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## **Managing HIV/HCV-related Risk at Private Places Among Belgrade Injecting Drug Users\***

Some of the results acquired by qualitative research conducted among Belgrade injecting drug users are presented: primary aim of the research was to establish relation between HIV/HCV prevalence and socio-cultural aspects of HIV/HCV vulnerability in population issued. Understanding the way of how HIV/HCV-related risk is managed among these people in their day-to-day injecting routines is crucial tool in operating social epidemiological prevention programs. Vital part of this understanding concerns the physical risk environments, i.e. places where injection occurs. The distinctive feature of Belgrade study among the similar ones is that this happens frequently at various private places, which is depicted and discussed.

**Key words:** HIV/HCV risk management; physical risk environments; injecting drug users; qualitative research; anthropology of AIDS

The qualitative research has been conducted on HIV/HCV-related risk in Belgrade injecting drug users<sup>1</sup> (further in text: IDUs) by performing total of 72 in-

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Translated by the author.

<sup>1</sup> It is in fact of relative importance what kind of drugs is preferred for injecting concerning what has been researched, but let it be known that heroin is predominantly used by each and every of the informants, and that informants' experiences with some other types of injecting drugs – including cocaine, speed-ball, poppy-tea, crushed amphetamine pills or else – are scarce compared to heroine (ab)use.

depth interviews and re-interviews, and by visiting their injecting sites, as well by observing their injecting habits – when and where that was feasible, of course. The overall goal of this study was to offer the reliable picture of IDUs risk management<sup>2</sup> concerning HIV and HCV by identifying causes of their HIV/HCV-related risk behaviour and by suggesting some clues to understand it – all of that after presenting the IDUs' risk perceivment concerning HIV/HCV and linking their risk negotiation conduct to that perceivment, as the way of explaining their risk behaviour, and finding out the manners which will help the IDUs improve their HIV/HCV-related risk negotiation and management.<sup>3</sup>

Whereas several topics emerged as the ethnographic core to which analytical and interpretative tools are to be applied in order to reach some firm conclusions – including sharing (mostly needles and/or syringes, but other parts of injecting equipment as well), risk environments, keeping and storing the injecting equipment etc. – the situational orientation of injecting organization toward numerous private places appears to be somehow specific characteristic of Belgrade case compared to similar studies,<sup>4</sup> i.e. the frequency and variety of using those places as otherwise living and habitual spaces of both IDUs and their cohabiting often non-IDU spouses, siblings, parents, relatives. Therefore, one of the aims of explaining risk perceivment, negotiation, and management related to HIV and HCV among Belgrade IDUs should be the review and the discussion of this situation.

Private living places should be considered as elements of the conceptual assemblage known as risk environment when they are involved in injecting routine. There are two basic aspects of risk environments<sup>5</sup> – the physical ones and the social ones; obviously, the divide is of mostly analytical value, because no matter how we deal with such concepts – if the attention is more paid to hygiene of space for an example, or to social netting, one cannot deny those conceptual types of risk envi-

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<sup>2</sup> Set of acts individually performed by almost every single IDU in the course of avoiding the situations eventually suitable for being infected by blood-transmittable diseases; that could include variety of self-imposed norms, do's&don't's, restrictions and patterns concerning the IDU behaviour considering use of the injecting equipment, injecting sites, and social ties and networks.

<sup>3</sup> For agenda and detailed research protocol on HIV prevention vulnerability initiatives visit [www.hpvp.org.yu/istrazivanje.html](http://www.hpvp.org.yu/istrazivanje.html), and see also *United Nations General Assembly Special Session on HIV/AIDS: Monitoring the Declaration of Commitment on HIV/AIDS – Guidelines on Construction of Core Indicators*, UNAIDS May 2003.

<sup>4</sup> Cf. Carl A.Latkin, Wallace Mandell, David Vlahov, Maria Oziemkowska, Amy Knowlton, David Celentano, *My place, your place, and no place: behavior settings as a risk factor for HIV-related injection practices of drug users in Baltimore, Maryland*, *American Journal of Community Psychology* Vol. 22 No. 3, 1994; Tony Barnett, Alan Whiteside, Yuri Kruglov, Valentina Steshenko, and Lev Khodakevich, *The HIV/AIDS Epidemic in Ukraine: Its Potential Social and Economic Impact*, *Social Science & Medicine* 51, 2000; Tim Rhodes, Larissa Mikhailova, Anya Sarang, Catherine M. Lowndes, Andrey Rylkov, Mikhail Khutorskoy, Adrian Renton, *Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment*, *Social Science & Medicine* 57, 2003.

