Why do they call me *Khiya*?:

Gender and Identity Construction amongst People Injecting Drugs in Thailand

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Abstract

Injecting drug users worldwide are often ensnared in a web of problems arising largely from what is commonly termed ‘structural violence’, a phenomenon that causes suffering and renders injecting drug users vulnerable to a range of social dilemmas and health threats. Political and social forces, which range from oppressive drug control policies to widespread stigma to discrimination, combine to marginalise injecting drug users and contribute to the sense of alienation that isolates users from non-users. These distancing processes become a potent barrier that excludes many users from pursuing conventional social lives and activities within mainstream society.

Understanding widespread injecting drug use and abuse in Thailand requires exploration of its linkage with all levels of society. The thesis examines how political-economy forces at the macro level have shaped the meaning of drug use and drug epidemics; as well, it explores the pressures that drug users are subjected to at the micro level within family and other interpersonal relations. Particular emphasis is upon HIV infection, its spread, and how Thailand’s drug users have invented a range of tactics that aim to lessen the impact of social rejection associated with disease and allow them to maintain their drug use behaviour. Women injecting drug users in particular, are caught in a difficult tension between the demands of being a Thai woman seeking to exist in a masculinised world of drug users and meeting Thai society’s expectations of womanhood. Harm reduction programs may prove the means of facilitating drug users’ increased public profile. This thesis also explores how new social movements allow drug users to engage in a habitable social space and fashion new forms of subjective identity.

Statement of Candidate

I certify that this work has not previously been submitted for a degree nor has it been submitted as part of the requirement for a degree to any university or institution other than Macquarie University.

I also certify that this thesis is an original piece of research written by me. Any assistance I have received in my research work and the preparation of the thesis has been appropriately acknowledged.

In addition, I certify that all information sources and literature used are indicated in the bibliography.

The research presented in this thesis was approved by Macquarie University Ethics Review Committee, Reference No. HE26MAY2006-D04733.

Niphattra Haritavorn

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I would also like to thank my family, my parents and siblings who have stood by me during the many years of this long journey. Their warm support and encouragement have assisted me to overcome all of the obstacles that have confronted me.

Last but not least, this thesis aims to tell the true stories of people injecting drugs in Thailand who are viewed as marginalised groups and considered by many as of little of value to Thai society. Beyond the written word, this thesis is dedicated to people injecting drugs in Thailand who shared their experiences with me and whose voices remain unheard in society. It is my fervent hope that this thesis will reveal other aspects of their lives that will lead to a better understanding of them. Nok and Rat in particular helped me throughout this research, inspiring me to explore new issues involving the drug field. I am equally indebted to the people working in drug NGOs, who allowed me to access their organisations and offered warm hospitality.

Abbreviations

ART	Antiretroviral Treatment
ARV	Antiretroviral drug
BMA	Bangkok Metropolitan Administration
HBVC	Hepatitis B Virus Core
HCV	Hepatitis C Virus
HIV/AIDS	Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome
MMT	Methadone Maintenance Treatment
NGOs	Non-governmental Organisations
ONCB	Office of Narcotics Control Board
PLWHA	People Living with HIV/AIDS
PSI	Population Service International
TDN	Thai Drug Users's Network
TNP+	Thai Network for People Living with HIV/AIDS
TTAG	Thai AIDS Treatment Action Group
UNGASS	United Nations General Assembly Special Session
WOD	War on Drugs

Prologue

Prior to embarking upon this research, I knew little about illicit drug, or about the various social entanglements and dilemmas faced by people who are involved with substance use and abuse in general. One thing I could recall about illicit drug use was a famous Thai novel (which was made into a movie) titled *The Story of NamPoo,* a story about a young boy who grows up in a broken family. Nampoo feels desperately upset when he hears that his mother is going to remarry. He starts socialising predominantly with certain friends who were using drugs. Later, he tries heroin and in time becomes addicted. When his mother becomes aware of this, she decides to take him to *Wat Thamkrabok,* a drug rehabilitation centre. After returning home, Nampoo feels unwelcome in the family; so, he recommences using drugs and finally dies from an overdose. More recently, after having begun my fieldwork, I watched a second movie about people using drugs in Thailand titled *Sia Dai,* which literally means 'pity'. I learned of this movie through a friend at a drop-in centre who, upon recommending it, said it was the best movie about drug use he had ever seen and that I must watch it. *Sia Dai,* which was released in 1996 and directed by Prince Chatrichalerm Yukol, was about four teenage girls, whose parents had let them down in one way or another. As a result, they turned to each other for support, finally resorting to using drugs, gravitating from smoking cigarettes to injecting heroin. Lacking family support, they came to rely on each other; over time, they developed a bond of friendship. For these girls, drugs meant happiness and a solution to the problems that assailed their lives. By the end of the movie, three of the four girls had stopped using drugs and were regretting the time they had spent on drug taking. They felt they had wasted their time using drugs and should have spent more time enjoying their teenage years. Despite my friend's recommendation of *Sia Dai,* I felt very clearly that what was missing from the two movies was that they failed to depict the social suffering of people using drugs in Thailand that I myself was beginning to comprehend, and how they struggle to deal adequately with both social exclusion and their embracing of the drug habit. The story of the girls in the movie reminded me not only of my own life but of friends I came to know during my data collection.

Living and growing up in the Sino-Thai middle-class surroundings of Bangkok, I have a strong embodied sense of myself as somewhat a conservative Thai woman. I was born in inner city Bangkok into an extended family. During my childhood, my life was comfortable and I seldom experienced hardship. When I was a child, I was taught that a good woman should behave circumspectly; for example, girls should not spend their leisure time going out with boys, especially at night. I attended a well-known private school, and then attended a university in Bangkok. When I was in high school, I spent my weekends at tutorial school or sometimes went out with friends. My life was that of a typical 'Thai girl', following a lifestyle pattern that people defined as 'well-behaved' or what is referred to in the Thai language as *riap-roi*. None of my friends or family members has ever used drugs (as far as I know). My family and my social group view drugs as polluting and dangerous. After I told my parents and friends that I would like to pursue the controversy surrounding and social rejection of illicit drug users as my PhD topic, they unanimously expressed their opposition to the idea. My parents asked me to change the topic immediately, saying: "You are a woman: how could you do something dangerous, especially to do with drugs. Haven't you seen the news?" They recalled the media depicting drug users variously as 'madmen', 'uncontrolled people', and 'criminals'. Conversely, many of my friends raised the question of what I stood to learn. As one said to me: "Their lives are nothing: they are just addicts, *khiya*; what will you learn from them?" Her opinion made me wonder why people using drugs are considered dangerous, why they are call *khiya* (junkies), why their lives seem unimportant, or at least not as important as those of others. These questions form the basis of this thesis.

My decision to research illicit drugs not only triggered my family's concern: it has also challenged me personally. I have had to change my way of life; for example, changing the way I dress and the language I use. The realisation that my lifestyle and those of drug users are vastly different made it difficult to collect data. My middle-class background and my lack of drug experience shaped my position as an outsider within the drug community. The boundary between drug users as insiders and me as an outsider arose between us during the course of my fieldwork. During the course of my

research, I have tried to dissolve this boundary- to become at least a partial insider- but, it has been difficult to remove completely as it is also part of my disposition. From the drug user's perspective, my background and experience as an educated middle-class woman defined me as 'other'. That is not to say it was considered impossible that I take drugs: the use of certain substances is widespread in all social classes in Thailand. Some drug users, after noting my skin type and healthy body, suggested that I looked the type to use methamphetamine rather than heroin. As Tee, one female injecting drug user observed: "You looked like people using ice rather than heroin. Your skin was white (yellow)." In Thai society, yellow skin or what is called *phiu khao (*white) implies middle class status or people from Sino-Thai families. Nok, a female injecting drug user to whom I allude in many sections of the thesis, is typically classified as 'other' in quite different ways. She experiences another social definition, that of a 'bad' woman who breaks the norms and/or rules of being a Thai 'good' woman. I first met Nok in 2006 (at the beginning of my data collection) at one of Bangkok's drop-in centres. Twenty-seven years old and an outreach worker, she was energetic, funny, and easy to get along with. She liked to talk loudly, and expressed her feelings - whether happy or angry - openly to others. Nok told me that she had been using drugs since she was 15 years old. Like other drug users, she was first introduced to drugs by her peers. Later, she started smoking, first cigarettes then heroin before finally injecting heroin, smoked and then injected. She lived in a flat in DinDang with family members: her parents were unemployed but her mother sometimes found temporary work as a cook. When Nok was 20 years of age, she learned that she was HIV positive. Nok's parents knew about their daughter's drug addiction and HIV status. Speaking tearfully about her parents, Nok said: "I am the worst daughter. I broke their hearts. I don't want them to know that I reuse drugs again. I want them to be proud that I am a good person who can work like others." Nok's boyfriends were also drug users, mostly heroin takers.

Nok's 40 year old boyfriend Rat, who was also an outreach worker, worked at the same centre as Nok. Rat was very thin and to most observers looked visibly unhealthy. He liked to talk to others; in particular, he liked to know what others thought about drug users. The first time I met him, he asked me: "What is the difference between you and

me"? Then, he answered himself, saying: "Destiny! Because I use drugs while you haven't." After talking to him various times, I noticed that Rat was very sensitive to how others responded to people using drugs. Once when I met him, he had quit using. On this occasion, he opened up about himself. Rat was the youngest son among 10 children. He told me that his mother was a drug dealer and that she had been arrested by his father who was a policeman. He continued about his past life that: "Because my mom was a drug agent, she made a lot of money. I could go to a famous school and get everything I wanted. Everything collapsed when I started using drugs and then my mother was arrested." Rat told me that his life was very complicated. Among his 10 siblings, he was the only child to use drugs. Due to his HIV infection, he was often unhealthy: many times he was hospitalised as a result of opportunistic infections. During this period, both stopped using drugs.

Nok and Rat's ability to stop using drugs had made them both very proud, particularly in light of the fact that many among the staff and drop-in centre members were still using drugs. Their comments about quitting sometimes caused unease in others. Nok told me that the important factor of her quitting was her boyfriend's support. But in 2008, Rat was sentenced to seven months prison after being charged for selling drugs. Rat's sentencing changed Nok's life radically. During his incarceration, Rat made friends with some drug dealers who were also serving time. After being released from prison, Rat, along with Nok, continued to meet them. Sometimes, they were given drugs for free. At first, Nok and Rat gave the drugs to other members of the centre and they gradually became the focal point at the centre for those who needed drugs. Nok told me that even the manager asked her to buy heroin for him. In time, both of them started using again. Initially they used methamphetamine: they thought they might not become addicted. They continued consuming an amphetamine type stimulant (called *yaba*[1] in Thailand) but started to miss the effects of heroin. Eventually, they both recommenced injecting heroin.

[1] 'In this thesis, I use a variant of the Royal Institute's new guideline for the transliteration of Thai, but recognizing that others use different spelling, for example, 'yabaa'.

Over a period of a few months during my fieldwork, I could sense that Nok had changed. She stopped picking up my calls: it seemed that sometimes she was unaware of what she was saying and doing; but, I never asked her directly. I simply waited until such time as she felt ready to talk about what was going on with her. One day, she told me that she was using drugs again, that she had tried her best to quit drug use. She went to the methadone clinic every day, opting to attend the clinic close by the drop-in centre rather than the one next to her house as she didn't want her parents to find out. She cared deeply for her parents and told me she always felt sorry that her drug behaviour had brought trouble to the family. In 2009, I received a phone call from Nok saying that her husband had been arrested on another drug charge and had subsequently been released. She had decided to move back to her parents' home because as she was now alone she could not afford her living expenses. As I write this thesis, the lives of Nok and Rat continue amidst various forms of violence and suffering. It is the manner in which these social forces impact on the lives of Thailand's drug users that forms the basis of this thesis.

As Peacock (2001:18) states: "Anthropology is concerned not only with holistically analysing the place of humans in society and in nature but also, and especially, with the way humans construct cultural frameworks in order to render their lives meaningful." The objective of this thesis is to provide an insight into the lives of people injecting drugs in Thailand, especially into how they feel and experience life as drug users. To this end, I examine how the larger social forces such as the law, policies, social perceptions, attitudes, and public health intervention impact upon the drug users' everyday lives and selves. Adopting this approach means exploring both the internal and external forces that shape the everyday lives of the friends I made during this research.

Chapter 1
Introduction: Approaching the Meanings of Drugs

In various geographic settings and historical times, drugs have been represented as medical, cultural and/or socially valuable products. Often they have been demonised. In each instance, drugs have multiple meanings and are often invested with substantial material and symbolic power. In the past, as much as in the present, some could not live without drugs: they used them for mundane routines such as food preparation as well as for more selective and specialised ritual practices. Perhaps most centrally, drugs have been an important component of medical culture from ancient to modern times. In the past, opium, which was introduced in a consumable form in 460BC, was referred to as 'god's own medicine' (Booth 1996). It was around this time that Hippocrates acknowledged its usefulness as a narcotic and styptic for treating internal diseases (ibid). Medical history subsequently recorded the use of opium for pain, diarrhoea, coughs, insomnia, and neurological and psychiatric disorders in many different settings (Kramer 1979).

Besides opium, humans have consumed other drugs for medical purposes. In ancient China, for example, the medical properties of cannabis were recorded in the classical herbal *Pen Ts'ao Ching* as a cure for various diseases and as an effective pain killer (Li 1975). In Cambodia, hemp was used to cure numerous maladies, while in Thailand it was included in medications to eliminate dizzy spells (*lom*) (Martin 1975). Tobacco was also originally used for medicinal purposes. Indigenous groups from Canada to Patagonia saw it as one of their most important medicinal and magic plants (Wilbert 1972). In the nineteenth century, cocaine was medically important in England as a very effective surface anaesthetic: cannabis was taken for its analgesic and sedative effects (Berridge 1999). Due to its tranquilising action and psychoactive properties, hemp has been used in India as a therapeutic and magical plant since Ayurvedic times (1400 B.C.) (Benet 1975). Self-medication with the various drugs mentioned above mitigated a variety of health problems, including mental distress. Page and Singer (2010:162), who emphasise the need to study the meaning of drugs, claim that:

> The use of drugs by human beings is a quintessentially anthropological topic of study because it directly connects diverse aspects of human condition, from internal emotional states to the global political economy, and from intense religious experience to adventurist pleasure-taking.

No matter what the individual's purpose for using drugs, a further important element is the user's pleasure. As psychoactive substances, drugs have the power to give users both pleasure and psychological relief. But, this component of their use has been largely ignored in most political economy analyses (Lyttleton 2004b). And yet, it is precisely their power to give pleasure that gives drugs a particular value and renders them desirable. Many drugs are associated with specific moods; even sugar was once linked to happiness, wellbeing, elevation of mood and, later, to sexuality (Mintz 1986). Zen Buddhist monks drink tea to keep them awake during their long hours of meditation whereas in England, tea provides regular punctuation of the working day and an energy boost (Faulkner 2003). Pleasure associated with dark chocolate consumption might also be justified from health and psychological perspectives (Lippi et al. 2009). In addition to its medicinal value, opium is regarded as a vehicle for pleasant fantasies, the dulling of pain, and release from anxiety. In the 1960s, during the 'flower-power' era, cannabis and LSD fuelled Western generations' quest for spiritual fulfilment and sensual enjoyment (De Rios 1977).

In addition, the power of drugs has been linked tightly to sexuality, further adding to their impact on emotional responses. The connection between drugs and sexuality has existed for thousands of years (Escohotado 1999; McMahon 2000; Palha 2008). As Escohotado (1999:36) notes: "Singly or collectively, the connection between eroticism and drugs detected by the inquisitorial mind always came wrapped in stereotypes." Certain drugs have the power to intensify sexual feeling; for example, due to Brahmanic traditions, hemp was used not only to make the mind agile, but to renew sexual prowess as well (Escohotado 1999). The level of sexual activity attained depended upon the type of drug used. Some drugs are thought to encourage a particular level of sexual activity in which people might not otherwise engage; for example, amphetamine users report greater interest in sex and greater frequency of intercourse (Klee 1993). Increased libidinal energy, improved sexual performance, and greater sexual pleasure are

important reasons underpinning the burgeoning use of certain types of drugs, in particular amphetamines (Grinspoon&Hedblom 1975). Like social anxieties generated by promiscuity, concerns over drugs are embedded in philosophical, medical, moral and legal paradigms and social norms, making it difficult to acknowledge the need to take drugs for pleasure. Surveillance encourages guilty and secret enjoyment in this context. Even this brief historical overview shows that drug use is a socio-cultural phenomenon that has become incorporated into people's daily lives worldwide and in diverse settings. Some drug plants have a special role wherein they become part of cultural beliefs and practices, e.g., shamanism: their hallucinogenic properties make drugs ideal vehicles for ecstasy and vision trances. Smoking tobacco or imbibing hallucinogens is a way of transforming the shaman from an actor in this world to an actor in another world (Goodman 1993; Wilbert 1972). In Eastern Europe, either hemp or cannabis was originally used in rituals or at special events such as Christmas Eve, when a soup of hemp was served for the dead souls to savour (Benet 1975). Cannabis is not only a medicine: it is also an important textile and food plant. In earlier times, the cannabis plant was farmed by nomadic tribes, who carried the cannabis from northeastern Asia to western Asia and India (Li 1975). *Ma*, a monosyllabic character of the Chinese language, can be traced back to the relationship of cannabis within the everyday economy of the Chinese (ibid).

Opium, together with hallucinogens, has been used for religious purposes since prehistoric times. In Afghanistan, the opium poppy is a means of survival, providing access to land and securing credit that is so critical for subsistence during the harsh winter months (Mansfield&MacDonald 2001). Opium consumption in this context usually takes place in gatherings made up of groups of people, mostly males. Opium consumers, who remain within limits of accepted behaviour, are considered ‘normal’. And, as usage has changed overtime, many palliative and addictive substances have become commodities marketed to serve individual desires and institutional and geopolitical interest (Sherratt 1995).

In addition to social and medical use, drugs are also a means of amassing wealth or of promoting business trade in which massive amounts of money are invested. Huge

amounts of money flow into the illicit drug trade to participants ranging from producers and state officials to street drug dealers. Calvani (2005:5) reports the value of the world's illicit crop production as 13 billion US dollars, at the intermediary sales or wholesale level as 94 billion US dollars, and at the retail level the value reaches 322 billion US dollars. Also, the illegal drug trade is a significant component in the 600 billion US dollars global money-laundering economy (Marcella 2001:4).

At the same time as promising untold wealth and fortune, drug trading can have profoundly damaging effects. It relies on an illicit economy that does not contribute to any form of sustainable social development. More importantly, illicit drugs can also create a form of dependency that threatens accepted social norms (Jenkins 1999). At the community level, drugs can be commodities: they can be used in exchange for food security, providing resources for those with poor access to land for agricultural production and credit during times of food scarcity (Cohen 1984; Durrenberger 1976). But, what makes drugs different from other commodities is that they have power: their psychoactive substances can provide users with both recreational and psychological relief (O'Malley&Valverde 2004).

Most importantly to this thesis, drug consumption is linked to the creation of identity. Drugs create a sense of belonging, i.e., an 'own' community composed of people who follow the same lifestyle and share the same interests. In many settings, drugs fulfil a variety of social roles that endow their consumption with meaning. They may be alternatively or simultaneously medicines, a sign of hospitality, a recreational commodity, a ritual substance and/or a symbol of either elite or marginalised culture. Opium was once a marker of social status in cultures of conspicuous consumption; for example, its taste and quality were reflected in its price range; in this way, it became a symbol of social distinction (Dikotter&Laamann&Xun 2004). And, whereas social elites may have regarded opium houses as suitable for intimate chats or business meetings, the poor often used them as cheap hostels in which to spend the night (ibid). In China, opium was consumed as a refreshing tonic for hard-working men (Zheng 2005). In the West, many forms of drug use first became widespread among the upper classes (Mintz 1986; Schivelbusch 1993). Drugs have at times symbolised the exotic

and fashionable, with consumption preferences reinforcing a given social order or a given social identity (Schivelbusch 1993). In other times and places, drugs have been primarily associated with the lower class or labouring groups, Chinese migrants in the early 20th century, for example.

Although drugs and drug-taking have many positive effects, conversely, excessive drug use can cause psychological effects of addiction, a condition that society identifies as 'loss of control'. During the eighteenth and early nineteenth centuries, the meaning of opium consumption changed from medication to 'bad habit' (Berridge 1978). The West saw opium as a pollutant in society. During the colonial period, opium was marketed primarily in Asia (Renard 2001): its enforced uptake turned China into a nation with a huge number of addicts (Trocki 1999). Growing concern about the effects of chronic drug dependence and the overall danger of opiates resulted in the medical profession in Western-influenced countries reconsidering the use of drugs, a change of approach which saw the boundaries between medicinal preparations and drugs redrawn. In the United Kingdom, the drug situation changed in 1920 when the dangerous drug legislation was introduced, legislation that prohibited the import, export and manufacture of raw opium, cocaine, heroin and morphine (Berridge 1999). Since then, the dispensing of medical opium and other substances has been limited to the pharmacist. For the western consumer, it was now time to think about what counted as 'medicine'. In December 1946, the UN formed the Commission on Narcotics, the aim of which was to control the supply of illicit drugs worldwide (Moorehead 1947). This commission could be considered the birthplace of the illicit characterisation of drugs in a global legal framework.

In Thailand, opium smoking was widespread until it was banned in 1956. Alcohol and marijuana were also increasingly considered socially undesirable (although this did little to lessen their use), as substances that tended to excite their users, thus presenting as a potential cause of conflict and embarrassment in tightly-knit village communities (Boyes&Piraban 1991). In 1978, the sale of poppy heads in Thailand was brought under control as a prescription-only medicine: the limits of recreational drug use were stated clearly and using these drugs crossed the threshold of social norms and defined

criminality. The boundary between people using and not using illicit drugs was established in accordance with national and legal mandates.

As delineated above, over time, the meanings of drugs have changed substantially across continents and regions. In the sections that follow, I explore how drugs articulate specific meanings to collective groups and individuals, meanings that have led to specific modes of identity formation in Thailand. I argue that drugs promote a shared subjective experience and reaffirmation of (sub) cultural identity. In this sense, it could be suggested that drugs are commodities with a distinct social life.

The Social Life of Drugs

The social life of drugs is reflected in the great diversity of practices attached to and influenced by drug consumption. As I have outlined above, drugs have been used in ceremonies, consumed as medicine, and traded as valuable commodities (Courtwright 2001; Westermeyer&Neider 1982). *The Cambridge Advanced Learner's Dictionary* (2003:378) defines a drug as "any natural or artificially made chemical which is taken for pleasure, to improve someone's performance of an activity, or because a person cannot stop using it." But, with time, many societies chose to classify drug users as deviants from the established norms, with many substances seen as problems in need of control (Berridge 1999). A key parameter shaping the experiences of drug users is the illegal aspect of drug use (Davenport-Hines 2002; Room&Paglia 1999) even as these experiences are not subsumed entirely by legal frameworks. Importantly, laws change the meaning of substances from legal to illegal, shifting their use from public to private and secret consumption. Appadurai explores commodities as things with social lives through the form of exchange:

> I propose that the commodity situation in the social life of any 'thing' be defined as the situation in which its exchangeability (past, present, or future) for some other thing is its socially relevant feature. Further, the commodity situation, defined this way, can be disaggregated into: (1) the commodity phase of the social life of any thing; (2) the commodity candidacy of anything; and (3) the commodity context in which anything may be placed (1988:13).

Appadurai (1988) suggests a new perspective of the circulation of commodities in social lives and claims that economic exchange creates value and that value is embodied in commodities that are exchanged. Menger (1892), who maintained that the value of a thing lies in its serving as a medium of exchange, emphasised that money is not valuable unless it is generated by a social and not a state institution. In other words, it is the social meaning that is attributed to the commodity that creates value. Van Der Geest et al. (1989) argue that medicines have social dimensions through which their meanings are related to both the experiences and conceptions of illness. They study medicines as 'intriguing' cultural objects, which have yet another meaning and another type of life. Whyte et al. (2002:13) maintain that: "It is useful analytically to trace the careers of material things as they move through different settings and are attributed value as singularities or as commodities for exchange." This means that through exchange, things move and have various meanings in different settings: they can be glorified in one place and demonised in another. Such dependence on meanings associated with them means that one must approach 'drugs' as complex commodities influenced by social, cultural, political and economic forces.

In human history, drugs have proven to be a highly important commodity with profound implications for social and economic relations. In other words, drugs, like any other commodities, have a social life. As I have suggested in the previous section, drugs have a particular history and, over time, their meanings and values have changed. In different times and places they have been highly valued for their effects and economic use; in others, they have been considered highly damaging and toxic. One way or another, drugs are found at the intersection between value, experience and regulation (Courtwright 2001). In this Introductory Chapter, I use the generic term 'drugs' in my discussion to refer to natural or synthesized drugs such as tobacco and opium, for example. In Chapter 2 to 7, my use of the word 'drugs' refers more narrowly to 'illicit drugs' such as heroin, opium or amphetamine. In this preliminary consideration, I follow Escohotado's definition of drugs:

> A drug - whether or not psychoactive - is a term that still means what Hippocrates and Galen, fathers of scientific medicine, understood it to

> mean millennia ago: a substance that instead of being "overcome" by the body (and assimilated in nutrition) is instead capable of "overcoming" it while provoking - in ridiculously small doses compared with those of other foods - large changes: organic, or in mood, or in both (1999:1).

Drugs are thus substances that have powerful effects on the human physiology: it is precisely because drugs act upon us that they have value. If currently illegal substances were made legal, their popularity would possibly increase, perhaps reaching the levels of licit, addictive substances, in the process increasing the related morbidity and mortality (UNODC 2009:164). Worldwide, tobacco and alcohol usage is generally much higher than illicit drug use: the sale of illicit drugs is prohibited based on perceived negative characteristics. This gives rise to questions of social morality and judgment concerning social values. According to various groups and multi-lateral agencies, illicit drugs such as opiate substances must remain tightly controlled due to the violence and corruption associated with their trade (UNODC 2008).

Illicit drugs are, therefore, among the most highly controlled substances in the world. The US government spends 35 billion dollars per year in its attempts to control both supply and demand (Boyum&Reuter 2005:1). Naim (2006) suggests that these efforts not only have had a profound effect on the system of production and trade but have also affected the conditions under which people are able to access drugs and their experience of using drugs. In turn, these controlling systems create a form of social distinction between those using and not using, those who conform or don't conform to what is perceived to be acceptable. Those who don't conform become designated as marginal groups in society due to their use of illicit drugs. In order to understand how and why they become marginalised, it is necessary to explore the process of social construction by which identities are formed and shaped by social forces, public attitudes and laws. My intention in the following chapters is to show that the moral framework underpinning these social forces is internalised by people in marginal spaces so that their experiences become refracted by these forces. In order to see drugs as a commodity with a social life, it is important to address the frameworks that shape this life as dynamic and multiple faceted. Drugs can be experienced in many different ways. Sometimes they are highly valued for their pleasurable and instrumental effects; at other

times, drugs lead directly to loss of life (through overdose, or execution in countries such as China) (Dikotter et al. 2004; Trocki 1999; Zheng 2005). One way or another, if we are to understand the impact of drugs on marginalised groups in Thailand we need to appreciate clearly how and why drugs are commodities with changing and sometimes contradictory meanings.

My starting point is the premise that drugs are natural and synthesized products that impact on all levels of society, even as they are appropriated and used for different reasons by various actors. Certain types of drugs play a very powerful role in both individual and group identities. Precisely how this occurs varies historically as drugs take on different meanings. Occurrence also varies geographically as different groups within societies assign different meanings to - and develop different practices associated with - drugs and drug-taking. In some cases they become cultural symbols, associated in the public imagination with certain groups such as ethnic minorities living in the highlands of Thailand, insurgent groups in the Golden Triangle or other parts of Southeast Asia, rural populations in the Andes, or urban sub-classes all over the world (Bello 2003; Booth 1996; Falco 1996). Interventions are tailored accordingly.Take the Columbia Plan, for example, whereby the US government offered technical support and funding to eradicate coca cultivation in Latin America (Haugaard&Isacson&Olson 2005; Petras 2000). Because Columbia was a major source of coca production, the US government initiated the Columbia Plan initiative between 2000 and 2006, a Plan that not only aimed to prevent the flow of illegal drugs into the United States, but also to help Columbia promote peace and economic development (Marcella 2001). As far as process is concerned, there are some similarities between the Afghanistan and Colombian strategies regarding opium poppy and coca cultivation respectively and how political and, in the case of the former, religious forces' policies impact on the countries' impoverished farmers. In Afghanistan, NATO and Taleban forces have in turn targeted poppy cultivation just as Colombia has invested millions of US dollars in 'pushing coca farmers around'.[2]

[2]'Columbia's Success: Time to Rethink Drug Strategy', by Marcela Sanchez http://www.washingtonpost.com/wp-dyn/content/article/2008/07/10/AR2008071001486.html

When looking at the historical evolution of drugs as a social commodity, we see that it was not only based on the power that drugs were afforded within the social context: it was also shaped by external forces such as political economy. In the Golden Triangle, where the topographical and climatic conditions are ideal for opium cultivation, the demographic conditions are conducive to an economic system rooted in drug culture, processing and trafficking. Much of the heroin processed from opium in the Golden Triangle transits by road from China to Hong Kong for overseas distribution.[3] In Thailand, for example, opium was highly valued among the ethnic minorities in the country's north who cultivated it until the Thai government changed its policy in 1956, declaring opium cultivation and sales illegal and that the growing of crops should be eliminated.

To sum up, one aspect of the power of drugs lies in their ability to connect people from period to period, continent to continent, nation to nation and community to community. Thus, it may be suggested that drugs have a social life that in turn shapes the subjective experience of their users. The subjective experience generated as society acts upon drug users and how drug users embody social perceptions allows insights into the meaning of drugs in specific contexts. As I suggest in Chapter 2, the intersection of legal mandates and subjective identity formation within drug using communities in Thailand have combined to shape the experience of the individuals in this study.

They call us Khiya or Junkie

Those who inhabit similar social contexts and share forms of subjective experience may also share certain aspects of social identity. Sociologists study 'identity' as the product of personal and social formation (Berger&Luckmann 1967; Blumer 1986; Mead 1967): it is a "way of thinking about the links between the personal and the social, of the meeting place of the psychological and the social, of the psyche and the society" (Woodward 2002:vii). Weedon (2004:6) notes that:

[3] 'Golden Triangle as Drug Source', 'Encyclopedia of Drugs, Alcohol and Addictive Behavior' http://www.enotes.com/drugs-alcohol-encyclopedia/golden-triangle-drug-source

> Identities may be socially, culturally, and institutionally assigned, as in the case, for instance, of gender or citizenship, where state institutions, civil society and social and cultural practices produce the discourse within which gendered subjectivity and citizens are constituted.

Identity not only creates a sense of belonging but also embodies a sense of difference by marking out 'us,' 'them,' 'me' and 'you'. Identity is linked with people's lifestyles and interests: each individual can have more than one identity within a sense of self (Mead 1967; Simon 2004). Identity is interpreted through symbolic interaction (Blumer 1986). In the case of injecting drug users, their identities are determined by objects such as drugs, needles and syringes, which are automatically imbued by certain sections of society with negative perceptions such as 'bad' or 'deviant'. This thesis seeks to show the drug user's identity as the product of a social construction based on perceptions and attitudes towards drug behaviour and those using drugs. The identity of heroin users is often structured by external forces and the degree of drug consumption; for example, Boeri (2004:236) suggests a typology of those injecting drugs as follows: controlled occasional users, weekend warriors, habitué, marginal users, problem addicts, using dealers/runners, using hustlers/sex workers, junkies, and relapsing addicts. Boeri's typology is classified according to the level of control over heroin use and the user's social control, combined with a sense of his/her identity and social roles. Socially negative perceptions impact on the selves of those injecting drugs through the form of social identity. 'Junkie', a social identity that most drug users reject, has strong connotations of negativity (Boeri 2004; Radcliffe&Stevens 2008): the 'junkie' identity conjures up negative images of drug users craving for drugs. In popular discourse, the term 'junkie' refers to the close association between drug use and crime (Radcliffe&Stevens 2008). As my friend Noo revealed: "I hate it when people call me a *khiya* (ขี้ยา junkie). I am not a *khiya*. I am just a drug user." Understandably, those who inject drugs are concerned with the way society identifies them: it impacts profoundly on their sense of self. Many rehabilitation programs have to confront the profound internalisation of negative identities. Through the addict's narrative on recovery, three tropes (themes) have been used to counter the danger and causes of stigma: first, to

reinterpret the addict's lifestyle; second, to reconstruct the sense of self; and third, to provide an explanation for recovery (McIntosh&McKeganey 2000).

Self, a product of social construction (Elliott 2001; Giddens 1996), is a concept often explored by sociologists and anthropologists. One difference between the two approaches is how self is perceived and viewed. Many sociology studies have taken self as the form developed by the social interaction of daily life. Cooley (1964) viewed selfhood as a form of social life in which the meaning was adjusted based on the person's interaction with others and the internalisation of collective norms. George Mead, who explained self and society using the metaphors 'I' and 'Me', stated that 'me' is the social self which the individual internalises through socialisation whereas 'I', the un-socialised self, comprises an assortment of personal desires, needs and dispositions (Elliott 2001). Mead (1967:135) further contends that:

> The self is something which has a development; it is not initially there, at birth, but arises in the process of social experience and activity, that is, develops in the given individual as a result of his relations to that process as a whole and to other individuals within that process.

While sharing many conceptual approaches, anthropologists more typically study 'self' as a holistic product of the intermingling of the individual, society and culture and, for this reason, probe deeply into the feelings and experiences of the individual, focusing on the subjective and intersubjective. Mansfield (2000:3) defines the term 'subjectivity' as follows:

> Subjectivity refers...to an abstract or general principle that defies our separation into distinct selves and that encourages us to imagine that, or simply helps us to serves to understand why, our interior lives inevitably seem to involve other people, either as objects of need, desire and interest or as necessary sharers of common experience.

Jackson (1998), who explores intersubjectivity and sees it as that which embraces centrifugal forces and constructive and destructive extremes of interpersonal interactions, has attempted to integrate universal perspectives with human subjectivity, i.e., to show that human reality is interconnected in a phenomenological sense. For my purposes, this means that the subjectivities of drug users are interrelated at many levels

from macro to micro. In order to understand this complex intermingling, Scheper-Hughes and Lock (1987) integrate three dimensions with an analysis of the 'mindful body': a body self, the social body and body politics. These three bodies cannot be viewed separately for they are interconnected and heuristic. Scheper-Hughes and Lock describe the boundary between each body as follows:

> When the sense of social order is threatened.., the symbols of self-control become intensified along with those of social control. Boundaries between the individual and political bodies become blurred, and there is a strong concern with matters of ritual and sexual purity, often expressed in vigilance over social and bodily boundaries. Individuals may express high anxiety over what goes in and what comes out of the two bodies (1987:24).

From this perspective, the social and political body can create structural violence as the drug user is blamed for his or her condition, opinion holding that their predicament is their own fault. In turn, their identities are negatively shaped by feelings of self-blame, guilt, and fear of difference, the last mentioned being the distance between themselves and those not using drugs. Farmer (2010:293) defines 'structural violence' as "stem[ming] from an abiding interest in the ways in which epic poverty and inequality, with their deep histories, become embodied and experienced as violence." Bourgois (2002) proposes that violence has many forms: political, symbolic and structural. Among the forms of symbolic violence are self-blame, inadequacy and survivor guilt. Victims are persuaded to believe that "their own actions are the cause of their own predicament and that their subordination is the logical [outcome] of the natural order of things" (Bourgois 2002:223). Biehl et al. (2007) emphasise that the memory of violence permeates the subjective experiences of people; indeed, one could suggest that violence in any form permeates the self. In what follows, I aim to explore this self-formation and to attempt to comprehend the inner lives of drug users and their interactions and relations within the drug community. Drug users in Thailand are trapped in - and struggle in - power relations of class, gender and race, which give rise to degrees of social suffering and inequality. Their sense of alienation creates a barrier between those who are using drugs and those who are not.

My chief argument is that the 'self' of drug users is subject to social forces. Manderson (2005:36) claims that: "The drug attaches itself to you, and you must work to be rid rid of the taint of it." Drug users interpret the stream of social reaction, e.g., law, stigma and discrimination, as an ally of the state, i.e., the enemy. Their experiences and feelings are part of their selves or individual bodies. If there is failure to understand the formative process of marginalisation, drug users' actions and behaviour may be misinterpreted. For example, nurses at methadone clinics may not understand why drug users can't stop taking drugs. This applies also to parents, who try to be vigilant and controlling when their children are using drugs. These reactions almost inevitably make drug users feel uncomfortable: they may ultimately become the driving forces that push users into relocating from broader society to the habitats of their drug peers or communities (Howard 1995). After living for a period of time in a drug community, users acquire the collective knowledge that allows them to convey the language, behaviour and actions that they have learned through their lived experience of drug use and the drug community.

The interaction between the individual body or drug user, the social body and/or parents, and the body politics or law and norms together create the social identities of drug users (Howard 1995). The use of physical control or incarceration is in conformity with the need for social and political order. For example, Foucault's Panopticon illustrates the relationship between the subject of the individual body and body politics (1995). Correction serves the purpose of producing 'normal' and 'docile' bodies for the state (ibid). The body politic creates structural violence, culminating in the drug users being blamed rather than their oppressors (ibid). After taking drugs, identities change in accordance with the influence of the social and political body. Drug users in Thailand are very commonly labelled *khiya* (junkies), terms established through social interaction which reflect Thai society's perceptions of people using drugs. The use of labels plays a part in identity formation through a process of embodiment. Csordas (1999:145), who applies a phenomenological paradigm to the self, sees "the body...as a biological, material entity and embodiment as an indeterminate methodological field defined by perceptual experience and by mode of presence and engagement in the world." Drug

users absorb negative and hostile feelings which transform their bodies. Study of the body politic and of the individual body lead to an understanding of how politics influence individual subjectivity and its embodied experience.

In recent decades, AIDS has added new dimensions of meaning for people using drugs inasmuch as it has designated them a 'risk-taking group'. Injecting drug users are referred to in the literature and by involved agencies as 'IDUs', an appellation based on both the lifestyles they pursue and the trajectory of HIV transmission. Lupton, who explores how risk influences subjectivity, observes:

> For the 'cultural/symbolic' approach, risk is used to reproduce and maintain concepts of selfhood and group membership, particularly in defining self from the polluting or 'risky' Other. [From] the 'risk society' perspective, reflexive awareness and concern about risk pervades modern sensibilities, creating new forms of relating to the self and others, including experts and institutions. [From] the 'governmentality' perspective, risk discourse contributes to the constitution of a particular type of subject: the autonomous, self-regulating moral agent, who voluntarily takes up governmental imperatives (1999:104).

Epidemiologists' and public health agencies' identification of people using drugs as 'IDUs' or 'risk-taking group' has further changed the public view of drug users and how they see themselves. Many people now consider people who inject drugs as the hub of disease transmission. Given the weight of negative perceptions, human rights play an important role in the socio-construction of people injecting drugs, casting light on the ways in which empathy for the sufferer is generated in relation to violence or its symptoms (Farmer 2010). The images of drug users formed over a period of time reflect how societies think of and label drug users. In Chapter 6 of this thesis, I consider how harm reduction is crucial to the transformation of positive forms of drug users' identity through empowering or restoring their relationships with others. Harm reduction helps to create conditions for developing positive forms of identity through prescribed activities. It could be considered the means by which drug communities re-emerge in public spaces.

In Thailand, as in many societies, deviant behaviour patterns become conspicuous when addicts start stealing from their families or selling their belongings to procure drugs. Such behaviour is one facet that contributes to stigmatisation and discrimination against people using drugs. Women drug users encounter more stigma than their male counterparts (Campbell 2000; Rosenbaum 1988; Taylor 1993). Taylor (1993) observes that their behaviour is considered unacceptable and costs them their status in the community. A central component of this thesis is its bid to determine why female drug use is socially less acceptable than male drug use, i.e., why Thai society views male and female drug users differently. Women injecting drugs face more stigma than men due to their perceived violation of the gender habitus (environment, norms and social expectations). I will examine the tactics that female injecting drug users resort to in their efforts to strike a balance in life between their conflicting gender and drug habituses. In many cases, use of the 'mindful body' analysis neglects certain dimensions of the sexualised and gendered body, which affect not only one's own experience, but also the nature of the body. Gender is embedded in people's everyday practices, beliefs and politics in many forms (Butler 2004, 2006). Young (1994:72) argues that women taking drugs cross the boundary that separates the private/domestic/feminine world from the public/street/masculine world. Young further maintains that the gendered body is embedded in the drug culture.

> The mechanistic 'fixing', jacking up with a set of works, getting a hit, blasting, making a score, crashing out or 'shooting up with a spike' are all tinged with reflections of a male and sometimes sado-masochistic world. In such a cultural milieu, street- dealing in smack, crack, horse or 'snow' contains few of the allegedly feminine attributes of 'love, peach and communal caring' which the symbolically feminine world of cannabis-use brought into the cultural world of the Swinging '60s (1994:64-65).

Consideration of the relationship between the environment and the embodied social actor allows us to see how drugs and the gendered body mutually construct different experiences for Thai women drug users.

Public and Private Space: Gendered Drug Use

Any number of drug histories show that human life has been linked to drugs from birth to death. The meanings of drugs have varied in line with historical periods, gender, social context and psychological effects: drug consumption, in itself, is culturally gendered. Both male and female roles can be connected to a wider trend of drug use, which reflects the cultural patterns of femininity and masculinity that obtain within these practices. Drugs, as commodities with profound effects, are symbolic of power relations within society and constructed around perceived masculine and feminine norms. How they use drugs determines the status of men and women in various cultural settings. Drug use perpetuates a social perception of men and women and how they should behave according to established norms. Gendered drug practices are therefore constructed around female and male ideals, more especially around society's expectations of men and women (Kandall 1996; Marchbank&Letherby 2007; McDonald 1994). As far as the physical practice of drug-taking is concerned, we see that women have traditionally been relegated to the private sphere whereas men have generally enjoyed more freedom in the public sphere.

Historically, drug communities have in most cases been masculine-dominated environments (McDonald 1994). Men's drug use has commonly been practiced in the public space as a form of recreational pastime enjoyed by males in groups. Drug behaviour tends to have been bounded by rules relating to appropriate occasions; for example, in Rome, the libation of wine was a normal practice for men who took part in sacrificial rites from which women were excluded (Purcell 1994). In China, opium dens also became sites of male sociability. A shared interest in drug-taking creates spaces for male gatherings. In the past, women were only allowed to consume drugs under more restricted circumstances; in the main, women's drug use was limited to the household only or to their private space as they were generally constrained to enjoy drugs only within domestic spaces (Brook&Wakabayashi 2000). Most societies expect women to be guardians of the home; that is, to be competent household managers (Berkhout&Robinson 1999). At the same time, hierarchical social mores tend to prevent them from consuming drugs, the fear being that drug use may give rise to

'uncontrollable behaviour'. A woman's ideal role is one of a mother, who is responsible for raising her children in a loving, congenial and stable environment. This contrasts markedly with the disorderly behaviour that may accompany 'masculine' drug taking.

There are limited circumstances, where female use of drugs is condoned, For example, in the nineteenth century, working women in the West, when kept awake at night by their restless children, sought relief in the soothing qualities of certain drugs (Kandall 1996). Opium use was the cornerstone of self-medication: a good housewife was expected to be able to blend cough syrups and other opiate remedies at home (Kandall 1996). The instant effect of dosing crying children with laudanum or paregoric was common and welcome knowledge.

Marginalised by association in specific cultural contexts, women embarked upon creating their own space in which they felt free to discuss their lives and concerns (Kato 2004). In many parts of the world, the tea ceremonies that were held in the home were associated more with women than with men as they required both application and artistry (ibid). Moreover, they were conducted for private consumption rather than public. In other words, the tea ritual allowed women the power of management: males deferred to their leadership on these occasions (ibid).

Over the years, modernisation in many countries has changed gender statuses, allowing women more freedom and more public space. Women were, potentially at least, able to enjoy life outside the home, an eventuality that changed the meaning of drug taking for women. They could work, earn money, and buy commodities to use for their own personal purposes. Some women now felt that they must learn to take certain substances if they were to assume a masculine role and conduct their lives in the public space. Gately (2001) maintains that in the West, by the 1920s, attitudes towards smoking had changed due to the 1914-1918 'Great' War when women had to assume male responsibilities in the home. (Again, during WWII (1939-1945), females, finding themselves outside of the home working shift work in factories that had hitherto been solely the sphere of males, emulated the male smoking habit, many seeing it as symbolic of the male stronghold they wished to invade). The drug manufacturers of the

1920s externalised a gender-stereotyped bias by launching special female-oriented brands to tempt women; for example, in 1924 Marlboro, a well-established cigarette manufacturer, launched a ladies' cigarette called 'Mild as May' (Gately 2001). Advertising stressed its mildness and lightness - here was a cigarette specifically produced for women. Women associated the cigarette with seduction - with 'lip eroticism' - which could be choreographed and served to enhance their sexual attraction (ibid). Drinking was another form of social recreation that gained in popularity synchronous with other social changes. In Japan, according to Hendry (1994), drinking alcohol was part of the Japanese male worker's life: he usually drank after work. Female drinkers were often found in male company as such occasions allowed the establishing of friendships among colleagues and, even more importantly, provided ways of achieving promotion (ibid). Now women could get together and drink socially: women who drank at home alone were commonly referred to as 'kitchen drinkers' (Hendry 1994). But, at the same time, women were perceived as more vulnerable than men to the effects of alcohol: it was assumed to be private matter and if found in public defined as a social problem (Thom 1994).

