No Sex without Chems:

Challenges and lessons of the health and drug services regarding Chemsex among men having sex with men (MSM) in Amsterdam

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Glossary and list of Acronyms

Barebacking	Anal/rectal sex without the use of a condom
Booty bumping	Drug route of administration in which the substance is absorbed via the rectum.
Chemsex	Voluntary intake of psychoactive and non-psychoactive drugs to facilitate and/or to enhance sexual encounters.
Designer Drugs	Substances developed in laboratories with the specific purpose of creating mind-altering effects
GP	Family Doctor
MSM	Men who have sex with men
Slamming	Use to refer to the intravenous administration of drugs
Tina	Commonly used term to refer to Crystal meth (also known as T)
Uppers	Stimulant drugs

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To the nine men whose names are not in this paper, thank you. Thank you for the rawness, sincere and powerful voices you gave to these stories. Your strength and resilience would continue to inspire me, beyond this day. May you live your lives free of judgement and full of joy. May you change others, like you have done with me.

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Abstract

This paper reflects in the policy aims of the Dutch drug and health services around the practice of combining chemical drugs with sex, commonly known as Chemsex, among men who have sex with men (MSM) in Amsterdam city. With Chemsex being a growing trend in MSM subgroups in Europe, public health concerns around the positionality of queer men in relation to HIV and AIDS had been raise. Through the use of storytelling, this research collects the experiences of nine MSM Chemsex users and their relationship with one or more of the most popular sexualized drugs in the market; Crystal Meth, Mephedrone, GHL and GBL. This paper explores gender narratives of hegemonic masculinity in The Netherlands health and drug services and argue that there is a need to facilitate the provision of intersectional sensitive care towards MSM Chemsex users. Furthermore, it intends to contribute to the debate on drug harm reduction in social health policy and to suggest possibilities for harm minimization and social inclusion.

Relevance to Development Studies

There is considerable public health concern about the combining of sex and illicit drugs (Chemsex) among men having sex with men. In The Netherlands, sexual and reproductive health and rights is one of the four key components of the Dutch development cooperation policy. The policy focus is on two main aspects, the respect for the sexual health and rights of discriminated and vulnerable groups and combating HIV and AIDS. Although the internationally and nationally the Dutch are well on target in these areas, this research intends to set out how the healthcare system in relation to Chemsex still has important challenges and lessons to learn, specially towards the rights of MSM population and its positionality in HIV and AIDS eradication. Participants that have contribute to my research, are an example of the ongoing bargaining within the Dutch society and its health provision system, with important implications globally given the intertwined world we live in. The research aims to unveil, within the public discussion on migration, sexuality and universal health a gap where men who practice Chemsex are not included and the importance of their inclusion for social integration and justice. As The Netherlands leads the way in this field and given the growing issues around Chemsex this study can help development policy makers to be aware of global tendencies of consuming Chems in sexual context in not only northern Europe but also Eastern European and Northern Africa countries, as an emerging development issues.

Keywords

Chemsex, MSM, Tina, slamming, drugs, HIV and AIDS, health services, social inclusion, policy aims

Chapter 1 Contextualizing Chemsex Practice

1.1 Introduction

"We are all in love with her [Tina], but is a suicidal form of love, we all love her until she destroys us."
Heydar, Tina is my favorite girl Story

The term Chemsex has been popularized in medical journals in the recent years. It responds to a combination of the word Chemicals (or chemical drugs) and sex. Briefly it refers to the social practice of the voluntary intake of psychoactive and non-psychoactive drugs in order to enhance sexual encounters. Although the combination of sex and drugs is not a recent practice, studies show that men who have sex with men (MSM) are the most likely to use illicit drugs in sexual contexts. (Ahmed *et al.,* 2016: 29) For this research, I analyze the practice of Chemsex in relation to the four most popular sexualized drugs for in the Dutch context; crystal meth, GHB, GBL, and mephedrone, in Amsterdam City.

I aim to contribute to the debate of whether Chemsex should be consider a public health concern or not. I would argue during this paper that the positionality of MSM in relation to HIV/AIDS and Hepatitis C, put them in a particular situation of vulnerability towards the health and drug provision systems. In the same way gender assumptions of masculinity, which are reproduce through health practitioners and social policy, hinders the possibility of providing an adequate service to MSM. I would explore how an intersectional approach to Chemsex, that acknowledge the recent migration waves to Amsterdam, may help create sensible care for MSM in the city and increase the impact of harm reduction strategies.

The first Chapter provides a contextualization of Chemsex practices in men having sex with men in Amsterdam city. In addition, the research question and methodology are explained in detail. The second chapter theorizes Chemsex through the concepts of syndemic theory, masculinities and intersectionality, which are later expanded in the case study of Amsterdam. The third chapter explores the narratives of the research participants and health and drug practitioners in relation to the drugs used in sexual contexts, the routes of administration and the dosage. The fourth chapter discusses the relationship of research participants and practitioners with the Dutch health and drug provision. The fifth chapters outline the main challenges of the health and drug services and the importance of sensitive care to MSM Chemsex users.

1.2 Background

Chemsex practice uses a particular set of drugs, commonly called as "sexualized drugs". (Bourne *et al.,* 2015) According to the European MSM Internet Survey (EMIS) "health and social care providers in several countries suggest increasing use of four newer drugs" (Schmidt et al., 2018: 4) which are methamphetamine (crystal meth), gamma-hydroxybutyric acid (GHB), gamma-butyrolactone (GBL), and methylmethcathinone (mephedrone). This means that there seems to be a shift in the pattern drug use in previous decades where cocaine, ecstasy and MDMA were

popular in the big European metropolis. (Ahmed *et al.,* 2016: 30) While the majority of studies conducted around the use of drugs in sexual contexts are in the United States and the United Kingdom there are studies around Chemsex in the European context which reflects the change of drug patterns. (González-Baeza *et al.,*: 114) Table **No. 1**, presents a selection of the most common substances used in the Dutch context and a brief explanation of their effects and routes of administration (meaning the path by which the drugs are taken into the body).

Table No.1 Overview of substances used by Dutch MSM during Chemsex

Name	Street Name	Background information	Effect	Routes of Administration
Crystal meth (methamphetamine)	Meth, Crystal, T, Tina, Ice, Yaba, Shabu, Shisha	Amphetamine-like stimulant, generates euphoria and its effect lasts longer than speed. Used by soldiers during WWII. Popular in "gay capitals" all over the world, and on the rise within the Dutch Chemsex scene	Energizing, aphrodisiac, euphoric	Nasal, oral, rectal, smoking, intravenous
GHB/GBL	G, Liquid ecstasy, Auntie G	Endogenous substance. Used to treat narcolepsy. Difficult to gauge correct dosage. Use can easily result in short-term coma or in more extreme cases death.	Sedative, euphoria, aphrodisiac, entactogen-like effects	Oral, rectal, intravenous (rare)
Mephedrone (4-MMC)	M-Cat, Drone, Meow meow, Miaow, Plant food	Cathinone-derivative. Achieved rapid popularity (especially in England); appears to be on its way out. Use tends to compel redosing. Its effect, for some, is similar to that of cocaine.	Energising, euphoric, entactogen-like effects, aphrodisiac	Nasal, oral, anal, intravenous

Source: Knoops, L.B. (2015) Tina & slamming

In 2014, the European Drug Report "noted that there was an increase on the use of Chemsex in Europe within some sub-groups of men who have sex with men (MSM)."(Knoops, 2015: 6) The higher prevalence rates of drugs use during sex "can be strongly related to the intersection of gender and age, as well as membership of particular social network" (Abdulrahim *et al.,* 2016). According to Abdulrahim et al Chemsex consumers are more likely to be male between the age of 25 to 35 years old. However, with the popularization of these drugs, the price has dropped extending the age range to younger populations.

Studies in the United Kingdom and the United States point to the propensity of MSM couples to consume drugs during their sexual performance can be three times higher than in the rest of the population (Bourne *et al.,* 2015: 1171). In the Netherlands "the rate of substance use among MSM before or during sex is higher than in

the general population".(Knoops, 2015: 6) However, it is important to clarify that although this practice seems to be more popular in the MSM community it is still only a small but significant part of the MSM population. Another important clarification is that MSM are not a homogenous population and the interaction of class, ethnic, and gender identities and its role in the way different people experience Chemsex has yet to be studied.

The profile of users of sexualized drugs seem to be different from other recreational traditional drugs. Chemsex users choose drugs that make them feel connected with their partners or social networks, rather than isolate them as with traditional drug users. In fact, social apps such as Grindr and Tinder play a key role in facilitating sexual encounters within Chemsex uses. (Macfarlane, 2016: 295) This is another reason why MSM populations seem to be more incline to methamphetamines and GBL rather than heroin or crack. Chemsex as a practice is normalized in subgroups of MSM communities in Amsterdam where "[c]ontact was often made through the various dating sites for gay men, where coded language was used to indicate the desire for Chemsex." (Knoops, 2015: 39)

Sexualized drugs (taken in clubs among consenting partners) can improve the sexual experience, creating a feeling of euphoria, disinhibition and sexual pleasure. However, according Jelte Sondij, a researcher on harm reduction policies in Amsterdam, the use of this drugs can intensify sexual risk behaviors and therefore the potential harmful effects can include "hyper-sexualization and unprotected sex, which may lead to an increase in sexually transmitted infections (STIs), including HIV." (Sondij, 2016) Some of these drugs are injected, a practice commonly known as slamming, which can carry additional health and safety risks and can be associated with the increase of transmission of viruses such us HIV, Hepatitis C and Hepatitis B. In some cases, the lack of inhibition produced by the drugs can induce to a coma or an overdose. In the Netherlands "there are reports of use associated with sexual assault." (Sondij, 2016) The emerging patterns of interjecting drug use during sex has influence the decision of countries such as the UK and Spain to declare Chemsex practices as a matter of public health concern. (Macfarlane, 2016: 237)

According to the European MSM Internet Survey (EMIS), "the use of drugs associated with sex between men varied substantially across European cities in 2010 (…) but drug use patterns appear to be culturally and socially determined". (Schmidt et al., 2016) Amsterdam was listed as one of the top 5 European cities with a high increase in recent crystal meth users(Schmidt *et al.,* 2016:5) Recent studies show an increase of Methamphetamines and Mephedrone laboratories in The Netherlands, suggesting an increase in the demand for these drugs. (EMCDDA, 2014) Another important aspect to consider is that many of these drugs are designer drugs. Designer drugs are produce in laboratories and that is why because of their "new chemical compositions, they are not initially illegal when they appear on the market"(Knoops, 2015: 8) Dozens of these drugs appear every year on the market which can mean it is difficult for the drug health services to keep track or to be updated on the current situation.

The Netherlands is part of the Single Convention on Narcotic Drugs (1961), the EU Action Plan to Combat Drugs (1995-1999) and the European Union Drugs Strategy

(2000-2004). However, the Dutch policy seem to perceive drugs as a matter of social and public health and that is why in the Opium Act (1919) and revised in 1976, creates a distinction between "soft drugs" and "hard drugs". (van der Goewe et al.,2009) This distinction makes a clear separation between individual and social risks and therefore separates the users and surveillance and control of both markets. The drugs studied in this research are considered "hard drugs" in the Netherlands and the possession (of more than one unit), dealing and trade are considered illegal. The Netherlands has been a pioneer in the use of Harm reduction policies for the use of drugs. Although Dutch strategies such us the Injection Drug User program (IDU) were implemented since the decades of the 60's (Hedrich et al., 2008: 507) , it was not until the mid-80's when harm reduction policies had a faster development. This was due in large part to the epidemic of HIV and AIDS, and the need to counteract bloodborne diseases. (Hendrich et al., 2008: 509)

1.3 Research Questions and objectives

This research intends to answer the following question,

What are the policy aims of the health system services in their response to the needs of Chemsex practices among men having sex with men (MSM) in Amsterdam?

The research aims to provide in-depth knowledge about the normalization of Chemsex practices in Amsterdam among men who have sex with men and how the drug and health services are struggling to respond to this practice. I look at how these social health policies need to be sensitive to the MSM population and the need to take into account the intersection of age, gender and ethnicity.

General Objective

To evaluate a generation of health drug services in Amsterdam (dates) and the aim to create sensitive policies for MSM population who are using sexualized drugs

Specific Objectives

- Identify favorable and unfavorable experiences with Chemsex practices including users access to the drug health services.

- Describe the institutional capacities of the health services and harm reduction programs to meet the needs of the users.

