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“In their perception we are addicts”: Social vulnerabilities and sources of support for men released from drug treatment centers in Vietnam

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Abstract

Background—Amid the global transition to treat opioid addiction as an illness, many people who inject drugs (PWID) face heterogeneous legal environments that include both punitive and harm reduction measures. In Vietnam, many PWID, who have a high burden of HIV, are sent to drug treatment centers, or “06 centers”, for compulsory detoxification, vocational training, and labor for up to four years. This study investigates the challenges and facilitators of reentry into community and family life among men who are released from “06 centers” and provides insights and recommendations for developing policies and interventions that address special needs of this vulnerable population.

Methods—In-depth interviews were conducted in 2011 by trained interviewers among a sample of 43 male PWID released within the past 2 years from “06 centers” in Hanoi, Vietnam to investigate the above issues and to recommend potential interventions. Participants were recruited from outpatient HIV clinics that serve PWID (n=22) and through peer referral from self-help groups for PWID (n=21). Interviews were audiotaped, transcribed, translated, entered into Atlas.TI qualitative data analysis software and analyzed for key themes.

Results—The interviews revealed persistent drug-related stigmatization, frequently paired with HIV-related stigmatization and discrimination, which hindered employment, increased participants’ social isolation and exacerbated their struggles with addiction. Families were participants’ primary source of financial, employment, and emotional support, but addiction-related family tensions also had negative psychological effects. Participants identified methadone

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maintenance treatment as an effective means of overcoming addiction, yet few could fully benefit from this treatment due to its limited availability.

Conclusion—Our study suggests that PWID released from “06 centers” would greatly benefit from the scale-up of community-based harm reduction measures that include addiction and HIV treatment, coupled with employment-support and family-centered mental health services.

Keywords

Injection drug use; HIV; Vietnam; compulsory detoxification; social reintegration; social vulnerabilities

INTRODUCTION

An estimated 14 million people inject drugs around the world (UNODC, 2013). People who inject drugs (PWID) face high morbidity and mortality, primarily from drug overdose and infectious disease, including HIV (Degenhardt & Hall 2012; Mathers, et al. 2013; UNODC 2013). Harm reduction efforts that address addiction and infectious disease prevention and treatment can markedly improve the health of PWID and reduce the risk of illness for others in the community, but implementation of these measures remains slow (Degenhardt, et al., 2010; Gowing, Hickman, & Degenhardt, 2013; MacArthur, et al., 2012; Strang, et al., 2012; Strathdee, Shoptaw, Dyer, Quan, & Aramrattana, 2012). Calls for the treatment of drug addiction as an illness and the removal of punitive measures have often resulted in a heterogeneous policy environments, wherein punitive measures remain in use alongside harm reduction efforts (Csete, et al., 2011; Edington & Bayer, 2013; Hall, et al., 2012; Wolfe & Saucier 2010; WHO, 2009). In several Asian settings PWID continue to experience lengthy detainment in compulsory detoxification and rehabilitation centers, where they often lack access to evidence-based addiction treatment and HIV-related services and may be subject to human rights abuses (Human Rights Watch, 2012; Juergens & Csete, 2012; Mendez, 2013; WHO, 2009). These concerns led the United Nations to issue a joint statement recommending the closure of compulsory detoxification centers (UN, 2012). Moreover, the large population of PWID who have been released after lengthy detainments face high relapse rates, are often in poor health, requiring additional care and resources (WHO, 2009). Our research highlights the experiences of such PWID released from compulsory detoxification centers in Vietnam and illuminates the key challenges, sources of support, and opportunities for intervention for this vulnerable population.

In 2012 there were over 171,000 registered drug users in Vietnam, nearly all men, the majority of whom (85%) inject heroin (UNODC, 2012), but the actual population of drug users may be over 300,000 (Government of Vietnam, 2012) and the prevalence of injecting drug use has continued to increase (UNODC, 2013). HIV-prevalence among PWID remains high at 13.4%, with wide variation among provinces ranging from 1.1% in Hoa Binh to 45.7% in Dien Bien (Government of Vietnam, 2012).