Drug use patterns reflect the different statuses of - and have different meanings for - men and women in the social context: it is due to this that different tactics are required to deal with drug use. In masculine drug environments, it is argued that women have typically either assumed the submissive role or became decorative components of male venue ambience (Dikotter et al. 2004). Because of their domestic ability, women prepared the drug or drug consumption equipment for their male companions (Taylor 1993). The beauty and talents of women served to decorate male environments such as nightclubs and opium dens, wherein women were responsible for preparing opium and alcohol for the male clients (Dikotter et al. 2004). Through these activities, women became components of the opium sex industry, which promoted opium smoking and sex for recreation (ibid). The distinctions of space as they obtained between men and women were based on the notion that men had the right to public space whereas women's space was confined to the home.

The drug community has thus been described as a world of masculinity wherein women are subjected to male power (Bourgois&Dunlap 1993). In some areas of research, male dominance (that is, male participation in interviews) has established the inferiority of women as objects of male power/masculinity in a ritualised way (Gurney 1991). There are a number of examples of female ethnographers who have conducted extensive research in the illicit drug area and confront in ambivalent ways, these power structures. Gurney (1991) describes the discomfort and anxiety she experienced as a female field researcher in a male-dominated setting. Taylor (1993) describes how her experience as a mother helped her both access and leave the field. In a somewhat similar sense, I also profoundly experienced a gendered status during my fieldwork.

> When in the drug community, my male informants treated me well. They welcomed me. I felt that they were at ease in my presence because I was a woman and would cause them no harm (in terms of male competition). They showed me drugs and sometimes asked me to go out with them.

Being a female ethnographer gave me the chance to infiltrate the drug community and readily begin conversations. At the same time, there were limitations to gaining data; for example, I couldn't socialise with male informants at night unless a female user accompanied me.

Methodological Considerations

a) Female Ethnographers in the Drug Field

Nowadays, qualitative methodology is widely employed for purposes of medical or public health research, based upon the realisation that quantitative research cannot provide an adequately comprehensive insight into the socio-cultural context of disease. Anthropologists, who have been using these techniques for many years, have become prominent (in medical applied health programs) over the last four decades. Biehl et al. (2007:7) stress that the role of the anthropologist is to explore the subjective lives of subjects by interpreting symbolic forms and their self-representation. It follows that in order to understand the subjective experience of people using drugs, one must learn to view their world from an emic viewpoint. Turner (1992:43), however, maintains that this is not straightforward: "…While anthropology has played an important part in

maintaining a scientific interest in the social and human body, in general terms anthropology has not been concerned to understand the phenomenology of the 'lived body': it has rather been concerned to understand the body as part of a social classificatory system." Peacock (2001:18) claims that by thinking holistically, one views the part as the whole; i.e., tries to grasp the broader contexts and frameworks within which people behave and experience life. Due to the nature of drug cultures and settings, conducting ethnographic research requires a close understanding of the subjective sense of people using drugs, as drug users constitute a 'hard-to-reach' or 'hidden' population (Lee 1994). Stigma typically permeates all aspects of drug users' lives; for this reason, they opt for the security that living in a drug community with their peers provides. This provides particular challenges for ethnographers.

Ethnography has been used as a key means of studying illicit drug-taking as it provides the researcher with an insight into both the drug context and drug behaviour. Page and Singer (2010:17) maintain: "The prime directive in the ethnographic study of drug use is to achieve an understanding of how and why the behaviors of interest take place in a given natural habitat and what forms these behaviors take." Significantly, the ethnographer has to try to capture the grassroots' point of view through spending time with them so that he/she can both understand and determine the meaning of their behaviour accurately. Power (2001) argues that participant observation should be included in drug research in order to comprehend illicit drug use and the activities and lifestyles of drug users. Taking part in their activities during one's fieldwork provides both insight into, and an understanding of, those studied. This is not to say that the researcher should also engage in taking drugs, but that he or she should be sensitive to the immediate context surrounding these practices.

By the 1990s, the AIDS pandemic became the prominent concern in the research agendas of public health professionals. Ethnographic research was now additionally employed in the public health paradigm as it provided insight into individuals' risky behaviour. The research literature strongly suggests that ethnographic research helps researchers to understand HIV-related behaviour among people injecting drugs (Bourgois&Bruneau 2000; Needle et al. 1998): the ethnographer undertakes to describe

what types and forms of environment and situations encourage risky behaviour, e.g., shooting galleries and drug-related 'rituals' (Bourgois 1998; Celentano et al. 1991; Chitwood et al. 1990; Fuller et al. 2003; Latkin et al. 1995). During this period, researchers also expanded their ethnographic studies to exploring marginalised and vulnerable groups within the drug community; for example, women using drugs (Maher 2000; Taylor 1993).

The fact that the drug context is dominated by males raises challenges for female ethnographers. Page and Singer (2010:150), with reference to the role of female ethnographers in the drug context, claim: "These researchers' most important contributions to the overall understanding of the human condition of drug users lay in analyses of female drug users' life circumstances and in their exposition of female drug users' perspectives and roles in the drug trade." Within the drug context, female ethnographers can contribute greatly to the comprehension of the inner lives and feelings of women using drugs as they share more intimacy in their particular gender habitus. Nowadays, one sees a growing number of female ethnographers working in this context. Seminal works include Rosenbaum's (1988) *Women on Heroin,* which provides an extensive account of the lived experience of women using heroin in the San Francisco Bay area and New York City. Taylor's (1993) *Women Drug Users: an Ethnography of a Female Injecting Community* explores the tenuous experiences of women injecting drugs in Glasgow. Lisa Maher's work (2000) *Sexed Work: Gender, Race, and Resistance in a Brooklyn Drug Market* provides an insight into women drug users in New York who work as sex workers. It is worth noting, however, that to date there has been little work on the intersection of gender and drug use in the developing countries.

Gurney (1991:54) maintains that: "A field researcher who becomes interested in a setting in which participants are predominantly members of the opposite sex may experience some awkward moments as he or she attempts to gain the respect, trust, and cooperation of those participants." There were times when I experienced this difficulty as a female ethnographer. A paragraph from my field notes highlights the inevitable gendering that occurs during fieldwork:

> It is midday; as usual, I am sitting on a bench at the drop-in centre. It is Saturday so many people I don't know are visiting the centre. Dang (one of the male staff) tells me that Kum and Poo have fought again and she has finally decided to leave him. There are two people sitting close by. They listen to what we are talking about and sometimes they nod as a sign of agreement. One man looks at me directly, as if he is about to ask who I am. But, he doesn't. Another starts talking about his relationship - that his wife has found out that he has been having a *gig* (affair) with a woman who is using drugs. His wife doesn't use drugs and she financially supports him. They talk about a porn movie and some of them hand around a porn CD. Suddenly, I realise that I am the only woman in the group and that Dang has left. This makes me feel uncomfortable about the topic as they now talk openly about sexuality and pleasure. Even though I know that what they are talking about is precious information, I feel uncomfortable and leave the group quietly. I walk to the backyard of the house (drop-in centre) where I know there is often a group of women. Nok asked me why I left the group so I told her that they started chatting about sex and porn movies. She nodded and said: 'That is why I didn't show up.' (21 October 2009)

Many times, males in the community, who thought I was a drug user, persistently asked me to go out with them. They stopped when they learned that I was a PhD student conducting drug research for it created a boundary between 'me' and 'them'. A wall attributable to our different backgrounds, e.g., education and lifestyles, became apparent. During my fieldwork, I faced questions from many people: what drugs had I been using? As I usually 'hung out' with people in different settings of the drug community during my fieldwork, several assumed that I used drugs or perhaps had drug experience. When I visited the hospital clinic with a person living with HIV, the nurse, who assumed that I was also a people living with HIV/AIDS (PLWHA), said to my friend: "That poor girl, she is too young to be infected." The nurse's assumption was built upon the people with whom I fraternised and/or the group I lived with. Despite obvious challenges, over time I increasingly gained access to - and formed enduring relationships with - drug users in Bangkok who were the primary sources of information for this thesis.

b) Background of Drug Situation in Thailand

Throughout the nineteenth and twentieth centuries, Thailand has experienced a drug epidemic of varying degrees of severity. Information provided by the recent National Household Survey on Substance and Alcohol Use in Thailand reveals that 2,521, 507 people have used drugs - at least one kind of substance - at some time in their lives; that is, 5.42 % of the total population aged between 12 and 65 years (Assanangkornchai et al. 2008:25s). The types of drugs consumed in Thailand include: Ganja (Cannabis Sativa), Kratom (Miragym Speciosa), Opium, Heroin, *Yaba* (ATS), Ecstasy, Ketamine, Cocaine, Ice (Methamphetamine), Hashish, Cough Mixture, and Psychotropic drugs. Among these drugs, amphetamines are the most widely consumed, ranking number one on the list of most consumed illicit drugs in Thailand.

As I will describe in more detail in Chapter 2, the first era of drug use in Thailand centred upon opium, which was grown in northern Thailand. After it was banned in 1956, heroin became popularly available in the 1960s as a substitute. Within a short period of time, heroin use spread among the Thai youth, particularly in the country's urban areas. Heroin in powder form was not only easy to obtain on the black market: it was easy to consume and carry. However, the spread of heroin use was not confined to the urban areas: during the 1970s, it also became widespread among the indigenous opium-using ethnic minorities in northern Thailand, groups located along the border areas. The prevalence of drug use is peculiar to specific geographical areas; for example, opium consumption mostly occurs in northern Thailand, an area adjacent to the Golden Triangle, which is host to prolific drug suppliers and cultivators of opium. While opium is cultivated mainly in Burma, Thailand is considered the hub of the drug illegal business trade (Lintner&Black 2009). During my fieldwork in 2008, I accompanied some NGO representatives to help them collect qualitative data in several provinces in northern Thailand. I noted that people injecting drugs in Chiang Rai had no knowledge of Midalozam (a short-acting benzodiazepine)[4], which nowadays is widely used in Bangkok and Chiang Mai as a substitute for heroin. Because Chiang Rai is

[4] Midazolam, a short-acting benzodiazepine, is available in Thailand in table form. It is produced under a Thai trade name Domicum. People injecting drugs in Thailand usually refer to this drug as 'Kum'. Midazolam tablet is crushed, dissolved in water, filtered and injected (Kiatying-Angsulee et al. 2004).

located adjacent to the Burmese border, heroin and opium are readily accessible in the area. Moreover, over the last few years, there is an increased flow of imported heroin from Afghanistan to Bangkok. As my informant Nok maintained: "Heroin is not difficult to find like in the last years. Brown heroin is available in the market now. It is brown powder not white. I guess it comes from other countries, perhaps Afghanistan, but the quality is not good, not like the white one."

During the 1990s, a preference for *Yaba* (Amphetamine) over heroin saw the number of drug users increase dramatically but with a far broader age and class demographic. This rapid increase in consumption forced the Thai government to launch an extensive anti-drugs campaign in 2003, which became commonly known as the War on Drugs (WODs), in an attempt to control the supply and demand of/for drugs. As a result of this government initiative, by 2003 the number of drug users had dropped noticeably; but, it increased again in 2007 (Assanangkornchai et al. 2008). During the first decade of the new millennium, there was a trend towards the use of illicitly obtained prescription substances, i.e., from heroin to psychotropic drugs such as Midazolam or Domicum. Today, one Midazolam tablet costs around 40 to 80 baht (1.2-2.5 AUD) whereas the smallest dose of heroin fetches between 400 and 500 baht (12-16 AUD-) and *Yaba* costs around 150-200 (5-6 AUD) baht. Midazolam may be bought from certain clinics specialising in psychological disorders in the urban areas: a limited amount may be procured from hospitals in Bangkok, for example. Rat told me:

> I went to the psychological department at the hospital. I tell them I have insomnia and can't sleep well. Then they will give me some psychoactive drugs including Midazolam. I have all kinds of psychoactive drugs at my house and sometimes I give them to friends at the methadone centre.

Even though there are reports suggesting an increase in numbers injecting *yaba*, my informants, who are familiar with injecting heroin, prefer Midazolam as the taste is similar to that of heroin. Jack (a male user) told me: "I tried injecting *yaba* once but I did not like it. It keeps me awake. I know heroin is very costly and I cannot afford it. So, sometimes I turn to *Kum* (Midazolam). It is much cheaper." Bangkok is currently home to several thousand injecting drug users.

The focus of my research is within this group, who primarily use heroin but who also use amphetamine (ATS) and Midazolam because of the high price of heroin. During my period of data collection, I regularly visited 4 drop-in centres in Bangkok central and its suburbs as well as 3 methadone clinics. I conducted informal interviews with roughly150 injecting drug users in Bangkok. Among my informants, 30 were female injecting drug users I met in the drug social context. Women injecting drugs rarely attend drop-in centres so I had to go to their homes or methadone clinics, to mutually acceptable places to interview them. The reason for their rare attendance at drop-in centres was mainly because of family commitments. Based upon my engagement with the drug community, I would estimate women users account for approximately 10 per cent of Bangkok's injecting drug user population although this is based purely on observation. Unlike their male counterparts, female users who attend the methadone clinic rarely hang out with others in this environment. In order to access the women, I often sought female outreach worker Nok's assistance: Nok helped me to access women injecting drugs. I found that female users, who lived at home with their families, did not have to go to work. Their parents felt that taking drugs at home provided a safe environment for them and that using outside of the home could be dangerous. Some gave their daughters a daily allowance, enough to buy drugs each day. Jib described this situation as follows: "I used to go out to work, but my dad was unhappy with this. He said that he gives me 200 baht as a daily allowance so why do I have to work? He wants me to stay home with my daughter."

Throughout this thesis, I will use the term 'drug user' to refer to illicit drug users in Thailand. In the broader context, this might include ATS, heroin and Midazolam users. As mentioned, my focus is essentially upon people injecting drugs: all of my informants were people injecting drugs (heroin, occasionally Midazolam and ATS). Discussions and quotations thus refer in the main to people injecting drugs unless otherwise specified. Also, I include the ages of all of my informants where possible. Moreover, in this thesis, I use the term 'friend' (เพื่อน), following examples set by Thai NGOs' who work in the drug field, to refer to informants. Thai NGOs use this term as a deliberate tactic to imply people working in the same fields and those with whom they share

particular feelings and experiences. I too regard these people I came to know as friends in ways beyond the adoption of the term for political reasons; however, I was always aware of the limits of these field-based relationships. In seeking to represent their lives, I understand that drug users interact with others in drop-in centre in a particular way as an attempt to deal with rules, relations and drug lifestyle. In demonstrating the way drug users have formed specific tactics to lessen the impacts of social forces and in seeking to understand these tactics does not mean that they are not problematic legally or socially, nor that they should be judged differently than others.

c) Gaining Access to the Field

During their research, ethnographers face various challenges including accessing, staying in and leaving the field. The ethnographer, who is closely engaged with those participating in the research, may unavoidably become involved in advocacy of the politics of fieldwork. Some ethnographies show that data can positively impact on policy, for example, the implementation of harm reduction (Campbell&Shaw 2008; Maher&Dixon 1999; Rhodes&Davis&Judd 2004). My intentions in this thesis are more modest. As an anthropologist, my objective is to gain insight into drug users' lives in order to better understand how injecting drug use and abuse in Thailand requires exploration of its linkage with all levels of society. The bulk of data collection in this thesis is based on participant observation and informal interviews with drug users in their respective communities, drop-in centres, or methadone clinics in Bangkok and surrounding suburbs. I carried out my field activities from 2006 to 2009, during which time I met many people working in the drug field, both nationally and internationally. The ages of my informants ranged from 20 to 55 years. Of my 150 informants, between 30 and 40 currently work for drug NGOs as staff and/or outreach workers. Their average income is between 3,000-6,000 baht (100-200 AUD). Most of my informants had grown up in Bangkok and its suburbs. Based on family income and living surroundings, most would be considered low class. This is not to say those in other socio-economic classes never inject drugs, simply that they are fewer and harder to access through the networks I used.

Once I began to meet people involved in drug use, I made clear the nature of my research: I also told them that their names and any information they provided would remain anonymous. This research has received ethical approval from the Macquarie University Ethics Committee. The names of all of the people I interviewed or spoke to during my fieldwork, and of the sites of the drop-in centres and methadone clinics accessed, appear in pseudonym form in order to avoid any possible identification. Due to the sensitive ethical concerns surrounding the investigation of illicit drug use, I also arranged preliminary meetings with NGOs and community leaders to explain the details of my research project and to assure them that their names and informants' names would remain anonymous.

Because establishing contact was constantly difficult, I initially sought help from drug activist groups and NGOs. In 2006, through TTAG (Thai Treatment AIDS Group), I volunteered to work for the Thai Drug Users' Network (TDN), a leading drug NGO in Thailand. TDN, along with other networks, receives a Global Fund grant under the supervision of its principal recipient Rak Thai. The TDN office in Bangkok has over time been relocated to two different sites. In June 2006, they rented a temporary office, a townhouse in, central Bangkok. Later, the committees and new staff decided that this office was not conducive to good work relations due to limitations of space. During this period of relocation, I started to spend more time at RakJai, a drop-in centre run by a leading international NGO close to a methadone clinic. The manager of this centre, Nayot (pseudonym), used to work as a TDN coordinator. One of the TDN staff told me that Nayot left the organisation due to conflict with the TDN committee. With his long-term background in civil society organisations, Nayot was soon assigned to organise this drop-in centre in Bangkok. A professor at a Thai University with whom I used to work arranged my introduction to RakJai. The majority of the staff and members are injecting drug users or ex-drug users: only two were not using drugs. During my data collection (2006-2009), I joined as many centre activities as I could, e.g., the risk reduction class, annual trip and the cooking club among others. For a period, I worked as a volunteer, helping with English translation and teaching English to the staff and members.

Oddly enough, my favourite hobby, baking, proved a successful means of getting closer to people at the centres. At first, I started bringing some cakes to the centre and they were surprised to learn that I had baked them myself. There is a tradition of celebration at RakJai. Each month, the centre hosts a birthday party for members or staff members who were born in that particular month. After they learned that I enjoyed baking, they asked me to bake cakes for special occasions. If I visited the houses of informants (who became friends), I usually brought a cake with me as a gift for their parents and the children. Soon, I received many calls from them asking me to bake some cakes or cookies for their loved ones as they had no money to buy them.

d) The Field Sites

My volunteer work at the drop-in centre and network allowed me to establish a rapport with other drug NGOs and drop-in staff members. Relationships were also forged by going to the centre each day and participating in special occasions such as celebrations, field trips and camps. As the months passed, going to the centre became my everyday routine. On occasions when the centre held some special events, people at the centre would call me and ask whether I would like to join in or not. The environment at RakJai was congenial and I felt comfortable spending time there. Unlike other places used by the drug community, the drug users who frequented RakJai fit within a more structured environment that we could share easily. I took RakJai as my entry into the drug using environment; but, I soon came to realise that while the centre represented the drug community in the public space, what was eluding me was life behind the centre. For this reason, I decided to accompany the outreach workers into the drug community as well as to visit their families. This allowed me to observe their interaction and relationships with family members. Notwithstanding historical trends, my thesis focuses primarily on people injecting drugs in Bangkok, the largest city - as well as the capital - of Thailand, with an area of approximately 1,568 square kilometres and a population of approximately 5,658,953 million people (as of 2005). Due to rapid economic growth since the 1970s, Thai society has experienced tremendous social change at all levels of society. Many people have migrated from the countryside to work in the urban areas,

especially to Bangkok. The modernisation of Thailand's big cities has changed the lifestyles of all Thais, especially family relations; for example, women increasingly work outside the home to supplement the family income. The family structure in the urban areas (and to some extent in the rural areas) has changed from extended family to nuclear family. Like other urban settings, many families rely to some extent on commerce, e.g., the selling of food. Nowadays, more often than not, both parents work; so, they have less time to take care of their children. Thailand today has one of the highest rates of female participation in the workforce in Southeast Asia; and, as this trend becomes more pronounced, children are becoming increasingly distanced from their parents. Money is spent on buying things for their pleasure: this rising commodity consciousness has resulted in materialism becoming a paramount value in Thailand (Cohen 2006; Mills 1999).

Thorbeck (1987) maintains that the poverty in the urban areas is usually explained by the high number of family members and the consumption of alcohol and drugs by some. During my fieldwork, I visited several of my informants' houses; some were stilt houses, built from wood and located in densely populated areas. Most of them were overcrowded dwellings wherein all amenities were shared; for example, Nok lives in a very small room in a DinDang flat with 6 family members. Near the flat, there are small stalls or shops where the locals usually spend their time drinking or chatting. Illegal activities such as gambling, drug dealing or money lending are not uncommon in the area. Most of Thailand's heroin users reside in the country's urban areas (Klongyut 2004). Like other urban drug users, people injecting drugs in Thailand live diffused throughout Bangkok and in condensed areas.

Plate 1. DinDang Flats – typical example of where many users live.

The feeling of insecurity created by recognition of widespread drug use is aggravated by media, police and community leaders: anti-drug campaign posters calling for a drug-free environment are found displayed throughout the local communities. Drug addiction is a matter of concern for community security and for parents worried about their children. In my study, I found that drug users both live with family and alone. Those living isolated from family choose to do so because of family tensions and disruption. Most drug users prefer to live with their peers, establishing their most important social contact with others in the drug social network. Those who are unable to provide childcare for their babies, and who suffer economic constraint, tend to stay with their families. The feeling of difference, and the lack of solidarity, is especially marked when they interact with others in the wider community. In the next chapter, in which focus is upon the relations between users and society, I look at how subjective experience emerges as the result of specific types of identity formation. In Thailand, much of the social apprehension circulating around drug use has its roots in the changing orientation to drugs. Nowadays, there is an entrenched population of injecting drug users in Bangkok, members of which formed the core group of informants providing the ethnographic data for this study. Drug use was not always illegal in Thailand. However,

over the past 50 years, drug users have become strongly associated with deviance and illegal behaviour.

e) Being in the Field: My Self and Representation

As an anthropologist conducting research in my own home town, I struggled between the role of 'self' and 'otherness'. As Lal (1996:105) emphasises: "Unavoidably, the many locations that shape my identity and notion of self, influence my choices, access, and procedures in/of research and also permeate the representation of research subjects in my writing." Because my background situated me outside of the drug-using community, I had to seek ways of entering the field. While initiating access with people injecting drugs in Bangkok, I was concerned about my self-representation. I was most concerned about how I should handle my presentation of self. As someone with no drug experience, it seemed to me that I couldn't share the subjective experience of drug use with my informants.

Social identity affects the field work process. Unlike the 'foreign' anthropologist conducting research in countries other than his/her own, I chose to conduct my research among my own community. As an anthropologist conducting research in my hometown of Bangkok, I encountered a different set of dilemmas of representation and identity concerning myself and the 'other'. At first, I felt fortunate as I did not have to learn languages, cultures and norms. But, soon I realised that this could become a difficulty, especially when confronted with the gap between 'me' as 'subject' and 'them' as 'object'. As I was the only new face in both the community and the drop-in centre, members or people in the field usually asked the staff who I was. They suspected that I was one of the staff or perhaps a drug user. I faced many kinds of questions, in particular: What kind of drug do you use? They invariably assumed I used 'amphetamine' as I looked robust. They said I did not look like a person who injected heroin, because they are generally thin. The more time I spent with them, the more I sensed the distance between the field and my own personal world, for as much as I attempted to deconstruct my 'self' in order to conduct research among the drug users, I

must acknowledge that I was not able to understand their lives completely, especially how drugs give them pleasure and happiness.

Conducting research in my 'backyard' forced me to clarify my position in the field. During my fieldwork, I was aware of the need to manage and produce an acceptable representation of who I was and what I was doing there. Shaffir and Stebbins (1991a:12) maintain that: "Because field researchers are virtually part of the data-collection process, rather than its external directors, their experiences there are critical." Initially, I felt worried about revealing my personal life to the people in the field as it had the potential to create a gap or distance between 'me' and 'them' but over time this changed. Dress became important: I usually wore a t-shirt, jeans and sandals. I avoided driving to the field, opting instead to take a bus or go by motorbike. My family and friends noticed this change of body image and activity, and, as my sister said to me somewhat critically one day:

> You know, you dress like a *tom* (lesbian). You always wear jeans and a t-shirt and carry a backpack all the time. My friends ask me whether you are tom because you have changed the way you usually dress as well as your hairstyle. My friends cannot remember who you are.

My sister's reaction towards my change of appearance made me realise that I was changing, and, like all anthropologists, I was beginning to embody my experience in the 'field'. Even though I felt relieved that as a local I didn't have to learn the language and culture of my thesis subjects, sometimes I envied anthropologists who collect data in countries other than their own, who could leave their everyday worlds behind and adapt themselves to new and exciting fields, languages and cultures.

While many researchers refer to the applied benefits of conducting qualitative research in the drug field, Sterk (2003:127) makes the interesting point that: "While representing the voices of drug users can serve as a means to advocate them, there is also danger of reinforcing negative stereotypes." This means that ethnographers should be extremely careful about the data they write and present. As I mentioned in my prologue, it was not possible for me to leave all my socialised perceptions and dispositions concerning drug use behind. I do hope, however, that I have moved beyond most of them and that what

follows reflects the candour and openness of the information my informants shared with me.

f) A Never Ending Story

The last phase of this research, that is, of writing-up, is concerned with my interpretations of my findings. An important aspect of field research is developing and maintaining close and long-term relationships with people in the field (Shaffir&Stebbins 1991b). After finishing their fieldwork, researchers return to their respective universities, armed with the requisite information that will facilitate the writing of their theses. They have to write and analyse based on the data they have assembled. Invariably, conducting ethnographic research creates a form of bond, a relationship between researcher and informants. The benefit of writing up in the field stems from the fact that the researcher can cross - check the accuracy of his/her data. On the other hand, the disadvantage of writing up in the field is that one constantly receives new data from his/her informants.

For example, on 20 April 2010, while I was writing up my notes, Nok called me to invite me to attend the wedding of a particular outreach worker. At the reception, I met several staff members from Rakjai. Since we hadn't seen each other for a long time, we were delighted to talk about what was happening in our lives. They complained about RakJai's management system and provided me with updates about their friends' lives. What surprised me most of all was that several of my friends had started using drugs again, even the RakJai manager. Late one night, Nayot called me, complaining about a personal problem with his wife. He admitted that he continued to use drugs and was trying to come to terms with the fact that his wife was leaving him. In 2010, I heard that several of my friends had been arrested, some of them for reusing drugs. It was like going back to the beginning again. They had to struggle with feelings of self-blame along with the stigmatisation and discrimination that persists both within the drug community and in society. Nok admitted later that she was reusing drugs. "My life has ... failed down again from the top to the bottom. Many people discriminate and insult me that I reuse drugs. One day, I will recover and will be at the higher position again."

So, even by June 2011, while trying to finish the final draft of my thesis, I was still adding data which I collected through chatting or hanging out with Nok. It is a question of knowing when to stop when the reality is that the things of which we write do not stop. Nevertheless, I have tried to present the lived experience of people injecting drugs in Thailand in ways that will help the reader understand the multiple processes that continue to shape their lives. Taylor (1991:238) maintains: "Leaving the field is not simply a matter of wrapping up a study, but of dealing with change in how one relates to the people one has studied." This is the intriguing point of ethnography. During their often lengthy periods of fieldwork, researchers develop varying degrees of relationships and bonds with the people in the field, bonds that can continue to provide opportunities to learn from each other. This thesis represents perhaps only the first stage of this process.

Thesis overview

The thesis explores the interplay of external and internalised forces and how they impact upon people injecting drugs in Thai society, particularly in Bangkok. I do not discuss drug initiation or how they become habitual drug users; rather, my focus is upon exploring the subjective sense and experiences of people injecting drugs in Thai society. The study sets as its central task investigation into how macro-level strategies are formed in response to drug situations and how drug users tactically respond to these strategies. The strategies employed by society combine to underpin public perceptions of drug usage and how drug users see themselves. In order to lessen the impact of social forces and at the same time continue to pursue their drug lifestyles, drug users employ tactics to accomplish these objectives which I collectively call 'management of self'. In this thesis, I explore the tactics that Thai drug users resort to in order to survive within and without the drug community: these include establishing an invisible boundary, means of self- representation, and the dynamics within drug community itself. Contrary to other research which claims that drug users are a marginalised group exclusively pursuing their drug careers, I will suggest that drug users devise and use specific tactics

in order to maintain relationships and interaction with a broader society as well as with each other.

Compared with other marginalised groups, people injecting drugs face high levels of stigma and discrimination. **Chapter 2** of this thesis sketches a framework of the meaning of drugs in Thailand. I consider how modernity and globalisation play important roles in drug representation and consumption. The drug culture amongst minority groups in northern Thailand exacerbates forms of cultural racism, making assimilation difficult. I discuss the history of and attitudes towards drug use in Thailand, applying the concept of 'apartheid' to the ethnic minority groups and drug situation. The law and political economy play key roles in creating processes of social exclusion of those involved in drug use, not only of the ethnic minorities but also encompassing urban drug users who form the basis of this study. In **Chapter 3**, I examine the various forces that shape the lives of urban drug users in Bangkok. As well, I explore social stressors which contribute to the social suffering and unhealthy conditions experienced by Thai injecting drug users. Elements of structural violence are comprised of broad political-economy and socio-cultural forces, such as stigma and discrimination, norms, laws and regulations, and gender expectations. These forces combine to create unhealthy or harmful conditions (in both physical and psychological forms) for those injecting drugs such as HIV/AIDS vulnerability and exposure to other forms of infectious diseases. Those injecting drugs embody these external forces. As a result, they become marginalised and this leads to specific choices that, in turn, lead to the formation of a drug community**.**

In **Chapter 4** I attempt to show how drug users cope with these external forces through specific management of their subjective sense of self. I show how in order to manage themselves in times of social stress they employ a variety of tactics which enable them to live between two worlds. This includes erecting a boundary which protects them from an outside 'gaze', creating an alternative sense of belonging that functions discreetly within the drug subculture, following its own norms and rules**.**

Around the world, women using drugs encounter more stigmatisation and discrimination than male drug users. My efforts to deconstruct the intersection of drug use and gender demonstrate the nature of drug communities as domains of masculinity. In **Chapter 5**, I address gender habitus specifically. In Thai society, socio-cultural factors impact significantly on the gendered subjectivity of female injecting drug users. Women drug users are more vulnerable than their male counterparts and, as already suggested above, face more stigma and discrimination. In this chapter, I explore how women using drugs manage their lives and the nature of the drug community which challenges gender expectations in Thai society.

The harm reduction approach, which is currently considered an effective way of promoting a healthy environment for people injecting drugs, functions through several strategies developed by public health and medical professions. In **Chapter 6**, I extend my argument based on the previous chapters, i.e., that external forces can create 'harmful' or 'unhealthy' conditions for Thai injecting drug users rather than 'harm' caused exclusively by individual behaviour. In **Chapter 7**, I conclude by suggesting that the harm reduction approach might usefully include critical medical anthropology as it has made a substantial contribution to holistic analyses of drug use patterns and their meanings.

Chapter 2

Political Economy of Illicit Drugs in Thailand

In the Introduction, I outlined some historical uses and meanings of drugs. During the 19th century, when the negative effect of drugs began to be emphasised in the West, a general sense of concern slowly took hold. Since then, in the public mind, various drugs have come to be equated with disease and deviance. In the 20th century, this perception spread to many countries including Thailand in the wake of international regulations. Media, and not only the Thai media, tend to intensify the negative aspects of drugs and drug-taking by featuring images of crazed users committing violence and crime. The impact of successive moral panic and drug control policies has been widespread, affecting all levels of society.

The political-economic dimensions of the opium problem among ethnic groups cannot be overlooked within this trajectory, for they rest on the cultural differences that pertain between the Thais and the country's ethnic minorities. Opium has been central to the lives of many people over many centuries (Poshyachinda 1995; Rush 1985). The usage of drugs as part of social activities, and the subsequent prohibition of these practices, has been among the most sweeping changes in Thai drug history. For various reasons, among which are marginalisation and stigma, the ethnic minorities in Thailand have at different times used drugs as the mainstay of their daily lives (Poshyachinda 1982b, 1995). The use of most drugs, and opium in particular, is prohibited in part due to its association with often already stigmatised minority groups. Jenkins (1999:3) observes: "One drug is banned because it is associated with some stigmatized ethnic or racial group, while another is tolerated, either because it is used or accepted by a social elite or because it becomes a profitable commodity for mainstream business." As a result, public attention has tended to focus on drugs and drug-use among the above minority groups. As Murphy and Rosenbaum (1997) stress, there is a significant dividing line separating ethnic people who use drugs. The cultivation of opium in the Thailand's rural areas has seen the country's mainstream society stereotype the ethnic growers and users, culminating in an ethnocentric notion targeting 'aliens' and drugs. Imbued with different cultural, religious and political backgrounds, immigrant working-classes are also

scapegoated as those who pollute the dominant society. In many countries, immigrant Chinese labourers' opium use, for example, is seen as a form of pollution (Helmer 1975; Manderson 1997b).

In fact, drugs seem unavoidably linked to the ethnic minorities of many of the world's countries, particularly in the Southeast Asian regions. The history of drugs and drug taking in Thailand is strongly linked to the ethnic minorities in northern Thailand, an area referred to as the 'Golden Triangle'. This opium triangle, which extends from the rugged Shan hills of north-eastern Burma through the mountain ridges of northern Thailand to the highlands of northern Laos, is one of the world's largest sources of raw opium as well as morphine and heroin (McCoy 2003). Many hill tribes live in the mountains of northern Thailand, in areas bordering Burma and Laos, e.g., the Akha, Hmong, Lahu, Lisu and Karen. The relationships and forms of interaction that obtain between the Thais and these ethnic minorities are influenced by political economy forces at both the national and international levels. To this end, I argue that political economy forces have significantly changed the meaning of drugs in Thailand, by extension affecting how mainstream Thais view drug use and those using drugs.

In different historical periods, political economy has played an important role in shaping how drugs are cultivated, traded and utilised. Prior to colonialism, drugs were cultivation monopolies, generally consumed within their community of manufacture (Matthee 1995). Throughout the 17th and 18th centuries, colonising Europeans expanded the use of drugs via production, importation and marketing in their own countries (Trocki 1999). Substances such as tobacco, tea or coffee, which came into fashion in Europe, were first popular among the elite class (Gately 2001; Smith 1995). The history of colonisation shows that the Europeans made huge profits from drugs such as opium and tobacco, which were largely cultivated for basic economic reasons (Matthee 1995; Trocki 1999). When the nation state became involved in the drug trade, it had as its object taxation. In Java, a former Dutch territory in the Indonesian Archipelago, the state cultivated opium farms as a form of monopoly concession for selling opium (Rush 1990). Over time, opium became an important source of national

income of many countries including Indonesia and Thailand (Jarunpattana 1980; Rush 1990).

Employing a political economy approach contributes to a more critical understanding of drugs and their use. Baer (1982:1) states that: "'Political economy of health' is in essence a critical endeavour which attempts to understand health-related issues within the context of class and the imperialist relations inherent in the capitalist world-system." He divides political economy of health into two sub-areas: the political economy of illness and the political economy of health care (ibid). Later, some researchers applied the political economy approach to other issues outside of the health care setting such as alcohol and illicit drugs (Mares 2005; Singer 2001). Singer (1986), for example, in his paper titled 'Toward a Political-Economy of Alcoholism: the Missing Link in Anthropology of Drinking', addressed subjects such as how political economy plays a predominant role in drug consumption behaviour. Building on their arguments, we see that global forces have in the past shaped drug economies both globally and nationally.

The political economy of illicit drug production explores the impact that the capitalist mode of production has had on supply, demand, and consumption (Baer&Singer&Susser 2003). It also reflects the inequality of class and race in terms of ethnic minorities using drugs (Bourgois 1995; Helmer 1975). An understanding of how drug policies gave rise to a drug epidemic in Thailand will provide a further understanding of how regulatory forces impact upon drug users. State control has had a profound influence on Thailand's drug use patterns in that it has changed the sources and modes of drug supply and demand. In order to examine the role that political economy has played in both the illicit drug trade and use in Thailand, I first consider drug use as part of the ethnic groups' lifestyles. Then, I explore the influence of political economy as background to the changing patterns of substance abuse now detected in urban settings. Thailand's drug policies, supported by international agencies, have facilitated a shift in the meaning of opium and heroin consumption in Thailand. Supported by international drug policies, they have not only exacerbated, but also created new forms of social exclusion of those involved in drugs. I emphasise that ethnic minority groups have not only become scapegoats but victims of political

strategies of control and assimilation. At the same time as forces of exclusion have targeted minorities groups, political economy has also shaped the drug epidemics in the country's urban areas. The incidence of ATS use, along with the prevalence of HIV infection among people injecting drugs, has accordingly risen as well.

Drug Panic

The moral panic surrounding illicit drugs has been noted on various occasions; for example, in February 1909, an 'opium commission' was formed in Shanghai which later led to the International Opium Convention of the Hague in 1912 (UNODC 2008) and saw new drugs like morphine or heroin emerge (UNODC 2009). Some four decades ago, Young (1971) noted that the moral panic over illicit drug consumption had resulted in the setting-up of drug squads by police departments. Jenkins (1999) uses the term 'synthetic panic' to refer to the anxiety that erupted in the United States during the mid-1970s which saw society employ several means in an attempt to control synthesised drugs. Moral panic, as a response, is "likely to clarify the normative contours and 'moral boundaries' of the society in which they occur, demonstrat[ing] that there are limits to how diversity can be tolerated in a society" (Goode&Ben-Yehuda 1994:29). Society feels impelled to find a way or ways of dealing with moral panic before it suffers even graver consequences. Goode and Ben-Yehuda (1994:31) claim that moral panic is "characterized by the feeling, held by a substantial number of members of a given society, that evil poses a threat to society and the moral order as a consequence of their behaviour and therefore 'something should be done' about them and their behaviour." Perpetrators are viewed as the enemy, as enemies of society or 'folk devils' (Cohen 1984). For this reason, they must be controlled and punished. This has led to the creation of social control over threat. When societies in general are confronted by threat, they react by seeking a means of control (Douglas 2002). Both are evident in strategies to control drug production and use.

Illicit drugs are frequently viewed as a threat to the social order; thus, steps need to be taken to protect 'good citizens' from their potential harmful effects. The idea of introducing protection is founded on the belief that innocent people may be victimised

by drug users. Fear surrounding drugs and drug users has been recognised as a major social problem (Reinarman&Levine 1997a, 1997b). In 1900s, moral reformers argued that the smoking of opium should be controlled before it spread to other populations in the Canada (Boyd 2004). In Thailand, recent drug panic is a direct result of media headlines promoting a negative image of drug users as they inevitably emphasise the more notorious features of drug abuse; for example, the devastating effects on communities and families. Friedman and Alicea (2001a:45) state that:

> By marketing the weird, the media keep viewers curiously tuned into messages that reinforce conservative discourses and keep the perspectives of marginalized people outside of dominant collective stories. The media-marketed voice of labelled deviants spins full circle and becomes part of the arsenal or discourses that negatively judge and exclude them.

News and media in Thailand tend to focus upon stories of violence or personal devastation, stressing that drug use is both wrong and harmful. For example, recent newspaper headlines trumpeted similar messages warning of drugs' pervasive presence.

- 'The Crazed Yaba User Robbed His Wife' (*The Nation*, 22 March 2011)
- 'The Arrest of Two Teenaged Pregnant Girls Selling Yaba' (*The Nation*, 22 February 2011)
- 'Collected 4 Akha Sellers in Bangkok' (*Daily News*, 22 February 2011).
- 'Arrested Monk using Yaba' (*Daily News*, 1 March 2011).
- 'Arrest of community leader carrying approximately 2,000 tablets of Yaba' (*The Nation*, 26 February 2011)
- 'Mother Selling Drugs brings her child with her to cell' (*Thairath*, 1 February 2011)
- Arrested Sellers who sell drugs in prison (*Daily News*, 4 February 2011)

These news headlines imply that *yaba* is a worrying part of the Thai people's everyday lives, indeed of Thai society in general. The rise of social anxiety over drug consumption in many places increases pressure on the state to put every effort into controlling drug use and distribution. Thailand's anti-drug campaigns, in particular the 2003 War on Drugs, reflect the moral panic surrounding the widespread use of *yaba*

(Cohen&McGregor 2010). Public opinion views violence as the major adverse result of drug abuse, reflected for example, in the panic which arose in Thailand in the late 1990s based on the widespread popular belief that amphetamine use stimulates violent behaviour by dissolving moral restraint. These perceptions have their basis in a long history of attempts to control the meanings associated with certain drugs.

Punishment: Social Control and Law Enforcement

As previously suggested, perceptions regarding drugs have shifted over time from those of efficacious medication to a damaging social menace. Jenkins (1999), who claims that limited and condemnatory views of drugs severely limit their potential usefulness for human well-being, further argues that drug policies should shift from policing to medical help, from zero tolerance to harm reduction, as the world - and the West in particular - confronts the damage caused by the illicit drug trade. Increasingly illegal drug use is characterised as symbolic of social threat and moral decay (Goode&Ben-Yehuda 1994; Jenkins 1999; Singer 2004). Many factors, especially media and drug law enforcement, are major influences portraying drugs as dangerous products. But, the appeal to users of these powerful psychoactive substances remains immensely strong. Because users are no longer constrained by traditional social practices and contexts of consumption, state control has been introduced in an effort to control their use (Duterte et al. 2003; Taylor 1998).

Prohibitions were enforced based on the view that opium had become a substance threatening the security of the nation. Jenkins (1999:4), commenting on drug prohibition, states: "Symbolic crusades and constructionist scholars seek to determine which particular interest groups or bureaucratic agencies are responsible for labelling substances as uniquely dangerous or damaging." Manderson (1995) argues that initially the anti-opium law did not regard opium as a dangerous drug in itself: the law arose out of the belief that addiction is unhealthy and/or immoral. Public concern over the effects of drugs has greatly impacted on public policy. Drug laws have come to assume the form of a social norm, written in a format that determines the moral and legal limits of what action can be legitimately taken by the state in pursuit of its social objectives

(ibid). In this way, legislation against drug use may become a way of asserting the legitimacy of the existing social hierarchy and the hegemony of the dominant social group by symbolically condemning drug using groups (Boyd 2004; Manderson 1995).

In response to a growing negative perception of drugs, the first international conference on drugs was convened in Shanghai in 1909 to discuss the world's narcotics problem. This forum laid the groundwork for the first international drug control treaty: the International Opium Convention of Hague, 1912 (UNODC 2009). Over time, many countries have enacted drug prohibition laws aiming to prohibit the use of addictive drugs for pleasure and to protect the health of their communities at large (Manderson 1995). In 1914, the United States passed the Harrison Act, a drug control law which aimed to prohibit recreational use of opiates and to allow only doctors to prescribe them for medical use (UNODC 2008). The Harrison Act put an end to the uncontrolled use of drugs for pleasure. Fearing the ability of drug addicts to spread violence across society, politicians employed anti-drug campaigns against drugs to incite political favour among voters. In 1924, the United Kingdom passed laws that put an end to the socially condoned use of drugs, declaring them closely intertwined with criminal activities such as robbery and street crime (Berridge&Edwards 1987). Cannabis was added to the list of internationally controlled substances in 1925. The US Congress passed the Marijuana Tax Act in 1937 as the result of a 'marijuana madness' scare.