- Determine the areas of effectiveness and ineffectiveness of the health policies in relation to Chemsex practices in Amsterdam

- Collaborate in the updating of the Report of Tina and Slamming (2015) with Mainline and SOAIDS; looking at MSM, Crystal Meth and intravenous drug use in a sexual setting

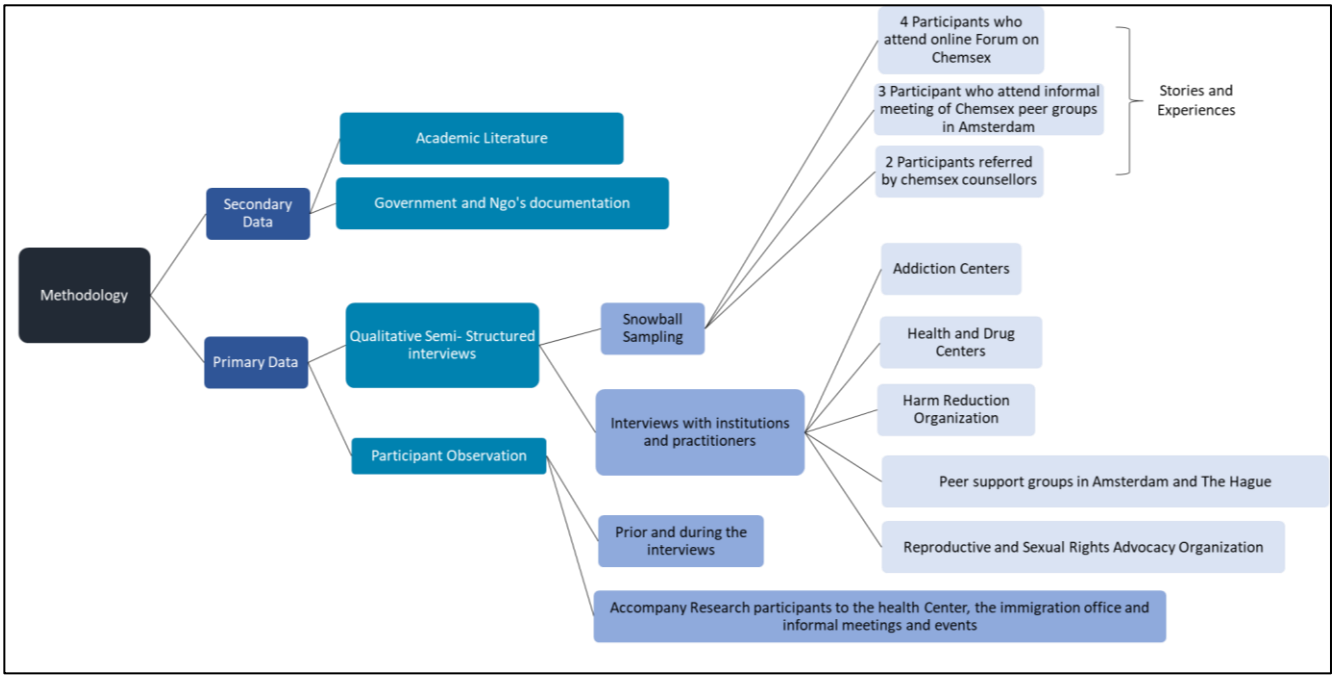
1.4 Using qualitative methodology

I used a range of qualitative methods to collect data and information regarding Chemsex practices in Amsterdam. I viewed my case study as a multi-layered practice that interacts within a specific context. The research is based on stories shared by research participants as well as by health and drug practitioners, in order to examine the interaction of sexuality, gender, ethnicity, and race in which Chemsex practice is contextualized. I have decided to use in my research storytelling. According to Messias & DeJoseph, storytelling is a mutual process, build around not only the narratives but also through the interpretive interaction among the researcher and the interviewees (Messias and DeJoseph, 2004: 45) In addition to using storytelling and the use of intersectionality, I applied a feminist perspective to knowledge production by co-producing knowledge with my interviewees. The layers in which this research unfolds are reflected in my selection of primary and secondary data.

The Methodology mind map represented in **Figure No.1,** shows how I went about my research. The secondary data I reviewed shows how I gained knowledge from academic literature and governmental and institutional documentation produced around Chemsex. On the other hand, the story telling is based on the primary data recollected for this research where I used semi structures interviews with research participants and health and drug services practitioners, as well as observations and insights from our interaction in different locations. See **Appendix 3.**

Figure No. 1

Methodology Mind Map



1.4.1 Secondary Data Selection

As a starting point to understand Chemsex dynamics and challenges, I use a selection of academic literature to review data collected around Chemsex practices and to contextualized it around MSM population. The data selection gave me a wider understanding of the links between the drug use and risky sexual behaviors. In addition, previous publications as GDD Amsterdam Cohort Studies, EMIS Report of drug use in 44 European cities and information regarding intravenous drug use among visitors of STI Clinics done by RIVM, within others provide facts and figures around dynamics and experiences of Chemsex users in Amsterdam.

A review of documentation of governmental institutions, drug service providers and crisis centers, gave me insights into the tendencies of drug use and how the Dutch provision systems around drug services respond to a specific political and economic context. Access to drug related treatments and health facilities in The Netherlands has strengthened in the last decades and a review of the latest publications allowed me to examine achievements and challenges. The information register in the Dutch Alcohol and Drug Information System known as LADIS (LADIS, 2015) and the reports done to the Trimbos Institute's National Monitor Drug Incidents (MDI) allowed me to find local data connected to Chemsex. (Trimbos Instituut, 2016)

1.4.2 Primary Data Collection

The primary data collected in my research revolves around two areas. There were the interviews with practitioners and professionals and in-depth interviews done to research participants who use or have used Chemsex. There was also participant observation around the locations, experiences and contexts I observed while performing my research. As part of an action research I have follow up policy documents and government commitments in relation to drug consumption, harm reduction services and HIV prevention.

Interviews with health and drug practitioners

The interviews with Health and Drug service provisions used for my data collection were conducted after a pre-selection of institutions and organizations working with Chemsex. Through semi- structured interviews, I was able to research experiences working with the health treatment service and how this shaped MSM population and Chemsex-treatment. I also looked at how the use of drugs and sex cases are recorded in the health system and if the system is sensible to the MSM population, noting any difference in relation to race, ethnicity and class. An overview of institutions and practitioners is presented in **Table No.2**.

Table No.2 - Overview of Institutions and Practitioner Interviews

Overview of Institutions and practitioner Interviews	
Interviewee	**Background**

Sjef Pelsser, Chemsex team and organizer of peer counsellor group at *Mainline*	*Mainline* is an organization dedicated to promote the responsible use of drugs through a harm reduction approach. Provides information to users and training to health practitioners in topics related to Chemsex. Furthermore, it has two peer support groups that meet regularly to share experiences and information around Chemsex.
Health practitioner, OLVG Hospital in Amsterdam	Emergency room practitioner with OLVG Hospital in Amsterdam, West Location. Previous training in Medical Microbiology
Nurse practitioner, emergency room, *Mc Slotervaart Hospital* in Amsterdam	Emergency Aid Nurse, working in the health system for the last 15 years, the las 3 in the Mc Slotervaart Hospital in Amsterdam.
Frederick Becker, Psychologist and institutional director of *CRT Addiction Centre*	CRT Addiction Centre in Amsterdam, is an institution focus on the treatment and management of addictions. Works directly with social workers, harm reduction organization, and local government offices to provide drug related services in Amsterdam
Chris Tearno, Chemsex Researcher and Nurse Practitioner, Department of Infectious Diseases at *Maasstad Hospital Rotterdam*	Chris Tearno has done research around Chemsex and HIV Positive MSM in the Netherlands, his work as health practitioner has provide him with a psychosocial view around medicine. In addition, The Maasstad Hospital in Rotterdam has provided special training to his medical staff around Chemsex risks and practices.
Dennis Heineman, facilitates Chemsex group in Centrum Seksuele Gezondheid, *GDD The Hague*	GDD is a Centre for sexual Health with representation in Amsterdam and The Hague. It offers tests and treatments for STI free of charge and provide a safe space for a Chemsex support group. It regularly receives people living in Amsterdam, Rotterdam and The Hague.

Interviews with Research Participants: The Power of a Story

As a central part of my research I carried out in-depth interviews with nine research participants. Conducting an in-depth interview "involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on an idea, program, or situation" (Boyce and Neale, 2006 : 3). My interviewees where recruited through a snowball process which began in three different places: Online forum of Chemsex, informal meeting of Chemsex peer groups and contacts of counsellors and addiction specialists. From the online Forum on Chemsex, four research participants contacted me through an email created for this investigation, none of the participants knew each other. I attended an informal meeting of Chemsex peer groups in a bar in the center of Amsterdam, where I shared my contact information and was later contacted by three research participants, who shared common experiences and sex networks. In my search for more participants, I contacted counsellors and addiction specialists who share an invitation to participate in my research through social media. I was contacted by six possible participants but could only manage to include two in my research due to a time restriction. In order to protect the identity of the participants their names have been changed and I have taken special measures for the protection of their personal data.

The interviews allowed me to listen and connect with the interviewees on a personal level. The purpose of these interviews was not to explore stigma related to the use of drugs in same sex couples but to focus on their experiences with the health and drug services in Amsterdam. To create a more personal connection I ask the research participants to choose the name by which they will like to be address in my research. In that way *Jeremy, Eric, Jonas, Hector, Daniel, Rud, Heydar, Hans and Ali*, became active participants of my work. The stories portrayed in this paper where collected between a fourth month (April- July) interaction within the research participants and myself.

Their stories reflected different narratives of positive and negative experiences with Chemsex and in that process we work together to title and give a voice to their stories. *The Harvest* by Rud, *Scabs and Vains* by Jeremy*, Ready to parTy* by Eric, *HIV is not who I am* by Jonas, *Coming out, Coming down* by Hector, *'Please let me know'* by Daniel, *Tina is my favourite Girl* by Heydar, *Is not about the bottom* by Hans and *High in the Method* by Ali. Extracts of their personal stories can be found in **Appendix 1.**

The main recruitment criteria were that respondents have or had engaged with Chemsex practices. Interviewees where all male who have sex with men (MSM), and do not necessarily self-identify as gay men. All of them live in (or regularly visit) Amsterdam and have consumed either Crystal Meth, Mephedrone or GHB/ GBL, during or before sexual encounters. In terms of demographics, 5 research participants were born and raised abroad (2 Ecuador, 1 Morocco, 1 Poland and 1 Ghana), 2 have a double nationality (1 German/Dutch, 1 Kenyan/Dutch) and 2 were born in the Netherlands (2 North Holland).

The range of age of the participants was between 26 and 40 years old. The median and average age was 32 years old. Regarding the age in which the respondents engage for the first time in Chemsex, the average is around the 30 years old. From the 9 participants, 7 had paid jobs and 2 were under incapacity benefits while they are undergoing drug dependency treatments. As relevant information for the purpose of this research, 4 of the research participants have been diagnosed as HIV+.

The use of storytelling allowed me to give an emotional and deep understanding of life experiences. However, it is necessary to mention that this methodology has its limitations. The first limitation is that this methodology can give importance to facts that reflect more a personal perception than the social reality of people experiencing the same situation. In the book 'Telling Sexual Stories. Power, Change and Social Worlds' (Plumer 1995) Ken Plumer reflects on this limitation and the importance of an analytical framework to highlight relevant data obtained during the fieldwork from conjectural information (Mahoney, 1995: 32).

Another limitation comes with becoming a trusted insider. I needed to assure my participants that I intended to be (as much as I could) respectful with their decisions and sexual practices, this however took more time than expected and it had profound effects on my way of seeing and relating to the participants. As Mahoney (2007) the process to become a trusted insider plays a role on how the researcher interprets their experiences and "where the lines within the public identities blur with the private selves" (Mahoney, 2007:579) In my research these lines are usually connected and

that means that boundaries within my research work had to be continually negotiated during my fieldwork. In the same way, time constraints during my research meant that some of the information share by them in our interviews lacked further reflection from my side. I have chosen aspects that I though where more relevant for my research, knowledge about the economic and market aspect for example was left outside and could be useful for future research.

Participant Observation

I have decided to include in my research the observation collected around the places, experiences and context in which I developed my relationship with my interviewees. The value of this observations is because of the insights I gained about their access to their networks and realities. Those observations are included in the narrative where I have chosen to share personal stories in a different dimension, almost in the form of an 'emotional' language. In my observation, I highlight sensations and thoughts I had prior and during our interviews. Furthermore, I share personal experiences with them, which include within others: accompanying Rud to an STI consultation, walking around the city center looking for a Grindr date for Jonas and visiting the immigration office with Ali. See **Appendix 3.**

1.5 Risks and ethics

One of my first ethical considerations was about how to locate the population of MSM within a community, without categorizing them specifically within LGBTI collectives in the city of Amsterdam. Likewise, I have found that the MSM community carries several stigmas related to their sexual practices and more specifically with the transmission of HIV and AIDS. Moreover, what I needed to be sensitive to is the moral panic related to social practices such as Chemsex within the LGBTI community. The media representation of Chemsex, seem to portrait this practice only through the negative experiences of MSM. As Hakim (2015) argues "current sexual health research agendas are rightly dominated by HIV prevention and harm and risk reduction"(Hakim, 2015) "and a tendency to pathologize both the practice and the reasons why these men engaged in it" (Hakim, 2018) I wanted to move my research away from these stigmas and judgments, and to focus on the realities and experiences transmitted by the interviewees. Chemsex is not a problem by itself, however it can carry potential risks that need to be address in the public policy agenda.

