A Dialogue with Injection Drug Users: 
Their Perspectives on Behavior Change for HIV Prevention
This report is part of a series on the perspectives of three population groups at high risk for HIV transmission on their own behavior change for HIV prevention: female sex workers, injection drug users, and men who have sex with men. If you would like copies of any of these reports, please contact FHI at 84-4-934-8560 or by email: fhvn@fhi.org.vn. This work was made possible by contributions from health educators and voluntary counseling and testing (VCT) staff. Special thanks to Mai Hoang Anh for her work analyzing and synthesizing the material.

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The 2005-2006 Integrated Biological and Behavioral Surveillance (IBBS) survey suggested that high-risk behaviors persist among injection drug users (IDUs) and that HIV prevention programs in some areas were limited in reach. Key areas identified by IBBS as needing improvement included:

- High prevalence of needle and syringe sharing in the past month
- Low rates of consistent condom use with sex partners
- Low access to and use of voluntary counseling and testing (VCT) services and irregular check-ups for sexually transmitted infections (STI)

The IBBS was designed to provide data regarding levels of HIV, STI, risk behaviors, and exposure to interventions in IDU populations. However, quantitative data from IBBS was not designed to provide program managers and health implementers with a contextual understanding of why risk behaviors persisted and why exposure to interventions was low in some cases. FHI/Vietnam is using qualitative data to improve HIV prevention for IDUs. The IBBS team conducted an IDU client needs assessment in July and August 2007 to define the program’s next steps. To address underlying personal, social, and environmental reasons for IDU risk behaviors, and the context in which these behaviors occurred, with technical support from Family Health International Vietnam (FHI/Vietnam) and funding support from USAID/PEPFAR, health educators and VCT staff conducted a rapid assessment in four provinces: Hai Phong, An Giang, Quang Ninh, and Can Tho. Through qualitative interviews with IDUs, health educators sought to better understand barriers to reducing unsafe injection, safer sex, and problems in accessing VCT and STI services. Qualitative in-depth interviews with IDUs have also provided client-level insights on barriers to behavior change and recommendations to improve interventions. Interviews were not meant to be ethnographic qualitative investigations but rather rapid interviews between health educators and the beneficiaries as part of a quality assurance and improvement function. This approach may lead to some bias, but has the benefit of health educators learning about the needs of the target population.
Key Findings

BARRIERS TO REDUCING UNSAFE INJECTION

1. IDU ‘trust’ for their sharing partner prevents reducing unsafe injection practices

Nearly all IDU clients said that they have shared needles and syringes at some point in their life. Most clients said that they only shared needles and syringes with those they were intimate with - a spouse, a lover, a family member, or a close friend. The primary reasons for sharing were trust and a belief that their sharing partner was safe. This sharing had the value of demonstrating trust for one another. Thus, refusing to share was difficult with someone with whom intimacy and trust had developed. Spouses believed that if one person was infected it was inevitable that they would also be infected.

“I heard that it was possible to be infected with HIV but we were intimate partners so I did not think of HIV anymore.” –Can Tho

“I have heard about HIV transmission, but we are a couple so we have to trust each other.” –An Giang

“We are husband and wife, so if one of us gets sick we will be sick together.” –An Giang

2. Shared injection equipment

Most IDUs stated that they knew the risks of sharing injection equipment but would still do so when they did not have enough money to purchase an individual dose. Drug dependence forced them to pool money for the purchase. IDUs also explained that when drugs were pooled, the group often pressured each person to share injecting equipment, insisting that separating the drug would cause bits of it to stick to the syringes and lead to waste.