Notably, some drug control policies have been strongly opposed because they were conducted in a way that violated basic human rights, on occasion resulting in loss of life and property. In 1971, US president Richard Nixon announced the first of America's drug wars (McCoy 2003). After arguing that drugs caused crime, Nixon, in his first term, asked Congress to fund a federal anti-drug budget of approximately $US750 million (McCoy 2003:391). Later, in 1980s, it was reported that the War on Drugs enacted in the United States resulted in the incarceration of 1,000,000 Americans annually (Mauer 2001). However, Wars on Drugs were not limited to the United States alone: they were widely implemented in neighbouring countries including Latin America and Mexico. Thailand announced its own War on Drugs in 2003. Even though Thailand had earlier conducted anti-drug campaigns, they were not as well publicised as

the program introduced during Thaksin Shinawatra's rule (2001-2006). The Thaksin government announced its War on Drugs on 1 February 2003 in response to an explosion in methamphetamine use in Thailand, the intention being to rid the country of drugs within 3 months. As a result of this government initiative, approximately 2,000 people died without explanation (Cohen 2004). The government's anti-drug campaign drove drug users into hiding, increasing their risk of overdose and HIV infection (ibid). The War on Drugs urged violence and discrimination against anyone suspected of using or trafficking in narcotics, a strategy that was questioned for failing to respect universal human rights (Roberts&Trace&Klein 2004). The Prime Minister's order (29B.E. 2005) stated that: "If a person is charged with a drug offence, that person will be regarded as a dangerous person who is threatening social and national security" (Roberts et al. 2004:4). Other drug control policies focused on the supply side in a bid to eradicate drugs. Plan Columbia, introduced in 2000-2006, was criticised by human rights specialists, who maintained that it generated social and political instability and contributed to the human rights abuse of peoples (Barry 2002). As Latin America was one of the major regions for drug suppliers, the US supported the build-up of its government's fighting capabilities by supplying funds, training and equipment (Sharpe 1988). Gua (1975) suggests that the 19th century introduction of opium as a cash-crop affected and changed the economy and society of the Hmong in Thailand, adding that the subsequent introduction of development programs aimed at removing its cultivation had profoundly interfered with the people's way of life.

In 1856, Thailand was impelled by Western countries to allow opium imports under the name of free trade; as a consequence, opium cultivation became legal in Thailand (Renard 2001). Before the Royal Opium Monopoly was established around the turn of century, 'tax farmers' were appointed to control the sale of opium (ibid). After 1855, opium cultivation became legal in Thailand as a means of collecting taxes and/or fees. In the mid- 20th century, opium production was promoted on the northern Thai border as a strategy to curb communist infiltration and to prevent any form of hill tribe insurgency. Based upon Renard (1997, 2001) I have drawn the timeline of key events in Thailand's drug history:

- 1856: Townsend Harris, Chief American Negotiators, successfully stipulated opium trade in Thailand.
- 1925: The Geneva Agreement bars Thailand and British Burma from overland trade in opium.
- 1956: Field Marshal Sarit, the prime minister, proclaims a ban on all production, sale and use of opiates in Thailand.
- 1976: By the provision of the Narcotics Control Act, the Office of the Narcotics Control Board (ONCB) was established.
- 1970-1990: Opium poppy replacement and alternative development was implemented among the highlanders of northern Thailand.

The handling of illicit drugs in Thailand has been strongly shaped by international organizations as well as policies internal to neighbouring countries, in particular Burma. In the late-nineteenth century, the United States and England developed an international agenda concerning narcotics in Asia which later contributed to the narcotics problem in these regions (Renard 1997). At first, the western countries viewed opium as a source of valuable commodity. Influenced by capital and free trade, Europe impelled many countries to support the opium trade. In 1856, Townsend Harris, the chief American negotiator, achieved the objective that forged Thailand to allow opium imports in the name of free trade (Renard 1997). Responding to British pressure, King Rama IV (1851-1868) introduced a royal opium franchise, which initiated a large scale of opium cultivation in Thailand (Lintner&Black 2009). In the 19th century, western countries viewed opium as a substance that caused physical and mental injury. Since then, opium has been banned throughout the western world. In tandem with other countries, the Thai government also banned opium in 1956. Because illicit drugs had impacted gravely upon the lives of many Americans, the US government has been involved with the politics of countries associated with the drug trade, e.g., regions such as Columbia, Turkey, Pakistan, Thailand, and Afghanistan. The US government employed several tools ranging from diplomatic pressure, political incentives, and military aid to direct intervention in the form of interdiction and eradication operations (Kaufman 2008). In the case of Thailand, the US backed the Thai government's implementation of drug

control programs including the Thai WOD in 2003 (ibid). Many countries including Australia, Germany, and Norway joined the US in controlling the production of opium in northern Thailand (Renard 1997), aided by various organisation such as the UN.

One can see from the above how directly Thai drug policy was influenced by international agencies and Western nations. The Thai government began to see drugs as a pollution threatening national security; for this reason, since the 1970s they have implemented several drug control policies, e.g., laws, drug crop eradication programs and the 2003 War on Drugs. As a result, the definition of drugs in Thailand changed from economic to illegal. Over time, Thai opium state policy has affected those who smoke or grow opium considerably. After the legal ban on opium in 1956, illegal heroin appeared in fairly large quantities almost immediately. In 1970, the Thai government discouraged its ethnic highlanders from growing opium poppy, demanding they replace it with other crops. Since then, although opium poppy cultivation has markedly declined, heroin use among the highland population has become a problem of increasing magnitude (Gebert&Kesmanee 1997). During the 1970s, due to the King Bhumibol's concern about national security and the welfare of the hill tribes peoples, the crop-eradication program, Highland Development Work, was initiated to replace opium with other cash crops (Renard 2001). The government's negative opium policy labelled those consuming opium as 'criminals', a group characterised by deviance, lack of control, violence and moral depravity (ibid). This led to a policy of social control which may well be referred to as social 'apartheid' (Beinart&Dubow 1995).

Apartheid: Social Control of Ethnic Minorities and Drugs

In the first half of twentieth century, the term 'apartheid' was used in South Africa to describe a form of segregation involving white and coloured people. This policy, which effectively widened the gap between colonisers and the colonised, implicitly implied the power embedded in society. Beinart and Dubow (1995:1) define apartheid as "a set of government policies and social practices which sought to regulate the relationship between white and black colonizers and [the] colonized." Apartheid was not only government policy: it also served as a form of segregation used and applied against

immigrant people in South Africa, Indian migrants, for example. It is now becoming popular to use the term 'apartheid' to refer to the inequality that distinguishes ethnicised drug use (Bourgois&Schonberg 2007). Bourgois and Schonberg (2009:42), writing about 'ethnicized habitus', links it with 'intimate apartheid'; that is, with "the involuntary and predictable manner in which sharply delineated segregation and conflict impose themselves at the level of everyday practice driven by habitus." More importantly, apartheid delineates differences in society, reflecting social inequality, racism, segregation and discrimination: it also has connotations of political economy practiced upon those in society with less power. Thus, the creation and maintenance of urban poverty, drug use, violence and crime could be - at least in part - attributed to racial segregation (Bourgois 1995). Forms of social segregation have implications for the lives of all drug users in Thailand, a country considered to be the hub of drug trafficking in Southeast Asia. It is from Bangkok that drugs are trans-shipped to other parts of the world; hence, the flow of drugs into the city is enormous.

In the past, images of pollution were strongly tied to immigration. Helmer (1975) suggests that substance use, which was linked to specific ethnic groups, led to direct cultural contact with the customs of particular groups of immigrants. The 19th century saw cocaine and cannabis stigmatised in the USA where their use was mainly associated with poor labourers drawn from racial minorities. During the late 1880s, black stevedores working in New Orleans began taking cocaine to help them endure their strenuous work conditions in great climatic extremes (Davenport-Hines 2002). In this way, drug use in the United States was linked to the immigrants of the day. By the late 1920s, there were reported crackdowns on Mexican marijuana users (ibid). Likewise, in Australia, alien immigration, mostly from Asia, was perceived as a threat to the social order in part due to association with drug use (Manderson 1997a).

A commodity sold worldwide, opium came to be regarded as a social problem requiring legal sanction. The law against opium smoking in many countries was the result of anti-Chinese agitation (Helmer 1975). California's first opium law, issued in 1875, was important in that it established social control over the Chinese and was part of a general anti-Chinese crusade aimed at ensuring the relegation of the Chinese to the lower rungs

of the labour market (ibid). During this time, opium prohibition was race based, with the law largely a process of social control. It was not the opium itself that the whites discriminated against but the 'smoking' habit of the Chinese (Manderson 1997a, 1999). Application of the criminal justice system against drug consumers, who were invariably members of marginal groups, in many instances increased their marginalisation, diminishing the capacity to offer treatment to those who needed it most.

The social history of drugs in Thailand similarly has its roots in politics and in ethnic distinction within the country. According to the historical record, opium was introduced into Thailand during the Sukhothai period (1238-1583). It was recognised by the Thai government during the reign of King Rama II (1809-1824), concomitant with the arrival of Chinese immigrants. In due course, the King decided to ban the sale and consumption of opium. But the drug had almost become a necessity for the labouring Chinese in Siam (now Thailand), with opium use resorted to most widely by those doing strenuous physical labour (Skinner 1962). And, while it was subsequently allowed under treaty arrangement for immigrant labourers, the Thai people were prohibited from using opium because of its addictive properties and perceived harmful health effects. The Thai government was fearful that the country would run up a foreign trade deficit because of its cost.

The different beliefs and religions observed by Thailand's ethnic peoples have constituted an ongoing barrier to assimilation with the Thais. In constrast, because the Chinese immigrants were Buddhist, they found it relatively easy to assimilate. This led to a perception among the Thai officials that non-Buddhists should be denied participation in the national community, thus increasing the sense of alienation already felt by some minorities (Keyes 1971). The Thai government treated hundreds of thousands of the country's ethnic minorities as residentially segregated people because they did not have Thai citizenship, even though some of them were born in Thailand (Sakboon 2009). Lyttleton et al. (2007) maintain that many ethnic minority groups in Chiang Rai have been denied access to subsidised health services because they lack full Thai citizenship. Under government policy, they are not entitled to access certain services provided by the state, e.g., the health and education systems, unless they have a

Thai ID card. Due to the enforced of eradication of opium, HIV spread explosively amongst ethnic users who began to inject heroin in the 1990s (Gray 1995; Gray 1998; Lyttleton et al. 2007).

Thailand's changing drug policies are well documented. As opium became vital to national income, the Thai government encouraged ethnic minorities in the northern regions to grow opium in areas where local conditions were amenable to cultivation. But, by the 1950s, drugs were deemed the source of various social's problems. When opium was declared illegal in 1956, ethnic growers started to be seen as a threat to the nation. Notwithstanding, between 1965 and 1966, the estimated area under opium cultivation was 18,500 hectares with a yield of 145 tons (Renard 1997). Thai mainstream society came to view ethnic groups as opium producers, dealers and consumers. For example, Siriphon (2001) claims that the various negative representations of the Hmong as narcotics growers, a threat to national security and responsible for deforestation were the result of political construction of 'otherness'. Because of their different cultural, religious and political backgrounds, highland ethnic groups and other immigrant classes - the Chinese, for example - were blamed for introducing an 'evil seed' into the dominant society.

Thais in general have a sense of superiority over 'alien' people, especially the country's 'uncivilized' hill tribes (Winichakul 1997). The former blame the latter, claiming that their distinctive and questionable cultures fuel social disorder, particularly their opium cultivation and consumption. Their everyday lifestyle is publicly considered a 'problem,' 'harmful' to the country's security. In effect, minorities have constituted an ongoing problem for all Thai political leaders and communities. The image of highland ethnic minorities is superimposed above opium cultivation and use, with drugs a barrier to minority assimilation into Thai society. The State views ethnic minorities and drugs as intertwined to the point where they need concerted social control. Thus, in Thailand, drugs are inextricably associated with stereotypes of the 'uncivilized' and 'unruly', i.e., those not worthy of full Thai citizenship or identity (Gebert&Kesmanee 1997).

In reality, opium has been actively encouraged as part of the lives of the ethnic minorities in the hills of northern Thailand. While the trade in opium was established later than the trade in tobacco, tea or coffee, it played a crucial role in the formation of the British Empire and in the creation of a global capitalist economy (Trocki 1999). By the 18th century, Europe's domination of the flow of opium from India to China resulted in a 'drug plague' in the latter country. At the time, Chinese tea was a commodity targeted by the British East Indian Company. Initially, they traded tea for silver; then, when the drain on silver increased, the British merchants forced China to accept opium, an enforcement that in time reduced the country to a state of opium slavery. In 1799, the emperor of China, Kia King, was so alarmed by opium's devastating impact on his people that he decided to ban the substance. The British initiated the 'Opium Wars' (1839-1842 and 1857-1860). The reason the British forced China to accept the opium trade lay in the fact that the European empires depended upon the 'super-profits' that accrued from monopolising the long-distance trade (Trocki 1999). Subsequently in 1906, various actions prohibiting poppy-growing were launched in Guizhou and Shanxi provinces, China's major opium production zones.

Opium's enforced presence in China in turn affected other countries in South East Asia. The economic value of opium was realised when the Thai government foresaw the benefits resulting from the cultivation and sale of opium. The opium tax was initiated during the reign of King Chulalongkorn (Rama V, 1868-1910). Opium revenue was first collected by tax-farmers in 1851; in time, it became one of the important sources of government income (Jarunpattana 1980). Ethnic minorities, being the cultivators, were subjected to this tax. Using opium was legal but only for the Chinese. The King decreed that any Thai who smoked opium must wear a red rope and pay the Chinese triennial poll tax (Skinner 1962).

In China, during the 1880s, opium was grown in the uplands of Yunnan and Sichuan by the 'Miao' (Hmong) and 'Yao' (Mien), minority groups who later moved to Thailand bringing cultivation with them (Renard 2001). Cohen's ethnography of the Karen and opium cultivation in northern Thailand reveals that their Hmong neighbours assisted the Karen to grow this crop and also paid the Karen workers with opium. In addition, opium

was considered medicinal; for example, it was consumed by the Hmong as self-medication to cure common diseases such as colds, or as a pain killer for the severely wounded (Sirasoonthorn 1988). Within local communities, drug dealers, who doubled as shop keepers, traded goods for opium through credit transactions. Cohen (1984) emphasises that economic interdependence between the Karen, the Hmong and the traders was a product of opium cultivation and commerce in the mid-20th century. In the everyday lives of the hill tribes peoples, opium was equal to money, a means of payment which they used to exchange goods (Cohen 1984; Durrenberger 1976). Renard (2001) wrote that rather than produce opium for individual use, the minority peoples produced it for sale (originally to the Thai government), being aware of the negative effects of opium addiction.

The complex and changing relationship of ethnic groups to the cultivation and use of opium shows clearly that drugs are common symbols that governments (and societies) use to stigmatise and stereotype minorities. Cultural stereotyping leads to discrimination. Up until the West banned its trade, opium was embedded in the ethnic minorities' everyday lives. Subsequently, it became a problem requiring regulation. Many of the above mentioned prejudices now inform conventional Thai attitudes towards drug users in general, whether they are minorities groups in the mountains or young men and women struggling with drug use in Bangkok.

The Urban Drug Use Situation

In Bangkok and its suburban areas, the drug trend is somewhat different from that of the mountainous settings of the north. As already suggested, the meanings associated with opium and its uses have changed over the decades. In 1956, in response to international pressure, Thailand banned the use and cultivation of opium: existing smokers were asked to identify themselves publicly through registration. During this period, there were 70,958 registered opium users throughout the country (and no doubt far more in the remote hills areas). Among those registered, 37,395 lived in Bangkok (Poshyachinda 1982a). When opium became harder to access during the 1960s and 1970s, heroin use increased sharply. The figures for 1978 to 1980 listed approximately

20,000 heroin users and 2,000 opium users (Poshyachinda 1981). The reason for its widespread use was that heroin, a welcome substitute for opium, was easier to conceal than opium. Jui (a 58 year old male drug user) reflected upon the emergence of heroin 40 years ago: "At first nobody knew about heroin. When I bought opium, the drug dealer usually gave a free pack of heroin. I tried it and I liked it. It is much easier compared to opium. Then, the teenagers saw heroin as a cool drug so they started smoking it." Unlike the majority of opium smokers, most urban heroin users were (and still are) ethnic Thais rather than Chinese (Poshyachinda 1981).

Thus, heroin use has been widespread in Thailand for more than 50 years, not only among the lowland peoples but also among the ethnic minorities living in northern Thailand. The mass production of heroin in the Golden Triangle, a side effect of the Vietnam War during the 1970s, impacted heavily upon the North American market (McCoy 2003). And, not confined to the US, heroin started flooding into other western countries, with the port of Bangkok the main conduit for shipping heroin to other countries. This flow had a pronounced effect on the local populations. Those in Bangkok who had initially smoked heroin now started injecting. Peak (2000) claims that American soldiers (GIs), who were posted to Thailand during the Viet Nam war (1955-1975), introduced Thais to the injecting practice. (McCoy&Read&Adams 1972). This practice, in turn, spread from the lowlands to the highlands where opium was more commonly smoked. It was through acculturation that the ethnic minority peoples opted to emulate the injection and heroin behavioural practices of pockets of drug using lowland Thais (Wiewel et al. 2005).

During the 1990s, there was a profound shift in illicit drug consumption in Thailand from heroin to *yaba* (ATS – an amphetamine type substance) use. By far, ATS is the most widely used illicit drug in Thailand, with an estimated 788,948 consumers in 2007 (Assanangkornchai et al. 2008:28s). Peak (2000:14) notes that while the rate of heroin use declined steadily from 76.2% of drug users in 1993 to 21.2% in 1999, the number of people using *yaba* increased substantially from 1.2% in 1993 to 58.4% of the overall number of drug users in 1999. At the same time, the numbers of those injecting decreased. ONCB reports show that in 1993, 24,654 people were injecting drugs; in

1999, the number stood at 12,123 (ibid). According to Lintner and Black (2009), the persons at risk of *yaba* taking include adolescents, labourers, workmen, fishermen, students and sex workers, a far broader demographic than those typically associated with heroin. Table 1 below shows that *yaba* has become the dominant drug in Thailand in the new millennium.

Table 1: Estimated Number of Drug Users in Thailand

2002 Estimates	Users	Addict(s)	Total
Yaba	2,024,487	543,934	2,568,421
Heroin	20,397	58,038	78,435
Marijuana	96,835	77,316	174,151
Others	124,410	84,350	208,760
Total	2,266,129	763,638	3,029,767

Source: Ministry of Public Health (2002)

Trends of drug use can be connected with broader social changes, in particular the massive spread of *yaba* usage (Lyttleton&Cohen 2003). It has been argued that modernisation has impacted upon the youthful cohort domiciled in the city's urban areas, leading to increased *yaba* uptake (Cohen 2006). Table 2 below, which shows the shift from heroin to *yaba* use, is reflected in the official statistics for drug users in treatment programs.

Table 2: People's Enrolment in Drug Treatment Programs

Duration	ATS	Heroin
1 Oct 2002 - 30 Sept 2003	213,953	6,953
1 Oct 2003 - 30 Sept 2004	26,044	3,208
1 Oct 2004 - 30 Sept 2005	35,619	2,141
1 Oct 2005 - 30 Sept 2006	42,623	1,916
1 Oct 2006 - 30 Sept 2007	48,426	1,517
1 Oct 2007 - 30 Sept 2008	80,588	1,374
1 Oct 2008 - 30 Sept 2009	101,848	1,565
1 Oct 2009 - 31 Dec 2010	123,215	2,021
Total	676,463	20,788

Source: Office of Narcotic Control Board

Table 2 clearly shows that the number of *yaba* users is significantly higher than the number of heroin users. The widespread use of *yaba* is believed by both policy makers and the larger social order to be less dangerous than heroin use as it is perceived to be less addictive. Different types of drugs tend to suit different categories of users. Chouvy and Meissonnier (2004) suggest that *yaba* is associated far more strongly with a form of youth culture. Sattah et al. (2002) deduced from their survey of vocational students in northern Thailand (Chiang Rai province) that ATS consumption correlated with other behavioural and psychosocial factors such as sexual activity, peer pressure, a positive attitude towards methamphetamines and absence of family confidence. Recently, crystalline methamphetamine (ice) has become more widely consumed in urban settings. Aramrattana (2004) notes that youth from high socio-economic backgrounds use ice mainly for entertainment purposes.

Places of drug consumption are characterized by distinction in how they are consumed in public and private spaces. The injecting of illicit drugs, by drug users in Thailand usually takes place in private spaces like apartment or bathrooms in their homes or friends homes. This behavioural practice is chosen because injecting drug users are afraid of disclosing their status to others. The injecting of drugs takes time: drug users tend to inject into specific areas of their bodies, e.g., their necks or legs, and this has become a highly private and stigmatised practice. Conversely, amphetamine users ingest drugs orally in public spaces, e.g., pubs or bars as they are used for increasing energy. The most intensive ATS consumption occurs in public spaces among workers, truck drivers, sex workers and fishermen in an attempt to increase their work output (Chouvy and Meissonnier, 2004). Yaba, often in the form of cultural sharing at the level of peer group, is widely taken among Thai youth population at nightclub set (Cohen, 2006).

From any perspective, Bangkok is a city awash with various illicit drugs. Out of an estimated total population of 4,374, 757, one survey showed that 466,622 had used drugs some time in their lives (Assanangkornchai et al. 2008). In 1991, it was estimated that there were 36,000 people injecting drugs in Bangkok (Mastro et al. 1994). A later survey taken in 2003-2004 showed that the estimated number of injecting drug users in

Bangkok had dropped to 3,595 (Wattana et al. 2007). This large decline in the number of people injecting drugs may have resulted from the implementation of Thaksin's War on Drugs program in February 2003, a radical policy that attempted to reduce the supply and demand of illicit drugs in Thailand. A direct effect of the WODs was a decrease in the supply and consumption of heroin; conversely, it increased the number of people using alcohol and volatile substances (Poshyachinda et al. 2005). As a result of the WODs, people injecting drugs switched from heroin use to other substances such as benzodiazepines (Poshyachinda et al. 2005).

Thus, as drug use patterns evolve in Bangkok, both licit and illicit drug consumption has been observed amongst injecting drug users; that is, there are some who, in addition to or instead of using heroin, also use Midazolam. In addition, the WOD policy drove drug users underground, increasing their HIV risk behaviour (Vongchak et al. 2005). But, the numbers are constantly changing and it is hard to derive an accurate estimate of the remaining number of drug users in Thailand overall or in Bangkok. In 2008, the National Household Survey estimated that out of 114,000 heroin users in Thailand, 15,000 lived in Bangkok. Based on an ONCB survey undertaken in 2008, the average age of people using drugs is between 12 and 65 years of age. Table 3 below shows a recent estimate of substance use in Thailand.

Table 3: The Estimated Population Reporting Having Ever Used Drugs (ONCB Survey, 2008)[5]

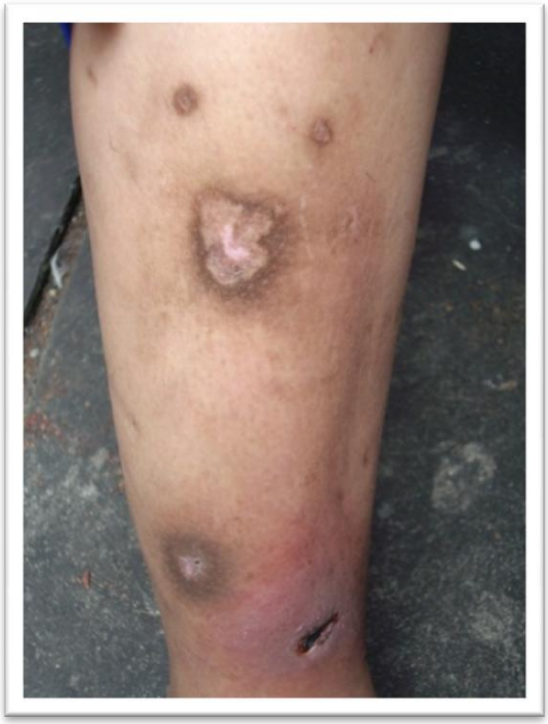
Type	Central	Bangkok	North	Northeast	South	Total
Heroin	21,000	15,000	18,000	59,000	n/a	113,000
Ecstasy	1,000	19,000	1,000	74,000	n/a	95,000
Methamphetamine	162,000	99,000	162,000	382,000	8,000	813,000
Ice	7,000	10,000	n/a	56,000	5,000	78,000
Cocaine	n/a	5,000-	n/a	37,500	5,000-	48,500
Kratom	154,361	119,600	31,000	204,361	571,196	1,080,518
Opium	34,700	14,000	45,750	89,300	n/a	183,750
Inhalants	43,000	111,000	25,000	67,000	n/a	246,000

[5]Source: http://nctc.oncb.go.th/new/index.php?option=com_content&view=category&id=163:2009-11-03-09-25-23&Itemid=101&layout=default

In 2008, the number of estimated population having ever used heroin in the northeastern region was the highest at 59,000 people (the northeastern region having the biggest population). This was followed by the central and northern regions and Bangkok. In addition to widespread *yaba* consumption in combination with heroin, people injecting drugs in Bangkok also use other psychoactive pharmaceutical drugs. This trend has been identified by researchers who claim that injecting drug users in Bangkok have in recent years changed their pattern of drug consumption from heroin to increasingly include Midazolam and/or methamphetamines (Kerr et al. 2010b; Kiatying-Angsulee N et al. 2004; Van Griensven et al. 2005). Of particular significance to my research is the fact that the official number of female injecting drug users living in Bangkok is still unknown. Based on Des Jarlais et al.'s figures (1994), among the 173 Bangkok injecting drug users who participated in their trial, 163 were male and 10 were female. This implies that in this particular city's drug community, males outnumbered women by more than 10 to one. Wattana et al. (2007) show that of the 963 injecting drug users recruited, 135 were female (14 per cent). This figure coincides with recent BMA methadone statistics which found that female injecting drug users who accessed the methadone program totalled approximately 10 per cent (see table 4).

Based on the statistical data available, it is clear that *yaba* dominates the illegal drug market in Thailand, and that the majority of users smoke rather than inject. A smaller group of Thai drug users inject to get high. While heroin is the preferred choice for those injecting, it is sometimes hard to find and expensive; thus, they turn to other substances such as Midazolam, methadone and other Benzodiazepines (Barrett et al. 2010). The most frequently used two drug combinations are heroin or methadone with Midazolam. Like Barrett, I too found that most injecting drugs users use other substances when the price of heroin escalates. Some choose to stay on methadone as it guarantees they will not suffer drug craving symptoms.

Plate 2. Wounds caused by Midazolam injection



In order to address increasing drug use, in 1976, the Bangkok Metropolitan Administration (BMA) opened a methadone clinic in the form of a clinical trial, promoting a 45 day treatment regime as the main modality of its drug treatment program. Currently, there are 20 methadone clinics in Bangkok. The Table below demonstrates the number of people injecting drugs enrolled in the methadone program in Bangkok. Again we see that approximately 10 per cent of those attending the methadone clinics are women.

Table 4: Number of Patients in the BMA Methadone Clinic

	2007	**2008**	**2009**	**2010**	**2011**
New Patients	417	388	291	312	231
-Sex					
1) Male	387	360	265	285	203
2) Female	30	28	26	27	28
Type of Addictive Substances					

	2007	2008	2009	2010	2011
1) Heroin	360	338	276	275	183
2) Opium	0	2	0	1	1
3) Morphine	0	0	0	0	1
4) Methadone	50	41	14	28	40
5) Others	7	7	1	8	6
Medical					
1) Medical treatment	376	371	272	289	224
2) Herbal Treatment	1	0	0	0	0
3) Both treatments	4	2	1	1	0
4) Never	36	15	18	22	7
Patients from last year	485	503	461	428	401

Source: Bangkok Metropolitan Administration

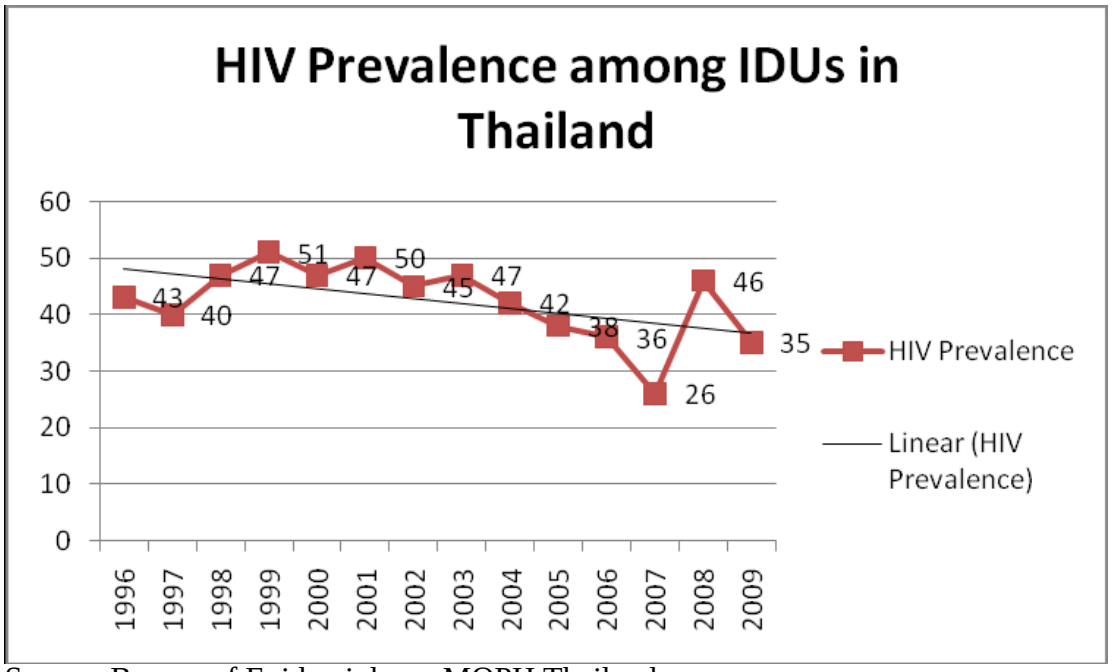
AIDS Related Risk among Injecting Drug Users in Bangkok

One issue affecting drug users of both genders is the risk of HIV transmission: people injecting drugs tend to share their injecting equipment among their peers (Des Jarlais et al. 1999; Rhodes et al. 2005). As a result, there is high rate of HIV infection among people injecting drugs in Bangkok. The AIDS epidemic in Thailand commenced when the first AIDS case was identified in 1984. Since then, many sectors - including public and private - have collaborated to reduce HIV/AIDS transmission. To this end, Thailand is now regarded as somewhat of a success story in the fight against AIDS. Major focus has been upon transmission through unsafe sex; with this uppermost in mind, in the early 1990s the government launched a prevention campaign called '100% condom' among sex workers (Lyttleton 2000). But, in contrast to the prevention policy targeting sex workers, people injecting drugs were largely ignored by the government, who paid little attention to harm reduction and needle and syringe exchange programs (Gray 1995; Gray 1998). The HIV epidemic has strongly affected drug users' lives in the city as large numbers of injecting drug users in Bangkok have been diagnosed as having

AIDS (Wattana et al. 2007). The majority became infected through sharing contaminated injecting equipment.

HIV prevalence among people injecting drugs in Bangkok has remained high for many years. In 1987, people injecting drugs were first diagnosed with HIV infection at the Bangkok Metropolitan clinic. Somewhat alarmingly, HIV sero prevalence increased rapidly from 1% in 1987 to over 43% in September 1988 (Brown et al. 1994).

Figure 1. HIV Prevalence among People Injecting Drugs in Thailand.



Source: Bureau of Epidemiology, MOPH Thailand

This graph represents the degree of HIV prevalence among people injecting drugs in Thailand. The recent prevalence rate (2009) of HIV is 35 %, a figure still worryingly high although lower than the 43 % recorded in 1996. One contributing factor to the high prevalence is that of sharing injecting equipment in prisons. Even though the Thai government denies the fact that illicit drugs are available in the country's prisons, many researchers state that their informants assure them that prisoners can buy drugs during their incarcerations. Thus, incarceration is a key factor exacerbating HIV transmission in Thailand (Beyrer et al. 2003; Choopanya et al. 2002).

Summary

The impact of successive national and international drug control policies has been widespread affecting all levels of Thai society. Viewed from a cultural perspective, drug cultivation is linked with the ethnic minority groups who grow opium in northern Thailand. It could be suggested that opium has emphasised the cultural differences between Thailand's ethnic minorities and the indigenous Thais given that opium cultivation strongly exemplifies the negative image of minority groups. In Thailand, the relationships between minority ethnic groups and lowland Thai often result in social conflict in which drug issues are invariably embedded Public opinion has tended associate drugs with 'uncivilised' ethnic groups, seeing some of the latter as criminals. An historical perspective reveals important insights into the political economy that revolves around drug use in Thailand. Drug consumption is not solely an individual problem: it is considered a national or international problem to be controlled by policy at state level. By examining its history, one can understand the roots of social oppression and popular stereotypes of drug users, and why and how society currently judges people who use illicit drugs to excess. Nonetheless, injecting drug users in Thai society overwhelmingly experience painful discrimination at a deeply personal level, which is the key focus of this thesis. Many have to endure the 'double stigma' of being drug users and being HIV infected. Through public health discourse, they are identified as the 'hub of HIV transmission' or what is called the 'most-at-risk- group'. In the next chapter, I will explore the social background to structural violence and its effect on people injecting drugs including HIV infection.

Chapter 3

Violence and Suffering: The Everyday Lives of Thai Drug Users

In Chapter 2, I highlighted political economy as one of the everpresent forces that shape the lives of Thai drug users. Based on Thailand's evolving approach to controlling drugs, the violence perpetrated upon people involved in drug use is rooted in state policies and programs that tend to exemplify their alienation and marginalise their sense of identity. The country's ethnic minorities are frequently accused of bringing pollution and harm to Thai society. Likewise, political economy forces underpin what can be thought of as structural violence which, over time, has caused social suffering for many urban drug users in Thailand. As Goffman (1963:2) notes in his study of stigma, individuals are not free to frame their experiences as they wish because they are effectively constrained by social structures and organisations. The meanings of both material objects and behavioural patterns are ascribed through the process of social interaction, which in turn is shaped by social forces. This parallels what Bourdieu (1977) terms ‘habitus’ or structuring structures that provide both a context for understanding experience as well as shaping the way experiences take place. Hence, in order to understand the lives of Thai injecting drug users, there is a need to understand the social structures which impact upon and shape them, structures which emerge from a wide range of socio-political contexts such as legal and justice systems, social norms, racism, political economy, stigma, discrimination and social suffering. In this chapter, I will argue that drug users, in particular, those who inject, are victims of structural violence. Their illegal status, ethnicity, and poverty make them particularly vulnerable to HIV/AIDS infection. In Chapter 2, I suggested that political economy analysis shows that ethnic minorities in northern Thailand are victims of historical processes that result in distinct marginalisation and associated health problems. While the specific characterisations based on ethnicity differ, the political economy of drug control also impacts upon drug use patterns in inner city Bangkok.

External forces like norms and laws, as both symbolic representations and concrete means of social control, are factors in the social construction of injecting drug users. This occurs through the socialisation of drug users and members of a broader Thai

social order. To protect against perceived (and sometimes real) threats to people's lives and assets, the law and justice system - as well as other institutions - work to jointly control or eliminate the causes. In turn, the legal system leads to norm-changing attitudes towards the individual or groups of people who perform the types of actions that supposedly threaten society. As a result, attitudes are transformed into discriminatory action against already stigmatised people. In order to understand this process, one needs to appreciate that stigma, from an holistic point of view, is the product of broader social, cultural, political and economic forces (Parker&Aggleton 2007). This implies that when examining the lives of drug users, there is a need to explore the broader contexts related to drugs.

Discriminatory social factors or what is also termed structural violence, play a vital role in establishing conditions that marginalise individuals involved in drug use, and in which the profound effects of stigmatisation create an environment of pervasive fear and distrust. This fear is generated by as certain individuals are believed to have the potential to harm society and, by extension, the social order. Drug user-related stigma is a complex, socio-cultural phenomenon which may take a range of forms in different settings (Paivinen&Bade 2008; Simmonds&Coomber 2009). Crucially, these forms are based on the belief that drug users are a threat to society. Following this line of thought, users 'should' be blamed for their individual behavioural patterns. The violence perpetrated upon Thai drug users takes various forms which require interpretation in terms of each particular context. More recently, the risk of HIV infection has caused further suffering in individuals' lives: the AIDS pandemic has radically transformed the cultural politics of drug use by identifying users as a 'risk group'; that is, not just as individuals who are at risk to themselves and society at large, and as deviants who commit criminal offences, but also as vectors of disease. This type of stigma has become the lot of sex workers, men who have sex with men (MSM) and drug users. (Malcolm et al. 1998). These days, it is hard to disentangle these dual elements (deviant behaviour and HIV) that are impacting on users' social identities. When HIV is associated epidemiologically with injecting drug users, it is portrayed as wholly negative and as a conquering force triggered by a dangerous and polluting disease. For

these reasons, injecting drug users living with HIV face doubly stigmatised receptions (Capitanio&Herek 1999). In this chapter, I will thereby argue that Thai heroin users face more pronounced discriminatory action than the country's other marginalised groups. Social factors such as racism, ethnicity and political economy create boundaries between drug users and others. Urban heroin users, as opposed to those in the national periphery, are less subject to ethnicised or racist stigma. However, this is not to say they are any the less marginalised, as they confront severe discriminatory action within their own communities and families.

Structural Violence

Drug use is socially constructed in the sense that drug using experiences are shaped by social values, relations and perceptions. Structural violence, a term commonly used by medical anthropologists, refers to forms of orchestrated social oppression that place a group of people or individuals in harm (Farmer 1999). Structural violence determines how various large-scale forces such as "the violence of poverty, hunger, social exclusion, and humiliation inevitably translate into intimate and domestic violence" (Scheper-Hughes&Bourgois 2004:1). Political economy, along with other social forces, can inflict extreme and premature suffering on the everyday lives of its victims. Farmer (2010) explores the structural conditions, in particular political economy, that have exacerbated the risk associated with HIV/AIDS, tuberculosis and other infectious and parasitic diseases in Haiti. Like Farmer, I emphasise that social forces and the environment have also structured risk into various forms of suffering for Thai drug users. Political and social transformation that fails to engage the moral reality of social discrimination must be contested (Das et al. 2001:24). As Jack, a male drug user maintained "I am not afraid of being imprisoned. What I am afraid of most is the reaction of others who look down on me because of my drug behaviour."

The memorialisation of violence alerts us to the high degree of suffering experienced by victims of various historical episodes of social and political violence. Memories of devastating experiences ranging from mass murder to mass imprisonment, enforced organ donations and many other forms of oppression cause residual long term suffering

in victims (Kleinman&Das&Lock 1997). Similarly, violence associated with drug control has profound implications. Sak, commenting on the Thai War on Drugs, said: "Many of my friends were killed during [the] war on drugs. Nobody cared how many…died because we are worthless to exist or to be remembered either by society or family." Kleinman et al.'s argument concerning memorialisation suggests that reconciliation with - and moving beyond - the trauma or violence of the past requires public acknowledgement. Every year in Thailand there is a memorial service for the Tsunami victims who died in 2004. In contrast, there are no processes of memorialising drug users who died during the War on Drugs. This is because drug users are not viewed as victims; rather, they are perceived as the root of social violence, as those who in many peoples' minds deserve severe punishment. In recent times (2011), a repeat version of the War on Drugs has been initiated by the current Thai government, signalling approval of - rather than regret for - the trauma caused by earlier hard-line policies. Moral lines or boundaries are important factors in deciding whether to include or exclude people from society given that they reflect the symbolic power exerted by the dominant over the subordinate and the resultant social inequality (Bourdieu 1989). Bourgois (2002:223) notes that symbolic violence and everyday violence mediate subjective experience and are major causes of suffering through the internalisation of social norms.

Structural violence, in its various forms, can represent how society and communities cope with what they see as social danger. Drug control policies are one example that reflects states' efforts to protect their peoples from drug use. At the interpersonal level, collective violence strongly affects the individual sense of self. And, it is because of both structural and personal violence that many Thai heroin users are consistently excluded from participation in the broader community. During one of our conversations, Jack told me: "I rarely go out with my parents or join any community ceremony. If I go, I will make them lose face."

Thai War on Drugs

Governments worldwide confronting drug use and its associated problems have reinforced law and order policies in their attempts to prevent the majority from being 'harmed' by people using drugs. Governments in general do not hold the view that drug users are victims of social suffering: there is a tendency to consider them to be the root of social disorder. Communities and families in general interpret the violence caused by drug users in terms of lying and stealing; thus, expelling users seems to be the logical means of protecting themselves. In Thailand, the national 'white community' program (or *muban si khao* หมู่บ้านสีขาว) aims to create a healthy community, one that lacks both crime and drug use. The notion of a moral community was implicit in the Thai government's recent campaign against the country's drug users. Use of the term *muban si khao* (White Village) conveyed a message depicting a clean, drug-free community. The 'White Village' message was part of a social endeavour to control those who either failed to observe or opted to break generally accepted rules and norms. This campaign in effect excluded drug users from their own communities. Pui, a 27 year old female user observed that:

> During the war on drugs, the community leader sent a letter to the tenants of the apartments in that area saying that he would take the room back if he found out that one of the family members was a drug addict. My mom had to remove my name from the household registration.

The 2003 War on Drugs was rooted in a social dynamic similar to war on the battlefield inasmuch as violent weapons in the form of guns were used against the drug users. The Thai government, led by (then) Prime Minister Thaksin, accepted the deaths of drug sellers or users without compunction. As a result, more than 2,000 Thais suspected of being drug sellers were extra-judicially killed within a period of three months (Roberts et al. 2004). These extra-judicial killings were criticised widely by many international NGOs; for example, Human Rights Watch and the Berkeley Foundation pressured the Thai government to clarify the facts surrounding this policy (Cohen 2004; Roberts et al. 2004). Some suspected that the killings were connected with users or with private business opponents. In the final analysis, it seems that Thai society opted not to question this particular government policy as much as the international NGOs did, for in their opinion, drug users represent an internal threat and deserve severe punishment.

Thais are much less questioning of State mandated policies and activities and are much more likely to comply with them. Thus, they came to view political killings as part of their everyday lives. As Anderson (1990:22) notes about politically-motivated murder in Thailand: "The state was still so frail and personalized in the sovereign himself that there was no sharp dividing line between execution and murder, between 'state' killing and 'private' killing."

In their work titled *Gun, Girls, Gambling, Ganja: Thailand's Illegal Economy and Public Policy*, Phongpaichit et al. (1998:261) describe Thailand's illegal economy, linking it to *itthipon meut* (dark influences) and a *jao pao* (godfather). This illegal economy was not limited to the underground only: it was also linked to all sectors of Thai society; e.g., policemen and politicians. Anderson (1990) argues that at the macro level, the State has for a long time sanctioned political violence against those they see as a threat. The violence of political dominance and State power has profoundly marked the illegal status of the drug users. The architects of Thailand's War on Drugs policy may have drawn their inspiration from the country's history of political killing. In a broader sense, the drug users' situation worsened dramatically after the government announced its War on Drugs policy in 2003, limiting drug users' access to Thailand's health and social services (Kaplan&Schleifer 2007).

On July 2008, I went to the police station to interview the police regarding their impressions of drug users. The officers told me that during the War on Drugs, all of the policemen at the station were assigned to catch any drug dealers or users operating in their particular area. One policeman observed: "We don't have to do anything, just catch the drug dealers in accordance with the State's order." The Ministry of Internal Affairs implemented the 'white community' campaign, emphasising that there should be no drugs in any village, the implication being that every community should be cleansed of drugs and violence. How this was to be done was loosely stipulated: community officials could devise their own ways of ridding their communities of drug users. In Banpang community (a community located in a suburb of Bangkok), for example, the nurse told me how the community dealt with drug users:

> The community leader asked all villagers to go to the meeting place. He did a count like an election where the villagers wrote down the name of suspected drug users in the community. Then, the villagers put the names into the box so no one knew the name of the drug users, except the community leaders and governmental officers. The leaders would ask the drug users to come to the clinic to get help to stop using drugs.

In reality, this was not voluntary as most were forced into drug rehabilitation programs run by the State.

Violence in Everyday Lives

Violence is not restricted to state forces. Living environments, which contribute to commonplace stigma that demarcates drug users from good Thai citizens, both produce and are products of drug using behaviour. A number of my informants relapsed after returning to live amongst other users. Their parents tried to keep them at home, away from the drug environment: but, they became uncomfortable living at home; they were unaccustomed to life in a drug free environment. They had lost earlier friends due to their drug use. They could not go back to study nor find a job. When they did find jobs, they were often short-lived. Some felt that they didn't have to work as they were living with their parents. Those who tried to work found they couldn't comply with the work schedule: it made them feel uneasy. Rat (a male user) said: "It was difficult for us to work like others. If I was on a high, I didn't want to go to work. Finally, I was fired because I was often absent." Many of my informants related their attempts to work, but no one would hire them because of their drug habit. Hence, many opt to be outreach workers for drug related NGOs as the work hours and conditions fit their lifestyles.