With this in mind, I have decided to ensure the anonymity and confidentiality of my interviewees in order to protect their identity and at the same time provide a safe space. In the same way I understand that these practices include the purchase and consumption of illicit drugs and that therefore the exposure of their names or personal data could have legal consequences. To ensure informed consent from my participants I provided information about the overall purpose and objectives of my research, as well as the risks of participating in it. More important, I made sure that they felt free to express their will and pull out of the research at any time if they felt the need to do so. My interviews, recordings and transcripts have been saved on a hard drive where they cannot be uploaded to the cloud. In the same way their names and profiles have been coded to protect their identities. The transcripts of my interviews were shared for review with the research participants.

Positionality as a researcher

When reflecting on my position as a researcher, I have thought about how my identity and my experiences can influence my work. I have been involved with LGBTI organizations in Colombia for some years. These recurring interactions with activists and institutions have allowed me to have a closer perspective on the dynamics of the community and the challenges in terms of social justice that must be overcome. In addition, since my arrival to ISS, I have joined the Sexual Diversity Committee of the university and participate in events and conferences about queer activism in The Hague and Amsterdam. However, even though I feel like a member of the LGBTI community in Colombia, it is harder for me to feel part of that community in the Dutch context. This is partly due to the fact that beyond being lesbian and a LGBTI activist, I am also a woman, student, Latin-American and research migrant. Despite feeling that I have a special link with my research and with the LGBTI community in Amsterdam, I do not feel part of this community. In my research process I may feel inclined to defend the individual decisions of my participants as part of my activism for sexual and gender inclusion, but at the same time I want to redefine that activism around a broader understanding of the power relations in which they find themselves and of the intersection of race, class and age.

Being a young woman researching a male population has its own challenges and advantages. On the one hand, it was beneficial to create a bond of trust, because the interviewees could see me as a party outside the relationships and network of the MSM in Amsterdam. However, on the other hand, the fact of being a woman resulted in a first barrier to find participants and that they share with me details of their private life. This could also be because my condition of 'outsider'. Furthermore, some of the spaces related to the practice of Chemsex in Amsterdam are exclusive for men. For example, this is the case of social apps like Grindr and clubs like Church in Amsterdam.

Language also plays an important role. My participants communicate with me in English, but this meant that in our communication some words that are part of the daily use and the Dutch queer "slang" where be lost and this might result in a diverse understanding on experiences. In the process of this research I hoped to create a safe and trusting environment for my interviewees, where their voice is not lost in the translation and where being aware of my personal bias I can redefine, resist or change my positionality.

Chapter 2 Theorizing Chemsex through syndemic theory, intersectionality and masculinities

This chapter serve as a theoretical framework to understand Chemsex practices within the policy aims of the Dutch health provision system. The main concepts selected for this section emerge from the literature review of medical, sociological and public health articles dealing with sexuality, gender, masculinity, intersectionality, disease and health inequities. In the first part of the chapter, I raise the importance of syndemic theory in understanding the vulnerability of MSM population to diseases such as HIV and AIDS and therefore acknowledge the delicate relation of MSM with Chemsex. In a second part, I address the wave of migrants to Europe and how the interaction with local spaces can spark more than one representations of gender and sexuality. I will reflect around the disparities and vulnerabilities of specific racial and sexualized groups, and how an intersectional approach can help provide sensible care to Chemsex users. To finish, I engage with the concept of masculinities, to understand how particular hegemonic constructions of the gender order assumptions can be reproduce in social policy.

When theorizing Chemsex, it is important to note that there has been an increase in medical studies on sexualized drugs. Those studies vary from the "mechanisms of action, the toxicity and the pattern of use and abuse of substances involved in Chemsex" (Giorgetti *et al.,* 2017: 764) to studies of the ingestion and medical experiences with gamma hydroxybutyrate (GHB) and its chemical analogues. (Barker, Harris and Dyer, 2007) The majority of studies, however, focus on understanding the relationship between substance abuse and the HIV epidemic. It is perhaps, this aspect of Chemsex which has been of most interest to development studies. Since the 1990s global programs on HIV and AIDS reduction, have received considerable financial resources. (Shiffman, 2007: 96) Those resources aimed to research the disease and its implications for public health expenditure. As a result, studies noted the disparity among populations affected by HIV, with focus on MSM populations.

Although MSM, represent a small fraction of the population living in The Netherlands, they make up the majority of the people living with HIV. According to the Stichting HIV Monitoring (SHM), from the 19,035-people living with HIV in the Dutch care system 11,928 are men who have sex with men (MSM) (Stichting HIV Monitoring, 2017). Which means that MSM account for around the 62% of HIV reported cases. However, until the 90s the medical approach to HIV and AIDS failed to reflect the complexity and underlying factors that determine the vulnerability of MSM population towards HIV. These limitations have been addressed in the growing academic interest towards the syndemic theory, which has enabled researchers to connect MSM, HIV and substance abuse.

The syndemic theory, was coined by medical anthropologist Merrill Singer in the 90s and has had a powerful effect in interlinking social interaction with diseases, risks and locations. Syndemic theory looks at "the tendency for multiple epidemics to co-occur and, in the process of affecting some of the same people, for the various maladies to interact with one another, with each one worsening the effects of the others"

(Klein, 2011: 466) According to Singer et al, in a biomedical approach, diseases were usually treated as independent from social contexts. Although this analysis was useful to understand direct consequences of medical diseases, it limited the possibility to understand the correlation among diseases, demographics, vulnerabilities to specific afflictions and social policy. Specifically, "how social forces, such as political violence and racism, come to be embodied and expressed as individual pathology." (Singer *et al.,* 2006: 2)

Recognizing co-occurring health problems also help illustrate how social marginalization of LGBTQI population play a role in sexual risk behavior and self-reported HIV infections. (Brennan *et al.,* 2012: 1752) Aspects that were once studied as isolated variables such as depression and violence among sexual partners are now seen as risk factors for HIV. As an example, in the article *The Impact of Mental Health and substance abuse factors on HIV Prevention and Treatment* (Walkup *et al.,* 2008), the author sets out the synergic connection within HIV, substance abuse and mental illness. In his analysis, health problems which correlate with one two or more afflictions (in this case substance abuse and sexual inclinations) can expand the risk for specific populations to suffer from blood- borne diseases. Syndemic theory may explains then, the burden that MSM have in relation to HIV. (Walkup *et al.,* 2008: 17) Moreover, syndemic literature shows how social behavior affect diseases and at the same time diseases affect social behavior and produce social outcomes.

Nevertheless, the increasing representation MSM in development interventions has lead to a scrutiny of their sexual practices rather than bringing "attention to the social complexities of their lives and overall health, or their experiences of stigma and discrimination" (Ferlatte *et al.,* 2018 pp510). In that sense, HIV prevention campaigns targeting MSM population without recognizing the social complexities of his population, might reproduce gender and sexual stereotypes, rather than create a sensible approach to the population. Furthermore, it is important to say that the MSM population is unevenly affected by HIV and AIDS.

Several studies have explored the underlining racial and ethnic factors that affect HIV risk population. According to an urban health study, "HIV prevalence among MSM is consistently higher for racial/ethnic minorities." (Garofalo *et al.,* 2010: 318) In another study, developed with young men having sex with men in the United States, African Americans and Hispanics/Latinos seem to be at particularly high risk for HIV infections. (Freese *et al.,* 2017: 276) The figures do not differ in the European context. The European Centre for Disease Prevention and Control (ECDC), report a higher propensity of MSM black population and Hispanic population in relation to HIV in European countries. (ECDC, 2009)

However, the recent increase in migrations to European countries by populations from sub-Saharan Africa, the Middle East and Latin America, have led to discussions about who has access to public health systems. In relation to Chemsex, the growing concern about HIV and AIDS has fed into the discussion about drug use and administration methods. To date, there is a lack of statistics and figures that map out clearly the full dimension of Chemsex practice and the populations implicated in the use of sexualized drugs. However, studies suggested that an intersectional analysis is required in order to represent the diversity of use and access to the health provision

within MSM populations. As Ferlatte et al. (2018) argue, the link between substance abuse and HIV risk factors are located in specific historical context, that reflects health inequity in relation to gay and bisexual men, that had been often hidden in public policy analysis. (Ferlatte *et al.,* 2018)

Inequities in the health system is rarely a consequence of just a single system of oppression (Fredriksen-Goldsen *et al.,* 2012) The use of intersectionality as an analytical tool can help acknowledge "multi-level interacting social locations, forces, factors and power structures that shape and influence human life and health" (Hankivsky et al., 2014).

Kimberlé Crenshaw who coined the term intersectionality in her book "Mapping the Margins" review the struggle of Afro American feminists in the US and explains how "strategies based solely on the experiences of women who do not share the same class or race backgrounds will be of limited utility for those whose lives are shaped by a different set of obstacles." This means that intersectionality needs to address at the same time, different burden of oppression in order to understand disparities in the distribution of power. Nevertheless, as Nira Yuval Davis pointed, intersectionality cannot become a set of rigid categories, where gender, sexuality, race and class are separated. Instead, she argues that intersectionality must celebrate the coexistence of multiple spheres of power, playing out in specific contexts.(Yuval-Davis, 2006: 13) The recognition of the narratives of oppression of specific groups, implies giving individuals agency to identify change and negotiate, their position.

In the same way, Lisa Bowleg noted that disparities in the health system and access to care facilities impact mostly ethnic minorities and/or migrants. She argues for an intersectional approach in the health system in order to counter historical oppressions and forms of racism within social policy. In her book, she also reflects on how assumptions of masculinity reproduce by health practitioners, hinders the provision of equitable health. (Bowleg, 2012: 1269).

However, adopting an intersectional approach in social policy might be a challenge. According to the article 'An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity', intersectional approach needs a negotiation within public and private actors to have occurred. (Hankivsky *et al.,* 2014) Meaning that the strategic alliances with health, drug providers and harm reduction organizations need a political and social commitment to engage different positionalities.

The concept of masculinity can also help clarify this discussion of multiple representations and expand the discussion of intersectionality. The concept of Masculinities, coined by R.W. Connell (2005), explain the complexity of gender relations and how they interplay with race and class. For the author, the construction of masculinity in the Western gender order has position certain groups of men and gender practices in privilege position in relation with others. (Connell, 2005: 76) This leads to unequal structures, where the power relations within the actors tend to benefit specific attributes more than others. (Tosh, 2004;49) As a result, a hegemonic masculinity is construct and this one dominates over other assumptions of masculinity. For Connell beyond the cultural stigmatization of gay men there is an oppression that "positions

homosexual masculinities at the bottom of gender hierarchy among men". (Connell, 1995: 78) This positionality is usually address as Subordinated masculinity.

At the level of daily social practices, the attacks over the gay masculinity help to marginalize MSM populations and reinforce the patriarchal order. MSM are then perceived as a betrayal of both hegemonic masculinity and heteronormativity. In that sense, men who engage in sexual acts with other men had been historically stigmatized and discriminate. A simplistic interpretation of MSM, tend to assume that they lack masculinity and in contrast they are closer to femininity. (Beasley, 2012) However, this interpretation is full of contradictions. First because masculinities are built in relation to other masculinities, and this can change depending on structure of gender relations of specific contexts. In a second place, masculinities are not fix categories and required broader discussion of privilege where other aspects beyond sexuality and gender (race, ethnicity, class) are consider. Masculinity is then a cultural process, but as Christine Beasley argues, it has a historical path that connects patriarchy to same sex criminalization and intimidation, is therefore not a surprise that public agendas reflect a hegemonic masculinity of the gender order.(Beasley, 2012)

The research participants interview for this paper, are continuously challenging the hegemonic masculinity embedded in a patriarchal order, however, at least in the local context, they seem to be affected differently by that gender order. Hans, a Dutch participant, reflected for example in how marriage, fatherhood and community life had been three spheres in which he had felt subordinated to a hegemonic masculinity. However, at the same time he felt there is a complicity within his positionality as a white Dutch man and his relationship with MSM Chemsex users who are migrants. This example, shows how masculinity is not a set of immutable categories, rather than a flexible negotiation within them.