Concern over the rapid escalation of drug use and HIV in the early 1990s led to government campaigns that linked the spread of HIV to drug users and labeled drug use a “social evil” (Hammett et al., 2008; Thi et al., 2008; Vuong, Ali, Baldwin & Mills, 2012). Measures to

reduce drug use included compulsory detoxification in drug treatment centers, or “06 centers” (following Government Resolution No.06 that established them), managed by the Ministry of Labor, War, Invalids and Social Affairs, where drug users undergo a brief course of detoxification, followed by vocational training and manual labor for 2–4 years (Hammett, et al., 2008; Quan, Hien, & Go, 2008; Vuong, et al., 2012). As a result of their association with “social evils,” both drug users and people living with HIV/AIDS (PLHIV) are highly stigmatized and marginalized (Hong, Nguyen, & Ogden, 2004; Thi, et al., 2008; Vuong, et al., 2012).

The expanding HIV epidemic in Vietnam prompted the institution of new policies in 2005 that recognized addiction as an illness and emphasized harm reduction, including needle exchange programs, methadone maintenance treatment (MMT), HIV testing and treatment in the community (Hammett, et al., 2008; Vuong, et al., 2012). Ambitious plans are underway to expand MMT services to 80,000 drug users by 2015 (Anon, 2013). These efforts, however, have not yet reached the majority of drug users and contradictory policies towards drug use persist (Edington & Bayer, 2013; Government of Vietnam, 2012; Vuong, et al., 2012). In 2009 drug use was decriminalized, but remains an administrative violation that may result in detainment in an “06 center” for 2 years for detoxification, possibly followed by 2 years of post-detoxification management in a labor center (Government of Vietnam, 2012).

Today 126 “06 centers” remain across Vietnam, where tens of thousands of PWID have undergone compulsory detoxification (UNODC, 2012). HIV prevalence at “06 centers” is very high, up to 50% (Government of Vietnam, 2012). Within these centers, the availability of HIV prevention and treatment is currently limited and evidence-based addiction treatment is lacking (Government of Vietnam, 2012). Few available health and social services are available to PWID after their release, hindering their ability to become healthy and productive members of their communities and families. An estimated 70–95 % of those released from “06 centers” relapse to drug use and are subject to repeat arrest, detoxification, and detainment (UN, 2012). PLHIV may experience additional challenges due to HIV-related stigma and HIV’s association with drug use (WHO, 2009).

Recently, Vietnam announced its intention to reduce its reliance on “06 centers” (Wolfe, 2012), and to shift drug treatment to community-based centers (Anon, 2013). Amid this transition it is important to consider the needs of the large number of PWID who have been or will be released from 06 facilities. Our research investigates the challenges and facilitators of reentry into community and family life among such men, with a special focus on PLHIV, and provides opportunities for developing policies and interventions that address the needs of this vulnerable population.

METHODS

In-depth interviews were conducted in 2011 among a sample of 43 male PWID in Hanoi released from “06 centers” within the prior 2 years. To investigate the experiences of participants living with HIV, half of our sample (n=22) was recruited through referral from outpatient HIV clinics that provide routine medical care and antiretroviral therapy (ART) to

PWID. The remaining participants (n=21) were recruited through peer referrals from self-help groups for PWID and by peer referral by fellow study participants. To document post-release experiences over time, half of this latter group was stratified by recency of release (less than 6 months n=10 and 6–24 months n=11). This study received ethical approval from the Institutional Review Boards of the Institute for Social Development Studies in Hanoi, Vietnam and from the Johns Hopkins Bloomberg School of Public Health in the United States. All participants provided verbal informed consent in Vietnamese.

Interviews addressed perceptions and experiences of current drug users and people living with HIV/AIDS in the community; participants' daily lives in their families and communities since returning from "06 centers"; ability to secure and maintain employment; use of HIV testing and treatment services; current drug use and any experiences of relapse; and knowledge of, access to and experiences with MMT. Interviews were conducted in Vietnamese by trained interviewers and audio-recorded, transcribed, and translated into English. Transcripts were entered into Atlas. TI version 6.2 (Scientific Software Development, 2012) for coding. Investigators read each transcript multiple times, examined the interviews for key themes and specific topics of interest, and developed preliminary codes based on these categories. Memos were written for each code. Codes were then refined and elaborated to explore emergent patterns in the interviews, and these patterns were examined across the different groups of respondents as well as within the context of individual respondents' narratives (Bernard & Ryan, 2009). The coding scheme and relationships among codes was discussed among investigators, which led to further refinement of the analysis and ultimately guided the development of the manuscript. Representative quotations were selected to illustrate key points and analytic insights.