Social environments and relationships not only place users in a high risk environment, but also contribute to ongoing use. As drug users, they live and survive in their own

world, in what we might term a 'drug community'.[6]The drug lifestyle is commonly described as a circle involving key places and people: peer - initiators using drugs - drug - treatment centre - police station - prison - relapse. Even though drugs are available in prison, not all users can afford them due to the high price. Often, heroin users, when imprisoned, find they have to stop using drugs due to difficulty of access. Users then suffer what they call *hakdip* (หักดิบ), the cravings and reactions associated with 'going cold turkey'. Almost a week will pass before the symptoms subside. Some of my informants gained up to 10 kilos in six months while in prison. After being released from prison, many return to their previous social drug environment; some find their families have moved, fearful that their drug-using children may opt to return home. Rak, a staff member at the drop-in centre told me about Toi, a male drug user:

> I found Toi in Sanamluang. He was just released from prison and had nowhere to go so he lived like the homeless. People are afraid of him as he has tattoos all over his body. I asked him to come to the centre. He needed medication, and I guessed he might have HIV. He seemed unhealthy. But he didn't have an ID card, so how could he access the medical system? I have tried to contact his parents to get some personal information. They have all moved. They are afraid that their son will return home and steal things so they decided to run away from him. One day, I sat in front of Toi. He talked to his mother on the phone saying he wanted to return home. "Where are you? I am a good boy now. I haves stopped using drugs. I will not behave like I did. Please tell me where you are, mom. I miss you."

In the public perception, prison serves many purposes including helping people to return to their families or rebuild their sense of normalcy. It functions like a treatment or rehabilitation program. Toi's story demonstrates specific aspects of the type of social suffering drug users face when this does not eventuate. Not only Toi, but other drug

[6] I use this term loosely not to imply a shared geographical base (although many do congregate in specific venues) but rather as a sense of belonging to a specific subset of individuals, who collectively share one identifying characteristic - injecting drugs.

users have had to endure a living environment that has forced them to continue using drugs. Joke (a male user) and Aor (a female user) told me about their individual experiences:

> I stopped using drugs for a while, but then my neighbour, who was a drug seller, was released from prison. It was a temptation because I passed by his house every day. How could I refuse it? I recommenced using drugs; first, I tried *yaba* because it was not addictive but I ended up injecting heroin (Joke).

> I was out of the prison and stayed home, but staying home was too boring. I have to confront my parents, who keep an eye on me to see whether I re-use drugs or not. I went to see old friends who use drugs. They usually hang out at the coffee street-vendor next to the methadone clinic. Even though I did not take drugs at that time, I loved to go out with them rather than stay at home. When the drug users were hanging out together, the thing they chatted about was drugs. Finally, I re-used drugs again (Aor).

Social responses to drugs and users in the forms of drug policies or imprisonment have in some cases exacerbated their drug usage. At the same time, drug users end up employing various tactics to lessen exposure to these impacts. Contrary to social expectations, imprisonment is largely unsuccessful when it comes to 'normalising' drug users. Being imprisoned is a way of connecting with drug networks that offer easy access to drugs. In prison, users befriend drug sellers; when they are released, many become retail drug sellers. In 2007, I accompanied Nok to visit Rat, her boyfriend, who was in prison. Rat gave her a note with a list of names and things that she should do. I looked at the paper, which was covered with many telephone numbers and names. Nok told me that she was helping Rat's friends in prison to contact their families outside as middlemen between the inside and outside world. She explained: "No one visits them so they ask me to call their relatives to tell them that they are about to be released, or asking for money or a visit." Nok helps her boyfriend's friends to maintain links with drug networks outside or to build on the connection after some of them are released. After Rat was released, Nok often mentioned the names of new people who gave her free drugs. Later, both Nok and Rat, who had both been using drugs, became drug sellers at the drop-in centre where they worked as outreach workers.

These examples show that for Thai people injecting drugs, macro and micro contexts shape drug users' interactions, feelings and reactions as they try to create positive images when interacting with others. Scheper-Hughes and Bourgois (2004:1) emphasise that social and cultural dimensions give violence power and meaning. Social environments, such as WODs and incarceration, contribute to HIV infection among drug users, a condition that significantly impacts on the physical and emotional health of the users as inability to access sterile equipment, leads to sharing contaminated injecting equipment.

Risk of HIV/AIDS infection

AIDS is the leading cause of death among drug users in many countries. Paul Farmer (1999, 2010) examines the HIV/AIDS epidemic in Haiti and shows how the country's political economy has rendered numerous people unhealthy and by extension vulnerable to HIV/AIDS. Structural violence emerges from the unequal distribution of resources. The spread of AIDS has magnified this problem for many marginal groups. In terms of understanding AIDS from a broader health perspective, Singer (1996:99) proposes the term 'syndemic', i.e.,"a set of closely intertwined and mutual enhancing health problems that significantly affect the overall health status of a population within the context of a perpetuating configuration of a noxious social condition."

The social production of HIV risk associated with drug users is a product of an interplay in which social and structural factors become intermingled with political economic factors (Rhodes et al. 2005). Drug users come to be viewed as the initiators of violence and of their own suffering, with most people picturing a drug user's life as one of sex-drug exchanges, crime and/or violence. In fact, from another perspective, they are victims of a social milieu manifesting political violence in the forms of Wars on Drugs and associated drug policies.

As well as structural forces, language and its usage reflect and empower social perceptions of - and attitudes toward - individual behaviour patterns. The AIDS epidemic has not only changed the public health paradigm, but has also shaped how

people see others through an epidemiological lens. Identifying them as 'risk groups' (to use public health terminology) affects how people perceive the linkage of individual behaviour and disease. Treichler (2004:11) proposes the term 'epidemic of significance' which sees language, culture, authority and evidence-and undoubtedly other factors-interacting in the production of meaning. She stresses that language invents reality, so much so that reality becomes what we as 'the public' are told. The label of 'risk group' typically stereotypes those who contract AIDS with fearful images descriptive of a particular group rather than of an individual. Lupton (1999:123-124) claims that:

> The cultural/symbolic approach, [with] its focus on risk and Otherness, goes some way to emphasize that anxieties and fears about risk tend to be projected onto certain social groups: those who are defined as the marginalized and stigmatized 'risky' Other.

Influenced by epidemiology, surveillance identifies the behaviour of particular 'kinds' of people such as men who have sex with men (MSM) and injecting drug users (IDUs). Inevitably, these groups embody these identities and come to feel that they constitute the hub of HIV/AIDS transmission. Pim (a female user) said: "I know HIV is not infected through day-to-day activities. But I am still afraid that my son will be infected. I try not to share any food with him."

'Risk' holds different meanings for different peoples. Public health professionals see the risk of HIV infection as associated with the injecting of drugs: they focus on how to reduce the number of new infections though various interventions such as needle syringe exchanges or outreach programs. But, in doing so, they neglect the social and cultural contexts in which risk is constructed. For the social scientist, internalised 'risk' adds to subjective experience and understanding of lay people concerning their own practices (Lupton 1999). Notably, the notion of risk is used to form boundaries between healthy and unhealthy/ objective and subjective, boundaries that create further sets of problems for the alleviation of health threats (Courtwright 2001; Lyttleton 2000).

HIV infection is not only exacerbated by social structures: it is also attributable to other facets of the drug user subculture, especially needle sharing. Because harm reduction is not strongly supported by the Thai government, there is a high rate of syringe borrowing

which may lead to HIV infection through the sharing of needles and contaminated injecting equipment among the drug users' peer groups and partners (Fairbairn et al. 2009; Perngmark&Celentano&Kawichai 2003; Saelim et al. 1998). In previously undertaken studies, injecting drug users report that the reason they share needles is not because they have no knowledge of the spread of HIV infection through dirty equipment but that their own equipment was not close by (Fairbairn et al. 2009; Haritavorn 2008). The drug users I interviewed claimed that they mostly inject heroin with friends or partners as they pool money to buy drugs. Rhodes et al. (2005) argue that HIV risk among injecting drug users is the result of interplay in which social and structural factors intermingle that is to say, as political economic factors shape the risk environment. They identify these factors that underpin the risk of HIV among drug users as follows: trade and population movements; neighbourhood disadvantages and transition; shooting galleries and public injecting environments; prisons and the criminal justice system; social norms and networks; social capital; social suffering and socio-political economy; law enforcement and policing; and, armed and complex emergencies (Rhodes et al. 2005:1026). These risk environments could be considered as collectively generated by forms of structural violence, which contribute to an individual's suffering, an outcome that, as I have suggested, takes many and varied forms.

According to many researchers, incarceration is an important factor of high HIV prevalence among injecting drug users (Clarke et al. 2001; Dolan&Wodak&Penny 1995). The same is true in Thailand (Beyrer et al. 2003; Buavirat et al. 2003; Thaisri et al. 2003). The number of drug users being incarcerated is increasing each year in Thailand as the result of the government's political directives and drug control policy.

Table 5: Number of Indictments

Year	Male	Female	Total
2003	98,855	37,157	136,012
2004	75,197	27,007	102,204
2005	70,070	22,347	92,417
2006	68,749	18,827	87,576
2007	75,546	19,901	95,447
2008	81,919	19,949	101,868
2009	93,252	22,309	115,561
2010	99,780	23,539	123,319
2011	110,151	25,460	135,611

Source: The Department of Correction

The experience of incarceration is common in the lives of drug users and becomes part of a particular form of everyday violence. At least once in their lives, nearly all of the drug users I spoke to - including women - had spent time either in police cells or in prisons. Prisoners are extremely vulnerable to HIV infection: the prison environment is an unhealthy place and the conditions in Thailand's correctional facilities are invariably poor. Dao described the environment of a Thai prison: "There are not many medications in prison. When you were sick, they just gave you paracetamol. That is all they have."

Based on sentinel sero-prevalence surveillance, the HIV prevalence among Thailand's imprisoned drug users reached 25.4% in 2001-2002 (Thaisri et al. 2003) There is a strong association between drug use in prison and HIV, attributable to prisoners engaging in particular activities such as being tattooed, sharing needles and razors, and unprotected sex (Buavirat et al. 2003; Thaisri et al. 2003). Despite common perceptions that HIV infection among those injecting drugs is spread mainly through sharing needles within their own communities, Buavirat et al. (2003) contend that drug users often become infected by sharing needles in police cells. Rat, one of my informants,

said: “There is the needle just like here. We all know that it was hidden in the block. It is the old needle. I know about HIV, but at that time I want drugs and I do not care about it.”

Latkin et al. (1995) stress the need to apply social network analyses to understand the social context of HIV/AIDS risk behaviour among urban drug users. Buavirat et al. (2003) argue that being tattooed in unhygienic prison conditions is also conducive to HIV infection. The typical culture within prisons has exacerbated HIV vulnerability not only through needle-sharing and tattoos but also via penis modification (*Fang Meuk* ฝังมุก) (Thomson et al. 2008). In the prison culture, penis modification is believed to enhance female sexual pleasure (ibid). But, one of its less favourable consequences is that the condom is likely to break and leak, leading to HIV and Sexually Transmitted Infection (STI) infection. As Haritavorn (2008) notes, male drug users who underwent penis modification could not wear condoms as there is no condom size that will fit them. Yak, one of my female respondents, commented after her partner served time in prison that: “My husband couldn’t wear a condom because he modified his penis while he was imprisoned. Thereby, there are none in his size.”

Social perceptions assume that incarceration is the appropriate social control for those using drugs. Nowadays, many countries, e.g., Malaysia and Australia, adopt harm reduction in the prison setting, thus providing drug users with more healthy living conditions. Thailand, on the other hand, has no guidelines ensuring access to antiretroviral treatment (ART) and clean needles, neither on entry to prison nor upon leaving. Thailand's prisons lack a methadone maintenance treatment (MMT) program as the Thai government denies the availability of drugs in prisons. In short, the environment in prison is conducive to further harming drug users. It produces a high level of risk behaviour as inmates have no access to sterile injecting equipment and condoms in prison. And, due to the lack of methadone maintenance, heroin-using prisoners have no option but to endure withdrawal symptoms. NGOs including Rak Thai, the Centre for AIDS Rights, the PSI and TTAG have taken steps to force the

correctional services to provide harm reduction programs in prisons, especially methadone programs. But, to date they have had little success.

The public fear surrounding HIV/AIDS, together with the moral judgments frequently levelled against drug users living with HIV, make it difficult for users to 'come out' into the larger society. The arrival of antiretroviral drugs in Thailand in accordance with Thailand's National Access to Antiretroviral Programs for People living with HIV/AIDS (NAPHA) has brought hope to those living with HIV. But, for drug users, this hope remains somewhat bleak because taking antiretroviral drugs does not integrate easily into their daily lives (Kiatying-Angsulee&Sringernyuang&Haritavorn 2006). One informant told me that he sometimes misses his appointment to collect antiretroviral drug (ARV) because he is unable to adhere to the treatment program. Rak commented that: "I have known that my CD4 count is lower than 200. Everyone asked me why I haven't taken the drug. How can I take ARVs while I am still using drugs? Every day when I wake up, the first thing I think of is drugs... not ARV."

In snowball fashion, compounded risk makes injecting drug users more vulnerable to suffering, to frequenting high-risk settings such as shooting galleries, and, in turn, to incarceration in prisons (Bourgois 1998; Celentano et al. 1991; Chitwood et al. 1990; Fuller et al. 2003; Latkin et al. 1995). One drug user said that: "When you crave heroin, no one cares how HIV is spread." Rat added that:

> I am quite sure that I was infected with HIV through needle sharing. At that time, I was in jail at the police station. There was one syringe hidden in the room. I didn't know how long it was there, but I did use it. Everyone is the room used that syringe because it was one way to survive.

Nowadays, people living with HIV- in particular women who have been infected by their husbands- receive more sympathy for their suffering than in the past (Liamputtong&Haritavorn&Kiatying-Angsulee 2009; Lyttleton 2004a). This is probably because antiretroviral drugs have changed the attitudes and appearances of people living with HIV (Kiatying-Angsulee et al. 2006). But Krusi et al. (2010) argue that to date, the ARV program lacks understanding of context-specific evidence of injecting drug user's adherence to the program as well as of social and structural factors.

In contrast to the transformation of PLWHA identities in Thailand in general, drug users are afforded no such gradual acceptance (Lyttleton 2004a). The risk associated with drug use, especially HIV, Hepatitis B, and Hepatitis C, portrays them publicly as the hub of transmission of, 'disease' and 'pollution,' contaminants that society fears will spread to them. Moreover, their HIV/AIDS infection is perceived as being caused by their personal behaviour. The difference between people living with HIV/AIDS (PLWHA) in support groups and drug users is that whereas many PLWHA nowadays receive social sympathy, drug users continue to confront diverse forms of stigma and discrimination.

Consequently, drug users are constrained to live lives shaped by structural violence. As a result, not only do many suffer from AIDS or the risk of infection but, in addition, their perceptions of self are assailed. The suffering that drug users face not only exacerbates their vulnerable health condition, but also invites stigma, which results in exclusion from full participation in civic and social life.

***Rang-Kiat*: Stigma and Discrimination**

The stigma directed towards drug users typically permeates every level of Thai society without necessarily being noticed or understood. Goffman (1963:3) refers to stigma as: "An attribute that is deeply discrediting,' one that is used to confirm the unusualness of the other." His notion of stigma, which is linked to an abomination of body, the blemishes of individual character, and the tribal stigma of race, nation and religion, focuses on the negative characteristics of people. Goffman emphasises that stigma signals 'undesirable difference' which extends to 'spoiled identity'. In later decades, Link and Phelan (2001:363) defined stigma as: "The co-occurrence of its components-labelling, stereotyping, separation, status loss, and discrimination - a.[further indication] that for stigmatization to occur, power must be exercised." Parker and Aggleton (2007) who analyse stigma in similar fashion, claim that it is linked with power and the legitimisation of social hierarchy and inequality. Yang et al. (2007) include moral experiences in stigma analysis when they state that instead of analysing individual characteristics of stigmatised people, focus should be upon the stigmatised

person's social network and conditions such as community and family. From this perspective, stigma customarily produces stereotyping, discrimination, scapegoating, dis-identification and/or depersonalization, making the stigmatised sufferer vulnerable to exclusion and marginalisation by expelling her/him from the community (Gilmore&Somerville 1994). Notably, stigma results from the labelling of the negative characteristics of those who are seen to be violating social norms.

Building upon Goffman's analysis of stigma, I will suggest that people using heroin are highly stigmatised because in the main they constitute three perceived unattractive categories: their unhealthy bodily appearance attributable to either drug injecting or HIV/AIDS; their identification as deviant and given to illegal practices; and, media representations, which are variously linked to ethnic minorities in northern Thailand or to other perceived 'unruly undesirables' (such as the unemployed or delinquent (*nakleng* นักเลง). People using drugs face considerable discriminatory action as all of their images appear to be inscribed with negativity. Taken together, stigma and discrimination impact profoundly on the mental and physical condition of people injecting drugs (Ahern&Stuber&Galea 2007).

Apart from the various other problems to which stigma gives rise, the stigma surrounding injecting drug use becomes a barrier to accessing health care (Kaplan&Schleifer 2007). Simmonds et al. (2009) found during their research conducted in England, that drug users internalise community pharmacists or other providers' negative perceptions of injecting drug users using their services. Through self-representation, drug users are pressured to feel dirty, ashamed and guilty because of their drug use behaviour, a process that happens in many social settings worldwide (Friedman&Alicea 2001b). For example, the impact of stigma upon people injecting drugs among the Dai ethnic minority in Yunnan, China, results in social isolation, marginalisation and invariably drug relapse (Deng et al. 2007). Conveyed through state policy and media, the image of drug-related violence is familiar at many levels of society. But, what most people fail to - or opt not to - acknowledge is the fact that crimes associated with heroin use are in fact relatively rare (Singer 1996). Public attitudes and policies reflect how drug users are treated: stigma marginalises them,

erecting a wall between those using and not using and reaches into the very core of the drug user's subjective sense of self. In the process, drug users become progressively distanced from the world of non-using drug people. Tong (a female drug user) said: "I hate it when people look at me. When I was on the bus, one passenger took off her necklace. She was afraid I would rob her." A most powerful influence on lives such as Tong's, stigma causes them to feel that they are no longer part of the broader community once they start using drugs. It is inherently discriminatory, and is most often expressed at the community and individual levels through social interaction.

Drug users around the world from Puerto Rican/African-American crack users to the Hmong in Thailand who inject heroin - become scapegoats for social disorder (Bourgois 1995; Renard 2001). Gilmore and Somerville (1994:1346) define the scapegoat as a person who is required to bear the 'sin' of the community being blamed for causing social problems. Some groups, especially drug users living with HIV, are considered to be even more scapegoated for their illicit drug use and HIV infection (ibid). When confronted by pervasive discrimination, the drug users I have come to know respond in two ways: first, there is resistance to prejudice and the pressure to conform. This takes the form of social mobilisation against stigma, i.e., attempts to establish forms of community belonging that act as buffers against negative perceptions. Second, drug users internalise these notions as their sense of subjective identity becomes strongly framed by the discursive impact of social notions of what being a 'drug user' entails. Drug users have internalised this pervasive discrimination. As a result, they feel different, unwanted, disturbed by a sense of being social outcasts. This feeling becomes the wall that separates people using drugs and those not using drugs. Eventually, it becomes the driving force that impels them to leave their families.

Jack told me that:

> I could not blame anyone for what I was now. It was my fault that I used drugs. Nobody forced me to use drugs. All family members asked me to quit but I couldn't. Their actions drove me crazy. Finally I left home and stayed with my friends who were also drug users.

Crawford (1994) analyses how the concept of health affects self and identity for those identified as risk groups. According to his analysis, health is not only a physical characteristic, but has moral underpinnings; to be healthy means to be good, respectable and responsible or to demonstrate what he calls the 'healthy self' (ibid). At the same time, this healthy self creates a sense of 'otherness' or unhealthy other. Crawford (1994:1349) further suggests that AIDS provides a sense of otherness to those infected "[The] AIDS epidemic is a 'spoiling' of identity, a fluidity that dissolves 'immunity'- the ability to distinguish self from non self." AIDS thus intensifies the images of drug users as unhealthy people. Most people acquire these unhealthy images of stigmatised people from media, socialisation and gossip that depict drug users as drug addicts imbued with junkie images. As Yang et al. (2007) maintain, stigma takes place in an intersubjective space in which the social world (values) crosses over the self, marking the subjective experience of bodily states and emotions. Other research suggests that the stigma exercised towards people injecting drugs impacts more at an emotional than at a physical level (Singer 2005; Taylor 1993). Strategies tend to stigmatise those injecting drugs, portraying them as being less socially acceptable in general. And, because society sees the injecting of drugs as both self-destructive and irrational behaviour, heroin users with HIV face more discrimination than other groups of drug users such as amphetamine users who are less associated with needle use.

***Song Deng*: Doubly Stigmatic**

Stigma and discrimination, violence, harassment and HIV/AIDS infection combine to constitute an ever present form of oppression to the lives of those injecting illicit drugs. These, drug users' social suffering becomes an integral part of their everyday lives. In the words of Kleinman et al. (1997:ix) "social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems."

A term in common usage in Thailand illustrates this dilemma well: *song deng* (*Song* means two and *Deng is* a poker term meaning unified pair) refers to drug users who are HIV+. The stigma associated with AIDS identifies AIDS as a deadly disease peculiar to

stigmatised groups; for example, sex workers, MSMs, migrants or drug users (Cao et al. 2010; Herek&Glunt 1988; Radcliffe et al. 2010). Translated literally, *Song Deng* means someone who is both addicted to drugs and HIV positive. *Sarm* (literally means three) *Deng* is added when the person has Hepatitis C. Tee (a male user) said: "Being a drug user is so grievous, knowing that your blood is also positive is whole-heartedly painful."

The commonplace use of this term as a means of self-reference shows how drug users with HIV feel doubly stigmatised, being also vulnerable to victim-blaming. Crawford (1994:1356) notes that: "AIDS, in its association with illicit drug use or an illicit, promiscuous, or extra-marital sexuality, powerfully reinforces this notion of health as the property of the normal self." AIDS epidemics exemplify the image of drug users as unhealthy, sexually promiscuous drug injecting people. In most communities, general opinion has it that drug users are 'polluted'; in other words, morally corrupt, dangerous, and irresponsible (Deng et al. 2007). HIV infection reifies these negative perceptions about them.

Most injecting drug users are subjected to pre-HIV testing before participating in clinical trials or programs. Many of the users I spoke to were not shocked by their results as they feel that HIV infection is an expectation, part of their everyday lives. The reality is that virtually all injecting drug users know that HIV is contracted through the transmission of blood and needle sharing. Even though they may not know conclusively, they suspect that they became infected through sharing needles rather than sexual intercourse. Mook commented that: "I was pretty sure that I was infected by needle. It must have been that one in the police station." Nohn (a male drug user aged 32 years) added that "I remember my friend told me that he was HIV, but at that time I wanted drugs. I didn't care about HIV."

This is not to say that drug users are simply passive recipients of social oppression. Drug users do not simply succumb to being victims of social oppression: they also initiate resistance tactics such as forming drug communities and using strategies of avoidance to minimise oppression. Avoidance is but one among several resistance strategies that injecting drug users utilise as a means to cope with stigma and

discrimination. They try to avoid contact with non-drug users, especially family members and friends, as they fear their reactions. As a demonstration of a particular sort of agency, they choose to confide in friends in the drug community rather than in family members.

In general, drug users are less fearful of telling their HIV status to their friends than they are of telling their family members. They feel that their drug friends genuinely understand how they feel and what they experience, although the multiple stigmas associated with drug use make them reluctant to disclose their HIV status to just anyone. Pra, a female drug user, said that: "I do not dare to tell anyone that I've got HIV+. I was sick and I told them that I've got a cold. But my friends told me that they all knew that I am HIV+ so there is no need to lie to them." In addition, the fear of others learning about their HIV status discourages them from making contact with the health services and family members. Those who have learned of their diagnosis often devise ways of hiding it. For example, many have been known to withdraw from society, to seek isolation by locking themselves further into the drug community. The negative depiction of people with HIV/AIDS, bolstered by the media, has reinforced fear, avoidance and the isolation of people with HIV.

Stigma permeates all levels of society; as a result, drug users are often explicitly excluded from treatment programs (Aceijas et al. 2006). Upon entering treatment programs, Thai users are viewed as unlikely to adhere to both antiretroviral and methadone treatment programs compared with other risk groups (Kiatying-Angsulee et al. 2006). Health professionals are in the main opposed to treating HIV-positive drug users because they believe that treatment will prove ineffective for them. For this reason, HIV-positive injecting drug users face further prejudice; that is, an unwillingness on the part of health professionals to meet their needs and demands (Kiatying-Angsulee et al. 2006). To counter these effects, various NGOs, e.g., TTAG, have worked on the advocacy of people injecting drugs in Thailand accessing treatment programs, a subject I return to in Chapter 5.

But, despite such obstacles, most men and women I interviewed recognised that enrolling in treatment programs is a means of social rehabilitation. To this end, many users try to meet social expectations by joining specific programs, an action undertaken in the interests of regaining some degree of normalcy. But at the same time, feelings of uncertainty, anxiety and fear of pressure force many to move outside of the mainstream community. Over time, they come to embody these feelings, accepting them as part of their selves. Besides the physical pain that results from being expelled from the broader community, stigma inflicts emotional pain, which can take the form of a devalued sense of self. Thus, stigma becomes part of a complex mosaic that social prejudice embodies (Scheper-Hughes&Lock 1987). Many of my informants felt impelled to leave their home environment as they, along with others, considered themselves to be 'polluted'.

***Sia Naa*: Family Suffering**

The notion of 'face' is important and valuable to Thai everyday social practices. Mulder (2000:88) stresses that the notion of 'face' is embedded in Thai culture; and that ignoring this may lead to unpleasant consequences such as revenge for a perceived insult. Losing face in Thailand is known as *sia-naa*. Mulder (2000:63) further opines that: "The good person remains dependent on the judgments of his near others and fears to 'sell face,' this bringing shame on himself or worse, on his group." Sia Naa is an emotion that drug users' parents experience in response to the latter's drug taking. In turn it makes their drug-taking children feel uncomfortable and becomes an internal force that drives them to leave their families and communities.

A significant number of users with whom I came in contact live with their families in flats or houses: some receive money and support from their parents. Stigma is linked with the families' notions of face. Parents, upon discovering that their children are using drugs, typically ask them to stop immediately; in many cases, their immediate reaction is to try to send them to a treatment centre. In some cases, however, they may have undergone treatment several times but still continue to use drugs. When the 'normality' strategy fails, parents reluctantly come to realise the unlikelihood of their children ceasing to use drugs. Their strategy then changes to one of trying to shield them as

much as possible from the drug society. Many of my informants told me that it was their mothers to whom they turned at this stage because they would give them a daily allowance, enough to buy heroin. Some mothers think that giving their children money to buy drugs is one way of saving them from outside threats such as the police and/or violence. The families' reaction towards children using drugs also conforms to broader social values.

Regulations, the tools of stigma, are a response to drug use as a social threat. The law, a powerful tool of social control, stereotypes people and establishes the dividing or boundary line between the 'other' and 'us'. At the same time, it draws a moral line between 'good' and 'bad' people.(Simmonds&Coomber 2009). Legislation reaffirms the 'sin' of using drugs and labels users 'criminals', people who should be kept under control. Law enforcement is thus another factor that alienates users. The WOD labelled injecting drug users 'criminals', a group characterised by deviance, lack of control and moral depravity. This form of denunciation ultimately contributes to a climate of violence and discrimination against persons who use drugs.

Since most drug users live in localised urban communities such as flats or slums, community norms and judgments sometimes become a further measure of social control that is perhaps even more powerful than the legal system. As Mulder (2000:50) describes Thai perceptions of non-intimate others: "If such persons are perceived as potentially harmful, then it is wise to maintain distance and encourage an atmosphere of fluidity while avoiding involvement in each other's problems." Community control addressing the family directly affects the users' respective senses of self, an important factor confining drug users to an existence in a marginalised society. Drug users face a strong sense of condemnation and devaluation attributable to words and actions directed at their families. Rak said: "I could take all the condemnation, but my family couldn't." Tui (a female user aged 27) commented: "I was like the black sheep in the family because I was an unemployed drug user". Nui (a female user) said:

> My younger sister was the community leader. She was a well-known person. Every month, she made a transfer allowance of around 5000 baht

> to me. She strongly prohibited me from either visiting her or calling her because she felt shame having a sister using drugs.

The gossiping of their neighbours further heaps shame upon them and their families. Gossiping neighbours passing on tales about men or women using drugs may make family members feel embarrassed, ashamed and risk loss of face in the community and among relatives. Loss of face results in feelings of inadequacy and shame. Joke and Nuke, two of my informants said: "My mom sold food in front of the flat. One day, the flatmate told her that I was about to inject heroin in the doorway. Then, my mom asked my dad to take me home. She was mad that I made her lose face." Nuke added: "I know they all gossip about my drug behaviour. I don't care if they talk about me only, but they all start talking about my parents."

The Thai penchant for gossip may be understood in this context. When faced with condemnation about their children using drugs, families suffer loss of face and embarrassment over their children's drug use behaviour. The latter's behaviour not only reflects self-fault, but also implies the parents' failure to raise their children in a proper manner. Ying, (a female user) said: "When my mother was at the police station, one of the policeman insulted her for raising a drug addict daughter like me. I felt sorry for causing her problem." Confronted with suggestions of failure, parents tend to redirect their recriminations towards their children, blaming them for taking drugs at the same time trying to hide them from public scrutiny. Reciprocity is expected within social interaction between families and communities. In line with a sense of collective sharing, one mode of reciprocity in Thailand is to save the community face or meet the goals assigned to them. Ruj (a male user) told me: "I have tried to be a good daughter as my mom expected, but I couldn't. All the time I just thought of drugs."

Loss of face puts pressure on drug users to attend treatment programs. Some attend the programs in order to please their parents, to absolve them from community social condemnation. But, according to Ho (1976), further anti-social behaviour occurs when the individual suspects that 'face' cannot be regained by his or her action. Most societies try to find a scapegoat when the community face is threatened; in response, members may choose to quit or hide their drug use behaviour in a bid to avoid the dual

onslaughts of stigma and discrimination. As I will discuss in the next chapter, living within the social boundary of a drug community away from outside gossip means that drug takers can use drugs without feeling shame and guilt.

Difficulties increase when users become unable to either control or handle their lives in ways that conform to everyday norms and expectations. Drug users do not suffer only from the physical and material demands of their addiction; perhaps more importantly, they suffer from a social depiction of them as targets for stigma. The forms of stigma that the drug user faces range from macro to micro levels or from policy to localised community reaction. Irrespective of range, they all emphasise that using drugs is an indisputable form of wrongdoing, an action that perpetuates the negative feelings of the drug users and becomes the motivating force that drives them out of the community. It is in this process of exclusion that the structural violence enforced by stigma is so effective. The stigma attached to drug use forces heroin users to develop their own social groups and/or networks and sense of social belonging. At the same time, any congregations of drug users generate community concern, concretising a belief that they will cause violence to the community, especially in places like methadone clinics. Bua (a male user) commented:

> I don't have anywhere to go after taking methadone, so I chat with my friends in front of the clinic. Well, of course, it is drug chat, but we haven't done anything, not selling drugs. The nurse came out and made us move to other places because she was afraid that we would sell drugs in front of the methadone clinic which would undermine the 'good' image of the clinic.

In sum, stigma widens the gap between those who use drugs and those who don't use drugs. In order to deflect stigma away from the family and community, some users I came to know opted to leave home at least temporarily. They might decide to return home if they have nowhere else to stay. Their sense of difference becomes enhanced all the more if they cannot stop using drugs. As a result, in many cases they relapse: their drug habit makes them feel profoundly alienated from their family. The accumulative result of stigma sees drug users lose their families and friends and become excluded from both community and social events. Drug-related discrimination in Thai society has

established a sizable gulf between those using and those not using drugs. In effect, it not only distances users, especially heroin users, from the majority of people in society, but heightens the associated fear of violence and death.

***Khiya*: Creation of an Alienated Identity**

Everyday discourse draws on notions of a social identity which is formed by the ongoing dynamics of social interaction (Jackson 1998). The term 'social identity' ostensibly refers to those who share the same experiences, what is commonly known as 'group identification' or 'social categorization' (Jenkins 1996). Social identity reflects certain assumptions regarding how an individual ought to be (Goffman 1963:2). It imposes social characteristics which in time will become identified with, internalised and/or embedded. Identity determines what and how society thinks of groups; and, it is according to identity that they are named.

The state and media play a significant role in disseminating information about the violence caused by drug taking, in the process promulgating a negative image. The media show how families have to endure their children's or relatives' drug addiction behaviour and how the community at large is threatened by the violent acts committed by drug users. Media emphasise the fact that 'good' Thai citizens can become innocent victims of the violence and disease caused by drugs. Conversely, drug users' suffering is rarely if ever revealed or addressed by the media. Lupton (1999) argues that people view risk more adversely when they see it as close to them. There is a widespread acceptance that drugs are available at all levels of Thai society and that all people could potentially use them. The threat is thus uncomfortably close to home.

Posters in public places portray drug users in highly derogatory fashion, the main message being that using drugs is 'bad'. And, whereas those who meet perceived social norms are defined as 'normal, good, healthy' people , 'others' are referred to as 'bad,' 'polluting' and/or 'unhealthy'. Posters emphasise the social perception of drug users and demonise what it means to be a drug user in Thai society.

Plate 3. Selling drugs deserves the death penalty.

Plate 4. Taking drugs destroys our future.

Plate 5. Love yourself, fear AIDS. Stop sharing needles and sex, and save your life.

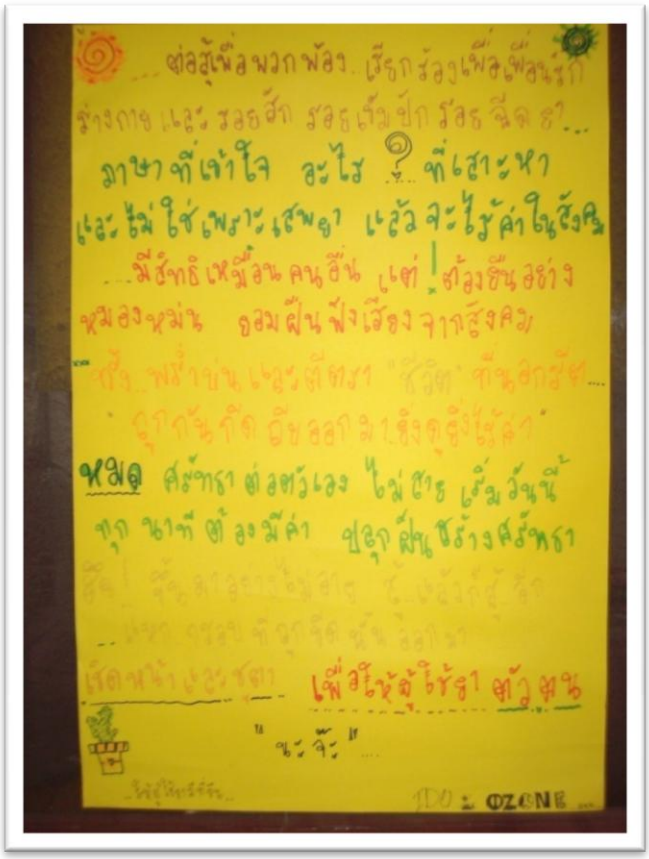
In Thai society, people commonly refer to injecting drug users as *khiya*: (ขี้ยา). When used grammatically as a prefix, *khi* (ขี้), which literally translates as 'shit', clearly has negative connotations; e.g., '*khi-kyat'* (ขี้เกียจ laziness) or '*khi-khuk'* (ขี้คุก prisoners). The junkie image, or *khiya*, signifies that members of this particular social group deviate from what society sees as 'normal'. Injecting drug users face increasing prejudice as the addicted body shows physical evidence of scars, blackened skin, loss of weight, tattoos and/or drug cravings. The term *khiya* invites public stigma; in turn, the injecting drug user responds to *khiya* as a form of punishment. Jui (a 34 year old male drug user) commented: "I hated when people called me *khiya*. I felt I was insulted." Thirty-five year old Pla observed: "I am a drug user, not *khiya*. I have never stolen anything or committed crimes. How could I be a *khiya*?"

After he returned from Chiang Mai, Muad told me of the stigma he experienced at his sister's wedding:

> Last month, I went to Chiang Mai to attend my sister's wedding. I don't have anything to wear so I wore my Thai Drug Users' Network t-shirt. Everyone looked at me strangely. I felt that I was not like them. One of my friends asked me where I worked. I told him that I worked at RakJai. He asked me, 'Is that a kind of restaurant?' I replied 'no', it was the centre that worked with drug users and HIV. He stopped for a moment and then said good bye to me. Most people discriminate against us and are disgusted with what we do. They ignore the valuable work we do.

The appellation *khiya* imbues users with negative self-definition. Drug users embody these images and sometimes question themselves as to whether they deserve the names that society allocates to them. This negative image not only sees them lose face: it also costs them their families and friends. But resistance to these messages is to be found in ways of managing self and in assistance by support groups.

Plate 6. Poster at RakJai Drop-In Centre.



The above poster written in fragmented form can be read as:

> Fight for equality, and demand it for our beloved friends. We are not useless to society because we use drugs and have tattoos and scars. We have equal rights, but it makes us sad to hear how society stigmatises us. Our lives are considered worthless and we are discriminated against. We have given up hope but it is not too late to build up our hopes and dreams. We must stand and fight to break the barriers so that we can be proud of ourselves and show them that we are here.

This message clearly reveals what members feel, what they suffer, and the violence that affect their sense of self.

Drug users internalise images created by social prejudice and state strategies of drug control. Bourgois (2002:223) notes that:

> Structural violence often becomes expressed in an everyday violence of interpersonal rage and delinquency as well as in a set of institutionalized relations and norms that dehumanize. These different expressions of everyday violence then reverberate into the symbolic violence of self-blame and shame.

This internalising process is far from an easy give-and-take process. Living in what we might call a drug use habitus, users are forced to accept such images because they lack adequate power to negotiate. But, at the same time, the ways in which they react, think or feel are also reflected in the resistance evident in the different tactics adopted by drug users. As Sak suggested, there are different ways of thinking about drug use:

> I just love taking drugs like someone who loves smoking cigarettes, drinking wine or alcohol, so what's wrong with taking drugs. You know that drinking alcohol may cause more social problems than taking drugs, but drugs are illegal. That's it. And we, drug users, we are identified as illegal.

Such counter manoeuvres must inevitably confront the stigma, coupled with embodied signs of drug addiction, which emphasises the users' sense of guilt and gives rise to the following question: Do I belong here (in the community)? Many informants indicated two choices that confront them; whether to try to be 'normal', that is, to follow social norms and quit drug use, or be excluded from society if they continue their drug use.

One factor in this difficult decision is the family. In Thai society, family relationships are extremely important and for this reason most family members encourage users to stay within their immediate social circle. Their strategy, like that of the treatment centres, is to try to bring them back into mainstream society and eliminate their *khiya* image. But, as we have seen, there is an implicit tension between the social forces that marginalise people injecting drugs and those who seek to provide a degree of family normalcy. Many drug users have to negotiate an internalised conflict between their 'good' and 'bad' selves. Despite their wish for normality, and their desire for family and community acceptance, the simple fact is that many find it overwhelmingly difficult to stop using drugs.

Summary

The lives of Thai injecting drug users are shaped by a range of forces operating at multiple levels which, in turn, determine the specific experiences associated with drug use in the everyday lives of my informants. If we are to appreciate the world of drug users in Bangkok with any degree of accuracy, it is necessary to understand the complex intersection of both the macro and micro forces that collectively operate as forms of structural violence and that shape individual subjectivity and experience.

People who inject drugs including the various individuals I have quoted face a dilemma: they oscillate between using drugs and achieving social responsibility. They suffer the moral dilemma of having to strive for acceptance in line with their newly-defined identity as drug users while at the same time confronting their socially-defined roles as parents, children or friends. Publicly, their lives represent a moral problem, one that gives rise to wide social concern, a concern worsened by society's realisation that HIV is associated with drug use. Society sees heroin users as polluting, as carriers of diseases that may infect others.

Social structures are based on the moral perspective that maintaining social harmony is not only the duty of governmental representatives, but also of every individual in society (Giddens 1986). Thai society is not individualist; in many respects, it has a

strong collectivist sensibility (Mulder 2000). Thus, abiding by social hegemony is the supposed duty of every Thai individual. Drug use is regarded as the cause and effect of moral degeneration, with the choice to use drugs an individual and thereby deviant decision. As many of my informants' voices show, they are considered a threat, a menace, and as the primary instigators of social disorder; hence, they are labelled *khiya*. A moral line underlies a popular belief that social disorder is caused by drugs: many now believe that all social disorder or menace such as violence, sex, crimes or theft can be sourced to drug use. This reflects the norms, rules and laws governing communities in which those taking drugs are seen as the social enemy. The implementing of drug laws, especially the War on Drugs, encouraged Thais to view drug use as harmful social behaviour.

Injecting drug users are aware of the differences between themselves and those members of society - the majority - who are not using drugs and even those who smoke *yaba* rather than inject. These differences are the driving forces and the concrete impact of structural violence that construct the barrier between drug users and society. Thai injecting drug users have had to learn how to solve these conflictual feelings by forming communities that serve as self-protection. By adopting a policy of viewing drugs as pollution, the state has sought to rid itself of those who produce such pollution, or at least to bring the problem under control by means of imprisonment, exclusion or stigma. In the next chapter, I will explore how drug users as individuals manage themselves against these external forces.

Chapter 4

Management of Selves: Survival Tactics

In the earlier chapters, I have described the living environment, stigmatisation and government policies as important factors in establishing the conditions that work to marginalise Thai drug users. I have argued that drug users are subject to a form of structural violence that politically and historically derives from social dimensions. As well, I suggest that typically societies use multiple strategies to deal with drug issues, which together contribute to a sense of difference by identifying and treating drug takers as socially polluting. Within this dominant social framework, the social order has built its own walls to protect itself from 'enemies' by identifying certain drugs as illegal, by extension discriminating against those using these substances. In this chapter, I will explore at a more subjective level how injecting drug users in Thailand employ particular tactics to cope with the external social forces ranged against them, for example the forces of stigma, and with internal forces such as the pleasure associated with drug- taking.

Public expressions of condemnation, together with an innate fear of drug users and the failure of drug users to meet social expectations or to fulfil their roles as good citizens, reify these differences (Friedman&Alicea 2001a; Hassin 1994). Those using drugs internalise this sense of difference as part of their selves. In order to cope with oppressive social response, they employ a variety of tactics to manage their sense of self. Management of self determines how injecting drug users deal with their relations with others during social interaction both within and without their peer community. Thus, it may be suggested that management of self refers to how individuals react to external forces in ways that connote rebellion, resistance, submission or resolution (Maher 2000; Miller&Neaigus 2002; Ning 2005).

Here I raise the following questions: Why do societies react to drug users aggressively? How do they manage the drug user's perceived 'madness' that underscores their deviance? In an attempt to answer these questions, I will explore the history of perceptions of madness and how they are linked to how society sees drug users.

Historically, addicted drug users have shared certain similarities with those diagnosed as mentally ill: both groups have been subjected to negative social attitudes and generally considered as diseased or deviant; in short, 'mad'. By way of response, different social institutions have over time developed different means of dealing with this 'madness', from exclusion ('ship of fools') to segregation (confined to the 'mad house') and from incarceration and surveillance (Panopticon) to rehabilitation. These evolving approaches have also been used with drug users who are regarded as a threat to both society and themselves. Such images, in turn, influence contemporary drug policy that inevitably regards drug users as enemies of the state.

One difference between people being treated for mental illness and drug users is that a structural cause exacerbating mentally ill people's suffering is the way in which loss of freedom is materialised: the prison and/or hospital become the concrete wall or boundary that prevents sufferers from interacting with outsiders. Concrete walls (hospitals and prisons) are built by social institutions at least in part to protect populations from the harm of mental illness. In contrast to mentally ill people, outside of commonplace incarceration, Thai drug users construct their own walls, their own invisible boundaries, as a response to society's condemnatory attitudes towards people who inject drugs. But, these boundaries do not necessarily alleviate suffering as they directly affect a person's sense of self.

Those injecting illicit drugs build invisible boundaries in the interests of self-protection. They form their own particular sub-groups and create their own social (often 'walled') space to enhance their sense of belonging. Behind the wall is the drug community: it is here that they share subjective elements common to their everyday lives. In order to survive, they not only have to learn how to live their lives in a milieu of drug socialisation and drug-related rituals, but also how to fraternise with those domiciled outside of their community; thus, of necessity, they acquire tactics essential to dealing with these contingencies.