Understanding masculinity, intersectionality and syndemic theory together helps us to frame substance abuse by MSM sexual politics discourse reproduce nowadays, in the access to provision systems. As an example, the article *"Combining intersectionality and syndemic theory to advance understandings of health inequities among Canadian gay, bisexual and other men who have sex with men"* illustrates how syndemic factors need to be understood alongside sexual identity, living environment and ethnicity. In this study, the syndemic relations with ethnicity, race and substance abuse reveals how marginal populations, in this case indigenous MSM populations in Canada, experience inequities within the access to the health services. For the author, these disparities respond to the "European colonial attitudes" which "simultaneously imparted homophobia leaving LGBT indigenous people dual marginalized". (Ferlatte *et al.,* 2018: 517) Another interesting study, by Frank Saldaño (2015) reflect about the colonial legacies in the European countries and how narratives of privilege and dominant position of the "white men" are reproduce in Europe through the public policy agenda. (Saldaño, 2015: 19)

Co-occurring health issues are related to social marginalization as well to representations and stigmatization over specific populations. For example, transgender women experiences on social marginalization is contextualized to specific locations and syndemic factors. (Brennan *et al.,* 2012: 1751) Nevertheless, to understand the disparities towards ethnic and racial MSM population, is necessary to understand the location

in which social spheres interact and how they play a role in the way sexuality is represented by others and at the same time works as a form of representation. Nigel Rapport and Andrew Dawson in their book *Migrants of identity* said that the "representation of location and dislocation between community identity and identity of certain of its members, such that some people are represented as more 'of' the community than others. A series of representational strategies are deployed" (Rapport and Dawson, 1998: 209) This means that mobility is embedded in a sense of localism but also in the possibility of connection with new locations. It is here where formal ways of representation are both understood and redefined by new actors and spaces.

As an example, Hector, the Ecuadorian participant portrayed in the story *Coming out, Coming down,* talk about migrating to the Netherlands, and how adopting a strategy of contestation, assimilation or change in relation with the way he is represented by others in the Dutch context has change the way he represent himself. At the same time, his local social connections with LGBTQ migrants has influence the way he interacts with Chemsex practices.

As a conclusion, theorizing Chemsex in relation to syndemic theory, intersectionality and masculinities, can help unveil how the health and drug service in Amsterdam reacts and engage with Chemsex practices of MSM. On one side, syndemic theory helps to understand the relationship between social factors, substance abuse and HIV/ AIDS interventions, highlighting the relation of Chemsex with the development agenda. On the other hand, an intersectional analysis, that reflects on the disparity between the access of MSM to health systems can engage with multiple understandings of masculinity and sexual practices, especially in relation with the wave of migrations to European countries and reflecting over an appropriation of queer politics as part of a narrative of privilege where representations of sexuality are constantly redefine.

Chapter 3 "The effect is determined by the method" Experiences of Dosage, Slamming and Chems

Our first meeting was short, but after a brief round of presentations, he said, "*The first thing you need to know is that the effect is determined by the method*" That was the day I met Ali, a Kenyan and Dutch citizen who moved with his parents to Holland in 2003. He has engaged in Chemsex practices for the last three years. In Chemsex practice, one must differentiate not only between the chemical substances that are being consumed but also between the routes of administration and dosage used. The drugs, the dosage and the routes of administration can help understand where the main risks related to the use of sexualized drugs lies and how Chemsex related treatments can be effectively provided by the health services. In the first part of the chapter, I expand in the Chems used in sexual contexts and how masculinity through sexual liberation informs social networks created by MSM Chemsex users. After that I expand in the routes of administration as a primary concern for HIV/ AIDS and Hepatitis C prevention, and how syndemic theory can help in the understanding of that relation with substance abuse.

Masculinity through Chems

Although, psychoactive substances used to enhance sex encounters may vary as the market changes, drugs as Mephedrone (4-MMC), Crystal Meth (Methamphetamines), GHB and GBL seem to be the most prominent ones in the Dutch MSM Chemsex practices according to a literature review. From the fieldwork observations, two thirds of the research participant use Crystal Meth as their preferred sexualized drug, follow by a combination of GHB and GBL (five participants). In my research, only one of the participants mentioned the use of mephedrone as the preferred substance, although almost all of them said they have seen a growing interest in the drug in their social and sexual networks. In addition, users usually combined drugs with other designer drugs in the market. From the five research participants who used GHB or GBL in order to enhance their sexual encounters, all have used it in combination with other substances such as ecstasy, MDMA and Crystal Meth. The combination of multiple substances is commonly known as "poly-drug use" or "combination use". The combined use of substances difficult their treatment because they can affect the dosage as well as the expected effects of the drugs. In some cases, "the combination of new designer drugs can entail additional risks" which can include psychological dependency, short term coma and nutritional deficiency (Knoops, 2015: 12).

In most of the stories portrayed in this research, the participants found in the drugs a sense of relief and freedom.

"I felt happy and complete, and limitless. Then we had sex and the sex was incredible. I had never felt so free with my body" Jeremy in Scabs and Veins story.

As Jeremy, Ali seem to find in drugs a sense of relief from the domination over queer men bodies.

"I thought for many years that I didn't had the right to feel pleasure. Because queer pleasure is always stigmatized and tear apart. But when I started consuming drugs it was like I finally had the right to own my body and my sexuality." Ali, in High in the Method story

The narratives of the research participants show a deep concern with the way their sexuality is represented by others. From relationships with family and friends, to interactions with medical and care staff, there seems to be a subtle fear of transgressing heteronormative dynamics. However, the consumption of Chems, seems to disinhibit and free the way they relate to others and to themselves. Connell states that gays experience "their gay sexuality as freedom" from gender restraints that govern queer bodies. (Connell, 1995: 153) Other authors, such as Markell and Waitt, have pointed to the liberalization of queer bodies in social celebrations and festivities such us Gay Pride Festivals. For them these spaces are needed to challenge public assumptions over gender and sexuality. (Markwell and Waitt, 2009: 144)

During the fieldwork, I asked the research participants about their experiences with homophobia or stigmatization in the Dutch context. All of them answer they experience subtle forms of homophobia rather than aggressive transgressions. However, all of them identified the use of language as an element often used to ridicule their sexual practices and their social connections. In addition, participants expressed that there is also a stigmatization around the use drugs in sexual contexts. Some of the narratives and experiences recall approaching to public and private services for help, but at the same time submitting their sexual practices to scrutiny. As an example, Jonas remembers telling his family doctor about his Chemsex practice, and looking how doctor "seemed surprise and disappointed".

To solicit help from public or private services requires emotional vulnerability and openness that queer men distrust providing. According to Beasley, historical hegemonic assumption of masculinity, over bodies and sexuality, has nourished a scenario in which gay and bisexual men hide traits of their sexuality so as not to be alienated. This balance of risks has feed social practices of queer communities with secrecy. (Beasley, 2012) As Chemsex, sexual practices are not only hidden in the privacy of the home, but they involve the illegal purchase of drugs through codes and undercover information. In this aspect, Chemsex practices require that the user get in a vulnerable position, in front of dealers and other users, which may hide injustice and other criminal practices that are not report to the institutions and authorities.

Chemsex users engage with Chems through social connections with other users. The creation of sexual networks is not new in queer communities. In fact, authors like Wilson, reflect on the historical creation of sexual groups where the identity of the members was protected and a nucleus of emotional (and in some cases economic) support was provided to counteract the subordination of queer masculinities. (Wilson, 2007: 52) In the case of Chemsex, social network are very important for MSM who consume drugs. For one side, this social network provides secure spaces for queer men to share and live their sexuality. In some cases, these connections represent the agency of queer men to create non- biological families from support and intimacy. For the other side, it may create a tie within friends, Chems and sex and this tie cannot be broken. In the words of Hans;

"I don't think my therapist understands Chems are what keeps me connected to my social network" Is not about the bottom story.

Eric, also said that when he tried to quit he felt separated from his social connections;

"*Is also hard to relate to your friend when they think you are judging their lifestyle just because you are not consuming drugs. After three weeks I decided to continue using drugs*" Eric, Ready to ParTy story

Crystal Meth peaks have increased since 2012 in the Netherlands and reports from GDD Amsterdam Centre indicate the increase of Crystal Meth displacing in many cases the use of ecstasy and MDMA.(Schmidt *et al.,* 2018: 5) The connection within crystal meth and Chemsex might be correlated due to strengthening of social and sex networks. A study from Mainline and SOAIDS in 2015, points to how sex networks play a role in opening spaces for participants to experience "more extreme sexual practices"(Knoops, 2015: 39) Those sex networks are nourished in big part by the social networks directed to gay men, where online chats, Grindr and Scruff apps play a key role. Jeremy recall how in online spaces codes help users to found Chemsex partners;

"It wasn't my first time in Grindr but once I understood the code, I started seeing T's and G's in capital letters everywhere in the most awkward places." Jeremy, 'Scabs and Veins' story

As Jeremy, many users in the web use codes as G (GHB/GBL) or T (Crystal Meth), to easily identifies Chemsex users. Usually these letters are found randomly in capital letters in the profile description of the users. The nine participants interviewed in my research state that online chats and social app is the main source to connect with new sexual partners. For most of them, these applications provide a safe space to connect with other MSM in Amsterdam using Chemsex. Furthermore, it eliminates many of the barriers and social costs associated with finding sexual partners in public places, clubs and sex parties.

Risks from Dosage and Routes of Administration

Different methods are used to administer drugs related to Chemsex. GHB and GBL for example, is commonly administered orally, although two of the participants interviewed in my research prefer to consume it anally. The effects of this drug on the body vary, but for most participants the sedative and aphrodisiac effect is more powerful when it is consumed orally. None of the participants use intravenous administration of GHB and GBL. However, because this drug is known as "liquid ecstasy" its dosage is complex. Hans, 40, remembers how at the beginning of 2017 he had an overdose with GHB and GBL that left him in a coma for 4 days;

"*I felt an energy rush after the first dose of G (Street name for GHB), but the effect lasted only a couple of hours. That's when I decided to consume a second dose of GBL. After that I only remember a quick euphoric effect. Then I started having trouble breathing until I completely lost consciousness. My partner, whom I had met only a few days before, had to drag me to his car and take me to the ER."* Hans, 'Is not about the bottom' story

Commonly known as "liquid ecstasy" GHB and GBL can result in a sedative state, short-term coma and in some cases death when there is not a correct dosage. Thijs, an emergency room health practitioner who works in OLVG Hospital in Amsterdam, explained that GHB / GBL is difficult to dose correctly because "people usually consume second doses when they feel that the effect is going down and want to

return to the previous state." (Thijs, 2018, personal interview)[1] However, what the second dose does is to power up the effect of the drug, amplifying its effects and increasing the risks of suffering adverse effects. According to Busarda and Jones (2014), there is not an antidote for treating an intoxication of GHB. Health practicioners around the world disagree in the protocol to treat the withdrawal effect produce by the drug. (Busarda, P. and Alan, 2014: 49)

Although the combined use of drugs, and their correct dosage increase the risks related to Chemsex, the practice which seems to concern health practitioners the most is slamming. As I had said previously, the route of administration (meaning the way the drug is supply to the body) and the dosage determines the intensity of the drugs. The intake of intravenous drugs (slamming) increase the percentage of the substance that reaches the bloodstream, generating an intense effect in the body that can last between 3 and 8 hours. However, an inappropriate administration of the substances can lead to an increase in the physical and mental risks of the users. The correlation within Crystal Meth and slamming as preferred route of administration has been evidenced in previous reports carried out by organizations such as GDD Amsterdam and Mainline. Eric, a Dutch participant recalls what it feels like to slam Tina (Crystal Meth) for the first time;

"Slamming Tina is indescribable. Once it kicks-off you feel free of every concern, of every thought. (…) The first time is scary if you have never injected yourself. Is like jumping from a cliff hoping to fall on your feet." Eric, 'Ready to parTy' story

I was able to verify these findings in my interviews. From the nine research participants, at least five of them use slamming as preferred route of administration in relation to crystal meth, and one participant used the slam method to inject Mephedrone. However, almost all of them claimed to have tried intravenous drug administration at least once in sexual encounters. When asked if anyone had previous experience in intravenous administration of medicine, all the research participants stated they did not have any previous experience before slamming in a sexual context. Moreover, seven of the nine participants learned how to slam from a sexual partner and two, found online information indicating the procedure. The experiences of the research participants suggest that the lack of knowledge in the administration of intravenous drug increase the risk of suffer a complication. In the story, The Harvest, the experience of Rud shows how slamming Tina without proper knowledge of the route of administration and dosage can carry terrible implications for the users.

"*Nothing moves. I was lying there for what seem hours until I saw him. I try to reach for help, but he couldn't understand me (…) I felt powerless, I couldn't pronounce my name, I couldn`t move, I couldn't say no, but he kept kissing and touching. He starts fucking me and It seems like it goes for hours. I remember losing consciousness and suddenly waking up with him on top of me."* Rud

In the broader picture and as it was said previously, slamming technique increase the propensity of MSM to suffer from HIV infection and other blood -borne diseases. MSM population continue to be the target population HIV and AIDS campaigns. Through syndemic theory, studies have found that the strong correlation within

[1] Personal interview with Thijs a Health Practitioner in OLVG Hospital, at Student Hotel West Cafe, Amsterdam, 14 July 2018

MSM and HIV, can extend to risky sexual behavior such us drug consumption. (Brennan *et al.,* 2012) According to my fieldwork, HIV/AIDS seem to be a main concern for most of the participants, and a current fear within their sexual networks.

