, 2012). Strict control of heroin traffic and severe punishments for heroin traffickers aimed to break the supply chain and

compulsory rehabilitation of consumers to reduce the drug demand (T. Vuong et al., 2012). Heroin users, together with sex workers, were labeled “social evils” and subjected to coercive interventions, including compulsory detention (V. T. Nguyen & Scannapieco, 2008; Windle, 2015). The Government spent a significant budget to quickly establish compulsory rehabilitation centers all over the country, from a few ones in mid-1990s to 123 facilities in 2010 (T. Vuong et al., 2012). Drug users were often sent to the centers by the police or by their family against their will (Human Right Watch, 2011). So-called treatment consists of detoxification, therapeutic labor and moral education (Human Right Watch, 2011). The detention length varied, but often included a detoxification period of three months to two years, plus another two years of post-detoxification management (T. Vuong et al., 2012).

The compulsory rehabilitation centers have been excessively criticized to be costly, ineffective, contrary to human rights and destructive to health (Human Right Watch, 2011; T. Vuong et al., 2016). The relapse rate of returnees from these centers was more than 90% despite the length of stay (Ministry of Labor Invalid and Social Affairs, 2010). Forced labor and physical abuse were largely reported (Human Right Watch, 2011). While drug use was minimal in the centers, HIV transmission risk is higher due to limited access to clean needles and syringes (Windle, 2015). Economic benefits from cheap labor for the centers’ managers and higher hierarchies might prolong the existence of these centers (T. Vuong et al., 2012; Windle, 2015).

The situation started to change with the arrival of an injection-drug-driven HIV epidemic and international funds to fight AIDS into the country (Edington & Bayer, 2013; T. Vuong et al., 2012). As injection became the most popular method to administer heroin and users began to share injection equipment, HIV transmission escalated among people who inject drugs (PWID) and increased risks that the epidemic would spread into the general population (Hammett et al.,

2007). In 2001, even as the government supported needle and syringe exchange programs, PWID accounted for 60% of identified HIV cases (V. T. Nguyen & Scannapieco, 2008; Windle, 2015).

Harm reduction projects, on the one hand, aimed to reduce HIV infection and mortality and, on the other hand, expected to move Vietnam drug policies into a more right-based approach (Edington & Bayer, 2013). The later attempt collided with the “drug as individual failure” logic of Vietnamese Government and progressed slowly (Edington & Bayer, 2013). Harm reduction pilots such as needle and syringe exchange and MMT produced promising outcomes but were limited in a few geographical areas due to unfavorable political environment (T. Ahmed et al., 2014).

The shift in Vietnam’s addiction intervention system happened with the outstanding success of methadone programs in preventing HIV incidence and curbing crime rates (T. Ahmed et al., 2014; Ministry of Health, 2012). Compulsory rehabilitation of heroin addicts had been unsuccessful (World Health Organization: Western Pacific Region, 2009). Between 2008 and 2010, Vietnam's Ministry of Health, with support from PEPFAR, piloted methadone treatment in Haiphong and Ho Chi Minh City, with the hope of curbing the HIV epidemic (Edington & Bayer, 2013). Vietnamese methadone programs have three objectives: 1) to reduce illegal opioid use in society, 2) to address health issues, including mortality and blood-borne diseases and 3) to improve individuals’ social functioning (Ministry of Health, 2010).

The pilot data not only showed only one new HIV case among almost 1000 methadone patients followed over two years, but it also revealed a decreased proportion of patients who reported engaging in criminal activities (from 40.8% to 1.3%) (Ministry of Health, 2012). These results created a momentum for the treatment to rapidly scale up—from six clinics serving nearly 1000 opioid users in 2010 to 280 clinics serving more than 52,000 opioid users as of June 2018

(Ministry of Health, 2012, 2018). In December 2013, the Vietnamese government declared that addiction was a chronic disease, which brought it under the purview of the medical sector rather than that of social affairs and public security while also limiting the scope of compulsory detention centers (Government of Vietnam, 2013).

However, although methadone is the only evidence-based addiction treatment available in Vietnam, methadone programs cover an unexpectedly small number of patients, and have expanded slowly. The methadone program has failed to achieve the target of 80,000 patients (estimated at 40% of all opioid users) by 2015. As of June 2017, only 52,054 patients were receiving treatment, a 5,600 increase from the previous year (Social Republic of Vietnam, 2014; Vietnam Administration of AIDS Center, 2016, 2017a). Meanwhile, the dropout rates were as high as 33.3% at 36 months (Khue et al., 2017). This raises doubts from other sectors about the effectiveness of the methadone program in controlling the drug issue.

Another threat to the success of harm reduction, represented by methadone programs, is an increasing methamphetamine consumption and the fear it causes in the society (Giang et al., 2013; United Nations Office on Drugs and Crime, 2012). Since methadone does not treat methamphetamine or other synthetic drugs addiction, pro-compulsory detention stakeholders voice out the needs to withhold the resources for methadone clinics and reopen compulsory rehabilitation centers (Duc, 2017).

The political environment, however, remains ambivalent regarding drug use, not only among the three Ministries of Health, of Labor, Invalids and Social Affairs and of Public Security but also within each ministry. The conflict between “old-time” law enforcement and harm reduction approaches translates into contradictory policies and community-level practices (Jardine et al., 2012; T. Vuong et al., 2012). While drug addiction is now officially a chronic

relapsing disease in legal documents, the use of heroin and other illicit drugs paradoxically warrants a treatment termination for methadone patients (Government of Vietnam, 2013, 2016, p. 90). Urinalysis is still in use to identify heroin addicts despite the medical guidelines of diagnosis (Government of Vietnam, 2016, p. 90; Ministry of Health, Ministry of Labour, Invalids and Social Affairs, & Ministry of Public Security, 2015, p. 17).

Quotas were applied for both compulsory detoxification in centers and methadone treatment for each district (Hanoi People's Committee, 2017, p. 21). Ward police, the standing agency in dealing with drug use, often feel stressful to meet these quotas, as they knew that rehabilitation camps were unhelpful but they were also unsure about the harm reduction approach (Jardine et al., 2012 ; T. H. Khuat et al., 2012a). In some communes, the prestigious associations of former soldiers protested against the harm reduction ideas as they continued to believe that addiction was a willpower issue (T. H. Khuat et al., 2012a). Under these expectations, police officers were more inclined to send drug users to compulsory rehabilitation (T. H. Khuat et al., 2012a).

At the government level, even officials who have been advocated for MMT for years sometimes expressed their lack of belief in methadone as the best way to treat addiction (Edington & Bayer, 2013). These struggles represent the ideological conflict that persists in Vietnam regarding the issue of drug use. Drug use, together with other “poisonous” Western cultural products like the popular movies and novels with sexual and violent scenes, were considered an attempt to “degrade” the young generation and to harm the socialist regime (Marr & Rosen, 1998). In the words of T. H. Khuat (2012), the fight against drug issues was not simply the fight against a practical issue but a class struggle.

Within the medical system, our observation also reveals conflicting discourses. In a meeting among Hanoi Medical University, Hanoi Centre for Disease Control and four methadone clinics in 2018, medical professionals criticized the Decree 96 that required methadone treatment to be terminated for patients with two consecutive positive urinalyses to violate the harm reduction principles. Nevertheless, they also suggested that clinicians should screen patients for their motivations at intake and that they should only provide treatment for those with high motivation to prevent concurrent heroin use and dropout. Although this intention aimed to address the critics of the police and social affairs sectors, it went against the harm reduction principles to provide low-threshold treatment for everyone. This also implied professionals' ignorance of the potential structural barriers patients were facing.

Socioeconomic context — Coming of age at Post-Renovation

1. Economic changes

Two third of our participants were born before 1986, during the dark post-Reunification decade 1975-1985. This period witnessed a humanitarian crisis with a large-scaled famine that touched millions of people due to the inadequate governing capacity of the new government, the economic confinement of the United States and the weakening of Soviet Union and East European countries. Besides the political migration wave to the United States and Europe after 1975 and the return to China of Chinese Vietnamese during the Vietnam-China border war in 1979 - 1989, more than one million Vietnamese fled to neighboring Southeast Asian countries, looking for a better life (United Nations High Commissioner for Refugees, 2000). Haiphong, with its seaport, was at the center of this phenomenon. Although official information about this period was scarce, online forums of ex-migrants and participants' narratives suggested that migration was a common experience of many families in the province.

To cope with the economic crisis, in 1985, the Government of Vietnam launched a radical transformation of the national centrally planned economy into a market-oriented model (Duiker, 1986; Long et al., 2000). This reform, called the “Renovation”, introduced drastic changes in the economic and social life of the country. Different than the previous governance, the market-oriented economy allows privatization and thus, encourages household production. The Government implemented various strategies to attract foreign investment. In the latter part of the 1980s, Vietnam became the second-largest host country for foreign direct investment, only behind China (Q. H. Vuong, 2014). As foreign capital flowed in, jobs were created, especially in export-oriented manufacturing sectors like textiles, footwear or apparel (Xuan & Xing, 2008). Within just two years, Vietnam rose from famine to become the third rice exporter in the world (Q. H. Vuong, 2014). That brought in major material improvements in the whole country. People got access to money instead of consumable goods checks, enjoyed material wealth and technological advances (Badiani et al., 2013). Vietnam had the largest gross domestic product increase in the world at the time (7-8%) and continues this economic growth until present, although significant challenges remain (Q. H. Vuong, 2014; World Bank, 2019).

The foreign investments in major urban areas including Haiphong in the 1990s encouraged a high workforce mobilization from rural areas to urban cities to fulfill the needs for labor in construction and industrial production. Trying to regulate this migration, the Government restricted migrants to low-pay, unstable occupations, refused to grant them household registration in the cities and preventing them to benefit from medical insurance and other social welfare (Long et al., 2000). Still, the income migrants earned in the cities was more important than what they could get from agricultural work. The remittance they sent home regularly was vital for the families they left behind (Thao & Agergaard, 2012).

This migration and the country's struggle in the pre-Renovation years negatively affected the national level of education. In the countryside, when men migrated, women had to stay at home and took care of all agricultural labor and tending the elderly and children. This challenge, plus the cessation of free schooling since 1989 made schooling unaffordable for many households (Long et al., 2000; Marr & Rosen, 1998). At the same time, in the cities, dismissing state-owned corporation without adequate support for workers put many urban households in difficulties (Long et al., 2000). On top of these, the lack of better jobs with more education discouraged youth to pursuit higher education (Marr & Rosen, 1998). The majority of youth in our participants' villages only completed middle school. Their parents were too busy working to feed the family and had no time to pay attention on participants' studies. As a result, participants quit school and worked since they were young.

For our participants, low-skilled jobs such as carriers, dish cleaners, bricklayers or small business owners were common in the early post-Renovation years. Most of them worked far from home, often in the inner city of Haiphong or in Quang-Ninh, at the border gate with China. In the lively economic atmosphere of that period, participants earned well with their jobs. However, as the economy grew and modernized, it favored more skilled labor and the relative position of low-skilled workers in the market weakened (Badiani et al., 2013). Our participants reported the escalating cost of living, the changing work market and a stagnant salary to be pressures that forced them to switch jobs and go back to live with their families. Although basic needs poverty was no longer an issue, perceptions of inequality intensified by an enlarging income disparity between different classes (Badiani et al., 2013).

2. Changes in social values

This socioeconomic change led to an ideological transformation among the Vietnamese youth at the time: from a restricted, communist personality to a more extravagant, individualistic personality (Marr & Rosen, 1998; H. Nguyen, 2015). The collapse of the economy during the pre-Renovation decade had turned off Vietnamese youth's enthusiasm to the communist ideals and the role of the Communist Youth League was no longer important to the new generation as it had been to their parents (Marr & Rosen, 1998). An analysis of two most popular magazines targeted teens between 1995 and 2005 showed a remarkable shift: the magazines' discourse moved from constituting a Vietnamese youth as being ideologically collectivist to being market-oriented (H. Nguyen, 2015). This market-oriented youth was encouraged to express her individuality through material possessions (H. Nguyen, 2015). This value change finds echoes in other studies conducted in Ho Chi Minh City, the economic center of Vietnam (Kay Hoang, 2011; Truitt, 2008). Consumables have become a criterion of judgment, which was alien to the communist ideals. One's appearance or the brand of one's motorbike became the markers of social classes and economic power (Kay Hoang, 2011; Truitt, 2008). A participant summarized this shift as follows: *"Before people stood up with bravery, now they stand up with money."*

Families that had members living abroad (Viet-kieu) had accessed to high-value foreign money and thus were the target of admiration and of envy by others in their communities. "Viet-kieu" has become a synonym to monetary wealth, although it was not always the case. One study participant had to pretend to receive remittances from her daughter who worked abroad while in reality, the daughter was in debt and the mother had to help her to pay it.

Rising from famine and getting access to money and wealth also facilitated self-indulgence. A former FSW reported that in the late 1990s, "enjoying life" or "self-indulging"

was the norm among her group. Making money was easy and people could buy what they wanted, unlike in the subsidy period. Those who refused to spend money on hobbies were deemed “rural,” “outdated” and singled out.

The traditional Vietnamese household has also undergone major restructuring. Together with the enhanced mobilization for work, nuclear families became more popular. Adult children, especially sons, who used to live with their parents, now lived far from home for an extended period and left behind the agricultural work. The labor division in a family also changed as women could also leave domestic responsibilities to migrate to the cities for work (Thao & Agergaard, 2012). Although Confucianism retained its importance in contemporary Vietnamese society, people observed less strictly its hierarchical and patriarchal values such as a negligent role of women.

3. Socioeconomic particularities of Haiphong

Haiphong, with a population of two million, is the third-largest province in Vietnam. Its geographical location (close to the sea and to the capital) attracts foreign investment and makes it one of the most important industrial centers in Northern Vietnam, together with Hanoi and Quang-Ninh. Besides trading, Haiphong has also been a military strategic place. In the 2000s, as Vietnam prioritized marine transportation and aquaculture to compensate for infrastructure projects, Haiphong became the focal site for cooperation projects with Russia (Nhan Dan Newspaper, 2000). These projects resulted in an expanded Haiphong port and increased fishery production (Nhan Dan Newspaper, 2000). Haiphong was among the provinces with the highest density of rich and poor people (Badiani 2013).

Haiphong was at the same time a major site for drugs and HIV/AIDS (Ministry of Health & National Institute of Hygiene & Epidemiology, 2014). Since the beginning of the HIV

epidemic, Haiphong has been the principal recipient for investment in HIV and drug interventions by the Government of Vietnam and international agencies (Ministry of Health & National Institute of Hygiene & Epidemiology, 2014). Haiphong hosted the first methadone clinic in 2008 and as of 2018, its methadone program served nearly 4000 opioid users, likely 80% of the whole opioid-using population in the province (Des Jarlais et al., 2018).

Haiphong

- Population (2018): 2, 013,800
- Major economic sectors: Trading, industry (food processing, light and heavy industries), agriculture & fishery
- Out-migration: 1.6%
- In-migration: 1.6%



Drug users: socio-demographic information and context of initiation to drug use

1. Socio-demographic information

The majority of drug users in Vietnam were of poor socioeconomic status (Khue et al., 2017; V. T. Nguyen & Scannapieco, 2008). While they were about mid-thirties, more than half were unemployed (Bergenstrom et al., 2008; Hayes-Larson et al., 2013; L. Li et al., 2013; Ministry of Health & National Institute of Hygiene & Epidemiology, 2014; V. T. Nguyen & Scannapieco, 2008). The others mainly had an unstable, low-waged job (Nong et al., 2017). Sex work is the main income resource for one to two thirds of female drug users (O. T. Khuat et al., 2015a). Drug users were predominantly male, about half were married or living with a partner (Bergenstrom et al., 2008; Hayes-Larson et al., 2013; O. T. Khuat et al., 2015a; L. Li et al., 2013). Surveys on drug addiction situation found that the majority of drug users inhabited big cities like Hanoi and Ho Chi Minh City (V. T. Nguyen & Scannapieco, 2008). Methadone patients were more likely to be married (Van Nguyen et al., 2017). The majority had at least middle-school education (Hayes-Larson et al., 2013; L. Li et al., 2013; V. T. Nguyen & Scannapieco, 2008; Van Nguyen et al., 2017). One study conducted in Hanoi reported a proportion of more than 30% drug users having been to high schools or higher education (Hayes-Larson et al., 2013). Until early 1990s, most drug users came from ethnic minorities in Northern highlands (V. T. Nguyen & Scannapieco, 2008). However, about ten years later, lowlands residents of Kinh — Vietnamese main ethnic group and urban citizens took over the scenes of drug use (V. T. Nguyen & Scannapieco, 2008).

As mentioned earlier, heroin remained the drug of choice for most drug users in Vietnam at post-Renovation (Vietnam Ministry of Labor, Invalids and Social Affairs, 2015). People started using heroin in their early twenties (Hayes-Larson et al., 2013; O. T. Khuat et al., 2015a;

Ministry of Health & National Institute of Hygiene & Epidemiology, 2014). Smoking was the initial administration route but then replaced by injection several years later (O. T. Khuat et al., 2015a; Ministry of Health & National Institute of Hygiene & Epidemiology, 2014). The concurrent use of methamphetamine and other synthetic drugs, however, became more and more popular among drug users (Duong Thi et al., 2017; Giang et al., 2013). Experiences with drug compulsory rehabilitation were common with about 50% reported having been to such programs (Bergstrom et al., 2008).

Drug users in Vietnam are prone to multiple health issues including overdose, HIV and viral hepatitis, and mental disorders (Clatts et al., 2010; Esposito et al., 2009; Quan et al., 2011). HIV prevalence among injection drug users is decreasing thanks to harm reduction strategies over the last two decades but remains around 10% (Vietnam Administration of AIDS Control, 2017). The mortality among injection drug users is 13-fold higher than the general population and mainly due to AIDS and drug overdose (Quan et al., 2011). Moreover, while studies found an alarming escalate of HCV prevalence from 30% among new injectors to 70% among old ones, HCV prevention and treatment remain under-resourced (Clatts et al., 2010).

Mental disorder among drug users is another ignored issue. When international data shows a high prevalence of mental troubles in this population (Astals et al., 2009; Callaly et al., 2001), studies of this topic in Vietnam are scarce. The few available works on methadone patients, however, suggested up to one third were suffering from common mood disorders (FHI360/USAID, 2012; Trang et al., 2016). Mental disorders not only affect drug users themselves but also their family members (L. Li et al., 2013). Mental healthcare, however, is scarcely available in MMT clinics or in the community.

2. Initiating heroin use in the 1990s and 2000s

Among the 58 participants we collected information regarding their first drug use, 42 were first involved with drugs between mid-1990s to mid-2000s. Ten individuals did it before 1995 and six after 2005. Heroin was the major drug of choice. Only four older participants had tried opium before they switched to heroin.

As participants recalled, heroin in the 1990s and early 2000s was pure, cheap and abundant. Along the rail track crossing the inner city, heroin vendors and their clients exchanged publicly, “as they did with vegetables”. One dose of heroin cost only 10,000 to 20,000 dong (0.5 to 1 euro). It was thus, affordable to everyone and a good substitute for those who used to smoke opium. Heroin was described as a “wave” that drowned students of whole middle-school classes or youth in whole villages.

The young workers, living far from home, and earning good money, were especially vulnerable to heroin as they lacked family control and relied on their peers for support. Using heroin was a way to assert oneself and to seek conformity within one’s group. Moreover, in early 1990s, the media did not yet talk about heroin and people rarely knew about it. One could smoke heroin in a tea stall and explain that it cured stomach ache without raising further questions. Still, many participants who started using heroin in the 1990s anticipated social disapproval of their drug-using behaviors, but as a bad habit rather than as an illegal behavior. However, some were confident that even if they developed addiction, they could still afford their habit, given the cheap price of heroin.

As antidrug campaigns became more common during the 2000s, individuals who started using heroin then were well aware of the drug's potential addictiveness. They continued to do so, however, out of peer pressure, curiosity or to self-medicate their distress. Due to police

breakdown and a tightened supply, heroin price went up sharply and put the habitual users into economic vulnerability. Their wages could no longer afford their consumption and the increased physical tolerance. Together with the growing number of compulsory rehabilitation centers was the growing number of drug users detained in these facilities (T. Vuong et al., 2012).

3. Support for drug users: community-based peer groups

Drug users could receive support from peer groups, or more generally, community-based organizations (O. T. Khuat, 2007). Such organizations increased sharply in quantity in the early 2000s thanks to international funding for HIV prevention (O. T. Khuat, 2007). Hence, the majority of them only worked in selected provinces of high HIV concentration and served mainly HIV-positive drug users (T. Ahmed et al., 2014). Peer support groups provided their drug using clients with harm reduction information and materials, referrals to care and compassion (Hayes-Larson et al., 2013; Walsh et al., 2008). Their work has been seen as critical to improve their client's well-being (Hayes-Larson et al., 2013). However, when international funding started to decrease over the last few years due to Vietnam's "middle-income country" status, such services were considered non-essential and have been eliminated in donors' agenda (T. Ahmed et al., 2014). The Government of Vietnam, while recognizing the importance of peer support (Social Republic of Vietnam, 2014), was reluctant to mobilize funding for these groups who lacked of qualification and bore a "social evil" status.

Summary

The chapter has described the social construction of the drug issues in Vietnam and the context where our participants initiated drug use. The use of drugs (opium until the 1990s and heroin in the subsequent period) has changed from being a bad habit of outdated people from the feudal and imperial regimes to a threatening "social evil", associated with other Western vices

and to an act of multiple statuses. The response to drug use, thus, has moved from re-education to punishment, isolation and to treatment. The societal perception of addiction and drug users is closely associated with current socio-political issues.

The beginning of the 21st century witnessed a major struggle between the moral and medical conception models of addiction in Vietnam. The official definition of addiction as a chronic disease has not been translated smoothly into actual practices of both medical providers and professionals of the social affairs and public security. The arrival of new psychoactive drugs has complicated the situation as no effective medication was available yet for the abuse of these drugs.

Our heroin-using participants grew up in a particular period of the country. Having survived from the poverty of the pre-Renovation decade to get into the sudden material wealth of the post-Renovation years, they had been exposed to radical changes in the social value system. The mainstream communist ideals became less important while the individualistic, materialistic paradigm prevailed. They were also exposed to the changing social perception of drugs and changing drug policies. Currently, people who used heroin constituted a vulnerable population, characterized by low education, low socioeconomic status and high mortality. Community-based organizations and networks, as a resource for drug users, have encountered increasing challenges for their sustainability. Against this backdrop, we will describe the two major issues related to stigma and HIV infection that our participants faced in their daily lives and the strategies they mobilized to cope with these hardships.

PART 2

CHAPTER 5. EXPERIENCES OF STIGMATIZATION IN DAILY LIFE

Drug use stigmatization and discrimination has been a complicated and devastating issue across the world and in Vietnam. Drug use stigmatization and discrimination are associated with lower access to healthcare services by preventing the stigma bearers from seeking health (Eggertson, 2013) and lower quality of care (Lloyd, 2013). As a consequence, discrimination towards people who use drugs leads to poorer mental health and physical health outcomes (Ahern et al., 2007). Drug use stigmatization is complicated since drug users also carry with them other devaluing marks such as HIV, mental disorder, poverty or race (Conner & Rosen, 2008). Each of these marks generates stigmatization that entangles with drug use.

The literature about drug users as such in Vietnam is limited. In the last two decades, studies had been focusing on the living experiences of people living with HIV (Dao et al., 2013). Since drug users account for the majority of HIV cases (V. T. Nguyen & Scannapieco, 2008), some drug-related issues have been raised. A significant part of the literature on drug stigmatization experiences dated before 2010 — the revolutionary methadone treatment era in Vietnam. Recent studies were mainly quantitative and focused on the methadone population. They revealed high levels of perceived stigmatization among patients. These studies, however, did not explore the socio-political context or the underlying individual beliefs that constituted such phenomenon.

This chapter aims to look beyond the relationship of drug use and HIV issues and describe the expressions of drug stigmatization that contemporary Vietnamese drug users were experiencing in their daily lives. We examine the participants' experiences, considering them in

light of Link & Phelan (2001)'s conceptualization of stigma to describe the extent of drug use stigmatization in Vietnam and the social norms underlying it.

Concept of Stigmatization

Stigmatization and discrimination — the unfair treatment towards individuals negatively labeled as having a characteristic that is contrary to a norm of a social unit — is a universal human phenomenon (Link & Phelan, 2001). Blaming the victim is the key feature of stigmatization where the stigma bearer is thought to be responsible for his or her condition, hence deserves it. This logic supports punitive policies and fosters social distance to stigma bearers (Kennedy-Hendricks et al., 2017; Stein, 2003). Social marginalization is detrimental to a range of outcomes including life opportunities, self-esteem, hope, self-efficacy and life quality of the stigma bearer (Corrigan, Larson, et al., 2009; Kerr & Jackson, 2016; Livingston & Boyd, 2010; Lloyd, 2013).

Theorization of stigma has gone through important developments since the classic work of Goffman (2009, [1963]). Goffman defines stigma as “a mark of disgrace” that relies within the individual. He focuses on the information and tension management that a person might adopt depending on whether his/her failing is discreditable or discredited. This conception of stigma, which has served numerous studies over the last sixty years, has been criticized so far for misleading research to neglect the power hierarchy in social interactions (Parker & Aggleton, 2003).

Link & Phelan (2001) offered a conceptualization of stigma as socially constructed in a given power structure, in the convergence of interrelated components. They proposed to use the term stigmatization and discrimination to better capture the reciprocity between the stigmatizer and the stigmatized. Stigmatization starts with distinguishing and labeling human differences.

This process is based on social selection of what differences should be more salient and depends on the context where people are embedded. The differences are then associated to negative stereotypes, causing a separation between “us” and “them” and resulting in status loss and discrimination towards the stigma bearer. Link & Phelan (2001) also emphasized the question of power in stigmatization and discrimination, or in other words, who have the power to stratify resources in the society. They offered four questions that could lead the analysis: 1) What is the difference? 2) How does this difference signify something negative in cultural and social norms? 3) How has the person been labeled and discriminated? 4) How do they react to negative treatment? Analyses in this direction would focus on the social construction of stigmatization meanings.

Parker & Aggleton (2003) employed Foucault’s conceptualization of knowledge and Bourdieu’s concept of symbolic power to further develop Link & Phelan (2001)’s thesis. They argue that stigma and discrimination should be explored at the intersection between culture, power and difference where the phenomenon is central to the constitution of social order. Stigmatization works in favor to the dominant groups, legitimates their dominant status within existing social hierarchy.

Fraser et al. (2017) argue that drug-related stigma is a political means to discipline human subjects into what is defined as legitimacy in today societies. As the existence of legitimacy is impossible without the existence of illegitimacy, drug-related stigma must be considered within the whole social complex (Fraser et al., 2017). The knowledge of the social norms underlying drug-related stigma would illuminate how the society functions and help us to rethink our interventions.

Stigmatization and discrimination have both psychological and social functions. Psychologically, separating “us” from “them” and blaming the victims provide people without the undesired trait in question a feeling of safety that they will not acquire such failing since they are totally different from the stigmatized group (Stein, 2003). Sociologically, stigmatization and discrimination reinforce social norms and the position of dominant groups in a given society by marginalizing individuals of deviant traits from subordinate groups (Link & Phelan, 2001; Stein, 2003). Stigmatization and discrimination towards a specific negative trait interact with other power axes such as gender, class, sexual orientation, race or ethnicity (Stein, 2003).

Drug — related Stigmatization

Goffman (2009, [1963]) classified drug use into the third type of stigma — a blemished character and personality. The literature describes four types of drug use stigmatization: public or enacted stigmatization, institutional stigmatization, intra-group stigmatization and self-stigmatization.

Social Stigmatization

Social stigmatization that directs at drug users expresses in negative public opinion, discriminatory treatment of drug users by health professionals and by family and friends. In a survey across cultures, drug use consistently received the highest social disapproval, together with a criminal record for burglary or alcoholism (Robin Room, 2005). Drug users were blamed for their condition and perceived to be more dangerous than people with mental disorders (Corrigan, Kuwabara, et al., 2009; Lloyd, 2013; Nieweglowski et al., 2018). The fear of drug users was disproportionate to the tangible harms drugs caused, compared to those of alcohol (Callinan & Room, 2014). Public shame was not only linked to active drug use but to drug-related conditions, including seeking and being in drug treatment (Vigilant, 2004). The severity

of public stigma was closely related to the level of support for punitive drug policies (Kennedy-Hendricks et al., 2017, p.).

Embedded in the same social contexts, health professionals adopted mainstream values and judged their drug-using patients based on these norms. Health professionals tended to see drug-using patients as non-compliant, irresponsible, demanding, dishonest and a waste of resources (Faugier & Sargeant, 1997; Gray, 2010; Kirtadze et al., 2013; Pauly, 2008; Rance & Treloar, 2015). This resulted in negative attitudes towards drug-using clients in pharmacies (Simmonds & Coomber, 2009), exclusion of drug users from HIV treatment (Bobrova et al., 2007) and lower quality of care for women who used drugs during prenatal and postpartum course (Eggertson, 2013; Howard, 2015). The denial of medical services and a derogatory attitude make drug users reluctant to discuss drug issues with healthcare professionals (Fraser et al., 2017).

Drug users' significant others constitute another source of stigmatization and themselves are victims of drug use stigmatization. Instances of family stigmatization included rejection, isolation (A. Gunn & Guarino, 2016; Haritavorn, 2014; Spooner et al., 2015), violence from intimate partners (Haritavorn, 2014) or negative judgment (A. J. Gunn et al., 2018). Courtesy stigmatization results in family being shunned by the community (A. Gunn & Guarino, 2016) and makes them not seeking help for children for fear of ostracism (Myers et al., 2009).

Institutional Stigmatization

Institutional stigmatization refers to institutional practices that intentionally or unintentionally undermine life chances of stigmatized people. Punitive drug policy is the macro-level form of this kind. While few countries went to the extreme of killing drug users for the sake of using (Corrigan & Nieweglowski, 2018), many have favored the war on drugs for years to

confine drug users in prison or in compulsory rehabilitation (Jürgens & Csete, 2012; Kerr & Jackson, 2016; Khenti, 2014). This massive imprisonment resulted in drug users being rejected from social services due to their incarceration status and destroyed their social capital, making recovery a hard task (Kerr & Jackson, 2016; Khenti, 2014). The ideology underlying punitive drug policy made it hard to introduce evidence-based interventions since policymakers tended to disregard scientific evidence that was not in line with their moral criteria (Edington & Bayer, 2013; Malinowska-Sempruch, 2016; Pienaar & Savic, 2016).

Another macro-level form of institutional stigmatization is language and the stereotyping of drug users in mass media. The vocabulary to depict drug use, even in scientific literature was traditionally pejorative, perpetuating stigmatization unintentionally (Broyles et al., 2014). The dichotomous language of “dirty” vs. “clean” urine failed to acknowledge the existence of functional drug use (Whitaker et al., 2011). Media tended to inflate the dangerousness of drug users, turning the exception into the rule, hence incited public fear of drug users (Lloyd, 2013). In popular American entertainment productions, illegal amphetamine users were stereotyped as violent individuals of low social class who bore all responsibility for their condition, hence deserved punishment (McKenna, 2011). At the same time, prescription amphetamine users were portrayed as members of upper-middle class who were victims of social pressures, therefore should be helped (McKenna, 2011). Such stereotyping not only fuels negative perception of illegal drug users and undermines the availability of resources for them, but also attacks the dignity of poorer social classes.

In agencies serving drug users, institutional stigmatization takes forms of unfavorable treatment policies and client stereotyping. Drug-using patients criticized the restrictive regulations in methadone clinics such as daily observed dosing, limited dosing window or unfair

treatment contracts for preventing them to fulfill their parental role (Chandler et al., 2013), to become self-sufficient (Bojko et al., 2016), tying them into the “addict” identity (J. Harris & McElrath, 2012; Järvinen & Andersen, 2009), hence interfering with their recovery (Fraser, 2006; Neale, 2013). Selseng (2017) identified four distinct formula stories constructed by a social welfare service. These stories that depicted drug users as addicted, unreliable, deteriorating and stigmatized serve to legitimate the agency’s practices and put the blame on drug-using clients’ lack of willingness when they did not meet the agencies’ expectations, rather than the agencies’ failure in meeting their clients’ needs.

Intra-group Stigmatization

Stigmatization among drug users is common and shed light on how drug users adopt the mainstream values and construct a hierarchy among themselves. A number of studies showed that drug users stigmatized against each other based on specific standards of morality.

Methamphetamine-using participants in a study of Mckenna (2013) distinguished themselves from more scandalous users who stole from individuals, unlike them who stole from companies.

Homeless users were at the lowest rung of the ladder for being “lazy,” “dirty” and “irresponsible” since they shared needles and used drugs in public (Simmonds & Coomber, 2009). “Soft users” of marijuana associated “hard users” of heroin or crack cocaine to the image of losing self-control while “hard users” stigmatized among themselves based on the criteria of hygiene, appearance or committing crimes against the family (A. J. Gunn & Canada, 2015).

Low-dose methadone patients looked down on high-dose ones, considering the latter to be irresponsible as they wanted to stick with methadone for life (Vigilant, 2004).

Internalized Stigmatization

Public and institutional stigmatization might lead to the internalization of stigma or self-stigmatization through previous experiences of stigma-related social rejection (Luoma et al., 2007, p. 20; Matthews et al., 2017). Internalized stigmatization included self-stigmatization and anticipated stigmatization. Self-stigmatization implies that drug users agree with mainstream opinion of stigma, applying it on themselves and causing diminished self-confidence and self-efficacy (Brouard, 2006; Corrigan, Larson, et al., 2009). Internalized stigma happens when the stigmatized individuals share the same judgment criteria with the stigmatizing group (Kusow, 2004). Self-stigmatization has an impact on the mental health of the stigmatized individual (Mak et al., 2015). Although self-stigmatization might result from public stigmatization, it does not necessarily decrease in case public stigmatization decreases as it relates to the person's own standards (Matthews et al., 2017). Anticipated stigmatization meant the drug-using individuals were aware of the social stigmatization and expected negative social treatment. This might undermine their capacity in forming supportive social relations.

Stigmatization and discrimination towards people who use drugs in Vietnam

Drug use stigmatization and discrimination constituted a major issue in Vietnam. Nearly all drug users reported having experienced blame and shame and social distance for their behaviors (Van Nguyen et al., 2017). Drug use stigmatization was often described as another layer of stigmatization that people living with HIV in Vietnam encountered due to the high prevalence of drug use among HIV-infected patients (Rudolph et al., 2012). Little work has tried to describe the stigma experiences of HIV-negative drug users in Vietnam.

Drug use and HIV, together with prostitution were linked together under the title of “social evils” — immoral conducts — in political and social discourses (T. H. Khuat et al., 2004). Widespread stigmatization and discrimination towards drug users in Vietnam translated

into repressive policies that favored long-term incarceration of these individuals and hindered the implementation of harm reduction programs (Hammett et al., 2007). While antidiscrimination social movements have successfully delinked HIV from “social evils,” drug users (and sex workers) were left behind and kept being entitled as immoral and dangerous deviants who deserved isolation and strict re-education (O. T. Khuat, 2007).