Certeau (1988:xix) distinguishes between strategies and tactics as fundamental to how social hierarchy operates: a strategy may be defined as "the calculus of force-

relationships which becomes possible when a subject of will and power can be isolated from an 'environment'." Based on Certeau's definition, a strategy is a tool that authorities or those with power use to control marginal groups through exclusion and oppression. Political-economy dimension could be considered as one demonstration of this form of social control as the implementation of drug control policies, wars on drugs, and stigma and discrimination give rise to strategies that societies use to deal with the illicit drugs problem and drug users, in the process isolating the latter from the mainstream environment. 'Tactics' are the ways in which the marginalised attempt to cope with, or subvert, strategic forces. Those employing tactics are subject to the power of authorities or external forces: in response, they devise their own ways of dealing with/lessening any impact. In this chapter, I describe the tactics that Thai drug users use to deal with external forces largely through the formation of a social boundary, a sense of belonging to the drug community and a reconfigured self-representation. Tactics are the means by which marginalized groups struggle or resist strategies of dominance (external forces). They employ tactics to resolve tensions between their drug behaviours and social forces and relations. As I will describe, such tactics provide a sense of agency in situations where dominant forces of social and political prejudice are ranged against them.

Images of Madness, Witches and Drug Users

Potter describes madness as follows:

> All societies judge some people mad; any strict clinical justification aside, it is part of the business of marking out the different, deviant and perhaps dangerous…Stigmatizing - the creation of spoiled identity-involves projecting onto an individual or group judgments as to what is inferior, repugnant, or disgraceful. It may thus translate disgust into the disgusting and fears into the fearful, first by singling out difference, next by calling it inferiority, and finally by blaming 'victims' for their otherness (2003:62).

As argued in the preceding chapter, when problems in any form assail society, governments search for ways to control them. This is the duty of government. One way to define what is troublesome is to identify it as pollution or disease, both of which require segregation from others. This approach has its basis in moral judgments and is

reflected in social norms, ethics and traditions (Crawford 1994; Foucault 1988). Specific forms of segregation are practiced according to the context, setting and population. Reception of the image of the drug user links many of the concerns expressed in this chapter as this could reflect how they will be treated by others and in turn how they treat themselves.

The construction of the 'drug user' is often connected to an image of insanity. Society tends to variously interpret intoxification as insanity, folly and irrationality (Young 1994), while 'drunkenness' is also considered a symbol of violence. I will explore the semiotics of mental illness as a means of understanding not only overt levels of meaning associated with drug use, but also the complex confusion that permeates the image of drug users today.

Searching back through human history, one finds a parallel between the social control of witchcraft, insanity and drug use, each considered to have the potential to pollute the citizenry. From the Renaissance to the beginning of the nineteenth century, the defining characteristic of 'madmen' was a product of cultural, belief, political, and medical construction (Khalfa 2006). With some important exceptions, many societies harbour the notion that these afflictions are the result of undisciplined and unproductive citizen-making; in other words, such people should come under the control of the state (Wahl 1995). Notably, mental illness is often perceived as immoral. In the past, witchcraft was an accusation of a symptom of disorder, moral collapse or moral breakdown. Likewise, according to Manderson (1997b, 2005), a general fear of otherness underpins the way uncontrolled behaviour of drug users is perceived by non-drug users. Across different cultures and at different times, mental illness has been interpreted as a form of deviant behaviour which is unacceptable in society as it could harm others. In some societies, mental illness may be underpinned spirit possession, causing the person to exhibit symptoms of disturbance of mind and body such as uncontrollable body shaking. In others, images of mental illness are linked to religious beliefs, including animist possession and devils: madness is often viewed as the gods' punishment for sins committed in some previous life.

Wagner et al. (1999) introduce the notion of spiritual affliction to depict common images of mental illness in India. Images of the 'fool' were considered the root of suspected mental illness in Germany (Gilman 1988). In Bali, symptoms of mental illness in the individual may be equated with both social and individual imbalance (Connor 1982). In the West, during some periods, unproductive citizens were viewed as weak social components, in particular mentally ill people (Gilman 1988). Thus, it becomes clear that mental illness is socially and culturally constructed. In the past, images of drug use and its parallel with mental illness combined to reify a notion of uncontrolled behaviour with images of devils or spirit possession. Drug users are closely assimilated into categories originally defined by conditions of 'madness'. People in many societies consider those who fit the madness category as demonstrating both uncontrollable and aggressive behaviour. Drug users who act aggressively and exhibit uncontrollable behaviour when craving for drugs take on these defining features of insanity in the public mind.

In turn, drug policies have specific semiotic implications. The witch-hunt or war on witches pursued in Europe and America between 1480 and 1700 resulted in the extrajudicial killing of women who were accused of being 'witches'. Over 200,000 people were killed due to official and public concern about demoniacal possession (Potter 2003). One might suggest a similarity between the witch trials and the War on Drugs. The drug policy, that is, the war on drugs, is rooted in social perceptions of insanity or what Manderson (2005:35) refers to as the 'sin of being possessed'. Manderson (2005) argues that there is a parallel between witches and drug users: both are considered to be possessed by demons or bad spirits. If drug use reveals what it is like to be possessed, i.e., to lose one's identity and capacity for individual agency, then we can be confident, by way of contrast, in our own autonomy. The drug user, like the witch, is held up as a potential threat to the modern ideology of autonomy and freedom; held up, set apart and struck down. In this way, anxiety around these questions can be neatly quarantined from infecting the rest of us (Manderson 2005:48-49). As Manderson (2005) elaborates, witches and drug users are the scapegoats of moral decay: both are condemned for their uncontrolled behaviour.

The mentally ill and the drug user, each in his/her own way, are subjected to power structures which regulate their everyday lives. Demons and drugs have the power to possess others, placing them on the 'abnormal' side of the ledger. Based on Manderson's trope of possession, drug possession could be described as the phenomenon of the drug's influence over both mind and body (ibid). According to Midelfort (1972), witches do not have power until they gain the help of the devil, and it is this that makes them feared. At the same time, it is argued that the image of witchcraft is a form of protest and resistance employed by powerless people (Niehaus&Mohlala&Shokane 2001). Drugs act upon drug users as devils act upon witches. Their imaginings are the products of hallucinatory drugs or dreams (Escohotado 1999). It could thus be suggested that those suffering from mental infirmity, along with witches and drug users, are subject to particular forms of social regulation. Images of insanity and drug users have evolved in tandem with the latter becoming subjects of increased medicalisation. The aim of rehabilitation is to transform the abnormal into the normal; in effect, to restore reason. "Suitable facilities could restore the mad to reason; therapeutic progress and institutional reform went hand in hand" (Tone 2009:4). The medical gaze, which gives madness and drug addiction a scientific explanation, prescribes a mode of curative action, even as witches, drugs and mental illness are persistent symbols of unreliability and irrationality.

There are other parallels that may be drawn. Fear of the violence of mentally ill people and drug users has historically resulted in insistence on collective restraint. What is feared is that the 'pollution' might spread to others, especially the uncontrolled threat of 'unreason'. In the interests of prevention, the state has built concrete boundaries such as prisons and rehabilitation facilities in an attempt to protect society from being threatened and tainted by this perceived danger. Foucault (1988) claims that in order to protect society from the uncontrolled body of mental infirmity, confinement to a madhouse or sanitarium was established as a means of containing madmen in isolation. Later, when mental infirmity was identified as a medical condition, institutions such as the *Hospital de Paris,* for example, were officially built as treatment places wherein medical personnel could restore the person to normality (ibid). Even though hospitals

and rehabilitation centres are socially represented as places in which to treat 'uncontrolled' people, they also act as symbols of incarceration and/or surveillance. With the passage of time, deviant behaviour came to be considered medical rather than moral.

Illicit drug use has over time become elevated as a symbol of insanity or uncontrolled behaviour. In Thailand, images of excessive and dangerous behaviour, graphically reported by the media, have rapidly come to epitomise the stereotyped image that characterises virtually all drug users. Thai society equates mental illness (*pen ba*) with the drug user image, just as amphetamine is referred to as *yaba* (crazed drug) which literally means a drug that turns people into monsters or madmen (or mad women).

Throughout earlier periods of human history, the meaning of madness changed from spiritual possession to a problem of the psyche. While showing some similarities in terms of fear of pollution and social disdain, drug users today are confronted with a more rigorous and intensified response from the law and media. Until now, the overlapping social representation of drug users and the mentally ill in Thailand has attracted little study, in particular from the social sciences. The drug and mental illness tropes most commonly reproduced are scientific or medical studies rather than socio-cultural explanations. And yet, popular fears and prejudices continue to underpin social responses.

Mental Illness and Drugs in Thai Society

Each society has its own values, beliefs and norms as its means of social response to 'uncontrollable' people. Their beliefs are explained through discourses that shape how people interpret uncontrollable behaviour. The meaning of mental illness in each social context is explained as society exhibiting concern regarding 'out of control', unproductive citizens.

Before the influence of the Western medical system became prominent in the 20th century, mental illness in Thailand was described as a religious phenomenon. Thai culture still allows a space beyond the medical in which to explain insanity; for

example, in Buddhism and animistic practices. Multiple explanations are viewed as the cause of *ba* or 'mad behaviour'. In Thai society, mental illness allows folk explanations through the belief in *phi* (spirits). The term *phi* in the Thai context refers to bad spirits or ghosts that have the power to possess human beings, causing them illness, misfortune or exposure to damaging consequences. In the country's rural areas, the concept of *phi* is widely recognised and used to explain illnesses for which medical discourse cannot provide answers. Madness in Thai society has thus been commonly referred to as possession by *phi ba* or 'bad ghosts'. The signs of symptoms of madness and spirit possession may be similar: sometimes the diagnoses include crazy behaviour (*pen ba*),'wind illness', nervous disorder or spirit possession, or any combination of these condition (Muecke 1979:274). Thais usually seek help either from a spirit medium or a Buddhist monk to cure these illnesses. Suwanlert (1976: 274), who links folk discourse in *phi pob* to mental illness in Thailand, categorises five symptoms of being possessed by *phi pob*: making noise, shouting, screaming at the top of one's voice, tensing or experiencing spasms all over the body, the shaking that may follow the spasms, fist clenching, timidity or shyness, and, the possessed host may speak. The similarity between a person taking drugs and one who is mentally ill is that both might hallucinate and/or their personalities undergo change. Suwanlert (1976: 293) notes that the personalities of people who are possessed by *phi pob* undergo change, what is medically referred to as 'dual personality'. Possession is manifested in symptoms of disturbance of both the mind and the body; in the case of the latter, it may take the form of body shaking and twitching. Here, I can draw parallels with some drug experiences I noted. This type of disturbance of mind and body is similar to the craving symptoms of drug users, a condition commonly called 'dopesick' or 'cold turkey'.

As far as the lay person in Thai society is concerned, the cause of madness or mysterious illness is still interpreted within a religious and animist framework that is an intrinsic part of everyday Thai life (Golomb 1988). Golomb maintains that labelling people who become possessed as in Northeastern Thailand as 'causes of pollution' is one traditional way of scapegoating, similar to society identifying drug users as *khiya*. Furthermore, many Thais believe that illness, misfortune and suffering result from bad

karma or moral demerit (*baap*). The severity of an illness is of fundamental moral significance; it is contingent upon the degree of merit the sick person has accrued in his/her previous life from merit-making activities (Muecke 1979). Thais generally believe that the amount of merit they accumulate impacts upon the severity of their health disturbances and how they cope with the degree of suffering they experience during life. If a family member makes excess merit, it may be extended to the member suffering mental illness. The latter may then regain his/her mental health.

Belief in spirit possession is still active in the country's rural areas, Even though limited study has been undertaken of the connection between drugs and folk explanations of illness, belief in karma is also sometimes used by drug users to explain their addiction. Drug use is considered a result of bad karma. Ben (a 47 year old male) said: "You know the truth…the reason that I became a drug addict is my bad karma in the previous life. I was brought up quite well, and I am the only one in the family or among my friends who became a drug addict. That's because of the bad karma." The Thai medical system has more recently been influenced predominantly by the Western medical model. Thus, contemporary images of mental illness in Thailand are - in the main - products of Western influence. Western modalities treat not only mental illness with pharmaceutical therapies, but also drug users; for example, in the 1980s, the Ministry of Public Health adopted Methadone Maintenance Treatment (MMT), a process used for detoxifying opiate addicts. Medical discourse is socially accepted as the legal social control for mental illness and drug users given that it has the potential to restore them from 'abnormal' to 'normal'.

There are also some important distinctions between drug addiction and mental illness. In the case of illicit drug users, unlike those afflicted by certain forms of mental illness, Thai society allows limited public space and alternative modes of causal explanation for their condition. Drug addiction is not interpretable from a lay person's perspective: the drug user tries to keep his/her problem out of the public gaze due to legal and media-disseminated panic which focuses on users as the potential cause of social collapse. Mental illness, on the other hand, is viewed as an individual problem, often with a

largely supernatural genesis such as malevolent spirits. What remains similar is that both mental illness and drug addiction are subjected to forms of social control.

Social Control and Segregation: The Concrete Boundary

Current forms of social control over drug use are influenced by previous forms of regulation over mental illness, which imply the separation of binary opposites: good and bad; healthy and unhealthy; normal and abnormal (Foucault 2006; Potter 2003). Many societies have used social control as a means of surveillance of those they saw as causing harm to society. Conrad and Schneider (1992) divide social control into two categories: informal and formal. Formal social control includes institutionalised structures such as the criminal justice system and education and welfare, whereas informal social control relates to self-control and relational control (ibid). Self-control, or what society calls 'conscience', is expressed in the form of internalised norms, beliefs, morals and concepts of self. Relational controls are a feature of the face-to-face interactions of everyday life such as gossip, praise and glances (Conrad&Schneider 1992:8). As I have suggested in previous chapters, people who inject drugs confront both formal and informal social control: their behaviour is socially labelled as deviant and polluting.

The segregation of disordered or unproductive people has a long history. During the Middle Ages, Bethlehem Hospital was the symbol of disastrous treatment for the insane (Neely 1991). Confinement-like prisons functioned as control units for housing the dangerous (Rhodes 2004). Foucault (2006) refers to the segregation of the madhouse or places that were built either to isolate or incarcerate undesirables, removing them from contact with the rest of society as though they were carriers of contagious diseases. According to Foucault, rather than being a symbol of protection, segregation is a symbol of unproductive citizenship. Increasingly from the 17th century onwards in Western countries, the state built places of incarceration such as prisons or hospitals in which they could segregate the afflicted. In more recent times, after being subjects of legal and medical intervention, patients/addicts are both treated and at times cured by a combination of the public health system and local doctors. However, this may also

imply that people are trapped or coerced into being subjects of social surveillance or into what has been referred to as the 'Panopticon'- the viewing of social regulation. Foucault describes the Panopticon as:

> … A type of location of bodies in space, of distribution of individuals in relation to one another, of hierarchical organization of disposition of centres and channels of power, of definition of the instruments and modes of intervention of power, which can be implemented in hospitals, workshops, schools, prisons (Foucault 1977:205).

The Panopticon was a particular construction designed to incarcerate perceived 'polluted' individuals such as prisoners, patients, workers or any groups in need of surveillance. What makes the Panopticon distinguishable is its internal structure: the inhabitants were put into cells/subdivisions/or compartments individually. Due to the design of the structure, the inhabitants could neither see the inspector nor communicate with others; but, the inspector located in the tower could observe and monitor the imprisoned at any time. Referring to this site of surveillance as a 'laboratory of power', Foucault (1977) claims that the Panopticon is an exemplary technology for disciplinary power of bodies, space, and knowledge. He further suggests that other institutions such as hospitals, factories and/or schools resemble the Panopticon in that they are suited to its surveillance structure. Foucault (1977:208) refers to Panopticism "… [as] The general principle of a new 'political anatomy' whose object and end are not the relations of sovereignty but the relations of discipline." The State used the Panopticon as a means of self-control: those within it must learn how to behave properly and control their self-body (Foucault 1988).

The Panopticon is not only a symbol of power: it is also a symbol of the disciplined body which, as an abstract notion, later spread to many forms of governance. Researchers have studied how the Panopticon has been adapted to new technologies such as CCTV (closed circuit television) or other forms of surveillance (Lyon 1994). Importantly, the key effect of surveillance is for people to be conscious of their behaviour at all times. Self-control is the ideal end result. One can also use notions like the Panopticon from the broader perspective of impacting the lives of drug users. For those injecting drugs, social responses are a key means of surveillance: family

members, policemen and/or community leaders function as inspectors, who take on the role of monitoring their behaviour, i.e., ascertaining whether they are currently using or not. In order to avoid the 'inspectors'' gaze, people injecting drugs in turn establish their own internal boundaries as a form of resistance that aims to protect their sense of self from constant discrimination.

Pollution, Morality and Drug Use

Injecting heroin or amphetamines have been linked to impure conditions, blood, and HIV, all of which coincide with what Douglas (2002:6) labels 'dirt' or 'disorder'. Douglas (2002) links notions regarding pollution that are embedded in our social reality to moral rules that have been constructed in response to a belief in dangerous contagious diseases. In the public perception, certain drug rituals, for example sharing injecting equipment among a peer group, create a public perception of impurity or disorder that impacts upon the notion of good citizenship. The negative connotations of drug use tend to arise from drug rituals such as the commingling of blood, needles and injecting (Manderson 2005).

In many cultural settings, blood outside of the body is synonymous with notions of pollution; e.g., the image inferred by the media that all drug users share one syringe filled with contaminated blood in hidden dark places in alleyways of urban slums. Rod, a male injecting drug user, said: "We are judged worse than other drug addicts. We are in the lowest status because we inject drugs. The problem is the injection. The society could not accept people who hurt themselves." Jack added: "My mom asks me why I have to hurt myself. Why do I have to use syringe and inject something into my body."

Douglas (2002) maintains that notions of hygiene and dirt are embedded in everyday life through rituals, rites and religions. Medical intervention has discouraged the sharing of unclean needles on the grounds of hygiene, a viewpoint based upon the well-known fact that users sometimes share the same syringe. Hence, advocates have tried to replace the idea of 'dirty' drug users with a hygienic image by promoting needle exchange programs and methadone programs. The social response to drug users is to try to

cleanse them of the contamination caused by the drugs they use. The equipment and conditions surrounding drug consumption such as needles, syringes, blood, HIV and body weakness are linked to the notion of an unhealthy body.

Drug users themselves on occasion exhibit overt markers that expose them to easy stigmatisation: signs of deviance such as many tattoos, together with thin build and blackened teeth, are nowadays taken as indicators of HIV. Society's everyday prejudices are based on the dichotomous notions of hygiene and dirt; for example, members of the higher class eschew contact with the lower because of the latter's 'impure' status. Douglas notes that:

> Hygiene, by contrast, turns out to be an excellent route, so long as we can follow it with some self-knowledge. As we know it, dirt is essentially disorder….nor do our ideas about disease account for the range of our behaviour in cleaning or avoiding dirt. Dirt offends against order. Eliminating it is not a negative movement, but a positive effort to organize [the] environment (2002:2).

Douglas (2002) argues that objects themselves are not necessarily dirty: it is the place to which society relegates them that is dirty. Drugs were highly valued in some eras and bedevilled in others. Living in an unhealthy environment inevitably translates into lower status, with those living in poorer settings assumed by some to be of impure status. Crawford (1994) argues that health is the symbolic domain that creates social selves and generates certain stereotypes. Health underpins a social self that symbolises the good, respectable and responsible persons who meet the requirements of the prevailing image of class, race and sexuality (ibid). The healthy paradigm is sustained in part by the creating of unhealthy others: those who fall outside of the healthy self are identified as unhealthy or 'other' (ibid). This 'other' is precisely the subjective state of a drug user who requires separation from other social orders.

Drugs, once having become the scapegoat for fear of disorder, are considered to transform good citizens into demons exhibiting uncontrollable behaviour in the form of religious defilement such as that associated with demons, evil creatures or malevolent ghosts. For these reasons, society has tried to exorcise drug possession using treatment

programs or rehabilitation. Seemingly inevitably, drug users are vulnerable to serious health conditions if they expose themselves to the risk of HIV infection and hepatitis among other illnesses. This, in turn, reinforces the stereotype of pollution. An unhealthy condition is not viewed as the province of the individual alone: it may be exacerbated by others' responses, e.g., their parents or the community. Luke (a male user) commented:

> I was weak because of my HIV status. I have to live in the shelter. My parents don't want me to live with them because they are afraid that the HIV will transmit to the rest of family. They blamed me that I didn't protect myself. They said having a son who is drug user is unacceptable. How could they accept the fact that I was also HIV positive.

Luke's unhealthy condition stemmed from his drug use that caused not only his own suffering, but also that of his parents. Drug use is no longer an individual problem: it has become a collective cause of social suffering. Moral rules are practices based on healthy norms and a sense of control. Social control is applied to those who are identified as deviant or unhealthy. And, while the perfect, healthy body, which is assumed to be the result of a healthy lifestyle (Crawford 1980, 2006), is paraded in public, conversely, the unhealthy body is hidden in private in a tactical space created of necessity by drug users themselves.

The state, has particular strategies in place which aim to ensure the good health of the people (Crawford 1994). Among these strategies is the methadone program; by substituting methadone for heroin, it is hoped that injecting drug users will regain their normal condition. Bourgois (2000:167) describes methadone programs as "an attempt to inculcate moral discipline into [the] hearts, minds, and bodies of deviants who reject sobriety and economic productivity." Drug programs are public hygiene programs that aim to purify the polluted bodies of drug users. Parents enrol their children in the hope that they will quit using drugs and return to normality. As Nok's mother informed me: "I have tried to send her to any treatment program that I heard could successfully help her stop using drugs no matter how far it is. But she just stays there for 3 days and runs away." For drug users' parents, treatment represents the only hope they have of bringing their children back to normalcy, even as they know that the result might not be

successful. These programs function somewhat like washing machines: they aim to wash away dirt and pollution. It could be suggested that they work in the same way as spirit doctors cure mentally ill people, that is, by expelling bad spirits. The patient recovers from the illness when the bad spirits are vanquished. Similar to the notion of Panopticon, methadone programs work to control the docile body under regulation (Keane 2009). Moral codes underlie specific health regimes ordered to enforce perceived appropriate behaviour. Later, this becomes the collective belief or popular perception concerning drug users. Injecting drug users are used as an analogy for expressing a general view of social disorder. The view of drugs as polluting and dirty becomes the social, moral framework used to oppose all things considered dirty and immoral. This framework allows the government to implement broad restrictions on drug users by issuing laws and regulations that when implemented are supported by the media, which in turn incite moral panic by reporting negatively on drug users. Due to inflammatory reporting, the injecting drug user is more stigmatised than other drug users. And, while ATS is by far the most prevalent illicit drug used in Thailand, injecting heroin attracts a different level of social disdain and condemnation. Injecting is more stigmatised as it ruptures the internal to external boundary.

The Potency of Needle Use

> If there are two girls who are injecting heroin and another is smoking amphetamine on the footpath, most people will stare at those who inject heroin. They would think it is disgusting playing with blood and syringes. Those women would be the ones to be blamed, but the one who is smoking wouldn't because the act of smoking is less scary (Tip, a 29 year old female drug user).

Tip's comment illustrates the way identities are constructed through the social symbolism of needle use. Among drug user types, heroin users face more stigmatisation than amphetamine users, the reason being that heroin use is associated with injecting and blood. Needle use implicitly suggests an experience of powerlessness: of submitting to it; of suffering discomfort. The pleasure derived from the drug outweighs the pain of the injection. But, the image of bodily violation outside of specific medical procedures

is unacceptable to society and it is from this that the fear of injecting drug users has arisen. The needle is also interpreted as a symbol of death given that it is related to the commingling of blood. Manderson contends that:

> It is partly the need we often feel to deny the dark side of ourselves, to maintain securely our boundaries of propriety, which makes the social reaction to the needles so intense. There is an unspoken battle symbolic meaning being played out there - a conflict between alternative symbols, certainly, but a conflict with 'normal' society too (1995:807).

Drug rituals have threatened the boundaries of the body politic both internally and externally. It could be said that society fears emissions emerging from inside the internal boundary, e.g., blood, urine and spittle, which are seen as dirty and impure. Contact with these types of bodily emissions may expose the outsider to infection and danger. As Douglas argues:

> All margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of idea is vulnerable at its margin….the mistake is to treat bodily margins in isolation from all other margins (2002:150).

Understanding the fears posed by transgressing boundaries leads to the conclusion that needle fixation becomes a symbolic defining characteristic that separates certain types of drug use from the healthy body in society. Habitual drug use, especially by injection, is condemned by most people as the bodily boundary no longer holds. This, in turn, creates a second kind of boundary which separates the drug user from society, one that is internal and external, visible and invisible. The established boundary is like the wall between the front and back regions; that is, the public and private space. The boundary or wall exists everywhere and in places either visible or invisible as self-protection. It is a means of protecting one's space (a tactic in De Certeau's (2002) terms), a form of resistance to stigma and oppression.

The Invisible Boundary

The drug users I came to know construct a symbolic boundary because they lack power in society. Rowe (1999:2), considering the timing of the conditions surrounding the border's construction, attributes it in part to the point at which mainstream society loses its hold and in part to perceptions of borders and the routes by which perception become reality." The wall must of necessity be invisible so that inspectors cannot determine whether it exists or not. Importantly, this wall intensifies the sense of 'us' and 'otherness': those concerned have internalised their senses of difference and/ or alienation through social interaction. Constructing their own boundary is interpreted as their having internalised society's negative attitudes.

Drug users attempt to resolve the conflict of self-definition by building a barrier with which to simultaneously protect and separate themselves from hostile and critical social attitudes and responses. This form of protection is not concrete like the walls of a prison: it is a separation which exists in - and is the exclusive property of - drug user's minds, manifested in the shared practices of those who use drugs. Bangkok's drug users, who are the subjects of this thesis, share a subculture, rituals and subjectivity. They are aware that society views drug abuse as non-appropriate behaviour, a judgment that generates a sense of difference. This sense of difference draws the line between internal and external spaces and demarcates the boundary between those using and not using drugs.

The 'invisible boundary' symbolises social inequality: it is a tactic that drug users have devised to combat the social strategies designed to control them. Because they have relatively little power, those using drugs have little chance of resistance when the state identifies them as deviant and out of control. Drug users build their invisible wall so that they can hide within its confines. They rarely open themselves to the public. The wall has meaning: it makes them feel safe; behind it, they can enjoy a sense of belonging and normalcy with those who share their subjective experiences. Joke (a 29 year old male) voiced a view commonly held by my informants: "Home is not home anymore since I use drugs. I feel like it is not my place." And Jack said: "Those who never use drugs would never truly understand us. How we feel when we want drugs? How we feel when others see us? It is only us who understand this feeling." In other

words, the invisible wall accentuates the sense of difference between 'we' and 'they' and 'I' and 'you'. Those who use drugs are considered to be 'us': those not using drugs are identified as 'them'. But, while users erected the boundary as a secure place, somewhat ironically it has only succeeded in excluding them from social activities and interaction. In similar fashion (although arguably for different purposes), society has also created its own boundaries for inclusion and exclusion, employing several strategies including the power to categorise drugs as illegal. The types of question typically being asked of drug users, by those around them for example: 'Are you still using drugs?' 'How can you raise children to be drug users?' 'Why can't they quit using drugs even though they know they render them unhealthy?' reflect the general social attitudes toward drug users. And yet, the more society creates stigma and discrimination, the more the subjective sense of invisible boundary is strengthened. It is therefore difficult for others to penetrate the boundary for it is invisible and hard to deconstruct; more importantly, it is linked to self-perception. Those protected by it have to present in ways that society will accept them: that by so presenting they can stop using drugs. Jack said:

> No one can accept drug users. It is like we are the most discriminated against group in society. Everywhere I go they just look at us with a disgusting look. That is because we use drugs. So how could you tell them you are still using drugs? There is no way they will accept drug users.

The wall reflects the users' belief that 'those not using have never understood us', a notion that is at the root of the conflict between the insiders and the outsiders. Nok said: "If you have never tried drugs, how could you understand us? How could you understand why we continue using drugs and how much pleasure it gives?" Jack added: "My family or the nurse at the methadone clinic did not understand why we could not quit using drugs. If quitting was easy, I would have quit it ten years ago."

In sum, societies have historically built prisons and concrete walls with the intention of incarcerating madness and drug offenders; but, similarly, those using drugs also build their own boundaries to protect themselves from the stigma levelled at them by society. This reifies the distinctive division of 'us' and 'them'. It is the wall that exists inside the

users' minds, formulated as part of their drug use habitus, a form of self-protection that shields them from being hurt by external forces, in particular by condemnatory social attitudes and stigma. The more subjective experiences they share, and the more they interact, the more their sense of community strengthens. Although living in a drug community helps drug users to feel a sense of belonging, invisible forces prevail, becoming part of their selves and concretising their sense of difference. This sense of alienation, countered by a distanced sense of group sharing, represents clear problems for health projects and harm reduction, a topic I address later in the thesis.

Social Life and Performance

Interaction and performance are part of humans' everyday lives. It is through them that we acquire the meaning of things and behaviours (Berger&Luckmann 1967; Blumer 1986). Drawing upon Goffman's dramaturgical analogy, the term 'performance' refers to "all the activity of a given participant on a given occasion which serves to influence in any way any of the participants" (1959:15). Goffman explores the concept of self-representation in social interaction using as example an actor and the performance. The performance, including all action and interaction, is divided into two performative spaces: front region and back region. Drug users, like all social actors, have to perform their roles in ways best suited to please or satisfy their audiences, which are already assigned to them by the director. Here, I employ Goffman's (ibid) concept of front and back regions as a framework to show how the injecting drug user seeks to manage his/her subjective sense of self.

The difficulty with Goffman's notion is that self-representation cannot be always neatly compartmentalised in terms of performance. The subjectivity of human beings is the complex sum of their past and current experiences, that together reflect their interaction with others and their selves (Biehl et al. 2007; Mansfield 2000). Earlier, I suggested that the everyday lives of injecting drug users are marked by the social suffering they experience through social stigmatisation and persecution by the law. The suffering they face underpins aspects of their subjectivity and influences their insight into their lives wherein answers may be found as to why they act the way they do and why they

'perform' as they do. Despite a somewhat static dichotomy, Goffman's regions help us to appreciate the potency of the boundaries that structure drug users' lives.

The front region is the setting or place wherein the performance is staged and the individuals present images of self in the hope of gaining others' acceptance. In order to be accepted, in congruence with statuses, roles, and relationships, they have to perform to certain standards. The front stage interaction between actor and audience could be compared to the way people injecting drugs interact with those not using drugs in the public space: the back region is the place where the actors wear their own clothes, are devoid of make-up, and chat with their dressers and other actors.

For drug users, the back region could be considered their social group, a place where they share a particular drugs-related subject. In this area, drug users talk freely about relevant issues such as where they can find different kinds of drugs and how much they pay for them. Because drugs are illegal, the back region becomes a closed community which does not welcome intruders. As mentioned, within the injecting drug sub-culture in Bangkok, users erect a boundary to protect their area from outsiders' gaze; at the same time, the boundary becomes their self-protection from the discriminatory or socially negative attitudes evinced towards those using drugs. On the stage, a thin wall or partition separates the back and front regions. The people in the back region can easily come out to the front: but, those in the front rarely see the back region as it is hidden from the audience's gaze. In real life, a socially constructed wall divides the public and private spheres. Sometimes, it is built as self-protection from what society defines as danger or pollution; but, it also serves to protect the vulnerable from discrimination.

The reason that people hide themselves back stage is because they fear specific forms of social reaction to their behaviour. Goffman (1963) argues that 'spoiled identity' is the result of what is socially defined as deviance. As mentioned, the drug user's identity is often shaped by social stereotyping and rejection (Boeri 2004; Hassin 1994; McIntosh&McKeganey 2000). In an attempt to escape from the front stage, the drug user becomes a member of a drug group and spends much of his/her day with his

friends back stage, where they perform differently from when they are front stage facing each other. The roles they have to perform are directed by an underlying moral framework that polarises good as front stage and bad as back stage. After using drugs, the users sometimes cannot perform the assigned roles that society expects of them.

Dealing with Life: Management of Self

People who inject drugs learn how to balance their drug use through forms of subjective representation to others, which becomes an important platform for the management of the self. Management of self reflects not only self-understanding that becomes either a fleeting or semi-permanent aspect of subjectivity, but also how drug users deal with their lives both in and outside of their social group. A major concern surrounds their dealings with others who are not using drugs and their fear of discrimination and legal surveillance. But, in some ways, trying to align their lives with perceived social 'norms' and expectations culminates in a conflict of expectations. They internalise notions that their drug use is 'wrong'; seeking to counteract this impression, they present a particular version of their lives to others, saying they have stopped using drugs. Exposure of these discrepancies invariably creates conflict between users and non-users. In the words of one nurse:

> Those receiving methadone still use drugs. They told me that they all quit using drugs, but later I found out that they still use it. When we have a urine test, they use other's urine of those not using drugs. That is why the result shows negative. It is hard to believe what they say or not because all the facts are turned upside down. I don't believe what they say.

Many of my informants live much of their lives in the drug community. They find it difficult to ignore the fact that they cannot survive alone. Of necessity, they avoid maintaining relationships with mainstream society and interacting with non-drug users. Hence, they have to employ tactics that facilitate a balance between their drug lives and their social lives or social selves through self-representation. What becomes apparent is that drug users cannot avoid social suffering by confining themselves to the drug community back stage. They have to employ appropriate tactics that will enable them to

balance their lives between two social spheres. One tactic they use is what Goffman (1959) alludes to as the 'technique of impression management'; in other words, how performers manage their selves to impress their audiences or deal with 'inopportune intrusions'.

By continuing to interact with those in the public arena, drug users try to convey the impression that they are following the social rules and norms of good citizenry. Take, for example, female drug users who have tried to raise their children themselves. In such cases, the female drug user is seldom considered able to perform the role of 'good' mother (Campbell 2000; Fraser 1997; Rosenbaum 1988; Taylor 1993). From the public's point of view, this is very harmful to children: society sees these women as 'bad' mothers. Drug users have internalised negative images of bad parents, who either wittingly or unwittingly introduced their children into the drug community. If they can, some ask their relatives to adopt their children or ask their parents or in-laws to raise them in the belief that living with non-users will give them a better chance in life. Altrenatively, some choose to raise their offspring themselves. This means trying to balance their personal drug-related needs with their social roles as parents. Ko confronts this dilemma on a daily basis.

Ko, a male RakJai outreach worker and father of two sons and one daughter, has been divorced twice. He asked his aunt to adopt his first son. Now, he lives with his parents in a small community. Ko's mother is a food vendor; his father, an alcoholic, does not work. Ko's daughter is 11 years old: his youngest son is 10 years old. Ko said:

> I have to admit that I used drugs sometimes because there is no way out. Last month, when I thought of committing suicide, I thought of my son. If I died, who will raise him? When I think of running away, I think of him, how can he live? He is the most valuable thing in my life. I don't want him to grow up like me.

Back stage is the place that provides assistance to the performer: the audience may not be able to see it as it is a private area; the audience may not intrude 'back stage'. It is treated as a place in which actors reveal the essence of their selves with little influence

or force from the front region. They do not have to act according to the demands of their roles. Goffman argues that actors try to hide any details that may discredit them.

> The past life and current round of activity of a given performer typically contain at least a few facts which, if introduced during performance, would discredit or at least weaken the claims about self that the performer was attempting to project as part of the definition of the situation (1959:209).

Front stage, the particular setting influences how they should perform in accordance with social expectations. These rules are very clear for drug users. "Do not use drugs." Resolving the disparity between the two social fields creates specific tensions that add to the overall dilemmas that drug users face. Jack admitted: "The nurse at methadone got mad at me after she found out that I am still using heroin. She refused to give me methadone for 3 days." Yim, a nurse, commenting on users' behaviour, stressed:

> If they want to take ARV, they have to stop using drugs first. Taking ARV needs to be well-disciplined because the patients have to take it punctually for the rest of their lives. How can they get ARV unless they show me that they stop using drugs? I heard some of them sold their drug (ARV) to others.

When the drug users I came to know interact with those not using drugs, they try to make a good first impression by pretending that they can successfully perform appropriate social roles.

> Nayot, a drop-in centre manager, stopped using drugs for many years. Many nurses and staff members admired his success. In 2008 (the second year of my data collection), I heard the rumour that he was reusing drugs. He hasn't admitted that he reuses drugs and has tried to hide his drug behaviour from others. Nok told me that he asked Sor to buy drugs for him. Nobody knows. He hasn't dared to tell anyone as he is afraid of losing face.

Overwhelmingly, the drug users I spoke with know that they cannot reveal life in the back region as it would lead to discrimination against them. Thus, when interacting with those not using drugs, they try as hard as possible to impress non-users by telling them that they have stopped using - even though, in fact, they are still using. These heroin

users present themselves according to certain assigned roles and social expectations. They must try to fulfil whatever society expects of them, try to improve and be considered 'good' so as to please others, e.g., friends and/or parents. They need to rid themselves of their negative drug user image. During my fieldwork, many assured me that they had quit using drugs and were now taking methadone to reduce their cravings. Later, I heard their friends gossiping that they continue to use drugs.

Nok spoke about one of her colleagues, Sor, as *lok tua eng* (หลอกตัวเอง) meaning 'to deceive oneself':

> She tells everyone that she has quit using drugs. In fact she hasn't. She is *tua-jing*, (ตัวจริง) a drug dealer. She takes drugs even within the house. She tried to present to others that she is clean now. It is disgusting. She doesn't accept her true self and keeps presenting the lie to others. If she uses drugs, why can't she accept the fact. She always denies it. She doesn't want to let anyone know that she is a drug user - that is why she would prefer to spend her time with the staff ftom headquarters (non-using drug staff). She tries every way to please them and be part of their group. She asked the staff to attend her sister's graduation day. She wants to show off to her parents that she now hangs out with only good people, not those using drugs.

Like others, Sor has her reasons for not revealing her use. The first time I met Sor, she told me that she had stopped using drugs and was now on the methadone program. A Muslim woman, who grew up within the Muslim community in Bobe, a commercial area of Bangkok, she lives with her mother and grandparents. Her parent divorced when she was young. Later, her mother remarried, to a policeman. In this marriage, her mother gave birth to two daughters and one son. Sor started using drugs when she was 14 years old, in time graduating from smoking cigarettes to injecting heroin. Her step-father was promoted to a high ranking police officer position. When Sor was caught by the police, her step-father bailed her out. Sor described the situation:

> I felt guilty. I couldn't get along with my step father, but he used his official [position] to bail me out. He should be promoted to a higher position, but he couldn't because of me. Because of my drug habit, the department suspects that he would be a drug dealer. He wasn't but I was.

For people injecting drugs, social acceptance means denying aspects of their selves and taking on the role of social norms (rather than drug norms) in public. Nok commented: "My parents could not take in the fact that I am still using drugs. So, when I am with them, I have to act like normal. I am craving but I have to hide it. It will break my mother's heart if she finds out that I am still on drugs."

Eventually the back stage influences the ways in which these individuals act in public. Drug users have to hide the fact that they use drugs, particularly from intruders or those without drug experience as they fear discrimination. But, for their friends who see both sides, the conflict of representation gives rise to negative attitudes as they appear to be deceitful people. During my field work, I met drug users for the first time at a drop-in centre. All of them told me that they had stopped using drugs

In November 2010, Nok, who I mentioned in the prologue, called me again. I was aware that she was high. Her voice was unclear and she could not focus on our conversation.

> Nok: My boyfriend, Rat, he was arrested. I am not….I am at prison now.
>
> Me: What? Have you been arrested?
>
> Nok: Yes…oh, I mean No.
>
> Me: Are you OK? Have you been using drugs?
>
> Nok: No, I didn't. I just sick and I vomit twice. Maybe I call you later tonight.
>
> Me: OK, take care.

Nok didn't call me. I talked to a staff member at the drop-in centre who told me that she was using drugs heavily. Everyone who shares the backstage experience understands why users choose not to disclose their habit; but, relapses fuel on-going suspicion. It was not only Nok who refused to acknowledge her drug relapses. Many drug users refuse to admit to each other that they are still using drugs. This becomes gossip among the drug community and also causes dissatisfaction among those not using drugs such as nurses, family and staff.

Thus, a conflict of representation occurs when the subjective experience does not meet the objective structures to which people are meant to conform. Conflict occurs when the audience discovers that the drug users' representation is just a performance that contradicts life back stage where they are dissatisfied with the degree of disorder. This conflict of representation might be dismissed if society could accept life back stage. In fact, the conflict between back (private) and front (public) stems from the fact that society lacks full understanding of the nature of the context of the back region (drug community). As a result, the public's negative attitude morphs into discrimination against drug users; in this way, a spoiled identity, i.e., *khiya*, becomes a predominant label and imposed identity.

The Back (Private) Region: the Meaning of Drug Community Formation

With a few notable exceptions, in the past the term 'drug community' was seldom used in literature on substance abuse as the term 'community' is usually imbued with positive meanings such as healthy community, or community empowerment and so forth. Recently, according to Bourgois and others, researchers have begun describing the drug community as a particular social space, a place for belonging, sharing, sheltering, resolving, conflict, fighting and consoling (Bourgois 1996; Bourgois&Schonberg 2007; Maher 2000). Singer (2006:72) refers to drug communities as 'assumed communities' 'constituting [a] community of people … [who] have shared experience, sentiment and interaction'. In order to appreciate the subjective sense of the drug user, one must familiarise oneself with engaging in, living in and making sense of their world.

In Bangkok, living in the drug community means separation from society or from the public in general. In response, injecting drug users have sought a hidden place for socialisation where they create their own space or group.

> While addicts fear exposure to the conventional world and the possibility of subsequent arrest and incarceration, non-addicts often fear exploitation of and theft by addicts. Consequently, addicts and non-addicts tend to stay away from each other; so for the addict, an insulated social world is formed, composed almost entirely of addicts (Rosenbaum 1988:48).

In Bangkok, heroin users congregate in different places as part of a social group. It could be a methadone clinic, a bus stop, around a street vendor or in someone's house. The community is initiated when through using drugs with peers. In the mornings, members of the drug community I researched usually gather in front of the methadone clinic, chatting about life and drugs, especially about where they can find the latter. Drug users experience feelings of sameness when they 'hang out' together. At the methadone clinic, they can talk and share drug information in public. And, despite the fact that the nurse or health professional asks them to leave as soon as possible after taking their methadone, the drug users often congregate at the bus stop or at a coffee shop on the footpath adjacent to the clinic. Noo said: "The nurse asks us to leave immediately after taking drugs because they are afraid that we would run the drug business in the clinic. So we have all moved to the next place." Nok added: "We don't have a place to stay. People are afraid of us. They think wherever we are, something bad might occur".

Plate 7. Bus stop in front of Methadone Clinic where users hang out

Many of my inform ty of time to hang out together: if they had money they bought drugs. Rat told me: "We usually pool money to buy heroin. In the past I injected with several friends. One is responsible for preparing

the equipment whereas the other may offer their place as an injecting site. The other takes the risk of buying heroin." In any public space, there are pressures to avoid any indication of drug use.

> Around 8.00 a.m., I went to Lad Prao methadone clinic with Nuu. Several of them were still waiting for the nurse. They were chatting. As I knew several of them already, Nuu didn't introduce me. Lao Prao clinic is next to the street. After taking methadone, they walk cross the street and sit on the sidewalk gathering as a group. Nuu said to me in hushed tones: 'We can't hang out in front of the methadone clinic because the nurse doesn't like it. She is afraid that we might sell drugs'. Around 9.00 a.m., they split into a small group and walked away. Ruck, a 45 year old male user was upset: "Damn it, they didn't let me go with them as I don't have money." He started complaining about how disgraceful those two guys were as he once used to give his drugs to them. I talked to Nuu quietly and asked what they were looking for as there were 5-6 people still sitting in the same place. Nuu answered: "Here she comes." Then, a young woman joined the group. She was around 20 years old. When she arrived, Jib said: You've come late today.' She replied: "I had big fight with my boyfriend." She took out her notebook, and asked: "How much for today?" The woman replied: "Five hundred baht". Jib handed her the money.

It is not just purchasing drugs but also within the drug community that female drug users learn how to inject from their male counterparts.

> At first, I was afraid to inject myself so I asked my friend to do it for me. I have to give him an amount of heroin for the fee. It is not worth it so finally I have learnt to inject myself. It was such a difficult task at first, but now other friends ask me to do it for them.

While supporting and consoling are part of the drug community's interactive role, in essence, drugs are the core component of the relationships. Phet commented "because of the high price, the drug users gather together and pool money to buy drugs. They are unable to afford heroin independently." People injecting drugs feel that their drug friends understand them; hence, they can reveal their innermost selves to them, a process known as 'drug socialisation'. Yui (a 31 year female informant) told me: "Since using drugs, I feel the difference. I do not like them, the friends who are not using drugs. I don't have time to play football or go out. Only thing I think of is drugs, where

and how I can get drugs." Yok (a female user) confirmed about her relationship with others that:

> When my friends found out that I am using heroin, they stopped talking to me. They refused to go out with me or even have lunch together like before. So I turned to a group of friends who are also using drugs. They have never turned me down.