Nevertheless, while inquiring about risky behaviors, three of the participants, said they had previously shared syringes with sexual partners but only when the clean syringes run out before the Tina is finished. Four of my participants claimed never to have shared syringes with sexual partners, but they had doubts about how to dispose the syringes safely. Eric, said he didn't have clarity on the safe measures to reduce HIV risk.

"*I thought I was taking all the precautions possible, but then one, two, three friends are found out with HIV. I realized then, that we have often share syringes and other implements without a proper safety measure* Eric in Ready to ParTy

In addition, none of the participants seemed to have information about the Dutch syringe collection system or the Testing centers available to test the quality of the drugs. Moreover, 2 of my research participants stated they regularly had anal sex without the use of a condom (barebacking) and 3 affirmed the occasional use of barebacking during sexual encounters.

I observed that there were myths and preconceptions about the slamming techniques and dosages. Jonas and Eric, for example heard that liking the needle before slamming was important to help the intake of Crystal Meth.[2] As a result, incorrect information on how to avoid health complications are often reproduced. Acknowledging the relevance of slamming in Chemsex, reflects the need to provide care and attention to decrease the risks that MSM populations take while using sexualized drugs. Furthermore, from the nine research participants who participated in my research, only Daniel had received information on how to avoid risk behaviors when practicing Chemsex.

As a matter of fact, the difficulty in assessing the risks and adverse effects of the dosage requires that the caregivers inquire about the drugs and substances consumed by the users. Louise, a nurse practitioner in Mc Slotervaart Emergency Room says, "we have to rely many times on what the patience tells us, but very often they do not have clarity about what they have consumed and the doses." (Louise, 2018, Personal Interview)[3] Sjef Pelsser from Mainline, states that a main difficulty lies in the variety of street names that sexualized drugs have within social networks of MSM in The Netherlands. Similarly, there is a lot of misinformation about the substances used during Chemsex, generating that "many users do not have accurate information about the chemical composition or overall effects of the substances that they consume." (Pelsser, 2018, Personal Interview)[4] As an example, Rud, the participant

[2] Mainline recommends not to lick the needle when slamming, because it would no longer be sterile to use.

[3] Personal interview with Louise a Nurse Practitioner in Slotervaart Hospital, at the Casa Sofia Coffee Place, Amsterdam, 5 July 2018.

[4] Personal interview with Sjef Pelsser from Mainline, at Mainline Office, Amsterdam, 22 August 2018

portrayed in the story *The Harvest,* remember seeing misleading information that suggested that Crystal Meth produce cancer.[5]

Furthermore, using syndemic theory researchers have identify that not all MSM are equally affected by HIV. On the contrary, black men and Latin migrants are at higher risk to the disease. (Singer *et al.,* 2006) A literature review on the reasons behind the disparity within MSM population and its vulnerability towards HIV, points out two important factors "a high prevalence of sexually transmitted diseases that facilitate HIV transmission and an undetected or late diagnosis of HIV infection." (Millett *et al.,* 1008) Although the studies are inconclusive, knowledge about HIV prevalence indicates that there are barriers in the access to the public health system for racial ethnic minorities of men having sex with men in Europe and the United States. As a result, strategies such as "treatment access, outreach/engagement/retention, continuing care/recovery support, and health literacy for minority"(Freese *et al.,* 2017: 275) had been proposed as part of a strategy to reduce HIV epidemic. As a result, although MSM population are the target of public and private institutions working in Amsterdam, there does not seem to be specific programs dedicated to black and Latin MSM minorities who consume Chemsex in the Netherlands. For example, organizations as Mainline, who are in the front row of harm reduction strategies, provide limited information around Chemsex harm reduction for non dutch speakers. (In Picture No. 1, Mainline brochures, only available in Dutch.)

Picture No. 1

Providing clear information is an important step in the prevention of negative experiences around Chemsex, however it seems that awareness campaigns related to Chemsex are not reaching vulnerable ethnic and racial populations. I expand in this subject in **Chapter 4.** As a conclusion is important to say that Chemsex practices respond to more than one representation of masculinity. MSM using Chemsex experience contradictions towards the way their bodies and sexuality are represented and the way they represent themselves. In practice Chemsex need to be seen as a cultural practice that concerns the health system. The relation of substance abuse, HIV and MSM, expand the need to inform users that this is risk behavior.

[5] Prolonged use of drugs may increase the risk of suffering from certain types of cancer, however there are not studies showing a clear link Crystal meth and cancer. Intravenous injection of drugs (slamming) can increases the propensity to certain types of cancer REF.

Chapter 4 Experiences with Care Providers

"I am a gay black Muslim man in the Netherlands, and no one seems to matter…Oh! well unless I go to the doctor. Then being gay means, I am victim. Being Muslim means I have a close mind to progress. Being black means I must be uneducated. Then, the doctor doesn't need to ask me why I consume Chems, because no matter what I respond he has already assumed that it is because I live in the margin of what is socially acceptable." Heydar, in 'Tina is my favorite girl' story

The common thread that connects the stories of the nine men who participated in my research, is the moment in which for some reason or another, Chemsex became a negative experience for them. Although their histories differ in context and severity, they all remember their first encounter with the health or drug system as a complex experience that requires better health and drug service provision. Their stories include experiences in consultations with family doctors (GPs), addiction centers and emergency aid as well as mental health support and informal peer support groups. In order to analyze my field work results, I have separated my observations of their experiences into three areas: 1. medical personnel of healthcare providers; 2. drug treatment centers and 3. peer support groups.

Healthcare Providers and medical Personnel

While collecting information from my research participants and healthcare providers, I realized it was important to distinguish drug related services and regular health providers. Healthcare providers might encounter cases related to drug use in sexual contexts but less so compared to drug related services. Consequently, there is a disparity between the information and treatment Chemsex users received from different caregivers and institutions.

From the nine research participants, seven have attended or accompanied a sexual partner to the Emergency room due to complications with the dosage or technique used for administering the drugs. In addition, nearly two thirds of the nine participants complain about the lack of information of healthcare providers regarding the drug tendencies in the market and the context in which does drugs are use. As an example, Jeremy talks about his experience in the ER;

"When we arrived at the hospital, the doctor asked me what I was taking. I kept saying 'tina, tina tina', but they just looked at me as if I wasn't speaking in Dutch, I fell sleep and woke up hours later. When my partner arrived, he had to explain to the doctors that I had an overdose on crystal meth. The doctors weren't familiar with the term Tina." Jeremy in Scabs and Veins story.

Jeremy story is not atypical. Sjef Pelsser, recalls how often in the weekly support groups organized by Mainline people complain about having to explain often what drugs they take "as if they were in charge of giving an introductory course to the medical staff'. (Pelsser, 2018, Personal Interview)[6] Although part of the problem lies in the rapid appearance of new drugs in the market, the fact is that at least four of

[6] Personal interview with Sjef Pelsser from Mainline, at Mainline Office, Amsterdam, 22 August 2018

the research participants, remember having to explain in detail the drugs they use without receiving an informed response or guidance from the medical personnel. Emergency Aid Nurse, Louise, at Mc Slotervaart Hospital states that although the percentage of drug-related emergencies in Amsterdam is high, hospitals and medical centers fail to train their staff regularly on psychoactive substances, which leaves them a step behind in the trend consumption of Chems. In her experience, the cost of training medical personnel specifically for Chemsex cases is weighed against the possibility to refer patients to drug related services. This is a disadvantage for her, because it underestimates the primary care that patients receive in the ER, "which is their first contact with the healthcare system. First treatment is equally important." Louise said. (Louise, 2018, Personal Interview) [7]

In the same way, Louise, nurse practitioner at Mc Slotervaart Hospital said in relation to first contact "Is a matter of time and that means that sometimes we cannot take a blood test until the patience life is out of risk." (Louise, 2018, Personal Interview)[8] Although Chris Tearno a Nurse Practitioner in the Department of Infectious Diseases at Maasstad Hospital Rotterdam agrees, he also argues that "doctors are sometimes busy focusing on their own specialty rather than on the whole picture."(Tearno, 2018, Personal Interview)[9] Which according to him means that there is not always a proper assessment on the drugs that the patients have consumed. In fact, both practitioners agree on the necessity for more microbiologist specialists in the Emergency room as well as quick toxicological analysis.

However, beyond practical problems in the care of Chemsex users, the medical personnel seem to reproduce conceptions of gender and sex. To underline this, I would like to refer again to the case of Rud. After having an overdose and a non-consensual sexual experience during the intake of Crystal Meth, Ruth went to the emergency room and ask for mental support for victims of rape;

"In some way, I think I felt as if I didn't have the right to ask for help. But I did, and the practitioner said she didn't think this applied as a non consensual experience and direscarded my request. Later I found out I could have gotten that help." Rud in The Harvest story

Although there are medical and legal provisions in the Dutch system to respond to cases related to sexual violations and / or non-consensual sexual activities, the system failed to provide Rud with these options. In fact, the assistance of a psychologist specialized in crisis and trauma is recommended for first treatment in emergency rooms. There is no clarity on how many cases of non-consensual sex are non-reported to the system, during my fieldwork there was another participant who revealed a similar experience and did not receive proper mental help. The reasons why their complaints were discarded can be varied, however it seems to indicate that the over sexualization of the bodies of queer men does not allow them to be legitimate subjects of rape. Doherty and Anderson, (2004) in their study, *Making sense of male rape: constructions of gender, sexuality and experience of rape victims,* reflect about the gender

[7] Personal interview with Louise a Nurse Practitioner in Slotervaart Hospital, at the Casa Sofia Coffee Place, Amsterdam, 5 July 2018

[8] Personal interview with Louise a Nurse Practitioner in Slotervaart Hospital, at the Casa Sofia Coffee Place, Amsterdam, 5 July 2018.

[9] Personal interview with Chris Tearno, Nurse Practitioner in the Department of Infectious Diseases at Maasstad Hospital Rotterdam, at Vascobelo Cafe, The Hague, 5 September 2018

discourses of queer men and how historical stigmatization of their sexual practices has catalogue them as sexual perverts. In that sense, the social representation of their pain, especially in relation to rape, is discredit. The subordinated masculinity of MSM, seem to create a double burden in relation with the gender order.

Another example of how the system may be reproducing hegemonic understandings of gender and sexualities can be shown in relation with MSM positionality in relation to HIV. To illustrate this example, Hector recalls the moment he shares with his GP that he was consuming Chems.

"He [GP] said that is why gay men end up with HIV. I told him MSM get HIV because many different things even when they don't consume chems. However, his words got me concerned and I decided to look for a STI Centre to get me tested" Hector in Coming Out, Coming Down story.

When discussing with research participants and medical practitioners about the positionality of MSM men in relation to HIV, most of them seem to be worried in the way MSM sexuality is represented. In an interview with Frederick Becker he said that MSM are often blamed for contracting HIV which does not demonstrate the complexity of factors that explain why they are more vulnerable to the disease. (Becker, 2018, Personal interview)[10] For Connell, the AIDS epidemic brought a "new wave of prejudice, dealing with AIDS illness and deaths and mobilizing resources for care, theorizing about gender have not been high on the list."(Connell, 2005: 144) As a result, she sees the respond to HIV and AIDS as part of the continuation of the dominance of hegemonic masculinities over queer identities.

One of the places where this experience is shared is in STI Clinics. Of the participants interviewed, six have visited in the last months an STI clinic. There they have noticed that the staff is trained to answer questions about Chemsex and provide relevant information for the management of risks related to this practice. The experiences with the centers of the participants are varied. Some participants believe that the STI clinics are free of judgment. While participants, especially those who were born and raise outside The Netherlands, stated that it was difficult to relate to the medical staff. When I asked why they felt this way, three participants said there was a language barrier that prevented a more empathic response. However, I found it interesting that five of them mentioned that even when they were doing routine exams they were referred more to drug treatment centers compared to "white Dutch" men. However, there is not specific data that can corroborate that observation.

As Syndemic theory explains, although MSMs are generally more prone to HIV and AIDS, racialized and sexualized populations are more vulnerable towards the disease. In this sense, migrant and ethnic/racial minority populations may require sensitive care attention from first care providers. This aspect needs an intersectional approach, to understand the dimension in which distinctive spheres such as race and ethnicity influence health provision services. In the narratives of the men I interview, race and religion seem to play a key role in the way care providers interact with them. As an example, Heydar remember the experience of visiting a "white Dutch" friend in the ER after he suffered an overdose and being accused by the medical personnel of being his dealer. I ask him, why did they think you were his dealer

[10] Personal interview with Frederick Becker at CRT Addiction Centre Office, Amsterdam, 4 July 2018

"I guess because… I am black?" His answer is also a question. Heydar in 'Tina is my favorite girl' story.