“When you are craving and you beg someone for heroin, you will be refused if you want to use separate needles and syringes.” –An Giang

“I can hardly refuse to share with my friends, especially when they ‘save’ my life [when I am suffering from withdrawal and have no drugs]. I dare not ask for separate needles and syringes.” –Can Tho

“For us, the drug is the most important. Three of us pooled money to buy one dose. It’s wasteful to use separately. We consider every single drop is like a drop of blood, so we put it all in one syringe and injected together. We did not think of diseases at that time.” –Quang Ninh

“Separate the drug? Some of us have to share a dose; if someone is clumsy and drops the drugs when separating, the drug is gone. We are not such fools to do so.” –Quang Ninh
3. Limited finances

Almost all IDUs said that when they shared injecting equipment it was due to lack of money. When they pooled money to buy drugs they had no money left to buy clean needles and syringes.

“I was suffering strongly from withdrawal. I used all my money for the drug. I didn’t have money to buy a needle and syringe so I shared with a few friends.” –Quang Ninh

“I’ve heard a lot about the risk of HIV infection but I still shared needles and syringes because cravings and withdrawals made me forget everything.” –Hai Phong

“We pooled together 100,000 dong, enough only for one dose. We didn’t have enough to buy a new needle and syringe.” –Quang Ninh

4. Low access to clean needles, especially at night

IDUs frequently cited that the most persistent environmental barrier to reducing unsafe injection was the inability to purchase needles late at night. Pharmacies were the most common place to purchase new needles and syringes and they were never open in the middle of the night, when many IDUs gathered to inject.

“Late at night, no one sells needles and syringes.”
–Can Tho

“… It’s usually very late at night and the pharmacist is closed when we get the drugs; we cannot buy clean needles and syringes so we just inject with whatever needles and syringes we have.” –An Giang

“If you inject at night, it is hard to buy needles and syringes; if we went to a pharmacy they would not dare open the door and sell to us.”
–Hai Phong
5. Stigma from the community

IDUs wanted to protect themselves and their families from stigma if identified as using drugs. They feared buying needles due to their association with drug use.

“I don’t dare buy needles and syringes for fear of being seen by my family or acquaintances, so I think it is better to share with a friend.” – Quang Ninh

“I have a lot of friends and family. They would find out about my drug use if they see me buying needles and syringes.” – Quang Ninh

“If the head of the residential section sees me buying needles and syringes, the very next day he will come to my house to complain and inform my family. Commune leaders will keep an eye on me all day.” – Quang Ninh

6. Fear of discovery by family

Fear that their drug habit will be discovered by their family drove many to share needles with others rather than be seen purchasing them.

“My family doesn’t know I am injecting. If I buy needles and syringes, they will tell my family. I will die if my wife finds out about it.” – An Giang

“Up to now, my parents don’t know that I am injecting drugs, so I am given some petty cash every day. If I now go and buy needles and syringes, they will know and blame me. They will force me to quit and won’t give me money so that I can’t inject anymore. It is safer to share with some of my friends.” – Quang Ninh

“I dare not buy needles and syringes to keep at home. My mom would kill me if she knew.” – An Giang

7. Fear of harassment/arrest by the police

IDUs feared being caught with drugs by the police, and thus chose to not carry needles and syringes with them when going to inject. They also viewed sharing as quicker and easier than shooting up separately.

“I am afraid that other people will know I am an addict if they see me buying needles and syringes. Also, the police will catch me if they detect that I am carrying needles and syringes with me.” – Hai Phong

“When we are short of needles, we share and just want to finish quickly so we will not be caught when the police suddenly show up.” – Quang Ninh

“When it is very late at night, the pharmacy is closed. I dare not call out loud to the pharmacist, as I am afraid of night watchmen.” – An Giang
8. Lack of a sense of personal responsibility to prevent HIV

In some instances, clients who knew they were HIV-positive continued to share needles, knowingly putting others at risk. This lack of personal responsibility to prevent HIV transmission presents a major barrier to limiting transmission, especially in provinces where sharing injecting equipment is common.