In this particular Bangkok milieu, it becomes apparent that the impact of external forces has been instrumental in injecting drug users' decision to remove themselves from mainstream society. Their sense of difference forces them to construct their own community as a way of establishing their own particular sense of normal interaction. It is a symbolic form of a practiced domain. Their community becomes the place within which they have to learn how to manage their selves and their relations with other drug users through social interaction outside of the community; that is, with non-drug users. Being with other drug users fuels a sense of 'us' among those who share the same experiences or destinies. For some drug users, their friends in the drug community are closer to them than their family members: there is no invisible wall between them. Nuu (a male user) said:

> When I first knew I was infected with HIV, I was stressed. I could not tell my family cause having a son being a drug addict is the worst yet. How can I tell them I am infected with HIV? They would definitely discriminate me. Finally, I talked to my friend in the drug community. I knew they would never act against me 'because they thought one day they may get AIDS as well as me. For us, AIDS is like the things live around us.

In recent years, public health approaches to harm reduction, along with the increased profile of advocacy movements, have significantly impacted upon the drug community (Singer 2006). The emergence of harm reduction in Thailand has profoundly changed the pattern of established markers in the Thai drug community. The drop-in centre has become a private space that exists in the public domain: it is the entrance through which audiences such as NGOs, workers or people like me can observe the back regions of

drug users' lives. The drug users now can congregate at the drop-in centre after taking methadone. Yui (a female user) said:

> At first, I didn't want to come to the centre. I didn't know what that place is. If I come, the police may come after me. Then, Dang, my old friend, told me that it is a place for us drug users. We can chat about drugs or meet old friends and share experiences. So I decided to go.

In short, the drop-in centre provides space which allows people to inject drugs in public: it acts like a bridge between the public and the private. It is a chance for drug users to return to normalcy; for example, to learn to live with others and join in some activities. It also provides non-users with an opportunity to understand how addicts live - indeed cope with - experiences that are not part of the ordered Thai society. In Chapter 6, I will explore further the degree to which drop-in centres play an important role in people injecting drugs' lives in Thailand.

Drug Socialisation

Whether it takes place at the drop-in centre or at more informal gatherings, drug socialisation is reflective of a society or community that instils social values into newcomers or introduces the individual to collective activities. The process of drug socialisation emphasises the meaning of the social and collective will; in the main, it provides members with information related to all they need to know to belong to the community; for example, where they can get drugs, which seller gives the best deal, which drug they should try if they cannot find heroin and, these days, how to access clean needles. Their everyday lives - or lives back stage - create the scenario wherein their lives are organised around drugs.

Drug socialisation introduces drug users to the drug community in which ritual ties connect them and help them survive. For example, at their meetings, I could see users from other urban areas share their drug information and the using methods they employ in their particular settings. Drug use becomes the central glue that binds the social network: the latter can extend beyond the immediate urban setting. Drug users in northern Thailand may know the groups in Bangkok through introductions made by

peers who used to live in the area and vice versa. In their extended community, in order to be a drug dealer, a good network is required as well as special skills, especially good connections. Many drug users establish these connections while in prison. Rat, who was in jail for nine months, said: "I made a lot of friends while I was in prison. Many of them were drug dealers, one big guy. That is why I get drugs for free. Sometimes I visit his house and then they just throw drugs to me for a favour. How can I refuse?"

According to my informants, when socialising among themselves, their conversation tends to revolve around drugs and the lives of other drug users; for example: Who will give you the best price? Who has good quality heroin? Who is infected with HIV? Who has been caught by the police? What should I do to get money to buy drugs? The following excerpt from my notes highlights the degree to which conversation centres on drug issues.

I accompanied Nok, a RakJai outreach worker, to the DinDang methadone clinic. Nok has collected her methadone here for many years so she knows all of the staff members who have worked there. Her friends also take methadone. It was early one morning, around 8.00 a.m. Three people were sitting on a bench in front of the methadone clinic. Nok greeted them and introduced me as a student working on a thesis about injecting drug users. They knocked as a sign of recognition. One male, who was young and well-dressed, started asking me questions. Then, the others started to talk to Nok about her life and other drug users in the neighbourhood.

> **Tong**: Did you know that Off was arrested by a policeman? He was too drunk because he takes glue. Someone told me that Goy robbed him.
>
> **Nok:** Really?
>
> **Tong**: Goy is very rich now. Have you seen her gold necklace and ring? She wants to show off.
>
> **Nok:** I remember that time she was homeless. She had nowhere to go, no home. She and her son slept on the hallway of my flat. She became a beggar and asked everyone for money.
>
> **Tong**: Yes, I remember. That time I gave her some money. She used to say that she remembers who helped her in the past.

> **Rak**: It might be Goy since now she sells Midazolam here. She wants to get rid of Off because he sells at a cheaper price than her. That is why she tells the police about Off.
>
> **Tong**: Yes, she is *neuw* (นี้ว a police spy) among us. She can tell us drug information. She tells the police to arrest the ones she hates.
>
> **Me**: Why do the police follow her orders?
>
> **Jack**: Because the policeman will be promoted if he arrests many drug users and I guess Goy may pay him some money.
>
> **Rak:** Well, but anyhow, Goy lent me some money to buy drugs. Have you heard about the heroin seller at LadPlow? The quality is quite nice. I have pooled money with him to buy heroin. It (the heroin) is coming back now.
>
> **Tong**: I borrowed money from Goy - 2000 baht to buy heroin. She said she did not ask me for the interest because she knew that I used to help her when she was poor.
>
> **Nok**: So now she lives with Au. Au is not a bad guy. I didn't like him before. **Jack:** He hit her several times but she could not leave him

The above conversation centred on the life of a female drug user, Goy, who is part of their social group. Amidst this gossip, the community fosters a sense of understanding and sameness among its members as well as highlighting who can or cannot be trusted. Too (a 40 year old female drug user) told me:

> I understand how she (Goy) felt when their parents did not allow her to be at home. They thought she might steal something. I have felt that. It is like you have no one. You couldn't go any place or talk to anyone besides your drug friends. They understand me the most, better than my parents or family. They know how hard it is to endure the symptom of drug craving.

As suggested earlier, activities associated with those injecting drugs are seen by many as harmful and likely to pollute society. The drug subculture and the drug users' activities become part of their everyday lives, even as their alienation is intensified. As the majority of drug users I knew were unemployed, some opted to work as drug suppliers or drug dealers. Drug dealing is considered a suitable job: its informal schedule guarantees the workers that they can use drugs whenever they choose. Money

is a major problem in most users' lives: borrowing and lending money is an everyday social occurrence because users need money to buy drugs. Most friends who lend money will demand interest for this is part of their income. For example, if they borrow 1,000 baht, they may have to add 200 baht as interest. The lenders are confident they will get their money back. Nok explained: "I just gave money back to Noo with some more money as interest, so he feels at ease to let me borrow money next time."

Living in the drug community, the drug users share their suffering and cravings, drug use, and the stigma, discrimination and criticism levelled against them. But, as we saw in the recent conversation, they also inherently fear and mistrust each other. It seems that it is difficult to establish good friendships in the drug networks, despite the fact that they share drugs and shelters. People who inject drugs start relationships by sharing drugs, pooling money to buy heroin, allocating drugs to craving friends or allowing them to share one's room. Rak commented: "sometime your friends make you feel at ease, but then a few minutes later they become your enemies. That's our life. It is like the word friend is like enemy."

Many informants mentioned that even when taking part in a shared drug experience as a form of social bonding, it can also be interpreted as fomenting distrust among friends. For example, a friend steals another's belongings when he/she is high: an addict gives money to friends because they may be the only persons able to access a seller. The 'friends' abscond with both the money and the drugs. While drug users may allocate some heroin to friends who are craving drugs, what they have learnt from the socialisation process and their own experiences is to distrust everyone. Almost all of the people I spoke to know that their closest and/best friends or partners will steal their drugs. Thus, their creed is: trust no-one. Jack said: "When I was on a high, my friends robbed me. Everything was gone, my money, my gold necklace and other stuff." Sak bitterly complained "I hate her. She stole my heroin. That girl can't be trusted."

But, it is not only theft that triggers distrust. The betrayal of drug users is referred to as *chi* (จี้), the act of being caught by police who have received information from other drug

users. Sometimes, however, *chi* is the means of avoiding being apprehended by the police.

> Tui is a female drug user and retail drug seller at the DinDang methadone clinic. She and her ex-boyfriend Kon sold Midazolam for 50 baht per tablet. She got annoyed with Kon because he undercut her price, selling the drug for 40 baht per tablet. He also beat her when he was high and refused to give her drugs. So, she reported Kon to the police, telling them he was a drug seller. Kon was duly arrested. Nok, unimpressed by Tui's behaviour, said: "She just did it again. She told the police who was selling drugs. My friends at the methadone clinic all hated her."

To avoid a prison sentence, some users will agree to act as spies for the police, Drug users tell the police the names and addresses of drug dealers; then, the policeman will pursue the drug dealer rather than the users. If the latter are caught by the police, negotiations commence between the two parties. The police offer to release them if they disclose the identities of the drug sellers. Catching the dealers boosts police profiles far more than if they only apprehend the users. In order to survive, the latter will say that the seller seduced them in their determination to peddle their drugs. Jo, a male drug user, described this arrangement: "The police don't want to just catch the drug users. They want to make a big profile in order to get promotion; so, when they catch us, they usually ask us to tell them the big name (the drug seller)." Buab (a male user) admitted:

> At that time, I had to survive. I had to tell them the name of drug seller even though they were my friends. What choice did I have? The answer was 'none'. If I didn't tell the truth, the policeman would make a big charge on my case. Everyone must do it the way I do. It is simply normal in our lives.

Nok related the following:

> Ott called me late one night. He asked me whether I could get *yaba* for him. I have no idea why he called me. He said his foreign friend wanted drugs and they are all nearby my house. He asked me the drug price and negotiated with me. He wanted many pills. There was a lot of noise like someone forcing him to speak. Finally, I told him I couldn't. It was a dark night. Not worth trying if I was caught by the police.

This turbulent, uncertain environment has created a sense of distrust among them. Even though drug users have to develop tactics to enable them to survive in difficult surroundings, it remains difficult for them to learn to trust others. Friendship is always compromised. As Sak said:

> In my life, I had never had a drug friend who I could trust. At that time, when the police forced us to tell who the drug seller was, we would tell the truth in order to survive. You see I rarely pick up the phone now, especially if I can't recall the new number. Well, I understand why they sell me. Maybe if I was slapped, I would tell the police all. I'd probably do the same as they do.

The drug community is considered by many to be a world of human faults, which taken together represent the darker side of humanity, both for the users themselves and those interacting with them. Social perceptions combine to create images of a drug world that is built around pollution, dirt and sin, all of which combine to cause social disorder. This coincides with the picture painted by the media that stereotypes the subjectivity of injecting drug users. Within this devalued context, users seek to reposition themselves both socially and physically.

The physical body is not only an entity that attracts social identification and stigmatisation. It is important to note that those injecting drugs use their bodies as sources of pleasure: this often reflects how they think about themselves, and how it is linked to their self-worth. The ways in which they use their bodies is inevitably a form of self-management, symbolic of their social interaction with others. Similar to a theatrical performance, the audience attempts to interpret the players' body actions in a bid to determine how they feel, i.e., whether they are sad, happy or mad.

In some cases, people I know also used their bodies as a means of gaining money to buy drugs. As I will suggest in the next chapter, sex is one way of achieving this. But, as drug using groups constellate as a form of social movement, so too their bodies have value as research commodities. There is a high rate of HIV among drug users; for this reason, the Thai authorities, in tandem with international organisations, have organised many clinical trials for HIV drugs, which have required the recruiting of drug users as

trial participants. The organisers of the trials give users money in exchange for blood tests and medicine trials. As the majority of drug users are unemployed, the money they receive for participating in the trials becomes their main source of funding with which to buy drugs. Noo, who participated in the Tenofovia clinical trial, said: "The money is not much, but I receive approximately 3,500 baht a month. I could survive with this money to buy drugs and food." Buab commented: "Usually, I received 200 baht per interview and 500 baht for giving my blood." This interest in drug use as having value to outsiders extends to researchers. Jack commented on his experience: "Any interviewing, don't forget, if you know someone needing people injecting drugs information, you have to tell me first." Noi said: "Even when I was in prison, the nurse came in asking me to answer some questionnaire or fill out a form." At a more personal level, men and women experience and exploit their bodies differently. For example, female drug users feel a sense of disadvantage compared to male drug users, especially if their veins are difficult to find due to constant injecting. Noi said: "My friends inject and are on a high for hours, while I am still looking for a vein to inject. Women are more difficult to find veins [in] than men."

In the injecting drug community, a woman's body is at a disadvantage due to its psychical characteristics; for example, as Noi indicates women sometimes have to seek help from their male counterparts when injecting. The drug community reinforces a sense of male domination. Male and female injecting drug users may use different tactics to deal with the situations they have to face or the people they have to interact with both within and without the drug community. Given that the drug community is male-dominated, female injecting drug users have to rely on other resources to survive in the community. And, as drug use is considered a male activity, using drugs projects women into non-feminine spaces, a subject I address in the next chapter.

Chapter 5
Gendered Drug Use

Preamble

Jeab, a female drug user, lives alone in a small, squalid, wooden stilt-house in an overcrowded area of Bangkok. The community, which is well-known among drug users as a drug sellers' hang out in Bangkok, is commonly called *Trok khi ma* (dog shit). I met Jeab twice, the first time at the RakJai drop-in centre and the second time at her house. She is handicapped; the veins in her leg became badly infected through needle use and now she has lost use of both legs. In addition to heroin, she also uses amphetamine. Jeab rarely goes out: she can only go to the centre if the outreach workers carry her to the entrance of the slum from where she can take a taxi to the centre. An outreach worker must accompany her back home; but, often no one is available so she can't visit RakJai on a regular basis. I noted that every time she goes out she seems energetic and eager to talk to others.

Due to drug use, Jeab has been unable to walk properly since she was 18 years of age. Like others in her neighbourhood, her house is situated next to the canal: sometimes she uses canal water for bathing, housework or for washing dishes. One of the house's support poles is old and about to collapse. Jeab told me that her father said that if he had enough money he would fix it. Jeab lives alone in this house; on occasion, she is helped by a neighbour. She has a 5 year old son who lives with her father and step-mother in the same locale. Her father asks her neighbours to prepare food for her; sometimes, her son brings food from her father's house nearby. Jeab had difficulty making a decision to become a mother as she noted that:

> At the time I was a handicapped drug user and also HIV positive. I became pregnant and the doctors, nurse and my family told me to have an abortion. They all thought that I was incapable of caring for a child. I cried a lot because I didn't want to have an abortion. Finally, I decided to keep him. I was lucky that my stepmother did not give my father a child so they adopted him. They love him very much.

Even though Jeab cannot walk, she earns some money as a drug middleman. When her friends come to her home asking for drugs, she calls a drug seller who is well known to her. She gets money either from the drug seller or from her friends; sometimes, she receives drugs as a bonus. Her ex-boyfriend occasionally stops by and gives her some money.

Jeab told me that she began using drugs with her friends when she was 14 years old. Soon, she was buying drugs, and, because she was pretty, the drug seller asked her to live with him and she agreed. She said:

> At the time, I did not have to worry about drug supply like others because my boyfriend sold drugs. I could use heroin as much as I wanted to. One day he was arrested by the police. I was so messed up. I did not know what to do or how to survive. So, I decided to stay with another man. He was a good guy. We decided to be retail drug suppliers. I knew a 'big guy' so I got the drugs from him. It was a good business and we made a huge profit until I was arrested. At the time, I was pregnant so my man asked the policeman to arrest him instead of me. He knew it was difficult for me as a handicapped and pregnant woman to live in prison.

Later, Jeab learned that her boyfriend had died while he was in prison.

> I was not quite sure whether he died of AIDS or another disease, but many people said he died of AIDS. I didn't know much about HIV or how scary it was. The nurse asked me whether I thought I became infected with AIDS via sex or sharing a needle. I think it might be from sex because we rarely use condoms. And, I usually used my own syringe as I injected at home most of the time.

When I met her for the last time in December 2008, Jeab seemed depressed and cried a lot. Tearfully, she said:

> I may have to move to the welfare home as there is no one to take care of me. I don't want to move to another place. They said I should move to live in an NGO charity house in another province, that it will be difficult to take ARV or see a medical doctor if I stay here. I will miss my son. What should I do?

In 2011, Nok told me that Jeab had passed away. Jeab's story details some aspects of the experience of being a female drug user in Thai society wherein dilemmas arise from the lack of fit between a drug use habitus and that of normative gender ideologies, especially those relating to being a mother. It is not only because of her unhealthy condition and drug use that society judges the female user as unfit for the mothering role; in addition, her living surroundings are deemed unsuited to raising a child. Jeab had to face many difficulties that accompanied being a woman using drugs.

Images of Women Using Drugs

Women using drugs face particular discrimination because they are seen not only as offending the traditional images of womanhood, but as engaging in disruptive behaviour, being morally deviant, violent and self-destructive. As well, they are victims not only of society but on occasion of their fellow drug users (Ettorre 2004; Howard 1995). In the United States, women who use crack are referred to as 'hypersexual deviants' who are incapable of managing their lives (Boyd 2004). Such women are considered by society in general to be sexually compulsive, bad mothers and prostitutes (Campbell 2000). Women using illicit drugs is described as particularly transgressive by a number of researchers who have emphasised the illegal, untraditional, law-breaking behaviour of female drug users (Maher&Richard 1998; Young 1994). The social perception of female injecting drug users who harm their foetuses using drugs fuels additional and widespread negative feelings and reactions (Murphy&Rosenbaum 1998).

Across the world, female drug users are ensnared in a web of problems arising from the structural violence in which drug addiction magnifies their vulnerabilities (Erickson et al. 2000). Women injecting drugs face multiple dangers and threats to their mental and physical health, e.g., HIV, hepatitis, and physical and mental abuse (Carricre 2008; Cusick 2006; Epele 2002). Despite this burden, these women are less recognised both nationally and internationally within public health programs.

Generally speaking, in drug using communities throughout the world, men outnumber women; hence, neither WHO nor the International Harm Reduction Network has

specific guidelines for the treatment and care of female drug users. In addition, political factors such as law and policy create particular forms of structural violence which damage the health of women using drugs (Bourgois&Dunlap 1993; Bungay et al. 2010; Miller&Neaigus 2002). The social suffering women injecting drugs face is not confined to physical illness but extends to dilemmas caused by tensions between drug use and an overriding gender habitus.

Drug use creates social distance between female users and other men and women in society. Aspects of embodied experience embed a new sense of subjective identity. In most social contexts, women and men are trapped in powerful conventional roles of masculinity and femininity which are not easy to reshape. In this context, women's entry into the drug field involves significant transgression in two areas: first, they are using drugs; second, they have moved into a world which is coded as masculine, an experience commonly recognised as problematic on several fronts.

Social forces, family, friends and community alienate these women to the extent that they have to change the way they live in order to survive. Living in a drug community, women have to re-define their gender roles. Violence, financial insecurity, a chaotic lifestyle, the risk of imprisonment and police abuse, predatory oppression and degradation by male drug sellers constitute the everyday environment of female users in downtown Bangkok. The nature of the heroin world has been described as a 'masculine' world wherein women experience different lives from those of men (Bourgois 1995; Bourgois&Prince&Moss 2004; Inciardi&Lockwoord&Pottieger 1993). Drug use prompts changes in gender structures; and, at the same time can also constitute new forms of power for women to exercise agency (Maher 2000).

Overall, Thai women using drugs, similar to their western counterparts, face more stigma than males. They have to struggle within a drug subculture revolving around a masculine culture that challenges the social expectations of womanhood. To date, the lived experiences of women injecting illicit drugs in Thai society are largely undescribed in either popular or academic discourse. In this chapter, I attempt to examine the formation of self and habitus structures which shape the lives of my female

informants. Women in drug communities (and in the broader society) internalise different expectations and norms. I will argue that the altered habitus of women drug users' lives has a direct bearing on their behaviour, feelings and actions.

Everyday Life

Bourdieu (1977), whose concept of habitus shines a productive light on sociological and anthropological approaches, considers that the agent or individual body and the social body together represent a two way process of interaction. The individual has the agency to construct the reality. The reality one confronts in turn constructs internalised dispositions, what Bourdieu (1977:72) refers to as 'objective structure of subjective experiences', i.e., 'habitus' as the objective structure or "the structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representation." Expanding this notion, Swartz contends that:

> Habitus results from early socialization experiences in which external structures are internalized. As a result, internalized disposition of broad parameters and boundaries of what is possible or unlikely for a particular group in stratified social world develop through socialization. Thus, on the one hand, habitus sets structural limits for action. On the other, habitus generates perceptions, aspirations, and practices that correspond to the structuring properties of earlier socialization (1997:103).

The objective structure of habitus acts as a formalised code for regulating behaviours which take various forms; for example, laws, cultures, norms, roles, religions and beliefs. Through social interaction, the individual living within a particular habitus internalises the objective structures, by extension constructing their embedded dispositions. The practices of members of the same groups, class or experiences create degrees of group conformity, implying that there is a chance of sharing the same habitus (Earle&Letherby 2003). We can thus generalise this concept to different social communities, shaped by gender or those using drugs.

In short, Bourdieu's insight shows us that individual agency derives from a set of internalised and embodied dispositions by which habituated forms of action both conscious and unconscious occur (Bourdieu 1977). Swartz (1997) interprets the characteristic of habitus as durable and resistant to change even though it is sometimes modified by new experience and as such constitutes the history of the particular logic or practices. Habitus is dominated by earlier experiences which make change difficult given that the individual is embodied in and by these experiences.

The concept of habitus helps explicate the gender constructions that govern men's and women's behaviour patterns and actions in respective societies. Krais (2006:121) claims that: "The gender-specificity of the habitus is among the fundamental elements of a person's identity. It touches the individual in an aspect of his/her self that is generally seen as 'pure nature': the body." Male and female habitus differs based on their socialisation and opportunity structures (Dumais 2002). Common to many societies, the influences of social forces have resulted in girls and boys being raised to follow different socialised lifestyles (Ashton-Jones&Olson&Perry 2000). Children internalise social and cultural gender roles in association with social institutions (Butler 2006). Social structure shapes and conveys the strategies of action for gender development; schooling, for example, is one social milieu for gender socialisation (Bradley 2007; Kimmel&Aronson 2005). The lives of female injecting drug users are implicated in gender and in the drug habitus. As gendered beings, they are required to make an effort to balance two conflicting worlds.

Gender Habitus and Drug Use

Gender is socially constructed: as evident in everyday practice, it is an inhabited space, a space constructed in ways that reflect common stereotypes and assumptions about male and female characteristics and social behaviour patterns (Marchbank&Letherby 2007). Gender stereotyping perpetuates the social perception of men and women and how they should behave (Ashton-Jones et al. 2000). Gender roles are determined by a specific context of interaction and specific social situations based on cultural systems which, taken together, lead popular opinion into developing particular stereotypes and

assumptions (Brettell&Sargent 2005; Rosaldo&Lamphere 1974). For example, gender habitus delineates the feminisation of the domestic role, requiring women's responsibility in either limited or private space (Krais 2006). Externalised forces in the social, cultural and economic context shape the roles and responsibilities of men and women in society, with public and domestic space constituting the separate spheres of male and female responsibility (Aslanbeigui&Pressman&Summerfield 1994; Dwyer&Bruce 1988). In this way, notions of gender are represented through the symbolic relations of private and public space.

> Existing only relationally, each of the two genders is the product of labour of diacritical construction, both theoretical and practical, which is necessary in order to produce it as a body socially differentiated from the opposite gender, i.e., as a male, and therefore non-female, habitus or as a female and therefore non-male habitus (Bourdieu 2001:23).

One should also take into account that major changes in technical medicine have given rise to simultaneous questioning of the nature of the body in relation to gender in politics and culture. "… Politicization of the body has brought into focus the complex interrelationships between citizenship, embodiment and gender" (Turner 1992:46). Like gender, drug use is socially constructed by expectations and practices. It takes place in a specific cultural and political context and is shaped by the structuring structures that inform consumption and experience.

> Certain social settings, social occasions and social activities (including legal and illicit drug use) provide the resources for 'doing gender.' Thus gender does not just influence the ways people 'do drugs,' but drug use itself can be seen as a way of 'doing gender': people construct their gender identity, their masculinities and femininities, in both traditional and non-traditional ways, through their experiments with and experience of drugs, the socio-cultural context of drug cultures and the drug-related attitudes and behaviours of women and men within those drug cultures (Measham 2002:351).

There are implicit tensions between a drug using habitus and a female gender habitus. One important role of women - or what society expects from them - is the duty of reproduction and child-rearing (Earle&Letherby 2003; Woodward 2003). In Thailand,

imposing the motherhood and reproductive role on women often means they are excluded from the male space (Whittaker 2002). As in many societies, motherhood is the central role for Thai women (Keyes 1984; Liamputtong 2007; Mulder 2000). What concerns society profoundly is the impact of unhealthy maternal habits upon their children, e.g., taking drugs or drinking alcohol.

Measham (2002), who emphasises that women 'do drugs' differently from men within the wider cultural context of gendered drug use, notes that individual drug-related attitudes, behaviour and social space result in different drug consumption practices in men and women (ibid). Throughout the history of drug taking, consumption such as smoking tobacco or drinking alcohol has been viewed as a masculine accomplishment while such behaviour by women has been seen as a de-traditionalisation of femininity (McDonald 1994; Thom 1994).

Some researchers, Taylor (1993) and Maher (2000), for example, who present an image of female injecting drug users as part of a vibrant drug social network, refute their 'bad' people image. Maher (2000:11) argues that the image of women drug users is rife with the notion of victimisation: "We need to move beyond mechanistic models of victimization and criminalization and the familiar discourses of external agents controlling women's behaviour." Taylor (1993:149) maintains that: "The women's active, as opposed to passive, role was emphasized by the women themselves when recalling how they had first begun using drugs." This is important inasmuch as it suggests that these women typically live within an oppressive structure in which gender differences are exacerbated in a particular social space. We cannot assume that such women have no agency.

Taking drugs at an early age might be part of a larger set of life choices brought about by, for example, a broken home or domestic violence. Nok, relating details of her past life, said: "At that time, my step father was about to rape me. I screamed and hit him. Then I ran away to my friend's house. I have never gone back even though my mom said she would take care of me. I was afraid it would happen again."

Femininity can be imbued with both positive and negative values depending upon social recognition (Sinnott 2005; Thaweesit 2004). Direct and public contact with men is portrayed as problematic for women; by contrast, the domestic function of women in the private sphere is deemed their appropriate duty. Contrastive gender habitus is used as a means of controlling the behaviour of both women and men. The female gender habitus is a difficult place for women injecting drug users to inhabit as it operates in contrast to their expected form of lifestyle. The women I met harbour a strong sense of injustice due to their social positioning and the negative judgments of others. Women attribute their suffering in life to drug abuse, a disposition embodied through their particular form of socialisation and their drug experiences.

The 'Unfit Mother' Role

The image of parent's drug use as a form of moral decay is nearly always one that is totally negative and unacceptable in most if not all societies (Klee 1998). Such images, are formed around social attitudes towards women injecting drugs, for as some insist, drugs and femininity are simply incompatible (Banwell&Bammer 2006). For example, the use of illegal drugs during pregnancy is considered lacking responsibility: the role of motherhood is to take care of children; those who don't defile the image of motherhood (Boyd 2004; Paone&Alperen 1998; Sales&Murphy 2000; Siegal 1997; Simpson&McNulty 2008). Murphy and Rosenbaum view the pregnant user as breaking the gender habitus:

> A pregnant woman is supposed to take care of protect her forming fetus. Women who purposely poison their wombs by using drugs are seen as failing in their reproductive role, and … must take their place among the most stigmatised groups in modern society (1998:1).

Mothers using drugs thus strongly violate the perceived traditional norms of parental care. In some instances, the state uses its power to control or punish such behaviour in women by threatening to remove their children unless they enter a treatment program (Boyd 2004; Paone&Alperen 1998; Taylor 1993). However, the state does not typically concern itself solely with women's mental states and standards of child rearing; often,

concern is with the physical environment and social context (Klee 1998). Fear of losing custody of their children thereby becomes a driving force for women to stop using drugs (Banwell&Bammer 2006; Taylor 1993). But, in contrast to western societies, Thai women using drugs are less threatened with losing custody of their children. Family support for child-rearing is still commonplace in Thailand (Liamputtong et al. 2004; Soonthorndhada 1992). As it is in many societies, being a mother is highly valued in Thai society.(Whittaker 2002). In the words of Muecke:

> Motherhood apparently was valued for numerous functions. It provided needed labour for agricultural subsistence; it provided sons who could make merit for parents by being ordained as Buddhist monks; it provided daughters to help with domestic responsibilities, to bring strong husbands into the household labour force, and to maintain the lineage through childbearing; it was evidence of accumulated merit and harmony with the spirit world; and it also was satisfying (1984:462).

Thai women drug users that I came to know usually ask their relatives or in-laws to take care of their children so they can continue their drug lifestyle. Too told me that: "My in-laws look after my son. I rarely see him. But, I call them once a month to check that he is fine." Jing explained further:

> I slept in a small house with my boyfriend. My aunt adopted my son. He was lucky living with them so I had nothing to worry about, but she did say to my son that if he was not well-behaved, she would ask me to take him back. I think it is because she was afraid that he will be 'bad' like me when he grows up.

While they do not fear the State taking custody, most drug using Thai women try as much as possible to hide the truth from their children. They shield them from the fact that their parents are dependent upon drugs: they are afraid that their children will feel embarrassed if their friends or others come to know of their parents' drug use. The main reason they send their children away is to avoid direct observation. They fear that their children will take their own behaviour and lifestyle as role models. Nui said:

> I did not want them living with me because they would grow up and get used to being with a junkie. That is why I sent them to my ex-husband and who quit using drugs. I believed that he would lead them better than

> staying with me. My in-laws agreed with this decision. They did not want money from me: they only ask me not to meet my children again.

Many female users also fear their children will be involved in their drug-taking lives. Mok (a 27 year old female user) said:

> Whenever my daughter saw me holding the brown paper bag, she rushed to grab the glass and spoon from me. She prepared the equipment for injection even though she was only three years old. That was frightening. Sometimes she saw me injecting drugs and asked me what I was doing. I just told her a lie … that I was sick and the doctor prescribed me medicine.

In the above ways, the women I met during my research attempted to remove or lessen the impact of their drug use on their children by choosing not to assume the mothering role. As occurs in various drug settings, the women themselves realise that it is difficult to balance the role of motherhood, that is, to render it compatible with their drug lifestyle. For this reason, they prefer that their relatives or in-laws adopt their children. In public opinion, mothers who use drugs are selfish and uncaring women, who neglect their children in order to pursue their own pleasure. They lack the 'motherhood' characteristics which are essential to the moral core of womanhood in general. Sometimes, families use adoption as a form of punishment for their wayward daughters. Ying told me that:

> … [Her] sister adopted her daughter when she was young. They, my family, thought that I was not able to raise her and I did not deserve to be a mother because of my drug use. My daughter called me 'aunt', but called my sister 'mom.' My sister asked her to do so. Sometimes she would call me 'mom' when I behaved well, especially when I stopped using drugs. You know I was so happy when I heard her call me 'mom' even though I haven't raised or supported her.

Yui commented: "When my son saw me injecting heroin in the bathroom, he asked what I was doing and why did I hurt myself. I lied to him that I was sick and the doctor prescribed me with injections." Taylor (1993; 1998), refuting the traditional images of 'unfit' motherhood, argues that the women in her study undertaken in Glasgow looked

after and cared for their children perfectly adequately. In my study, the Thai context of extended family facilitates drug using women's avoidance of adopting the mother role rather than actively seeking to challenge negative images. But while having family assist in caring for children might alleviate some social stigma, there are numerous other arenas where gender and drug use awkwardly intersect.

Breaking Norms: Gender in Thai Society and Drug Use

The past decade has seen a dramatic increase in modernisation, which has affected gender roles in Thai society. Although women are now required to work outside of the home, they are still expected to be responsible for the private domestic sphere (Muecke 1984) and gender expectations that structure their roles and responsibilities still limit women's engagement in the masculine field (Liamputtong 2007; Muecke 1984). The boundaries of women drug users' lives are even more sharply drawn between the public and private sphere than those of other women. I employ the public and private divide as an ideological marker for women drug users for, like the invisible boundary discussed in Chapter 4, it distinguishes between their roles in the household and the roles they play outside of the home.

The Thai gender habitus is influenced by certain religious and traditional beliefs. Pongsapich (1997) writes that the spread of Hindu, Buddhist, Islamic and Confucian traditions was instrumental in bringing patriarchal practices to Thailand. Confucian traditions, which the immigrant Chinese in Thailand practice in their everyday lives, permeate the roles of many Sino-Thai men and women (Bao 1999). For others, the unequal status of men and women is evident in the Buddhist doctrine wherein only a man can be ordained (Keyes 1984). The parent-child relationship is referred to in the deep-rooted morality of *bun khun* (บุญคุณ): "Meritorious acts of parents toward their offspring, the love and care given, and the many sacrifices made to see the child to maturity should call forth in return … lifelong gratitude (*kattanyu* กตัญญู) and respect (*khwaamnapthue* ความนับถือ) from [the] children (increasingly as they mature)" (Mills, 1999: 139). *Bun khun* defines the role of parents toward their offspring: this includes

how to raise and care for them. Similarly, the children must also care for their parents when the latter are old in order to repay their gratitude. However, as Muecke (1984) argues, men and women have different opportunities to repay their gratitude.

In conventional Thai society, gender responsibilities are clearly demarcated: the private space of women is the household; the men's space is public. The woman's role as daughter, wife and mother defines most of the responsibilities a woman is required to assume within the family system (Bumroongsook 1995). A Thai woman is expected to undertake domestic tasks and to be submissive to her husband (Pongsapich 1997). A daughter stays at home to help her mother with the household chores. When she is old enough to get married, she has the status of *Mi-Ruean (*มีเรือน) conferred upon her, literally meaning 'having a house' (ibid). *Ruean* (เรือน house) implies household or woman's own space. In earlier times, during more traditional forms of courtship, a man came to meet a woman in her parents' home (Bumroongsook 1995). These days, while the capitalist economy encourages Thai women to work and socialise in the public space, this does not mean that women and men share equal participation in all activities. Women still assume responsibility in both the private and domestic spaces.

In times past, women were neither allowed to go out at night nor to attend social functions with men (Bumroongsook 1995). After marriage, a woman assumed the role of wife and mother: she was responsible for the economic maintenance of the household and for caring for and supporting her children and husband (Thorbek 1987). At the same time, a woman was expected to take care of the couple's elderly parents or in-laws. As regards the gender role, women were deemed to have a nurturing instinct whereas men were considered aggressive and competitive (Marchbank&Letherby 2007). A Thai woman's good image was effectively linked to her role inside the house. Traditions strongly influence Thai men and women towards staying in their defined places. This includes relationships as Thaweesit (2004) observes that the term 'bad women' refers to women who are intimately involved with more than one man, a relationship considered promiscuous.

In contrast, men were allowed to enjoy their public space. Boys helped their fathers work in the fields or at their workplaces. When a boy grew up, the school (in the temple) was where he socialised his role in relation to others (Keyes 1984). A man was expected to imply his maturity or gain a sense of adulthood. After marriage, he assumed the role of head of the household: this required that he provided economic support for the family (by working outside the home) (Thorbek 1987). And, while male premarital sex was considered a symbol of masculinity, conversely, female virginity at the time of marriage was highly valued in Thai society (Bumroongsook 1995). As a means of relaxing after a hard day's work, Thai men were allowed to seek pleasure in drinking alcohol or visiting prostitutes (Bao 1999; Lyttleton 2000), with visiting sex workers/prostitutes seen as a form of male socialising and/or sexual entertainment.

Even though gender habitus is somewhat resistant to change, modernisation processes have directly impacted on the above stereotyped Thai gender roles. The social change that has occurred over the past 60 years has strongly affected gender expectations. Economic transformation increasingly allows women more education and opportunity to enter the labour force to provide support for their families (Bell 1997; Mills 1999; Pongsapich 1997). But, even though women are less constrained socially and economically there is still pressure to maintain their domestic roles.

Confronting these persistent expectations, female drug users have to adhere to gender expectations as daughter, mother and wife. Taking drugs makes it hard to fulfil these roles; thus, they have to decide whether to quit using drugs and stay in the normative gender habitus or give precedence to the drug habitus. Once having taken drugs, they struggle with performing the roles defined by gender habitus and their drug lifestyle. Their struggles have largely been ignored by the state, policy and society as far as any sense of compassion is concerned; and, if and when acknowledged, they are interpreted negatively. They are seen as women violating their femininity.

Moving out of Home

Female injecting drug users are seen as ‘doubly stigmatised’ (Haritavorn 2008), more so than their male counterparts. This is particularly noticeable in Thailand when women

fail to fulfil their traditional feminine roles as mother, wife and daughter. A daughter should be grateful: she should behave properly; a wife must obey and respect her husband; a mother is responsible for taking care of the household and children. Through specific social interactions, women are expected to embody these expectations.

The drug habitus challenges the rules and norms which govern female gender roles. Female drug users do not fit Thai society's female stereotype, which requires the 'proper' woman (*riap-roi* เรียบร้อย) not to be involved in drug use, lying and stealing being considered characteristic attributes of such people. Yui described her experience as follows: "My parents and my brothers kept an eye on me like I was going to steal some things in the house. This made me uncomfortable and finally I ran away."

Because their families cannot accept their drug use, female drug users are mostly estranged from their families and live outside their community. The heightened stigma associated with female drug use tends to preclude them from mixing with their families and the community in general, more so than their male counterparts. Even when families try to endure their children's drug-use behaviour, the community may make this difficult. Gossip spread by neighbours about women who use drugs may render family members both embarrassed and ashamed. A daughter with a drug habit exposes her family - particularly her parents - to shame and loss of face, far more than a son using drugs. Pui said:

> My mom sold food in front of the flat. One day, the flatmate told her that I was about to inject heroin in the doorway. Then, my mom asked my dad to take me home. She was mad that I made her lose face. Women using drugs are targeted by gossip in the community. I know they all gossip about my drug behaviour. I do not care if they only talk about me, but they all start talking about my parents.

Even though the household is a safe place to inject and to avoid the police, women cannot stay there forever. Many move out, opting to stay either with friends or with their partners. There are other reasons why women move from private to more public spaces; for example, looking for drugs, finding someone to inject them, and seeking help. The lack of any sense of belonging is one important reason why they feel they

have to leave. The more harshly stigmatised the woman becomes the more likely she is to leave the family home. For example, like Yui, Nok told me: "I could not be there. They (family members) keep an eye on me all the time like I am going to steal something." Ying said: "I don't want to be at home. My step-father tried to rape me several times. Finally I decided to run away and stay with my friends."

Because they do not fit the female stereotype in Thai society, drug using women feel uncomfortable living in their home community. In the public perception, women who appear to deliberately hurt themselves are seen as deviant or bad. Thai society typically does not accept this type of behaviour, especially in women. Moreover, craving heroin adds to the stigmatisation of those who use it. Ying explained:

> Injecting symbolizes death. When other people who do not use drugs see women injecting drugs, they think that these women are bad because they harm their bodies. Hurting themselves is strongly forbidden for women. But men can do it. Maybe drug use is men's area.

In the lives of these women, stigmatisation is a painful experience that becomes part of their disposition: it is socially informed and it overlays emotion in everyday practice. People believe that taking drugs is highly likely to lead to criminal activities. The role of the female injecting drug user is also interpreted as one who commits crimes, not as the submissive victim of crime. Sometimes women drug users resort to petty theft such as shoplifting or burglary (Young, 1994). After serving their sentences, they returned to the community, to circumstances in which the conditions of their original offence are re-created. It seems, however, that these occurrences are rare. Nok noted: "The only criminal offence I ever did was shoplifting or stealing a mobile phone from my friends to sell for money. I am not brave enough to commit a big crime like to rob a Seven Eleven or a bank." Jib (a female user) said:

> I have never thought of quitting using drugs. Even though I use drugs, I have never caused anyone trouble. I don't understand why the outsiders (those not using drugs) assume that we drug users are troublemakers. They think we are the centre of any social problems. I did steal once, but that was because I was high and unconscious. That time, I felt ashamed and

> then I promised myself I wouldn't do it again. Being charged as a thief is more shameful than being charged as a drug user.

Typically, my female informants' families were wracked with anxiety over their daughters' drug use behaviour, fearing that the latter can no longer fit the 'good woman' image. And, because they act against the traditional practices, there are many ways in which they have difficulty relating to the dominant expectation of femininity Ped told me:

> I used to have a good job working in a hotel. My mother used to be proud of me. That is why she could not accept the fact that I use heroin. Everything suddenly collapsed when everyone found out that I use drugs. They keep an eye on me like I am going to steal something in the house. I could not stand such an environment so finally I left home and started my new life.

Mii said: "My mother told me she would rather have a child who is a prostitute than one who's a *khiya*. She could not accept the fact that I use drugs. If I went back home, she would hit me badly. So why should I go back home?"

As the above quotes demonstrate, drug use results in women transgressing social norms wherein they engage in activities usually indulged in by males. When living or interacting with non-using drug people, women injecting drugs users fail to fit their gendered habitus and inevitably have to confront the dissonance of taking on 'masculine' practices.

The World of Masculinity: The Drug Using Habitus

Like femininity, the specific form of masculinity is constructed through practices in which males live and within their social milieus (Connell&Messerschmidt 2005). Unequal gender relations are expressed in the everyday violence that women face in the drug community (Epele 2002; Howard 1995) culminating in the essential nature of women being questioned, undermined and threatened. Drug activity very often generates a distinct type of masculinity that is manifested in violence, harassment and crime. In the case of women users, drug activities may serve to separate them from all

that is feminine, affirming a particular type of masculinity. Messerschmidt (1993:83) notes that: "Masculinity is based on social action that reacts to unique circumstances and relationships, and it is social construction that is renegotiated in each particular context." Drug use is one very specific context that over-emphasises forms of masculinity. Rosenbaum (1988:22) uses the term 'outlaw' in relation to male "toughness, the willingness to engage in violence and a variety of thefts." Within the drug community, women play an 'old lady' role (as a companion to the 'outlaw' men); in other words, women share in men's traditional violent and criminal role.

As I have described in Chapter 2, in the Bangkok drug community, men outnumber women. This sees the male habitus reinforced as the drug culture allows men an outlet for their masculine power**.** Based on my observations at the drop-in centre and methadone clinic, only a few women attend; overall, women may account for roughly 20% of total attendances. Messerschmidt (1993) observes that men use crime as one means of accomplishing their masculinity. Like crime, using drugs can also validate masculinity. Drug use is considered a male domain due to values held in common regarding the all-round male culture, e.g., violence, sex and illegal activities (Bourgois 1996). Drug use reflects the more dangerous and unruly aspects of the masculine nature which threaten the lives of women (Rosenbaum 1988). Using drugs thus places a burden on a woman to maintain the gender and cultural stereotype that moves in an opposite direction to that of her masculine counterpart (Banwell&Bammer 2006; Haritavorn 2008).

Rape is one means men use to exercise power over women. Bourgois (1995)' ethnography addresses the dimension of gendered brutality through gang rape which is practiced in the drug community in New York. Gang rape is a component of the young male crack addict's rite of passage, one essential to his attaining adulthood. This violent and collective action suggests that violence is a component of this particular masculine culture wherein men are stereotyped as rough, active and, on occasion, highly aggressive (Bourgois 1996). According to one of my Thai male informants, who discussed the topic of gang rape with me at a drop-in centre, participating in sexual

violence has also become a male ritual for these men. Jack described the violence that permeates the drug community:

> Yes, there was once in my life. When I was teenager, I joined the gang rape. It was a male ritual at that time. We, a group of 7-8 males, took turns raping a woman. I was the last one. She cried and begged me not to rape her. She said her body (he avoided using the word 'vagina' because I was a woman in the group.) hurt. That was the time I realised the violence in my life.

Observing of this type of violence was common among the women I met. Ning said: "I was there when the guys took turns raping a woman. I couldn't say anything; I just watched. That was scary." Pui added:

> Sure, rape is a typical situation in the drug community. Imagine that you were craving, walking in Klong Toey, searching for drugs without knowing anyone. What would you do? If someone came to you saying 'Girl, I will get you drugs, but you have to sleep with me first', you wouldn't object. If they slept with you without giving you either drugs or money, you cannot do anything. It is just risky.

Many people - even male injecting users - continue to believe the stereotypes surrounding female heroin injecting drug users, considering them as behaving badly. The degradation of women exemplified in sexual violence extends to female injecting drug users' partners, who may use different types of drugs and judge the injecting women as worse than them. Male partners in general dislike their girlfriends injecting drugs. Ying said:

> My boyfriend is a drug supplier. He sells mostly *yaba* and he himself uses *yaba*. He does not want me to use heroin. He told me that a woman craving heroin is disgusting and she will do whatever to get drugs. He gave me many tablets of *yaba* to use instead of heroin. But I exchange them with others for heroin. The taste is different and I dislike it.