Drug users, in different parts of the country, experienced social avoidance, both from their community and from their own family (O. T. Khuat et al., 2015a; Pauline Oosterhoff, 2006; Rudolph et al., 2012; Van Nguyen et al., 2017). If they stayed with their family, they were constantly attacked by their family members’ anger and frustration towards them (Rudolph et al., 2012). People assumed that women who used drugs had to sell sex to afford their drug habits (O. T. Khuat et al., 2015a). Drug users who had been to drug rehabilitation centers and whose status was publicly known, found it hard to get a job and to be reintegrated into the society (Pauline Oosterhoff, 2006; Tomori et al., 2014). Van Nguyen et al. (2017) suggested that unemployment could strengthen the perceived stigma and the feelings of stigma were associated with anxiety and depression. These potential layers, however, have not been investigated yet.

HIV-positive drug users suffered both psychologically and financially since neighbors stopped soliciting their business once they knew about their HIV positivity (Maher et al., 2007; Rudolph et al., 2012). This devastated the living resources of the whole family and sometimes forced them to leave their hometown (Maher et al., 2007). When medical care was vital for people living with HIV, healthcare workers often rejected HIV-positive drug users (Maher et al., 2007). If these patients did receive treatment, the services were not decent since healthcare workers refused touch them, for fear of HIV dissemination (Maher et al., 2007).

While drug use is an individual behavior, addiction stigmatization and discrimination do not only affect the individual drug user but also their care providers, including family members and healthcare professionals (Pham et al., 2012; Salter et al., 2010). The connectedness of individuals and their families in Vietnamese societies dictates the unavoidable feelings of shame and dishonor that the families of drug users experience. Negative moods of drug users also result in their families' psychological disturbances (L. Li et al., 2013). Secondary stigma also affects healthcare professionals, causing dissatisfaction and turnover, which result in low quality of care (Pham et al., 2012).

Methadone maintenance treatment: global expansion and persisting ambivalence

The landscape of drug use in Vietnam has changed since 2010 with the expansion of the game-changing methadone maintenance treatment program. The pharmacological effect of methadone eliminated the withdrawal symptoms and craving for heroin that constituted the major reason of relapse. Methadone maintenance treatment (MMT) had been proved to eliminate HIV infection among injection drug users, to improve patients' well-being and social security (Ministry of Health, 2012). Still, a significant number of drug users did not opt for this treatment (Ministry of Health, 2017).

Methadone maintenance treatment started in the 1960s in the United States and has now expanded to more than 150 countries in the world (World Health Organization, 2017). Using methadone for maintenance treatment revolutionized the field of addiction treatment by redefining therapeutic success as patient stability and functioning rather than abstinence (Newman, 2009). MMT has been promoted by many who are in favor of treating addiction as a disease (Volkow et al., 2014). Abundant literature, mostly quantitative, has proved its effectiveness in reducing illicit opioid consumption, improving social security, and reducing

public health harms related to opioid injection (Fullerton et al., 2014; Sun et al., 2015). This serves as a rationale for global methadone expansion, especially in low- and middle-income countries. However, for those who oppose the model, prescribing methadone is merely “trading one drug for another” (Volkow et al., 2014). For this reason, many Asian countries only reluctantly authorized MMT in the early 2000s to reduce HIV infection related to unsafe injecting drug use (Reid et al., 2014). Still, multiple barriers, including stigma and discrimination against former drug users, criminalization of drug use, lack of a favorable legislative framework, and preference for non-evidence-based interventions such as compulsory abstinence and rehabilitation, have all hindered MMT’s diffusion on the continent (Degenhardt et al., 2014; Reid et al., 2014).

While the evidence of MMT’s effectiveness in improving health outcomes for opioid users was strong (Fullerton et al., 2014), studies revealed the more nuanced impacts of treatment on patients’ lives. For example, MMT’s modes of delivery could restrict patients’ functioning (Fraser, 2006; J. Harris & McElrath, 2012). The underlying beliefs about addiction and treatment of professionals (Bojko et al., 2016; Edington & Bayer, 2013) and the socioeconomic status of patients (Rhodes et al., 2015) could also undermine the treatment’s effectiveness. Studies have also questioned the ability of MMT to meet patients’ needs and to help them reach the level of social stability and functioning that many MMT supporters had led to expect (P. Bourgois, 2000; Reisinger et al., 2009).

Studies have also pointed to multiple factors influencing retention, for example, the perceptions of methadone as a substance (Fischer et al., 2005; Goldsmith et al., 1984; Malvini Redden et al., 2013) or patients’ experiences with services structured around methadone (Bojko et al., 2016; Fraser, 2006; J. Harris & McElrath, 2012). Many PWID considered methadone to be

halfway between drug and medication (Langlois, 2013; Malvini Redden et al., 2013; Neale, 2013). As a drug, it could be purchased on the black market to replace heroin and sometimes to procure pleasure. As a medication, it would be prescribed by a doctor in a clinic with the aim of relieving opioid withdrawal and then taken by patients under close supervision. Seeing methadone as a drug might lead to unconventional treatment management strategies like self-discharge (Langlois, 2013).

Some patients appreciate methadone because it protects them against relapse and provides them with the daily stability, but they also fear the potential harm and addictiveness it could cause. (M. Harris & Rhodes, 2013; Malvini Redden et al., 2013). Relief from drug dependence is thus the immediate motivation pushing many opioid-addicted individuals to enter into and continue MMT (Mitchell et al., 2011). At the same time, many consider MMT to be the last resort after multiple failures to go drug-free (Bojko et al., 2015; Grønnestad & Sagvaag, 2016).

For many patients, the ambivalence arises more pronouncedly from the conditions of service. These may include inconvenient treatment conditions (Fraser, 2006; Rhodes et al., 2015), negative therapeutic relationships (Bojko et al., 2016), and challenges in the patients' daily lives (P. Bourgois, 2000; Conner & Rosen, 2008). Taking daily dosages is universally considered a key factor preventing patients from securing the employment necessary to afford a decent lifestyle, hence damaging their sense of agency (Bojko et al., 2016; Fraser, 2006; M. Harris & Rhodes, 2013; Lin et al., 2011; Rhodes, 2018). Furthermore, methadone clinics are criticized as sites of interpersonal and institutional stigmatization (Bojko et al., 2016; P. Bourgois, 2000; Fraser, 2006; J. Harris & McElrath, 2012). Patients from various facilities reported being treated as "subhumans" by methadone providers (Bojko et al., 2016; Hayashi et

al., 2017). Arbitrary regulations in some clinics such as “feetox,” which discharged patients who were unable to pay treatment fees (Reisinger et al., 2009), or treatment contracts that listed punishable behaviors only for patients and not for providers, held patients in a vulnerable position (J. Harris & McElrath, 2012).

The poor reputation of methadone services stems especially from the relationship between patients and providers. Methadone providers often failed to appreciate patients’ different treatment expectations. They failed to see that patients needed more than just achieving abstinence to return to a “normal life” (Mitchell et al., 2011). When patients did not receive support for their goals from the programs, they often self-discharged (Reisinger et al., 2009). Multiple life challenges that MMT could not intervene, such as intersecting stigma towards addiction, HIV or poverty, lack of social support or damaged health could also lower treatment continuation rates (Conner & Rosen, 2008; Vigilant, 2008).

Heroin use: from being discreditable to being discredited

Since participants were not home as they were first involved with drugs, they could keep their behavior secret from their families and people outside their peer groups. For most participants, their failing became discredited to their families two or three years after they started using drugs. It was usually about the time when their income could no longer afford an increased tolerance and they started experiencing withdrawal without timely drug provision. Some participants told their families about their addiction for help when they felt they could no longer afford it themselves. For half of the participants, their families heard rumors about their drug use, then paid attention to their unusual behaviors and found out the secret. In a village where everyone knew everyone else, it might be hard to keep a secret. Hanging out with known drug users (what Goffman termed the "with" relationship) could also spread rumors about them.

Rumours are usually confirmed when participants got arrested and sent to compulsory drug rehabilitation or to prison. The status then became discredited and often associated to the label of a criminal. In Vietnam's laws, getting prison sentence is conviction when being sent to compulsory rehabilitation is offense. Both kinds of law violations are registered in the official individual dossier, which would be known by local government, other administrative instances or potential employers. Once again, in a community where everyone knows everyone else, it is hard to keep the status secret.

Social Stigmatization towards people who use drugs

In the following sections, we describe different kinds of stigma in four different social spheres: family, neighborhood, workplace and healthcare settings. The healthcare setting that many PWID frequented is methadone clinics. HIV-infected participants also received antiretroviral medications at HIV outpatient clinics once a month. Participants, however, did not report stigma experiences in this setting. It could be that in HIV clinics, the drug user status was much less salient than the status of HIV patients. For this reason, the analysis will focus on methadone clinics as the site of institutional and interactional stigmatization.

1. Stigma in the family: no rejection but mistrust and disrespect

A close investigation of family reaction to addiction revealed that it was complex and heterogeneous and that families were supportive but not exempted of stigmatization. Families typically expressed anger, disappointment or sadness when they first learned about the individual's drug addiction. The news was like "*a bolt from a blue*" that paralyzed drug users' parents. One father was so angry that he told his son to leave the house and that he no longer considered him his son. Some mothers cried the whole night. After having recovered from the shock, family members tried to persuade the individual to stop and discussed with him or her

drug cessation options. Families provided their members with detoxification of all kinds: at home or center-based, in private or public facilities, or sending them to somewhere far away, preferably in their rural hometown to live with their relatives, hoping to make them forget drugs. A wealthier family even sent their son abroad for six months to cease drug use. Detoxification attempts, however, were not successful. After a short period of abstinence, the individual often relapsed upon returning home. Witnessing repeated failures and the painful withdrawal the individual was going through without drugs, families felt discouraged and gave up.

No family kicked their drug using member out of the house. They still allowed him or her to stay under the same roof. Families typically subsidized drug users with food and other living amenities. Most families gave individuals money per request. Typically, they would give drug users enough for a dose when they saw these individuals in withdrawal or to remedy the consequences of their loved ones' behaviors. The sister of a participant did not have money but gave him a bag of rice to sell whenever he showed up in front of her looking "*pale as a sheet.*" His children gave him money to ransom the things he "borrowed" from others when he was in need for drugs. Such support acted as a safety net that saved individuals from committing illegal acts for drugs.

Family also provided their drug using members with child care. Typically, grandparents would take care of their grandchildren when their drug-using children were away, struggling with their addiction. Siblings of drug-using individuals would contribute money, time and efforts to raising their nephews. A 37-year-old participant who worked as a female sex worker had two small children with her clients. The malnutrition and lack of antenatal care resulted in the disability of the younger one. While she left the children right after delivery, heading to

downtown Haiphong for drugs, the difficult child-rearing responsibility was on her mother and her brother's family.

Relatives often maintained their relationships with the drug-using individuals and families. Sometimes, relatives constituted an important support source for drug users. When encouragement and advice, the most popular type of support, did not seem to be meaningful, some extended families might provide more tangible help. Some participants worked as motorbike taxi drivers and many of their clients were their relatives. Relatives might hire drug users for jobs like construction workers or carriers. Others could call on them for some odd jobs like repairing something, cleaning the house that helped them to earn some money. They might also give some money to the individual. In a rural neighborhood where one often had many relatives and where relatives lived close to each other, this money became a significant source of income for drug users and reduced their risks of getting in legal troubles. Acting in the same vein with drug users' families, wealthy relatives would provide partly for the study and living expenses of drug users' children.

The support families provided for drug users did not mean they did not devalue the tainted individuals. Stigmatization expressed in intimate, daily interactions between the family members and the drug user by the mistrust and disdain from family members. "*The addict must have stolen it*" is an often-heard exclamation in families whenever someone did not find something, although they were the ones who were absent-minded. Some families refused to invest in participants' start-up proposal although they were financially able to afford that. Others believed participants' proposals of getting in methadone treatment or buying motorbikes were just attempts to get money for drugs, hence rejected these requests. A father made it clear that he would not provide his son with anything beyond food and a vehicle since "*you addict will sell it*

right away.” This father also considered the participant’s complaints of physical discomfort to be just a pretext to keep doing drugs.

Receiving financial support from their siblings, a female participant recognized they were looking down on her because of her drug use. Her siblings explicitly told her that she needed to be self-reliant and that they could not help her more than that amount of money. In some families, siblings kept the individual at a distance. Communication became minimal. Despite the fact that they lived close to each other, in the same village or neighboring villages, they only met and talked during family’s events such as the death anniversaries of their grandparents or parents. Exceptionally, a woman was not allowed to eat with the family and she had to sleep in a corner since her mother was afraid that she would spread addiction into the family. This fear might be a reaction to her degraded appearance.

Within one family, the degrees of negative reaction of each member towards addiction varied. Mr. X, a father of two drug-using sons, was frustrated about his children. He blamed his wife for spoiling them and refused to visit his older son when this guy was dying in a hospital because of AIDS. His wife, on the other hand, although similarly feeling ashamed when she came to take care of her son in the hospital, provided him with heroin since she could not remain calm at his painful withdrawal. A number of couples were separated or divorced several years after one found out about the other’s involvement with drugs. When it was the man who was using drugs, this phenomenon was explained by an unbearable financial crisis, rather than by stigmatization. When it was the woman who got involved with drugs, she might deliberately leave her man for self-stigmatization.

Relatives ceased to take seriously the opinions of drug-using individuals and their families. Monetary loans were no longer available at the drug-using individual’s request. A

participant, living in downtown Haiphong, explained this frustrating experience by poverty — a consequence of addiction— rather than by addiction itself:

Addiction leads to poverty, then to affections. People who have money have a say.

Without money, no one will listen to you. (Male, 38 years old, unemployed)

On the other hand, another participant living in the countryside explained it by the reduced prestige of drug users' parents:

If I'd been successful, my father would've been able to scold his younger brothers, because he is the oldest in the family. But since I'm an addict, my parents feel like because they fail to educate me, who else could they educate? (Male, 31 years old, unemployed)

Thus, not only participants but also their parents suffered from status loss also as a result of secondary stigma.

2. Stigma in the neighborhood: avoidance, suspect or indifference

A typical rural neighborhood is often a village that consists of extended family and long-term neighbor relationships and a critical area for participants. In rural areas where families produced food for their consumption, living closely to the family helped drug users who typically earned modest income to live more comfortably without having to pay for essential amenities. Since many participants used to work as bricklayers or plumbers, their neighbors could also be their clients or potential employers. In such context, a bad reputation ruined not only one's personal life but also one's income-generating activity. Since the majority of the individuals' social relationships happened within the neighborhood, it was not surprising that drug users reported being stigmatized mostly there.

Indeed, stigmatizing reaction towards the drug users within the neighborhood was not overt. The major expression of social disapproval consisted mainly of a perceived social distance. When dropping in each other's house and watching houses for each other were the usual bonding acts performed by neighbors, drug users no longer felt welcome. When they visited a neighbor, they experienced a difference in the way people treated them. Whether their neighbors would deny their visits or they would hide their valuable possessions away when drug users entering their houses. The hosts were no longer confident to leave the house for drug users to watch while they were running errands. Encountering suspicious, watchful regards from neighbors was a common experience of our participants. People who got out of prison got worse treatment. A participant, living in a rural district, said:

Before we used to visit each other often, since I was released from prison, when I visited her at home and she needed to leave me alone for a while, I saw her paying attention to her stuffs, like some TV remote controls." (Male, 35 years old, plumber)

Outright aggressive stigmatization such as calling someone "a junkie," "an addict" on the street existed but was quite rare. Negative talks about drug users mostly happened behind their back. The individuals became aware of such rumors when they overheard or were told about these. Participants reported their neighbors were rather indifferent to their drug use as long as drug users did not "touch" them (do any harm to them).

More explicit stigmatization happened with the local government. Several participants reported being summoned by the local police whenever villagers reported a burglary. These drug-using individuals needed to provide proofs of innocence first before they were discarded from the suspects. Even when nothing happened, the local police or chief of the village would pay them regular visits just to remind them not to disturb the social security.

3. Stigmatization at workplace: Barriers to secure a socially approved job

Incidences of stigmatization at workplaces were much less frequent but not less devastating. The low frequency was explained by the fact that few individuals were able to maintain a professional activity. A female ex-drug user who worked as a bus inspector reported being constantly suspected by her co-workers as no one lent her money, even as small as VND 50,000 (about 2 euros) and that everyone guarded their possessions at her presence. Another participant who was a motorbike taxi driver of a decent manner usually worked for a company as a transporter of their official correspondences. However, whenever cash was involved, the company called a non-using driver to do the job, instead of him. Another drug user explained his multiple being rejected by employers whenever he knocked their doors asking for jobs by his known drug user status and by his physical mark of being too thin.

Workplace stigmatization also applied to ex-drug users who worked as peer outreach workers together with non-drug-using individuals in a research setting. It was indeed hard to tell if actual stigmatization existed since reactions towards drug users were not outright negative but they were more of a felt social distance. This felt stigmatization could result from drug users' self-stigmatization.

H. kept saying that he most liked Ngoc and me for "you are sociable, not like the girls here (other research staff) who distinguished [them from us]." They seemed very sensible on the way people treated them and appreciated little signs of good treatment." (Field notes, 5 Oct 2017).

My time spent in being with the peer outreach workers seemed to enable them to be more open. L. told me when he got to chat more with me, he felt like I was approachable. I

understood that before he considered me as someone from the research team, and definitely not from the outreach team like him.” (Field notes, 27 Sep 2017)

Social and institutional stigmatisation in methadone treatment setting

All participants appreciated the benefits of methadone as they began their treatment. However, the institutional practices of the treatment program and the stigmatization by service providers did not meet participants’ expectations of living the lives they expected to live when they entered treatment. This made participants frustrate.

Addiction to heroin or dependence on methadone treatment?

Participants used the word “*nghiện*” (addiction) exclusively to refer to heroin habits and “*phụ thuộc*” (dependence) to indicate methadone treatment. “*Phụ thuộc*” refers to the external forces and constraints inherent to following a methadone program; in “*nghiện*,” the forces at play are rather related to the internal, compulsive nature of drug-using acts.

The feeling of “*phụ thuộc*” came from the inability to travel and from the time constraints that prevented patients from securing stable employment, therefore causing treatment fatigue. Heroin still allowed users to travel and work. Methadone treatment, however, requires patients to trade job opportunities against the ability to obtain daily medication from clinics during office hours. Although participants accepted this trade-off, they still experienced regret:

I can’t travel far. I had a good opportunity to go to work in Saigon but I can’t take it since I depend on methadone. The clinic opens at 7:30 for dosing and medical examination. And it closes at 11. If I worked, I would work during the same time. How could I ask to go out every day? And if I told them I was on methadone, I for sure wouldn’t be able to keep that job, so I decided to stay at home. (Male, 42 years old, single, currently under MMT)

Participants were rarely able to hold a job while following treatment. Only participants with flexible work schedules who worked for a family business or took night shifts managed it. Securing employment became more challenging as patients anticipated stigmatization if they told employers about their addiction treatment. In fact, it is the explanation one of the four dropout participants gave for leaving treatment. The inability to coordinate a suitable work schedule with the rigid dosing window resulted in many patients losing their employment. During interviews, our participants estimated 70% to 80% of methadone patients were unemployed. Since they had nothing else to do, many hung out at tea stalls the whole day after receiving treatment.

The main reason MMT-naïve users chose not to enter into treatment was that they believed they were in control of their drug use. The majority mentioned detoxification as a solution in case they wanted to quit. Among them, four had high-paying jobs that could support their habits. This, along with the belief that the procedures to enter MMT were complicated and costly, kept them away from treatment.

Our group discussions with PWID under 30 also suggested that those with a stable job were reluctant to get into MMT. Truck or ship drivers had to travel for several days and only stayed in Haiphong for a short period. Participants who did not follow treatment believed that MMT made patients dependent on others to make a living. This perspective was especially unappealing to younger people. They often opted for street methadone to control their drug habits.

When my heroin dose increases and I can't afford it, I stop it for a while so it stabilizes... I ask my friends to bring me some methadone. They leave me a bit from their doses. I buy some hundred thousand dong's worth to treat heroin withdrawal. (FGD with PWID under 30 who had used street methadone)

The difference between women and men regarding time constraints reflected gender roles in Vietnamese society. Women felt less pressured than men to get a job. While nearly one fourth of current and former methadone patients in our sample were women (16/58), most of them described themselves as housewives or as being self-employed. Their treatment fatigue originated from difficulties “going on errands,” “going to pagodas,” “visiting family,” or “having to go out in bad weather.” The majority of women wanted to get off methadone, but many accepted the idea of staying in treatment for an indefinite period of time. Men, on the other hand, were more frustrated by this kind of dependence. Patients often spoke of quitting methadone if they got a good job and mentioned patients who missed doses because of work commitments. Some male patients voiced a clear plan to taper off treatment.

Sometimes I receive offers to work far from home, but methadone doesn't allow me to take them [...] But next year, I will try to reduce my dose. I am at 75 mg, this month I will reduce it to 70, next month to 65, then 60, and so on. Or if I get another opportunity, I will stop methadone. (Male, 39 years old, cook)

This frustration intensified with the feeling of being manipulated by methadone programs. Dosing schedules were irregular, but unfavorable to patients. Many wishfully mentioned a methadone clinic in a neighboring province that opens at 5:30 am since they could not get treatment there.

Before they [Haiphong MMT clinics] delivered doses at 6 am ... but now they open at 7:30. They treated patients better before, they brought methadone home to us if we couldn't come. But now they don't care whether you get methadone or not. (Male, 37 years old, builder's laborer)

One clinic in Haiphong asked patients to pay an additional sum on top of their monthly treatment fee to get dosed earlier in the morning. Some patients who had more financial means found this request reasonable while others saw it as the clinic's attempt to "rob" them.

Lack of a trustful relationship with MMT providers

Methadone patients in our study declared that they did not receive good support for their personal treatment goals within methadone clinics. They had a rather problematic relationship with their medical setting. The relationship was already complicated before the first day of care, since a popular assumption circulated that patients had to bribe clinic staff to receive treatment. While some participants had to pay to get into methadone programs, this was not the case for the majority of our participants, for whom DRIVE made referrals. This belief, however, had transformed participants' perception of therapeutic relationships into a business transaction. Scepticism about the transparency of methadone programs led patients to question clinic requirements such as lab test prices or the additional fees they were asked to pay.

I don't understand the 50,000 dongs extra they asked us to pay. They said it was for security guards and daily hygiene of the clinic like washing cups. But these people already receive salaries from the government. They don't only work for this clinic; they work for the whole healthcare center. They didn't hire extra security guards because of us. (Male, 34 years old, odd jobs)

In participants' stories, methadone staffs were described as irresponsible, inconsiderate, and inhumane providers with inadequate expertise. Patients often got angry when staffs did not seem to care about their needs. One described his frustration with the administration staffs when the clinic opened its doors and patients rushed in to get their medication and start their work day.

They were like ... walking around, doing nothing. First they washed their hands, dried them ... then they wiped the table, wiped the glass. Only after a while did they start their work and give us doses. Patients were all in a hurry. We had to go to work on time. They were irresponsible. We have to pay for our treatment. They have to give us medication on time, so we can work. Otherwise how can we pay for the treatment? (Male, 37 years old, builder's laborer)

Others complained about missing their doses just because they came minutes after closing time.

These people shouldn't be allowed into care. They are inhumane. Some of us have jobs. They close at 11 am. But even if we are just one minute late and we tell them, "Could you please give me my dose? I am just one minute late." You see, it is just about sympathy. The dosing window opens at 7:30 but the staffs also come at 7:30. They do their things and only start dispensing methadone at 7:45. We have never complained about it... But when it comes to us, we are just one, two minutes late and they lock the medication away. (Male, 42 years old, waiter)

The rule of "money first" requiring payment before medication delivery was considered too strict and unreasonable. This caused quarrels between staff and patients every month at the time of payment. One patient warned about the potential consequences of this rule:

I think late payers will pay for their treatment anyway. They might not be able to make payment on the 5th, but on the 10th or 15th. Staffs are government officials, they should be more flexible. Without medication, patients would have to do heroin. So the staffs facilitate patients' relapse. And when they relapse, they leave treatment. So why can't the staffs wait a few more days? (Male, 34 years old, builder's laborer)

Participants rarely complained about baseline fees; they knew that 300,000 dong a month was much less than the amount they had been spending to maintain their heroin consumption. They explained that they experienced difficulties paying for treatment on time or at all because they struggled to maintain employment under the constraints of methadone programs.

Stigmatizing attitudes by service providers

Participants described the tense atmosphere of methadone clinics, where staff-patient communication mostly included “yelling,” “blaming,” “punishing,” and “threatening to kick out of treatment” when patients screened positive for drugs or when they missed doses. In relation to the lack of transparency in methadone programs, one patient who was discharged against her will because she had missed too many doses interpreted this treatment termination as an attempt to get rid of her, to then sell her spot to another candidate. Some patients reported no communication at all with staff, except when they were late settling their co-payment. One woman explicitly criticized the staff for caring only about money rather than about patients’ well-being.

Patients reported being subjected to stigmatization by providers. Some physicians, for example, displayed a suspicious and humiliating attitude when patients requested a dose change, as one participant angrily reported:

I told my physician I wanted a decrease of 5 or 10 mg. [...] He said: “You want a decrease to get high faster?” And so on, it was so mean, you understand? I replied: “It’s our responsibility to control our drug use. You don’t need to encourage us, but don’t say so.” I know it’s good for us not to do drugs. Of course since we are addicts, people won’t say nice things to us. But we all have our self-esteem. We have gotten in here, we are now a member [of the clinic]. We also pay for our treatment. They aren’t giving us anything

for free, right? So we have our rights. [...] But sometimes what they tell us is so mean. That's why people don't really feel like being in treatment. (Female, 39 years old, homemaker)

Patients did not feel respected when spoken to by the providers. Young staff spoke to older patients without the politeness required by Vietnamese age hierarchy culture. This disrespectful attitude pushed away patients and thwarted any attempt to build a good relationship.

We clearly feel the distinction they make between them and us, through their attitude and their way of addressing us. Although they are younger than me, they call themselves "anh" (older brother), "chị" (older sister). They don't respect us. They distinguish themselves from us and they are unwelcoming. (Male, 39 years old, peer worker)

While these negative opinions regarding methadone clinics and their staff were prevalent, a minority of methadone patients described healthcare providers on more positive notes such as “devoted” and “welcoming.” These patients appreciated the help they received from their physicians and counselors. All of these patients were currently on treatment, except for one who was forced to leave for deliberately missing his co-payment and was looking to re-enter treatment.

Intra-group Stigmatization

Goffman (1963) wrote: “The stigmatized individual exhibits a tendency to stratify his ‘own’ according to the degree to which their stigma is apparent and obtrusive. He can then take up in regard to those who are more evidently stigmatized than himself the attitudes the normal take to him.” Consistent to this observation, intra-group stigmatization was not uncommon among drug-using population. Seeing oneself as better than others is a well-documented natural

psychological phenomenon (Iyengar, 2010). When a stigmatized person adopts the values of the “normals” to criticize his/her peers, it was considered to be an expression of internalized stigma. This mechanism serves to protect the self-esteem of the stigmatized person against the negative judgment of themselves by the outside world and by her inner self. In this study, we report the three principal social values that served at the basis of this stigmatization among heroin users in Vietnam. These values included the concept of self-control, morality and self-reliance. We will also report the subtle hierarchies that existed among the drug-using population.

Self-control

Self-control was the criteria to separate worthy drug users from those who were not. The ability to self-control included the ability to consume drugs in moderation. Self-labeled moderate users said they were able to maintain their heroin dose without increasing it, hence they could avoid the desperate situation where they could no longer afford their drug use. These people used drugs to regain a feeling of normalcy and not to feel high:

I do drugs, I still feel high but I don't go beyond limits. I don't self-indulge. I just do drugs to feel normal. Many others do drugs until they “nod” (sleepy). I don't do like them. (Male, 44 years old, odd jobs)

Self-control meant despite a long history of drug use, the person was still able to keep smoking and not injecting. Smoking meant one would afford more quantity of heroin in order to get the same high as by injecting it. Users also needed to spend more time for a fix. However, smoking was safer since it prevented discrediting injection marks, overdose and blood-borne diseases. People who smoked heroin were supposed to be better-off than those who injected. Injectors also stigmatized among themselves. Those who were new to injection stigmatized those who had injected for a long time for this latter seemed more “dirty” (*bét*) and lack of self-control.

Injectors who shared needles and syringes were labeled "omnivorous" (*ăn tạp*). They were considered to be the most desperate type of users since they did not dare to spend just 3000 dong (about 20 cents) on new syringes. Addicts who injected publicly on the street were the users who "didn't care", who "had nothing else to do," in contrast with better-off ones who rented a hotel room to safely enjoy a fix. No participant in our sample reported equipment sharing or public shooting behaviors. All expressed a frightful attitude towards these "junkies." One woman explained that sharing needles had led her friends to become prostitutes and then died.

Methadone users who had broken up with heroin criticized other methadone users who were still using drugs for their lack of willpower. Those who had quit heroin usually said they did not understand why others kept using drugs, and that if they still wanted to do drugs, they should not get into methadone. Interestingly, among the methadone patients who continued to do drugs, those who switched to methamphetamine self-perceived to be more competent than those who were still unable to quit heroin.

People who had ever used methamphetamine classified themselves into mentally strong and mentally weak types. Mentally strong users could consume meth the whole day without developing delusion while mentally weak users would become paranoid the first time they smoked meth. Strong minds could be "*cuốn*" (feeling the high, repeating some actions) but should never be "*béch*" (or "*ảo*," paranoid).

The power relation within drug-using population was also enacted through intra-group stigmatization where the stigmatizers (the better-off addicts) exploited the lesser addicts, making the latter's addiction more visible and concealing the former's addiction. In a close-knit rural

community where it was challenging to keep one's behavior secret, wealthy drug users might ask other users to buy them drugs instead of doing it themselves.

I do drugs at home. No one knows my status. I am not like T. [the drug user he hired to buy drugs for him]. Everyone knows he is an addict. (Male, 40 years old, welder)

Morality

Morality was the virtue adopted by the majority of our participants. Morality encompassed social responsibilities and individual qualities. Drug users were ranked according to their reasons for starting and maintaining drug use. The least users were those who wanted to “keep up with their friends” by doing drugs. Initiating drug use out of distress and being led into addiction by friends were seen as nobler reasons. Regarding their continued drug use, all active users claimed that they used heroin to be able to work and to afford their families, not like the “spoiled” (*hư đốn*) ones who sought pleasure. We will present this distinction in detail as a technique of neutralization (appeal to higher loyalties) in the next chapter.

Self-reliance

Self-reliance was another virtue that Vietnamese heroin users appreciated, although not all could live by. Self-reliance included the ability to afford one's drug use by conventional means and the skillfulness in dealing with oppressive, threatening situations.

Users who had a good job and who were able to earn good money looked down on those who were unemployed and poor. A methadone user expressed his disdain in his comments about treatment fees as a burden leading to dropout:

If they cannot earn 300,000 dong a month, they are useless. Before [when they were addicted], [they] could get as much money as they needed. How come now they could not earn 300,000 dong? (Male, 37 years old, shoe polisher)

Drug users also looked down on those lacking survival skills, for example skills to deal with bullying situations in compulsory rehabilitation centers or encounters with the police while seeking drugs out on the street at night. These skills were considered to be vital in a “big fish eating small fish” world. Those who were not tough enough would be erased. People living in the drug worlds could not trust anyone 100%. Our participants maintained their relationships with drug-using peers for pragmatic purposes like to share a dose or to get information about drugs. They, however, described their addict peers as untrustworthy people who were ready to rob others for their benefits. Our peer outreach worker colleagues and participants had warned us thrice that living naively in an academic world was dangerous and that we should “*collide*” more with life since the real life was harsh.

Ex-drug users peer outreach workers were at the border between drug-using and non-using populations. Since they had lived the life of drug users, they were supposed to be the “wise” — in Goffman’s words — who understood and developed sympathy with these stigmatized people. However, it seemed like peer outreach workers did not really appreciate their clients. They shared the popular opinion that drug users were bad and untrustworthy. B., a CBO worker, was disappointed when we told him we had paid the methadone treatment fees for an interviewee since she was unable to do it and could relapse without treatment. He said we had been exploited and that next time we should consult them (the CBO members) before doing such things.

Table 3: Hierarchy for intra-group stigmatization

High status	Key values	Low status
Moderate use	Self-control	Uncontrolled use
Smoking		Injecting

Private use		Public use
Using own' injection equipment		Sharing needles
(Methadone patients) Being able to quit heroin		(Methadone patients) Can't quit heroin
(Methamphetamine users) Being mentally strong		(Methamphetamine users) Being mentally weak (paranoiac)
Reasons to start using drugs <ul style="list-style-type: none"> - Distress - Being passively introduced into drugs 	Morality	Reasons to start using drugs <ul style="list-style-type: none"> - Keeping up with friends
Reasons to continue drug use <ul style="list-style-type: none"> - Being able to work 		Reasons to continue drug use <ul style="list-style-type: none"> - Seeking pleasure
Being financially autonomous (having a good job, earning money)	Self-reliance	Being unemployed, poor
Having survival skills (dealing with the police and other drug users)		Lacking survival skills

Internalized stigmatization

We know no society can accept such evil things we have done. No one can accept. Even me, I can't accept myself. (Male, 40 years old, builder's laborer)

Internalized stigmatization was omnipresent in participants' accounts. Self-stigmatization expressed in negative self-judgments while anticipated stigmatization made participants reticent to social relationships.

Self-Stigmatization

Self-stigmatization expressed in drug users' devaluing discourse about themselves and about drug-using population in general. Methadone patients were particular since they were proud of their current selves but depreciated their old addict selves before methadone.

Participants employed devaluing terms such as “the junkies” (*bọn nghiện*), “a male or female junkie” (*thằng nghiện, con nghiện*), “social evils,” “self-indulgent” (*chơi bời*) or “spoiled” throughout their narration in company with a bitter tone. In an age hierarchical culture like Vietnam where elderly people typically received social respect, an old addict remained an addict and was still called a junkie, not a Sir or a Madam (*thằng nghiện, con nghiện chứ không phải là ông nghiện, bà nghiện*).

A participant introduced himself at the opening of our interviews as follows:

I moved into Haiphong with my family since 1990. As a teenager, I tried to keep up with my friends and indulged myself with drugs. I fell into this evil addiction, drug smoking and injecting and have been there since then. That's a brief about me. (Male, 31 years old, driver)

In this brief introduction, he showcased his awareness of the mainstream view of addiction. An addict stereotypically started by trying to keep up with friends to self-indulge. By continuing drug use, he then drifted away from the right route and fell into addiction (sa ngã).