“I have been tested. I am infected already so why do I have to use separate needles and syringes and waste the drug.” — Cam Pha

Overcoming barriers to reducing unsafe injection

A primary prevention message that IDUs wanted to give to others injecting is to not ‘trust’ their friends. IDUs emphasized that friends and family were not to be trusted as free from infection and that one should always be prepared by carrying separate needles and syringes.

“Always keep clean needles and syringes in a safe place to use in the night to prevent sharing them with others.” — Chau Doc

“I recommend one person one needle. If not, then you have to give up the drug.” — Quang Ninh

A second recommendation by IDUs was to greatly expand distribution of clean needles and syringes and give more needles for each day. For the severely addicted, reducing unsafe injection was secondary to alleviating withdrawal symptoms. IDUs indicated that needles and syringes need to be abundant and on hand otherwise many would ignore the need to reduce unsafe injection for a quick fix.
“We should be provided with three to four needles and syringes and bleaches a day.” – Hai Phong

“Each day I inject three to four times. If you give only one needle, this isn’t enough to use separately.” – Quang Ninh

The schedule for needles and syringes distribution needs to include evenings and locations where IDUs congregate.

“At night no one sells, and I don’t like to go and ask for needles all the time from Thinh. Also, many times I am far away (from Thinh).” – Quang Ninh

Others recommended that drug addiction treatment be offered at clubs.

“I thought the clubs would have some drug addiction treatment available on location but there was nothing.” – Quang Ninh

“The club should provide free medicine to treat drug dependence for us, as we used drugs by mistake and became dependent. It is hard to quit now unless we are treated by medicine.” – An Giang

One person recommended that families be trained and sensitized to give support to drug users who were attempting to quit.

“I really want to quit, but whenever I do quit, no one believes in me. I don’t know what to do and so continue injecting.” – Quang Ninh
**BARRIERS TO CONSISTENT CONDOM USE**

1. **Love for partner**

Condoms were considered inappropriate when there was love and intimacy with a partner. For many, condoms symbolized distrust, thus, to not use condoms was an indicator of trust in the partner and in the relationship.

“For best girlfriends who look strong and healthy, I think it’s safe, as they do not have any diseases [so I don’t use a condom].”
–Can Tho

“I don’t use condoms with my girlfriend because I trust her.”
–Hai Phong

Even when one partner knew the other had a high risk of being infected, they risked HIV transmission as an act of love.

“My [ex] husband died of AIDS. I loved him and we never used OK (condoms). Because I loved him.”
–Hai Phong

2. **Lack of ability to negotiate condom use with partners**

It was not uncommon for IDUs’ partners to be the ones that refused condoms. Interviewees said that they tried to convince their partners to use condoms without success.

“I didn’t use a condom last time, as my girlfriend didn’t want me to use one.”
–Can Tho

“We’ve been in love for two years but had sex with each other for about the past year. My girlfriend doesn’t want me to use a condom. She said that she had an ‘itch’ once when she used a condom and never used them again.”
–Quang Ninh

3. **Alcohol and strong physical attraction to a partner**

Alcohol was cited as a behavior that negatively impacted on condom use and impaired safe sex decisionmaking.

“Two years ago, once when I was drunk, and asked to have sex with a FSW, she agreed after I insisted. Now I feel disgusting anytime I think of it.”
–Quang Ninh

Many indicated that their resolve to use condoms lessened if there was a strong attraction to their partner, especially if they were purchasing commercial sex.

“She looked too attractive for me. Using a condom would lose my ‘high’ feeling.”
–Quang Ninh

4. **Misunderstanding among IDUs about HIV and routes of transmission**

For some, unsafe sex was the result of not fully understanding how HIV can be transmitted.

“…I think it doesn’t matter with oral sex. I never use condoms when having sex with FSW.”
–Quang Ninh

“In the past, I did not use condoms when having sex with FSWs, as I did not know much about the routes of HIV transmission.”
–Hai Phong
In addition, some had the misconception that there was less risk if their partner was attractive.