One of my informants, Nok, said: "My boyfriend injects drugs but he doesn't want me to do it. He said I am a woman, I shouldn't inject drugs. It is disgusting to see a woman craving heroin. She will do whatever to get drugs."

Tee added:

> My partner and I both use drugs. I inject heroin, but he smokes amphetamines. I don't really understand how he can complain about my drug use. He often says that I should not use drugs, but he himself uses them. He can't give me a good explanation. He just says I am his wife and he doesn't want me using drugs. He doesn't want others to look down on me.

Rak, explaining her circumstances, noted:

> My boyfriend is an amphetamine dealer. He used to take heroin but he stopped using it while he was in prison. He hit me when he found out that I use heroin. He would say it is bad for women to use heroin and that women will do anything to get heroin, like have sex with a drug dealer. He gave me 10 tablets of amphetamine to stop heroin withdrawal, but it didn't work. The taste is different.

In response to particular conditions and situations wherein different types of masculinity prevail, females injecting drugs are pressured to adopt masculinity, i.e., to 'wear the shoes of their male counterparts' in order to continue living in the drug community. In this way, women embody certain practices in terms of gender roles, expectations, drug consumption and experiences.

Adopting Masculinity

Women have to find specific ways of dealing with their lives in a social world that constitutes the conditions for suffering. The women in Rosenbaum's 1988 study of women using heroin in the United States who mostly lived in San Francisco Bay area used specific tactics to deal with structural violence. 'Hippies' who rebelled against the gender habitus opted to leave the confines and isolation of restricted family life: 'outlaws' dropped out of school; women entered the fast life to escape poverty. Entering the drug world, like any new experience, involves learning a unique set of tactics, behavioural patterns and meanings. As males outnumber females in the drug community, values are held in common with the male culture through which women become cognisant of the deviant aspects of the drug world. And even though female

drug users face difficult lives, at the same time they respond with a degree of agency that emphasises their transformed habitus as the product of a shared lived reality that is patterned by history, social conditions and experiences (Maher 2000).After spending many years dealing with drugs, women become more capable of handling the numerous threatening situations in their lives. They are required to adopt masculine norms and values in order to survive in the drug world. Women injecting drugs take on male characteristics such as dressing, talking or behaving like their male counterparts. Ways of concealing injection scars include tattoos, the wearing of 'butch' clothing, t-shirts, jackets and jeans. Scars are usually located in and around the leg and arm areas of the body. Recently, when I was chatting with Tip, a female drug user, in her DinDang flat, she showed me her scars caused by injecting Midazolam. While we were chatting, one of the men sitting close by overheard what we were talking about and suddenly asked what caused Tip's large wound. Nok said that it was caused by diabetes. After he left, Nok told me that as the man was a policeman she knew she had to lie to him.

Plate 8: Woman whose finger was amputated after injecting Midazolam

Some women adopt new forms of embodiment as an expression of their power over other women. In women's prisons, for example, in order to survive, the female heroin user will take the masculine role while amphetamine users usually take the feminine role. Complex relationships develop between people using amphetamine and heroin users. Women injecting heroin see themselves as different from amphetamine users: they view women using *yaba* as much more feminine: younger and more attractive and who trade their bodies for drugs. Dang (a 50 year old male user) mentioned the association of women using amphetamine and selling sex: "When I used drugs, I wished I was reborn as a woman. They are lucky. They only have to sleep with drug sellers or have sex with them to get drugs. I could not do that because I am a male. None of the drug sellers wanna having sex with men." Women heroin users on the other hand seldom adopt a feminine style of clothing. Nok said:

> Oh, I have never thought why we never wear jeans or dress like women. I think we have to wear something that is suitable for our lifestyle for example running from policemen. It would be so funny if we wear beautiful dresses going to drug community to buy heroin. When using drugs, we have never cared how we look, only thing we care is how to survive with drugs.

For women injecting drug users, the notion of gender is not fixed: it is flexible and in flux according to the social environment. When identity conflict occurs, women resort to various tactics such as adopting masculine roles that will attempt to bring balance into their lives; that is, they seek to reconcile the image of the 'good' Thai woman with their drug relations. Sod, demonstrating how hard this was, commented: "Being a woman injecting drugs is worse than being a prostitute. The prostitute can live like normal married women, have children, but women drug users can't." The difficulties extend to seeking an income. In order to survive in the drug milieu, a woman is required to gain income both for buying drugs and living expenses. In this regard, the careers that women can pursue are limited to certain areas.

Pursuit of Careers

Women drug users' careers are typically limited to crime, risk and chaos, all of which drive them into the drug milieu (Inciardi et al. 1993; Maher 2000; Taylor 1993). Finding jobs is not easy for these women. Some are poorly educated, having achieved little more than a junior high school diploma. For this reason, their work options are limited to cleaning or waitressing. They tend not to be able to keep their jobs due to the demands of their drug lives: they are frequently fired or quit their jobs. Mii said: "I used to work as a waitress but only for a week before being fired because I was absent quite often."

Women risk their lives by exposing themselves to multiple kinds of dangers and threats. Epele (2002) maintains that unequal gender relations underpin the daily violence that women face in the drug community. This is certainly true in Thailand. Often, while using drugs, their choices of income are limited to sex work or selling drugs, but both options require collaboration with men, thereby exacerbating their subordination. Women drug users, describing episodes of everyday violence, sometimes resort to selling sex in a bid to make money although this is more commonly associated with female yaba users. Ying maintained that: "I used to work as a sex worker but it was not like in the past. Now the sex business is competitive. The client usually chooses the girl who uses *yaba*, who is young and more beautiful." At the same time, those women who do sell sex maintain degrees of choice. Nok said:

> I used to work as a sex worker for one year to get money to buy drugs. I never traded sex for drugs directly. I was proud that I can work to make money to buy drugs myself. Men drug sellers mostly think that they could have any girls they want through trading sex for drugs, but I am not like that.

In most circumstances where women need to sell sex to buy drugs, the sex business is controlled by men; invariably, women are subjected to demeaning conditions (Bourgois&Dunlap 1993; Fairbairn et al. 2008; Shannon et al. 2008). Bourgois and Dunlap (1993)'s ethnography reveals that women using drugs in the US considered a career in prostitution a safer and more ethical way of earning an income compared to stealing and drug dealing. Shannon (2008)'s work describes the subjective suffering of a

sex worker who worked to sustain her drug habit and supply for both herself and her partners. The women in her study have had to subject themselves to the power and control of their male counterparts, a requirement that has limited their control of their own personal lives. For their part, male users claim that female drug users can use their bodies to gain money and drugs whereas men are forced to commit crimes. Maher (2000) writes that sex work is commonly the channel through which women gain income or obtain drugs from sellers. In the public opinion, sex is considered an easy way for women to procure money and drugs within the drug community.

However, among my informants, sex work was seldom chosen as a primary means of making money. In terms of income, female injecting drug users prefer to work as retail drug suppliers which will guarantee their drug supply. The females injecting drugs I met felt that they could not compete with others in the sex market, especially with amphetamine-using women. Injecting heroin is both perceived and experienced as causing women to appear unhealthy and unattractive.

Instead, my female interviewees primarily worked either as outreach workers or drug sellers. The majority sold drugs as it guaranteed them a regular supply and was preferable to prostitution. Mii said: “When I was young, I often stole men’s money. I agreed with them to trade sex for money, but it ended up that I stole his money before having sex. Sometimes they came over to my workplace and beat me up.” Moo said: “I haven’t worked as a sex worker. I was a minor wife of a married man. That was better. He paid me monthly so I spent that money on drugs. Being sex workers you may be forced to sleep with many men, but being a minor wife you just slept with one man.” Nok said:

> Well, I used to work as a sex worker when I was young, not now. Look at me now... who would want to have sex with me? No-one. I turned black and so skinny since I injected heroin. Many men would pick the young and beauty girl like those using amphetamine. They have sex appeal because amphetamine increases sexual arousal ...not like heroin.

In contrast to other studies undertaken on this topic, in Bangkok it seems that women injecting drugs are less likely to work as prostitutes or as sex workers believing that they cannot compete with younger women taking amphetamine. A further and quite different option for women using drugs (although also built around the drug experience) is to work as outreach workers, a subject I explore in chapter 6.

Enduring Violence

In the drug community, drugs are symbols of power; hence, those controlling supply feel they have the ability to control other drug users including their intimate partners. Frequently, men exercise their control over women users by withholding drugs as a penalty (Sales&Murphy 2000). There are exceptions. Too, who used to be a drug seller, said: "Ten years ago, I used to be a drug seller, a big one. My boyfriend pleased me because he wanted drugs. He did what I wanted, even did the housework. That is because I had drugs." But, despite examples like Too, women in general are in a less powerful position to negotiate. In everyday life, men control the drug supply; by extension, they control women's lives. Some women, upon running out of money, trade their bodies to buy drugs (Murphy&Rosenbaum 1997). And, in a seemingly vicious cycle, the more violence the women experience, the more drugs they use (Sales&Murphy 2000). Women who inject drugs are commonly subject to sexual harassment from both intimate partners and within a broader social circle. Some of the female drug users I interviewed had experienced sexual harassment by policemen. Porn, a female user aged 40, related her experience as follows:

> When I left the drug dealer's house, the policeman caught me immediately. I knew that the drug dealer was a police spy - he ratted on me. There were five or six policemen. They searched me for drugs, but they couldn't find them because I hid the drugs on my waist and my shirt covered them. Then they said that they would search carefully so they ordered me to go into the bathroom. Then they asked me to take off my plant. Fortunately, I dropped the drug into the canal. They turned on the flashlight and looked in my vagina. They took turns doing this. I was so ashamed, but could not say a word because I was thinking about the heroin. Finally, even though they could not find heroin, they took me to

> the police station. My mother was mad about what happened to me so she sued the policemen for sexual harassment.

Physical violence is a key indicator of male power in the drug culture. Bourgois' ethnography (1995) emphasises that among crack dealers in East Harlem, New York gendered brutality - especially rape – engulfs their street drug culture and adolescent socialisation. Female drug sellers, according to Covington (1985), are at the bottom of a male-dominated drug hierarchy. While some female drug users become involved in crime, the reality is that these women are victims of violence and crime in the drug community. Many are beaten or killed by close friends. And, although the women report the violence in their relationships to people working in drug networks, domestic violence committed in private is considered a personal matter. Living in the drug-using community, Thai women frequently experience regular violence at the hands of their intimate partners. I heard of instances when they have been slapped, punched, beaten - and worse. Two female injecting drug users from my circle of informants died in 2008 as a result of domestic violence. One was beaten to death by her drug-using/dealer partner: the other's body was found with bruising on her neck. Friends suspected that her boyfriend, who was using antiretroviral drugs that sometimes caused hallucinations, killed her.

Domestic violence is thus a part of their everyday lives that women have to endure. Thirty- nine year old Kae said: "My boyfriend hits me badly. He kicks me and slaps my face whenever I get a little bit of heroin. If I got more, he would suspect that I slept with a drug dealer." Tip told me: "When he is high, he is unconscious and can't remember what he has done. One day, he put a rope around my neck. Luckily, I wasn't using drugs at that time so I was conscious. Later, I told him what he had done. He said he couldn't remember anything." Jib said: "My boyfriend, when he is high, always jabs a syringe into me. I have to try not to be targeted. If our friends are there, he holds a knife the whole time." Sa said: "My friend hit his girlfriend badly when he was craving. I felt pity for her, but I could do nothing. It is their personal business."

The broad-based violence embedded in the drug subculture makes it difficult for women to survive in the drug community. It requires specific tactics such as moving out to other places or living with a new man to deal with this oppression: even if it does not remove all violence. A key attempt is to select the most appropriate partner.

Love Me or Drugs: Relationships with Partners

Because of their engagement in a drug habitus, women drug users mostly find their partners among their group of drug-using friends, men who are able to provide them with shelter, food and, most importantly, drugs. For some women, drugs are introduced by their male counterparts as one of the initial stages of entry to this world. They have learnt drug consumption through their male peers. As in many drug use settings, women users believe that having a partner who uses drugs suits them better than a partner who does not use. Using drugs together forges a bond that can become the core of the relationship. Rak told me that:

> I got to know Pat through peer introduction. I met him at the methadone clinic. At that time, he was just released from prison and had no one (partner). At first, he came to me asking for drug information like where he can buy drugs. Then, we started hanging out together more and more. At the end I decide to stay with him.

Having a partner who also uses drugs can provide a level of support: they both understand each other's needs and emotions within the collective habitus of using drugs. They share subjective experiences such as craving symptoms, stigma and discrimination and (either real or potential threat of) HIV/AIDS, things that a non-drug using partner cannot truly understand. Nok said:

> I cried heavily when I knew that I got HIV, but my boyfriend said that it is not a big deal. Even though he does not have HIV, he understands me the most. He refuses to use condom when we have sex. He said one day he would be infected HIV so it doesn't matter whether to use condom or not. I know he just wants to make me feel better.

Rak said:

> When I am craving for drugs, he knows how to deal with this mood. He would give me medicine and prepare cold water for me. I used to have boyfriends who are amphetamine users, but they have never understood me. He assumes that taking amphetamine would stop the heroin craving symptom which is not true.

Nearly all of the women in my data have partners who use drugs. They refer to a partner who does not use as not understanding their drug habit and not being sympathetic if the women fail to fulfil the gender expectations of a good wife and good mother. When living with a partner who is not using drugs, women may experience even more pronounced domestic violence, particularly if the man opposes his girlfriend's drug use. These relationships seldom last for long. Ning said:

> I used to have a boyfriend who did not use drugs. He was mad every time he saw me use heroin. One day, he put a full cup of heroin in front of me. He asked me to make a decision to choose either him or heroin. As you know, I finally chose heroin. Soon after, he left me.

Rak told me:

> I have had many boyfriends who didn't use drugs, but the relationship could not last long. They cannot truly understand me at all. They felt that women using drugs are disgusting. They could not stand a woman who used drugs. Some of them said I bring them and their family shame.

The women strongly emphasise that having a heroin partner benefits them even though they may have to endure domestic violence. Women users seem to opt for a specific partner who is using drugs whereas males will on occasion take non-using partners. The men's preference for non-using partners became evident during my fieldwork. Tarn, Nuu's wife, who has never used drugs, said: "I knew since the beginning that he used heroin, but he has never caused me any problem." The reality is that women's choices are limited only to their male injecting counterparts as several of them were certain that non-using males would not accept their drug behaviour. Rose (a female user) said: "I use to have boyfriends not using drugs, but it always broke up because they could not accept my drug habit. They said it was disgusting for women to crave for drugs."

Compared to men, woman using drugs' space is restricted to that within the drug community as using drugs identifies them as breaking the gender habitus.

Women, HIV/AIDS and Harm Reduction

The women I came to know do not only face high levels of gendered violence. Male and female injecting drug users also face different risk factors, especially the risk of HIV transmission. By sharing contaminated injecting equipment and engaging in unprotected sexual intercourse with infected male injecting drug users, women who inject drugs are at particular risk of becoming infected with HIV (Klee 1993). Sasse et al.(1991) have shown that in Italy, males injecting drugs may play a greater role than female injecting drug users in sexual transmission to their partner. Realising the high HIV prevalence among sex workers, most Thai men use condoms when engaging in sex with sex workers (Lyttleton 2000). Injecting drug users in Thailand are less likely to use condoms with their regular partners believing that a permanent sexual partner is safe (Perngmark et al. 2003). Under such random circumstances, sexual encounters are likely to be unprotected. Suffice it to say that women injecting drugs not only confront the range of problems previously discussed: they also face the risk of HIV/AIDS infection.

Nearly all of the women I spoke to reported inconsistent condom use with their heterosexual partners. Condom use may be seen by partners as a sign of infidelity or suspicion. Non-condom use is seen to connote trust. A woman may agree to have unprotected sex to prove her fidelity. Condom use also signals a distance that is seen as inappropriate in the context of an intimate relationship. Kob, who is HIV positive, said "my boyfriend refuses to use condoms. We both work as outreach workers and we have known that there is the possibility that I will receive his ARV resistance or other OIs [opportunistic infections], but he refuses to use a condom. He said we had agreed at first that we would not use condoms." Rak said:

> Most men do not like condoms. I do wanna use condoms when we have sex, but he refuses. I work every day while he is unemployed. Don't know where he goes during the day - to buy drugs or perhaps sleep with some girl; but, I can't force him to use condoms.

My female interviewees all emphasised a strong need to use condoms, at the same time stressing that drug use also plays a role in the inability to insist. Many claimed that since using heroin they don't find sex pleasurable: it has become something they have to put up with. It seems drug taking frequently renders intimacy a secondary pleasure. Ning said: "Sex has never given me pleasure but drugs do." Phet, a male drug user, noted "after using drugs, I'm high and then I forget about using a condom." Nart, a male drug user, said "after injecting 'Kum' (Midazolam), I don't know anything. I knew that I had sex when I saw the used condom in the bin. I hadn't even realised that I had sex last night." Jib, a female drug user, said: "it was that time that I got infected with HIV by him. Actually, we used condoms regularly, but we had sex after he used drugs. Heroin has an effect on sex. He felt like he could not reach orgasm so he suddenly took the condom off."

In addition to sexual transmission, needle sharing also has gendered underpinnings. Choi et al. (2006), who examined needle sharing among Chinese injecting drug users, discovered that needle sharing among peers represents friendship. In contrast to male drug users, sharing needles tends to be a private matter practiced in intimate relationships for Chinese women injecting drug users, who tend to share with their main sex partner (Choi et al. 2006). In common with Choi's research, I discovered that Thai female injecting drug users generally share needles with partners but not with peers when it is difficult to access sterile equipment. Nok said that: "I knew how HIV transmission was, but there was one syringe so I had to use my boyfriend's."

Thai female injecting drugs users are more HIV vulnerable compared to their male counterparts. This emerges from the lack of fit between gender and drug using habitus and is manifest in both the sharing of needles and engaging in unsafe sex. Condoms are accepted as the most effective HIV/AIDS prevention. For this reason, many in the public and private sectors have tried to promote the use of condoms in general and within vulnerable populations in particular. In contrast, in the drug subculture, condom use, under particular circumstances, may not be considered a viable option, e.g., men who have been in prison may be physically unable to use them after having inserted

small objects under their foreskins. In Thailand, penile modification such as *Fang Muk* (inserting pearls into the penile shaft) is sometimes practiced, especially among men who use drugs. Most Thai men believe that this type of modification heightens their partners' sexual pleasure (Im-em&Siriratmongkhon 2002; Thomson et al. 2008). The women I interviewed claimed that having sex with men who have modified their penises in this way is more painful. Kae said "my husband could not wear a condom because he modified his penis… there is no size for him." Dao said:

> When I saw his penis, I was shocked. How would he put his penis into my body? It was too big. He modified it while he was imprisoned. If I turned him down, he would hit me. Since I have stayed with him, I have never felt sex is pleasurable anymore. It was too painful. For me, using drugs gives me more pleasure than having sex.

Particular social and cultural contexts relegate women to a subordinate position where they find it difficult to negotiate sex and condom use. Based on these findings, it is not only women drug users who risk contracting HIV/AIDS infection (through infected syringes): those with drug-using male partners are at risk through sexual contact, an eventuation aggravated when their partners conceal their HIV status. Sak, a male injecting drug user, who has a non-using drug partner said: "I couldn't dare to tell my girlfriend that I am HIV+. I am afraid that she would leave me if I told her the truth. What I do is to try to use condom every time we have sex."

Summary

The drug field, that is to say the social milieu wherein men and women use drugs, is strongly gendered given that men and women contemplate - and deal with - drugs in different ways. In order to survive in the drug community, women have to overcome multiple challenges as they confront more social pressures and stigma than men (Simpson&McNulty 2008). Within this particular habitus, they are often subjected to male power and accordingly assume a subordinated role. In contrast to men, female drug users in Thailand are believed to commonly violate traditional gender dictates. Hence, women have to adopt certain male characteristics as one tactic to survive in the drug world. Even though men and women might technically use drugs in the same way,

social reproduction functions in such a way that women are more victimised and vulnerable than men (Bourgois et al. 2004; Magura et al. 1993). The former typically play numerous social roles such as mother, wife and daughter, social roles that are inevitably transformed by drug use.

Even though harm reduction is considered nowadays to be the most effective HIV/AIDS prevention among injecting drug populations, the model lacks the means of adequately addressing broad risks to female injecting drug users. Miller and Neaigus (2002) argue that harm reduction is not embedded in the sex-risk reduction program for female drug users in the sex business. In contexts wherein the stigma directed towards women using drugs is high, pregnant drug using women are reluctant to seek help as they fear a negative backlash (Simpson&McNulty 2008). In their work addressing the treatment of women drug users, Sarin and Selhore (2008) note the lack of diverse treatment options for women drug users in Delphi, India. Gray (1995), reporting on a small harm reduction program in Chiang Rai, observes that female injecting drug users did not participate in the program. Again, women are more likely to be introduced to drugs by a male partner (Howard 1995); thus, one might argue that harm reduction is a male-oriented model. Treatment programs are not designed to meet the needs of female clients; for example, there is a lack of childcare services and counselling (Banwell&Bammer 2006; Erickson et al. 2000; Haritavorn 2008). This lack of gender sensitivity makes some women feel uncomfortable joining programs or attending drop-in centres (Pinkham&Malinowska-Sempruch 2008).

Stigma is a powerful force, a subjective structure forming the injecting drug user's habitus. Bourgois and Schonberg (2009), who view drug use as part of social suffering, maintain that injecting drug users are forced into a submissive position whether intentionally or not. Using drugs is not solely a dimension of social suffering: it projects users into a new realm of lived experiences in which they learn how to interact and respond. Injecting drug users worldwide devise tactics that constitute new forms of struggle. Harm reduction is one strategy that helps people injecting drugs to communicate their feelings to the public. In this chapter, I have attempted to demonstrate that HIV/AIDS infection is not the sole factor of female drug users'

suffering. Stigma against women using drugs is more severely felt. The 'harm' caused by the lack of fit between gender and drug habitus is what the female injecting drug users suffer the most. The stigma of drug use is traditionally greater for women than for men, and even more so for pregnant drug users (Murphy&Rosenbaum 1998). Therefore, harm reduction should be emphasised for female drug users, a group who are marginalised, vulnerable, at risk, and exposed to a high degree of social suffering. But, as the interviews in this thesis show, while being a woman in a drug using community is most often a disadvantage, there are certain situations where women who use drugs can use their gender to their advantage. As in most studies of gender, social stratification is not fixed. Drugs complicate these structures and create multiple forums of harm, a topic I address in Chapter 6.

Chapter 6

Harm Reduction, Social Movement, and Space

Taking drugs poses numerous difficulties for users, even as they allow moments of pleasure. One dilemma is real or potential infection by HIV. The spread of HIV among people injecting drugs gives rise to major concern regarding effective prevention. To this end, harm reduction has been developed as a means of reducing HIV infection and other diseases spread via needle use. It is not only a public health priority: it also requires mutual cooperation from all levels of society, from state-based and international policy formation to individual willingness to embrace safe practices. In this chapter, while recognising concrete benefit of general public health approaches, I argue that in Thailand, there is a need to strengthen the harm reduction model, and to recognise the 'harm' caused by the combined negative impacts of drug policy, stigma, discrimination and low self-esteem that I have been describing. Harm reduction, the focus of which is on the health of the individual drug user, often fails to broadly operate within a suitable definition of harm.

As both a policy and set of instrumental practices, harm reduction is not determined solely by the needs of people who inject drugs. Rather, it was formed in part to serve the needs of the public health paradigm and in response to the AIDS epidemic (Brettle 1991). The medical profession has made clear that drug users are one source of infectious disease, with spread exacerbated by the sharing of (contaminated) injecting equipment. But, care must be taken not to conflate those vulnerable to disease with being the cause of the disease (Watney 1996). Given the pervasive levels of health threat faced by injecting drug users, harm reduction has been implemented in many countries of the world, e.g., Switzerland, Canada, England and Australia. Analysis of the daily lived experience of Thai injecting drug users underscores the urgent need for a renewed harm reduction strategy that addresses the users' needs beyond solely focusing on HIV/AIDS prevention. The lives of Thai drug users illustrated in this thesis demonstrate the intersections of multiple forces in producing and reproducing harm.

NGOs working with drug users in Thailand have put a considerable amount of effort into implementing harm reduction policies in various settings of high prevalence HIV infection such as Bangkok and Chiang Mai. They have established drop-in centres as buffer zones, spaces in which people using drugs can seek protection from being mentally and physically oppressed by outside socio-political influences. But, the feelings of self-blame, disgrace and anxiety that accompany drug use may be exacerbated by conflict within these drop-in centres; that is, between users and staff who are not using drugs. Feelings of 'pain' stemming from discrimination give rise to fear and distrust of the world in general. The establishment of drop-in centres could be considered as one model of a new social movement given that it brings the private into the public arena. Members of centres, in turn, have to find ways of balancing their private and public lives and handling the competing demands on management of self. I commence this chapter with a discussion of 'harm'; then, I examine emerging forms of new social movement related to drug phenomena in Thailand. I argue that social mobilisation can contribute to the creating or defining of a new identity, a transition that ultimately affects the meaning of self. We can think of drop-in centres and drug-related networks as a new form of social movement, as a particular kind of collective behaviour which confronts the difficult boundary between legal and illegal conditions of existence.

During my fieldwork I spent twelve months at a drop-in centre, RakJai, and at the Thai Drug Users' Network. My focus is upon the social relations that pertain within and without the centre and on how - through its activities - the centre provides a sense of normalcy to the drug user. It should be noted that drop-in centres function not only as public health or welfare service providers: they also have a profound impact on individuals engaging with this environment. I will describe the everyday subjectivities of the drug network and drop-in centres, with emphasis upon the centres as a public space for those in the drug community to inhabit.

Harm Reduction: A New Chapter in the Lives of People Injecting Drugs

Harm reduction, which represents an important recent chapter in the history of drug use, impacts upon policy and individual safety in various ways. Initially, it emerged from a

drug policy introduced in the Netherlands in 1984 where it was first implemented as a health promotion approach promoting needle and syringe exchange programs that aimed to prevent the spread of hepatitis infection among injecting drug users (Riley&O'Hare 2000). In the UK, implementation of a harm reduction model was first officially launched in the Merseyside region in 1986 (in the Liverpool area), a program later termed 'the Mersey Harm Reduction Model.' This program aimed to reduce the risk of HIV infection among drug users in the community (Ashton&Seymour 2010). The success of the Liverpool model was widely noted and, as a result, implementation was adopted elsewhere. Inciardi and Harrison's (2000) term 'Harm Reduction' refers to programs, policies and interventions; for example: advocacy for change in drug policies; HIV/AIDS-related intervention; broader drug treatment options; drug abuse management for those who wish to continue using drugs; and, ancillary intervention (such as entitlements, housing, and support and advocacy groups). Currently, harm reduction provided in Thailand includes: methadone maintenance programs (not available in prisons); needle syringe exchange programs; and, drop-in centre support and facilities. But, despite the fact that many countries accepted the logic of harm reduction initiatives, others remained sceptical. Their governments questioned whether this form of intervention might inadvertently encourage drug users to consume more drugs, an outcome that would not only impact severely upon the health of the users but perhaps more importantly where governments were concerned, could lead to social disorder. Broadly speaking, harm reduction aims to reduce the consequences of the risky behaviour engaged in by drug users, which might result in HIV/AIDS infection, overdoses and other debilitating health consequences. Because the harm reduction policy was developed based on a public health perspective, evidence-based research and evaluation developed quantitative indicators to measure both risky behaviour and HIV spread. Hence, intervention was oriented towards reducing the risk of HIV infection that was spreading with alarming rapidity around the globe. In recent years, research funding provided by Global Fund has strongly supported the development of an HIV/AIDS preventive model for application among drug users.

During the period 1998-2003, the number of injecting drug users worldwide was estimated at approximately 13.2 million (Aceijas et al. 2004:2295). Based on the availability of research undertaken in 78 countries, HIV prevalence among over 20% of injecting drug users was noted in at least one site in 25 countries and territories (ibid). Later, in 2007, the global estimate of people injecting drugs was 15.9 million people in 148 countries: HIV infection was reported in 3.0 million injecting drug users from 128 countries (Mathers et al. 2008:1733). When contemplating these figures, it is, important to acknowledge that HIV prevalence among drug users varies. The largest populations of HIV positive injecting drug users were reported to be in Eastern Europe, East and Southeast Asia and Latin America (ibid). In 2010, the International Harm Reduction Association (IHRA 2010:16) indicated that the HIV prevalence level among people injecting drugs in Thailand was approximately 42.5 per cent. The consistently high prevalence levels rang an alarm bell signalling the urgent need for the introduction of a more successful preventative model. The majority of public health research supporting the effectiveness of harm reduction emphasise that this approach may well reduce HIV infection (Brettle 1991; Peak et al. 1995; Wodak&McLeod 2008). According to the International Harm Reduction Association, currently there are 82 countries (including Thailand to a very limited degree) employing needle and syringe exchange programs; in addition, 10 countries have introduced needle and syringe exchange programs in their prisons (IHRA 2010:2).

The needle syringe exchange programs (NSP) operating in many countries have proven that improved hygiene and providing clean needles for injecting drug users reduces the risk associated with the sharing of needles (Gibson&Flynn&Perales 2001; Hart 1990). The establishment of safe injection facilities has also helped to reduce the incidence of HIV/AIDS infection (Keane 2003; Kerr et al. 2005b). But, it is not always readily instigated. In contrast to needle exchange facilities, the provision of methadone as a harm reduction approach is more readily accepted in countries such as Thailand because it is controlled by the medical profession (Ball&Ross 1991; Gibson&Flynn&McCarthy 1999). In addition to the above interventions**,** harm reduction involves other activities, e.g., advocacy for change in drug policies; HIV/AIDS related initiatives; broader drug

treatment options; drug abuse management for those who wish to continue using drugs; and, ancillary intervention (Inciardi&Harrison 2000). Together, these activities/interventions are developed based on the philosophy of harm reduction; that is, as a means of reducing the harm caused by the individual's drug taking behaviour.

Overall, harm reduction has, according to many public health research reports, proved successful in reducing the individual's risk of infection (IHRA 2010). Since its inception, a number of countries have incorporated this particular strategy into their national drug policy control programs. For example, in 1985, Sydney (Australia) implemented a needle and syringe exchange program in a central city area (Kings Cross) which continues into 2011. In 1995, the Brazilian Ministry of Health piloted two needle syringe exchange programs in Santos and Salvador (Inciardi&Surratt 2001). Based on the IHRA (2010:8)'s 2010 report, 93 countries and territories worldwide now support a harm reduction approach.

Today, this approach is not restricted to drug users alone; sometimes, it is extended to those in society who are deemed vulnerable, i.e., people who engage in unhealthy practices such as smoking, drinking (alcohol) and engagement with sex workers (Hatsukami&Lemmonds&Tomar 2004; Rekart 2005; Shiffman et al. 2002). But even though harm reduction is implemented in various high HIV prevalence settings, e.g., in prisons, there is still a need to develop more finely tuned models in Thailand particularly for vulnerable users such as female injecting drug users, prisoners and ethnic minorities.

The framework underlying the harm reduction model is not only related to public health: it is also related to a human rights paradigm promoting the equal rights of drug users. Elliott et al. (2005:106) argue that: "Harm reductionists, therefore, in effect, are human rights advocates, contributing to a larger effort aimed at securing universal respect for, and observance of, fundamental human rights." Human rights, which provide the basic framework for many civil society organisations, also force the state to reorient its thinking about rights violation caused by drug control policies such as the Thaksin's War on Drugs (WODs). Such drug control policies are seen as seriously

harming the rights of drug users. Ezard (2001) contends that a human rights framework could facilitate an understanding of the users' vulnerability to drug-related harm: it could also be used as evidence-based advocacy. Unlike other health promotion approaches, harm reduction is situated between the notion of disease and morality in the sense that it seeks to preserve dignity free from oppression (Marlatt 1996). But, while public health reports claim that harm reduction reduces HIV infection, often society in general views this approach as likely to encourage excessive drug consumption. Thus, there is a need to carefully define the term 'harm' and how it relates to drug users.

The Definition of 'Harm'

In the everyday lives of the drug users I have described, the components of objective versus subjective harm are intertwined. For this reason, those in the health area working with injecting drug users may not always be able to distinguish them clearly. These forms of harm can and are - to some extent - alleviated by focus on behavioural modification and the individual's risk behaviour. In response, a harm reduction approach has been initiated as one form of health promotion. But based on the data provided in previous chapters, harm reduction could also usefully embrace broader societal and political-economy dimensions. Although it is a particularly effective strategy for reducing risky behaviour, as it is currently practiced harm reduction operates with minimal understanding of subjectivities. More importantly, harm reduction could prove a strategy for changing the social perception of drug users. Hence, I will suggest that the concept of 'harm' in public health discourse is somewhat different from that promoted by the social sciences.

Howard maintains that the harm experienced by adolescents using drugs variously stems from the cultural, legal, social and economic context of use.

> Furthermore, harmful effects of substance use by young people are often felt by families, communities and society at large. Harm results directly from personal use as well as from the use of those around them; including other young people, family members and other adults. Harm also results from the criminalisation of users, and in particular their incarceration, which can increase their marginalisation and decrease their access to and

> participation in interventions to address any substance use-related harm (1995:144).

As this description implies, in order to understand the meaning of harm, one should explore more broadly the meanings of 'risk' and 'health.' The concept of 'harm' is rooted in 'dangerousness.' Lupton (1999:91) identifies the latter as "processing…the inherent qualities to present a danger [i.e.,] a danger to themselves or to others, and therefore as prime targets for governmental intervention and treatment." Unlike the notion of dangerousness, risk is more selective and applies to a larger group of people (Lupton 1999). Miller (2001) views harm reduction as somewhat similar to Foucault's 'governmentality,' which likens public health to a regulatory regime. Miller (2001) further argues that while harm reduction works as surveillance, at the same time it fails to address the dominant medical, legal and economic discourses that impact on drug use.

Crawford (1980), suggesting that 'healthism' can be interpreted as social regulation, views 'health' in heuristic terms. Health, he maintains, is socially and culturally constructed by social forces and defined through activities, individuals and collectives of health (Crawford 1980:386). Unlike disease, 'healthism' perceives an unhealthy condition as illness: it should treat "individual behaviours, attitudes, and emotions as relevant symptoms needing attention." From this perspective, social forces can both advertently and inadvertently encourage unhealthy conditions for people injecting drugs. Public health approaches do not always adequately view health as the product of socio-cultural and political-economy construction. Mann et al. (1994:9) maintain that the concept of health should embrace the broader societal dimensions and context of individual and population wellbeing.

Drawing on Crawford's (1980) notion of 'healthism,' one might suggest that public health discourse should take into consideration not only how social identity is constructed but also how drug users view the world. While harm reduction is defined in terms of a set of objective factors, insofar as Thailand is an example, little regard is given to users' subjective conditions and experiences. While from the objective perspective, the 'harm' of people injecting drugs lies in disease and other infections,

from the subjective perspective, 'harm' is caused by both external and internal forces, e.g., political-economy and self-blame.

Clearly and quite logically, the objective of harm reduction from within a public health paradigm is to reduce the harm associated with drug use through individual behavioural modification. The 'harm' caused by injecting drug behaviour is typically referred to as HIV/AIDS, overdosing, hepatitis and STIs (Inciardi&Harrison 2000). This harm, as defined by medical or public health discourse, is attributable to the individual's risk behaviour. It is based not "on addiction, dependence, or the problem drug taker *per* se**,** but on the problems associated with a particular way of taking drugs-injecting" (Stimson&Lart 1991:1266). Thus Stimson claims that:

> HIV has simplified the debate and we now see the emergence of what I will call the public health paradigm. Rather than seeing drug use as a metaphorical disease, there is now a real medical problem associated with injecting drugs (1990:333).

Interventions such as needle syringe exchange programs, drop-in centres, outreach and methadone clinics are introduced to protect drug users from the danger associated with injecting drugs. In medical discourse, which has dominated the harm reduction domain, harm is considered to be the result of specific injecting habits. There is no doubt that harm reduction has in fact saved many lives through its specific focus on risk behaviour. Lenton and Single note that:

> The central defining characteristic of harm reduction is that it focuses on reduction of harm as its primary goal rather than reduction of use per se, secondly that strategies are included to reduce the harm for those who continue to use drugs; and, thirdly that strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a new reduction in drug-related harm (1998:213).

But, it may be that the 'harm reduction' approach initiates other forms of harm for users through its intervention, i.e., harm caused by the strategy itself. Radcliffe and Stevens (2008) claim that in England, drug users are reluctant to go to a methadone clinic for fear of being identified as 'junkies'. Alternatively, drug users may become addicted to methadone (Bourgois 2000). The bio-politics of methadone distribution emerges in the

practice between health profession and users (Bourgois 2000; Keane 2009). Nuu told me about his regular trips to the methadone clinic: "I receive the lowest amount of methadone. Probably it is only syrup, but I am still going there every day. I know I can just stop taking it, but I am afraid of the craving symptoms that might occur." Going to the clinic for methadone every day becomes embedded in the user's everyday routine. Joy complained about her daily trips, saying: "I have to be there every day. I can't go to other provinces to visit my family. I asked the nurse for take-home methadone but she refused. I guess she is afraid that we might sell it."

Plate 9. BMA Methadone Treatment Centre at DinDang

While clearly effective in reducing disease, what is missing in much of the harm reduction process is the inclusion of the lived experiences of drug users into programs in ways that address what I term 'subjective harm'. Based on a broader human rights paradigm, harm reduction has developed a response to the nature of the harm associated with injecting drug activities based on the notion that drug users cannot stop using drugs

as it is their personal way of pursuing pleasure. From this perspective, there is another aspect of invisible 'harm' which, I will argue, is equally important in the lives of drug users; for example, social perceptions of people using drugs. Harm is not caused solely by the individual's injecting practice: it is also attributable to external stressors such as policy, negative social attitudes, stigma and discrimination (Lenton&Single 1998). Harm reduction, as it is currently implemented, does not change the social perception of drug users: they are still considered a form of social pollution. Some have suggested, therefore that the harm reduction program should first gain an understanding of - then utilise - elements of the injecting drug user's own culture before attempting to change his/her behaviour (Lam 2008). The notion of vulnerability that underlies individual risk taking could be included in the harm reduction framework as it will help to eliminate harm through the careful examination of high-risk behaviour in different settings and times (Ezard 2001). Harm reduction could then mediate the lived experiences of injecting drug users in response to the structural and social level of violence that exacerbates the social suffering. Other researchers argue that harm reduction has failed to address the moral frameworks informing policy (Fry&Treloar&Maher 2005; Shelley 1999), Sometimes, the suffering caused by policy, society and practice has a broader impact than the harm caused by HIV/AIDS as it impacts directly on the subjective sense of self. Rhodes et al. (2006) argue that the objective of harm reduction should be to focus not only upon behavioural modification but also upon forming a healthy environment for drug users; for example, changing the public perception of drug users from a negative to a neutral way of thinking. As suggested above, drug users in Thailand are pressured to join harm reduction programs, which define harm according to public health guidelines which focus directly upon individual behaviour. While this may be a logical approach, it has its limits. In previous chapters I emphasised that a broader dimension of potential harm to Thai injecting drug users is rooted in social policies and a social environment, aspects of which combine to strongly impact upon the user's sense of self. Harm reduction, as it is currently practiced in Thailand, ignores the more destructive consequences of 'subjective harm', the structural violence that further exacerbates the suffering of people injecting drugs. It does however promote forms of social belonging that have multiple outcomes.

Harm Reduction in Thailand

Even though public health research compiles data on the effectiveness of implementing harm reduction for people injecting drugs in various settings, harm reduction is still an ideal rather than a reality in Thailand. The first needle syringe program, which was implemented among 9 hill tribe communities in the Northern Thailand Mae Chan area, was funded by AUSAID. Gray (1998) maintains that this program successfully reduced HIV transmission among the local people injecting drugs. But, despite its success, there has been little subsequent advancement of needle exchange programs. Because Thai injecting drug users find it difficult to access sterile syringes, there is a high rate of syringe borrowing. The sharing of needles and injecting equipment among injecting drug user peer groups and partners has culminated in the spread of HIV infection (Kerr et al. 2010a; Perngmark et al. 2003; Saelim et al. 1998). People injecting drugs claim that the reason they share needles is not because they lack knowledge of how HIV infection is spread but because their own equipment is not conveniently at hand (Haritavorn 2008; Kerr et al. 2010a). As a result, people injecting drugs inject with friends or partners, pooling their money to buy drugs.

At the United Nations General Assembly Special Session (UNGASS) conference on HIV/AIDS in 2006, the Thai government was questioned regarding the progress of its HIV/AIDS prevention policy for people injecting drugs. The government renewed its commitment to ensure HIV/AIDS services for Thai injecting drug users in line with its 2007-2011 National AIDS Plan (Kaplan&Schleifer 2007). But, it was difficult to implement as the goal was not drug abstinence. In the popular view, harm reduction encourages or supports drug users to continue their drug use in contrast to the preferred goal of drug abstinence. Most people expect that drug policy control will stop the demand, in the process rendering the community safe from drug pollution.

Thailand's drug control policy was developed based on the popularity of an abstinence-based approach to drug use. The introduction and implementation of the 2003 WODs was a direct response to the populist appeal of such an approach. In many countries, the law states that all equipment used to inject illicit drugs is illegal: carrying a syringe

identifies a person as a drug user leaving him/her liable to charge by the police. The police department is considered a barrier to harm reduction implementation as drug users fear police surveillance, drug planting and arrest (Fairbairn et al. 2009). This remains the case in Thailand. The Thai Drug Users' Network (TDN) has been unable to persuade the Thai government to include harm reduction in its national drug policy. Needle exchange programs have proven difficult to implement in Thailand due to the attitudes of the authorities towards injecting equipment. According to Kaplan and Schleifer (2007), Thai authorities condemn the syringe exchange program as 'immoral' or 'foreign', not Thai, saying that in effect they encourage drug use. As a result, outreach workers are compelled to conduct their syringe programs underground.

Drug NGOs argue that because this mandate has driven drug users underground, it is difficult for the latter to access health treatment and prevention programs (Cohen 2004; Kaplan&Schleifer 2007). Instead, NGOs working on drugs have fought for full implementation of harm reduction programs such as providing clean needles for drug users and equality when accessing services. With the international and local support of these NGOs, drug users have formed their own network as a tool of social movement and advocacy. This movement represents an important chapter in the Thai drug history. By emphasising that drug users are not criminals, that they are individuals with their own sets of personal aspirations and dilemmas like everyone else, it has transformed the drug community and to a lesser extent its public profile.

Social Movement and Civil Society

The rise of civil society in Thailand and other countries has empowered harm reduction approaches at all levels from the international to the national. As Whittier (2002:289) maintains "state structures, dominant cultures, and civil society shape movements, and, in turn, movements can reshape the states, policies, civil societies, and culture within which they operate." More importantly, social movements, as well as connecting networks through informal interaction, also create a shared collective identity (ibid).

Nguyen (2008:127) argues that the growing coalition between the public and private sectors in relation to HIV treatment constitutes a phenomenon he refers to as a 'therapeutic economy' that "conjugates confessional technologies, self help strategies, and access [with] drugs in novel ways." With reference to the rise of PLWHA support programs, he (2008: 142) defines 'therapeutic citizenship' as "a form of stateless citizenship whereby claims are made on a global order based on one's biomedical condition (being HIV+), and responsibilities worked out in the context of local moral economies." In similar vein, bio-politics have shaped the drug user's identity in Thailand and impacted profoundly on their subjective sense of self.

Harm reduction programs encourage the creation of groups of drug users and empower them to take an advocacy role in response to human rights violations and HIV infection. Global funding grants have created a new social movement for Thai people living with HIV (TPN+) in the form of the TDN. The AIDS civil society in Thailand plays an important role in accessing AIDS treatment and advocacy (Lyttleton 2008). HIVself-help groups in Thailand have in the past focused primarily on the creation of a sense of belonging (Liamputtong et al. 2009; Lyttleton 2008). In this respect, the TPN+ network performs in the nature of a somewhat closed community: their work is based upon 'friendship relations'. In facilitating a sense of belonging, TPN+ and TDN include 'friendship' and 'sharing subjective experiences' as the core principle of their networks.

For drug users, social movements are generative processes that invest new meaning and expand their public space. These movements develop new forms of social intervention that cast the goals of human rights in universal terms. As the notion of human rights develops, it changes and promotes integration in various disciplines as well as in public health. Concomitant with the United Nations promotion of the Declaration of Human Rights in 1948, the civil rights movement emerged in various settings over ensuing decades, especially among the marginalised and most vulnerable groups, e.g., ethnic minorities, migrants and middle class workers. Among these groups, drug users ranked lowest as far as their rights were concerned. The reality is that drug users in Thailand are the group whose rights are frequently violated. They suffer inordinately as a result

of neglect of their health concerns: they are frequently denied access to social services unless they agree to quit using drugs.