From participants' accounts, an addict looked dirty and smelly since he spent all his energy scoring drugs. In withdrawal, he was dangerous since he dared to do anything. He could cheat on his surrounding people, shamelessly ask them for money or even kill them for a little sum. Stories of addicted children violently forcing their parents for money were told in disgust and desperation. Although none of our participants had gone to such extreme, many talked about themselves in words that evoked this widely circulated stereotype of drug addicts.

Our participants talked about drug users as another race, an "addict" race. This race had distinct characteristics. For example, they were good at scoring money, much more than "normal" people; they did drugs anytime they could and they cheated on each other. Individuals of the "addict" race had a strange lifestyle. They did not like to socialize; they just went home to eat and sleep, and to be able to get out of the house the next day scoring drugs. A participant who tried to conceal his status, said: *"I do drugs but I still need to maintain the appearance of a human."* And another wanted to help other addicts *"to get back into the human life."*

The adoption of the social stigmatization did not only lead the individuals to describe themselves in pejorative terms but also to accept the negative social treatment towards them as reasonable. Drug-using participants shared the same reasoning with the mainstream society and gave it every right to reject them. A participant blamed himself for betraying the good care that people provided him by his relapse:

After I had quit heroin for a while, people came back to me. They waited for me to prove my perseverance first. They had advised me, had provided me with favorable conditions.

If I could not do it, it is necessary that they give up on me. (Male, 34 years old, odd jobs)

Self-stigmatization brought about a feeling of illegitimacy, shame and helplessness.

Many felt like they were less than others and not decent. A mother even wanted to kill herself since she failed to meet the motherhood standards:

When I was using, I constantly felt tired. I loathe myself. I'm a mother but I could do nothing for my kid... Sometimes I felt so sad that I wanted to kill myself. I had nothing to brag about, nothing to be proud of. At that time, I just wanted to jump in front of a car and get killed. (Woman, 38 years old, sex worker)

Some drug using women deliberately left their non-using men for feeling ashamed of themselves, although their husbands were supportive and caring about them despite their drug use.

Anticipated stigmatization

Similar to self-stigmatization anticipated stigmatization was prevalent in our sample. Participants believed that when their drug user status became known, everyone would inevitably think negatively of them and their families would feel ashamed.

This type of stigmatization was clearly expressed in the accounts of two participants. Both assumed that the interviewer was hiding a disdain attitude and challenged her:

You talk to me because this is your business. Later when you go home, you will tell others that today you talk to a junkie. (Male, 31 years old, driver)

To be frank, we talk because this is your job, otherwise, even though you knew us, you would have never talked to us, right? (Male, 40 years old, builder's laborer)

At a lesser extent, all of our participants thought that others looked down on them and avoided them. In their opinion, other people were afraid that drug users were trying to get their money.

One participant bitterly reported:

Since I got addicted, people stopped hanging out with me. If I hadn't gotten involved with drugs, I would've waved to some friends on the street and they would've been willing to come have a drink with me. But because I'm an addict, sometimes I really wanted to treat them a drink, but they refused or ignored me for they thought I wanted to ask them for money. (Male, 30 years old, unemployed)

Participants also believed that others had lost the trust in them. A person felt the need to quit drugs first before he attempted to do anything for the following reason:

If you are still addicted to drugs, don't mention your intention to anyone, since they would not believe you. (Male, 31 years old, unemployed)

Another participant, whose bicycle had been stolen by a drug-using peer, felt the need to prove to her family that she did not lie about this event by going to see the peer by herself with a knife, and hence, putting herself in danger.

Women seemed to center their concerns around the family while men were more preoccupied with relationships in the broader society. Daughters were afraid to shock their family with the bad news. A daughter-in-law tried to conceal her status of a drug user from her family-in-law, even though she did them a favor when she, being HIV-negative, married their son who was HIV-positive. Mothers did not dare to tell their children they were using drugs for fear of being looked down by their children. Projecting that their children will be shamed by their peers at school because of their mothers' status motivates some women to quit heroin.

There is a clear difference between rural and urban men. Rural men in our sample cared more about the relationships with surrounding people. They described social reactions in terms of “*keeping a distance*” or “*fear to be asked for money.*” The subjects of these reactions were “*neighbors,*” “*friends*” or “*relatives.*” In contrast, urban men described social reactions at a greater adversity like “*looking down on us*” or “*no one could accept us.*” The subject of these reactions was vague and not precisely located such as “*they,*” “*people out there,*” “*the society*” or “*the community.*” Urban men often concerned about losing their job opportunities while their rural counterparts did not.

Discussion

The function of stigma to reinforce dominant social values has been extensively theorized (Fraser et al., 2017; Link & Phelan, 2001; Parker & Aggleton, 2003). The meaning of stigma is thus, not static but dependent on the regime in power. Stigma must be understood in a context of relations between the individual and the society (Matthews et al., 2017). In tandem with significant socioeconomic changes in Vietnam over the last thirty years, the expressions and meaning of stigma towards PWID have also evolved. Compared to the late 1990s and early 2000s, public stigma seemed to express less in aggressive acts but more subtly in daily interactions, through social distance or lack of trust. Stigma towards PWID in Vietnam is a common phenomenon. However, this stigma appeared to center around the value of self-reliance, rather than on the drug-using behavior. Self-reliance, which, together with self-regulation and self-determination, is a hegemonic value in the global free market (Alexander, 2008; Moore & Fraser, 2006). It implies that one should rely on one’s own ability and resources to take care of oneself (Moore & Fraser, 2006).

Our findings about the mixed, supportive but tense familial attitudes towards people who use drugs find echo in previous works, but with another emphasis (A. J. Gunn et al., 2018; Higgs et al., 2009; Rudolph et al., 2012; Tomori et al., 2014). Like Tomori et al. (2014), we found that the family was a major resource for participants, especially for their basic needs of food, housing and healthcare cost. However, while in other studies, familial tension expressed through verbal (shouting) or physical (home confinement) aggression (Higgs et al., 2009; Rudolph et al., 2012; Tomori et al., 2014), our participants reported subtler devaluing attitudes whereby family members disregarded their opinions and requests. These reactions could be more hurtful to their self-esteem.

The feelings of shock and disappointment that our participants' families expressed are consistent to what has been described in other Vietnamese communities and collectivist contexts (Fereidouni et al., 2015; A. Gunn & Guarino, 2016; Higgs et al., 2009; X. Li et al., 2012; Rudolph et al., 2012). The individual's drug use is not an individual affair, but it affects the whole family. Such feelings reflect the family cohesion and possibly the fear of "losing face" that are salient in many family-focused cultures (Fotopoulou et al., 2015; Yang & Kleinman, 2008). For that, the family feels responsible to rescue the individuals, and the family itself, from drugs. As the conception of addiction as chronic disease is relatively new in Vietnam, most families continue to see addiction to be an acute condition that detoxification and more determination can solve (Higgs et al., 2009; Tomori et al., 2014).

The practice of stereotyping drug users as untrustworthy people has been reported in other studies (V. Earnshaw et al., 2013; Rudolph et al., 2012). Similar to previous findings, the families in our study readily viewed PWID as liars and potential thefts that could deceive their families for money. Although some experiences might validate such stereotype, maintaining

such negative definition of PWID closes the opportunities for the family to appreciate the good intentions of participants and to provide them with the needed support.

The familial appreciation to participants who could manage their drug use by themselves illuminates the social expectation of self-reliance in the Vietnamese context. Drug users might still secure respect from others if they can prove their financial independence and fulfill their role duties such as a provider, although this respect might still be compromised by the stereotype of drug users. This finding explicates the aspiration to financial self-reliance we found among PWID who self-discharged from or refused methadone treatment to be able to work (T. T. Nguyen et al., 2019).

While the social distance and mistrust towards drug users in the community have been commonly reported in different contexts (Maher et al., 2007; Nieweglowski et al., 2018; Rudolph et al., 2012; Tomori et al., 2014), the indifferent attitude of neighbors, given that the drug users did not bother them, is quite novel. This perceived indifference might come from both sides. The neighbors might be more indifferent to how their drug-using neighbors do; and drug users might also pay less attention on how neighbors see them. Alexander (2008) suggests this indifference results from a weaker engagement in the communal life in an encompassing market economy. This attitude might indicate a lack of community interest in its members and that the result — being self-reliant — is more important than the means to achieve it.

The challenges PWID encounter to find a socially approved job were well known (Lloyd, 2013; Nieweglowski et al., 2018; Pauline Oosterhoff, 2006; Tomori et al., 2014). Limited professional training might restrict participants' job opportunities to low-wage, low-skilled occupations. A known drug-use history might discourage potential employers and attract negative rumors and prejudices among co-workers (Nieweglowski et al., 2018; Tomori et al.,

2014). Moreover, the inflexible operation of methadone treatment programs might also close participants' opportunities to secure a job (T. T. Nguyen et al., 2019). The stigmatizing attitudes from co-workers could discourage people with a drug use history from engaging in their jobs (V. Earnshaw et al., 2013). This finding suggests stigmatization towards people who use drugs in Vietnam has not improved, compared to earlier findings (Pauline Oosterhoff, 2006; Tomori et al., 2014).

As the family and community stressed on self-reliance, they seemed oblivious to the barriers that prevented participants to achieve this ideal. This might push drug-using individuals into the Mertonian deviant conformism whereby they engage in illegal activities, trading their health and safety for social status within their immediate networks (Ogien, 2012). Bourgois (2003) found similar findings in his seminal ethnographical work in a drug-laden neighborhood of New York where its Puerto Rican inhabitants internalized the American virtues of self-reliance and material wealth and sought to achieve it in the clandestine economy after multiple failed attempts to get a socially approved job. Those who could not conform to social expectations are prone to depression due to a feeling of failure to achieve important goals (Ahern et al., 2007).

Patient attrition threatens the clinical and public health achievements of Vietnamese methadone programs. Little information on PWID's treatment experience is available. Our findings point to evolving patient experiences of MMT. Although patients were satisfied with the pharmacological effects of methadone, it did not lead to the straightforward outcomes that patients had imagined when entering treatment.

Using "*nghiện*" (addiction) and "*phụ thuộc*" (dependence)—two words with similar meanings—to describe their conditions with heroin and MMT respectively, our participants

restated the common “trading one addiction for another” view of MMT (Volkow et al., 2014). Patients revealed their frustration by highlighting external forces in their descriptions of “*phụ thuộc*.” As it allows patients to shift from addiction to dependence, the current methadone program relieves the compulsive element of using drugs, but does not offer a radical solution to the quandary that heroin users face. Interestingly, it is the treatment program, rather than the medication, that patients compared to heroin. Patients felt trapped by the program’s requirements of daily dosing within office hours, which prevented them from working and becoming self-reliant. This finding expands on the works of Khue (2017), who explains that one reason for methadone patient attrition is the financial burden of treatment fees. Our study shows that complaints about treatment fees might be rooted in patients’ deeper frustration at being unable to support themselves and their families under treatment. This finding adds to the previous literature that opioid users consider treatment and abstinence not as ends in themselves but as means to achieve a functioning life (Mitchell et al., 2011). While the Confucian society of Vietnam expects men to be providers for the family, its market-oriented economy encourages autonomy. Under such pressures, the inability to achieve financial independence might threaten participants’ sense of self-worth.

Following Gomart (2002)’s argument that the perception of a substance is inseparable from the context of its practices, we believe that the feeling of dependence on methadone is inseparable from the contexts of methadone programs. When patients reported being “*detained*” by methadone, or when potential patients stayed away from treatment for fear of dependence, it was less about the pharmacological effects of the product itself and more about the daily observed dosing practices.

The reputation of methadone programs as lacking transparency stems from the early days of MMT. At the time, MMT was reserved for the most severely addicted individuals who had failed multiple detoxification attempts, including compulsory rehabilitation. The admission procedures spanned different governmental levels and used to last up to several months. At the time, bribing providers to get a spot in the program was common practice among better-off drug users. The expansion of MMT starting in 2012 allowed people with an opioid addiction to enter treatment more easily. But bad first impressions remain.

The rule of “money first” is quite comparable to the relationship patients had with drug dealers. This strengthens the already negative reputation of methadone programs among PWID. Moreover, this businesslike policy excludes the most vulnerable patients, who cannot pay treatment fees on time; which could possibly push them back into drugs.

The actual practice of methadone programs appears to go against its third objective of improving individuals’ social functioning (Ministry of Health, 2010). It echoes the observation of Edington & Bayer (2013) that the ultimate objective of Vietnamese methadone programs is “to make people’s lives drug free, not to make them better.” Our participants, similar to other Vietnamese methadone patients, were in their mid-thirties when they entered treatment. The majority of them had only completed primary or middle school (Khue et al., 2017). The industrial city of Haiphong provides factory jobs to people with low education. Our participants, however, could not arrange to receive treatment within the traditional eight-to-five job schedules. Other offers such as construction work and truck or ship driving positions require frequent travel, which is incompatible with daily dosing practices. Additionally, no supportive mechanism is in place to facilitate social integration. As a consequence, for unemployed patients, seemingly reasonable treatment fees can represent a significant enough burden to quit the program

(Hammett et al., 2018b; Khue et al., 2017). Moreover, since having a job is critical to individuals' sense of "normalcy" (Rhodes et al., 2015), such constraints negatively impact the transformation of patients' identity and their re-entry into what might be understood as a "normal" life.

The problematic staff-patient relationship is common in many methadone programs, where stigma and discrimination have been rampant (Bojko et al., 2016; J. Harris & McElrath, 2012; Lin et al., 2011; Reisinger et al., 2009; Wolfe et al., 2010). Their vulnerable socioeconomic status and high HIV prevalence put PWID at risk of becoming targets of addiction stigma, but also of poverty and HIV stigma (Conner & Rosen, 2008). Vietnamese society traditionally views drug use as a "social evil" opposed to cultural virtues. Unsurprisingly, stigma and discrimination towards people who display this behavior are prevalent (Windle, 2015). Conflicts arise when patients do not feel respected by providers. Challenging the credibility of methadone programs by criticizing the staff's inhumanity and lack of transparency in their operations could be a way for patients to defend themselves against the negative treatment they receive.

Looking at the issue from the staff's perspective, a study in China reported most methadone staff felt discouraged in their work (Lin et al., 2010). Heavy workload coupled with low incomes, lack of recognition compared to professionals in other medical specialties, and inappropriate training to cope with daily work issues all contribute to staff burnout and dissatisfaction. Many providers consider methadone clinics only as launching pads towards better jobs (Lin et al., 2010). These negative feelings could be projected on the patients they serve.

This study's findings are in line with some of the issues found in other methadone programs in the Asian-Pacific region, including widespread belief in abstinence as the ultimate goal of addiction treatment, complaints about methadone's side effects, and a negative relationship between patients and providers. Still, logistical issues (e.g., ID requirements, distance) and police crackdowns in methadone clinics that were reported in other Asian countries (Hayashi et al., 2017; Lin et al., 2011; Yin et al., 2010) seem to be less problematic in Haiphong.

The global issue of stigma and discrimination in MMT programs manifests itself differently in high-income versus lower-income countries. While in high-income countries, stigma towards patients translates into stigmatizing institutional practices like queuing, unequal treatment contracts, or intrusive urinalyses (Fraser, 2006; J. Harris & McElrath, 2012), methadone patients from low/middle-income countries in SouthEast Asia and Eastern Europe experience more interpersonal and overt stigma through the negative attitudes of healthcare staff towards them (Bojko et al., 2016; Hayashi et al., 2017; Wolfe et al., 2010).

In comparison with recent work done in Kenya, where MMT was established more recently (Rhodes, 2018), our study highlights other challenges of treatment in helping individuals to manage addiction. Vietnamese drug users no longer doubt the potential of methadone to help them to change. Today, they find it more challenging to figure out how to fit treatment into their quest for a normal, meaningful life.

Self-stigma and anticipated stigma were common in our sample, similar to previous research in Vietnam (Tomori et al., 2014) and in other contexts (A. Gunn & Guarino, 2016; Luoma et al., 2007; Mak et al., 2015; Matthews et al., 2017; Sallmann, 2010; Vigilant, 2004). The men who were released from compulsory rehabilitation centers in Tomori et al. (2014)'s research adopted negative terms such as "social evil" to talk about themselves. Moreover, despite

having been abstinent for a long time in rehabilitation centers, they still felt inferior to others (Tomori et al., 2014). Women who sold sex and who used drugs in Sallmann (2010)'s study defined themselves in devaluing terms and described how their sense of self-worth went down with the sticky label of being a prostitute. Methadone patients in Vigilant (2004)'s study felt ashamed for the things they had done in life.

Our participants self-stigmatized for two reasons. They might feel indecent because they did not live up to their role expectations like the motherhood ideal, in other words, they did not pass their own survey. Women often referred to this reason. Drug-using men, if they were HIV-negative, did not perceive they failed their role standards. We will talk about this more in Chapter 7 about living with HIV. The second reason is that participants might also adopt the mainstream negative view of drug users and the dominant pejorative language to judge their own experiences. These two reasons are comparable to the concerns of moral face and social face in Confucian cultures in Mak et al. (2015)'s analysis.

The self-identification of participants as belonging to the “addict” race, instead of the human race is original. This relates to the usual concern of the society regarding the health of the Vietnamese race (Gammeltoft, 2014; Ho Chi Minh, 1945). Ho Chi Minh, in his Declaration of Independence, considered alcohol and opium as an imperialist attempt to weaken the Vietnamese race (Ho Chi Minh, 1945). Gammeltoft, in her treatise of reproductive health in Vietnam, also pointed to the significance of the Vietnamese race in politicians' discourses (Gammeltoft, 2014). From this viewpoint, our drug-using participants might feel out of place in their society.

Anticipated stigmatization has been commonly reported in previous research (Coupland et al., 2019; V. Earnshaw et al., 2013; Howard, 2015). This type of stigmatization might cause participants' social withdrawal, thus, undermine their capacity to form meaningful relationships.

This reticence might prevent them to establish their linking and bridging networks with people outside their family and friends. These networks, however, are sources of informational and other useful support for their rehabilitation (Ferlander, 2007; Macinko & Starfield, 2001)

The separation among users of different drugs and stigmatization against each other are popular among drug users. Cannabis users disapproved the use of “harder” drugs such as heroin or cocaine (Peretti-Watel, 2003). “Hard” users stigmatized against “soft” users (A. J. Gunn & Canada, 2015). Steroid users considered heroin users to be inferior to them (Simmonds & Coomber, 2009). Stigmatized people might feel the need to differentiate themselves from similar others, to assert their position in the hierarchy (Copes et al., 2016). Pointing to the “dangerous” methamphetamine users, Vietnamese heroin users not only reflected this phenomenon, they were even fiercer in their attempt to bring justice back.

The reframing of drug-related stigma as poverty stigma is unique although some entanglement between drug use and poverty stigma have been reported in other studies (Conner & Rosen, 2008; Lim et al., 2013; Rudolph et al., 2012). Conner & Rosen (2008) argued that PWID were subjected to poverty stigma, besides negative treatment for their drug-using behavior. Previous studies conducted in Vietnam showed that economic power differences were positively associated with the level of drug-related stigma (Lim et al., 2013) and financial dependence was the cause of PWID’s lost status in their family (Rudolph et al., 2012). This finding suggests the meaning of drug use behavior has evolved from an anti-communist or evil act to the opposite of self-reliance. In this perspective, the modern Vietnamese society may be subjected to social changes whereby material wealth becomes the utmost criteria of judgment.

The relationship between addiction and the free market mechanisms has been discussed by Alexander (2008), although he theorizes the causal relationship between the psychological

dislocation brought about by the global free-market economy and addiction. This can be indeed a vicious circle whereby relative poverty causes addiction and addiction reinforces poverty through stigma mechanism or vice versa.

Summary

In this chapter, we argue that a major hardship that PWID in Vietnam had to face is stigmatization. Stigmatization of different types happened in most important social contexts to the individuals including family, neighborhood and workplace. The public or enacted stigmatization expressed subtly in direct, daily interactions through social avoidance, mistrust and disrespect by people around the drug-using individuals. Public stigmatization centered on the neoliberal social expectation of self-reliance. The family and the community expected PWID to manage their issues by themselves while ignoring the structural challenges PWID were facing such as a low competitiveness in the job market, a constraining treatment regime and rejection by potential employers. Methadone maintenance treatment, the only evidence-based treatment available so far in the country, was a site of both institutional and interpersonal stigmatization, limiting participants' capacity to be self-sufficient, forcing them to choose between addiction to heroin and dependence to methadone treatment. Internalized stigmatization damaged participants' well-being and hindered the development of their social networks. In the next chapter, we will present the strategies participants employed to deal with stigmatization and the resources they mobilized. We will also discuss the effectiveness of these strategies given the current context of Vietnam.

CHAPTER 6. NEGOTIATING DRUG-RELATED STIGMA AND DISCRIMINATION

In the previous chapter, we explained that stigmatization and discrimination are still tough issues in Vietnam. Stigmatization exists in different social spheres: in the family, the neighborhood, at workplaces, at methadone clinics and more importantly within the drug users themselves. This chapter explores different strategies people who use drugs employed to manage social and internalized stigma and the cultural resources they put in place to negotiate their social status. The term “stigma resistance” instead of “stigma management” has been advocated by authors like Frederick (2017) or Riessman (2000) to emphasize the positive and empowered coping of stigmatized individuals. We employ, however, the term “stigma management” to better convey the feeling of passivity in our participant’s accounts. The findings will be articulated in light of the socioeconomic complexity of contemporary Vietnam.

* * *

The stigma management literature suggests individuals are not passive in the face of stigmatisation. They are often aware of negative social perceptions of their attribute and seek to defend themselves against discrimination (Goffman, 2009). The strategies to deal with stigmatization are multiple and have different impact on improving the situation (Goffman, 2009). Their effectiveness depends on various factors including how individuals mobilize their cultural or social resources in social interactions (Biancarelli et al., 2019; Chang et al., 2016; Perez-Brumer et al., 2017, p.).

People who use drugs are greatly stigmatised worldwide (Rusydi Room et al., 2001). In Vietnam, they are considered ‘social evils’ and a threat to the society (T. H. Khat et al., 2012b; Luong, 2006). The now widespread biomedical conception of drug addiction as a brain disease

has not alleviated the stigmatisation of this population (Meurk et al., 2014; T. T. Nguyen et al., 2019). As an estimated 5.5% of the global adult population had ever used an illicit drug (United Nations Office on Drugs and Crime, 2019), understanding how this population deals with drug-related stigmatisation, and how effective their strategies and resources are, is valuable for both clinical work and policy development.

By highlighting the tactics of information and tension management people who injected drugs (PWID) in Vietnam employed to deal with their feelings of guilt and shame and to negotiate their social status, we unveiled the cultural knowledge they mobilized to create their social image. The study findings illuminate various aspects of people who use drugs, thus, counteract the simplistic stereotype of drug users.

Dramaturgical work and techniques of neutralization

The sociologist Erving Goffman has laid the base for the study of stigma management with his two sentinel works: “Stigma. Notes on the management of a spoiled identity” and “The presentation of self in the daily life.” (Goffman, 1959, 2009). Goffman theorizes everyday life as a performance where the individual is constantly on stage in the presence of others. He then engages in a “dramaturgical work” to manage the impression of others about him. This labor includes two parts: first, the individual needs to display the cultural cues that speak of his persona, and second, he needs to conceal the details of his life that contradict the performance. The failure to do so would be devastating to the relationship that the individual cultivates with his audience, and then to his self-esteem.

Stigma, as an individual characteristic that goes against the norm of a particular social unit, has the power to ruin one’s social status and lead to negative outcomes (Link & Phelan, 2001). As a consequence, people employ various strategies to prevent and manage stigma,

notably information management and tension management. Information management aims to conceal information whenever possible, while tension management helps to reduce the discomfort of social interactions between the stigma bearer and her 'normal' audience when the stigmatised trait or behaviour is visible (Goffman, 2009).

As drug use is not readily detectable, people who inject drugs employ information management by hiding bodily evidence of injection (Whitaker et al., 2011) and by striving to maintain normal functioning (Askew & Salinas, 2019). They might withdraw from social encounters or avoid getting into intimate relationships (S. McKenna, 2013; Spooner et al., 2015). Information management strategies may have negative health outcomes, because PWID tend to stay away from health services (Spooner et al., 2015) or downplay their need for medication or treatment to avoid being stigmatised (Biancarelli et al., 2019).

When the information is, however, eventually disclosed, the failing become discredited. The individual then needs to manage the tension that emerges at his encounters with normal people. A number of strategies can be employed including deflection, education and action. Deflection aims to divert the attention away from the stigma. A heroin user might downplay their stigma status in the presence of medical providers by understating his need for pain medication (Biancarelli et al., 2019). A drug-using youngster might divert his parents' attention from his drug use with his academic accomplishment and his duty fulfillment around the house (Fotopoulou et al., 2015).

Stigmatized people can actively educate their nonstigmatized audience about the nature of their stigma (Goffman, 2009). Drug-using patients in the U.S. told their providers that addiction was a brain disease and that everyone could get it (Biancarelli et al., 2019). Some have

published their insider accounts on the compulsivity of addiction (Fraser, 2015), hence paint a more complex picture of the condition, away from the stereotype.

Stigmatized individuals can also seek solidarity in their own group of similar stigma and among the sympathetic nonstigmatized people to protest and advocate for the rights of their group (Goffman, 2009). Recent drug recovery movements in the U.S. where hundreds of people who used or had used drugs went public to put forth recovery-enabling policies showed it well (White, 2007).

The strategies described above, however, do not ensure success. They can be indeed exhausting since it involves multiple calculations in the decision-making processes and constant efforts in concealment of discrepant details (Kanuha, 1999). In healthcare, the attempt to manage drug use information by delaying medical care or not revealing their needs for appropriate medications, can result in negative consequences for the drug-using patients (Biancarelli et al., 2019).

Goffman's theory has proved useful in studies on the micro-level interpersonal interactions in various stigmatized populations such as physical disability (Taub et al., 2004), overweight (Miller & Myers, 1998), homosexuality (Kanuha, 1999; Yip, 1999), prostitution and substance abuse (Sallmann, 2010), and the macro-level interactions among groups and nations (Adler-Nissen, 2014). However, although Goffman implied that stigmatized people internalize the same values with the mainstream society and judge themselves on such values, his analysis did not focus on how stigmatized people deal with the feeling of shame and guilt as the outcomes of such internalized stigmatization. While some stigmatized populations might disregard the social stigmatization against them for adhering to a totally different system of meanings (Kusow, 2004), Vietnamese drug users, as seen in the last chapter, adopted the same prevailing values of

the mainstream society. This is where we find the techniques of neutralization of Sykes & Matza (1957) relevant. Concurring with Goffman's assumption that the stigmatized and the nonstigmatized share the same value system, Sykes and Matza seek further to illuminate how stigmatized people deal with the feeling of shame and guilt after the action has taken place. They argued that the avoidance of stigma and impression management came from the strong urge of avoiding shame, which Goffman did not explicitly address. Theorizing from delinquent studies, Sykes and Matza propose five neutralisation techniques that help stigmatised individuals to justify their behaviours, reduce the dissonance between their attitudes and actions, and persuade their audience of their decency: denial of responsibility, denial of injury, denial of the victim, condemnation of the condemners and appeal to higher loyalties. These techniques have been reported in research of various deviant behaviors such as genocide (Bryant et al., 2018), sex work (Levey & Pinsky, 2015), pimp (Hannem & Bruckert, 2017) or methamphetamine use (Copes et al., 2016). Other scholars (Bryant et al., 2018; Kaptein & Helvoort, 2019) add appeal to good character and claims of victimisation to this list.

Managing the discreditable information

Goffman (2009) classified drug use as a discreditable stigma, a personality blemish, in contrast with the tribal or physical marks. However, in a collectivist society like Vietnam, it is often challenging to keep secrets about one's failing (Riessman, 2000). As described in the previous section, most drug users in our study were able to keep their drug use hidden until they experienced increased heroin tolerance and consequently financial crisis. Moreover, our study employed respondent-driven sampling for recruitment, hence the users who came to the study were known to some extent as an injecting drug user. At the time of our interviews, their status was no longer a secret to at least some people in their families and friends. The people who

managed to hide their status from their neighbors live in the city and not in their home neighborhood. Among them are migrants, those who came to Haiphong from the countryside and did not own a house. The failing information included starting, continuing drug use and relapse on drugs. The following analysis focused on how drug users attempted to conceal their drug use in situations they thought they still could. We draw many of the quotations from the interviews with a female participant who was very intentional in preserving her reputation. However, others insisted on using these strategies too.

1. Passing

Passing is a performance in which the individuals present themselves as what they are not. Typical examples of passing involved deceit such as the stigmatized individual attacks other stigmatized individuals in order to claim his membership in the non-stigmatized group. The following illustrations do not involve violence. However, they demonstrate the attempts of drug-using individuals to pass for non-using, “decent” people.

Opiate withdrawal is often described as a horrible condition that sufferers seek to relieve at almost any cost. However, some participants were able to overcome withdrawal symptoms to maintain a presentable appearance in their daily encounters:

No matter how sick I am, I'm middle-aged now, I have to hide it. Even though I was in withdrawal, I'd have to collect myself. I can't let people see me like this. I keep myself in check. (Female, 45 years old, sex worker)

Her effort to cover the signs of addiction is not an exception. Another participant also took great care to make sure the effects of drugs on him would not interfere with his work or be discovered:

Q: How could you control your bodily reaction when you are using or when you are in withdrawal?

A: No, no, no. The key thing is you need to do just enough [of drugs]. Don't overdo it, so that it would not [over] stimulate your neurons and make you oversensitive. This is called being too "high." You just take your sufficient dose, not more. Regarding withdrawal, you have some solutions to treat yourself when your intake is delayed. You might yawn, get goose skin, sneeze or vomit. But during this time, you separate yourself, don't be close to others, hence no one would know you are an addict. (Male, 31 years old, bus driver)

Other concealment strategies included covering one's face when going out to buy drugs or maintaining a low profile when consuming drugs. The same participant reported:

I use drugs at home. If I feel sleepy, I'd go to bed. Some people are ridiculous. When they get high, they cry, they sing, they laugh, they do all these things on the street. [...] I'm not like that. (Female, 45 years old, sex worker)

This participant tried her best not to draw attention to herself. When she relapsed and had to sell her electric bicycle to purchase heroin, she was tormented by fear that people would notice her vehicle was missing and ask questions that might lead them to suspect she was a drug user.

While peer support groups aim to provide their members with supportive social relationships, their effects seemed to be confined within group meetings. Some women avoided socialising with other members off-meeting. They were careful since hanging out with drug users would reveal their drug using status.

Passing does not only serve to avoid the tension in daily encounters between the stigmatized and the normal, it also serves to protect the cultivated image of the stigmatized in front of her audience. In the case of the above woman, one motivation for her passing efforts was to avoid being arrested, hence to avoid her reputation in her hometown being tainted:

Sometimes I go out to pick some recyclable junk, pretending that I'm a hardworking person. If people call me to come and clean their houses, I'll go. So, looking from the outside, I still have a job, not a stable one but enough for people to see me as someone who works. (Female, 45 years old, sex worker)

The image of a hardworking woman that this participant created was similar to that of another participant who reported always wearing *áo bà ba*¹ when she left home. They hoped that this would project the image of a hardworking, modest woman, in contrast with the stereotype of a self-indulgent drug user.

Also, since nonusing individuals would stay away from stigmatizing places such as hotspots or methadone clinics, passing for nonusers means avoiding these places. Not getting into methadone treatment or trying to delay treatment as long as possible was a way to pass. The family of a participant lived in another province and they were not aware she was a drug user. If she wanted to get into methadone treatment, she would need to get some residency certificate from her hometown's government and this meant her status would be disclosed. This was a reason for her not getting treatment until this requirement was dismissed. And even then, her daily company to her husband to the methadone clinic was explained to her in-laws as to help her husband to adhere to treatment and not to get methadone herself.

¹ A modest, long-sleeved, loose-fitting shirt, a garment typical of rural Vietnamese women.

Passing might not be a good strategy, as a home visit to her one year after our first interview revealed. Although she had kept her drug use from her immediate family, her in-laws (with whom she had been living with her two young children since her husband had been incarcerated for dealing drugs) discovered it and accused her of deceiving them. Our visit was interrupted several times by her brother-in-law, who accused her of ruining the reputation of the family by going out at night to take drugs, and threatened to kick her out of home if she did not stop.

Purchasing and taking drugs covertly was not an option for all participants; in fact, only better-off users could afford to do so. These participants might hire peers to buy them drugs every day; often the price of this service was a dose for the purchaser. Hence, even though he had been addicted for years, his neighbors knew nothing about it. Many participants knew drug users in important social positions who had heroin delivered to their homes or who bought expensive street methadone instead of visiting methadone clinics.

With people who did not live close to the individuals, lying could be done to deal with the incessant inquiries of whether the person had given up drugs. Some individuals kept telling their family members who lived far away from them that they were clean to avoid being nagged about their habits. Individuals often opted for not disclosing their drug use and trying to hide it from their in-laws whenever they could. In this case, they needed the cooperation of their spouses. While trying to pass for non-users, the individuals also refused the possibilities of asking for help when they were stuck in addiction.

2. Social avoidance

Social avoidance goes hand in hand with passing. In order to pass, it is often necessary that the individual does not get into high intimacy-level relationships. A few participants in our

sample who maintained a professional activity avoided making friends with non-using people at work. A woman kept a distant relationship with co-workers and lived by the motto “*one should mind only their own business.*” When she relapsed on methamphetamine, she moved out of the family under the pretext that she had to work late at night. When another participant relapsed and ran out of money, she stayed at home and avoided her acquaintances so they would not see her sad face. When she came across someone she knew, she turned away and pretended not to recognize them. There are few occasions, however, for drug users to employ social avoidance in managing discrediting information since not many participants still had opportunities to engage in relationships outside the circle of their drug-using peers and family, e.g. work. Hence, they did not even have the decision of whether or not disclose their information.

Managing external and internal tension

The drug use of most participants was known to others, so they applied tension management rather than information control to manage social stigmatisation and internalised stigmatisation and preserve their sense of self-worth. This section focuses on how individuals constructed a socially accepted self, using cultural cues, to resolve intrapersonal feelings of guilt and shame and negotiate status with their audience. The strategies they used were social avoidance, appeal to good character, denial of responsibility, denial of injury and condemnation of the condemners.

1. Social avoidance

To people with known stigma, the strategy of social avoidance serves different purposes than to manage the failing information. The first and most evident purpose is to avoid potential judgment. This often resulted from previous experiences of humiliation. Many decided to avoid old friends and neighbors since they had experienced rejection in the past. One person offered an

old friend tea but the latter ignored him. One neighbor cursed someone who stole her possessions after a participant's visit and the latter believed this targeted him. The experiences of humiliation could be real or anticipated. Some were reluctant to socialize since they felt unworthy and that they could be subjected to critics. As a consequence, participants protected themselves by avoiding new relationships, restricting their social circles to drug-using peers and immediate family. A peer educator had seen many of her clients lock themselves in their rooms for fear of discrimination.

Not all participants encountered such negativity in their social relationships, nonetheless. People of relatively high social positions reported that their extended family and other acquaintances treated them well despite their drug use and/or addiction. Still, some opted to withdraw from these relationships to spell out their difference and distance themselves from the stereotype.