RESULTS

Nearly half of the participants were married and only few attained education higher than high school. Participants had long histories of drug use (median 12 years) despite their relatively young age (mean 35 years), and had spent up to 36 months at an "06 center" (Table 1). Sixty-three percent (n=27) reported HIV-positive status. Participants' reported numerous challenges after their release, including pervasive stigmatization, employment problems, family tensions, and struggles with drug addiction, but also identified their families and addiction treatment as potential sources of support.

Experiences of persistent drug-related stigma

Participants reported widespread stigmatization of drug users in their communities and encountered pervasive drug-related stigma upon their return. Although most men returned to their communities after extended periods of abstinence from drugs, community knowledge of their prior involvement with drugs and their detainment marked them as drug "addicts" – a highly stigmatized identity:

Look at it this way, people may know our past even though we are no longer addicted. We may have been drug free for one month, two months, or half a year for instance, but in their perception, we are addicts. (age 25, released 1 month ago)

Over time, some participants were able to distance themselves from their prior drug use. Most participants, however, continued to experience the effects of drug-related stigma in their everyday interactions even when they were no longer injecting.

Participants noted that just as current drug users were feared, avoided, and viewed negatively in their communities, those who were released from “06 centers” were perceived in a similar manner. Participants found that community members limited interactions with them and they were excluded from meaningful social interactions. In one case, a participant learned that some children’s families discouraged them from interacting with him because of concerns that he would induce them to use drugs. Several participants noted that stigmatization extended to their families, adding to participants’ sense of shame and social isolation.

In several cases, participants perceived that detention at an “06 center” contributed to drug-related stigmatization because detainment confirmed circulating rumors about their history and severity of addiction. Furthermore, many participants perceived that they were the subject of rumor and continual monitoring in their communities, awaiting signs of relapse and criminal activity:

[...] through their actions, I realize that they look at me inquisitively wherever I am. It seems that they are on watch for me all the time. (age 33, unknown HIV status, released 19 months ago)

Some participants also experienced stigmatization from their own families, which had major impact on them:

Many people say that it is up to ourselves whether we use drugs or not, but the truth is that we suffer from serious stigma. ...For me myself, the words of stigma from my beloved people make up the biggest difficulty [in keeping away from drugs]. (age 35, released 13 months ago)

As in the above case, family-level stigmatization could prompt episodes of relapse.

The layering of HIV-related stigma

HIV-positive participants experienced the burden of attempting to reintegrate into their communities while managing their illness and the stigma associated with it. Several PLHIV reported that they were already suspected to have HIV since they were known as drug users in the community. While detainment at an “06 center” was not always explicitly mentioned in relation to HIV-related stigmatization, releasees’ prior drug use, detainment and return from “06 centers”, present activities, and potential post-release drug use were frequent subjects of neighborhood gossip. As one participant explained, illness and death after returning from “06 centers” was automatically interpreted as the consequence of AIDS acquired through years of addiction:

...like my cousin, he had been addicted for a time, but he didn’t have it [HIV]. But when people just heard that he was dead after he returned from the [06] center, they thought that he had the disease [AIDS]. (age 27, HIV-positive, released 2 years ago)

News of participants' HIV-status quickly spread in communities when they manifested visible symptoms of HIV infection or when their status was disclosed by family members, friends, or health care workers, and resulted in stigmatization. To many community members, detainment confirmed the length and severity of addiction and thus strengthened the association between drug- and HIV-related stigma.

The association between HIV and drug use also resulted in self-stigmatization among participants. Several men expressed shame and regret about their illness because they acquired it through drug use and considered HIV-stigmatization a punishment for their behavior:

The addiction couldn't bring me anything but finally because I indulged in pleasure, I have to suffer from the *century disease* [HIV]...so I feel regret but now it is too late [...] after I have been treated, I see my health get better but still have to suffer from the stigma of the society. [...] I really feel that, in general I made mistake so I have to accept, I have to pay a too heavy price for it. (age 36, released 4 months ago)

Feelings of shame and guilt undermined men's sense of self-worth and hindered their ability to create successful relationships:

I still have an inferiority complex. I think I will bring miseries to any woman who is involved with me. [...] I still feel it [inferiority], for many reasons, people still regard me as an addicted person, a prisoner, an idler. I don't know who will take care of whom when I get married. (age 31, receiving ART, released 14 months ago)

The combined effects of drug-related and HIV-related stigma also likely deterred some participants from seeking HIV-related services, including two participants who felt that they were at risk for HIV but did not get tested for HIV.