<sup>5</sup> The most original and elaborated determination of this concept is to be found in Tim Rhodes, *The "Risk Environment": A Framework for Understanding and Reducing Drug-Related Harm*, *International Journal of Drug Policy* 13, 2002.

ronment are intertwined in reality. This is also true for private living places as injection places: while physical risk environment paradigm embodies health- and storage management of injecting equipment, plasticity of the space injecting is happening within, infrastructure conditions and evaluation of their suitability for safe injecting, non-human hygiene, etc, social risk environment is found in every kind of interpersonal involvement occurring while using such places for injecting purposes.<sup>6</sup>

Risk environments should be looked at from two basic standpoints considering IDUs strategies of personal HIV/HCV harm disconnection: from the aspect of established injecting routine and from the aspect of its disruptions.<sup>7</sup> Injecting routine is the habitual model of IDUs behaviour which depicts individual preferences concerning type of drugs and its amount per some unit of time (i.e. daily, weekly or monthly dosage), as well the frequency of use, people and places with whom and where *scoring*<sup>8</sup> is customary and/or desirable, way of obtaining the drugs and people dealing with it etc. – in fact every single detail which participates in formatting the IDU practice. It is the model of control over the IDU habit, which is eventually designed to meet the best demands of protecting oneself while satisfying the IDU need.

Somehow key notion for every such routine is safety; it includes moments of physical exclusion from the world necessary to prepare the substance for injecting and to score it in a bit relaxed manner, evaluation of hygiene of injecting equipment to be used and of physical space where it all happens, judging reliability of people either just present when someone is scoring or involved in that act by any manner (ranging from joint investment in buying the substance to sharing the equipment in using it) by social and epidemiological standards (if they could be trusted not to talk before the police, if they will help in the case of overdose, are they infected, or suspected to be so but denying the true display of their status).

Therefore, disruption of injecting routine is not just relative lose of control, it means bringing up to light the potential for serious endangerment of somebody's safeness, targeting all or any of the above named aspects of it.<sup>9</sup> It usually comes from IDUs urge to satisfy their need at any cost – which mostly means at any place, where any notion of safety is repressed, as well the required procedure otherwise built in injecting routine. So, it is obvious how physical spaces could contribute to

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<sup>6</sup> Concept of social risk environment is not limited to the matters of injecting sites or intra-IDU relations at all; in fact, it comprises such factors which influence injecting routines as policing practices, economic sustainability of IDUs, their immediate non-IDU social environment etc. See for an example Latkin et al, op. cit.; Tim Rhodes and Milena Simić, *Transition and HIV risk environment*, British Medical Journal 331, 2005

<sup>7</sup> For some more details on the case and the elaboration of concept, see Bojan Žikić, *Anthropological Analysis of HIV/HCV-vulnerability and Risk Behaviour in Belgrade*, Свакодневна култура у постсоцијалистичком периоду (Everyday Culture in Postsocialist Period), Зборник радова Етнографског института САНУ 22, Beograd 2006.

<sup>8</sup> Terms from Belgrade IDU slang are always print *italic* when occur for the first time; later, there is no reminder on their sociolinguistic nature.

<sup>9</sup> Cf. B. Žikić, op. cit.

HIV/HCV risk management, not by themselves of course, but after appropriate control over them by the IDUs: exercising such control is perhaps the ultimate tool of maintaining the safe injection conditions in someone's environment.

When physical environments are concerned, IDUs mostly stick to either living space or *shteks*<sup>10</sup> in their injecting routines. Living space is mostly used by those IDUs who live alone or with another IDU. Some of them make it possible for their friends to, more or less regularly, also inject in their flats or houses, while others are strongly against it, where ratio is about 50-50%. Those who let their friends use their living space for injecting do this for two main reasons – as a favour to a friend and as a kind of exchange for another service related to IDU practice. When this is the case, the person who was given the place to inject can in return offer a portion of their heroin, help in a different way that someone who provided the space, give merchandise to the people who come to inject there for a better price, or simply give money, which is also the least common case.