“She looks so healthy and beautiful. How can she be infected?” – Quang Ninh

“I don’t use condoms because I believe that my partner doesn’t have any diseases.” – Can Tho

Similarly, judging only by physical appearances, some believed that there was more risk for HIV transmission if the sex worker was unattractive.

“I never use a condom, unless I am with a woman who is too ugly.” – Hai Phong

5. Feelings of powerlessness, especially among those already HIV-infected

Some clients who knew they were HIV-positive indicated that they felt that they had the power or responsibility to protect others from HIV. However, some clients continued to have unprotected sex with female sex workers.

“I am already infected; I don’t need to use condoms anymore.” – Hai Phong

“I don’t use condoms with female sex workers because I have already been tested and know the result.” – Hai Phong

“Since knowing that I was infected with HIV, I have had sex once or twice with sex workers without using a condom.” – Hai Phong
Recommendations to create consistent condom use

Clients emphasized the need for increasing social awareness of HIV risk and a need to heighten individual responsibility for protecting one’s health as well as the health of others. Some indicated that mass media and information campaigns could be intensified and targeted at entertainment establishments.

“Now, I want to protect myself a lot. But I dare not tell my friends to do so. If the project can provide information and guidance for many others like me, they will accept change.” –Quang Ninh

“Spread out IEC activities and distribute a lot of condoms at bars and restaurants. It can be included with the message: You are so beautiful, but I still have to use a condom.” –Quang Ninh

BARRIERS TO VCT SERVICES

1. Low awareness of the benefits of knowing HIV status

Clients said that they hesitated to take advantage of free VCT services because HIV was an inescapable part of life as an addict. They said that knowing would not provide any benefits, but would only cause them “worry and anguish”.

“I can live for some time without knowing anything about my health status. There is no need to have a test, as I am most likely infected already!” –Hai Phong

“I am probably already infected. If I don’t know for sure, I don’t have to worry as much.” –Hai Phong

2. Disbelief of risk and lack of symptoms

Despite risk behaviors such as needle sharing, some clients said they did not believe they were at risk for HIV, were HIV-infected, or had reason to go for testing because they showed no physical symptoms of ill health.

“I feel that I am healthy. I don’t have any symptoms at all.” –Hai Phong

“I’ve never had a test, as I don’t see or feel any signs/symptoms of the disease even though I did share needles and syringes.” –An Giang

Some stated hopelessness in protecting themselves against HIV because of their addiction, and said that knowledge of HIV status was of no value.

“I haven’t gone to get tested because I still feel healthy, but when you are addicted like me there is not much use in getting tested.” –Hai Phong
3. Fear of stigma and discrimination from health staff

Fear of stigma and discrimination was a common barrier for many in accessing VCT services. IDUs feared testing would both reveal that they used drugs and they were HIV-infected.

“I don’t like to get tested and have other people know my HIV status. If I knew, I would just be ashamed and think too much.” –Hai Phong

“I haven’t had any test because I am afraid to worry and that my family will know about it.” –Can Tho

4. Fear of knowing HIV status

Clients commented that they were fearful of knowing whether or not they were HIV positive. Many indicated that they were psychologically unprepared to handle the knowledge of a positive test result.

“If I got tested and found out that I had HIV, I would worry all the time. What a headache.” –Hai Phong

“I didn’t go there before because I dared not face it (HIV).” –Can Tho

“If I got tested, I would worry more. If I was positive, I would be scared.” –Quang Ninh

5. Lack of awareness of VCT services

While the majority of IDUs were aware of VCT services in the community and could remember their names and locations, several clients said that they were not aware that such places existed.

“I don’t know where, and I am a new user so I dare not go there.” –An Giang

BARRIERS TO STI SERVICES

1. Lack of symptoms

Clients frequently said that they did not test for STIs because they showed no physical symptoms of illness. Many male clients did not realize that STIs could be present without noticeable symptoms. Thus, they mistakenly assumed they were healthy without testing.