Participants, whose HIV status became public, feared exclusion from social relationships. To pre-empt exclusion, many HIV-positive participants restricted their own social interactions:

When I go out, truly speaking, sometimes I feel very afraid because sometimes I see that they don't want to communicate with me so I don't want to contact them too. It means that now I feel hesitant with even those who I know because eventually there is no problem if we talk with each other but once they feel afraid, I will not want to have much contact with them. (age 45, released 23 months ago)

Social avoidance in response to perceived stigmatization greatly limited participants' ability to reintegrate into their communities.

Many participants stated that the degree of perceived HIV-related stigmatization varied with visible symptoms of the disease. In a few cases, participants who did not manifest any recognizable symptoms of illness could avoid stigmatization by concealing their HIV status. One participant, for instance, received HIV testing and treatment at a distant clinic in order to avoid contact with neighbors and community members, and lied about his treatment at work:

[...] people do ask me what kind of medicine I take; I say it is medicine for neuralgia. In general the place to take medicine [ART] is often a secret place. (age 35, released 19 months ago)

While this participant succeeded in preventing inadvertent or undesired disclosure of his status, the sustainability of such an intensive stigma-management strategy remained unclear.

Despite the acute stigmatization many PLHIV experienced, several men also noted that growing knowledge about HIV in their communities has gradually diminished this response:

Generally speaking, the society's view toward HIV-infected people has been less critical, thanks to public education. Very different from what was some years ago. [...] The view is now friendlier, closer. Some years ago when I had not been tested for HIV, I myself avoided HIV-infected people, too. (age 50, released 10 months ago)

Consequently, participants believed greater levels of HIV knowledge decreased stigmatization in recent years.

The economic and social costs of unemployment and underemployment

The difficulty of finding stable employment with adequate pay presented another critical obstacle for participants released from "06 centers". Nearly a third of participants (n=13) were unemployed at the time of their interview and many more struggled to make ends meet while working in low-paying manual or service jobs in the formal or informal sector, such as a laborer, driver, or grocer. Participants shared that community perceptions of their addiction made it difficult to find employment, since they were judged to have poor moral character and considered addicted even after their return. Most participants believed that potential employers feared relapse to drugs and theft or destruction of their property. Employment opportunities were further hindered by lack of skills and necessary education. The inability to find adequate employment was often identified by participants as leading them to relapse, reinforcing fears of relapse as a justification for not employing men released from "06 centers".

Although the interviews did not always reveal how potential employers learn that these men were detained at an "06 center" due to their drug use, some participants mentioned that certain jobs required police background checks while sometimes employers were informed via local gossip. Honesty about having been at an "06 center" only yielded rejection:

I could do a lot, but people already know that I return from the drug treatment center, the society now is not good. [...] Right after I returned from the drug treatment center, when I asked the others to find me a job, I told them up front that I had just returned from the drug treatment center so that they could decide to give me the job or not. I didn't want people to discover it later and then talked about my addiction and looked down on me. That is why I stay at home. (age 30, HIV-positive, released a year ago)

For PLHIV, HIV-related stigmatization and discrimination also played a critical role in hindering employment. One participant reported that he was unable to work because several

positions required him to present certification of HIV-negative status. One participant's experience poignantly illustrates the challenges faced by those attempting to create self-employment opportunities:

After release [from the "06 center"], as I know how to cut hair, I opened a barbershop but people didn't want to use my service, they were afraid of getting the disease [HIV] [...]. It is difficult because people don't know about ways of transmission, and they don't care. They just said that, "Ah, he has HIV, [we] shouldn't go to his shop." As a result, I didn't have any customers all day. After I stopped doing that job, I changed to cleaning vehicles to earn some more money. At first, some of my friends came, then gradually they stayed away, and finally they went to other place to have their vehicles cleaned, and didn't come to my place. (age 46, released 20 months ago)

The failed businesses left this man bankrupt and forced him to resort to making votive articles, raising birds and trees for sale – jobs that failed to provide a stable income.