Although it is not possible to corroborate the reason why Heydar was treated in this way, daily experiences of racism and homophobia seem to be present in his life and the lives of others of the black participants.

In the other hand, two participants complain about the STI personnel. In the story, Scabs and Veins, Jeremy recall the painful experience of visiting A STI Clinic.

"I kept in silence until the blood test was over, the nurse approached me again and ask, why have you done this to yourself?" Jeremy, 'Scabs and Vains' Story

Jeremy is reflecting about his body image and how the prolonged used of Crystal meth through slamming has damages his veins and leave scabs in his body. His story seem to show a judgement from the care provider toward his consumption of Chems. Most of the narratives of the research participant reflect similar trajectories, where they felt judge, shame and even stigmatize. Chris Tearno said this is one of the biggest challenges for care providers in contact with Chemsex users, "to provide safe spaces free of judgement means we can give better attention to users" (Tearno, 2018, Personal Interview)[11]

During my field work I was able to find informative pamphlets on sexual practices such as barebacking in bars and spaces destined for the LGBTI population but they were not explained in the Chemsex context. However, these pamphlets tended to condemn the sexual choices of men who decide to practice barebacking (a popular practice in some MSM networks). The content of the information was only in Dutch but revealed a negative attitude towards MSM without the use of protection. None of the nine research participants seem to have contact with this information. From my interviews I found out that during the medical consultations with GP doctors, the interviewees felt unmotivated to talk about their sexual preferences, since they fear the stigmatization that barebacking has within the medical sector.

All the participants talked about the difficulties derived from having to mobilize between STI Clinics, drug treatment services, informative harm reduction centres and mental health support. For them, the lack of integrated healthcare systems related to Chemsex made it difficult for the MSM population seek help (in case of need) within the Dutch health provision system. Dennis Heineman, who works in Centrum Seksuele Gezondheid, GDD The Hague, affirms that the lack of co-located care is one of the main flaws of the Dutch health and drug services, in relation to other countries who already provide integrated services for Chemsex users. (Heineman, 2018, Personal interview)[12] However as Walkup refer, "substance abuse, mental illness and HIV-related organizations are accountable to different licensing and regulatory bodies, draw from different budgets, commonly develop quite different professional cultures, and seek different sources of legitimacy." (Walkup *et al.,* 2008: 18)This means that there may be strong incentives to not put forward in the agenda the full integration of Chemsex services.

[11] Personal interview with Chris Tearno, Nurse Practitioner in the Department of Infectious Diseases at Maasstad Hospital Rotterdam, at Vascobelo Cafe, The Hague, 5 September 2018

[12] Personal interview with Dennis Heineman at Centrum Seksuele Gezondheid, GDD, The Hague, 24 September 2018

Drug - treatment providers

From the nine men I interview, seven have some experience with drug-treatment services. Among those, one has completed a drug intern treatment, two have received outpatient consultations and treatment and the other four only went to a consultation or accompany someone to an intake interview. There is a multiplicity of stories about how they got there. Ali, for example, was referred to the drug treatment center after a professional from STI Clinic insisted he went to an addiction therapist. Rud, asked his family doctor to refer him to a drug-treatment facility, after his unfavorable experience with Crystal Meth. His doctor told him that his health insurance did not cover this type of addiction (the doctor did not know much about Crystal Meth) but said if he wanted he could be referred as a consumer of ecstasy. Rud decided to visit a drug- treatment facility for himself and confirmed that his medical insurance covered Crystal -meth users.

The seven of the interviewees were unsatisfied by the drug treatment services and said the assistance failed to fulfil the need of MSM Chemsex users. They complained about two things. First, that the staff was not trained to understand drug use in sexual contexts where social networks play a very important role.

"When I was admitted, the psychologist told me I needed to attend at least one group discussion meeting every week, I was feeling 'dapper'(brave), but when everyone started talking and I realized no one had experience drugs in sexual contexts, I felt ashamed" Eric, Ready to parTy story

The second was that the clinics did not have 'safe spaces' for MSM to talk about their experiences with crystal meth and mephedrone. This last complaint was related to the training of the personnel, who was not used to dealing with this type of chemical substances. For users, the practice of Chemsex is not the same as consuming party drugs since they do it in a private setting arrange previously.

"When I went to a consultation with a drug treatment therapist and I told him that I used crystal meth he told me that he did not have much experience with this drug but that he had treated many cocaine users." Daniel in Please let me know story.

According to Frederick Becker, Psychologist who works with CRT Addiction Centre[13] the Dutch drug service is outdated in relation to Chemsex MSM users. For him, party drugs as cocaine and MDMA might be use in Chemsex but are not as popular as GHB, GBL, Mephedrone, Ketamine and Crystal Meth. "What we should understand in drug services is that Chemsex users are tied to a particular context and therefore do not behave as users of other types of addictions such as cocaine or opioids." Becker says that Chemsex users tend to maintain their social networks and these are strengthened once they start consuming Chems. In the same way "users often maintain their family relationships, their jobs and their community life" In our interview, Frederick said that drug treatment facilities have had trouble reporting to the National Alcohol and Drugs Information system, which makes it difficult to see the

[13] A private rehab clinic in Amsterdam, who recently open free consultations for MSM Chemsex users.

trend of drugs like Mephedrone and Crystal Meth in MSM men. (Becker, 2018, Personal Interview)[14]

It is possible to affirm that none of the research participants was satisfied with the support provided by the drug treatment services. The difficult experiences with the drug-treatment providers, has led to most of the research participants look for help in the private care sector or in peer support groups. Until now there is not specific programs in the drug- treatment facilities design for Chemsex users.

Peer Support group

The peer support groups are spaces in which MSM Chemsex users can share their experiences and information, with other users. This strategy seems to be very important for the users and reports of Mainline and SoAIDS suggest that is a s an essential tool to strengthen harm reduction campaigns. All the research participants said they are participating or interested in participating in this kind of groups. However, I noticed an important difference between 'white Dutch interviewees and interviewees with different nationalities and race.

In one end, 'white' research participants, found that the support groups provided by organizations such as Mainline and GDD have been of great help in understanding the risks of using some of these substances and making a more responsible use of drugs. In the same way, they have found a place free of judgements where they can create community and demystify misconceptions around Chemsex. In Mainline for example users can choose between attending a group for active users or attending a group for people who have stopped using Chemsex. For Pelsser, Mainline support group can help men talk of their personal experiences with people that are going or have gone through the same experience. Besides, listening and being listened to, is an exercise that helps participants work on their mental health, "an aspect that is sometimes left out while talking about Chemsex, but that should be a priority in every public health conversation on the topic" (Pelsser, 2018, Personal Interview)[15]

However, something that was evident in my conversation with the institutions and practitioners, is that it is not considered how people from different nationalities and backgrounds experience Chemsex. This observation was relevant because my research participants said they did not feel comfortable in the peer support groups offered by Dutch organizations and health providers. For example, the experience of Ali:

"Some of my friends don't go because they don't speak Dutch. But I speak Dutch and I didn't feel comfortable either. All of the other participants were 'Dutch white', I was the only black men in the room." Ali in 'High in the Method' story

[14] Personal interview with Frederick Becker at CRT Addiction Centre Office, Amsterdam, 4 July 2018

[15] Personal interview with Sjef Pelsser from Mainline, at Mainline Office, Amsterdam, 22 August 2018

When I spoke with Ali, I wanted to know if someone had made him feel uncomfortable in the support group session. He answered that some of the participants asked him how you paid for the drugs[16], when he answered that he had a well-paid job in Amsterdam, a guy seated beside him said he must have many "well-paid clients" suggesting that he was a sex worker.

Other interviewees such as Daniel, also mentioned similar experiences with peer support groups in Amsterdam.

"*At first everything was great, I felt comfortable and because I was there everyone agree to speak in English. Then I had the opportunity to speak, I shared my experience using Chemsex for the first time and how it had given me a sense of belonging when I have needed it. Everyone seemed annoyed by my comment."* Daniel, in 'Please let me know' story.

When I asked Daniel, why he thought they were upset, he said that some of the participants had approached him at the end of the session to talk to him about how he cannot let other people influence him to take drugs, and that it was a personal decision and not an imposition. He tried to explain to them that, that was not what he meant. He was indeed responsible for his actions but what he intended to say is that he felt as an outsider in the MSM networks because he wasn't doing Chems.

The experience of Ali and Daniel suggest that the care provision and harm reduction strategies are designed for a "white dutch" MSM population. In that sense, white male experiences of 'gayness' may need to be understood in a different way than black and Latin men queer experiences. The recognition of this intersectionality is embedded in diverse representations of the masculinities of MSM. Furthermore, studies analyzing migrant populations and locations show representations of sexual freedom in parallel to homophobic narratives. A recent use of homonationalism may be useful to understand how the provision of care is subjected to a political agenda that regulates sexuality and bodies. Homonationalism is a concept that rethinks the relationship of sexuality and the state. It was coined in the United States by Jasbir Puar in the context of the war for terror. The term has travelled widely to other contexts. Homonationalism refers to the process by which political narratives line up with queer discourses but at the same time hide narratives of racism and xenophobia(Puar, 2017). In the Dutch context, Murat Aydemir of the University of Amsterdam, sees homonationalism as a "disarticulation of sex and race within the Dutch context" (Aydemir, 2013) and refers to disparities on treatment due not only to sexuality but to a multiplicity of intersections of social spheres. In that sense adequate provision of care could benefit in particular of an intersectional based approach.

In this Chapter we have seen how the medical personnel of healthcare providers, the drug treatment centers and peer support groups play a role in the narratives of Chemsex users. We have also seen how sensitive care in relation to MSM has yet to be achieve. In that sense, representation of gender as part of a discourse of hegemonic masculinity, are still reproduce in the care system and need to be acknowledge and counteract. In addition, there is a need to reflect over MSM positionality around HIV and AIDS. Finally, is important to take into account an intersectional approach that recognizes disparities within MSM users and address them through safe spaces and support.

[16] Some of the substances use for Chemsex as Crystal Meth cost around 100- 15 euros per gram.

Chapter 5 Toward Sensitive Chemsex care for MSM

After analysing the narratives and stories of research participants and health practitioners this chapter discusses starting points for future social policy interventions in the matter. In the first part, I talk about the bottle neck effect in relation to patient flows in the medical and care services. In this section I explain how a set of monitoring and prevention strategies can diminish this effect. In the second part I open the dialogue among caregivers and users in order to reflect on how sensitive care provision around Chemsex and MSM could be achieved in the Dutch context. Finally, I talk about alternative and informal ways of care as an example taking the example of an Expat Peer Support group in Amsterdam.

5.1 Monitoring and Preventing

In biological terms the bottleneck effect is an analogy use to represent the drastic reduction of population due to specific variables that prevents the expected development of a species or communities. For the purpose of this research I would use the same bottle neck effect to illustrate what happen with Chemsex users once they reach the care system. Chemsex users may address the health and drug services through different resources and institutions. From visit to the emergency rooms, family doctor and STI Clinics, to peer support groups and drug treatment clinics. Nevertheless, the process by which the users move from the first attention or contact to sensitive care is still vague. This means, that only a small amount of the total of cases that reach the health system are address.

The narratives and voices of the nine participants collaborating in this research, prove that although the harm reduction approach of the Dutch government has valuable elements, like the safe disposal program for syringes, is not enough to counteract sexual risk behavior related to drug consumption. Monitoring and prevention strategies need to be deployed in order to make effective referral of the MSM Chemsex users to STI Clinics, addiction centers and other drug treatment services if needed.

An analysis of the reports presented by the Trimbos Institute's National Monitor Drug Incidents (MDI) and the Dutch Alcohol and Drug Information System (LADIS), reflect however that the data that is collected in relation to drugs used in sexual context is not consistent with the trends observe by practitioners and drug users.(LADIS, 2015) (Trimbos Instituut, 2016) This fact hinders the development of specific programs for MSM Chemsex users and the budget that should be destined for it. In order to reduce the bottleneck effect that occurs in the system, and to be able to monitor trends in drug use, addiction clinics and drug treatment services that report to information systems, must be able to report each sexualized drug in a separate category. This is especially important in the case of Crystal Meth, which as I have argued can increase the risk of suffering complication with Chemsex. It is equally important that the information systems register the routes of administration of the drugs since this also determines the risks in the drug consumption.

On the other hand, prevention strategies and harm reduction practices are important in order to provide safer measures for Chemsex users. This means that instructive information about how to do Chemsex, in relation to different dosages, routes of administration and Chems. Prevention campaigns also need to recognize sexual practices linked to Chemsex. As I report in my fieldwork, this include for example barebacking practices within MSM, which means specific information related to the practice need to be display.