“I am free of disease. I have neither ‘mồng gà’ (genital warts) nor ‘hột xoài’ (lumps), so why the hell am I going to have STI screened?” –An Giang

“I don’t have any disease so I don’t go. My ‘exhaust-pipe’ is very good, my ‘gun’ still works well.” –Quang Ninh

“I don’t have anything wrong with me so why get tested? When I have something wrong, I will think about it. But for now everything is fine.” –Quang Ninh

2. Inconvenience

A few IDUs stated that using STI services was inconvenient and time-consuming. They were especially discouraged to go because of a perception that the procedures were complicated.

“No, I don’t go because the administrative procedures are too complicated.” –Hai Phong
3. Fear of knowing STI result

Clients commented that an STI-positive test result would cause worry and anguish. No clients mentioned that the long-term benefits of knowing and treating an STI would outweigh the initial concern about the cause of a positive test result.

"Many days I am scared. I am afraid it will make me worry and think more... there are times I really want to go." – Quang Ninh

“If I got tested, it would worry me more. If I was infected, I would be scared.” – Hai Phong

4. Cost of services

Respondents frequently noted cost of STI services and medicines as a barrier.

“I don’t want to use it. Other reasons? I don’t like to go because I think it will cost money.” – Hai Phong

“Because I can fix the problems at home and it will cost less money.” – Quang Ninh

NOTE: THIS QUESTIONNAIRE DID NOT ASK RESPONDENTS FOR RECOMMENDATIONS ON VCT SERVICES.
Conclusions and Recommendations

In addition to structured interviews with participants and peer educators, FHI held a focus group with staff members from the programs. Following is a summary of their recommendations.

**DECREASE UNSAFE INJECTION**

- **Increase clients’ commitment to protecting themselves as well as their sense of accountability for others.** Interventions focused on building clients’ “self-efficacy” to protect themselves and others from HIV are essential and should be prioritized. Many IDUs expressed hopelessness about protecting themselves, believing HIV to be inevitable. The HIV epidemic spreads in IDU networks due to their low self-esteem, despair, and feeling that they can’t make a difference. Interventions to build a sense of personal accountability in protecting others would also help reduce the spread of HIV through risky injecting behaviors.

- **Increase access to needles and syringes through non-traditional outlets using non-PEPFAR resources.** For injection drug users who cannot or will not stop injecting, sterile needles and syringes remain the most effective approach for limiting HIV transmission. Comprehensive drug treatment and prevention programs, including risk reduction that can reduce needle sharing, need to be strengthened and expanded within the policy parameters of specific donors as well. The lack of access to needles, especially late at night, was cited by many IDUs as a primary barrier to reducing unsafe injection.

  Currently, the selling and distribution of needles and syringes is primarily through peer educators of non-PEPFAR-supported projects, pharmacies, clinics and hospitals. IDU clients and peer educators recommended using non-traditional outlets (NTOs) for the sale of needles and syringes in Vietnam, such as through motorbike taxis or through small street vendors. The expansion of NTOs for condoms has greatly increased availability and use of condoms for safe sex; similar programs should be piloted for clean needles and syringes for reducing unsafe injection.

- **Coordinate with donors to support risk reduction programs.** Risk reduction is an essential component of a comprehensive and effective HIV and drug intervention program. It is currently not prioritized and is under-funded in Vietnam. International agencies and government agencies need to advocate for funding and coordinate the use of these funds with agencies currently working in this area.
• Develop policies to create a destigmatizing and enabling environment for reducing unsafe injection. Needle sharing practices are common among IDUs and make them vulnerable to HIV transmission. Widespread interventions to reduce unsafe injection, including needle exchange and distribution programs, are lacking in Vietnam. Stigmatization of IDUs could also hinder effective social marketing for reducing unsafe injection as well as expansion of NTOs for clean needles and syringes. Policies need to be developed to create an enabling and destigmatizing environment for the sale and distribution of needles and syringes.