Finally, although the majority of HIV-positive participants were receiving ART at the time of the study (Table 1), late diagnosis led to severe illnesses and disabilities, which hindered employment. One participant, for instance, who had already been quite ill when he tested positive at an "06 center", was too weak to work after his release despite continually receiving ART since his diagnosis.

The impact of unemployment and underemployment had a significant negative psychological impact that also affected some participants' sense of masculinity. As one unemployed man explained:

Let me ask you: Though I am still a young person, I already feel very upset, so how could a person with a burden of a family and children feel better. He has a lot pressure! For a man, he might not be able to provide for all his family, but he should at least feed his children and probably his wife has to earn her living herself. Now that a man is considered as nothing in the family, he will be demoralized. (age 31, HIV-negative, released 10 months ago)

Consequently, employment challenges limited participants' ability to engage in a wider network of social interactions beyond their families, attain economic security, and fulfill cultural expectations for men to provide financial support for their families.

Family support and tensions

In contrast to communities, most families actively attempted to facilitate participants' reentry into community and family life through encouragement for drug cessation and ongoing HIV-care, employment and financial assistance (housing, food, funds for medical care), and emotional support. Parents, wives, and siblings provided the majority of this support. Parents were particularly significant sources of support for divorced and single men.

At the same time, participants also reported that their history of drug addiction and ongoing struggles placed enormous burdens on their families and often led to considerable tension:

My family is not contented with me, they don't want me to use drugs, they try to advise me to stop using drugs but it is in vain. So they are disappointed, and my parents, my wife and my children shout at me. (35-year-old HIV-negative man, released 13 months ago)

Several divorced or separated participants reported that their wives chose not to support them and sought separation and divorce due to concerns about drug addiction and fear of HIV status. Moreover, some family interventions aiming to protect participants and prevent relapse to drug use, such as prohibiting interactions with friends and limiting movements beyond the house, blurred the boundary between support and unwanted control. These acts incited negative emotions among several participants, sometimes prompting their return to drug use instead of preventing it:

My first time [injecting drugs again after being released] [...] the reason was that on that day, when I went to my uncle's to drink wine. While I was drinking, my brother and my mom continuously called me [to check on me] and I got upset. When I returned home, I met a neighbor who sold drugs. He gave me drugs and then I used it again. (35-year-old HIV-negative man, released 13 months ago)

Therefore, while families provided often the only safety-net for these men, family relationships could also be a major source of stress and conflict for some participants.

Nevertheless, most participants relied on their families for support in multiple arenas, even despite challenging relations. Upon their release, men returned to live with their spouses, parents, or siblings and relied on their assistance. Since employers were reluctant to hire anyone with a history of drug addiction, nearly all who were able to secure employment in the formal or informal sectors did so through family connections. For instance, one 36-year-old mechanic found work through his brothers. He explained that, "Finding a job was not very difficult because in my family my brothers also worked at construction site, so when I was back, they asked me to work with them." Those who were unable to find formal employment often performed work for their family members in the informal sector, such as a fruit stand, or provided assistance for their family's business.

Despite the tension surrounding drug addiction, family members were usually the only ones who accepted and cared for participants who relapsed to drug use. Many families actively sought out resources for treating drug addiction, and facilitated participants' enrollment in MMT. For instance, one participant learned of MMT through his mother, who sought out information from another woman in the community. Participants who were able to maintain abstinence from drugs often attributed their success to their families' support:

When I engaged myself in [drug use], my family, none of them including my parents, siblings, wife and children, felt a complex and spoke loudly with me, my family helped me to overcome those social evils... (age 36, unknown HIV status, released 19 months ago)

Notably, this participant referred to drug use as a "social evil," having internalized the moral language of earlier state policies.

Finally, several participants highlighted the importance of family's emotional support in facilitating their daily lives:

[...] my family is very sentimental, my brother is very sentimental too, he put me at ease, create good favorable conditions for me. My mother, she has never spoken to me excessively, just tried to make me understand to stop using drugs but never said like this or like that, never. (age 32, HIV-negative, released 7 months ago)

The emotional support that many participants' families demonstrated served as a buffer against the obstacles participants encountered upon their release, and often provided strong motivation to pursue abstinence from drugs, care for their health, and seek employment and other means to assist their families.