HIV and AIDS, are major concerns in the policy program of health practitioners and caregivers and is a constant fear for MSM who practice Chemsex. Harm reduction campaigns in the Netherlands have made an effort to reduce the risks linked to HIV and AIDS and provide wide information around the subject, however there is still misinformation in other types of diseases such as Hepatitis C and how specific practices such us slamming and barebacking increase the risk of blood-borne diseases. In order to connect with Chemsex users' information provided need to be free of judgements and preconceptions of gender norms. This can only be achieved if there is a dialogue between the users of sexualized drugs and care providers.

5.2 Setting the dialogue within caregivers and users

"I run away from home not because I didn't love my home, but because I love myself more. I think I am a rebel. How else could I describe myself? Love, especially self-love is always disruptive. Is anti-social and revolutionary." Heydar in 'Tina is my favorite girl'

MSM users far from being a homogenous group are a diverse population with diverse representations and complexities. Setting up a dialogue around Chemsex brings together the intersectionality of the social spheres of gender, sexuality, race, ethnics and class. A dialogue is an invitation for both Chemsex users and healthcare practitioners to work together to reduce disparities in services. Similarly, it can help to change the way hegemonic masculinity informs sexual and gender relations. This conversation needs to happen to lead to informed understanding of Chemsex drugs and a strengthening of social inclusion.

In relation to informed understandings of the drugs, it is clear that Chemsex users need accessible, clear and accurate information about the drugs they consume, the correct methods and ways to administer these drugs, and the spaces provided by the government to discard safely the implements used. Such information must recognize the context of Amsterdam, with its high migrant population. That is to say that such information should ideally be provided in different languages.

Likewise, the healthcare system needs to provide proper training and information to caregivers and first care providers. This might include the emergency room medical staff; however, its priority should be towards GPs and STI Centers, which are in contact with users and have the ability to refer such users to drug treatment services. The increase in the knowledge of care providers on Chemsex dynamic and practices can help make the system more approachable and reliable for MSM. This requires that the sexual practices related to the use of drugs to be understood not as an

addiction but as a complex social practice. This can lighten the emotional burden that Chemsex users feel when sharing their sexual practices with health and care providers.

Secondly, the conversation needs to move towards strengthening the social inclusion of Chemsex users into the health and drug services and provide care alternatives that are consistent with their identities and trajectories. In terms of the health system, this means that there must be a clear commitment from healthcare providers to recognize and discuss hegemonic and heteronormative assumptions of gender and sexuality and recognize how subtle forms of homophobia and racism can be embedded in the provision system for Chemsex users. As the health system responds to a broader context of the government's public agenda, that conversation must be held at different levels of power, and ideally it must provide measures to counteract the vulnerability of specific MSM populations towards HIV, AIDS and other blood-borne diseases. In the same way, Chemsex users they must have spaces in which they feel safe to share their sexual practices without feeling marginalized. Peer support groups can be a center stage for alternative care to happen

5.2.1 Alternative care and the case of the Expat peer support group

Self-help- groups are the most effective harm reduction strategy for Chemsex users because it provides a space for them to share their experiences of Chemsex, ideally without the stigma related to the use of drugs. Practices like Chemsex depend on social connections and sexual networks. However, Chemsex users may require additional ties of trust and support, and this is where peer support groups can contribute. Peer support groups might help to reduce the risks due to lack of knowledge and information around sexualized drugs and safe ways of consumption.

During my research I saw the importance of the peer groups, among MSM networks of friends and acquaintances in talking about the use of drugs in sexual contexts, but also to provide an alternative mental support to users. In the fieldwork, I identified that although there are already support groups that work in the city of Amsterdam, these do not necessarily represent a safe space for non-Dutch speakers and migrants.

Notably, groups designed specifically for migrants are rare, as is information available in non-Dutch language. Over the three months of my field work, a participant decided to create a support group for expats. Although, initially he decided to do it informally, over time the group received more than twenty responses. The first meeting, was held in English but provide improvise brochures with information in Arabic and Spanish of where to go in case of emergency and where to safely dispose used syringes. The second meeting, held on August 30, had fourteen participants. In this meeting participants share their experiences and participated in a workshop run by a nurse in how to reduce risks when slamming.

The demand for peer support groups for expats seems to suggest that there is a need among the MSM community that practices Chemsex to offer specific care services for migrants. However, by not having the necessary information or training, these groups could reproduce myths and misconceptions that revolve around Chems. The

support of harm reduction organizations is essential in provide professional support to informal peer groups. Recently the Expat support group has contact Mainline in order to received proper training and information. Is in the best interests of all, that this kind of space nourishes care provision which is sensible to migrant and multiracial MSM populations.

To conclude, is important to note that although the creation of sensitive care is yet to be reach in the Dutch health and drug service provision for Chemsex users, efforts are being made to strengthen the system. These efforts, however, should include strategies for the monitoring and prevention of risks derived from Chemsex and the open conversation between caregivers and users. The case of the Expat support group, helps bring to context, how those conversations can take place in practice. The creation of sensitive care around Chemsex needs to be address by social policy makers, not only for the relation with HIV and AIDS, but rather for the recognition around queer sexuality and bodies.

Chapter 6 Conclusion

Chemsex practices use by MSM are a growing trend in sub-groups of MSM population in Amsterdam. The use of drugs in sexual contexts should be of public concern for the Dutch government and the social policy agenda because it has direct effects on HIV and AIDS prevention programs as well as in the harm reduction drug policy of the Netherlands. In that sense, special consideration of drugs and routes of administration used by Chemsex users, need to be made. The impact of intravenous interjection known as Slamming and the close relation with Crystal Meth in the bodies of queer men, present important challenges for the harm reduction programs in the city.

In addition, the health and drug service providers seem to reproduce hegemonic concepts of masculinity where MSM are treated different due to the social understanding of what is acceptable in the gender norms. This aspect seems to impede access to neutral and non-judgmental sensitive care. MSM men are constantly negotiating their social position in the gender hierarchy, by which their sexuality and practice is represented. As a result, queer experiences of Chemsex help counteract assumption of masculinity and evoke further understandings of the way they represent themselves in the Dutch Context.

However, is important to highlight, that MSM population is not equally affected by HIV and AIDS which suggest that MSM are not equally affected by the risk derivate from Chemsex according to a Syndemic theory analysis. In other words, mean that a syndemic approach towards Chems, sex and HIV need to identify specific groups to be target. From the narratives of the research participants, drug and health services related to Chemsex are intended for "white, gay, male", failing to take into account the trajectories and narratives of MSM population of different races, religions and class. In order to resist the over- simplification of queer men sexuality, the health and drug services in the Netherlands could benefit from an intersectional approach to Chemsex.

Alternative risk reduction strategies and sensitive care provision are needed. In that sense some important recommendations are;

- Supply accurate and accessible information, away from judgments and heteronormal conceptions of sexuality and gender.
- Provide training to ER Personnel and first care givers in the health / drug system, in order to ensure secure medical spaces for MSM populations.
- Study the possibility to provide mental care through sexologist or Chemsex therapists.
- Reinforce needle exchange program and workshops about safer measures to do Chems.
- Update the Dutch Alcohol and Drug Information System known as LADIS with a proper categorization of the drug's use in Chemsex, in order to produce data about the latest tendencies in sexualized drugs. Specially in relation to Crystal Meth.

- Provide peer support groups in English and implement strategies to ensure that this are safe spaces for people from different races, ethnicities and backgrounds.
- Implement co-located care facilities, where Chemsex users can found all the services related to Chemsex without the need to be referred or mobilize to distinctive institutions.
- Do Chemsex risk reduction interventions target to specific populations, such as migrants and ethnic minorities.

To conclude, the policy aims of the Dutch health and drug services regarding Chemsex practices of men having sex with men (MSM) need to acknowledge the experiences of users in a step to provide sensitive care. In that way, social interactions within care givers and Chemsex users, can expand the dialogue over queer sexualities and gender.

Appendices

Appendix 1- Research Participants Stories

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The Harvest

Rud

"When we are suffering, when we are really in pain, the only place to go is home, but from a while now home doesn't feel like a safe place for me" Rud

The first time I met Rud, 39, I had the feeling we had met before. He was a tall, white male who had move from Poland 5 years ago in order to work in the tourism industry. We decided to meet in the Central station and slowly walk towards a coffee place nearby. He was wearing an old grey sweater that cover his body almost until the knees, black pants and a green navy bag. On our way to the cafe he stopped to give me some information about Amsterdam, I felt as if it was the first time I visit the city. I listen carefully, and I realize how passionate he is when he talks about the canals, the market, the architecture.

When we finally arrive to the coffee place, an hour has already passed. He starts talking about what it feels to move to another city, another country, another culture. He wanted to know about me, my work and my family. I try to move the conversation towards my research, but again and again he subtly changes the subject. I wonder internally if he really wants to tell me about his experience, but I wait patiently until he finally starts talking.

"The truth is that I have not talked much about that night for some months. Is not that I don't want to tell you, in fact I've wanted to talk about this for a long time. But now that you're sitting in front of me it seems hard to find the words. " I smile, a part of me value that sense of familiarity that he gives me, and I don't want to pressure him. He waits some minutes and continue talking.

"We met online, I guess no surprise there. He was always connected in the early mornings when I couldn't sleep, so we developed this chat dynamic that stared at 2 am and lasted until 6am. Back then I was just starting to experiment with Tina, and I could spend complete nights without a minute of sleep." Rud made a small stop, to order some herbal tea and then he continue. "We decide to meet after chatting for two weeks. He offered me to go to his house, but I had always felt safer at home. When he arrived, I thought he was pretty shy and young. I offered him a beer and took him directly to my room. We kiss and play for a while. I had already prepared some Tina to snorted before the action, but he said he had better plans. He went to the living room and took a plastic bag from his haversack. In there, he had a set of needles, a pair of gloves and alcohol. He finally asked me if I had ever slam Tina before."

Rud stopped there and ask me if I knew what slamming meant, I nodded quickly, and he continued his story.

"You know, now that I tell this story I feel like I did the most stupid thing in the world, but that day it just felt like the right choice. I had never slam before, but he had been doing it for about six months and said he had experience in nursing, which made me more confident." I start to feel like his story has taken another rhythm, he often stops and seems to reflect on the things he is saying as carrying a great weight in each word. "I ask him about the dose, he said the dose needs to be bigger than when you snorted. He took my arm and did a tourniquet with two condoms. I remember laughing about that and asking him if he has brought the condoms just for that."

Rud took a deep breath, looks at me and said; "Is strange how that is the part that torments me the most" What part? I asked. "Me laughing" he answered.

I feel his pain and the only thing that occurs to me is to put the cookie of my tea in his plate. He seems to appreciate the gesture and continue talking. He tells me about the euphoria, the empathy, the happiness he felt for some hours after the first dose. He told me they have sex for hours, with meaningless conversations in between. After some time, they decide to take a second dose.

This time the euphoria lasts less. "I started to feel funny, you know, like when you are really drunk, and you can hear yourself talking weird. Then I started to sweat, and I felt like I couldn't breathe. I went to my room and lay on my bed alone. I couldn't think properly, I try to know the time, but my phone was too far away, I try to reach it, but my body didn't move. Nothing moves. I was lying there for what seem hours until I saw him. I try to reach for help, but he couldn't understand me. In one moment I even though I was speaking in Polish, but I think I wasn't even speaking at all. He started kissing me and I try to stop him, not because I didn't desire him but because that person lying there wasn't me. It wasn't me" Rud stops. He looks like he's going to cry, but he does not. He never cries in front of me.

He continues. "I felt powerless, I couldn't pronounce my name, I couldn`t move, I couldn't say no, but he kept kissing and touching. He starts fucking me and it seems like it goes for hours. I remember losing consciousness and suddenly waking up with him on top of me." I look at him, he looks self-absorbed in the story.

"I don't know how long it goes but when it is finally over, I roll down into the bathroom and throw up. After that I sat there, trying to cover myself with the towels and cry for a while. I never left the bathroom, not even when he said goodbye and pick his things. I never saw him or talk to him again. I think he knew (…) I think he knew he crossed a line that night and so did I"

Rud look at me for a while and I ask him if he wants to continue the story or stop there. He makes a pause, he drinks his tea, answer some messages on his phone and show me a picture of his mom, in the wallpaper of his phone. We do small talk for a while, in an attempt to cope with the information, he has just shared with me previously.

He finally says, "Well I didn't know what to do. I call a friend and he came to my house immediately. It was already 3pm, by then I had been under the effect of meth more than 18 hours. I was scared I would lose consciousness again while I was alone. When my friend

arrived, I could barely tell what happened. He stood with me and took care of everything. The coming down effect of Meth is horrible, I couldn't sleep, and I vomited all night.

On Monday I call work and told them I was sick. In the afternoon, I decided to take some of my things, pack them on a bag and called an uber. I went to the hospital, I had this incredible urge to make me check by the doctor. To may sure I was fine, to heard that I was fine. When the nurse asked me what happen, I try to be as honest as possible, but I was ashamed. So much shame. The nurse barely talked to me, she looked horrified by my story, but I think she also though I deserve it, or maybe it was me who felt I deserve it."