Both cases of providing own living space to others as a safe place for injecting include a certain selection of those to whom this will be allowed. Informants who were talked to refused, without exception, such a lack of control over the situation where complete strangers would be there or people known to be infected with HIV/HCV, or those suspected of being infected. Most of them stated – excluding the eldest<sup>11</sup> amongst them – that they had never been in such *junkie places* where “promiscuity” of injectors happens, nor did they know of such (someone's) specified (living) space, but, naturally, they could not deny that it could have happened that a person presumably considered reliable in relation to possibility of being infected with HIV/HCV would sometimes bring someone along who was not in the closest circle of IDU contacts, and who would be, as a verification of their lack of risk to HIV/HCV, given only verbal guarantee by the person who had invited them.

What probably makes the Belgrade study different from other similar research is that a considerable number of informants here live with their families<sup>12</sup> – or relatives – or they lived like this during a considerable period of their IDU career. Some of them have or had their own part of the living space, physically separated from the rest of the family. Some others still keep from the people closest to

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<sup>10</sup> The form “sh” is used as a kind of the spelling suggestion, because the original term is *stek*, which of course hardly gives a clue to someone not acquainted with Serbian diacritics. *Shtek* is a place where IDUs inject regularly when they have no possibilities to do so within some private space, for whatever reason. It is mostly the cellar of some residential building, but this kind of physical environment sometimes includes desolate buildings, abandoned factories, even semi-exposed constructions of bridge foundations etc.

<sup>11</sup> Over 45; makes about 7% of sample.

<sup>12</sup> Cf. T. Rhodes et al, *op. cit.*; Tim Rhodes, Mark Davis & Ali Judd, *Hepatitis C and its risk management among drug injectors in London: renewing harm reduction in the context of uncertainty*, *Addiction* 99, 2004; Tim Rhodes, Lucy Platt, Svetlana Maximova, Evgenya Koshkina, Natalia Latishevskaya, Mathew Hickman, Adrian Renton, Natalia Bobrova, Tamara McDonald & John V. Parry, *Prevalence of HIV, hepatitis C and syphilis among injecting drug users in Russia: a multi-city study*, *Addiction* 101, 2006.

them that they are IDUs, while some have people closest to them – usually parents – strongly fighting their IDU practice. Some people's families have accepted their IDU practices and do not interfere with it – in some cases they even try to provide an optimal financial and safety situation for their IDU children – and in other families IDUs and their family members live in tacit agreement, IDUs pretending they are not so, and the family pretending they do not know about it.

Depending on the attitude that someone's family have to their IDU practice, this person chooses whether to inject in their own living space or to look for a different safe place, most often a shtek. What naturally prevails here is that the people closest to someone do not agree with their IDU practice, because of which IDUs try to dislocate as many aspects of it as they can from their living environment. Those IDUs that live with their families and inject in their own living space, also try not to include the people living with them or socially connected to them in their IDU practice, so that they most often inject either by themselves or with just one person who is their regular injecting partner. Unlike IDUs living in their flats or houses, completely separated from their families, IDUs who live with their families, even when they go relatively undisturbed through their injecting routines at their place of residence, they also include shteks in this routine, even though they do not use them as often as they use their direct physical environment, or living space.

Seen from the research perspective, it is the simplest to organise a relatively safe injecting routine for those IDUs who have their own living space. They are in a position to manage it themselves by dividing such injecting environment into physical and social: if in this environment no one who does not also live there injects, then HIV/HCV risk management practically comes down to controlling the relation between keeping the physical space clean and using and storing injecting equipment, i.e. needles and syringes. IDUs who can always inject at the same place where they live do not need to find special places within the living space where they will keep their (used or unused) needles and syringes: they do not need to hide them from anyone, or keep them away, and therefore, they do not need to store them at places which are usually less clean than those, in a flat or a house, more frequently used in everyday life.

All they need to do about controlling risk on HIV/HCV regarding the space they use to inject comes to almost routine maintenance of the space, and managing the specified risk from the aspect of treatment of injecting equipment. If, however, such injecting routines do not normally include the injecting of people who do not live there, but are allowed to, from time to time, inject drugs in this physical environment, then all the efforts of the IDU hosts, directed towards managing risk within this physical environment, need to be partly redirected also towards controlling the social environment: it is a disruption of the injecting routine, which should not be mixed up with the routine that includes other people's more or less frequent injecting in some IDUs' dwellings. The difference is in the focus on the social aspect of HIV/HCV risk control: regardless of the fact that both aspects of social risk environment generate higher risk on HIV/HCV opposed to, for example, only physical environment where only people who live there also inject there, the factor

that in the latter of the two cases influences higher alert to the risk is the preparedness to the situation and functional expectation of other people's presence.