While some PLHIV experienced stigma from family members earlier on in their illness, this stigma diminished over time, and most HIV-positive participants experienced higher levels of acceptance and support than other participants. Families sought necessary medical care, served as primary caretakers, and assisted with medications and doctor's visits for nearly all of these men, many of whom experienced prolonged periods of acute illness and disability. The physical duties of caretaking and associated household duties were usually taken on by mothers and wives. Moreover, those who could not work due to illness, disability, or other reasons, received financial support from their families. When participants were single, their mothers often insisted that they live with them so that they could be cared for. One recently released 33-year old participant explained that because he was unable to find work and decided to stay at home to avoid arrest, his mother offered to "take care of everything." In such cases families provided a degree of refuge from the challenges PLHIV encountered after their release.

Struggles with drug addiction

Participants were acutely aware of the negative effects of their addiction on their own and their families' lives. They also understood that relapse could lead to arrest and repeat detainment at an "06 center." Indeed, 15 participants reported that they had experienced multiple periods of detention. These multiple detentions at "06 centers" provided further fodder for community gossip, adding to participants' perceptions of stigma and social isolation. While participants expressed strong determination to avoid using drugs after their most recent release, available treatment was practically limited to detoxification in "06 centers". Access to MMT appeared arduous because of high demands and admission requirements, including the local authority's verifications of residency and addict status. The latter requirement inadvertently obstructed access to MMT for most releasees because admitting relapse to drug use carried the risk of new detainments. These participants' renewed struggles with drug addiction were often prompted or exacerbated by their experiences with stigmatization, unemployment, and other environmental factors, such as meeting old friends who injected drugs and family tensions. Consequently, by the time of their interview, 19 participants (44%) reported having returned to injecting drugs after their release; some within days, others after weeks or months of attempting to reintegrate into their communities.

For several participants economic pressures and family issues were intertwined reasons that prompted relapse. One participant recalled his relapse after a previous detainment:

As for me, I found that the life was so hard and I sought an easier life to avoid being in a standstill and I used drugs to forget things. When I couldn't solve anything, I used drugs to forget it [...] The income from the job I was doing is not enough for our living, my education level is limited so the job is also at a limited level, therefore the earnings was not enough for my family so I felt being at a standstill [*thây nóbê tấ c*]. That standstill in turn caused problems in my family, which was another standstill. [...] Well, little chips light great fires [*Áythê l'á tiê ptuccá inod'ô ncá ikia*], so I felt upset and continued to use drugs again. (age 35, HIV-negative, released 3 months ago)

Participants frequently cited the feeling of rejection from being unable to find adequate employment as a significant factor in prompting their relapse.

Employment difficulties led participants to boredom and frustration even in supportive family environments, since they were often confined to their homes and interactions with their families. Once they met old friends, however, many participants perceived that drug-use and relapse were nearly inevitable:

Right after I returned, I felt that I was released, relieved, at first I just worked in my family. [...] couldn't find a job in the society, I just worked at home until after a while I went out and met my old friends again [...] I just thought that I would just use drugs for fun for only one time, and was determined to not use it again from the day after. But...one time and several days after...I went out with them again and [...] I addicted to it gradually. (age 31, HIV-negative, released 7 months ago)

This participant reported that in his community everyone, except for his supportive family members, avoided him. Therefore, while drug user friends may have offered some support for socially-isolated participants, they also presented a significant temptation for relapse. Relapse, in turn, reinforced community perceptions that those with a history of drug use always return to drugs, leading to further stigmatization and isolation.

Access to and experiences with addiction treatment

In light of participants' on-going struggles with addiction, most participants perceived effective addiction treatment as an important facilitator of their reintegration. Though MMT was not available in Hanoi until 2009, of the 41 participants who were asked about it, only three lacked any knowledge about MMT, and another two were unsure about their need for treatment. 16 participants felt that while MMT might be helpful for others, they did not need it because they were no longer using drugs. While some of these participants were able to lead stable lives, others expressed strong beliefs that only individual moral responsibility and determination could lead to drug cessation, which likely discouraged them from seeking addiction treatment.