Social avoidance to self-affirm is common among our participants. It is even more noticeable among those who lived in the countryside where members of extended family lived in the same village and tended to visit each other every day. Since the individual reacts to the image he supposes others are seeing them, our participants' retreat from social interactions might result from their awareness of the stereotyped image of drug users.

I never, never come to my uncles and aunts' houses. [...] Because, being an addict, if I come to see them, they would question my motives. (Male, 30 years old, unemployed)

Since I got addicted, I've hardly come to see my relatives. [Why?] I don't know, I don't think they'll avoid me. [...] I'm afraid that they'd think I come to borrow money from them. Well...it's just my feeling. (Male, 40 years old, welder)

The above testimonials were representative to other participants. The stereotyped image of drug users she invoked was of an evil individual who would shamelessly ask others for money and would introduce “innocent” people into drugs. Such stories were popular. Since the early 1990s, parents often told their children not to hang out with strangers for fear of being drugged. Scandalous news regarding primary school students being introduced to drugs and forced to become drug dealers or drugs being diluted in popular beverages continue to be circulated in social media nowadays. There has been no evidence, however, to back these stories.

By avoiding acquaintances, these participants reduced the opportunity for these people to think negatively of them. Hence, fear of being misunderstood prevents or damages meaningful relationships and limits users’ ability to display other aspects of their identity.

2. Techniques of neutralization

As Sykes and Matza clearly state, the analysis of the techniques of neutralization does not aim to assess the truthfulness of what people say. Indeed, the analysis seeks to understand how these events were selected among a myriad of events and feelings and how they were deployed to make sense of people’s story. The techniques of neutralization serve as self-protective mechanisms against the threatening stigmatization (Crocker & Major, 1989). They can be used with intention to reframe the situation into a more favorable state in front of the audience or unintentionally to protect the user’s sense of self-worth. The values deployed in the techniques must be placed in the context of interviews when the interviewer introduced herself as a Ph.D. student who belonged to the research team that her informants were part of. This specific condition of the context might affect what information is selected and how it is presented. The techniques of neutralization were woven into intra-group stigmatization where participants tried to distance themselves from more “problematic” users.

Appeal to good character

Efforts to make a good impression started with the narration of participants' childhood and the time before they turned to drugs. This period, which we termed "a glorious past" was often talked about with great regret and went into contrast with their gloomy present. The development of the glorious past served as a background upon which a pro-social self of the individual was established.

Participants often stressed on the fact that they used to be good children with a good family background. This description asserted that they were not spoiled "by nature" and that what happened afterwards was not their true self.

I'm not a spoiled person. When I was young, I did well at school. My brother and I were the best-behaved children in our neighborhood. My parents were government officials. None of my relatives did drugs. Before I got married, I was very innocent. Only since then that I became depressed and turned that way. (Female, 40 years old, homemaker)

This participant used positive adjectives such as "best-behaved" and "innocent" to describe herself in the past. These words went together with her description of a "basic" family — a popular term to denote a decent family whose members were assuming positions in the government and who maintained their good reputation. Against this backdrop, drug use became unexpected and could not be explained by anything other than external forces.

Other participants went on to portray a positive image of themselves as young adults who had ambitions, achieved greatly in school, had a prestigious job or made a lot of money. These virtues are embedded in Vietnamese culture, where education is valued highly and the ability to make money is admired. This selection of values to display is likely to have been intended to generate sympathy from the interviewer through comparison with her own status.

Stressing that one adheres to the highest social expectations despite one's deviance is another aspect of the appeal to good character. Participants asserted that they lived faithfully by the ideals of womanhood and manhood. Most women described themselves as asexual:

Unlike my friends who want sex after meth, I can't do it. (Female, 45 years old, business owner)

Others emphasised their qualities of self-respect and trustworthiness by differentiating themselves from other "thick-skinned" users who bore the shame of asking for favours:

I couldn't afford my methadone then. The admin staff said if I couldn't pay for my treatment, I would no longer receive it. I was so ashamed that I stopped coming to the clinic. Other addicts said I should come anyway and insist to get my dose. But I couldn't. I'm not as thick-skinned as they are. (Female, 42 years old, waste picker)

Manhood ideals centred on readiness to bear the consequences of their actions, fearlessness, strong will and ability to self-mock. A young participant stressed that he "*dared to do, dared to take responsibility*" and that he could quit heroin if he really wanted to. Another one playfully admitted that although he made good money, his wife and children hardly saw it for he spent it all on drugs. Irony, in this case, served to display honesty and a good capacity for making money.

Denial of responsibility

The denial of responsibility is the most popular strategy used by our drug-using participants. Sykes and Matza (1957) define denial of responsibility as negation of personal accountability, a claim that deviant acts are accidental; blame is then deflected to external forces

beyond the control of the individual. In denying responsibility, the individual admits the deviant acts while asserting his attachment to the normative system.

Denial of responsibility in our participants' accounts takes two forms: blaming fate and blaming other external causes. These two forms are not always exclusive. Blaming fate, or divine will, means one believes that one's situation is predestined, and for our participants was usually the overarching explanation of significant events that happened and diverted their lives. One man in his sixties considered his bankruptcy to be the key event that led him to drugs. However, he placed this event into a broader context of divine favour: "*God pampers everyone, but for just some time in life.*" He used the fact that he had lived with one opium-addicted friend for a year without developing addiction to assert that his subsequent involvement with heroin was God's plan.

Another participant held on to the concept that everyone had their own predefined function in society to explain how a successful person from a good family (like him) could end up taking drugs, being incarcerated and with HIV infection. To illustrate this idea, he contrasted one's wishes with the reality:

For example, in Haiphong, there is only one mayor, right? If everyone could be the mayor, there'll be no society. [...] No one wants to become addicted or sick. But it's their fate that forces them into their current position. (Male, 31 years old, unemployed)

Another case with this kind of belief is a former businesswoman who used to make a lot of money. She then lent all of her money to help a close friend but did not get it back. She considered it the turning point where her degradation started. Now looking back, she realized that the fortune-teller she had consulted was right. That teller told her that she would lose all her properties but she did not believe in it at the time. She also tried to explain her other lack of luck

in the name of fate. Because she did not have a “good fate” (*duyên*) that she had never met some clients who could support her like other female sex workers did. The selective interpretation mechanism is quite clear when we considered the fact that she had also had at least two long-term partners who supported her financially for many years, until recently when her second partner passed away.

The fatalistic beliefs in the above cases were clear and more fundamental in their explanations of every event in their life. The other participants adopted this belief partially, to explain how some events happened to them at a certain time. We were quite surprised when a participant mentioned his critical turning point at the age of 28 when he was incarcerated for the first time for robbery and drug use. There is a Vietnamese proverb—“*49 has not yet passed, 53 has come*” to signify a time in life where people often experience some degradation in different aspects of their lives. Late forties and early fifties seem to be the critical period when one’s health worsens, so one would be more likely to get into accidents or become moody and quarrel with others. However, the age of 28 does not appear to be such a conventional point. That participant might have constructed it to explain his negative events in the name of fate.

By referring to fate as the script of all life events, participants gave up their responsibility and depicted themselves as powerless and passive. However, some external factors – ignorance, drug availability, peer influence or crises – did serve to explain why participants initiated drug use and why they continued. One woman reiterated her ignorance when she was first exposed to drugs:

I was young then, I didn't know how harmful [heroin] was. I was proud of my capacity to make money. I thought that even if I got addicted, I'd never run out of money. (Female,

33 years old, sex worker)

Back then, we saw those who did not do drugs as outdated. Right, it was our shallowness. We just grew up, we were so ignorant. Yeah, we're really shallow. We thought doing drugs was stylistic, fashionable and so on. We didn't boycott them but we thought they're "rural," they didn't dare to spend money on food and clothing. We thought we're great.

(Female, 33 years old, sex worker)

This ignorance was coupled with a number of other factors including the availability of drugs, peer influence and a lack of parental control or a painful event. A typical situation of first drug use consisted of participants as the only nonusers among drug-using friends who persuaded them to "give in to" drugs by saying, "you can't get addicted with one try." Only in retrospect did they recognise their error. A lack of parental control was the key reason in the story of a participant whose parents were divorced and who assumed he was spending time with the other parent so that he was able to hang around with his friends. And painful events often created the emotional state that facilitated drug use. These events might be being betrayed, losing one's house or going broke.

Sykes and Matza (1957) call this justification the "billiard ball" approach in which the deviant "sees himself as helplessly propelled into new situations." By evoking the image of an innocent and helpless person, these participants refuted the labels of "social evils" and "self-indulgent" that were attached to drug users and sought compassion from their audiences.

This image of a victim continued to be constructed throughout participants' explanation of their relapse and continued drug use. Objective factors included an "unclean" environment where drugs were readily available and that was populated by drug users, a lack of understanding from their family, having no job to fill their free time and to direct their mind away from drugs or the painful effects of heroin withdrawal were mentioned as the insurmountable challenges for

one to quit drugs. These challenges are conventionally understood as what facilitate addiction. Referring to them emphasizes the helplessness of drug users in the vicious cycle of addiction. Controlling addiction, hence, goes beyond the individual's capacity.

This denial of responsibility, however, is unlikely to be persuasive. There is a popular saying in Vietnam that instructs people not to listen to drug users, implying that they are liars. Both users and nonusers tend to dismiss this kind of justification, arguing “*if you don't take it, who would force you? Who would put it into your mouth?*”

Even other drug users protested this kind of reasoning. A participant who made good money and who swore to adhere to methadone treatment until his death, commented on the time conflict reason some patients mentioned to explain why they dropped out from methadone.

It's all about oneself. One needs to adjust one's schedule [to fit the treatment]. To be fair, it's our fault and not their [the providers'] fault. It's us who pushed us into this condition. We're getting treatment, so that we need to adjust our work. We can't have them to follow us. It's all because of us. If we drink it [methadone], we need to stay in Haiphong, we should not travel far. [...] They give us medications, they support us. How come that they have to take care of our travels? (Male, 37 years old, shoe polisher)

Participants sometimes voiced this sentiment; one seemed to wrestle between an urge to bring in external forces to explain his drug use and the social demand for individual responsibility:

When my generation came of age, the media didn't talk about drugs as widely as it's doing now. It's not to blame the society, it's our charge. The society did its part, but it's just a part. (Male, 35 years old, unemployed)

Some users went to the other extreme, bearing all the responsibility for their addiction. By adopting this attitude, they distanced themselves from the people they deemed irresponsible:

In general, it's all because of us. I am what I am now, I don't blame anyone. No one has forced me to do drugs. Some people put the blame on the situation or on their distress, it is just an excuse. Whether one does drugs or not, it's him who decides. I wanted to take it so I took it. It's us to be blamed. So that whether one can keep being abstinent or not, it's all about him. Friends might ask you to join them, if you don't want so, who could force you? I have been irresponsible, so I have to accept that. (Male, 23 years old, unemployed)

Denial of injury

. By claiming that their acts do not hurt anyone, the individuals break the link between their acts and the consequences and redefine their behaviours as illegal but not immoral (Sykes & Matza, 1957). This parallels the debate about the need for criminalisation of drug use and whether one is free to do anything if it does not hurt others (Sher, 2003). Participants denied the injuries their substance use may have caused by underlining their morality and self-reliance. Morality in this context is closely related to the Confucian notion that fulfilling one's duties to others is the golden rule that keeps society in order. The accounts of our participants reflected this ideology. Parents in our sample claimed that although they used drugs, they took good care of their children:

I do drugs but I always care for my child. Once, she wanted a doll as we were going out. I only had enough money for the next dose [of heroin] then, but I bought her the doll immediately. [Since I thought] I could score [some money] later. Even if I couldn't, I was ok to skip that dose. (Female, 40 years old, homemaker)

For this woman, prioritising the desires of her children was important for her self-image as a good parent; even anticipation of painful withdrawal did not keep her from doing so. She also laid stress on parents' "correct" behaviours at home as criteria for good parenting. Being "correct" meant she fulfilled the duties and obligations of parenthood and was able to command respect from her children.

I can be really filthy out on the street. But when I'm home, I'm correct. Mom is mom, dad is dad, and kids are kids. (Female, 40 years old, homemaker)

The image of a parent contrasts with that of a "filthy" drug user on the street. By adhering to the mother role in front of her children, she affirmed that her private habit did no harm to her children.

Of course, these definitions of good parenting were personalised to suit the lifestyles of drug-using parents. Outsiders can always criticise them for not spending more time at home with their children or accuse them of abandoning the children to grandparents or relatives.

Nonetheless, a realistic definition that fit their lifestyles might help them to deal with their guilt (Copes et al., 2016). This protective function of the technique of denial of injury is clear in the following quote of another mother who was not so sure about whether she fulfilled her parental duties:

Everyone loves their children... People who are not addicted take good care of their children but an addict like me... Of course she is now living well with her father. She doesn't lack a thing. But I'm guilty, I'm a mother but I couldn't do much to my child. Sometimes I feel so sad. Sometimes I just want to jump in front of a car to kill myself.

That mother was depressed. She was ashamed of not being able to take care of her child like other parents did. However, in the middle of the sentence, we see her attempt to persuade herself and her interlocutor that her behaviors did not harm her daughter. This rationalization is then a mechanism to self-protect against the feeling of guilt and shame.

Participants' denial of injury was often backed by the claim that their families were happy and that their children loved them. Parents proudly declared that their children achieved greatly at school. Some mothers asserted that they were best friends with their daughters, and many fathers reported that their children preferred them to their mothers. Since children are supposed to have a natural inclination towards good people, how can someone be immoral if children love him or her that much? By emphasising this aspect, participants challenged the public stereotype of drug users and constructed their image as good people by nature.

Alliance to the family is a key tenet of the Vietnamese value system; for single participants, loyalty to parents was considered to be the highest virtue. One participant said: "*Addiction is acceptable, but disloyalty to parents is not,*" and that he would "*spit in the face*" of those who were disloyal to their parents. Another participant differentiated himself from those who yelled at their parents to get money for drugs; just the thought of doing so to his parents terrified him.

The second injury that people denied related to what one participant termed "correctness" (*đàng hoàng*). Correctness covered different aspects. The first one is related to financial matters. Despite their deviant act of using drugs, drug users reported they bothered no one. Except two participants with a record for robbery, all declared that they had never stolen from anyone. They worked to afford their habits. And since everyone knew that working would not be sufficient,

they admitted that their parents or friends gave them money sometimes, however, never because these people felt forced to do so.

I've never cheated on my friends. If I'm too stuck, I'll ask a good friend, "Can you give me one hundred or two hundred [thousand dong]?" If he's willing to give me, he'd do it. Otherwise, he'd not. I've never borrowed money and not returned it. This is why I've many friends, good friends. (Male, 40 years old, shop assistant)

In the above quote, the participant asserted his correctness by stressing on the fact that he had never forced people to provide for him, that he was asking them in a casual and respectful way, and that he was relaxed about whether the others would give him money. The decision to give him money or not is totally the others.' Since he did not press them, if they gave him, it was an act of love. Exploitation was a kind of emotional blackmail in order to get what one needs and this was definitely not what the individuals saw their behaviors. Pointing to positive motives of the money-giving act helped the individuals to reframe their asking for money in a positive way.

Our participants not only asserted that they hurt no one, they showed that they strove to protect others. An HIV-positive man proudly said he always wore condoms when going out with sex workers to protect them, although these women "*at the bottom of society,*" with "*nothing to lose,*" would accept unsafe sex for extra money. Participants reported a range of activities they undertook to minimise the impact of their drug use on their families, such as requesting a divorce to protect their spouses from their own financial difficulties, or insisting on keeping the family's savings intact. This thoughtfulness and self-sacrifice went against the negative stereotype of the self-indulgent drug user.

Another instance of denial of injury was the juxtaposition of heroin with methamphetamine. By contrasting the “benign”, “therapeutic” heroin with the “harmful”, “evil” methamphetamine, participants claimed greater virtue for heroin users:

[Opium] is the panacea for all illnesses. If you do meth, you might feel okay now but you'll feel exhausted the next days. On opium, you'll feel good all the time, not high but comfortable. Opium isn't harmful. Meth is. (Male, 40 years old, welder)

The participant in the above quote emphasized the pleasure and therapeutic effects of heroin. In his opinion, heroin use itself is not an evil act, but the lack of money to maintain a regular dose is. Comparing heroin with methamphetamine, he called attention to the crucial difference between the benign and therapeutic heroin and the harmful methamphetamine.

The comparison of heroin versus methamphetamine was popular among drug users, both in our interviews and in daily conversations. Vivid stories of paranoiac methamphetamine users who killed or injured family members and others were offered as proof that methamphetamine was much more dangerous than heroin. This discourse echoes the pejorative rhetoric of the media regarding methamphetamine, which has caused great anxiety and fear in Vietnamese society towards this drug.

People who had ever used methamphetamine classified themselves into mentally strong and mentally weak types. Mentally strong users could consume meth the whole day without developing delusion while mentally weak users would lose their mind the first time they smoked meth. Strong minds could be “*cuốn*” (feeling the high, involving in repetitive actions) but would never be “*béch*” or “*áo*” (paranoiac).

Tapping on this societal fear of methamphetamine, heroin users offered evidence to deny the injury heroin might cause and divert the blame for drug-related harm onto methamphetamine

users. Moreover, as one participant pointed out, heroin addiction could be controlled by methadone, while no medication could hold methamphetamine users back. This deployment of common knowledge helped them to be more persuasive in justifying their heroin use.

Condemnation of the condemners

This technique of neutralization is defined as “the delinquent shifts the focus of attention from his own deviant acts to the motives and behavior of those who disapprove of his violations. His condemners, he may claim, are hypocrites, deviants in disguise, or impelled by personal spite. [...] [B]y attacking others, the wrongfulness of his own behavior is more easily repressed or lost to view.” (Sykes & Matza, 1957)

The targets of condemnation by our drug-using participants were family members, neighbours, methadone providers and society. Drug users living in the countryside often blamed the discrimination against them on the ignorance and low education of the stigmatisers:

Educated people, who read newspapers and watch television, see us in one way. Ignorant and uneducated people see us in another way. I heard that people abroad think of addiction as a disease that needs treatment, unlike people here, the rural ones who insist that addiction is a vice, a social vice. (Male, 31 years old, unemployed)

This participant defined educated people not by educational attainment but by their up-to-date understanding of addiction as a disease. It’s interesting to see that he defined educated people as those who read newspapers and watch news and not only by educational attainment. Educated people for him were people who kept learning and updating themselves with scientific progress, hence with the new understanding of addiction as a disease. Being a rural person (*nhà quê*) is often associated with low education in the accounts of rural drug users. Indeed, “*nhà quê*” is a pejorative term that denotes devalued characteristics. Although he was also rural, he

distinguished himself from his fellowmen by his “modernity” and “progressivity”. By criticising rural people as ignorant, he distanced himself from them and sought to gain the interlocutors’ sympathy. (L. was within earshot while we were doing this interview). At the same time, he displayed an internalized stigma towards rural people.

Urban drug users condemned their stigmatisers from a different perspective. They criticised society for being hypocritical and unhelpful. While drug users were repeatedly told to reintegrate into society, it did not give them opportunities to do so:

I’ve knocked on so many doors, asking for a job, but they firmly refused. If they didn’t, things might have gone another way. [...] Maybe because I’m too thin, and I’m labelled an addict. They might hire me during the New Year period, but afterwards they kick me out. (Male, 43 years old, unemployed)

This person bitterly accused that it was the society that threw him away after they exploited him and pushed him further down in his degradation. In mentioning his stereotyped appearance, his “addict” label, this person accused society, with its stigmatising attitudes, of causing his degradation. This blame was echoed in other urban users’ accounts.

Participants also cited a lack of sympathy from their families and the distrust of people around them to be the main reasons for their relapse. They stated that their families often expressed doubts about participants’ efforts to abstain and falsely accused them of taking drugs. They complained that rehabilitation centres that were supposed to help drug users instead provided an oppressive environment that pushed them to seek relief in drugs right after discharge.

Methadone patients reacted to what they saw as methadone providers' disdainful attitude towards them by criticising them for being corrupt, inconsiderate and inhumane as we reported in the last chapter.

Sometimes I feel really frustrated. We always have to wait. I tell you. Normally three, four staffs should be there, right? One would check the patient card, another would sign, another would dispense medication and another would enter information on the computer. there is only one person. He has to find our record, then dispense medications, then enter information on the computer. Isn't it frustrating? It was in office hours but they are going out for coffee. How are they allowed to do that? I agree that everyone could take some time off, but they should be absent for a short while. They can't do it in front of all patients. People have to go to work, we are hurried. It's unacceptable that we have to wait for them. (Female, 38 years old, unemployed)

Another strategy of condemnation employed by stigmatised people is to selectively devalue the deviant dimension and highlight aspects in which they excel (Crocker & Major, 1989). Some of our participants felt superior to their stigmatisers regarding the ability to make money, which comforted them whenever they experienced negative attitudes from others. A former driver who used to make good money told himself:

They despise me but they don't do it as well as I do. Let's wait and see. (Male, 42 years old, builder's laborer)

Others, in the other hand, put considerable emphasis on other values such as emotional loyalty (*trọn tình trọn nghĩa*) or filial piety. Being emotionally loyal is a virtue in Vietnamese culture. This meant a felt obligation of an individual towards those who had once helped her,

despite all the bad treatment she might receive from them. A woman adhered closely to this emotional responsibility. Her first husband used to treat her brutally when they were together. However, she came back and looked after him during his hospitalization due to AIDS. Another also acted similarly. Her husband betrayed her publicly and her in-laws threatened her to leave the city. Still, at the annual death anniversaries of her in-law family, she visited them with gifts. She did not forgive them. However, by acting this way, she proved her superiority over her in-laws, at least to herself.

From another perspective, drug users explained their unjust treatment as the outcome of other injustices such as poverty or immigrant status, not of their deviant behaviour:

Addiction leads to poverty, then it destroys affection. People who have money have a say.

Without money, no one will listen to you.” (Male, 38 years old, unemployed)

In short, a drug addict without addiction is a poor. A clean poor, clean of drugs. They work hard but they are still poor. In a society of the rich, they will, of course, feel inferior. Right? Not only addicts [would feel that way]. (Female, 45 years old, factory worker)

By explaining addiction stigma in terms of other injustices, the individuals diverted the attention into other socially protested stigmatizations, portrayed themselves as victims and hence were able to project a righteous anger towards the unjust treatment. This diversion to poverty stigma was quite popular among both urban and rural drug users. Loan explicitly explained how addiction and poverty stigma were intimately linked:

A participant said, “*being poor is being guilty.*” Since when you are poor, the others have to donate things to you to live on, you have to live on their charity. “Being poor as being guilty”

because you do not rely on yourself to overcome this situation. The current practices of many local governments implicitly declare this idea. Numerous reports and personal accounts criticized the ridiculous criteria some local governments used to declare someone was no longer poor such as having a television, regardless of whether they bought it themselves or someone gave it to them (Bich Chau, 2017; Hammett et al., 2018a). One should not be poor, since it would affect the reputation of the neighborhood, of the district and of the city. A person is entitled to stay poor for only two years, for example (Hammett et al., 2018a). Overall, this pointed to a tendency in the neoliberal atmosphere in Vietnam where personal virtues were measured by material achievements. In this climate, the poor were stigmatized. This also linked to the stigmatization of rural people since they were generally poorer than their urban countrymen.

Another injustice that participants mentioned was stigmatization towards migrants, people who did not own a house in the city. This stigmatization was historically constructed. In the early 1990s after the Renovation, the government applied strict regulations to brake the rural-urban migration flow (Long et al., 2000). These regulations included denying household registration of migrants and restricting their job opportunities to the lowest occupations (Long et al., 2000). One woman justified her social avoidance by such strenuous relation between migrants and residents rather than by her substance use.

I'm not close to anyone. Since they think I'm a tenant, they don't try to get close to me.

[...] Tenants are different from owners. (Female, 45 years old, sex worker)

By explaining addiction stigma in terms of other injustices, the individuals diverted the attention onto other social stigmatisations, portrayed themselves as victims, and hence were able to project a righteous anger towards the unjust treatment.

Appeal to higher loyalties

This technique tries to explain the failure of the deviant to follow social norms. Indeed, “the deviation from certain norms may occur not because the norms are rejected but because other norms, held to be more pressing or involving a higher loyalty, are accorded precedence” (Sykes & Matza, 1957). The deviant in this case could see himself as caught up in a role conflict. For example, our participants explained their continued use of drugs as necessary to fulfil their parental or work roles. As parents, they worked hard to feed their children; as workers, they were diligent. Using drugs was not a violation of norms but needed to fulfil their duties.

A single mother, who reported being physically abused by her parents as a child, swore that she would raise her son until her last breath. She differentiated herself from “irresponsible” drug users who hung around with each other and took drugs constantly. The reason why she continued using heroin was that she could not afford detoxification:

Participant: If you want to detox, you need financial support that allows you to rest.

Interviewer: You mean if you get detoxed, you'll have to stay at home?

Participant: Exactly. Without a cent, how can you do it? You can't just lie down. You can't. (Female, 42 years old, waste picker)

Other participants needed to use heroin to keep working. A single father, infected with HIV and tuberculosis, used small doses of heroin when he felt really weak. He did it strategically, not exceeding two weeks of consecutive use to prevent development of addiction:

I use drugs to recover from exhaustion. [...] Since I first used heroin, I've never intoxicated myself. I take just enough so I can work. (Male, 44 years old, employed intermittently)

One participant reported using heroin to maintain the quality of his output:

I can't let myself go into withdrawal. That's the only way for me to work well, to provide people a good service. (Male, 40 years old, welder)

By describing themselves as people who worked hard, participants dismissed the negative association between addiction and self-indulgence or crime and asserted their observation of social norms.

Discussion

Most individuals are not passive but resourceful in dealing with stigma. Studies have documented multiple examples of coping strategies among people with stigmatised attributes (Bryant et al., 2018; Couvrette et al., 2016; Hannem & Bruckert, 2017; Levey & Pinsky, 2015). Our study sheds new light on the motives of people who use drugs in managing stigma and reveals the cultural resources they mobilised in this process. By drawing attention to the complexities of PWIDs' emotional lives, their beliefs and methods employed to combat stigma, we challenge the stereotype of an inhumane, irresponsible drug user and show the humanity of PWID.

Our participants employed many of the same tactics reported in previous studies, such as using drugs in private, concealing markers of drug use from nonusers, or withdrawing from social relationships to control information (Askew & Salinas, 2019; Spooner et al., 2015; Whitaker et al., 2011). However, they seemed more concerned about their social image than social rejection if their status was disclosed. Not only did participants try to conceal information, they actively constructed a pro-social image that directly contradicted the stereotype of drug users. This image was aligned with strong values in Vietnamese society, such as selflessness,

hard work and harmonious living with others. Such effort put into curating one's social image might relate to the importance of "saving face" in collective societies (Fereidouni et al., 2015; Fotopoulou et al., 2015; Mak et al., 2015).

The various motives for social avoidance that we describe represent a novel finding. While previous studies mention social avoidance as a way to conceal information (S. McKenna, 2013) or avoid judgement (A. J. Gunn et al., 2018), our participants employed this tactic to prevent others from thinking negatively of them; thus, they affirmed their distinction from the stereotype.

The narration of a conventional, "glorious" past to emphasise participants' true selves is comparable to the technique athletes use to explain how they came to use performance-enhancing drugs in competition (Yar, 2014). While athletes typically emphasise a problematic childhood, pure love of sports, honesty, and responsibility as their inherent qualities, our participants depicted their true selves to be consistent with Vietnamese values such as academic achievement, filial piety, ambition to work for the government and good family background. This backdrop serves to frame drug use behaviours as accidental rather than intentional. Thus, participants agreed with mainstream society that drug use was bad, but distanced themselves from meth users or more scandalous heroin users by arguing that the latter were inherently bad.

Participants' consistent emphasis on adherence to social expectations echoes the findings of previous studies of drug users, sex workers or homeless people (Couvrette et al., 2016; A. Gunn & Guarino, 2016; A. J. Gunn & Canada, 2015; Haritavorn, 2016; Hill & Stamey, 1990; S. McKenna, 2013). Women who use drugs worldwide embrace the ideals of motherhood and womanhood that dictate their devotion to children, modest sexuality and abhorrence of commercial sex (Couvrette et al., 2016; A. J. Gunn & Canada, 2015; Haritavorn, 2016; S.

McKenna, 2013). Male drug users espouse manly ideals like fearlessness and ability to make money that represent a mix between traditional heroism and the goals of neoliberalism.

The fatalistic beliefs that our participants endorsed are novel, being much more common in studies of people living with HIV or cancer than of people who use drugs (Drew & Schoenberg, 2011; Hess & McKinney, 2007). Consistent with participants' appeal to good character, drug addiction was framed as an accident that befell them. Hence, participants refused to see drug addiction, HIV infection or incarceration as the consequences of their drug-using behaviour but as their misfortune. However, blaming fate or external factors is ill-suited to the social norm of individual responsibility; this might explain why participants' denial of responsibility was not really convincing to others or to the individuals themselves.

Denial of injury by asserting one's duty fulfilment was exemplified in a study of mothers who use methamphetamine (Couvrette et al., 2016). This study found that a deviant good mother model makes drug-using parents feel good about their parenting competency. Thus, beliefs about doing their best for their children might have helped our participants to feel confident in their parenting. This finding shows that parenthood is an important aspect in the lives of PWID and goes against the stereotype of irresponsible drug users. Family has been identified as a major factor in addiction treatment and in the general recovery process of people who use drugs (Filges et al., 2018; Li et al., 2013). One addiction treatment component should be to help patients to strengthen their family relationships.

Distinctions between users of different drugs and related stigmatisation are popular among drug users. Research has shown that cannabis users disapprove of the use of "harder" drugs such as heroin or cocaine (Peretti-Watel, 2003), "hard" users stigmatise "soft" users (A. J. Gunn & Canada, 2015), and steroid users consider heroin users to be inferior (Simmonds &

Coomber, 2009). Stigmatised people might feel the need to differentiate themselves from similar others to assert their position in the hierarchy (Copes et al., 2016). Pointing to “dangerous” methamphetamine users, our Vietnamese heroin users not only reflected this phenomenon, but they also affirmed that they were totally different from these criminal meth users.

Beside its function of diverting the transgression onto the stigmatisers, the use of the “condemnation of condemners” technique reveals other issues in contemporary Vietnamese society, including stigmatisation towards rural dwellers, migrants and poor people. These kinds of stigmatisation could be considered more unjust than the stigmatisation towards drug users. By reframing the negative treatment they received due to these unjust stigmatisations, participants’ anger became more righteous. This was the strategy of female sex workers in Sallmann's (2010) study, who explained the stigmatisation towards them as a gendered phenomenon and not as being caused by their sex work.

The stigmatisation towards migrants in Vietnamese cities is historical. In the early 1990s, after the *Đổi Mới* (“Renovation” – economic reforms) of the mid-1980s, the government applied strict regulations to slow the rural-urban migration flow (Long et al., 2000). These regulations included denying household registration to migrants and restricting their job opportunities to the lowest occupations (Long et al., 2000). This history describes the broader context in which the individual incidents of stigma that the participants described took place; however, they also served to divert the light away from their own transgressions.

The evidence that participants put forth to appeal to higher loyalties goes against the stigma attached to people of low social status who indulge in drug use, in contrast to middle-class users who consume drugs to enhance their performance (S. A. McKenna, 2011). These testimonials echo findings among drug users in other contexts (Antunes Lima, 2017). This shows

that people who use drugs adhere to the same social expectations as non-users and are more similar to nonusers than it is usually believed.

In investigating how Vietnamese PWID resist drug-related stigmatisation, we did not find problem-focused coping strategies such as education or advocacy as has been the case in research into other marginalised groups (Basu & Dutta, 2008; Buseh & Stevens, 2006; Carricaburu & Pierret, 1995). Scholars argue that people often resort to emotion-focused coping when they lack structural support (Carver et al., 1989; Folkman et al., 1986; Lazarus & Folkman, 1984). Emotion-focused coping might reduce feelings of guilt and shame, but it might not improve the situation greatly (Dageid & Duckert, 2008).

Individuals tend to employ problem-focused coping if they perceive the situation to be changeable and emotion-focused coping if the situation has to be accepted (Folkman et al., 1986); hence, we infer that drug-related stigma in Vietnam is different from HIV-related stigma, because people living with HIV can obtain legal assistance to protect themselves and can speak out to educate people about their condition (Abrahams & Jewkes, 2012; Buseh & Stevens, 2006). Studies suggest material and social resources play an important role in how people feel about shaming and how they cope with it (Adler-Nissen, 2014). This indicates that Vietnam lacks a support structure that can protect drug users – and help them to protect themselves – against stigmatisation.

Summary

Our analysis of the techniques that PWID in Vietnam employed to manage drug-related stigma shows a variety of emotion-focused coping strategies. These strategies helped to manage the failing information, the feeling of guilt and shame and to negotiate a social status for the individuals. During this process, participants mobilized their cultural resources to build a pro-

social image that imbued the key values in Vietnamese society. This embodied cultural capital might help them to gain a higher social status within their immediate, bonding networks. However, they lacked the objectified and institutionalized cultural capital that might be more valuable in linking and bonding networks. That PWID have the same concerns and aspirations to nonusers advocates against the simplistic stereotype of the irresponsible drug user.

The lack of solution-focused strategies signifies that the existing coping tactics of PWID might not have a significant impact in improving their situation. While family and drug using peers do not seem to help participants to deal with stigma, the role of institutional mechanisms that provide support to PWID was invisible. Thus, our participants were not passive in dealing with stigma in their everyday life. However, the effectiveness of their stigma management strategies was limited in reducing the negative feelings about themselves and in negotiating their status within bonding networks. Participants lacked qualifications and support structures that could help to lift them out of their situation.

CHAPTER 7. LIVING WITH HIV IN THE ERA OF EXPANDED TREATMENT — THE BIOGRAPHICAL IMPACT OF HIV

HIV/AIDS in Vietnam

The Asia-Pacific region with 5.2 million people living with HIV (PLWH) is the second-largest area of the HIV epidemic behind Africa (UNAIDS, 2019). The region has a high prevalence of HIV among key populations of people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW) (UNAIDS, 2019). Treatment coverage in Asia-Pacific is much lower than in Africa, Western Europe and North America (UNAIDS, 2019). Although studies in Thailand, China or Vietnam have contributed important knowledge on the lives of Asians living with HIV (Liamputtong et al., 2012; Ma et al., 2016; Tran et al., 2018), current literature regarding the HIV experiences is still limited, compared to what has been documented in African and Western countries. If in Africa, HIV affects the general public instead of key populations (Taylor et al., 2013), in Western countries, the epidemic's driver is homosexual sex, instead of injection drug use (Sullivan et al., 2014). The preoccupation of Western HIV patients has moved from early death to aging with HIV (Wing, 2016). Our study contributes to the knowledge gap by describing how HIV-infected PWID live with the infection in Vietnam, ten years after ART has expanded nationwide.