The TDN began as an alliance of NGOs determined to change government policy on harm reduction. In December 2002, along with his colleagues, Paisan Suwannawong, who personally experienced the trials associated with attempting to access an HIV/AIDS treatment program in Thailand, decided to found the TDN as the country's first official drug user network. In 2003, the TDN staged a peaceful protest against the War on Drugs while the Minister of Public Health was delivering a speech on stage during the IHRA conference convened in Chiang Mai. The TDN demonstrated the need for involvement in the development of harm reduction programs in Thailand: its advocacy could be viewed as a platform for the human rights movement in Thailand. Among national and international civil society organisations, the TDN is considered a significantly powerful lobby group. The approaches used to further their advocacy have included: case documentation, letters to policymakers, campaigns and protest. Both at the international and national levels, they collaborated in lobbying against the War on Drugs policy. Activists demonstrated outside Thai embassies worldwide while TDN members and Thai activists presented letters to political leaders in which they railed against the WODs (Fink 2005).

But, despite this regulation, based on my own personal observations, the TDN does not work as comprehensively or effectively as the TPN+. The former faces more difficulty when attempting to implement harm reduction in Thailand for it seems that only NGOs support this approach. The more powerful social interpretation of 'drugs' pressures the government to reject harm reduction implementation. The retirement of key persons like Paisan Suwannawong and Piyabut Nakapew who opted to work for other networks has resulted in unsustainability and conflict within the TDN network, unlike the successful collaboration of national and international NGOs in relation to ARV provision and the numerous achievements empowering PLWHA groups in the broad social and livelihood sectors (Lyttleton 2008).

One key distinction between the drug networks and other drug organisations is organised around those continuing to use drugs and those who have stopped. Drug users believe that only injecting drug users can understand each other, a belief that has caused a rift between staff using drugs and those not using both within and without the TDN. The invisible boundary described in Chapter 4 is a form of self-protection for people injecting drugs: they feel that those who do not inject cannot understand their subjective experiences, especially their drug use behaviour. This boundary not only exists at the individual level but also at more macro levels. It has an ongoing impact within the functioning of drug-users networks. Lyttleton (2008) notes the linkage between the Global Fund funding mechanism and the growing power of a positive people's network (TPN+); for example, it has allowed them to work closely with the Thai government in response to the HIV epidemic. In 2003, the TDN's submission of a proposal requesting $1.3 million highlighted the harm to which drug users in Thailand are exposed (Kerr et al. 2005a). After receiving a grant from the Global Fund, the TDN hired drug users and non-users to work in the organisation. Non-using staff and administrators worked within the organisational structure. The majority of outreach workers were drug users, whose responsibility it was to contact other drug users in the broader drug community. Unfortunately, the social and politicised distinction between those who do or do not use drugs still creates a divisive obstacle and in this respect the invisible wall is not diminished.

The working styles and environments of RakJai and the TDN are very different in style. Each network has its own working style and subculture. The president of the TDN was a drug user, as were the committee members; they used both during and after the meetings, even at meetings convened by other organisations. After the lunch breaks, the TDN representatives would disappear; later, they would return. Even though no direct comment was made, people attending the meetings, who worked in the drug field, were aware that all of the TDN staff members were using drugs. One member of the staff told me of the problems associated with the TDN.

> Can you believe it... all committee members using drugs? I don't mind that they are still using drugs, but at least it should be under control,

> especially during meetings or conferences. Like, during the meeting, some of the participants approach the committee asking for money to buy drugs. They give them some because they totally understand the craving feeling. That is not right. Last year, TDN had a big problem. Money and equipment were stolen and staff quit, especially non-using drug staff. In Chiang Mai, TDN Harm Reduction was closed because of the problem between drug using and non drug using colleagues. Those using thought their non-using drug colleagues would not really understand them whereas those who were not using drugs were mad about their working style and were punctual.

Despite such difficulties, funding was received that allowed these networks to continue functioning. The 2002 Global Fund Round 3 program, which extended from 1 October 2004 to 30 September 2007 and was called 'Preventing HIV/AIDS and Increasing Care and Support for Injection Drug Users in Thailand' (the total signed amount was US$ 1,236,108), aimed to support Thailand's drug NGOs' enhancement of the capacity of their networks to expand their work, e.g., establish drop-in centres in areas of high HIV prevalence.[7] The fund was distributed among the major drug NGOs of the time: the TDN, the Thai Treatment AIDS Group, RakThai and Alden House. These funds aimed to improve the unhealthy conditions of injecting drug users in Thailand and to protect them from the dire problems of HIV/AIDS infection, hepatitis and overdosing, i.e., to pursue a conventional harm reduction approach. This funding has allowed the networks to expand and to establish drop-in centres in Chiang Mai and Satoon. But, at the same time, it has had unintended negative consequences, for as one key person in TDN observed: "Global Fund helps us to expand our work and I am thankful for that. On the other hand, it has ruined our organisation. People started thinking about how much money they will get or what benefit they will take. Some of the TDN committees asked for unbelievable salaries."

Despite the above tensions, realising that harm reduction should focus not only on the individual, the networks have tried to build connections with various sectors; for example, with researchers, nurses working at methadone clinics, and policemen, allowing two-way information exchange about the harm caused by drug usage. More

[7] http://portfolio.theglobalfund.org/en/Grant/Index/THA-304-G06-H

importantly, the drop-in centre has now become a crucial link between the private and public, that is, between the drug community and society.

Life in Public: The Drop-In Centre

Many of my informants told me how they seek refuge in isolated or drug communities, fearful of stigma and discrimination. It is useful to explore drop-in centres as emerging social movements that transform the private into the public or back stage into front stage. Living as they do on the margin, drug users are constrained from accessing social services and support; in many cases, they experience unhealthy conditions which put them at high risk of HIV infection or other health threats. Public perception identifies the drug community as a 'dangerous space,' a space for violence and crime. In the previous chapters, I have explored the nature of the drug community as the hidden organisation or private space in which drug users hide their drug habit from the non drug using public, employing specific tactics to cope with their everyday interactions. Currently, there are four drop-in centres in Bangkok operated by various drug NGOs, funded mainly by the Global Fund.

The social presence of public drug networks helps drug users enormously. It allows them to reveal themselves as drug users to certain sectors of the populace so that they do not have to always take refuge on hidden ground. Networks and drop-in centres are established to allow a more open space for the drug user's subculture. The harm reduction approach, together with social movements such as the above networks, facilitates new identities for people using drugs and through the drop-in centres builds a public space for combating the dilemmas facing drug communities denied an acceptable social presence. Thus, a harm reduction approach is important not only for its behavioural aspects, but also for its potential to empower and contribute to a sense of normalcy. The objective of the drop-in centres is to provide care and a climate of prevention for drug users; as well, it provides a space for them to engage in activities such as computer learning or playing guitars. Drop-in centres can usefully be considered as social spaces. Bourdieu (1985:723-724) describes his notion of social space as follows: "The social world can be represented as a space (with several dimensions)

constructed on the basis of principles of differentiation or distribution constituted by the set of properties active within the social universe in question, i.e.., capable of conferring strength, power within that universe, on their holder." Soja (1996:2) refers to social space as "the habitus of social practices, a constantly shifting and changing milieu of ideas, events, appearances, and meaning." One can apply the notion of social space to the drop-in centres in urban Bangkok to demonstrate that drug communities can exist in a public space. For drug users, drop-in centres serve as social spaces that protect them from danger, intruders and police harassment, for example. The centre manager typically explains the objective of the centre to the police authority in order to obtain permission to establish it in the area. Collaboration with the police department is essential because it guarantees that the police will not arrest the outreach workers while they are working in the field. Later, the manager issues staff cards that may be presented to the police and others, with the proviso that if any staff member is charged with drug procession the organisation will not support her/him legally.

RakJai: Introduction to a Drop-In Centre

RakJai, a spacious and well-maintained two-storey house and garage set amid a community compound piece of land, functions as a drop-in centre for people injecting drugs who reside in the neighbouring areas. Located in central Bangkok, it takes approximately 10 minutes by motorcycle to travel from the centre to the nearest methadone clinic. Usually, users park their motorcycles in the garage: the lawn is used for centre activities and/or parties. The house includes living and dining areas. A reception desk was located near the entrance: everyone who visits the centre must sign the visitors' book and fill out a membership form. All information remains anonymous. A house receptionist, always seated behind the desk, is ready to welcome any newcomers and to introduce the house services. New members receive a membership card which they can use to collect points when they participate in house activities; for example, risk reduction or self-medication classes. The points can be redeemed and put towards gifts or the yearly house annual trip.

Adjacent to the reception area was a newspaper corner and couch. Each morning I found members sitting there, some reading newspapers. In the afternoon, some members used this space to play chess. There were three computers on the left hand side on the way to the living space. People were usually playing games or chatting. The living space was the area in which people seemed more relaxed for it was there that they enjoyed watching television and videos and sleeping. The coffee corner was situated on the right hand side of the living room: most of the members brought their own cups; the centre provided its members with coffee, sugar and cream. In the kitchen at the back of centre there is a small, broken, wooden table; this is where people ate lunch and dinner. The centre provided rice, condiments, cooking oil and fish sauce for people who preferred to do their own cooking. But, most brought their own food or bought it from street vendors. The dining area was where people felt truly relaxed: it was there that they smoked and chatted. Because the table faced the house door, people in the backyard could see who were going in and who were coming out. When I visited the house, I usually went straight to the wooden dining table, joining those who were already sitting there.

The upstairs space was for the staff and outreach workers. There was a nursing room which was made available to members of the medical profession who came to conduct check-ups. Collaboration with other service providers and networks such as methadone clinics, police officers and drug and HIV/AIDS NGOs helps the centre to conduct its programs effectively. In collaboration with MSF, a doctor and nurse attended RakJai house every week to offer medical advice or training to the members and staff. Often, it is used as a working office for researchers who collect data on people injecting drugs. Each year, both Thai and foreign researchers attend. Even though centres like RakJai represent a safe and personalised space, hierarchy is not absent. Downstairs and upstairs implicitly reflect the unequal status between members and staff as members are not allowed on the second floor: it is reserved for staff and visitors only. I could sense that members who came to centre preferred to hang out on the first floor rather than the second. Some guests showed signs of discomfort when they observed some members slept in the living room.

During the time I collected my data, there were 6 permanent staff and 7 outreach workers. The majority of the staff had experience with drugs including the house manager. There was a constant staff turnover rate; for example, Jak was asked to take leave because he used drugs heavily and was unable to work. The availability of staff positions became competitive among outreach workers. Being hired as a staff member meant gaining more power and benefits. Rat said: "I also applied for a staff position. Actually, the salary is not much higher, but it becomes a position and others in the house will give me respect."

Use of drugs during working hours is an issue with which the organisations are seriously concerned. Management and staff have put specific rules in place in an attempt to deal with certain aspects attributed to the drug users' lifestyles. These include no selling or using drugs in the house, no violence and no stealing. Those who violate the house rules are prohibited from re-entering the centre. This rule is used as a means of ensuring that neither members nor staff will commit any violence or crime. Following the house rules is the first step in learning how to live in the public arena: it means that attendees cannot lead their lives as they did in the drug community. But, even though the rules are stringently enforced, there were still many transgressions, especially among those selling or using drugs in-house. Muad, one of the RakJai staff, said:

> It is impossible to prohibit drug users to talk about or sell drugs because drugs are the only topic and concern in our lives. When we start chatting, we talk about where we can buy the cheapest and good quality drugs. The conversation usually ends up when we decide that we will pool the money to share drugs and one of them will volunteer to buy them while another is responsible for preparing the injecting equipment.

The centre is a social space wherein drug users live, interact, learn and share their experiences, a space defined by both the official terms by which it has been established as part of harm reduction and by the complex dynamics of social life within these contexts. The discipline established creates relationships and certain forms of employment. The centre reflects the daily lives of - and interaction between - drug users and others through social activities. If the users are 'well-behaved', they are rewarded,

perhaps invited to join the camping trip, for example. Rewarding and punishment in the house are considered means of controlling both the house order and the lives of the drug users simultaneously. The prohibitions in place regarding the taking of drugs in the house and management style are criticised by other drug networks, who claim that they violate the human rights of the drug users.

Re-establishing a Sense of 'Normalcy'

Using disciplinary techniques, the drop-in centre is a partial move towards re-establishing a sense of social 'normalcy' for those attending. Through social interaction, drug users learn skills that will be prove of benefit to their future employment, e.g., computer skills, cooking and painting skills. Social events such as birthday parties and New Year celebrations have become part of RakJai culture. Every year, RakJai prepares the merit-making ceremony prior to the day on which it is held. All busily clean the house and prepare food for the event. Muad said: "the outreach allocates their transportation money (50 baht) to buy a dessert for tomorrow to serve to the monks." Even though the money is relatively little, it creates a sense of community merit-making and shared responsibility. At the end of the year, the centre provides trips for staff and members who regularly frequent the centre as a reward for participating in activities. The trip - an event they eagerly await all year - creates a sense of joy and family closeness: some staff members take their families along with them.

In 2006, I went camping with the group at Chanthaburi for three days and two nights. The trip was arranged prior to the Christmas and New Year holiday. I was notified that the bus would leave the RakJai at 8 o'clock in the morning. I was surprised that it seemed to be a family trip rather than staff/member camping. Nuu took his wife, his 3 year-old daughter and 5 year-old son: May took his 4 year-old niece; and, Sor took his 13 year-old nephew. Upon boarding the bus, I sat next to Tong, one of the staff, who told me:

> Last year, there were less people than this year so we decided to go to KaoYai by two vans. The van driver arrived at the RakJai early in the morning, but when he saw our friends, he felt scared of us. Then he turned us down giving the reason that he was scared that we would be

> troublemakers or thieves. The van driver said he would transfer us to his friend's van. When the second van arrived, he turned us down for the same reason. The bus driver told me: 'Those people look scary. They have tattoos all over their bodies". In the end, we rented a van from one of our friends. The owner used drugs so he was more understanding. The chaos was not only in the beginning but it went on until the end of the trip. Some of our friends took drugs with them: they were awake all night. I, Nuu and Nong kept an eye on them to make sure that they were under control and did not scare the others. It was such an exhausting trip.

That night, some of them - Nok, Rat, Sor, Kong, Dai and others - sat in the yard playing guitars and drinking whisky. Tee gave me a cup of soda water: he knew that I didn't drink alcohol. It was a time of joy, not regret. Rat played a guitar and sang a song that satirised their drug lives. "They said our life is worthless because we want drugs. We do not want to use drugs but we did. What should we do? We regret for that, but what could we do? Only thing we can do is just using drugs."

In their everyday roles at the centre, the staff and members of the centre engage with people who are not using drugs, e.g., visitors, public relations personnel, researchers, health professionals and staff from the main office in Bangkok. Participating within the network provides opportunities to interact in ways that define a normative state in the world, to speak up in public, and to come into contact with people from various organisations from both the national and international sectors. Some drug users go abroad to attend drug conferences: others attend meetings or training facilities in other provinces of Thailand. Participating in such meetings allows them a chance to share their subjective experiences of life with drugs as a meaningful resource. They have learned to speak up in public, to tell others about their lives. They attempt to hide their current drug use habit or at least to control their behaviour in order to present a positive image of themselves and their organisations. At the same time, they are managing their social reputations, trying to control their behaviour in the public space. But, even though the centre and staff have tried to create a healthy environment for them, in time, many stop attending because they cannot stop using drugs. This sees some staff members quit their jobs and move to other NGOs.

Invisible Boundary: Conflict within the Organisation

Within these spaces, specific conditions are based on degree and type of drug consumption. 'Well-behaved' (*praphut tuadi* ประพฤติตัวดี) staff or members are evaluated by the manager for the degree to which they keep their drug use under control and refrain from involvement in violence or crime. Even though the harm reduction approach does not ask drug users to stop using drugs, the drug users themselves often feel that the way to gain a better life is to quit. The centre and its operation strongly reinforce this point of view. In fact, this may prove one of the hardest tasks they ever attempt in their lives; and, the public may well be unaware of this aspect of drug use. It takes courage, strong intention and motivation to stop using drugs. People injecting drugs all know that to stop using is extremely difficult; for this reason, they have strong admiration for those who succeed.

Those who continue using are under pressure to hide their drug behaviour, especially in front of those with whom they are not acquainted. As Nok and May said 'only ghosts know who the ghost is': in other words, only drug users can recognise other drug users. Nok commented:

> I just only have to look to know whether they are still using drugs or not. Ja underestimated how long I knew her and how long I used drugs. During my second month at the drop-in centre, I noticed that even though they have 10 outreach workers, there are only 4-5 who always hang out there. I asked Nuu about this during the way back from the methadone clinic. Nuu explained that those who use drugs rarely come to Rakjai because they think it is a barrier. There is the gap between who have quit using drugs and are still using drugs. Also, they don't have time to hang out in RakJai because they spend every minute looking for drugs. Even though we forbid them to sell drugs in the house, they still do although not obviously.

The gap between those who quit using drugs and are still using appears more pronounced within the centre. Those who are able to stop using feel that this is something to be proud of: quitting has given them superiority over those who are still using. When public meetings and conferences are held, those who have stopped using are chosen by the staff to attend the meetings because they could better represent the

RakJai rather than those who were always ‘on a high’. Cessation of drug use is what they prefer to showcase to others. As the RakJai director, who used to be an injecting drug user, said at a weekly risk reduction meeting in October 2007 “I used to be just like you, but soon people find out that not only drugs make them feel happy. Other things like playing with your son can also make you feel happy as well.”

When the Director made this comment I looked around the faces in the room; but, no one was making eye contact with him. They were all staring down at the meeting table. Sor, an outreach worker, was currently in the awkward position of someone who is between using drugs and not using drugs. Those using drugs would not come to the house or come inside when they were high. Sor told me that she had stopped using drugs but was still taking methadone at the Narcotics Clinic. Many people said behind her back that she was a heavy drug user. Rut related the following: “I stayed in the room with Sor. I opened the door and saw her back. I knew right away that she was injecting drugs, but I pretended not to see what she was doing.”

One time, we were sitting in the backyard. Sor walked in and May glanced at her. May said

> Well, she is high again. Just take a quick look. I knew immediately that she is using drugs. She told everyone that she stopped using drugs. I don’t know why. You know when we went on the trip to Trat province we slept in the same tent. She kept asking me to take drugs. At that time, I had Midazolam while she had heroin. She wanted to mix it up. (After hearing May, I said I recalled that during the trip Nok told others that there was blood in the female bathroom and suspected that someone might be injecting.)

Because they felt that they couldn't ‘fit in’ with the centre's rules and subculture, some members sold drugs to other members while others sometimes ended up stealing or becoming involved in brawls with other drug users.. Jack said: “I don’t wanna be there. Rat and Nok look down on me as I use drugs heavily. They used to be drug users. They should understand how I feel.”

Stopping drug use commands attention at the centre on a daily basis. The manager chooses staff members who are 'well-behaved' (non-drug using) to attend the meetings to ensure that they will not create any chaos and will present a good image of the centre. At the drug meetings, participants who either sell or use drugs are criticised afterwards: some ask if they can leave the meeting immediately. Even though the staff members often participate in meetings or conferences, those who have quit using are considered more trustworthy than those who have not.

The social reality is that the centre was constructed around the interaction of a blend of drugs, power and identity. Because the centre is in the public arena, the same social dynamics results in drug users embodying a sense of self-blame. People who can stop using are placed in a somewhat superior position to those still using. Thus, even though supposedly representing a 'free' place, a social space devoid of prejudice, even within the centre the user is under pressure to conceal his/her drug use behaviour, knowing that it is officially and socially considered both illegal and deviant. The invisible wall is not removed but to a certain degree further consolidated.

Fitting Work with Our Lifestyle: Outreach

Outreach programs are considered to effectively access the hidden population, especially injecting drug users (Elliott et al. 2005). An outreach worker position is one that the majority of drug users I met felt they were suited to as it fits a particular lifestyle. The time is flexible and allows workers to socialise with their peers in the public space. Many outreach workers at the centre expect to be promoted from casual to permanent staff, the latter receiving additional benefits such as social security services, vacations and a monthly wage. Casual outreach workers, on the other hand, are paid 200 baht per day plus 50 for transport costs. Those who feel uncomfortable with one particular centre subculture tend to quit and seek work with other drug organisations. The outreach workers, staff and members know each other well: they all inhabit the drug community. The RakJai aims to gain access to as many injecting drug users as possible. To this end, outreach workers are responsible for bringing their friends to the centre. There are various reasons why people attend: many of them come hoping to get

jobs as outreach workers; in other words, to earn an income. Others may come looking for drugs, shelter or companionship, while others may be seeking health advice.

I have already mentioned that injecting drug users face difficulties finding jobs primarily due to their drug lifestyle. Visavakum (2010), exploring the meaning of work to injecting drug users who worked as HIV peer educators at one of the treatment centres, discovered that for Bangkok drug users, this work provides them with an opportunity for self-development, a legitimate income and the chance to make a social contribution. Moreover, working as peer educators broke their drug use pattern, resulting in their adopting more positive ways of thinking about life. From their perspectives, work helps restore a sense of self: it assists in rebuilding relationships with one's family and community (Visavakum 2010). In similar vein, at a staff weekly meeting, Bee, a peer educator, shared the following story of rebuilding a relationship with the community: "People in general hate drug users. They think that we commit crimes in the community. I and my friends helped them build the community playground and that helped change their opinions of people using drugs. At least, we can contribute something to the community."

Drug users' outreach work has gone some way to alleviate society's negative image of users by demonstrating the latter too can work to help their peers. But, inevitably they have to negotiate their encounters around their drug and public lifestyles; they try to show others that they are 'normal,' people who can live lives similar to those of non-users. Some drug users present their work employment records to the court to prove that they are capable of contributing to society. Rat, one of the outreach workers, was arrested many years ago before he worked as an outreach worker. His charge was submitted to the court and he had to await the judgment. Rat said: "I told the court that now I am a good person who is not using drugs anymore. I am clean now and willing to help others. That is why I work as an outreach worker."

The role of an outreach worker is thus not simply to provide help to his/her peers but to become the linchpin between the private and public space. Outreach workers can showcase a positive image of drug users, of persons who pursue normal lives by helping

others. But, sometimes their attempts lead to dissatisfaction or conflict with their peers at the centre. Some of my informants refer to this as 'denying their true selves' for it creates a gap between those currently injecting and those who have successfully quit. People feel embarrassed to acknowledge that they are still using drugs; therefore, they hide visible evidence of their habit. Such deception suggests to others that they are not 'open hearted' with their friends, that they do not trust their friends. Rat, commenting on a female user said "she has a drug problem, but she has never told anyone in the house. She has never accepted the truth. I think she has a problem in her heart. Well, what can we do if she will not open her heart to anyone here? One day I will ask her the reason."

Based on my observations, drop-in centre staff are able to substantially integrate harm reduction approaches by providing good care and prevention policies for drug users. They act as middlemen between drug users and health professionals. Sometime it is clear these initiatives can save people's lives. Yark, a male user, noted that:

> Most of my friends didn't like to go to hospital or social services as they were afraid of being discriminated [against]. Most of them finally died because of their sickness. Since I have been working as an outreach worker, I helped them to cooperate with the nurses at hospital. I took them to hospital. Or sometimes I contacted their family to tell them that their son was hospitalized. I was proud of what I was doing. It made me feel that at least I could do something for others.

Outreach workers function in a bridge-building capacity, establishing contact with drug users in drug communities that are hard to reach. In the field, workers face multiple dilemmas regarding their professional careers and personal identities. Having drug experience allows workers to share subjective experiences with other users; for example, the sense of being rejected by society. At the same time, working in the drug field may cause them to relapse as they participate in drug activities and socialisation. Nok observed as follows: "It is impossible to stop using drugs if you are still in the drug field. You see your friends on a high or they offer you cheap drugs. How can you resist that? That makes you think about drugs."

Despite these tensions, forming networks at the drop-in centre has proven a successful method of harm reduction in that it has projected the drug community into the public arena, allowing drug users to re-discover dimensions of normality through activities provided by the networks. Unfortunately, from a broader perspective, harm reduction has done little to reduce public stigma and the stereotyping of drug users. This is because neither the medical profession nor the public health domain considers subjective experiences relevant. Thus, in many ways the centre is where these tensions are played out and is a microcosm of a larger social order. It is here that some drug users have access to a 'normalcy' that is not available to all. The tensions that obtain between users and non-users and extend to members and staff, can in turn exacerbate stereotyped identities, e.g., those who succeed and those who fail.

The emergence of harm reduction as an overreaching strategy has both highlighted existing hierarchies as well as brought new meaning to people injecting drugs. Injecting drug users in Thailand are affected by this public health scheme in a variety of ways, e.g. methadone treatment programs. As a result of the introduction of harm reduction, Thai people using drugs have formed their own organisation, the Thai Drug Users' Network, which strongly focuses on the human rights of Thai drug users and advocacy. One effective scheme of harm reduction is the drop-in centre.

My study shows that drug users suffer from being both cause and repository of society's negative responses. Such social perceptions act to legitimise the exclusion of drug users from mainstream activities. The drop-in centre strategy has proven a relatively successful way of providing a space for drug users; in effect, it is a drug community that functions publicly. To some, the subculture within the centre could represent everyday life with all its on-going negotiations, successes and failures.

Unlike the hidden community, the drop-in centre, as a social space for drug users, reflects their everyday interactions which inevitably revolve around drugs. The experience of the centre as a place where drug users can freely talk about drugs allows them to reveal their feelings more openly. It acts as bridge between the private and the public and can help to dissolve the invisible boundary. As a result, it contributes to a

healthy life for drug users. In this way, what began as a top down strategy has become a tactic employed by drug users to improve their well-being and assertion of self. But, despite assisting with HIV reduction, there is still more to be done. I argue that harm reduction programs should also focus on the broader perspective, that is, the socio-cultural context of drug use. They should focus more upon subjective experiences and structural violence at all levels of society.

Chapter 7
Conclusion

In December 2008, I received a phone call from Nok saying that the previous night Dao, one of the outreach workers, had died at a friend's house from an overdose. I had met Dao several times, both as part of the drug community social networks and at the drop-in centre. A 45 year-old male drug user, Dao had a long experience of working in several drug-related programs. Nok told me that after receiving his monthly salary, Dao would withdraw all of the money from his account to buy drugs. That was why he often borrowed money from friends and why his friends called him 'Dao, one day' (*wan diaw* วันเดียว) the implication being that he spent all of his money on drugs in a single day. Dao lived with his mother in a slum area in Ladpao. His father had left after taking a minor wife; but, he continued to give Dao and his mother a monthly allowance. Because his mother was very old, friends at RakJai helped her to organise her son's funeral. Dang and Muan went to the police hospital to fill out the required form: Nok and Rat went to the temple to prepare for the funeral.

I arrived at the funeral around 4 p.m. to find only a few relatives present. One said that she could not reach his father because he had not given them his address. He was embarrassed by his son's drug addiction and feared that Dao would come to his new family asking for money to buy drugs. His mother said tearfully "I hope in the next life you will not be reborn as you are now [as a drug addict]. Be my son again in the next life. I love you'. Pat, who stood beside me, told me that: "It was usual that nobody came to the funeral. We drug users become dead to our families the day we start using drugs." At the funeral, Nok turned to me and pointed out one pavilion (*sala* ศาลา) saying: "Many drug users are burned here. Ake was burned at *sala* number 1. And, this time, Dao will be burned at *sala* 2. Maybe sala 3 belongs to me." I was surprised that Nok could joke about her death for in Thailand such comments are considered strange an inauspicious. One of the nurses who overheard Nok looked disapprovingly at her for making a joke about her own death. For a family, any suggestion of the deaths of their children makes them feel sad; but, perhaps during their quieter moments, parents feel mixed emotions

for as Dao's mother said, her son would not suffer anymore from drug addiction. Dao's death was not the only depressing incident I experienced during my fieldwork. Since I started collecting data in 2006, I have experienced the deaths of many of the drug users I befriended. I have seen the tears of their parents, heartbroken over their children's deaths. I have seen children call out the names of their mothers or fathers when seeing them lying in their coffins. Some drug users are fortunate to have family members attend their funerals; for others, perhaps only a few friends attend. Substance use has resulted in the deaths of many addicts either through overdoses or HIV infection. When a person dies from an overdose, the body is examined to ascertain the cause of death. Usually, a heart attack is identified as the cause in order to save 'face'. After the examination, and after procuring a death certificate, the relatives can take the body and prepare for the funeral. Normally a relatively simple process, it can, however, prove difficult for elderly parents. Funerals are customarily times when families gather together to mourn; but, in some cases, parents have not seen their children for long periods of time and for this reason opt not to attend. Temple authorities keep users' bodies only for short periods of time for fear of HIV/AIDS contamination. Nok told me about Am's funeral. "They just kept the body for 2 days and then burned it because she died of AIDS. Although the stigma upon PLWHA is not so much now, it still exists. She had that disease so no one wanted to keep the body for long. They just wanted to burn it as soon as possible."

In 2006, I attended a drug training session hosted by Rak Thai, an NGO working with drugs in Thailand. Several representatives from various drug networks attended this training. Nart, a drop-in centre manager, walked over to me to tell me that Kai, a drug user I knew, had died from an overdose. I was shocked because I had met him only the previous week. People attending the training had also heard this sad news. Some of them cried: some speculated about the reason for the overdose. After the meeting ended, many left hastily to attend his funeral in Samut Prakarn, an area at the periphery of Bangkok. They tried to help as much as possible by donating some money. It was a moment of sharing the tragedy that haunts many drug users' lives.

Drug users' deaths not only motivate problematic family gatherings: they are also occasions that invite the cooperation of the drug users themselves. In cases where the person is homeless, or even someone they have only met recently at a training session, users often gather together to organise the funeral. In light of their frequent occurrence, losing friends becomes a shared experience as users confront death as part of their daily lives. Many feel that death is a constant reality; if they continue to use drugs, it will inevitably claim them one day. Many drug users I met had experienced overdoses: some were fortunate enough to have been saved by friends; others died. Because heroin has become very expensive, drug users have resorted to injecting other substances. Overdoses nowadays tend to result mainly from mixing substances, e.g., amphetamine and Midazolam.

This thesis, which is primarily concerned with the subjective experience of drug users in Thailand, has attempted to explicate how drugs are socially constructed in the sense that their meaning is shaped by social relations. Death is all too commonly one final point of this ongoing process. My work has explored drugs within a socio-political context and sought to locate meaning in terms of interpersonal and gender relations, providing an understanding of the social dimensions of drug-taking as phenomena rooted in social conditions and relations. I argue that individuals, society, gender and politics are not separable phenomena. These four dimensions, which are closely linked, each in their own way pose a threat to both the health and well-being of drug users, who embody negative social responses as they become typecast as 'deviants'.

I have offered an alternative exploration of the social construction of Thai drug users' given that most of the drug literature in Thailand has virtually ignored medical anthropology approaches. Biehl et al. (2007:7) note regarding the role of anthropologists in the study of subjectivity that: "[A]nthropology, from this perspective, understands subjective life by analysing the symbolic forms - words, images, institutions, behaviours - through which people actually represent themselves to themselves and to others." My thesis has attempted to show that in order to understand the subjective experience of the drug user, it is important to understand the intersection of the cultural, social, political and economic contexts. As Lock and Scheper-Hughes

(1987) argue, the political, individual and social body is intermingled and cannot be viewed separately. A propos of health and illness, they consider the 'mindful body' as the interaction between the mind/body and the individual, the social, and the political body.

Certeau (1988:xxiv) notes that "[T]he fragmentation of the social fabric today lends a political dimension to the problem of subject." The political dimension, or body politic, has the power to control or change both the social and the individual. In order to achieve this objective, the state has to form strategies to regulate people's lives. The state believes that social problems occur because a group cannot or will not assimilate or conform to certain norms due to differences of political or economic background. The Thai government has employed several strategies to control drug cultivation and consumption in Thailand, ranging from 'apartheid' targeting the ethnic minorities who cultivate opium in northern Thailand to its recent drug policy known as the 'War on Drugs', strategies that have severely impacted upon the social and individual body. As the result of these strategies, at the social level, a negative view of people using drugs has become entrenched in most people's minds and attitudes; at the individual level, they have changed some drug users' patterns of drug consumption from illicit to licit (methadone, Midazolam), a switch that may lead to dangerous combinations of alternative drugs.

Control strategies operating at macro levels impact on the lives of Thai drug users. One effect has been the changing pattern of drug consumption in Bangkok: in addition to increasing ATS injection the last decade has ushered in a new era of psychoactive drugs use by people who previously predominantly injected heroin. The reason underlying this new trend of poly-drug use is that licit drugs are easier to procure and their use avoids legal and social punishment. But, while drug users can get Midazolam from private clinics throughout Bangkok, injecting Midalozam potentially causes more health problems; for example, increased risk of soft-tissue infection, gangrene and thromboembolic events (Kiatying-Angsulee N et al. 2004). This trend of injection diminishes the boundary between 'illicit' and 'licit' drugs, and, like opium in the past, psychoactive drugs may in the future be declared illicit. If this happens, other drugs will

in all likelihood take their place. These trends require not only insight into the changing subculture of injecting drug users, but also present the need for harm reduction strategies focusing on new types of drugs and new types of harm. This is an issue in urgent need of further exploration. Because my research was restricted to Bangkok and its suburbs only, further research could explore the pattern of drug user's subculture in the local context, especially in the rural areas, research that could signal the need to implement new approaches.

The social body has a particular impact upon Thai injecting drug users. One key reason underlying the severe responses to people injecting drugs is informed by a perceived similarity between drug use and mental illness. The violent behaviour occasionally attributed to mentally defective persons and typically to drug users has historically resulted in forms of collective constraint. Sometimes, for drug users, the violence caused by social attitudes is more severe than that caused by policy. For example, some drug users feel they suffer more from how the community treats them than when incarcerated in prison. Among the various structures that underpin the violence they endure, stigma plays a pivotal role. The suffering that drug users experience is attributable in the main to their oppressive life conditions and to adverse health consequences, especially HIV infection. The social forces which have led to the creation of a particular social identity for people injecting drugs exemplify the difference between people not using and those using, the latter being labelled 'wrongdoers'. Drug users' embodiment of these social perceptions and actions shapes their subjective sense of self. In Thailand, the term *khiya* represents the social construction of identity of people using drugs. Users, in their attempts to refute this image, blame society for their drug use.

An invisible boundary, that is, a form of self-protection against violence, the negative reaction of non-drug users, and stigma in particular, is difficult to dissolve because it is strongly linked to - and has become part of - user's disposition. The existence of this protective social and subjective boundary gives truth to the perception that conflict exists between people using and those not using. The conflict that obtains between users and non- users occurs when the latter fail to comprehend aspects of users' lives and fail

to either accept or accommodate them. Lack of awareness of the way drug users must distance themselves from society not only renders non-user and users frustrated: it leads to non-users condemnation of users as untrustworthy. The reason why users tell others that they have quit using drugs is because they fear an overall negative social response. In order to avoid negative reactions, drug users retreat into their own community wherein they can share their subjective experiences and at the same time take pleasure from using drugs. In other words, the drug community is a hidden space for drug users, a 'back stage' where they can conceal their lives from public scrutiny or from what they may see as the 'front stage'.

While Scheper-Hughes and Lock (1987) opt not to include specific discussion of the gendered body in their 'mindful body' theoretical framework, it is clear that the notion of gender is vital to any understanding of the subjective experience, in particular of (injecting) drug users. Significantly, men and women experience control strategies in different ways and respond using different tactics. In Thailand, women injecting drugs do not fit the Thai 'good' women image. The particular lifestyle they pursue and their use of drugs are together considered a male-dominated domain: their socially prescribed roles as 'good' women are stripped of meaning due to their male-oriented drug use behaviour. Thus, because society has certain expected norms of Thai girls and women as mothers and carers, their attitude towards female drug users is harsher than that towards male. The stigma experienced by females injecting drugs is, therefore, greater than that experienced by their male counterparts. The expectation that women customarily fill the domestic roles of daughters, wives and mothers is unarguably problematic for women injecting drugs. In this context, women experience considerable role conflict.

The notion that drug use is essentially a masculine subculture poses a further problem for females injecting drugs; subcultures, norms and practices, indeed the everyday experiences associated with drug use generate and sustain high risks for women. Like male users, they are subjected to violence, stigma and the potential or real threat of HIV/AIDS infection. But, as stated above, women injecting drugs face more severe discrimination compared to that levelled against male drug users because for women

society equates the injecting of drugs with self harm which runs directly counter to the 'self-less' disposition required of Thai women. Women craving heroin violate the traditional image of the appropriate or 'good' Thai woman. Gender inequality also helps to explain why the suffering of women using drugs exceeds that of their male counterparts. This is due to power differentials: women's rights are violated in many ways; they have to endure the crimes of domestic violence and rape. Little to no attempt is made to change social attitudes: nor is there any focus on gender sensitivity primarily because male drug users outnumber female users. Male drug users invariably opt to use specific tactics to deal with social forces; in similar fashion, women using drugs employ different ways of dealing with social disdain. But, they become trapped in conflicting gender and drug habituses as they try to balance traditional gender expectations with their drug-related lifestyle. Looking at the lives of my female informants, one could say that only a few have been successful. Many among them, no longer able to fulfil social expectations, have chosen to totally immerse themselves in their drug habitus. Importantly, the thesis shows the urgent need for implementation and development of harm reduction for Thai female drug users.

In general, harm reduction should address the gendered imbalances that pertain among drug users who take their place alongside other marginalised groups such as ethnic minorities, sex workers, men who have sex with men, and people who for various reasons cannot access the treatment and prevention programs. Anthropologists have much to offer in relation to insight into the lives of individual or groups who are to some degree seen and rejected by others as 'outsiders'. In order to improve the way harm reduction functions, it is necessary not only to explore the linkage between the macro and micro levels, but also to analyse and explain the complex interactions and relations that link the social and the individual. Nowadays, anthropologists not only study the local small scale: they also explore the relationship or linkage between large and small scales in a broader social context. The rich information that results from this integrated perspective is useful for public health professionals in that it will help them to develop more effective models of harm reduction based on a broader, holistic perspective.

While Lock and Scheper Hughes' concept of 'mindful body' helps to provide an understanding of the subjective experiences of drug users, Singer and Baer more specifically develop the idea of a critical medical anthropology that acknowledges the interrelation of macro and micro levels and the part they play in the shaping of the drug user's lived reality. More importantly, critical medical anthropology may be used to explain how the implementation of effective harm reduction programs impact upon/may benefit drug users. Singer and Baer (1995) claim that critical medical anthropology combines what actors think and feel with an analysis of the socio-political forces shaping their lives. As regards harm reduction, this should lead to a reinterpretation of the meaning of 'harm' for drug users and what really causes 'harm' to injecting drug users. It does so by developing a cultural understanding of drugs: it adopts a different approach to interpreting the drug user's subjective sense and develops a harm reduction model that is most suited to his/her socio-cultural context. Building upon the above, this thesis maintains that rather than treating drugs in isolation, the study of drug use requires an understanding of 'harm' in terms of broader perspectives.

Much research has demonstrated the benefits of harm reduction as an effective prevention program for people injecting drugs (Ashton&Seymour 2010; Wodak&Cooney 2005; Wodak&McLeod 2008). While social scientists, by contrast, interpret harm based on the subjective experiences of drug users, public health professionals tend to interpret harm as rooted in the physical actions of people injecting drugs, in their contracting of HIV/AIDS as a result, and in overdosing, all of which combine to render users unhealthy. Throughout this thesis, I have shown that the 'harm' that contributes to drug users' suffering comes not only in the form of disease but is also attributable to structural violence, e.g., stigma or social response that fuels prejudice against drug users. These forms of harm are destructive because the drug user embodies the resultant feelings and reactions as part of his/her disposition. Embodying these forms of social reaction makes users feel worthless, i.e., that all they can rely upon is their drug taking. The pleasure they gain from drug use is a consistent and reliable happiness they can pursue. Thus, it may be that harm reduction could also function as the link between the macro and micro levels rather than solely at the individual level.

Harm reduction policies deliver significant benefits through behavioural modification such as needle syringe exchange programs but could also aim to change the nature of the social attitude towards drug users. Despite the success of drop-in centres, that is, their role as public spaces for drug communities, people working in the drug field might also aim to further normalise drug user' lives by introducing activities that link them with other sectors of society. This could help to dissolve the invisible boundary and increase the Thai users' sense of self-worth.

Many scholars present the lives of drug users as being subjected to social forces that give rise to and exacerbate their suffering (Bourgois 1995; Singer 2005). While Thai drug users' subjection to social strategies is unavoidable, they also have agency to create forms of resistance, a topic I explore throughout the thesis. In response to hegemonic practices' impact upon drug users in Thailand, drug users have engaged with others in the following tactics: the formation of drug user networks and activities working on harm reduction implementation and advocacy that impact at the macro level; at the micro level, community members have banded together to share subjective experiences and to resist stigma and discrimination; and, at the individual level, in order to eschew self-blame, they have constructed a form of boundary separating them from other. These tactics and practices represent their attempts to resist or lessen the impact of socially-constructed strategies. They deny the image and definition of *khiya* and try to redefine their new identity through harm reduction programs. Females injecting drugs confront both similar and different patterns of structural violence and suffering from those experienced by their male counterparts; for this reason, they have formulated different tactics to lessen the impact of this oppression such as adopting masculine roles, enduring domestic violence, asking others to raise their children and so forth.

In the Introduction to this thesis, I describe the story of Nok and Rat, a couple entrapped in specific forms of structural violence. After a period working with NGOs, their degree of drug consumption decreased. Eventually, they felt they were able to stop using drugs. This contributed to a more 'normal' sense of living which has included employment and travel, for example. But, in 2010, Nok and Rat were asked to leave the centre because their behaviour was 'out of control': they came to be regarded as troublesome by staff

members and friends at the centre; so, they started using drugs again. One of the staff members told me: "They both not only use drugs but also sell drugs to other members. Many members are afraid to come to centre because they heard a rumour that RakJai is a dangerous place." Eventually, Nok and Rat went back to Nok's parents' home because they had no other place to stay. They tried to look for jobs as outreach workers with other NGOs but were turned down because of their drug addiction. One of the RakJai staff members said: "They both came to me asking whether they can live in my rehabilitation centre, but I have to say 'No'. They both use drugs. It may cause others trouble." I was surprised at this response as I knew that many of drop-in centre staff use drugs. Nuu, one of the staff members at RakJai, expressed his concern about the two, saying "I was worried about them. If they cannot work, they will spend all of their time using drugs. Life becomes nothing for them anymore."

Living with Nok's parents is now causing difficulty for both of them. Nok's mother is annoyed with Rat for not working: he seems to have no intention of working at all. At the same time, Nok's addiction makes the family feel uncomfortable. "My mom wants me to leave. She hates me. She claims that my brother's smoking cigarettes is caused by my drug addiction. Why does she blame me for everything? Dad also smokes cigarettes so why don't they blame him? Sometimes I want to die. It is hurtful to live like this." Nok is not only using heroin now, but also other drugs including Midazolam. She described that: "Rat receives many kinds of psychoactive drugs from hospitals. He pretends that he is mad so the doctor gives him drugs. We both use these drugs to get sleep. I will also get high when I feel depressed or sometimes after I have a fight with my mother. I just want to forget everything, especially my suffering life." Subsequently, Nok and Rat went back to the RakJai asking if they could return to work as outreach workers but, the manager turned them down because of their excessive drug use. Rat told me angrily: "They are just like the others. They said they work for us and harm reduction is the policy that will improve our life, but they judge us because we still use drugs." Even though their lives originally took a positive direction way through their involvement in the centre, Nok and Rat found that their involvement failed to alleviate their drug-using dilemmas. Drop-in centres ostensibly act as bridges between the public

and private or between people using drugs and not using drugs. Even though I argue that drop-in centres constitute one successful means of harm intervention, and seek to dissolve the boundary between people using and not using drugs, ongoing distinction between the two persists. In this sense, the centres mirror the tensions that prevail in the larger social order. While drop-in centres to some degree achieve reduction of harm, they continue to replicate the social distinctions between users and non-users that further entrench the seemingly impassable divide between the social and subjective lives of drug users and those who do not use drugs. In so far as Nok and Rat are typical examples, it would seem that the implementation of harm reduction in Thailand has so far proven unable to substantively alleviate the suffering of Thai people using drugs. As suggested earlier in this work, harm reduction, with its focus on behavioural change, has to some degree failed to create a healthy environment for people injecting drugs. Despite the well-meaning motivation underpinning its introduction, Thai people injecting drugs are still confronting violence and suffering in their everyday lived reality. This is not unusual, drug users face social and political discrimination in many countries. But as Nok and Rat show, its commonplace nature does not make it any easier to live with.

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Appendix A of this thesis has been removed as it may contain sensitive/confidential content