Twelve participants were receiving MMT at the time of their interview and an additional seven participants desired to enroll in a treatment program. Several of the latter could not access MMT because it was locally unavailable or because of administrative obstacles:

[...] it would be good if there are any programs or medicines for people to take to make them forget drugs completely. It is necessary to create favorable conditions for drug addicts. Now, for me, I really want to join those programs [MMT] to get medicine but it is really difficult, I am asked to get this stamp or that stamp and have to write requests. Oh, it is difficult. (age 45, HIV-negative, released 2 months ago)

Some others had attempted to access MMT in the past, but were unable to do so. For instance, one participant was arrested after he previously sought MMT. Although fears of arrest and detention were not explicitly mentioned, such concerns might have deterred some participants from inquiring about MMT.

Those enrolled in MMT overwhelmingly found it helpful for treating their drug addiction. The following participant's comment was typical of those receiving MMT:

I consider methadone very good. Taking it makes me forget drugs, and after taking it for a long time, I don't have any feeling even if I use drugs again, methadone drowns out that feeling. (age 36, unknown HIV status, released 19 months ago)

Several participants reported that they experienced feeling hot, constipation, and reduced sexual drive and ability after treatment initiation, but because these men agreed that MMT provided the most effective means of discontinuing drugs, they were willing to tolerate these uncomfortable side effects.

Participants' key concerns about MMT were the limited number of MMT sites and the challenges of scheduling treatment:

The only thing is time. I take the medicine every day, it is ok to live near [the MMT clinic] [...]; but my house is far, and it takes me nearly an hour to travel every day. It takes the whole morning: I leave my home at 9 am, and arrive here at 10am, so the morning is gone. I cannot do anything in the morning. (age 37, HIV-negative, released 18 months ago)

Thus, while many participants recognized MMT as an important resource for treating their addiction and potentially enabling them to work and lead healthier lives, this possibility was not fully realized due to MMT's limited availability.

DISCUSSION

Our research sheds light on the interaction and collective impact of difficulties men encounter after their release from "06 centers" in Vietnam – including drug- and HIV-related stigma, employment difficulties, family tensions, limited access to MMT – that make them socially vulnerable and often exacerbate their struggles with addiction. Although previous research has shown pervasive stigmatization and discrimination against PWID in Vietnam (Hong, et al., 2004; Thi, et al., 2008), our study draws attention to the persistence

of stigmatization even after detoxification and lengthy detainment at “06 centers”. Detainment at “06 centers” not only fails to rehabilitate these men from the perspective of their communities, but often contributes to their “spoiled identity” (Goffman, 1963). Stigmatization limits participants’ ability to find adequate work, leads to social exclusion, and contributes to family tensions through negative community perceptions of PWID and their families, and to a lesser degree, stigmatizing attitudes within the family toward PWID. Coupled with the absence of supportive services, experiences of stigmatization play a significant role in prompting relapse to injecting drugs. In turn, the high percentage of participants who eventually relapse fuels the stereotype that drug users always remain drug users, creating a vicious cycle of fear and social exclusion that could further push participants to return to drug use.

HIV-positive men released from “06 centers” often experience the layering of drug-related and HIV-related stigmatization (Nyblade, 2006), which stem from earlier government efforts to reduce HIV through eliminating the “social evil” of drug use. Many participants were suspected to have HIV, and PLHIV bore the double burden of social exclusion from fears of transmission and moral condemnation because they acquired HIV through drug use. Similar to Messersmith et al’s research (2012), study participants also experienced HIV-related discrimination despite laws that prohibit it, including the disclosure of their HIV status and employment discrimination. Although most PLHIV were recruited from HIV clinics where they had access to HIV care and treatment, they often began treatment at an advanced disease-stage. As documented in earlier studies (Hong, et al., 2004; Rudolph, et al., 2012; Thi, et al., 2008), we found that layered stigma hindered disclosure of HIV infection and might discourage some from seeking HIV-related services, leading to poor health and limiting employment. Thus, HIV created both social and physical barriers to community reintegration. Yet, our data show encouraging signs that community education efforts are reducing HIV-related stigma and creating a more favorable environment for PLHIV.