Whatever types of interactions may be in cases when injecting routine includes other people coming to the living space of an IDU, they are, at least consciously experienced to be under control. Namely, they are accepted as a part of injecting habits, like something included in, at least elementary safety procedures. The most important fact, from IDU standpoint, to their advantage – is the one suggesting an element of joint IDU experience, and it is, when blood transmitted diseases are concerned, such that no one got infected. Therefore, from IDU standpoint of course, everything normally done during injecting procedure is functional in for managing risk on HIV/HCV, and this includes a certain attitude towards interaction using injecting equipment and the estimate of how reliable the people present are. What can therefore make the above mentioned occasional transformation of the physical into the social environment using the high HIV/HCV risk generator for IDUs whose routine is completely individual, is the lack of awareness of routine disruption, or the lack of standardised behaviour as in the previous case.

However, we should note that to some extent, there is a social environment even with the IDUs who live alone and who inject in their living space. This is the case when two IDUs live together. HIV/HCV risk management, or some attempts to prevent risk, is in these cases based on mutual trust: such persons are considered to be HIV/HCV safe, that is, with them sharing is acceptable, if occurs<sup>13</sup>. An important difference from such examples is, however, that the living community – based on the sharing of the same living space – is that with IDUs who live alone does not need to be the injecting community in relation to such routine.

This is especially relevant to the eldest IDUs we talked to, and who, basically, represent this category of informants. It is most often a question of two different injecting routines, which are sometimes divergent even when it is a question of obtaining drugs. These informants consider that simply by managing storage and use of injecting equipment – which in their case is mostly the whole set, not just needles and syringes – they are completely safe from HIV/HCV risk, i.e. that there is no possibility of being infected by the people they live with. They do not think of each other as regular injecting partners and they also claim to be behaving in this manner, meaning that their years of IDU practice and the success in prevention of seriously damaging their health gives them reasonable grounds for being able to avoid accidents that could serve as HIV/HCV risk generator.

IDUs who do not live alone (we are referring to those living with anyone who is not an IDU) have a different, in some degree a reciprocal problem. Their social environment is practically reduced to themselves, due to the factors with a different value in terms of IDU practice, but which are in this case complementary: on

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<sup>13</sup> The “official narrative” of the informants is that each of them, living together, posses his/her own injecting equipment and use it separately; alas, it is not considered as kind of a routine disruption to satisfy the unresisting urge by partner's needle&syringe, and the excuse is that it “seldom happens”.

one hand IDUs themselves limit their contact with the IDU world in their own physical environment – whether because they hide their belonging to this world, or to avoid bringing this world in connection with their own (family) environment, which is an irrelevant distinction in this case – and on the other hand, those that these IDUs live with, if they know of the IDU practice they try to, as much as possible, minimise the contacts of the specified IDU with the IDU world – again, regardless if they have come to terms with this IDU practice, or they are trying to eliminate it (INT).

Such a situation, however, makes risk management in physical surrounding more complicated for IDUs who live alone. IDUs that do not live alone, and use their own living space for injecting need to take certain precautions in order to separate physical space in which they prepare and use drugs and in which they keep their injecting equipment, from the rest of the living space they share with their relatives. What they do to this end is relatively similar to actions undertaken when injecting, almost anywhere outside of their flat/house: IDUs try to keep away from other people's view while they are preparing drugs and injecting them, then while they are stoned from the drugs' effects, while accessing water; they have special places where they keep needles and syringes, so that they do not have to leave the physical space that they have prepared for injecting in order to be able to use them.

Most often these IDUs use either their rooms or bathrooms in the flat/house as their injecting environment. It is obvious that there are differences between these rooms that could influence risk management when injecting in them; the most important difference is that IDUs do not have permanent control over bathrooms, unless they are the only ones in the specified living space who use them. This primarily relates to keeping needles and syringes and then to the very act of injecting, when HIV/HCV risk management is concerned. The focus on hygiene of the place where needles and syringes are kept – actually regardless of their hygiene – and the need to keep them hidden from other cohabitants, and still close at hand, is undoubtedly directed towards the latter. Similarly, the need to inject, or to perform this act without interference by others – in this case cohabitants – wins over more thorough reflection on where to put down the *gun*, what to do with the cooker or if there is some blood left on the body or the clothes.