Vietnam's HIV epidemic remains concentrated in key populations. PWID have the highest HIV prevalence (14%), followed by MSM (12.2%) and FSW (3.7%) (UNAIDS, 2018b). According to some statistics, PWID contribute up to half of new HIV infections (World Health Organization, 2014). Compared to other Southeast Asian countries, Vietnam has a lower HIV prevalence among adults (0.3%) and among PWID (UNAIDS, 2018a). No incident data is

available. The epidemic peaked with 263,000 PLWH in 2005 and ART before this year was almost absent (UNAIDS, 2018b). Since 2005, Vietnam has received major funding from PEPFAR and Global Fund to provide free ART in all provinces. This expansion resulted from the global AIDS response that reduced treatment costs and increased support to AIDS care in low-income countries (Messac & Prabhu, 2013).

Improvements on treatment thresholds boosted the number of people receiving treatment and decreased AIDS mortality. In 2005, PLWH were entitled to ART only when their immune system was gravely compromised (D. B. Nguyen et al., 2013). As treatment eligibility with regards to CD4 count at intake increased from 200 to 350 and from 350 to 500 cells/mm³ in 2009 and 2015, the number of people receiving treatment has gone from 38,100 in 2009 to 125,000 in 2017 (Ministry of Health, 2009, 2015; UNAIDS, 2018b). However, despite having the greatest access to care, only 53.4% of PWID in Vietnam were on ART (UNAIDS, 2018b).

HIV and the biographical disruption framework

HIV infection became a chronic disease since the advent of ART in the mid-1990s (Messac & Prabhu, 2013). PLWH have since enjoyed a healthier life with little compromise of life expectancy. However, uncertainty is common and threatening patients' well-being (Furlotte & Schwartz, 2017). HIV infection is particular for its long-term asymptomatic nature and highly stigmatized status. It is associated with socially disapproved behaviors such as drug use or sexual promiscuity. Coping with stigma is, therefore, central in living with HIV (Kaplan, 2014).

The biographical disruption theory posits chronic illness as an experience “where the structure of everyday life and the forms of knowledge underpin them are disrupted” (Bury,

1982). Living with chronic illness involves the disruption of taken-for-granted assumptions and behaviors of the person who must figure out what is going on and then give meaning to her illness. The person, thus, embarks on a fundamental rethinking of her life and identity. How a chronic illness means to a person depends on its practical consequences and symbolic significance to her. Response to the disruption caused by chronic illness involves the mobilization of different resources.

Many studies about the experiences of living with HIV or HCV using the biographical disruption framework have critiqued and extended Bury's classical theory. Different factors might alter the symbolic meaning of a chronic disease and therefore define its biographical impact to be disruptive or reinforcing (Carricaburu & Pierret, 1995; M. Harris, 2009; Olsen et al., 2013; Wouters & Wet, 2016). Such factors include prior hardships in life (Ciambrone, 2001), patients' socioeconomic status (Kaplan, 2014; Olsen et al., 2013), the experiences of injecting drugs (Olsen et al., 2013), or contextual factors (Dageid & Duckert, 2008; M. Harris, 2009). As PWID possibly experience multiple life struggles due to their drug use, the biographical disruption approach would help to illuminate the relative importance of HIV infection in participants' lives and the ways they cope with it.

We arrange three main themes chronologically as the disease unfolded. The first section describes how people reacted to the diagnosis that formally established their HIV-positive status. The second part is about adjustments to the new situation, including strategies to deal with uncertainty and to enhance survival. The last part presents participants' key social resources, particularly family and peer group support.

The diagnosis event

1. Initial reactions

“I cried all the way home”

Receiving the HIV positive diagnosis was traumatizing for most participants in the sample. Generally, the ones who did not anticipate the diagnosis felt most shocked. They talked at length with intense emotions on this experience. Many of them reported having been extremely careful with their injection practices:

I'd been very strict with my consumption. I really don't know how I got infected. When I received my diagnosis, I cried all the way home. (Male, 36, married, peer worker)

Young and single men appeared to be more devastated at the foreseen incapability to fulfill their role expectations of prolonging the lineage and tending aged parents. During active drug use, they still considered a normal life to be just a decision to stay abstinent away. However, with the positive diagnosis, this project became unrealistic:

If I hadn't been infected, I would've been married. Since that day, I'd no more intention to build a family of my own. (Male, 34, single, odd jobs)

In Confucian societies, adult children, especially sons, have a moral obligation to look after aged parents (Warmenhoven et al., 2018). The failure to conform to this obligation tormented participants. A participant cried when he described how sorry he was for not living long enough to return the service his parents had given him:

When giving birth to a child, parents expect him to live a good life. First, it's for him. Second, it's for them to rely on him. [...] With my bad luck, all I can tell my parents is I'm sorry. (Male, 31, single, unemployed)

Men with children seemed to deal better with the HIV diagnosis. They felt depressed but they were more preoccupied with how to keep their loved ones safe from the infection. Moreover, having children, these participants had their role expectations somehow achieved.

“I thought I’d be sick”

The other participants who remained calm at the news somehow had prepared for it. Four women in our sample contracted HIV from their partner and had witnessed their partner dying of AIDS. They reported feeling distressed at the diagnosis but did not elaborate much on how the diagnosis affected their life. They seemed to have come to terms with their diagnosis.

He told me he got it [HIV] as he came back from the hospital. I said: “That’s fine. We will die together.” I got tested after I left rehab. It was positive, and I got on medications. I felt fine, because I already accepted I had it. (Female, 40, cohabited, sex worker)

For others, seeing friends with whom they had shared needles dying of AIDS prepared them for the worst:

I felt okay, since I thought I’d be sick. Because the people in the group I did drugs with, all got sick. (Male, 31, married, bricklayer)

Others in this group received their diagnosis in rehabilitation centers. The high HIV prevalence between 30% and 65% (Martin et al., 2009) might make being HIV-positive a norm rather than a difference: Moreover, that HIV-positive participants in rehabilitation centers received support and not rejection might explain their calmer reactions.

Learning about it in the center was not too hard. I was surrounded by people like me, and many were positive. (Male, 35, single, billboard worker)

2. Secret and disclosure

Keeping the diagnosis secret was a common practice. Participants who were most shocked felt disclosure a more challenging task. While being diagnosed with HIV infection brought about the image of physical death, the expected social death as people knew their status looked more daunting. Most participants withheld the secret until they felt ready to cope with their family's reactions. However, some still had not found the right moment to disclose although they had received their diagnosis years ago:

My parents keep asking why I'm so thin. They don't know I'm sick. I don't want them to be shocked. Their hearts aren't good. And I'm the only son. (Male, 42, single, waiter)

Being the one carrying the family lineage, this person did not dare to disappoint his parents with his status.

Living with the secret could make participants feel depressed and worsen their health by blocking treatment. A young man received his diagnosis a few months before our interview. Although peer workers kept urging him to enroll in treatment, he hesitated, fearing that his neighbors would learn about his status. He died a year after we met, still without treatment.

The story below of a female participant shows how keeping secrets could lead to disastrous consequences. That woman and her boyfriend were both HIV-positive. However, they were unaware of each other's status. She learned about her boyfriend's secret when she saw a bottle of ART medications at his home. Still, she did not disclose her status since in his eyes, she was a "good girl." That woman decided to stop treatment as she moved in with her boyfriend. At seven-month pregnant, she ran away from him as he became violent on

stimulants. Her baby girl was infected. The participant blamed herself badly for “having wasted” her daughter’s life.

Keeping secrets could go the other way. In the two cases whereby participants were tested during hospitalizations, their parents received the news first-hand. However, the parents were too afraid to disappoint the young men whose lives were “largely open” that they decided to keep it a secret. The patients only learned about their status several years later and enrolled late in care.

Most family reacted positively as they learned about the diagnosis. Parents and spouses cried with participants and urged them to get treatment. A participant felt relieved when his mother accidentally found his test results but did not react as he had imagined:

Now things have gone back to normal. I had thought disclosing to her was announcing her my death sentence. (Male, 35, married, plumber)

Even in families whose reaction was not entirely supportive, no family expelled the participants because of their infection. Panic eventually occurred, often due to misunderstanding of HIV transmission. Although participants might not see their diagnosis as a catastrophe, they might feel depressed because of their family’s reactions:

My daughter cried that we’d be issueless, that our family had only a grandson, and I should let my son’s family move to live with his in-laws [to prevent the children from being infected]. (Male, 63, divorced, unemployed)

This man had thought about killing himself as his grown-up children prevented him to touch his grandchildren. In another case, a woman panicked when she learned that his brother-in-law

who had been looking after her young son was HIV-infected. She brought the boy to the hospital for a test, then left the house with her children.

Adaptation phase

Unlike the reactions to the HIV-positive diagnosis, the adaptation strategies are quite homogeneous in both genders and across the age range. Most socio-economically disadvantaged individuals seemed to struggle with more challenges. As the initial emotions were over, participants gradually adjusted their taken-for-granted life assumptions. This did not, however, exclude moments of depression and regret as they looked into the past. Three prominent aspects of this phase included feelings of uncertainty, attempt to control one's mind and other adjustments.

1. Uncertainty

The uncertainty of being HIV-infected remained consistent throughout transcripts, although most participants were on treatment. HIV-infected peer workers who, by their good health and meaningful lives, had helped many clients to get into treatment, were not immune to this feeling. In one casual conversation, we were surprised to hear peer workers talking about buying lands for their tombs. This topic, unsuitable for people in their forties like them, suggested peer workers projected their future in terms of early death.

Uncertainty expressed in a lack of confidence in the future. A participant explained why he could not project his life in three years:

I know people who've been on ART for twenty-five, twenty-six years and they're fine, just like everyone. However, ART's effects depend on individuals. Those who respond

well to it will last long. Those who don't won't, and will develop illnesses. (Male, 36, single, unemployed)

This apprehension about the future contrasted with the hopeful tone of HIV-negative participants who typically projected getting married, getting a job and taking care of parents after quitting drugs.

The dual attitude of belief and skepticism regarding ART in the above testimonial was common among HIV-positive participants. That person believed ART saved lives. However, he was unsure whether he could be one of “those people” who enjoyed such effects.

The skepticism about ART efficacy possibly resulted from participants' common exposure to AIDS-related deaths in the previous period when people received ART late and died en masse. Half of our participants had witnessed someone dying of AIDS. Sometimes, that person was their partner or dear friend. Participants in their thirties commonly said peers of their age, whom they used to hang out with, all had died. The horrendous image of AIDS-related deaths kept haunting our participants and prevented them from feeling relaxed in treatment.

2. “It’s all about your mind” — The key strategy to survive from AIDS

As participants considered the progress of HIV infection to be unpredictable, the only thing they felt in control was their mind. Participants consciously tried to maintain an optimistic attitude. Positive talks immediately followed narratives of “down” moment, as if talking in a depressive tone would harm their survival. Maintaining optimism involved cheering themselves up, guarding against negative thoughts and maintaining a lifestyle “as if I was not sick.”

For our participants, optimism was not only an attitude, but a survival strategy. Survival was “all about your mind” and a positive mindset contributed to half of the success:

If you can't control your mind, [HIV] 'd take this opportunity to progress, you'll develop disease after disease. When you're mentally strong and you take medicines, medicine 50 [percent] and your mind 50 [percent], you're almost normal. (Male, 36, single, unemployed)

This person's commitment to positive thinking came from a fear of negative thinking. A weak mind would trigger degradation, “disease after disease” that inevitably leads to death. In this battle with HIV, although he did not deny the role of medication, he could not totally trust it either. He assumed responsibility for his survival, constantly watched and redirected himself into positive thinking.

Participants tried different means to avoid negative thoughts. Some distracted themselves in social encounters while others relied on work:

When I go out and see people, I can forget [about my situation]. But when I'm home alone, I can't keep myself from overthinking. (Male, 31, single, unemployed)

This is why I like going to work. Working prevents me from being pessimistic, from delving into my sorrow, from ruminating about my mistakes. (Female, 45, divorced, factory worker)

3. Other adjustments

As the initial shock was over, people focused more on self-care and caring for the family. Two thirds of participants reported good ART compliance. Non-compliance, however, did not necessarily mean no self-care. Four participants in the non-compliant group showed great concern for their health. Nonetheless, they trusted their bodily feelings such as

“darkened” or “brightened” skin, or general impression of health, more than medical information. Skepticism in treatment efficacy might lead them to manage their treatment themselves.

Self-care sometimes involved self-medication with drugs. As mentioned earlier, some participants used drugs to divert their mind from negative thinking. They also used heroin to dismiss symptoms like tiredness or diarrhea. One person refused getting into methadone treatment for thinking methadone was bad for PLWH’s health.

Lack of self-care interwove with the lack of social support, poverty, addiction and comorbid mental disorders. Having no supportive social connections (e.g. those living alone) appeared to be the major cause of self-negligence. These participants, often preoccupied with making ends meet or getting drugs, had no energy to look after themselves. A participant who was depressed and drunk a lot said:

My life is so uncertain that I can’t take care of myself. I don’t even try. People who have a job, a family, something to hope for, are different. I have no reason to live for. (Male, 50, single, unemployed)

This attitude was typical among most disadvantaged participants. Not only were they stuck in difficulties, they had no motivation or support to overcome the situation.

Most participants were concerned about their family. When HIV-positive parents learned about their infection, they worked harder to save for their children in case they would pass away early.

Now I’m just preoccupied with how to make money to raise my two children. [...] But later ... when I’d no longer be able to work, I’d have to ask others in my family to help them. (Male, 36, married, peer worker)

This participant was confident in his children's future as he still had siblings and his mother. Family in many cases was the most reliable support source, at least for basic needs. Individuals without children committed to treat their parents and other family members the best they could as long as they were alive.

Men without children felt more relaxed when they found a male heir to carry on the lineage and ancestor worship. They invested in their heirs time and material possession. Two participants gave their nephews their inherited lands as an exchange for the care that the heirs would give them when they passed away.

My younger brother has a boy and a girl. So no need to worry that no one would offer me a bowl of rice [when I die]. I teased my nephew: "When I die, give me a bowl of rice. If you can't, just send me to a pagoda." (Male, 35, married, plumber)

Resources

Our participants' main resources were family and peer support groups. The role of religious faith and relationships with treatment providers were less significant. While not all participants were actively looked for support, most engaged in maintaining their social support with reciprocity.

Family support. As families knew about participants' HIV-positive diagnosis, they provided individuals with food, medical care and reminded them to take medications on time. They became more indulgent with participants. When Mrs. X, mother of a son hospitalized for AIDS, saw him agonizing in withdrawal, she cried and went to beg a drug dealer to sell her a heroin dose. Family members often ceased to tell participants to quit drugs. They gave participants pocket money with an implicit understanding participants would use it to buy drugs.

When my parents weren't aware of my diagnosis, they told me to quit drugs and get married. But now they no longer talk about these things. They just ask how I'm doing, encourage me to reduce my drug intake and to eat more. They're afraid that too much [of heroin] would damage my viscera. (Male, 31, single, unemployed)

Thus, their families were no longer preoccupied of participants' future. They prioritized participants' health and survival instead.

Taking care of HIV-infected individuals was an act of both family obligation and love. After the disclosure, some parents called a family meeting and explicitly asked the siblings to take care of the participant. Family members seemed to believe participants would not live long with HIV, hence they tried to accommodate their loved ones as much as possible. A wife of an HIV-positive participant worried about her husband:

He can die anytime, who knows. All depends on heaven's will. I will do the best for him until he lies down. (Female, 31, widow, unemployed)

Peer support. Peer support was important for both participants and peer outreach workers. When clients came to group meetings of PLWH and realized many people were like them, they no longer felt isolated. The following quote retrieved from our conversation with a peer worker, wife of a drug user, exemplified this mental transformation:

I used to have HIV in my mind, in my sleep, on my lips when I ate. [...] The first time my husband and I attended a peer group meeting, I recognized many people were like us. Afterwards, I was no longer obsessed with the infection. (Female, 47, widow, peer worker)

This realization was common among participants who came to the first group meeting. Joining peer support groups motivated that person to become a peer worker herself.

The sense of belonging and emotional assistance participants had at peer group meetings contrasted with the stigma and discrimination they encountered in the outside world:

People care about me. Before [I joined the group], no one did so. Now people care when I get sick, and they buy me insurance. (Female, 40, cohabited, sex worker)

People come to group meetings to be understood. In this society, we have no right to ask others to treat us equally when we're sick [HIV-infected]. (Female, 45, divorced, factory worker)

The importance PLWH gave to peer group meetings was of a different quality than what HIV-negative individuals assigned to this socialization. Although HIV-negative participants appreciated the group's atmosphere, they did not see it as influential to their lives.

For peer outreach workers, seeing their clients' improvements brought meaning to their existence. Seeing others' situations might move them from hopeless to hopeful:

Many were doing worse than me. Some didn't even have enough to eat, they had no family, nowhere to live. I asked myself, "why these people still wanted to live, but I didn't?" (Male, 36, married, peer worker)

Relationship with HIV treatment providers. Participants appreciated treatment, however, the relationship with HIV treatment providers did not appear to be meaningful to them. Although all participants described HIV professionals as "nonstigmatising," "devoted" or "supportive," they did not communicate with providers about their drug interactions concerns or co-morbid diseases.

Discussion

This article expands the knowledge of how HIV-infected PWID in an Asia-Pacific context where HIV treatment became available much later than in developed countries. Using

the biographical disruption and intersectionality frameworks to investigate participants' experiences from receiving the positive HIV diagnosis to subsequent adjustments, we argue that how PWID live with HIV depends on different social processes according to their gender, age and the physical and structural environment they were in.

The diagnosis event. Vietnamese PWID perceived the HIV-positive diagnosis in similar ways that people of different cultural backgrounds did (Anderson et al., 2009; Kaplan, 2014; Liamputtong et al., 2012). The diagnosis triggers a process of disruption and adjustment. Feeling shocked signifies the diagnosis clashed with participants' taken-for-granted life assumptions, shaped by different factors including their gender and age. Young and single men experienced being HIV-infected as more disruptive than addiction. Doing drugs still allows them to fulfill social expectations of prolonging the family lineage and tending elderly parents. However, HIV-infected individuals are perceived as no longer able to produce a healthy male heir or to be people their parents could rely on.

Having children means differently in different contexts. Current literature focuses on European, American and African contexts. Other than being described as a biological need, the procreation desire relates to the universal meaning of parenthood as a normality expression (Carlsson-Lalloo et al., 2016) and a personal achievement that enhances individuals' social status (Taylor et al., 2013). Having children is a way to be remembered after one's death in Africa (Taylor et al., 2013). In resource-limited settings, children can serve as parents' "life insurance" that supports them in their old age (Dageid & Duckert, 2008). Procreation is important to our participants to fulfill their role duty, which is critical to one's identity in Confucian societies. However, unlike most South African participants in a study who felt encouraged by ART in childbearing (D. Cooper et al., 2007), our participants were not

confident to consider it, maybe because of the negative status of HIV in Vietnam and the lack of trust in treatment both ART and prevention of mother-to-child transmission services (Tran et al., 2018). The (perceived) inability to reproduce was devastating to their role-related identity.

Gendered social norms might explain why drug-injecting women appeared to live with HIV infection more peacefully than their male counterparts and why drug-injecting men perceived HIV infection to be more disruptive than addiction. This finding concurs with what Olsen, Banwell, & Dance (2013) found among HCV-positive women who inject drugs. They show that living with HCV reinforces instead of disrupting the biographies of these women as people living with constant stressors. While Asian societies often tolerate men taking risks, they expect women to stay discreet and assume caretaking responsibilities (Haritavorn, 2014). Thus, drug-using women might have already been subjected to a fiercer social rejection when their folks learn about their drug-related behaviors (O. T. Khuat et al., 2015b). Gendered norms might also enable women to invest in their other identities (such as mothers) instead of their HIV-infected one (S. Wilson, 2007).

Violence might also be salient in the lives of women who use drugs (Haritavorn, 2014; O. T. Khuat et al., 2015b). Although our female participants talked little about what they had endured, violence might have disrupted their biography prior to their HIV diagnosis. Extending Sinding & Wiernikowski (2008)'s claim that certain life circumstances might neutralize the experience of a chronic illness, our study suggests whether an illness is disruptive depends on whether other hardships fit the individual's social expectations.

The gender difference in starting ART concurs with studies that suggest women face greater stigma and more structural constraints than men in accessing HIV services (Amin,

2015) but men are more likely to present late to HIV care (Jeong et al., 2016). We explain this difference that women might come to terms more quickly than men with their HIV diagnosis.

The insistence on safe injection, right as participants began to inject drugs, suggests harm reduction campaigns have been effective. Still, our drug-using participants were less guarded about other transmission routes, especially unsafe sex. Since participants distinguished themselves from the stereotyped “careless” user, the feeling of injustice might heighten their shock at the diagnosis.

Different social norms govern different social contexts. The contrasting reactions to HIV-positive diagnosis of participants within and outside rehabilitation centers mirror the experiences of HCV-positive PWID inside or outside their community (M. Harris, 2009). Participants’ accounts reveal not only the normalization of HIV in rehabilitation centers, but also the role of peer support in dealing with the positive diagnosis, given that detainees often learn about their HIV status without counseling (Maher et al., 2007).

Managing one’s HIV-positive status to protect oneself and one’s family from discrimination is a common practice (Doyal & Anderson, 2005; X. Li et al., 2012; Pierret, 2007). For our participants, secrecy about HIV is to preserve others’ impression about oneself — the Goffmanian dramaturgical work, in the case of Duong, and to protect significant others from emotional pain, in the cases of Phong and the parents hiding the diagnosis from their infected sons. In the Vietnamese collectivist culture where people pay attention to each other’s life and where most adults cohabit with their parents or relatives, it is possibly hard for our participants to manage the secret. Keeping secrets could be consequential to the formation of intimate relationships (Carlsson-Lalloo et al., 2016). It could also lead to delayed treatment uptake and suboptimal treatment compliance.

The adaptation phase. The feeling of uncertainty characterizes the experiences of PLWH (Burchardt, 2010; Conroy et al., 2013). Their experiences relate to specific historical contexts of ART (Conroy et al., 2013), participants' socioeconomic status and available resources (Pierret, 2007). Coping with HIV involves family and peer support (Liamputtong et al., 2012; Wekesa & Coast, 2013), religious faith (Wekesa & Coast, 2013), or medical knowledge (Kaplan, 2014).

The availability of treatment affects how PLWH perceive the disease. Since ART in Vietnam has only been expanded since 2009 (Ministry of Health, 2009), the number of PLWH under treatment for more than ten years at the time of our interviews is insignificant. Thus, while most participants had experienced the short-term lifesaving effects of ART, they needed more time to build their trust in treatment's lasting efficacy. The few examples of people growing old with HIV could not dispel the horrendous image of AIDS-related deaths in the previous era. The testimonials of HIV-positive peer workers show how scientific knowledge is still at odds with participants' worldview constructed from their daily reality. Pessimism about the disease progression, prevalent in the contexts of nascent or non-existent ART, goes in contrast with the typical preoccupation of PLWH in developed countries about aging with HIV (Conroy et al., 2013; Pierret, 2001; Thompson & Abel, 2016).

Participants' emphasis on positive thinking as the most viable survival strategy finds an echo in the cancer literature. However, its scientific evidence in curbing the disease progress is inconclusive (Trusson & Pilnick, 2017). Moreover, repressing negative thoughts due to the overwhelming stress on positive thinking might compromise individuals' well-being (Jouret, 2010). At the collective level, repressing negative thoughts could enable blame on and isolation of those who express their depression (Jouret, 2010). Dageid & Duckert (2008) suggest that

positive thinking, as an emotion-focused strategy to cope with HIV, gains more popularity in resource-limited communities than in resource-rich contexts as people lack means and structures to do otherwise.

Controlling one's mind might compensate for the incomplete trust in medicine and the paucity of resources. Participants took care of themselves with what they had — their mind and what they already knew —self-medicating with drugs. The emphasis on the mind reflects the perception of Vietnamese PWID about willpower as the ultimate condition to quit drugs. The belief in self-discipline to overcome adversities might relate to the country's long history of warfare.

Drug use is often described as being driven by a biological need to cope with stress (Sinha & Jastreboff, 2013). However, our participants stressed it as a purposeful behavior whether to maintain their mental equilibrium or to self-medicate bodily symptoms. This exemplifies how drug issues interrelate with other life struggles and how interventions must target the intersection of different social and individual factors in the consumption of substances.

Consistent with other studies, we find that participants who live alone, who suffer from poverty, addiction and depression encounter more difficulties in coping with HIV (Dageid & Duckert, 2008; Liamputtong et al., 2012). However, unlike studies in Western countries, these individuals constitute a small minority in our sample, as living close to parents and siblings is the norm in Vietnam. Still, the structural barriers they encountered are worrisome. In countries with more resources, these patients might rely on professional care and welfare benefits to deal with such issues (Pierret, 2007). However, in contexts of limited welfare, overcoming life struggles is difficult (Dageid & Duckert, 2008; Liamputtong et al., 2012). This finding shares

the observation that the most disadvantaged HIV-positive individuals continue to suffer despite treatment advances and availability (Moyer, 2015).

The biographical disruption theory suggests the re-identification of life priorities would follow the disruptive phase as individuals rethink their lives and give meaning to their new situation. Other than trying to control their mind to cope with HIV, caring for the family becomes another priority for our participants. We agree that taking care of children is the greatest concern of parents living with HIV (Damar & du Plessis, 2010 ; Doyal & Anderson, 2005). Our participants also stressed on filial piety, including tending their parents and lineage continuity. This reflects the still prevalent Confucian ideology in Vietnam.

Resources. While the families of non-using PLWH predominantly respond negatively to an HIV-positive diagnosis (P Oosterhoff et al., 2008; Thi et al., 2008), the families of our participants were much more supportive. A study in China with HIV-infected PWID reports similar observations (X. Li et al., 2012). Being HIV-infected is likely a less stigmatized label than being a drug addict. HIV-positive individuals might acquire the sick status, which possibly activates the mutual support commitment within their families.

Peer support is a major resource for PLWH in most contexts (Kaplan, 2014; Liamputtong et al., 2012; Wekesa & Coast, 2013). Participation in PLWH support groups provides individuals a communal identity and facilitates their self-acceptance (Tsarenko & Polonsky, 2011). Our study confirms this observation and highlights that peer support means more to participants with HIV than to their negative counterparts. First, infected PWID might endure double stigma of drug use and HIV. Thus, they are more vulnerable and hold dearly the social support available to them. Second, PLWH appreciate the mental relief resulted from their

participation in support groups more as such attitude is critical to their survival. Third, for peer workers, helping others to get lifesaving treatment gives meanings to their lives.

The insignificant relationship between our participants and their medical providers differs from other contexts where patients highly appreciate their medical professionals' informational and emotional support (Carlsson-Lalloo et al., 2016; Kaplan, 2014). This might result from the short time given to patient—provider encounters. Typically, after the first month in treatment, patients will visit the clinic monthly to collect medications. Patient—provider encounters generally last a few minutes with a focus on adherence checking. No other support such as assessing patients' mental health or other life challenges is available. This practice is popular in most medical settings (Forsberg, 2011). As ART has gradually moved from specialized clinics into the insurance-covered healthcare system (Hammett et al., 2018a), the HIV patient-provider relationship will possibly become even more insignificant.

Our finding that the experience of living with HIV is embedded in an array of multiple social processes confirms earlier reports (Ciambrone, 2001; Dageid & Duckert, 2008). Still, it remains distinctive in its target population of PWID who are underrepresented in the HIV literature. Our community-based recruitment possibly captures more diverse perspectives of the general PWID population than a clinic-based strategy would do. Our study identifies important aspects that might serve to improve Vietnam's HIV intervention program.

Summary

Our data illuminates PWID's experiences of living with HIV in Vietnam, a lower-middle income context where ART has been expanded nationwide in less than a decade. Different factors shape participants' reactions to the HIV-positive diagnosis, including their gendered and age expectations, location where they received their HIV diagnosis, the role of

peer support, and HIV transmission routes. The HIV-positive diagnosis made participants rethink their taken-for-granted life assumptions. The adjustment strategies to deal with the disease are culturally shaped and reflect Vietnam's historical availability of treatment. Family and peer support groups, the major resources for participants to deal with the emotional burden of HIV, are critical to HIV intervention outcomes.

CHAPTER 8. CONCLUSION

Supporting people who use drugs to overcome the drug issues by themselves has gradually become the new focus in the antidrug strategies of several developed countries (Duke, 2013; Fleury et al., 2016; White et al., 2012). This goes in line with the perspective of harm reduction approach. Although significant evidence indicates that this is a real phenomenon, little is known about how people do it. Existing literature focuses mainly in Western countries where the socioeconomic conditions are much different than those in a lower income country. This research, with insights from Vietnam, contributes to illuminate how people who use drugs deal with drug-related issues, what facilitates and what hinders their efforts. To our knowledge, this study is the first of its kind that investigated the experiences of drug users in Vietnam over an extended period. Adopting a social constructionist perspective of drug use, this study paid attention to the power hierarchy in the Vietnamese context which might shape how the meaning of drug use is constructed. Seeing drug users as people who make choice, we looked for their strategies in coping with their daily hardship and underlying beliefs. This study registers in the perspective that drug issues are inseparable from other developmental issues. Looking at drug-related issues from that angle may allow better intervention initiatives to be developed.

Key findings and contributions related to PWID's daily hardships

This study started to inquire the current life situation of PWID in Vietnam and their daily challenges. Stigma and the stress of living with HIV emerged as the two major hardships our participants encountered in their daily lives. These challenges were pervasive in all facets of their lives and participants were preoccupied with them most of the time. Stigma seemed to have imbued in all fibers of participants' lives, left them nowhere to hide. While stigma towards

drug users is an obvious reality that no one denies, the reason for what drug users are stigmatized for is less clear.

While drug users have been stigmatized more or less since opium smoking became illegal in Vietnam in the 1950s, understanding what has turned them into a threat to the society would shed light on our society's functioning. While opium smokers represented the backward, colonial society that had been defeated, heroin users in the early 1990s represented the "poisonous" Western culture that went against the communist ideals. Drug-related stigma in today society implies the norm of self-reliance, whereby individuals were judged for their perceived lack of self-reliance. Individuals would probably regain the respect for themselves if they could demonstrate their self-sufficiency, no matter if they use drugs or not. The ability to be self-reliant depends largely on the socioeconomic conditions of participants, shaped by their education, vocational competency, and structural conditions like trends in the job market or the country's economic reform. Looking this way, drug-related stigma is functioning to keep the disadvantaged social classes in place. Poor people have insufficient education and vocational training. They remain in their disadvantaged place and have no opportunity to climb up the social ladder. Thus, drug-related stigma might be an expression of the underlying inequality but also a means to maintain the current hierarchy.

The prevalent internalized stigma in our sample might be a barrier to their effective coping. While stigma internalization is common, it is not necessarily an outcome of social stigmatization (Kusow, 2004; Riessman, 2000). Internalized stigma might lead to low self-esteem and low self-efficacy (Corrigan et al., 2016; Corrigan, Larson, et al., 2009), makes it hard for participants to resist social stigma and discrimination.

For those living with HIV, HIV-related stress seemed to wipe out the concerns related to drug addiction. The shock of learning about one's HIV positive diagnosis came from the image of not only a physical death but also a social death as the HIV-positive individual was deemed incapable to fulfill his or her role expectations. Despite medical advances, the feelings of uncertainty were prevalent in our sample. They might be characteristic to the common exposure to AIDS-related deaths due to the low coverage of ART until 2009.

Key findings and contributions related to coping strategies

Findings indicate that participants were active in coping with their daily hardships and they used all available means to do so. However, their coping was essentially emotion-focused as it looked to deal with negative emotions, to make the individual feel better without actions to alter the source of stress. Other vulnerable groups employed a more active style of coping. For example, gay men in the U.S. gathered together to create social movements to tackle the stigma towards homosexual sex (Carricaburu & Pierret, 1995); or American PLWH called upon legal assistance to deal with discrimination and attack towards them (Abrahams & Jewkes, 2012; Buseh & Stevens, 2006). Among the drug-using population, we found little literature about solution-focused strategies. Such instances include the social movements of people who use drugs in the U.S. to advocate for recovery-assisted policies (White 2007). Drug-using patients in the U.S. also have educated their medical providers about addiction as a brain disease and that everyone could become addicted. Such resistance is little to see in Vietnam. Some civil societies with support from non-governmental organizations advocated for the rights of people who used drugs but these activities have not been sustainable. In this research, we heard no indication of protest against the public stigma. Participants opted to withdraw from the source of stress (their relationships with neighbors, relatives or acquaintances) and not to try more

solution-focused strategies like education or protest. Evidences of long-term recovery have served social movements of American drug users to advocate for recovery-supported policies (White, 2007). Decriminalization of drug use has been shown to bring significant benefits to drug users (Greenwald, 2009). These kinds of support should also be considered in Vietnam.

People of higher social status seemed to experience less public and internalized stigma. However, our participants mostly possessed the characteristics that were appreciated only within their bonding network (like being the eldest son). They lacked the assets valuable in linking and bridging networks such as higher education, financial capacity or vocational skills. Thus, they did not have advantages in dealing with stigma in the broader networks.

The strategies to deal with HIV-related stress reaffirm that coping depends much on contextual factors and available resources. The lack of trust in ART and the great exposure to AIDS-related death made participants perceive that the only resource they could rely on was their mind. Thus, controlling one's thoughts became critical for the survival of participants. This also shows that participants perceived a lack of resources available to them and that they could not rely on their healthcare providers, or treatment. This attitude differed greatly from the confidence that people living with HIV in developed countries exhibited regarding medical advances in prolonging the life of HIV-infected patients.

Key findings and contributions related to the social and cultural capital of PWID in Vietnam

This study looks specifically at social and cultural capital as key resources that might help PWID to cope with their daily hardships. In general, we see that while these resources were helpful in negotiating patients' status in immediate networks such as families and friends, and securing most critical support, they had less impact in larger, more formal networks.

Social capital

As stigma gets into the fibers of participants' intimate relationships such as within their families, relatives and neighborhood, it damages their social support. As reciprocity is a motivation for making social support available, the perceived lack of self-reliance in the individual makes family members and others stop expecting to receive a similar support from the individual, thus, they might support the individual mainly due to value introjection or the obligations (Portes, 1998). Moreover, if parents in Confucian societies often expect to rely on their children once they get older, they do not look for it in their addicted children.

As the volume of social support depends on the network's size and on the volume of capital possessed by each member, we can see that the social network of most participants was limited and consisted mainly of their immediate family members and drug using peers as both internalized and social stigma made participants avoid social relationships. The relationship with drug using peers is pragmatic/symbiotic rather than supportive. Hence, participants often underlined that their drug using peers were not their friends. For participants who received methadone or HIV treatment, their relationships with healthcare providers were not significant (with HIV providers) or even negative (with methadone providers). Thus, it was unlikely that they received good support from these relations. Since the key networks of our participants were with family and peers - people who were similarly poor and of low education, the volume of their capital was likely to be low. Thus, participants might get access to emotional support or instrumental support but they were not likely to access to other kinds of support that could bring them opportunities to change their situation. Within their networks, most job opportunities they could find were low-skilled, low-pay and physical-intensive labor. Hence, it was hard for participants to accumulate capital to significantly improve their situation.