Previous research suggested high unemployment among those released from “06 centers” and that unemployment plays a prominent role in relapse (WHO, 2009). In our study multiple factors, including drug-related and HIV-related stigma, lack of skills, relapse, and illness contributed to nearly a third of participants being unemployed. Men who could secure employment did so with difficulty and through family support, and most remained in low-paying, marginalized work. Unemployment and underemployment undermined participants’ economic position, and led them to question their self-worth and value to their families. Although women’s economic contributions are valued in Vietnamese families, men’s work and responsibility to generate income for their families remain important to ideologies of masculinity that are rooted in Confucianism (Werner, 2009). These cultural expectations, coupled with economic concerns, help explain the psychological impact of employment difficulties and their role in triggering relapse.

Our research illuminates the complex interactions between PWID released from “06 centers” and their families. Families often provided the only available economic and emotional safety net, ranging from housing and employment opportunities to support for drug avoidance, addiction treatment and HIV-related services. While less prevalent than

community-level stigmatization, however, our research also documented harmful stigmatizing attitudes among family members, which may partially reflect secondary stigmatization of families of PWID (Salter, et al., 2010). Fears of relapse and relapse itself prompted even many supportive families to restrict participants' activities, precipitating tension and relapse to drug use. Such conflicts reveal the burden on families caring for these participants and reflect the need for mental health services for both PWID and their families.

The relatively fewer reports of family-level stigmatization compared to previous research (Hong, et al., 2004; Rudolph, et al., 2012) may reflect participants' long histories of drug addiction and lengthy detainments, which may have provided opportunities for families to either remove their support, as some wives had done through separation and divorce, or rework their relationships with these men. Additionally, over half of our sample consisted of PLHIV, who experienced a greater level of acceptance both in our current and previous study (Rudolph, et al., 2012) likely because illness helped reorient families' perceptions of participants from partaking in morally problematic behavior, towards a sick relative needing care and support.

Despite community perceptions of men released from "06 centers" as incorrigible "addicts," our participants actively tried to abstain from drugs. Their efforts, however, were impeded by perceptions of drug addiction as a moral deficiency and by limited availability and cumbersome administrative requirements of addiction treatment. Moreover, while those receiving treatment found it valuable, they were unable to fully reap MMT's benefits because travel times to distant facilities interfered with employment. These findings reinforce the importance of local, community-based MMT to reduce drug use coupled with other services.

Although this research was not conducted within "06 centers", men released from these centers faced enormous challenges. The United Nations' and the WHO's call for eliminating compulsory drug treatment and encouraging Vietnam's efforts to expand harm reduction measures, including community-based drug treatment, HIV related services, employment training, and psychological services (UN, 2012) may significantly alleviate these challenges. Our research suggests that employment support could not only enhance economic standing, but also psychological well-being, and community perceptions of PWID. Moreover, our findings highlight the need for incorporating families into support services. These services require continuous assessment to ensure that they serve the needs of PWID and demand financial commitment both from Vietnam and international sources (Government of Vietnam, 2012).

Due to the nature of qualitative research, our study is limited by its small sample size and its focus on men released from "06 centers" in one urban setting in Vietnam. More research is needed to investigate the barriers to social reintegration, the needs of PWID without family support, and the pathways for reducing and overcoming these obstacles. Despite these limitations, this research sheds light on the post-release struggles and sources of support of PWID, many of whom experience detention in "06 centers". Our findings will be useful to public health practitioners and policy makers focusing on improving the health of PWID in

Vietnam and in similar settings where many PWID have experienced compulsory detoxification and detainment.

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Table 1

Selected characteristics of participants (N = 43).

Characteristics		Number	Percent
Mean age (range)		35 (23–52)	N/A
Marital status	Married	18	42
	Divorced/Separated	7	16
	Single	17	40
	Widowed	1	2
Education	Primary	5	12
	Secondary	25	58
	High school	9	21
	College/university	4	9
Employment	Unemployed	13	30
	Manual labor	18	42
	Grocer/family business	6	14
	Trucker/driver	4	9
	Disabled soldier	1	2
	Office worker	1	2
HIV status	HIV+	27	63
	HIV–	11	25
	Unknown	5	12
Antiretroviral therapy (ART)*	Yes	24	89
	No	3	11
Median months of detention at “06 center” (range)		22.5 (6–36)	N/A
Median months since release (range)		10 (1–24)	N/A
Median years of drug use (range)		12.4 (2–28)	N/A
Currently injecting drugs		19	44
MMT	Enrolled	12	28
	Not enrolled	31	72

* Of those reporting HIV+ status.