IDU rooms are more reliable places to organise injecting in, regarding HIV/HCV risk management, than bathrooms, just by being the embodiment of someone's social and spatial autonomy within the living space shared with others. However, considered from this aspect, IDUs have certain doubts if these are completely safe places to inject: this, generally, depends on the kind of attitude the cohabitants have towards IDU practice. Anyway, places used by IDUs, for example, to keep needles and syringes in their rooms are also hidden – and not just in the sense that it is impossible to see them at first glance: they are hidden so that they are in the places IDUs think they are the only ones who can find them. Additionally, because there is normally no running water in the room, IDUs are forced to prepare such physical space for injecting in advance so that, besides taking the gun out of the secret stash, they also need to get water, cooker, citric acid, etc, doing which

they again come in contact with physical environment which they cannot fully manage.

A special case – somewhere between the “categories” of IDUs living alone and those who live with their families but inject in their living space, like the first – are married IDU couples<sup>14</sup> living with children – more precisely, most often one child. They certainly have their own living space where they organise injecting, but the organisation of their IDU practice is determined by certain conditions. The most important conditions, therefore, are that the child, regardless of its age, does not know that its parents are IDUs – which means that it is not only forbidden to inject before the child, but also to handle the injecting equipment in any way – which, in fact, leads to absolute rejection of any element of other people’s IDU practice in their flat/house.

This orientation of their IDU context in relation to their parental role puts these IDUs in a somewhat paradoxical situation: on one hand, they are forced to follow very strict safety procedures of the injecting routine, and on the other hand they are in the position to, when it comes to this routine, give up control over a (large) part of their physical environment. Finally, unlike those IDUs who live alone – so, not as, for example, a married couple or, two brothers – IDUs who are married couples and parents need to include their micro-social environments into their own safety procedures, regardless of how socially isolated they may be from the IDU setting to which they otherwise belong or they belonged to before they, by forming a family, exited it.

Similarly as in the cases with IDUs living together, but in their own living space, IDU couples-parents base the social aspects of HIV/HCV risk management on mutual trust, but their situation is still more similar to the one with regular injecting partners and acceptable sharing. IDUs who are couples-parents are regular injecting partners: they invest together in drugs and equipment purchase, they prepare together and inject one by the other. Apart from this, if they claim they have each their own injecting equipment, this mostly refers to having each their own needles, and then also syringes, and on top of it they do not deny the possibility of sharing needles and syringes in some “extreme situations”, certain in the correctness of their own judgement of the other person’s safety of possible HIV/HCV infection.

IDUs who are couples-parents pay actually more attention to possible HIV/HCV risk of their physical than their social environment. Their perception of risk is, in this sense, divided in relation to who of the two is in question: one of them who does not participate in drugs purchase – does not go to score – is aware that they cannot fully influence the social risk environment, i.e. whether the other

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<sup>14</sup> An interesting, but due to the paper’s purpose here somehow inapplicable distinction eventually relevant for analyzing types of injecting drug-abuse related risk intersected with relational categories of couples is postulated by Stephanie Kane and Theresa Mason, *“IV Drug Users” and “Sex Partners: The Limits of Epidemiological Categories and the Ethnography of Risk.”*, Gilbert Herdt and Shirley Lindenbaum (eds.) *The Time of Aids: Social Analysis, Theory, and Method*, Newbury Park, CA: Sage Publications, 1992.

one will inject with someone else, which is why they start directing their control towards social behaviour within their own living space, taking great care not to let in it a third person who would inject, but also taking more care about knowing which equipment is whose, i.e. about keeping them separately, in different places. In this way they actually expand the organisation of their physical surrounding in order to adjust in the best possible manner the need to inject and the need to keep the child from finding out that its parents are IDUs.

As to the physical spatial injecting organisation, IDUs who are couples-parents have similar prerogatives as other IDUs who live with their families, and inject in their own living space. Injecting equipment must be kept away from the physical and visual reach of the child, which again includes those places in the flat that are cleaned less frequently than the spaces normally used every day. It is similar with the act of injecting. What is specific for these IDUs, when we are talking about their physical injecting environment, is that they need to organise the time of injecting. Their injecting routines are mostly taking into consideration their children's daily schedule, so that they inject drugs when the children are not in the flat/house: when they are at school, when they are asleep, etc. There are of course exceptions to this injecting time management, when there comes unresisting urge to inject, and then they treat their physical environment as those who share their living space with the people who are not IDUs, but inject in it, which means by retreating to places within it where no one could disturb them for the moments of scoring.