Vietnamese society is changing. The connections within the neighborhood might be less intensive. This definitely would bring changes in participants' social capital. Moreover, as the family reactions to participants' drug use show, survival support might be available but emotional company and guidance to drug users to improve their situation might be limited.

Still, evidences show that awareness-raising campaigns have been effective in relieving some of the stigma towards drug users. As drug use was less associated with HIV infection and that methadone was known to rehabilitate drug-dependent individuals, community stigma towards drug use seemed to improve. Also, some families also served as employers of drug-using participants. But this opportunity seemed to be in favor of participants with resources.

In the case of participants living with HIV, the key support consisted of necessities like food, housing or medications. It might catch the individuals when they "hit bottom" and help them to survive. Relatives might provide participants with some job opportunities, but these jobs were unlikely to be sufficient to sustain their living. In general, financial and informational support, critical to improve their situation, was not available to participants.

The only significant bridging network of most participants was the peer support groups. However, this network is not sustainable due to lack of constant funding. Our participants could also benefit from the bridging network in DRIVE where they could get referral to treatment and more information support regarding treatment.

Cultural capital

When assessing the cultural capital of participants, we were careful to take into account the context where specific cultural competency was valued. As theorists of cultural capital

stressed on the importance of domestic and scholastic transmission, my participants were at great disadvantage. Growing up in the economically gloomy decade after 1975, most families were unable to take time from work to invest in their children. Many participants had to drop out from school and leave home early for work. They also had no other formal education. Thus, all of them lacked the institutionalized cultural capital that was valuable in linking and bridging networks, especially in the market economy that is in favor of high-skilled workforce. Through this lens, the dominant group consists of businesspeople or the capital owner. As participants lacked institutionalized cultural capital and most had no means to acquire objectified capital (although some tried to do so by purchasing expensive motorbikes), what they had was the embodied cultural capital. This kind of capital expressed through their highlights of the key values they lived by: morality, self-reliance and correctness. These values were important in daily, informal exchanges to build informal relationships and might help them to gain a higher social status within their immediate, bonding networks but not immediately meaningful in broader networks. Low cultural resources also contributed in participants' lack of recreational and social activities that could build their linking social networks.

While we were unable to assess participants' mobilization of cultural knowledge in their social relationships, at least we could see it in action during the interviews. Participants used various techniques of neutralization negotiate their social status with the interviewer. Their emphasis on shared values might have established a common ground for positive interactions.

The assessment of participants' social and cultural capital shows that participants possessed the assets that were valuable in immediate networks such as the embodied attitudes, beliefs of moral norms and positions in their families, they lacked the resources that broader networks recognized like qualifications.

Although we focus on social and cultural capital as key resources for PWID to cope with life hardships, the role of financial capital is undeniable. Better-off drug users could afford more protection against stigma such as not having to show up in public to buy drugs or being able to maintain a decent appearance. We also see that wealthier families were able to secure job opportunities for participants. This confirms the hierarchy-maintaining role of social stigma.

Policy implication

The findings on stigma show that it is necessary to place drug-related stigma within the larger social context. Link & Phelan (2001) suggest intervention must be multifaceted and multileveled to address both the individual and structural discrimination. We recommend concerted interventions that take into accounts the many facets of PWID's challenges in life instead of narrowly focusing on the drug-use behavior.

At the policy level, income-generating legal aid would help PWID to regain a sense of self-reliance. First, it is necessary to have mechanisms to improve the implementation of current financial assistance laws for PWID such as low-interest loans (Government of Vietnam, 2014). Given the structural challenges of PWID, assisting them to navigate the administrative procedures and to build their capacity would be beneficial to increase their uptake of such legal aid. Second, the Government could recruit PWID for jobs that use best their expertise and at the same time benefit the society such as peer workers in treatment support programs. An insider's knowledge would help them to work effectively with other PWID to deliver harm reduction information, refer clients to treatment and assist patients during the treatment process. This

would not only help PWID to be financially independent and increase their social status but also give a meaning to their lives.

At the program level, findings regarding participants' experiences with institutional stigma in MMT clinics suggest that we need to develop addiction medicine, with specific training in medical schools. Addiction treatment professionals must learn that caring for people with substance use disorders requires more skills than just prescribing methadone. They should be trained to view the big picture where drug problems interrelate with other personal and structural issues to develop a comprehensive treatment plan with referral to social services. This might not effectively reduce institutional stigma but it could help to improve the quality of care.

Family should be considered to be the key player in helping PWID to better overcome their drug-related issues for two reasons. First, protecting family's happiness is a major motivation for PWID to end their relationships with drugs. Second, family is participants' main resource. Family should be involved in treatment plans to foster family commitment in helping PWID to regain their sense of self-reliance. Such recognition is important to reduce stigma and enable more support for PWID to achieve their life goals. We should remain aware that being on MMT could place the patient's identity in a "limbo" where they are viewed as "not quite junkie" but "not quite conventional" (Neale, 2013). This unintended outcome of treatment might have a negative impact on patients who wish to recover a "normal life" within their family. Programs should invest more efforts to strengthen patients' family support and to enhance the connection between clinics and families to improve treatment retention.

Medication-assisted treatment programs should be more patient-friendly. Since employment directly impacts quality of life and treatment engagement (De Maeyer et al., 2011;

Jackson et al., 2014), Vietnamese methadone programs should apply a more patient-centered dosing schedule to attract and retain service users, especially to accommodate those with traditional eight-to-five work schedules. As M. Harris & Rhodes (2013) argued, “generous constraints” would be beneficial in improving patients’ sense of control, in assisting their self-sufficiency, and in reducing risks, Vietnam can learn from other countries and allow take-home medicines for stabilized patients. This would also help significantly decrease the workload at the clinic. Other effective medications like buprenorphine or extended-release naltrexone, which require looser supervision, might also be helpful to improve the convenience of addiction treatment.

Findings about the experiences of living with HIV suggest that peer support is particularly helpful to patients to overcome the shock of the HIV-positive diagnosis and to positively adjust their post-diagnosis life. Sustaining investment for peer support organizations would greatly benefit treatment outcomes and patients’ quality of life — a new indicator of HIV treatment success (Guaraldi et al., 2019). Peer support organizations would likely compensate to the insufficient coverage of medical care for PLWH by providing much needed psychosocial services for patients.

Given the uncertainty of HIV patients regarding treatment advances, more informational support should be available at the clinics and at peer support groups. Healthcare providers might find novel ways to communicate such information with patients and help them to feel more confident in treatment. Peer support groups with the intervention of healthcare providers might allow patients to voice out their concerns regarding treatment effectiveness and have them clarified in a persuasive manner.

Limitations

Our peer-based recruitment compensates for PWID's usual mistrust of official institutions and facilitates open exchanges, which in turn generates rich data. PWID seemed open and willing to share their experiences. Still, the findings should be examined within our limitations. Most of our participants belong to the lowest social classes characterized by low education and poverty. They might encounter different barriers to assert their self-reliance than their counterparts with greater resources. Haiphong might also be unique in its transition from a rural, collectivistic lifestyle to a more urban, individualistic one. Thus, the challenges our participants experienced might be different from PWID in larger cities or in more rural areas.

The small number of women in our sample signifies the common challenge in recruiting drug-using women for research and intervention. Moreover, with a small sample of participants without social support, we cannot be certain about our observation regarding the convergence of different social processes among women and the role of social support in coping with HIV. The relative homogeneity in participants' socioeconomic background did not allow us to assess the impact of social status in HIV experiences.

The 1-year follow-up period is likely insufficient to see significant changes in the lives of participants. Our ethnographical observation at peer support groups was informative, however, peer outreach workers might be at a more privileged position as they were involved in more linking and bridging networks (e.g. with governmental offices, with the research team) and thus, had more social and cultural resources to cope with their drug-related issues. Moreover, while home visits could be a rich source of information, and discussions with family members would provide triangulating information about the challenges participants were

encountering, we could not do home visits as much as we wanted since participants preferred to not involve their family members into their drug issues.

Social desirability might prevent participants to disclose some of their income-generating activities that might be illegal such as sex work or drug dealing. This might somehow impact our assessment of their resources. Still, since our study focuses on social and cultural resources, this limitation should not gravely affect the study findings.

Future research

Several directions of research could emerge from this study. First, we can continue to investigate the question of recovery from drug addiction by conducting observational studies with people who use drugs, both in and out of treatment, over a longer period of time. Moreover, we could get a more comprehensive and accurate understanding of drug users' situation by observing them in their daily lives. Peer outreach workers with their insider knowledge could be trained to do this ethnographical observation.

Second, we can work with drug users and peer outreach workers to pilot initiatives to improve their lives. These initiatives should focus on improving their quality of life and strengthening their social functioning. Take-home doses for methadone patients and other treatment options, plus supporting services could be piloted to see the impact on participants' lives. We can use social workers to guide them through the current administrative process of social welfare and connect them to training and vocational opportunities. Prevention programs that target children from substance-affected families (Bröning et al., 2012) should also be piloted. These measures should aim at maintaining children in school and providing them with emotional assistance and guidance. As drug issues are interrelated with human history and inseparable with the mindset of our society, there is no quick fix but we can try to strengthen

the resilience in vulnerable individuals and build supportive communities to prevent drug-related issues.

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APPENDICES

Appendix 1 — Informed consent form

Notice of information for study participant

Title of Project: Recovery experiences of people who use drugs in Vietnam

Hello,

My name is Nguyen Thu Trang, a research staff at Hanoi Medical University and student of a doctoral program in France. I would like to invite you to participate in my research about the *Recovery experiences of people who use drugs in Vietnam*. The study seeks to understand the lives of people who use drugs, how they manage their lives and their resources overtime. Thus, we can develop appropriate programs to help them deal with their drug-related life struggles. The findings of this study will be presented in my dissertation, journal and conference articles in English.

Information about the study

This study belongs to the qualitative component of the DRIVE research. We would like to invite you to participate to this project for your experiences as a person who use drugs and for you have participated in DRIVE. We intend to invite 20 people who use drugs for interviews.

When you participate in this research, you will allow us to interview you at two rounds. The first round is from October 2017 to January 2018; the second round is from July to October 2018. Each round consists of one or two interviews. We would also want to visit your home and talk to your family, if you agree. Each interview lasts between one and two hours.

Recording

We ask your permission to record the interviews. The tapes serve solely for the research purpose. We will transcribe verbatim all recording tapes and use the transcriptions for analysis. We will not use the recording tapes and transcriptions for any other purpose.

The recording tapes might include personal information that is unintentionally disclosed during the interview, as we will not ask for your identifiable personal information. We will delete all these information before we conduct the analysis. All recordings and transcriptions will be labeled with codes and not with names or other identifiable information. We protect them with passwords in hard-drives. Only research staff can access to this data source.

Please sign at your choice:

_____ Yes, I agree to be recorded as described.

_____ No, I do not want to be recorded.

Risks

You might feel uncomfortable when you participate in this research. You might feel confused or distress when you are asked to reveal your personal information.

You can disclose your information unintentionally during the interviews although we will not ask for your personally identifiable information. We will not record this information.

Benefits

This research will not benefit you directly. It may provide helpful evidence and suggestions for others in future policies and programs. This might benefit people who use drugs in the future. Moreover, as you participate in the study, you can share your experiences and ask for information regarding HIV and addiction treatment or other related services. We will connect you to the DRIVE study for detailed instructions regarding the registration and referral process to ART and methadone clinics that meet your needs. If you feel uncomfortable or if you have any mental issue during the screening process, you will be referred to appropriate services at DRIVE.

Other options

You can decide not to participate in this study.

Confidentiality

As you participate in this study, the research staffs can access to your personal information including name, phone number and home address. If you agree to participate in this study, you allow us to access to the information you provided for DRIVE, including your drug use, HIV status, treatment status... All your personal information are kept confidential. We will do all means to protect your information, although we cannot ensure they are absolutely safe.

Unexpected issues might happen, at small chances, like laptops being stolen.

We apply a procedure to secure your information: (1) All electronic information will be encode and saved on a hard drive protected by a password; (2) The study team will not put your name on any saved copy of data; (3) Your data and consent form will be kept in a locked cabinet at Hanoi Medical University.

Compensation (incentives)

You will receive 200,000 Vietnamese Dong for each interview that lasts between one and two hours. You do not have to pay any expense for participating in this study.

Voluntary participation

Your participation in this study is totally voluntary. If you refuse to participate, you will not lose any benefit or medical service that you are receiving. You can stop the interview at anytime or ignore a question that you do not want to answer.

Other information

If you have any questions, please feel free to contact me:

Nguyen Thu Trang

Center for research and training on HIV/AIDS

Room 604, Building A1, Hanoi Medical University

No.1, Ton That Tung street, Hanoi

Phone: 0988 424,871

Email: ngn.thu.trang@gmail.com

Declaration of agreement to participate in research

I have read the notice of information and understood my role in this research. I have had the opportunities to ask for clarifications. If I have other questions, I can ask the investigators named above. I know that I can refuse to participate or withdraw from the interviews at anytime without my work, treatment or other benefits being affected. The investigators did not influence my decision. If I have any question relating to my rights as a research participant, I can call Nguyen Thu Trang at the phone number 0988 424,871 or email her at ngn.thu.trang@gmail.com. I certify that I am older than 18 years old and I decide to participate in this research. I will be given a copy of this consent form.

Data / /2017

Study participant
(sign and write your full name)

Investigator
(sign and write your full name)

Bản cung cấp thông tin cho người tham gia nghiên cứu
Trải nghiệm phục hồi của người sử dụng chất tại Việt Nam

Chào Anh, Chị,

Tôi là Nguyễn Thu Trang, nghiên cứu viên của Đại học Y Hà Nội và hiện đang theo học chương trình nghiên cứu sinh tại Pháp. Tôi mong muốn mời Anh, Chị tham gia nghiên cứu của tôi về *Trải nghiệm phục hồi của người sử dụng chất tại Việt Nam*. Mục tiêu của nghiên cứu là nhằm tìm hiểu cuộc sống hiện tại của người sử dụng chất, cách người sử dụng chất quản lý cuộc sống của mình và nguồn lực vật chất, xã hội của họ, cũng như những thay đổi trong cuộc sống của họ theo thời gian. Kết quả nghiên cứu này sẽ được trình bày trong luận án của tôi, viết bằng tiếng Anh, và được viết thành các bài báo khoa học, báo cáo hội nghị quốc tế và trong nước. Mục đích cuối cùng của nghiên cứu là giúp mọi người hiểu hơn về cuộc sống của người sử dụng, từ đó, chúng ta có thể xây dựng chương trình hỗ trợ phù hợp, cùng người sử dụng vượt qua các vấn đề họ gặp phải.

Thông tin về nghiên cứu

Nghiên cứu *Trải nghiệm phục hồi của người sử dụng chất tại Việt Nam* thuộc cấu phần định tính của nghiên cứu DRIVE mà anh, chị đang tham gia. Chúng tôi muốn mời anh, chị tham gia nghiên cứu này vì anh, chị có trải nghiệm của người sử dụng ma túy và đã tham gia nghiên cứu DRIVE. Chúng tôi dự kiến sẽ mời 20 người sử dụng ma túy tham gia phỏng vấn.

Khi tham gia nghiên cứu, anh, chị sẽ cho phép chúng tôi phỏng vấn anh, chị hai đợt. Đợt một trong giai đoạn từ tháng 10/2017 đến tháng 1/2018. Đợt hai trong giai đoạn từ tháng 7/2018 đến tháng 10/2018. Mỗi đợt sẽ có một hoặc hai phỏng vấn. Ngoài ra, chúng tôi cũng mong muốn được đến thăm nhà anh, chị và trao đổi với người nhà, nếu anh, chị thấy phù hợp. Mỗi cuộc phỏng vấn kéo dài khoảng 1 đến 2 giờ đồng hồ.

Ghi âm

Chúng tôi sẽ xin anh, chị cho phép ghi âm cuộc phỏng vấn như một phần của nghiên cứu. Các băng ghi âm sẽ chỉ được sử dụng cho mục đích phân tích bởi nhóm nghiên cứu. Chúng tôi sẽ chuyển tất cả các bản ghi âm thành bản giải băng dưới dạng chữ viết và sẽ sử dụng bản giải băng đó cho mục đích phân tích. Chúng tôi sẽ không sử dụng các băng thu âm cũng như bản giải băng vào bất kỳ mục đích nào khác.

Băng ghi âm có thể bao gồm các thông tin cá nhân mà có thể được tiết lộ không chủ định trong quá trình phỏng vấn, mặc dù chúng tôi sẽ không hỏi anh các thông tin cá nhân có thể giúp người

khác nhận diện được anh. Chúng tôi sẽ xóa toàn bộ những thông tin nhận diện như vậy trước khi đưa bản giải băng cho nhóm nghiên cứu phân tích. Mọi băng ghi âm và bản giải băng đều được dán nhãn với mã số nhận diện riêng biệt chứ không đề tên hay những thông tin nhận diện cá nhân khác. Các bản ghi âm và bản giải băng sẽ được lưu trữ dưới dạng file có mật mã bảo vệ và trong ổ cứng. Chỉ những cán bộ có thẩm quyền mới tiếp cận được với nguồn dữ liệu này.

Xin hãy ký tên vào lựa chọn của anh, chị:

_____ Có, tôi đồng ý ghi âm như miêu tả phần trên.

_____ Không, tôi không muốn bị ghi âm.

Các nguy cơ

Anh, chị có thể có một vài điều không thoải mái khi tham gia vào nghiên cứu này. Các cảm giác đó có thể bao gồm sự bối rối, cảm xúc buồn bã hay khó chịu liên quan đến việc tiết lộ thông tin cá nhân.

Anh, chị có thể làm lộ những thông tin cá nhân một cách không chủ định trong quá trình phỏng vấn mặc dù chúng tôi không yêu cầu anh tiết lộ bất kỳ thông tin cá nhân nào. Chúng tôi sẽ không ghi lại bất kỳ các thông tin nhận dạng cá nhân nào trong quá trình phỏng vấn.

Các lợi ích

Anh, chị sẽ không nhận được bất kỳ lợi ích cá nhân (trực tiếp) nào khi tham gia vào nghiên cứu này. Tuy nhiên, những thông tin từ nghiên cứu này có thể giúp ích cho những người khác trong tương lai. Ngoài ra khi tham gia nghiên cứu, anh có cơ hội chia sẻ trải nghiệm cũng như hỏi các thông tin về điều trị HIV, điều trị nghiện chất hay những dịch vụ liên quan. Chúng tôi sẽ kết nối anh, chị tới nghiên cứu DRIVE để được cung cấp những chỉ dẫn chi tiết về đăng ký và chuyển gửi đến các cơ sở điều trị ARV và Methadone nếu anh cần những dịch vụ này. Nếu anh, chị cảm thấy không thoải mái hay gặp bất kỳ vấn đề về sức khỏe tâm thần nào trong quá trình sàng lọc, anh, chị sẽ được giới thiệu đến dịch vụ phù hợp tại nghiên cứu DRIVE.

Lựa chọn khác

Anh, chị có thể từ chối tham gia vào nghiên cứu này.

Bảo mật

Do anh, chị là người tham gia nghiên cứu này nên nhóm nghiên cứu có thể biết các thông tin như tên, số điện thoại, địa chỉ liên lạc của anh. Đồng ý tham gia nghiên cứu này, anh, chị cũng cho phép chúng tôi tiếp cận được thông tin anh, chị đã cung cấp cho nghiên cứu DRIVE, bao gồm việc sử dụng chất, tình trạng HIV, tình hình điều trị... Mọi thông tin cá nhân của anh, chị sẽ hoàn

toàn được bảo mật. Chúng tôi sẽ làm tất cả mọi việc để giữ an toàn thông tin của anh mặc dù chúng tôi không thể hoàn toàn đảm bảo chúng được bảo mật tuyệt đối do những vấn đề không mong muốn, mặc dù ít có khả năng nhưng vẫn có thể xảy ra, ví dụ như trường hợp máy tính bị mất trộm.

Một quy trình sẽ được áp dụng để đảm bảo sự an toàn cho các thông tin mà anh, chị cung cấp cho chúng tôi: (1) Tất cả những thông tin điện tử đều được mã hóa bảo vệ và được lưu trên ổ cứng có mật mã. (2) nhóm nghiên cứu sẽ không đề tên của anh trên bất kỳ bản lưu trữ nào của điều tra; (3) dữ liệu và bản thoả thuận tham gia nghiên cứu của anh sẽ được giữ trong tủ có khoá tại Đại học Y Hà Nội.

Hỗ trợ (thù lao)

Anh, chị sẽ nhận được 200,000 VND cho mỗi phỏng vấn kéo dài từ một đến hai giờ đồng hồ. Anh, chị không phải trả bất kỳ chi phí nào khi tham gia nghiên cứu.

Tự nguyện tham gia

Sự tham gia trong nghiên cứu này là hoàn toàn tự nguyện. Từ chối tham gia phỏng vấn trong nghiên cứu này, anh, chị sẽ không phải mất đi bất kỳ các lợi ích hay dịch vụ y tế nào mà anh đang được nhận. Anh, chị cũng có thể ngừng dừng cuộc phỏng vấn bất kỳ lúc nào cũng như có thể bỏ qua bất kỳ câu hỏi nào mà anh, chị không muốn trả lời.

Thông tin khác

Nếu anh, chị có câu hỏi hay thắc mắc nào về nghiên cứu này, anh, chị có thể liên hệ với tôi tại địa chỉ:

Nguyễn Thu Trang

Trung tâm Nghiên cứu và Đào tạo về HIV/AIDS

Phòng 604, nhà A1, Đại học Y Hà Nội

Số 1 Tôn Thất Tùng, Đống Đa, Hà Nội

Điện thoại: 0988 424,871

Email: ngn.thu.trang@gmail.com

Tuyên bố đồng ý tham gia nghiên cứu

Tôi đã đọc bản thỏa thuận tham gia nghiên cứu và hiểu rõ vai trò của tôi trong việc tham gia vào nghiên cứu này. Tôi cũng đã có cơ hội trao đổi về các câu hỏi. Nếu tôi có những câu hỏi nào khác về nghiên cứu, có thể hỏi các nghiên cứu viên đã liệt kê phần trên. Tôi biết rằng tôi có thể từ chối tham gia hoặc rút khỏi cuộc phỏng vấn bất kỳ thời điểm nào mà không ảnh hưởng đến công việc, điều trị hay những quyền lợi khác mà tôi có. Các cán bộ nghiên cứu không ảnh hưởng gì đến việc quyết định của tôi. Nếu tôi có bất kỳ câu hỏi nào về quyền lợi của mình với tư cách là một người tham gia nghiên cứu, tôi có thể gọi cho Nguyễn Thu Trang tại số điện thoại 0988 424,871 hoặc email ngn.thu.trang@gmail.com. Tôi chứng nhận rằng mình từ 18 tuổi trở lên và tự quyết định vào việc tham gia nghiên cứu này. Tôi sẽ được cung cấp một bản phô-tô của bản thỏa thuận này để lưu giữ.

Ngày / /2017

Người tham gia nghiên cứu
(ký và ghi họ tên)

Nghiên cứu viên
(ký và ghi họ tên)

Appendix 2 — Interview guides

First interviews

General Information

I would like to begin the interview by asking you to talk about yourself, including your age, your occupation and your family.

- How old are you ?
- How many are you in your family? How many of them live with you?
- Since when have you lived in Haiphong?
- Where do you live most of the time? (in your own apartment/house, at your parents', your family's, in the street ...?)
- Are you on methadone treatment? antiretroviral treatment? How long have you been with each treatment?
- How much is your monthly income? What do you think of this amount of money? Do you have a paid job? If so, what is it like? Is it full-time or part-time? When did you start this job? What training have you done?
- Do you have other financial support? If so, from who?

History of drug use

Past

Tell me how your drug use started.

- What is the first illegal drug you have done?
- How did you start using it? (Describe the situation: with whom, where, when, why?)
- What did you (and your friends) think about that drug at the time?
- And how did your drug use progress?
- What other substances have you consumed? (legal and illegal)
- What do you think about these drugs?
- Before, when you started using drugs, how did your family react? And your school? How did your studies go?
- Have you tried to stop using it? How many times have you tried to do so? How successful were these attempts? Why did you want to do so?
- Tell me about these periods. How did you stay sober? What helped you (or did not help)? Was there any important event that took place at those times? What had changed and made you stay sober?
- Describe your life in these periods of abstinence and of active drug use.

Present

- And now, what substances do you consume? Since when (if it is different from the first substance)? In which situation? Why did you change to this substance?

- Describe how you consume substances at the moment (frequency of each substance, routes of administration, where, when, with whom, cost of a dose)
- How can you afford this consumption?
- Describe the effects of each substance. What are your motivations to consume each of them?
- Is drug use a problem in your life? If so, which substance is the most problematic in your daily life? How has this affected your life?
- Now, do you think of stopping drug use? Why? If yes, how do you plan to do it?

Relations with friends

- How many friends are you frequenting right now? How many are close friends? Are they drug users? Do you have friends who do not use drugs? or who have ceased to use drugs?
- What do your friends and you do together? With the friends who do drugs? With those who do not?
- What do you like about relationships with these friends? And what do not you like? Why?
- Do you have any other acquaintance that you often see? Who are they? What do you do together?
- Is there anyone you admire among your acquaintances? If yes, why?

Relations with medical services

- When you get sick, do you go to medical services? How do you find them?
- What is good about these services? And what is not?
- What do you think about methadone treatment? What is good? or not good?
- What do you think of antiretroviral treatment? What is good? or not good?

Future

- When you were little, what did you want to become? Have you achieved it? If not, why? If yes, what do you think of this success?
- What are your wishes at the moment?
- What do you plan to achieve? What will facilitate your project? What are the difficulties?
- In your opinion, who and what could help you reach your objectives? And how ?

Second interviews

Objectives

- To collect additional information for the theme of Navigating stigma and discrimination
- To further investigate the theme of recovery capital, including how people actively build their recovery capital

Drug use — from discreditable to discredited

- Can you describe how you started using heroin?
- How often did you visit your family at the time as you worked far from them? Why did you go back to live with your family? How was your income then?
- When did your family know about your drug use? In what situation? Who knew first? Then why others knew? How did people react to that news?
- Changes in social evaluation towards drug users:
 - o When did you start perceiving that others stigmatized you? How did their attitudes change over the course of your drug use?

Social status

- What is your birth order in your family? In your extended family? Are you responsible for worshipping ancestors?
- What is your inheritance rights?

Family stigma (addiction)

- How do you perceive the attitudes of your family towards you? How about your siblings? How about your parents? How about your relatives? How do your relatives' attitudes affect your family?
- How about your in-laws? (parents, siblings, relatives?)
- For what reason do you think they react that way?
- How do their attitudes affect your life?

General experiences of stigma

- Where do you feel like being stigmatized most?

Coping

- When you hear people talking negatively about you, how do you feel?
- What do you do to cope with that? To feel better?

Intra-group stigma

- Heroin vs. Meth users:
 - o Where do you get information about ice? Which magazine? Do you use social media?
- Have you ever perceived any discrimination from other drug users? How?

Social stigma

- How do you feel that stigma towards drug users prevent you to work?
- What benefits do you think stigma towards drug users is taking away from you?
- Who do you think would benefit when you are stigmatized?
- Has somebody told you that you were a dependent person? Who said so?
- How does your drug use affect your life? Other than the trust of your family, what do you think you lose when you're addicted to drugs? (e.g. your inheritance rights?)

Recovery capital

Community capital:

- What communal activities that you have in your neighborhood? Have you ever joined these activities? How do you see the social ties in your neighborhood? Have you ever joined the communal meetings? How satisfied are you with that neighborhood? Do you think about moving to somewhere else?

Workplace:

- How about your workplace? Do you have communal activities? Do you join these? How do you think about these activities?
- How satisfied are you with your workplace? Do you think about getting another job?

Family capital:

- In your extended family, how often do you see each other? How do you join your family activities? What do you think about these?

Personal capital:

- Do you exercise? How often? How do you take care of yourself?

General:

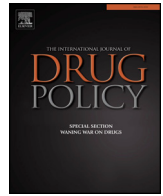
- What do you think helps you to be relatively stable like you are now? (e.g. not in jail or in compulsory rehab, still living with family...)
- Are you satisfied with your life now?

HIV

- How does being HIV-infected affect your thoughts about your children?
- How does being HIV-infected affect your parental responsibilities?
- When you learned about your HIV, what did you think about its impact on your role (as a child? As a spouse? As a parent?)

Appendix 3 — Published and submitted manuscripts

1. Nguyen, T. T., Luong, A. N., Nham, T. T. T., Chauvin, C., Feelemyer, J., Nagot, N., ... Jauffret-Roustide, M. (2019). Struggling to achieve a “normal life”: A qualitative study of Vietnamese methadone patients. *International Journal of Drug Policy*, 68, 18–26. <https://doi.org/10.1016/j.drugpo.2019.03.026>
2. Nguyen, T. T., Jauffret-Roustide, M., Le, M. G., Visier, Laurent. How to be self-reliant in a context of stigma? The dilemma of people who inject drugs in Vietnam. Manuscript accepted to *International Journal of Drug Policy* (August 2020)
3. Nguyen, T. T., Jauffret-Roustide, M., Des Jarlais, D., Le, M. G., Visier, Laurent. “It’s all about your mind” – key strategies to survive AIDS for people who inject drugs in Vietnam. Manuscript submitted to *AIDS Care* (manuscript prepared)
4. Nguyen, T. T., Jauffret-Roustide, M., Des Jarlais, D., Khuat, T. H. O, Duong, T. H., Nagot, Nicolas, Le, M. G., Visier, Laurent. “I’m not like others”: stigma navigation by people who inject drugs in Vietnam. Manuscript submitted to *Drugs: Education, Prevention and Policy* (May 2020)



Research Paper

Struggling to achieve a ‘normal life’: A qualitative study of Vietnamese methadone patients



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ABSTRACT

Background: Methadone maintenance treatment, initially introduced in Vietnam for HIV harm reduction, has marked a significant switch in the country’s drug policy – from addiction as a moral issue to addiction as a brain disease. After the some initial outstanding achievements, the programme is facing a high dropout rate that threatens both goals of HIV prevention and drug treatment. This sociological study, as part of an HIV intervention research project, explores the challenges and opportunities that individuals who use drugs are faced with in relation to addiction treatment.

Methods: A qualitative study among drug users with and without methadone maintenance treatment experiences recruited by peer outreach workers. We conducted 58 in-depth interviews and 2 focus groups between 2016 and 2017.

Results: The start of treatment brought about significant feelings of success as heroin use was no longer compulsive. However, being in treatment programmes is also challenging with respect to continuing the recovery process. Barriers to retention include a popular fear of methadone as another harmful drug, a feeling of dependence related to the current practices of methadone treatment programmes and a poor therapeutic relationship. In the face of such challenges, the two major motivations that keep patients in care come from the desire to completely break up with heroin and the pursuit of family happiness.

Conclusion: The current practices of methadone programmes pose challenges to patients’ recovery efforts from addiction and threaten treatment retention. Prompt interventions are needed to help Vietnam attain its objective of providing better care for larger vulnerable populations.

Background

Methadone maintenance treatment (MMT) started in the 1960s in the United States and has now expanded to more than 150 countries in the world (World Health Organization, 2017). Using methadone for maintenance treatment revolutionised the field of addiction treatment by redefining therapeutic success as patient stability and functioning rather than abstinence (Newman, 2009). MMT has been promoted by many who are in favour of treating addiction as a disease (Volkow, Frieden, Hyde, & Cha, 2014). Abundant literature, mostly quantitative, has proved its effectiveness in reducing illicit opioid consumption, improving social security, and reducing public health harms related to

opioid injection (Fullerton et al., 2014; Sun et al., 2015). This serves as a rationale for global methadone expansion, especially in low- and middle-income countries. However, for those who oppose the model, prescribing methadone is merely “trading one drug for another” (Volkow et al., 2014). For this reason, many Asian countries only reluctantly authorised MMT in the early 2000s to reduce HIV infection related to unsafe injecting drug use (Reid, Sharma, & Higgs, 2014). Still, multiple barriers, including stigma and discrimination against former drug users, criminalisation of drug use, lack of a favourable legislative framework, and preference for non-evidence-based interventions such as compulsory abstinence and rehabilitation, have all hindered MMT’s diffusion on the continent (Degenhardt et al., 2014; Reid et al., 2014).

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Context: the introduction of MMT in Vietnam

After the country adopted a market-oriented economic model in the early 1990s, Vietnam's drug market changed. Heroin was smuggled into Vietnam from neighbouring countries and replaced opium as the drug of choice (Windle, 2015). This market change also transformed drug administration patterns. While smoking was the preferred mode of drug use in the mid-1990s when opium was the norm, injection became the more popular method in the early 2000s as heroin took over the market (Nguyen & Scannapieco, 2008). As users began to share injection equipment, HIV transmission escalated among people who inject drugs (PWID) and increased risks that the epidemic would spread into the general population (Hammett et al., 2007). In 2001, even as the government supported needle and syringe exchange programmes, PWID accounted for 60% of identified HIV cases (Nguyen & Scannapieco, 2008; Windle, 2015).

This situation pushed Vietnam to endorse MMT. From 2008 to 2010, the government piloted MMT in two provinces, with the hope of curbing the HIV epidemic (Edington & Bayer, 2013). Vietnamese methadone programmes have three objectives: 1) to reduce illegal opioid use in society, 2) to address health issues, including mortality and blood-borne diseases and 3) to improve individuals' social functioning (Ministry of Health, 2010). The pilot data not only showed only one new HIV case among almost 1000 patients followed over two years, but it also revealed a decreased proportion of patients who reported engaging in criminal activities from 40.8% to 1.3% in the same period (Ministry of Health, 2012). With these results, Vietnamese policymakers were convinced not only of MMT's effectiveness in controlling the HIV epidemic but also of its significant impact on crime rates (Ministry of Health, 2012). In December 2013, the Vietnamese government declared that addiction was a chronic disease, which brought it under the purview of the medical sector rather than that of social affairs and public security while also limiting the scope of compulsory detention centres (Government of Vietnam, 2013).

While the government has revised regulations to make it easier for opioid users to enter MMT if they so desire, take-home methadone is still not allowed for fear of diversion. Patients must visit their MMT clinics daily (Ministry of Health, 2015). Although MMT is the only evidence-based addiction treatment available in Vietnam, methadone programmes cover an unexpectedly small number of patients, and have expanded slowly. Of the government's 2015 target of 80,000 patients (estimated at 40% of all opioid users), only 52,054 were following treatment in July 2017, a 5600 increase from the previous year (Social Republic of Vietnam, 2014; Ministry of Health, 2016, 2017). Meanwhile, overdose deaths, police arrests for drug-related crimes, side effects, and lack of motivation to continue with treatment raised dropout rates as high as 33.3% at 36 months (Khue et al., 2017). While this figure is similar in other countries (Huissoud, Rousson, & Dubois-Arber, 2012; Zhang et al., 2013), it is important to understand why participants decide to drop out in the specific context of Vietnam, where MMT has received strong support from the government.