• Facilitate a supportive environment for reducing unsafe injection through family, community, and peer involvement. Recommendations from IDUs and peer educators stressed the need for involving family, community, and peer support for reducing unsafe injection. Recommendations included expanding peer outreach programs and involving IDUs’ partners, family members, “xe om” drivers and other peers to encourage and remind IDUs to use clean needles and syringes.

• Make effective drug treatment programs widely available. The lack of effective drug treatment and drug substitution in Vietnam perpetuates drug use and drug relapse, yet special interventions for recovering drug users from 06 centers would be effective in reducing risk behaviors. With the release of several thousand recovering drug users in the coming years, this population will require medicated, assisted therapy, such as methadone, to prevent drug relapse.

• Expand risk reduction programs. For IDUs who cannot or will not stop injecting, using sterile needles and syringes remains the most effective approach for limiting HIV transmission. Comprehensive drug treatment and prevention programs, including risk reduction that can reduce needle sharing, need to be strengthened and expanded. These interventions should be promoted not only among traditional drug user networks but other most-at-risk populations including female sex workers and men who have sex with men. Outreach and community programs must also be strengthened to reach those IDUs that do not access needle exchange programs and are not readily being identified.
CONSISTENT CONDOM USE

- **Increase clients’ ‘self-efficacy’ and accountability to others.** Clients need personal commitment and resolve to protect themselves and others from HIV. Intervention programs need to build their belief that they can take control of their actions and that they can effectively protect their loved ones.

- **Increase injecting FSWs’ ability to effectively negotiate condom use with their regular partner.** Many injecting FSWs stated that they did not feel they had the skills to effectively negotiate condom use with either their regular partners or their male clients. Barriers to condom use differ among FSWs and their clients. Therefore, negotiation skills need to be adapted for different types of FSWs and their partners.

- **Dispel misperceptions about HIV transmission and beliefs that prevent consistent condom use.** Results from the rapid interviews indicated that misperceptions on HIV transmission were still a barrier for IDUs. Mass media and behavior change campaigns need to address these knowledge barriers and myths, which are still very common in IDU networks.

- **Facilitate a supportive environment for consistent condom use through peer involvement.** Peer educators stressed the need for involving peer support for consistent condom use. Recommendations included involving IDUs’ partners and other peers to encourage and remind IDUs to protect themselves and their partners from HIV/STI transmission.
INCREASE UPTAKE OF VCT AND STI SERVICES

• **Build awareness of the benefits of regular testing.** HIV continues to spread when people do not know they are infected and continue to have unprotected sex even with their regular partner.

• **Improve quality and convenience of VCT/STI services.** Many IDUs stated that VCT and STI services needed to be improved and provide greater convenience. Both IDUs and peer educators recommended that drop-in centers, VCT, and STI sites should provide integrated services that include VCT, STI services, medicines, edutainment, and referrals.

• **Increase access to VCT/STI services through innovative branding and targeted outreach.** Targeted interventions are needed to increase uptake of VCT/STI services by IDUs. Mobile clinics that provide integrated VCT and STI services could be piloted to reach IDUs who live far from the city center or who lack transportation.

• **Increase capacity of VCT and STI health service providers to deliver client-friendly services.** IDUs have many barriers to going for regular check-ups, including shame that they will be identified by the doctor or health staff as a drug user and thereby receive judgmental treatment. Training and sensitizing VCT and STI service providers to provide friendly and destigmatizing care and treatment can help improve regular uptake of VCT/STI services.

• **Media campaigns to destigmatize use of VCT and STI services.** IDUs cited fear of stigma and discrimination as a key barrier to accessing necessary treatment of STIs as well as counseling and testing of HIV. In Vietnam, use of VCT and STI services is stigmatized and many think that these services are only for most-at-risk populations. Rapid expansion of and communication on VCT/STI services, especially for clients of sex workers, would reduce the stigma associated with these services and also improve the level of risk awareness.