Private places used as injecting sites are powerful resources for controlling the HIV/HCV-related risk<sup>15</sup> and maintaining safety procedures, which is demonstrated for several categories of IDUs according to their habituating status. The possibility to regularly inject at such places directly enable the IDUs to play an active part in reducing the harm eventually produced by their injecting habits: both social and physical environments could be relatively easily controlled by person(s) in charge either of the whole living space, or of its part where person is actually residing. Spatial autonomy of everyday living thus becomes source determining somebody's injecting routine: if an IDU is able to use his/her own living space also as own injecting site, he/she will be more likely able to establish such injecting routine based on as safe procedure as it possible due to sole practice of drug-injecting.

This is not an advocacy for injecting the drugs in every home around, of course, and this report and the accounts it is based upon strongly oppose the standpoint which eventually deny the IDUs' willingness to protect themselves from various epidemiological threats which come along their injecting habits. There is serious need nowadays to bring more institutional help to their efforts due we live in cultures and societies where spread of certain types of diseases is simply encouraged by the way they function,<sup>16</sup> where in fact becomes irrelevant if one belongs to

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<sup>15</sup> As well the other risks, such as those from being arrested in random police raid, or by being exposed as IDU.

<sup>16</sup> Cf. Paul Farmer, *Social Inequalities and Emerging Infectious Diseases*, Emerging Infectious Diseases, Vol. 2, No. 4, 1996; Ronald Barrett, Christopher W. Kuzawa, Thomas McDade, and

potential vulnerable group or not in relation to eventual determination who is to be infected before someone else, or – where the very notion of vulnerability serves perhaps as the category of statistics. There is where I hope it fits.

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## **Управљање ризиком од ХИВ и ХЦВ у оквиру приватног стамбеног простора међу београдским интравенским корисницима дроге**

*Кључне речи:* управљање ризиком од ХИВ и ХЦВ;  
физичко ризично окружење;  
интравенски корисници дроге;  
квалитативно истраживање;  
антропологија AIDS-а.

Рад је заснован на резултатима квалитативног антрополошког истраживања које је спроведено у Београду међу интравенским корисницима дроге (ИВКД). Методима дубинских интервјуа, реинтервјуисањем, посетом местима на којима се врши интравенско коришћење дроге и посматрањем одговарајућих навика испитаника прикупљени су разноврсни подаци везани за социјал-епидемиолошке аспекте преваленце ХИВ и ХЦВ међу припадницима дате популације, од којих се овде разматрају они који се односе на утицај посебног вида ризичног окружења, на начине на које испитаници покушавају да установе што успешније безбедоносне процедуре у погледу своје зависничке навике спрам могуће заразе вирусима о којима је реч, и крвљу преносивим болестима опште.

Ризично окружење може да буде, у основи, физичко и социјално: физичко ризично окружење део је датог теоријског концепта који се односи на пластичност простора у којем се врши регуларно интравенско коришћење

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George J. Armelagos, *Emerging and Re-emerging Infectious Diseases: The Third Epidemiologic Transition*, Annual Review of Anthropology 27, 1998.

дрогe, док је термин „социјално ризично окружење“ део истог концепта и односи се на разноврсност људских ресурса уплетених у ту праксу на овај или онај начин. Приватни стамбени простори, као вид физичког ризичног окружења, разматрају се као референтни оквири и, у извесном смислу, детерминанте посматране праксе припадника дате популације у погледу поступака који се, у датом контексту, односе на синтагму „управљање ризиком“, односно на одабир места за инјектирање, и разлози за то, општа хигијена простора, чување и складиштење прибора за инјектирање, контрола над особама којима је допуштено да исти простор користе у сличне сврхе.

Фреквентно коришћење приватних стамбених простора, од стране оних који у њима обитавају, као примарних простора за интравенско коришћење дроге представља, у извесном смислу, специфичност београдске студије у односу на слична истраживања која су спроведена како на Западу, тако и у земљама у транзицији. Овде није занемарљив ни број испитаника који, или поседују сопствени стамбени простор, или живе у заједници са другим/другом ИВКД или кохабитирају са не-ИВКД особама, најчешће родитељима или другим блиским сродницима – а упражњавају своју навик у управо у том стамбеном простору, уз, наравно, различит евалуативни однос сустанара према томе.

Резултати показују да постојање поуздане контроле над местима у којима се редовно инјектира од стране ИВКД, представља један од основних фактора успешног руковођења безбедоносним процедурама, односно смањења ризика на крвљу преносиве болести.