Factors influencing retention in methadone treatment

While there is strong evidence of MMT's effectiveness in improving health outcomes for opioid users (Fullerton et al., 2014), studies on the lived experiences of patients revealed the more nuanced impacts of treatment on patients' lives. For example, studies have questioned MMT's mode of delivery (Fraser, 2006; Harris & McElrath, 2012), interrelations of MMT with personal and structural barriers for PWID — such as underlying beliefs about addiction and treatment — (Bojko et al., 2016; Edington & Bayer, 2013), or the socio-economic status of PWID (Rhodes, Ndimbii, Guise, Cullen, & Ayon, 2015). Studies have also questioned the ability of MMT to meet patients' needs and to help them reach the level of social stability and functioning that many MMT supporters had led to expect (Bourgois, 2000; Reisinger et al., 2009).

Studies have also pointed to multiple factors influencing retention, which may be related to perceptions of methadone as a substance (Fischer et al., 2005; Goldsmith, Hunt, Lipton, & Strug, 1984; Malvini Redden, Tracy, & Shafer, 2013) or to experiences with services structured around methadone (Bojko et al., 2016; Fraser, 2006; Harris & McElrath, 2012). Many PWID considered methadone to be halfway between drug and medication (Langlois, 2013; Malvini Redden et al., 2013; Neale, 2013). As a drug, it could be purchased on the black market to replace heroin and sometimes to procure pleasure. As a medication, it would be prescribed by a doctor in a clinic with the aim of relieving opioid withdrawal and then taken by patients under close supervision. Seeing methadone as a drug might lead to unconventional treatment management strategies like self-discharge (Langlois, 2013).

Some patients appreciate methadone because it protects them against relapse and provides them with the daily stability, but they also fear the potential harm and addictiveness it could cause. (M. Harris & Rhodes, 2013; Malvini Redden et al., 2013). Relief from drug dependence is thus the immediate motivation pushing many opioid-addicted individuals to enter into and continue MMT (Mitchell et al., 2011). At the same time, many consider MMT to be the last resort after multiple failures to go drug-free (Bojko et al., 2015; Grønnestad & Sagvaag, 2016).

For many patients, the ambivalence arises more pronouncedly from the conditions of service. These may include inconvenient treatment conditions (Fraser, 2006; Rhodes et al., 2015), negative therapeutic relationships (Bojko et al., 2016), and challenges in the patients' daily lives (Bourgois, 2000; Conner & Rosen, 2008). Taking daily dosages is universally considered a key factor preventing patients from securing the employment necessary to afford a decent lifestyle, hence damaging their sense of agency (Bojko et al., 2016; Fraser, 2006; Harris & Rhodes, 2013; Lin, Wu, & Detels, 2011; Rhodes, 2018). Furthermore, methadone clinics are criticised as sites of interpersonal and institutional stigmatisation (Bojko et al., 2016; Bourgois, 2000; Fraser, 2006; Harris & McElrath, 2012). Patients from various facilities reported being treated as “subhumans” by methadone providers (Bojko et al., 2016; Hayashi et al., 2017). Arbitrary regulations in some clinics such as “feetox,” which discharged patients who were unable to pay treatment fees (p.289, Reisinger et al., 2009), or treatment contracts that listed punishable behaviours only for patients and not for providers, held patients in a vulnerable position (Harris & McElrath, 2012).

The poor reputation of methadone services stems especially from the relationship between patients and providers. Methadone providers often failed to appreciate patients' different treatment expectations. They failed to see that patients needed more than just achieving abstinence to return to a “normal life” (p.5, Mitchell et al., 2011). When patients did not receive support for their goals from the programmes, they often self-discharged (Reisinger et al., 2009). Multiple life challenges that MMT could not affect, such as intersecting stigma towards addiction, HIV or poverty, lack of social support or damaged health could also lower treatment continuation rates (Conner & Rosen, 2008; Vigilant, 2008).

Most of the existing literature is from studies of Western methadone programmes. Little is known about how opioid-dependent individuals in Asia experience MMT. This represents a major gap in policy literature, given the fact that the region is known for its tough drug policy and nascent harm reduction and drug treatment programmes. This paper draws on the accounts of current and former MMT patients and current heroin users without experience with MMT (MMT-naïve users) in Haiphong, Vietnam. It seeks to provide a detailed description of the barriers and motivations influencing users to start and continue MMT.

We describe patients' MMT experience in a temporal sequence. We start with impressions from the beginning of their treatment. We then inquire into retention barriers as patients' initial feelings fade out. Finally, we cover the most important motivations that kept patients in care. Although this paper relies primarily on the accounts of individuals who have experience in MMT, we sometimes use testimonials of MMT-

naïve users to illustrate the popularity of the issue in question.

Methods

We collected data between August and October 2016 and in June and July of 2017. This qualitative study is part of an intervention research programme to reduce HIV incidence among PWID in Haiphong (known as DRIVE). DRIVE recruited PWID in the community using respondent-driven sampling and carried out assistance initiatives (harm reduction, referral to treatment, social support) through community support groups (Des Jarlais et al., 2016).

Haiphong is an industrial city in Northern Vietnam with 16 methadone clinics serving about 4000 patients (Ministry of Health, 2018). The clinics open during working hours, from 7:30 am to 4:30 pm. Since 2014, Haiphong methadone programmes, as per national guidelines, require a monthly treatment fee of VND 300,000 (\approx U.S.\$15). Previous assessments showed that patients thought this was an acceptable price (Tran, 2013).

This study draws on 58 in-depth interviews with both MMT-experienced and MMT-naïve heroin users and two focus group discussions (FGD) with young injectors and street methadone users. We first conducted FGDs, which informed interviews with ideas to be explored further. The information from FGDs and from interviews with MMT-naïve users served to solidify our findings from interviews with current and former MMT users on the perceived challenges of following MMT. Two researchers conducted FGDs in peer support group offices and interviews in the same offices as well as in hotel rooms for privacy.

We selected potential participants from the DRIVE cohort database based on age, sex, HIV status, hepatitis C virus (HCV) status and MMT status. Peer outreach workers contacted and recruited participants and brought those lacking transportation to the study sites on motorbikes. Each encounter lasted one to two hours. FGDs and interviews were audio-recorded and transcribed verbatim. Names and other personally identifiable information were omitted from the transcripts. Participants signed an informed consent form prior to the interview and received VND 200,000 (\approx U.S.\$10) for their participation. The study was approved by the Institutional Review Board of the Haiphong University of Medicine and Pharmacy.

Data was investigated and coded with NVivo11.0 using a thematic analysis approach. A codebook of the topics of interest was first developed from the literature. Initial codes included: administrative barriers, methadone perception, time conflict, staff, and finance. As additional topics of interest emerged during the coding process, we included them into the codebook: stigma, drug management strategies, life projects, and family. The first and second authors coded the first five transcripts independently and discussed all differences in coding until we reached a consensus. To give context regarding social status and MMT experience, we noted the gender, age, marital and MMT status of quoted participants. The first author translated the quotes. The translation and original quotes were then reviewed by a Vietnamese-American collaborator who is fluent in both languages. Insights from the peer outreach workers on the preliminary findings confirmed our interpretations. In our analysis, we aimed to gain a more subtle understanding of MMT perceptions by relating the social experience of PWID to the Vietnamese social and political context. Working from a social science perspective helped us overcome the naturalistic view of MMT promoted by biology and public health and reveal the more complex and contradictory nature of MMT (Neale, 2013).

Table 1 shows the participants' socio-demographic characteristics. Participants were primarily male (72.4%) and in their late thirties, and 44.8% reported being married or living with a partner. People living with HIV made up one third of the sample. Among male participants, 17% were recruited through men who have sex with men (MSM) peer groups. Although most female participants were recruited through female sex worker peer groups, only a few women confirmed that they were sex workers. Some reported doing it occasionally to make ends

meet.

Results

Initial experiences of success: regaining decency and feeling hope

Current and former methadone patients in our sample all appreciated regaining control of their life as an immediate treatment benefit. As they stopped experiencing morning withdrawal or pleasure from heroin, participants felt confident in their ability to break up with the drug. Although some could keep doing heroin, they felt that this behaviour was decided through their own free will rather than compulsive.

"I still use heroin sometimes when I feel bored. But if I don't feel like it, I don't take it."

(Male, 46 years old, married, currently under MMT)

Relief from heroin dependence freed drug users from the daily burden of seeking money for drugs. This carefree feeling after decades of addiction was an intense experience of freedom. They did not have to worry when they did not have "100,000 dongs in my pocket before going to bed at night" (the price of one or two heroin doses for the next day). Some participants declared that they felt happy all day. They had the opportunity to work when they felt like it. They said that they felt more secure as they did not have to risk their lives and the lives of their loved ones while going out in bad weather to seek drugs.

Another effect of MMT was that PWID reported radical changes in self-perception and others' perception of them. As patients became more financially stable without drugs, they did not need to ask others for money. This made them feel they were being positively perceived. MMT helped users see themselves as more decent persons.

When I was using drugs, I didn't want to do anything. Just to earn quick money. I was afraid to talk to people. I always thought they were looking down on me. When I was using drugs, looking at my daughter made me feel ashamed. When I stopped, I felt much more dignified and confident, totally different.

(Female, 30 years old, divorced, currently under MMT)

With money in their pockets, patients did not need to avoid acquaintances or to lie to them to get money. Everyday gestures of politeness such as buying others drinks became easy and helped them regain normalcy. Once unthinkable habitual pleasures like beer drinking now could be savoured when patients wanted to.

One participant gave a vivid description of the contrast between heroin addict and methadone patient:

A guy on methadone looks clean, has good clothes, good shoes and a watch. He goes out for breakfast. An addict doesn't even have a bicycle.

(Male, 57 years old, married, currently under MMT)

This newly gained confidence gave participants hope for a conventional life: getting married, building their own house, and having children. One participant proposed to his girlfriend after he entered MMT and felt like he would be able to take care of her. As they no longer had to pay for their habits, participants could save money for their families. Some reported that they experienced regaining their family's trust.

Since my family sees me getting methadone daily, they trust me more. For example, they trust me with money to perform family tasks, tens or even hundreds of millions of dongs.

(Male, 27 years old, married, currently under MMT)

Men and women participants reported similar experiences with respect to their positive perception of methadone. We found no difference between HIV-positive and HIV-negative participants nor among participants of different levels of education.

Table 1
Characteristics of sample.

	Currently under MMT (N = 40) N (%)	Dropped out (N = 4) N (%)	Never been under MMT (N = 14) N (%)
Men	28 (70)	3 (75)	11 (78.6)
Recruited through MSM peer groups	5 (12.5)	1 (25)	1 (7.1)
Women	12 (30)	1 (15)	3 (11.4)
Recruited through FSW peer groups	10 (25)	1 (25)	3 (21.4)
Age (median)	37.5	35.5	39
Married/Cohabited	20 (50)	0	6 (42.9)
Having a job	34 (85)	4 (100)	11 (78.6)
HIV positive	8 (20)	3 (75)	10 (71.4)
ART	7 (87.5)	2 (66.7)	7 (70)
Median length of MMT (years)	1.25	2	1
Median length of drop-out (years)		3	
Reasons of drop-out		Fear of methadone side effects	
		Time conflict with work	
		Being discharged for missing too many doses	
		Being discharged for not paying treatment fees	

Challenges to achieving a “normal” life

When the excitement of methadone faded away, participants came to realise the downsides of treatment, including fear of addiction to another drug, constraints for a functioning life, and lack of a trusting relationship with MMT providers. These inconveniences interfered with their daily life to different degrees.

Fear of methadone as another harmful drug

Patients actually had mixed feelings about methadone. On the one hand, the main motive to enter treatment was methadone’s protective property against heroin. Methadone was the last resort when participants were exhausted from the cycle of detoxification and relapse, and accepted they could not quit heroin by themselves. On the other hand, there are widespread beliefs about methadone’s harmful effects across all participant groups. Methadone was considered “hot,” meaning in traditional Vietnamese medicine that it caused constipation and acne. Most current and former patients reported side effects including tooth decay, tooth loss, worsened memory and reduced sexual desires. Sedation interfered with work and daily functioning. One participant almost got into an accident on his way home from the clinic as he was feeling extremely sleepy. These side effects were common but not insurmountable; many of them waned over time. One HIV-infected participant dropped out of antiretroviral treatment (ART), fearing the potential harms caused by the interaction of the two drugs. Another stopped taking methadone after he started ART for the same reason.

Methadone-naïve participants displayed similarly negative though less specific perceptions of methadone. Most methadone-naïve participants learned about such side effects from word of mouth. Methadone in their mind was “harming,” “making people gain weight,” “worsening memory” and “if you do heroin while you are on methadone, you will die.” One woman who quit heroin unassisted looked up the medication online and tried to persuade her husband to give up the treatment since “its consequences are not less than heroin’s.”

Both methadone-naïve and more experienced participants also reported being afraid that they would be unable to get off methadone. Drug users unanimously equated a drug’s addictiveness with the length and severity of the withdrawal it induces. From this perspective, it was widely reported that methadone was more addictive than heroin. Since tapering from methadone takes months or even years, some patients tried to keep their doses low or to decrease them, even if they had not yet planned to quit methadone.

Addiction to heroin or dependence on methadone programmes?

Despite the widespread rumour about methadone’s long-lasting and difficult withdrawal period, most patients in our study had never experienced it. Only three people had undergone full methadone

withdrawal when they were sent to compulsory rehabilitation. Another few participants had experienced mild symptoms after missing a couple of doses. Current and former methadone patients got frustrated with methadone programmes because they were unable to live the lives they expected to live when they entered treatment. Participants used the word ‘nghiện’ (addiction) exclusively to refer to heroin habits and ‘phụ thuộc’ (dependence) to indicate methadone treatment. ‘Phụ thuộc’ refers to the external forces and constraints inherent to following a methadone programme; in ‘nghiện,’ the forces at play are rather related to the internal, compulsive nature of drug-using acts.

The feeling of ‘phụ thuộc’ came from the inability to travel and from the time constraints that prevented patients from securing stable employment, therefore causing treatment fatigue. Heroin still allowed users to travel and work. Methadone treatment, however, requires patients to trade job opportunities against the ability to obtain daily medication from clinics during office hours. Although participants accepted this trade-off, they still experienced regret:

I can’t travel far. I had a good opportunity to go to work in Saigon but I can’t take it since I depend on methadone. The clinic opens at 7:30 for dosing and medical examination. And it closes at 11. If I worked, I would work during the same time. How could I ask to go out every day? And if I told them I was on methadone, I for sure wouldn’t be able to keep that job, so I decided to stay at home.
(Male, 42 years old, single, currently under MMT)

Participants were rarely able to hold a job while following treatment. Only participants with flexible work schedules who worked for a family business or took night shifts managed it. Securing employment became more challenging as patients anticipated stigmatisation if they told employers about their addiction treatment. In fact, it is the explanation one of the four dropout participants gave for leaving treatment. The inability to coordinate a suitable work schedule with the rigid dosing window resulted in many patients losing their employment. During interviews, our participants estimated 70%–80% of methadone patients were unemployed. Since they had nothing else to do, many hung out at tea stalls the whole day after receiving treatment.

The main reason MMT-naïve users chose not to enter into treatment was that they believed they were in control of their drug use. The majority (10/14) mentioned detoxification as a solution in case they wanted to quit. Among them, four had high-paying jobs that could support their habits. This, along with the belief that the procedures to enter MMT were complicated and costly, kept them away from treatment.

Our group discussions with PWID under 30 also suggested that those with a stable job were reluctant to get into MMT. Truck or ship drivers had to travel for several days and only stayed in Haiphong for a short period. Participants who did not follow treatment believed that MMT

made patients dependent on others to make a living. This perspective was especially unappealing to younger people. They often opted for street methadone to control their drug habits.

When my heroin dose increases and I can't afford it, I stop it for a while so it stabilises... I ask my friends to bring me some methadone. They leave me a bit from their doses. I buy some hundred thousand dong's worth to treat heroin withdrawal.

(FGD with PWID under 30 who had used street methadone)

The difference between women and men regarding time constraints reflected gender roles in Vietnamese society. Women felt less pressured than men to get a job. While nearly one fourth of participants were women (16/58), most of them described themselves as housewives or as self-employed. Their treatment fatigue originated from difficulties 'going on errands', 'going to pagodas', 'visiting family,' or 'having to go out in bad weather.' The majority of women wanted to get off methadone, but many accepted the idea of staying in treatment for an indefinite period of time. Men, on the other hand, were more frustrated by this kind of dependence. Patients often spoke of quitting methadone if they got a good job and mentioned patients who missed doses because of work commitments. Some male patients voiced a clear plan to taper off treatment.

Sometimes I have offers to work far from home, but methadone doesn't allow me to take them [...] But next year, I will try to reduce my dose. I am at 75 mg, this month I will reduce it to 70, next month to 65, then 60, and so on. Or if I get another opportunity, I will stop methadone.

(Male, 39 years old, married, currently under MMT)

This frustration intensified with the feeling of being manipulated by methadone programmes. Dosing schedules were irregular, but unfavourable to patients. Many wishfully mentioned a methadone clinic in a neighbouring province that opens at 5:30 am since they could not get treatment there.

Before they [Haiphong MMT clinics] delivered doses at 6 am ... but now they open at 7:30. They treated patients better before, they brought methadone home to us if we couldn't come. But now they don't care whether you get methadone or not.

(Male, 37 years old, single, dropped out for 8 years)

One clinic in Haiphong asked patients to pay an additional sum on top of their monthly treatment fee to get dosed earlier in the morning. Some patients who had more financial means found this request reasonable while others saw it as the clinic's attempt to "rob" them.

Lack of a trustful relationship with MMT providers

Methadone patients in our study declared that they did not receive good support for their personal treatment goals within methadone clinics. They had a rather problematic relationship with their medical setting. The relationship was already complicated before the first day of care, since a popular assumption circulated that patients had to bribe clinic staff to receive treatment. While some participants had to pay to get into methadone programmes, this was not the case for the majority of our participants, for whom DRIVE made referrals. This belief, however, had transformed participants' perception of therapeutic relationships into a business transaction. Scepticism about the transparency of methadone programmes led patients to question clinic requirements such as lab test prices or the additional fees they were asked to pay.

I don't understand the 50,000 dong's extra they asked us to pay. They said it was for security guards and daily hygiene of the clinic like washing cups. But these people already receive salaries from the government. They don't only work for this clinic, they work for the whole healthcare centre. They didn't hire extra security guards because of us.

(Male, 34 years old, single, dropped out for 2 years)

In participants' stories, methadone staff were described as irresponsible, inconsiderate, and inhumane providers with inadequate expertise. Patients often got angry when staff did not seem to care about their needs. One described his frustration with the administration staff when the clinic opened its doors and patients rushed in to get their medication and start their work day.

They were like... walking around, doing nothing. First they washed their hands, then dried them... then they wiped the table, wiped the glass. Only after a while did they start their work and give us doses. Patients were all in a hurry. We had to go to work on time. They were irresponsible. We have to pay for our treatment. They have to give us medication on time, so we can work. Otherwise how can we pay for the treatment?

(Male, 37 years old, single, dropped out for 8 years)

Others complained about missing their doses just because they came minutes after closing time.

These people shouldn't be allowed into care. They are inhumane. Some of us have jobs. They close at 11 am. But even if we are just one minute late and we tell them, 'Could you please give me my dose? I am just one minute late.' You see, it is just about sympathy. The dosing window opens at 7:30 but the staff also come at 7:30. They do their things and only start dispensing methadone at 7:45. We have never complained about it... But when it comes to us, we are just one, two minutes late and they lock the medication away.

(Male, 42 years old, single, currently under MMT)

The rule of 'money first' requiring payment before medication delivery was considered too strict and unreasonable. This caused quarrels between staff and patients every month at the time of payment. One patient warned about the potential consequences of this rule:

I think late payers will pay for their treatment anyway. They might not be able to make payment on the 5th, but on the 10th or 15th. Staff are government officials, they should be more flexible. Without medication, patients would have to do heroin. So the staff facilitates patients' relapse. And when they relapse, they leave treatment. So why can't the staff wait a few more days?

(Male, 34 years old, single, dropped out for 2 years)

Participants rarely complained about baseline fees; they knew that 300,000 dong's a month was much less than the amount they had been spending to maintain their heroin consumption. They explained that they experienced difficulties paying for treatment on time or at all because they struggled to maintain employment under the constraints of methadone programmes.

Participants described the tense atmosphere of methadone clinics, where staff-patient communication mostly included 'yelling,' 'blaming,' 'punishing,' and 'threatening to kick out of treatment' when patients screened positive for drugs or when they missed doses. In relation to the lack of transparency in methadone programmes, one patient who was discharged against her will because she had missed too many doses interpreted this treatment termination as an attempt to get rid of her then to sell her spot to another candidate. Some patients reported no communication at all with staff, except when they were late settling their co-payment. One woman explicitly criticised the staff for caring only about money rather than about patients' well-being.

Patients reported being subjected to stigmatisation by providers. Some physicians, for example, displayed a suspicious and humiliating attitude when patients requested a dose change, as one participant angrily reported:

I told my physician I wanted a decrease of 5 or 10 mg. [...] He said: 'You want a decrease to get high faster?' And so on, it was so mean, you understand? I replied: 'It's our responsibility to control our drug use. You don't need to encourage us, but don't say so.' I know it's good for us not to do drugs. Of course since we are addicts, people

won't say nice things to us. But we all have our self-esteem. We have got in here, we are now a member [of the clinic]. We also pay for our treatment. They aren't giving us anything for free, right? So we have our rights. [...] But sometimes what they tell us is so mean. That's why people don't really feel like being in treatment.

(Female, 39 years old, divorced, currently under MMT)

Patients did not feel respected when spoken to by the providers. Young staff spoke to older patients without the politeness required by Vietnamese age hierarchy culture. This disrespectful attitude pushed away patients and thwarted any attempt to build a good relationship.

We clearly feel the distinction they make between them and us, through their attitude and their way of addressing us. Although they are younger than me, they call themselves 'anh' (older brother), 'chị' (older sister). They don't respect us. They distinguish themselves from us and they are unwelcoming.

(Male, 39 years old, married, currently under MMT)

While these negative opinions regarding methadone clinics and their staff were prevalent, a minority of patients (8/44) described methadone providers on more positive notes such as 'devoted' and 'welcoming.' These patients appreciated the help they received from their physicians and counsellors. All of these patients were currently on treatment, except for one who was forced to leave for deliberately missing his co-payment and was looking to re-enter treatment.

Factors of patient retention?

Methadone programmes retained patients for two reasons: methadone offered its users assistance in coping with an environment where drugs are ubiquitous; and patients wished to protect their recently regained happiness in the context of their families.

Since for many methadone was the last resort after numerous attempts to stay away from heroin, participants were dedicated to remaining in care until they felt confident that they could keep away from heroin. They reported feeling 'safe' with methadone and revealed fears of relapse without it. Some considered using methadone 'until they died.'

I will keep getting dosed in the coming time. I guess it would take a few more years... But I will only stop methadone if I am really confident ... it means I would feel nothing, be totally indifferent when others offer me drugs. Now I am still struggling with this desire each time, although I haven't accepted their offers, because I think of my wife and children.

(Male, 37 years old, married, currently under MMT)

The importance of the family as patients' anchor in treatment was echoed in the narratives of most participants. Being on methadone fit in their plan of caring for their families. Single participants prioritised taking care of and making their parents happy. Married participants thought about the needs of their spouse and children to get them through the hardships of treatment. They wanted to keep "bringing smiles back into the family."

First it was for me, second it was for my wife and children. They were miserable. My wife didn't dare spend money on her food but gave me two, three hundred thousand dong every day. That's why I felt ashamed in front of her and my kids. I had to confront the reality. I couldn't run away any more. So I got on methadone. Before, I didn't dare to disclose my treatment, but now I tell my employer upfront, and say if he accepts my treatment, I will work for him. Otherwise, I won't.

(Male, 39 years old, married, currently under MMT)

Discussion

Patient attrition threatens the clinical and public health achievements of Vietnamese methadone programmes. Little information on PWID's treatment experience is available. To our knowledge, this is the first qualitative study drawing on a large sample of PWID with and without MMT experience in the country. During Vietnam's major shift from compulsory rehabilitation to the rapid implementation of MMT, understanding patient experience in care settings from their perspective is crucial to improve service quality.

Our findings point to evolving patient experiences of MMT. The immediate positive changes that methadone brought to our participants at the beginning of treatment are impressive. Individuals resumed control of their lives as methadone liberated them from heroin addiction. Heroin withdrawal was no longer a fear, and patients did not have to avoid it at all cost. This advantage was the very justification for methadone maintenance treatment (Gomart, 2002). The significance of MMT for Vietnamese drug users must be measured within a context traditionally characterised by compulsory detention as a punishment for drug use. The arrival of MMT then marks a new era when living a decent life becomes possible for drug users. MMT may be more significant to Vietnamese users than to users in high-income countries where it is just one option among other evidence-based interventions.

Although patients were satisfied with the pharmacological effects of methadone, it did not lead to the straightforward outcomes that patients had imagined when entering treatment. Patient experiences were affected by their negative perceptions of the substance. Despite the spreading biomedical discourse of addiction that advocates for methadone as a medication, the majority of our participants, regardless of their methadone experience, continued to perceive it as just another drug whose properties they could not trust. Indeed, some studies reported that methadone patients seem to attribute any physical discomfort they may feel after starting treatment to methadone (Bojko et al., 2015; Goldsmith et al., 1984). Goldsmith et al. (1984) explained this belief system by pointing to drug users' autonomy in managing their physical condition, which encourages close attention to the effects of drugs in their body. Interpreting the effects of methadone by comparing it to known drugs helps individuals deal with the anxiety of unknown treatment experiences. Besides constipation, tooth decay, or reduced sexual drive, existing clinical research suggests that these symptoms may indicate undiscovered medical or living conditions (Leavitt, 2003). Over-sedation could be a symptom of inappropriately high dosages.

Patients' anxiety that they would be unable to escape methadone seemed more compelling than their fear of side effects. Many PWID believed methadone was more addictive than heroin (Bojko et al., 2015; Langlois, 2013). This concern explained the attempt by some participants to get the lowest dose possible by asking to be tapered off even when they had no immediate plan to quit treatment. While this practice has not been commonly reported, it remains worrisome, as an inadequately low dose is a risk factor for abandoning treatment in many programmes (Khue et al., 2017; Proctor et al., 2015).

Langlois (2013) proposed a typology of medication-assisted patients based on the combination of high/low motivation to fight addiction and the perception of the substance as a medication or as a drug. Perceiving the substance as a medication produces conformist (high motivation) or ritualistic (low motivation) users who comply or seem to comply with treatment requirements. Perceiving the substance as a drug leads to 'therapeutic craft' (high motivation), where participants deliberately adjust their doses as they see fit (whether secretly or overtly); or choose to terminate treatment or divert the substance (low motivation). Although other factors such as desire to take care of oneself and treatment constraints also influence patients' compliance, and 'therapeutic craft' does not necessarily stem from a perception of methadone as a drug (M. Harris & Rhodes, 2013), we find Langlois's typology useful in understanding the reactions of our participants. Unlike Langlois's French

sample, who mainly perceived opioid agonists as treatment, the majority of our participants fit into the quadrant of patients who are highly motivated to quit heroin and who think of methadone as a drug. Their attempts to get the lowest possible dose could be an outcome of their patient profile. This difference might reflect social conceptions of addiction in the two countries. France adopted the biomedical model of addiction as a chronic brain disease in the early 1990s and currently has one of the best medication-assisted treatment coverage in the world (Jauffret-Roustide & Cailbault, 2018). In Vietnam, the perspective of addiction as a chronic disease only officially appeared in 2013 (Government of Vietnam, 2013) and recently became more popular. “MMT as a medication-assisted therapy,” started to replace “MMT as a substitution therapy” in Vietnamese medical discourse around the same time. However, the conception of addiction as a moral fault probably remains prevalent in Vietnamese society. Yet, other factors should be taken into account to explain the different conceptions of addiction.

Using ‘*nghiện*’ (addiction) and ‘*phụ thuộc*’ (dependence) – two words with similar meanings – to describe their conditions with heroin and MMT respectively, our participants restated the common “trading one addiction for another” view of MMT (Volkow et al., 2014). Patients revealed their frustration by highlighting external forces in their descriptions of ‘*phụ thuộc*.’ As it allows patients to shift from addiction to dependence, the current methadone programme relieves the compulsive element of using drugs, but does not offer a radical solution to the quandary that heroin users face. Interestingly, it is the treatment programme, rather than the medication, that patients compare to heroin. Patients felt trapped by the programme’s requirements of daily dosing within office hours, which prevented them from working and becoming self-reliant. This finding expands on the works of Khue et al. (2017), who explains that one reason for methadone patient attrition is the financial burden of treatment fees. Our study shows that complaints about treatment fees might be rooted in patients’ deeper frustration at being unable to support themselves and their families under MMT. This finding adds to the previous literature that opioid users consider treatment and abstinence not as ends in themselves but as means to achieve a functioning life (Mitchell et al., 2011). While the Confucian society of Vietnam expects men to be providers for the family, its market-oriented economy encourages autonomy. Under such pressures, the inability to achieve financial independence might threaten participants’ sense of self-worth.

Following Gomart (2002)’s argument that the perception of a substance is inseparable from the context of its practices, we believe that the feeling of dependence on methadone is inseparable from the contexts of methadone programmes. When patients reported being ‘detained’ by methadone, or when potential patients stayed away from treatment for fear of dependence, it was less about the pharmacological effects of the product itself and more about the daily observed dosing practices.

The reputation of methadone programmes as lacking transparency stems from the early days of MMT. At the time, MMT was reserved for the most severely addicted individuals who had failed multiple detoxification attempts, including compulsory rehabilitation. The admission procedures spanned different governmental levels and used to last up to several months. At the time, bribing providers to get a spot in the programme was common practice among better-off drug users. The expansion of MMT starting in 2012 allowed people with an opioid addiction to enter treatment more easily. But bad first impressions remain.

The rule of ‘money first’ is quite comparable to the relationship patients had with drug dealers. This strengthens the already negative reputation of methadone programmes among PWID. Moreover, this business-like policy excludes the most vulnerable patients, who cannot pay treatment fees on time; which could possibly push them back into drugs.

The actual practice of methadone programmes appears to go against its third objective of improving individuals’ social functioning (Ministry

of Health, 2010). It echoes the observation of Edington and Bayer (2013) that the ultimate objective of Vietnamese methadone programmes is “to make people’s lives drug-free, not to make them better.” Our participants, similar to other Vietnamese methadone patients, were in their mid-thirties when they entered treatment. The majority of them had only completed primary or middle school (Khue et al., 2017). The industrial city of Haiphong provides factory jobs to people with low education. Our participants, however, could not arrange to receive treatment within the traditional eight-to-five job schedule. Other offers such as construction work and truck or ship driving positions require frequent travel, which is incompatible with daily dosing practices. Additionally, there is no supportive mechanism in place to facilitate social integration. As a consequence, for unemployed patients, seemingly reasonable treatment fees can represent a significant enough burden to quit the programme (Hammett et al., 2018; Khue et al., 2017). Moreover, since having a job is critical to individuals’ sense of ‘normalcy’ (Rhodes et al., 2015), such constraints negatively impact the transformation of patients’ identity and their re-entry into what might be understood as a ‘normal’ life.

The problematic staff-patient relationship is common in many methadone programmes, where stigma and discrimination have been rampant (Bojko et al., 2016; Harris & McElrath, 2012; Lin et al., 2011; Reisinger et al., 2009; Wolfe, Carrieri, & Shepard, 2010). Their vulnerable socio-economic status and high HIV prevalence put PWID at risk of becoming targets of addiction stigma, but also of poverty and HIV stigma (Conner & Rosen, 2008). Vietnamese society traditionally views drug use as a ‘social evil’ opposed to cultural virtues. Unsurprisingly, stigma and discrimination towards people who display this behaviour are prevalent (Windle, 2015). Conflicts arise when patients do not feel respected by providers. Challenging the credibility of methadone programmes by criticising the inhumanity of their staff and lack of transparency of their operations could be a way for patients to defend themselves against the negative treatment they receive.

Looking at the issue from the staff’s perspective, a study in China reported most methadone staff felt discouraged in their work (Lin et al., 2010). Heavy workload coupled with low incomes, lack of recognition compared to professionals in other medical specialties, and inappropriate training to cope with daily work issues all contribute to staff burnout and dissatisfaction. Many providers consider methadone clinics only as launching pads towards better jobs (Lin et al., 2010). These negative feelings could be projected on the patients they serve.

This study’s findings are in line with some of the issues found in other methadone programmes in the Asian Pacific region, including widespread belief in abstinence as the ultimate goal of addiction treatment, complaints about methadone’s side effects, and a negative relationship between patients and providers. Still, logistical issues (e.g., ID requirements, distance) and police crackdowns in methadone clinics that were reported in other Asian countries (Hayashi et al., 2017; Lin et al., 2011; Yin et al., 2010) seem to be less problematic in Haiphong.

The global issue of stigma and discrimination in MMT programmes manifests itself differently in high-income versus lower-income countries. While in high-income countries, stigma towards patients translates into stigmatising institutional practices like queuing, unequal treatment contracts, or intrusive urinalyses (Fraser, 2006; Harris & McElrath, 2012), methadone patients from low/middle-income countries in South-East Asia and Eastern Europe experience more interpersonal and overt stigma through the negative attitudes of healthcare staff toward them. (Bojko et al., 2016; Hayashi et al., 2017; Wolfe et al., 2010).

In comparison with recent work done in Kenya, where MMT was established more recently (Rhodes, 2018), our study highlights other challenges of treatment in helping individuals to manage addiction. Vietnamese drug users no longer doubt the potential of methadone to help them to change. Today, they find it more challenging to figure out how to fit treatment into their quest for a normal, meaningful life.

Recommendations

This study's findings suggest that we need to develop addiction medicine, with specific training in medical schools. Addiction treatment professionals must learn that caring for people with substance use disorders requires more skills than just prescribing methadone. The development of addiction medicine as a specialty would offer possibilities for professional development and career advances for current methadone providers. Investing in methadone programmes (lighter workload, increased support and incentives) would alleviate work-related stress for professionals and reduce the conflict of interest between professionals and patients.

Since employment directly impacts quality of life and treatment engagement (De Maeyer et al., 2011; Jackson et al., 2014), Vietnamese methadone programmes should apply a more patient-friendly dosing schedule to attract and retain service users, especially to accommodate those with traditional eight-to-five work schedules. As M. Harris and Rhodes (2013) argued, 'generous constraints' would be beneficial in improving patients' sense of control, in assisting their self-sufficiency, and in reducing risks. Vietnam can learn from other countries and allow take-home medicines for stabilised patients. This would also help significantly decrease the workload at the clinic. Other effective medications like buprenorphine or extended-release naltrexone, which require looser supervision, might also be helpful to improve the convenience of addiction treatment.

Widespread negative beliefs about methadone are not easy to transform. However, clear communication during treatment initiation on what methadone can do (reducing medical and social complications related to heroin) and cannot do (curing patients from addiction), in consideration of patients' treatment goals, would reduce misunderstanding and prepare patients to better cope with the constraints of treatment. Properly addressing methadone's side effects is important to promote a better image of treatment among potential patients (Lin et al., 2011).

Methadone programmes would benefit from understanding the elements that retain patients in care given the daily struggles they face. Patients were committed to ending their relationship with heroin and to protecting their family's happiness. This finding reflects a specificity of Vietnamese collectivism by which fulfilling family obligations is critical to individual identity (Burr, 2014). It also confirms the sociological view of drug users as conformist citizens rather than offenders of established norms (Jauffret-Roustide, 2009). Such recognition is important to reduce stigma and enable more support for PWID to achieve their life goals. We should remain aware that being on MMT could place the patient's identity in a 'limbo' where they are viewed as 'not quite junkie' but 'not quite conventional' (Neale, 2013). This unintended outcome of treatment might have a negative impact on patients who wish to recover a 'normal life' within their family. Programmes should invest more efforts to strengthen patients' family support and to enhance the connection between clinics and families to improve treatment retention.

Future research could provide more insights into how significantly changing PWID's perception of methadone and addressing time constraints and office-based stigma and discrimination would affect treatment retention. Longitudinal studies following methadone patients over the course of their treatment might help understand how the challenges mentioned above develop over time, and how patients pursue their life goals despite adverse conditions.

Limitations

Our peer-based recruitment compensates for PWID's usual mistrust of official institutions and facilitates open exchanges, which in turn generates rich data. PWID seemed open and willing to share their experiences. Still, the findings should be examined within our limitations. Since DRIVE referred most of our participants to methadone

programmes, their MMT experiences were relatively short (1–2 years). They might have different profiles than users seeking treatment on their own in terms of commitment to care. Their experience could also differ from that of patients with longer MMT experience regarding treatment fatigue. Additionally, male voices dominated our results. While the male – female ratio among current methadone patients is acceptable (28/12), we have too few women in the two groups of users who dropped out of MMT (3/1) and of users who had never followed MMT (11/3). This reflects the commonly difficult recruitment of female drug users for research, especially those who are not in care. The fact that most of our female participants were recruited through FSW peer groups but only few confirmed that they sell sex implies that their accounts may suffer from potential social desirability bias.

Conclusion

This paper showcases the experiences and perceptions of PWID towards MMT in Vietnam. The beginning of treatment brings about a significant feeling of success as heroin use gradually ceases to be a compulsive act. However, being in treatment also poses challenges for patients to lead a functioning life. The desire to break up with heroin and the pursuit of family happiness constitute the anchors that keep patients in care. This study's findings advocate for patient-centred changes in treatment delivery and for the development of addiction medicine as a medical specialty to improve the quality of addiction care.

Conflict of interest

The authors declare having no conflict of interest.

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How to be self-reliant in a stigmatising context? Challenges facing people who inject drugs in Vietnam

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ABSTRACT

Background: Stigma works to reinforce dominant social values. The meaning of stigma is therefore not static but dependant on the regime in power. Taking into account the significant socioeconomic changes that took place in Vietnam over the last thirty years, this study explores the meaning of stigma directed at Vietnamese people who inject drugs in different social spheres.

Methods: This qualitative study was conducted as part of an evaluation of a peer outreach program that distributes harm-reduction supplies and information, and provides treatment referral assistance to people who inject drugs in Haiphong, Vietnam. We conducted ethnographic field observations with peer outreach workers, home visits, and 54 in-depth interviews with participants in 2017 and 2018. Grounded theory led our theoretical sampling and analysis.

Results: Stigma towards people who inject drugs seems to centre on the ability to be self-reliant rather than on drug-using behaviours. Participants described how their families and neighbours expressed expectations that they should manage their substance use issues by themselves, without considering the barriers they face in the job market. Participants interpret stigma directed at them in terms of poverty rather than drug use. As a result, they sometimes engage in illegal income-generating activities to pursue financial autonomy and to regain their social status.

Conclusion: People who inject drugs were struggling to conform to social expectations of self-reliance with limited support to realise it. Effective interventions must consider the many facets and challenges individuals encounter in their daily lives.

Introduction

Stigma towards people who use drugs is a complicated and alarming issue across contexts (Room, Rehm, Trotter, Paglia & Üstün, 2001; van Boekel, Brouwers, van Weeghel & Garretsen, 2015). Stigma may lead to social alienation, and may incite the general public to exclude individuals who use drugs from communal activities (van Boekel, Brouwers, van Weeghel & Garretsen, 2013, 2015). People who use drugs might be perceived as dangerous without tangible evidence that they pose any real threat (Callinan & Room, 2014). As a consequence, stigma may negatively impact their physical and mental

health and prevent their ability to access healthcare services (Lloyd, 2013; Stone, 2015).

Some interventions targeting drug-related stigma have achieved promising results in reducing stigma, but their long-term effects have not been quite convincing (Livingston, Milne, Fang & Amari, 2012). Education targeting medical students might make it easier to discuss substance use issues with patients but does not necessarily improve medical students' attitudes towards patients with substance use disorders (Bland et al., 2001; Ramirez-Cacho, Strickland, Beraun, Meng & Rayburn, 2007). Biomedical reframing of addiction as chronic disease was expected to reduce stigma by placing drug use out-

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side of a moralising context (Volkow & Koob, 2015). However, this did not appear to be successful (Garriott & Raikhel, 2015; Meurk, Carter, Partridge, Lucke & Hall, 2014). Redefining addiction within a biomedical context can also reinforce stigma by shifting the process of stigmatisation from a moral to a medical ground: from that perspective, people who use drugs who do not succeed in adopting good practices to manage their addiction are not considered bad people, but irresponsible patients. (Jauffret-Roustide & Granier, 2017).

Stigma is conceptualised as an apparatus that maintains social order by reinforcing social norms (Link & Phelan, 2014). It is a site where the power relations present in a given society operate; therefore, the meaning of stigma depends on its relational context (Goffman, 2009; Parker & Aggleton, 2003). Stigma works in favour of dominant groups by legitimising their dominant status within existing social hierarchies (Link & Phelan, 2014; Parker & Aggleton, 2003). Fraser et al. (2017) argue that drug-related stigma is a political means to discipline human subjects into what is defined as legitimacy in contemporary societies. As legitimacy could not exist without illegitimacy, drug-related stigma must be considered as part of a complete social system (Fraser et al., 2017). Better understanding the social norms that underlie drug-related stigma can illuminate how society functions and help us rethink our interventions.

A number of studies have explored stigma towards people who use drugs in Vietnam. Studies reported methadone patients commonly experienced stigma and discrimination (Tran et al., 2016; Van Nguyen et al., 2017). Such negative treatment of methadone patients were related to participants' anxiety/depression, level of education, HIV status and number of previous drug rehabilitation episodes (Tran et al., 2016; Van Nguyen et al., 2017). Drug-related stigma was associated with lower access to HIV and harm reduction services (Lan, Lin, Thanh & Li, 2018; Salter et al., 2010). From a structural perspective, Lim et al. (2013) suggested that income inequality and education inequality might also be associated with HIV stigma reported by people who use drugs and community members.

Vietnam presents a unique context in which drastic economic reforms led to major changes in the system of social norm (H. Nguyen, 2015; Marr & Rosen, 1998). In 1986, the country transformed its economy from a centrally planned to a free-market regime and opened its borders to foreign trade. This socioeconomic upheaval has brought in substantial material wealth (Q. H. Vuong, 2014). People gained access to money instead of consumable goods checks and enjoyed technological advances (Badiani et al., 2013). Free trade and access to money might have made drugs more accessible. Vietnam had the largest gross domestic product increase in the world at the time (7–8%) and continues to show this rate of economic growth today, although significant challenges remain (Q. H. Vuong (2014); World Bank (2019)). Drastic economic reforms also led to an ideological transformation amongst Vietnamese youths who came of age in the 1990s: that generation went from upholding a restricted, communist personality to valuing a more extravagant, individualistic one (Nguyen, 2015; Marr & Rosen, 1998). Neoliberal ideals have become increasingly dominant in contemporary society (Nguyen, 2015; Kay Hoang, 2011).

Perceptions of drug use, whose social signification is subject to socio-political changes, has evolved over time in Vietnam: from a bad habit of the bourgeoisie in the feudal and imperial regimes (Ho Chi Minh, 1945; Ministry of Social Welfare, 1958), to a "social evil" influenced by Western cultural products in the post-reform years (Luong, 2006). With the decriminalisation of drug use in 2009 and the success of methadone maintenance treatment in minimising new HIV infections amongst methadone patients and ensuring public safety, people who use drugs came to be understood as patients (Luong, Le, Lam & Ngo, 2019; Pham, Le, Dinh & Edington, 2012; Vuong, Ali, Baldwin & Mills, 2012). However, there remained ambiguities about the nature of drug use and about how best to achieve demand reduc-

tion; ambiguities which created confusion and stress for professionals working directly with people who use drugs (Luong et al., 2019).

This article is based on a qualitative study exploring the daily hardships facing people who inject drugs in Haiphong, and the ways they cope with these challenges. Haiphong is one of the provinces with the greatest wealth disparities in Vietnam (Badiani et al., 2013). This harbour city is also a major site for drug use and HIV/AIDS incidence (National Institute of Hygiene & Epidemiology, 2014). Haiphong hosted the first methadone clinic in 2008 and as of 2018, its methadone program has served nearly 4000 opioid users, likely 80% of the entire opioid-using population in the province (Des Jarlais et al., 2018). These characteristics made it an interesting location to study this research question.

The theme of stigma emerged as salient in participants' accounts. In this article, we investigate the meaning of drug-related stigma from the perspectives of people who use drugs. We argue that drug-related stigma reinforces neoliberal expectations of self-reliance while also making it impossible for individuals to achieve that self-reliance. In the following sections, we will describe how stigma towards people who use drugs in different settings conveyed expectations of self-reliance and how participants attempted to conform to these expectations.

Methods

This qualitative study is part of a five-year longitudinal intervention (known as DRIVE) aiming to reduce HIV incidence amongst people who use drugs in Haiphong, Vietnam. DRIVE employs respondent-driven sampling to recruit drug-using individuals in the community and provides an intervention package of harm reduction, referral to treatment, and peer support (Des Jarlais et al., 2016). The Ethical Board of the Haiphong University of Medicine and Pharmacy approved DRIVE and its qualitative component. DRIVE participants provided written informed consent. On top of compensation for each study visit, participants received VND200,000 (~U.S.\$10) for each in-depth interview.

Grounded theory led our data collection and analysis. Grounded theory is a sociological approach that is based firmly on data (Glaser & Strauss, 2009). The approach aims to generate theory through comparative analysis. Theoretical sampling is a process of data collection whereby the analyst 'jointly collects, codes and analyses his data' to develop the emergent theory (Glaser & Strauss, 2009).

We conducted in-depth interviews and ethnographic field observation. The first round of interviews was done in the summers of 2016 and 2017. From the DRIVE database, we selected participants who represented a variety of characteristics including age, gender, substances used, MMT status, and HIV status. These interviews explored participants' potential hardships and social support in relation to methadone and HIV treatment (Nguyen et al., 2019). During the first round of interviews, the interview was not directly focused on stigma but stigma emerged as a spontaneous and crucial topic in participants' discourse. For this reason, adopting an inductive approach, we decided to investigate this topic more thoroughly with an additional sample in order to use participants' perspective as a way to build our second interview guide.

The second round of interviews, which we conducted in 2017 and 2018, explored stigma and other hardships that people who inject drugs encountered. We selected participants who came to the research sites in June 2017 based on criteria similar to those of the first round. Due to transportation challenges, we did not select participants who lived farther than 20 km from the city centre. We then communicated the list of potential participants to peer workers who invited them to participate in our in-depth interviews. Out of 32 people on our list, 15 could not be reached due to incorrect contact information; 17 agreed to be interviewed. No one declined the invitation.

The second round of interviews served as our main data source. After we began analysing our data, we realised we needed more data

from women and people living in downtown Haiphong to assess our emerging hypothesis concerning the intersection between addiction, HIV status, gender, and residency. Thus, we conducted theoretical sampling to retrieve the transcripts of participants with these specific characteristics from the first-round interviews. In total, the analysis was based on the accounts of 54 people who inject drugs.

From June 2017 to January 2018, and from September throughout December 2018, the first author stayed at the research sites in Haiphong for about ten days a month. Since the research sites also served as offices for peer workers, she was able to join them in their daily activities (e.g. having tea and lunch together, discussing cases) and to meet some of their clients when they came to the sites. Thanks to the introduction of peer workers, she also visited some participants' homes as a member of the DRIVE research team. Our field notes recorded observations outside the interviews and provided valuable context for the information we received from in-depth interviews. From our ethnographical work, we were able to directly observe interactions between participants and their families in concrete situations, and thus to complement participants' accounts with their families' perspectives. For example, we were able to assess how the norm of self-reliance underlies both participants' and families' discourses.

We used an iterative approach between data collection and analysis (Charmaz, 2006). We coded our interview transcripts and field notes. We used open coding until no new themes emerged (after ten cases). The codes were then grouped into larger categories to create a coding frame on NVivo 12. The subheadings in the Results section were formulated from these categories. For example, under 'family reaction to drug use', we included 'family obligations', 'family as a safety net', 'family as a source of depression', 'breadwinner' and '*kiến già nhất phận*' (each sibling cares for herself). The codes across categories included 'money is imperative' and 'poverty stigma'. Memo-writing and constant comparison were central in our analysis (Corbin & Strauss, 2014).

All interviews were conducted in Vietnamese, tape recorded and integrally transcribed verbatim. A summary of each interview and field notes (in English) were reviewed by LMG and LV. The first author coded and analysed data on NVivo 12 and discussed her insights with the other authors throughout the investigation, since many members of the research team do not speak Vietnamese.

Results

Table 1 presents the participants' sociodemographic characteristics. Men made up two thirds of the sample. Most participants were between 30 and 50 years old and lived in downtown Haiphong. 40.8% reported being married or living with a partner. Half of the participants had intermittent jobs or were unemployed. Almost 60% were currently receiving methadone maintenance treatment.

Stigma in the family: No rejection but mistrust and disrespect

A close investigation of family reactions to addiction revealed that it was complex and heterogeneous and that family spaces were supportive but not exempt from stigmatisation. Most families expressed anger, disappointment, or sadness when they first learned about the individual's drug use, often through rumours. Their first reactions included attempts to persuade their family member to stop using drugs and to support them with seeking out detoxification at home or in a facility. These attempts, however, often failed. After they witnessed repeated relapses and painful withdrawal from drug users, many families felt discouraged and gave up.

As in other Confucian societies, Vietnamese adult children, especially sons, often cohabit with their parents. Disclosing drug-using behaviour did not lead to rejection by the participants' families; they allowed their family member to continue to live under the same roof and

Table 1
Characteristics of participants (N = 54).

Age	
< 30	4 (7.4%)
30–39	21 (38.9%)
40–49	25 (46.3%)
> =50	4 (7.4%)
Sex	
Male	35 (64.8%)
Female	19 (35.2%)
Education	
Primary and middle school	20 (37%)
High school	7 (13%)
College	2 (3.7%)
No information	25 (46.3%)
Residency	
Inner city	37 (68.5%)
Outer suburbs of Haiphong	17 (31.5%)
HIV status	
Positive	33 (61.1%)
Negative	21 (38.9%)
Marital status	
Married/Cohabited	22 (40.8%)
Single	20 (37%)
Divorced/Separated/Widowed	12 (22.2%)
Occupation	
Unemployed	12 (22.2%)
Intermittent jobs	15 (27.8%)
Relatively stable jobs	27 (50%)
Currently under methadone treatment	
Yes	32 (59.3%)
No	22 (40.7%)

provided them with food and other amenities. For those who had children, families and relatives also offered childcare and provided for the children if needed. A female sex worker who had two children with her clients, described how her mother and her brother's family assumed child-rearing responsibilities:

I only came home for delivery. I did not breastfeed them. I left them with my mum and headed back to the city. They don't know who their mum is. They only know their grandma. (F, 37, sex worker, countryside)

While families did provide support for participants, this did not prevent them from devaluing their drug-using family member, whom they saw as morally compromised. Stigma deriving from the mistrusting and disdainful attitudes of family members towards participants was expressed in intimate, daily interactions within the family. Whenever a family member could not find something, they tended to exclaim: '*The addict must have stolen it!*' even when they had misplaced something through their own absent-mindedness.

After they felt their trust had been broken, some families readily rejected participants' requests for financial support, whether it was intended for a start-up project or for treatment-related activities. Family members suspected these were just new attempts to get money to purchase drugs. This attitude sometimes made participants feel helpless and frustrated:

[My parents] used to give me money but I spent all of it. Now they don't trust me anymore. I asked them to buy me a motorbike to go to treatment but they replied: "So you can sell it." Well... what else can I say? (M, 44, unemployed, downtown)
My health is not good. I often get sick. [...] but when I complain, my father says I just fake it to use drugs. (M, 38, unemployed, downtown)

As evidenced, participants were sometimes met with discrediting reactions from their families when they requested support for something other than everyday necessities. This deprecating behaviour might give them little opportunity to move beyond what are considered their past failures.

Family assistance often came with moral lectures stressing the importance of self-reliance without considering the structural barriers participants might face. A woman discussed the reason why she did not go home after relapse:

My siblings said I needed to look after myself, to save myself, that no one could save me and that each person had her own life... Of course, I know this, but sometimes [I feel sad]... They have their family, and I have no one. (F, 49, sex worker, downtown)

Although this woman believed her siblings' lessons were morally right, she felt like they did not take into account her struggles as a middle-aged woman living alone, with little education, an unstable income, and a drug dependence issue. She felt she needed support beyond lectures and money. Her family's overemphasis on self-reliance might have prevented them from playing a more important role in her recovery.

During our field observations, families showed appreciation towards individuals who managed to afford their drug use without bothering their family for money. One participant we visited at home was a peer worker's partner. He was an active methamphetamine and heroin user, but he kept bringing money home, from gambling and drug dealing. His income covered expenses for the whole family, so his partner could save her salary to pay for her own daughter's debt. She expressed her appreciation for him:

I feel better since I live with him. He is a talented person. He can earn a lot of money despite his addiction. The neighbours think I live with him because of his money but I'm very clear about that. I take care of my debt and my own expenses. (F, 42, peer worker, countryside)

She told him to quit using drugs, but her suggestions had little impact. Still, they got along well and her children loved him. By fulfilling the role of provider in the family, this participant and others similar to him were able to secure the respect and continued support of their loved ones.

Stigma within the neighbourhood: Avoidance, suspicion, or indifference

Most neighbourhoods in Vietnam, especially in the countryside and in small cities like Haiphong, consist of extended families and long-term neighbours. For many people, this is where most of their economic and social relationships occur. This makes the social space of the neighbourhood an important context of stigma.

Stigma was expressed in more diverse ways within the neighbourhood than within the family sphere. In general, it included social distancing based on fears of being bothered for money, suspicions that the drug user could not be self-reliant, and indifference when the participant was perceived to be self-reliant. Explicit aggression in the form of insults ("junkie" or "addict") on the street was rare.

Social distance was the most common form of perceived stigma and many participants believed their acquaintances avoided them for fear of being asked for money. Participants felt their neighbours no longer welcomed them. Rural neighbourhoods typically engaged in bonding acts such as dropping by or watching each other's houses. However, neighbours would find a reason to turn down participants' offers to do so. Communication became minimal even when neighbours lived close to each other. A participant felt she was unfairly treated when her acquaintances avoided her for something she did not do:

I'd never asked anyone for a dime. I did everything by myself. But people still see me in a disdainful way. [...] They heard about my drug use and they're afraid that I will come and beg them for money. (F, 41, sex worker, downtown)

Money-begging, or lack of self-reliance, therefore, has become part of the stereotype of drug users and a reason for which they are stigmatised.

On top of suffering from the begging stereotype, participants felt that people in the neighbourhood gave them suspicious or watchful looks:

We used to visit each other often, but after I was released from prison, I dropped by her house and she had to leave me alone for a while. I saw her looking vigilantly at her stuff, like some TV remote controls. (M, 35, plumber, countryside)

In the countryside, some local governments explicitly assumed that people who use drugs were potential thieves. Several participants described being summoned by the police whenever villagers reported a burglary. Individuals with a drug use history needed to provide proof of innocence before they were eventually dismissed from the list of suspects. Even when nothing happened, police officers or a chief villager still paid them regular visits to remind them not to disturb public peace.

Besides the above reports of discriminating attitudes, a majority of participants living in downtown Haiphong reported that their neighbours were indifferent to their drug use as long as participants did not bother them (or "touch" them, in the literal translation). An active user with a publicly known criminal record and compulsory rehabilitation history described how he maintained an apparently normal relationship with his neighbours by making sure he would not "touch" them.

Interviewer: How is your relationship with your neighbours?

Respondent: It's alright.

Interviewer: Do they know you're using drugs?

Respondent: They do. But since I never steal in the neighbourhood, I don't have a bad reputation.

(M, 23, unemployed, downtown)

This example shows that drug-using behaviour alone may not be the reason for perceived stigma towards people who use drugs within a neighbourhood, especially in the city.

When families and neighbourhoods stereotyped drug users as people lacking the values of hard work and self-reliance, they implicitly requested participants to manage their own financial problems and seek money somewhere else without thinking about how they might achieve that. This pushed participants to look outside their immediate networks for opportunities to support themselves. However, the larger social sphere did not respond favourably either.

Barriers to secure a socially approved job

Like in many countries, there are few job opportunities in Vietnam for people with a history of drug use. Although half of the participants had a relatively stable job, many held illegal occupations such as full-time sex work or pimping. Typically, employers are extremely reluctant to hire a person when they suspect that person to be a drug user:

I've knocked on so many doors asking for a job, but they firmly refused. [...] Maybe because I'm too thin, and I'm labelled as an addict. They might hire me during the New Year period, but afterwards they kick me out (M, 43, unemployed, downtown)

Blue collar jobs like assistant mason or delivery worker were often the first choice for people who use drugs, as they require minimal

skills. Participants were usually recruited for these positions through the recommendations of acquaintances, who for the majority were not drug users themselves. However, for many participants, years of struggle with addiction had damaged their network of non-using friends. In addition, many middle-aged participants with HIV infections could not endure the hardships of demanding physical labour.

The few people who were able to secure a legal job also encountered mistrust and social distance at their workplace. One participant, a well-spoken college graduate and methadone patient, had been working for a company delivering official correspondence. However, whenever cash was involved, the company called on a non-using driver to perform the task.

I protested to the manager, "why can't I carry this package?" He said, "This involves money. If you deliver it to a wrong address, it'll be complicated." But I immediately understood that he was afraid I'd take that money. (M, 53, motorbike taxi driver, downtown)

Although that person had secured enough trust from his manager to deliver correspondence, the drug user stereotype continued to bar him from performing certain tasks that involved cash delivery.

Workplace stigma did not exempt ex-drug users who worked with non-using individuals, even in rather tolerant environments. The following observations made on our research sites showed that, rightly or wrongly, peer workers believed their non-using colleagues engaged in stigmatising behaviours with them. While there was no obvious act of discrimination, participants did feel significant social distance.

X. kept saying that he liked us because we were "sociable, not like the girls here (the interviewers and lab technicians working at the study site) who distinguished [them from us]." (Field notes).

What were people who inject drugs stigmatised for?

Several participants witnessed negative social treatment not as a consequence of their drug-related behaviour, but as an outcome of their poverty. A participant rejected our hypothesis that his drug use caused the disdainful attitude of his relatives towards him. He argued that despite his addiction, he had never "touched" them. He said: "*Being poor is being guilty*" and explained animatedly:

You ask why being poor is being guilty? Society is helping the poor, right? The poor gets 100% free medical care. Where does this money come from? People ask, "why are you poor?"! No one wanna be poor. You work but don't have enough to eat. Don't you feel humiliated? (M, 40, mason, downtown)

The poor were guilty because others had to help them. The question "why are you poor," implied blame on the individuals who were seemingly not self-reliant enough to overcome their situation.

Sharing the above opinion, other participants pointed to the intimate link between stigma stemming from poverty and addiction, and framed their situation in terms of poverty rather than addiction.

Addiction leads to poverty, then it destroys affection. People who have money have a say. Without money, no one will listen to you. (M, 38, unemployed, downtown)

From this perspective, poverty, rather than addiction, is the direct cause of the individual's loss of status. Thus, individuals' social status seems to be dictated by their economic situation rather than by their behaviour.

Discussion

The role of stigma in reinforcing dominant social values has been extensively theorised (Fraser et al., 2017; Link & Phelan, 2001; Parker & Aggleton, 2003). The meaning of stigma is not static, but

dependant on the regime in power. Taking into consideration the significant socioeconomic changes of the last thirty years in Vietnam, this study explored the meaning of stigma towards people who use drugs in various social spheres of contemporary Vietnamese society. Self-reliance, together with self-regulation and self-determination, is a hegemonic value in the global free market (Alexander, 2008; Moore & Fraser, 2006). It implies that one should rely on one's own ability and resources to take care of oneself (Moore & Fraser, 2006).

Our findings regarding simultaneously supportive and tense familial attitudes towards people who use drugs parallel previous works, but with a different emphasis (Gunn, Sacks & Jemal, 2018; Higgs, Jordens, Maher & Dunlop, 2009; Rudolph et al., 2012; Tomori et al., 2014). Like Tomori et al. (2014), we found that the family was a major resource for participants, especially for basic needs like food, housing, and healthcare costs. However, while other studies reported that familial tension was expressed through verbal (shouting) or physical (home confinement) aggression (Higgs et al., 2009; Rudolph et al., 2012; Tomori et al., 2014), our participants reported that family members disregarded their opinions and requests through more subtly derogatory attitudes. Such reactions could have long-term implications for their mental health (Charles, Piazza, Mogle, Sliwinski & Almeida, 2013).

The feelings of shock and disappointment that the participants' families expressed are consistent with what has been described in other Vietnamese communities and other collectivist contexts (Gunn & Guarino, 2016; Fereidouni et al., 2015; Higgs et al., 2009; Li, Wang, He, Fennie & Williams, 2012; Rudolph et al., 2012). The individual's drug use is not an individual affair; it affects the whole family. Such feelings reflect the importance of family cohesion, and possibly a fear of "losing face", both of which are salient in many family-centred cultures (Fotopoulou, Munro & Taylor, 2015; Yang & Kleinman, 2008). For that reason, families feel responsible for rescuing individual members, as well as themselves, from drugs. As methadone maintenance treatment and the perception of addiction as a chronic disease have only recently been introduced in Vietnam, most families still believe addiction is an acute condition that can be solved with detoxification and determination (Higgs et al., 2009; Tomori et al., 2014).

The practice of stereotyping people who use drugs as untrustworthy individuals has been reported in other studies (Earnshaw, Smith & Copenhaver, 2013; Rudolph et al., 2012). As in previous findings, the families in our study readily viewed participants as liars and potential thieves who could deceive their families for money. Although the stereotype might have been construed from lived experience, maintaining such negative definitions of drug users makes it impossible for families to appreciate the good intentions of participants and to provide them with needed support during their recovery.

Familial appreciation of participants who were able to manage their drug use by themselves illuminates the social expectation of self-reliance in the Vietnamese context. People who use drugs might still be able to secure respect from others if they can prove their financial independence and fulfil their expected duties, including those of provider, although what respect they secure as providers might still be compromised by drug user stereotypes. This finding explains the aspirations to financial self-reliance we found amongst drug-using individuals who self-discharged from or refused methadone treatment so that they may be able to work (Nguyen et al., 2019).

While social alienation and mistrust of people who use drugs have been commonly reported in previous studies (Maher, Coupland & Musson, 2007; Niewegłowski et al., 2018; Rudolph et al., 2012; Tomori et al., 2014), the indifferent attitude of neighbours towards participants who did not bother them is quite novel. This perceived indifference might come from both sides. The neighbours might be more indifferent to how their drug-using neighbours are doing; and partici-

pants might also be paying less attention to how their neighbours see them. Alexander (2008) suggests this indifference results from a weaker engagement in communal life in an encompassing market economy. This attitude might signal its members' lack of community interest, but also that the end goal in a neoliberal society—being self-reliant—is more important than creating the necessary means to achieve it.

The challenges people who use drugs encounter in securing a socially approved job have been well known (Lloyd, 2013; Niewegłowski et al., 2018). Participants' limited professional training may restrict their job opportunities to low-wage and less skilled occupations. A known drug-use history may discourage potential employers and attract negative rumours and prejudice amongst co-workers (Niewegłowski et al., 2018; Tomori et al., 2014). Moreover, the inflexible operation of methadone treatment programmes may also hinder participants' opportunities to secure a job (Nguyen et al., 2019). In addition, the stigmatising attitudes of co-workers can discourage people with a drug use history from engaging in their jobs (Earnshaw et al., 2013).

While we observed that families and communities seemed to judge participants based on their ability to self-sustain, we cannot say that activities generating illegal income were socially approved. Families and neighbours might assume that participants were good enough to secure a legal job to support themselves and their family while being oblivious of the structural barriers they face. This might push drug-using individuals into the Mertonian deviant conformism whereby they engage in illegal activities, trading their health and safety for social status within their immediate networks (Ogien, 2012). Bourgois (2003) found similar findings in his seminal ethnographical work in a drug-laden neighbourhood of New York where its Puerto Rican inhabitants internalised the American virtues of self-reliance and material wealth and sought to achieve it in the clandestine economy after multiple failed attempts to get a socially approved job. Those who could not conform to social expectations were prone to depression due to a feeling that they had failed to achieve important goals (Ahern, Stuber & Galea, 2007).

The reframing of drug-related stigma as poverty stigma is unique, although some entanglement between drug use and poverty stigma has been reported in other studies (Conner & Rosen, 2008; Lim et al., 2013; Rudolph et al., 2012). Conner and Rosen (2008) argued that people who use drugs were subjected to poverty stigma besides negative treatment for their drug-use behaviour. Previous studies conducted in Vietnam showed that economic power differences were positively associated with levels of drug-related stigma (Lim et al., 2013), and that financial dependence was the cause of drug users' loss of status in their family (Rudolph et al., 2012). This finding suggests that the interpretation of drug using behaviour has evolved from an anti-communist, evil act to the opposite of self-reliance. From this perspective, modern Vietnamese society may be undergoing social changes whereby material wealth becomes the utmost criteria of judgement.

The relationship between addiction and free market mechanisms has been discussed by Alexander (2008), although he theorises the causal relationship between the psychological dislocation brought about by the global free-market economy and addiction. This can be indeed a vicious circle whereby relative poverty causes addiction and addiction reinforces poverty through mechanisms stigma or vice versa.

Recommendations

This study's findings show that it is necessary to place drug-related stigma within a larger social context. Link and Phelan (2001) suggest intervention must be multifaceted and multileveled to address both individual and structural discrimination. We recommend concerted interventions that take into account the many facets of participants' challenges instead of narrowly focusing on drug-using behaviour.

At the policy level, further aid on income generation would help people who use drugs regain a sense of self-reliance. First, it is necessary to put in place mechanisms to improve the implementation of current financial assistance policies for this population such as low-interest loans (Government of Vietnam, 2014). Given their low education, assistance to develop a sound project and to navigate the administrative procedures would increase the uptake of such aid. Second, the government could recruit people who use drugs for jobs that best suit their expertise, e.g. peer outreach workers or peer educators in community-based organisations or in treatment programmes. An insider's knowledge would help them work effectively with other users to deliver harm reduction information, refer clients to treatment and assist patients during the treatment process. Thus, this would foster their financial independence, increase their social status, and most importantly help them gain a sense of meaning.

At the programme level, medication-assisted treatment programmes should be more patient-friendly. A flexible dosing schedule and medications with longer-term effects (e.g. extended-release naltrexone (Jarvis et al., 2018), prolonged-release buprenorphine (Vorspan et al., 2019)) should be made available to accommodate those who work or seek a job. Most importantly, addiction professionals should be trained to view the big picture where drug problems interrelate with other personal and structural issues, so that they can develop a comprehensive treatment plan with referral to social services. To foster more meaningful family support, treatment programs might start by developing a three-party treatment plan that involves families, patients, and addiction professionals. One goal of the treatment plan would be for patients to regain their self-reliance. The plan would specify how different parties would contribute to achieving this goal. Regular reviews of the treatment plan would help families better understand the broader situation of patients, and would enable them to provide assistance to their family member.

Limitations

The findings of this study should be examined within its limitations. Most of our participants belong to the lowest social classes and therefore face poverty and low levels of education. In attempting to assert their self-reliance, they might encounter distinct barriers from people who use drugs with greater resources. Haiphong might also be unique in its transition from a rural, collectivistic lifestyle to a more urban, individualistic one. Thus, the challenges our participants experienced might be different from people who use drugs in larger cities or in more rural areas. The methods we used for this study would have been more rigorous if we had been able to conduct more interviews to strengthen our findings instead of using previously conducted interviews, although the two samples had similar characteristics and came from the same population.

Conclusion

This article describes the meaning of stigma towards people who inject drugs in Vietnam. It sheds light on the evolving values of contemporary Vietnamese by evincing what is considered legitimate. Stigma towards drug-using individuals was expressed in daily, intimate interactions within families and in neighbourhood contexts. Stigma was perceived as being not centred on drug-using behaviour but on the ability of individuals to be self-reliant. However, participants do not receive the support they needed to overcome the obstacles necessary to secure a socially approved job. Consequently, in order to conform to social expectations of self-reliance, many have taken part in the illegal economy. Thus, instead of focusing exclusively on drug-using behaviour, effective interventions must take into account the multileveled, multifaceted issues of people who use drugs.

Author contribution statement

The idea and methods of this sociological study was conceived by Nguyen Thu Trang, in consultation with Le Minh Giang and Laurent Visier. Nguyen Thu Trang carried out the interviews, ethnographic observation and home visits. Laurent Visier and Le Minh Giang supervised the field work.

Nguyen Thu Trang investigated the transcripts and discussed findings with Le Minh Giang and Laurent Visier. Le Minh Giang validated the findings based on his familiarity with the population. Nguyen Thu Trang discussed the idea of this article with Laurent Visier and Le Minh Giang.

Nguyen Thu Trang was in charge of developing the manuscript. The drafts were reviewed multiple times by Marie Jauffret-Roustide, Le Minh Giang, and Laurent Visier.

Le Minh Giang and Marie Jauffret-Roustide acquired the funding for this sociological project. Laurent Visier is the thesis director of Nguyen Thu Trang.

Ethics approval statement

I confirm that the study titled *DRug use & Infections in ViEtNam: ending the HIV epidemic amongst people who inject drugs in Haiphong, Vietnam* (NIDA R01 DA041978 / ANRS 12,353 DRIVE study)) and its qualitative component, on which this manuscript is developed, has been approved by the Ethical Board of Haiphong University of Medicine and Pharmacy.

Declarations of Competing Interest

None

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