He stood quiet and I just run to say "but you don't, you don't deserve it"

"I know that know, it took me more than a year to accept I didn't deserve any of this. But when I was in the hospital I felt so …powerless. The doctor that came to see me gave me a talk about how dangerous is to do drugs, she kept saying I needed to be more responsible. When I told her, I wasn't conscious for hours, she responded that I could probably be infected with HIV or many other blood diseases, because there was no way I could recall wearing a condom. She proceeded to send me blood tests and refer me to a STI clinic, where they had more experience 'treating with gay men'. It was as she thought all gay men do Chemsex or as if all cChemsex users where gay.

I left the clinic feeling worse, I think I was also hoping they could refer me to someone to talk to, a psychiatrist, a counsellor, I don't know… someone." I nodded and after that we talk for a while about the hospital. He told me he could had received mental support offer to victims of rape or sexual crimes. "In some way, I think I felt as if I didn't had the right to ask for help. But I did, and the practitioner said she didn't though this apply as a non consensual experience and discard my request. Later I found out I could have gotten that help."

"So, what did you do?", I asked.

"I went home, I called my mom and talk to her about everything except this, because she doesn't even know I am gay." Rud answered.

I met with Rud four more times after that day in the café. We never went back to the story of that night, instead we talk about his life after. He told me he asked his family doctor to refer him to a drug-treatment facility. His doctor told him that his health insurance did not cover this type of addiction (the doctor wasn't familiar with Crystal Meth) but said if he wanted he could be refer to as a consumer of ecstasy. Some months after, Rud decided to visit a drug- treatment facility for himself and confirmed that his medical insurance did covered Crystal -meth addicts.

He went to treatment for some months, he said it help him to forgive himself for what happen that day. But, he felt that in the addiction centre no one understood very well what Chemsex was or how to talk about it. His counsellor however gave him an advice, he told him to find a place where he could feel safe again.

"When we are suffering, when we are really in pain, the only place to go is home, but from a while now home doesn't feel like a safe place for me. Instead I go out, I walk through the city, I think about me and my family and my life in this country. I think I am trying to teach myself to harvest. To grow from the pain."

Rud still do drugs, but he hasn't tried Meth since then.

Scabs and Veins

Jeremy

I never saw Jeremy without his long sleeve sweater. His sweater is his armor. He said he only wears it when he goes to sleep or when he has sex. "Lately, only when I go to bed." He says laughing.

Jeremy, was born in Ecuador, he grew up in a conservative catholic family and when he told his mom he was gay she asked him to leave. He moved to Quito for some years but found a job in a Dutch company and applied for a transfer to the Netherlands four years ago. Since then he lives in Amsterdam. He said Amsterdam is beautiful and scary at the same time. He is 31 years old and he lives with his cat in a small apartment in the outskirts of the city.

We met through a Chemsex counsellor, but we quickly developed a friendly chemistry. The true is that Jeremy is always laughing. It is hard to see that beneath the laughter there is a man suffering.

I wait for him in a Park besides the Rijksmuseum. He said he needed to go to the market before heading back home and I offered to go with him. We walk together, and he told me about the first time he did Chemsex.

"I wasn't really looking for it, but I had recently arrived in this city and was very hard for me to meet gay men. One day I met this beautiful Dutch man, tall, blue eyes, the most incredible body; and he comes to me in a bar and invites me out. I was speechless, I look at him and gave him my number on the back of a receipt. He wrote me in WhatsApp and we arrange a date some days later. We went for some beers and after a very brief conversation he said he was into Chemsex." I look at Jeremy wondering what he felt when he first heard that.

"I felt awkward. Is like when people tell you a secret that you don't really want to hear. I look at him and smile while in my head I was thinking 'what the hell?' He insisted I should try it. He kept talking about this underground sex network and how I was losing myself from the opportunity to fulfil many desires" Jeremy laugh, he says it sound superficial to speak about this out loud, but that was what attract him the most to Chems.

"I had occasionally consumed cocaine when I was younger but never saw myself as a drug user. That night we went back to his place and I was already feeling less apprehensive towards Chemsex. He gave me some GHB and I fly. I felt happy and complete, and limitless. Then we had sex and the sex was incredible. I had never felt so free with my body. I knew he was a regular user because he had bottles of water spread through all the apartment and small containers with disinfectant soap. When we finally came down, we said goodbye and barely saw each other again since then."

So, what did you do then? I asked

"Well, it wasn't my first time in Grindr but once I understood that there was a code, I started seeing T's and G's in capital letters everywhere in the most awkward places. I realized I was hungry for more. Chemsex open the door for me to meet new people and to feel part of something", Jeremy said.

We went to the market and then he told me how after that night he started strengthening his social network around Chemsex. He became a GBL and GHB regular user. But "It was about a year after doing Chemsex that I discover Tina. Tina changed it all" he affirms with a sad look in his eyes.

"I met a guy, he was also Dutch and handsome. I think he really liked me, you could tell just by seeing the way he looked at me. The thing is that he was very young when he started playing with Chems and he had all this signs of having taken drugs too far. His body was full of scabs and you could see his veins already damage because of slamming meth. But; there is always a but in every story; he was kind. He took me to the wildest parties and present me to his friends. He made me feel connected, I felt like someone care for me." Jeremy stops for a second, look around to make sure no one is watching and continues. "One day we were on a sex party, everyone was having fun and doing drugs. Then the host of the party comes to us and offered some Meth. We were still sober, but we wanted to have fun, so we agree and snorted a small amount. The effect was almost immediate, and it was one of the best nights of my life.

But the morning, I hated the morning. The coming down effect was horrible. I felt the craving of doing it again just to deal with the hangover. The problem is that since then, I kept craving for more. My partner, was already an addict to Meth, so making the transition for me was pretty easy, at least that was what I thought".

We left our conversation there that day, I left Jeremy in a tram station, with two bags full of food. I wrote in my notes that day, that I felt as if I have left without hearing the whole story. Some days after, he invited me to have coffee at his apartment. I went early in the morning and his cat was waiting curious by the door. After a quick round of hugs and with a cup of coffee in my hand we recap our last conversation.

Jeremy told me he had have an overdose ten months ago. "I was here, at my home, and then I started to feel bad. I felt in the floor and a neighbour found me and called an ambulance. When we arrived at the hospital, the doctor asked me what I was taking. I kept saying 'tina, tina tina', but they just look at me as if I wasn't speaking in Dutch, I fell sleep and woke up hours later. When my partner arrived, he had to explain to the doctors that I had an overdose on crystal meth. The doctors weren't familiar with the term Tina. After that everything was blurry. I remembered feeling tired and sad, and hearing someone said it was a miracle I wasn't dead. It was one of the worst moments of my life. I decided to end my relationship with the Dutch guy. But unfortunately, I was already hook up with Tina."

We stayed quiet for a while and then I comfort him saying it was already in the past. He stood quiet and then said in a deep voice. "Well now I have other concerns." He said.
After contemplating for a while if he wanted to share something else he said, "I am HIV positive." I look at him in silence and it seem to me that he had freed himself of a secret. I responded calmly and ask him how he felt. Jeremy said he had felt better, but he was dealing with it. He told me about the day he went to take the HIV test.

"The nurse asked me to take off my sweater, I did. I kept in silence until the blood test was over, the nurse approached me again and ask, why have you done this to yourself? I could see the look in her face after seeing the scabs and veins in my arms. I couldn't face it, I looked away and went home. I came for the results some days letter and found out I was positive."

Ready to parTy

Eric

"Looking for some sinGle to minGle" I read out loud. Eric smiles while he shows me the catchy phrase in his Grindr profile. I am amazed by the amount of matches he has. "In a common day I can get more than 20 responses" he says, "but many guys are just looking for regular sex and I am not interested in that anymore."

Eric was born in Eindhoven but moved to Germany with his parents when he was about 5 years old. He started consuming Chems in Hamburg, but three years ago he came to Amsterdam to live with his partner and found a local dealer. After some months Eric discovered his partner was cheating on him with a co-worker and decided to leave him.

"I was feeling lonely. It wasn't because I didn't have friends or family in the Netherlands, it was because I changed my whole life to move here with someone I loved, and suddenly I found myself alone." Eric stopped, I lift my head to face him, but I found him smiling to the waiter. Moments later the waiter comes back with food and they seem to flirt for a while. I got the impression Eric is used to the attention.

I go back to my notes and ask him about Tina. "My best friend had started consuming Crystal Meth some months before me. I thought we may be able to do it together. He usually snorted it and had this bizarre sex parties at his house. When I became single I decided to participate more often in those encounters. I snorted Tina, but quickly realized the effect didn't last long enough for me. My friends suggested to slam it and so I did." He stops, eats a bite of a Portobello sandwich and continues.

"Slamming Tina is indescribable. Once it kicks-off you feel free of every concern, of every thought. However, the first time is scary if you have never injected yourself. Is like jumping from a cliff hoping to fall on your feet." He says.

I look at him while I thought about the analogy and I asked, "How did you manage then, to do it for the first time?" He laughs and said he took a tutorial online.

"Where you alone?" I asked "No, I was in a sex party. My sexual partner suggested we did a small dose first and then slowly find out how much we can handle." He stops one more time while the waitress come to check we are fine. We nodded at the same time and continue talking. "I think I became good in the process but after some months of occasionally slamming Meths I had an episode similar to an overdose. It was a scary moment, so I decided to stop my Chems for a while. It worked for some weeks, but I realized I didn't enjoyed sex without Chems anymore.

Is also hard to relate to your friends when they think you are judging their lifestyle just because you are not consuming drugs. After three weeks I decided to continue using drugs, I just insisted we do it in a more responsible way." He has already finished his sandwich and he is looking for the waitress again.

"Anyhow, I thought I was taking all the precautions possible, but then one, two, three friends are found out with HIV. I realized then, that we have often share syringes and other implements without a proper safety measures." He takes a deep breath. "We need to accept the consequences of the decisions we take, but that is easier to say than do. I took an HIV test short after, and the results were negative." I finally finished my sandwich, just on time to order something for desert.

We continue talking about harm reduction measures, he recalls talking to his friends about looking for professional information about safer used of Chems but failing on finding accurate information online. "There are so many myths and misconceptions online, that even in medical pages the information can be confusing." He also told me his sexual network has become closer and that they are giving their best to keep themselves safe and healthy.

Eric continued his story, "I decided to register for workshop on Chems given by a friend who is a nurse. In there, someone called my name and when I look back I saw a bony, worn out man walking in my direction. It was my ex-boyfriend. He looked different in every aspect, he seemed older. I could see his right hand shaking involuntarily from one side to another." Eric take a deep breath and continues.

"It broke my heart to see him that way. Few days after, I call my mom and told her I wanted to register myself in a drug treatment center. She cried. Telling her was the hardest part, but I knew I needed some help if I wanted to continue enjoying my life without becoming a sad version of myself. When I was admitted, the psychologist told me I needed to attend at least one group discussion meeting every week, I was feeling 'dapper'(brave), but when everyone started talking and I realize no one had experience drugs in sexual contexts. I felt ashamed." He said.

Eric continued his story "I was happy for a while but all the sudden I started wanting to go back to my old life. I left the drug treatment center but kept attending anonymous meetings once a month. Nowadays I take extra precautions when it comes back to Chemsex." He ends up by saying, "before you are ready to parTy, you need to know how to play with Chems."

After that day at lunch we saw each other again two months after in the same restaurant. Eric told me his ex-boyfriend has moved back with him while he recovers from a complication during Chemsex. I never asked what he meant by a complication, but I got the feeling is something more serious than what he makes it look like. He looks tired, but he says I don't need to worry about him. He hugs me tightly, promise to stay in contact but we never saw each other again.

HIV is not who I am

Jonas

There are stories that begin with an end and ends that begin a new story. Jonas was 34 when he was diagnosed with HIV. He recalls going to pick up his results in the STI Centre. It wasn't the first time he did the test, so he waited calmly in line to pick it up. After he got the exam, but before he had opened the envelope, a nurse told him he should arrange a consultation for the next week. "I knew then that something was wrong, I opened the test and realized it was positive. I was speechless."

"I call a friend and told him the news, I thought he was the only one who could understand me because he also does Chems. He said I should go to my GP and ask for more information regarding future treatment. He offered to come with me, but I have always preferred to do this thing alone." Jonas looks at me thoughtfully. "I grew up in the Netherlands, I had been seeing the same GP for years, he is a close friend of my parents, so on my way there I felt very anxious." Jonas stayed quiet for a while, like trying to remember what he did next.

"The doctor was happy to see me, he inquired about my family and I smiled politely trying to avoid the subject. He asked me what was going on and I told him I had found I was HIV positive. He remained silent for a moment, but he started to talk to me about medication and plans of action. He said it wasn't the end of the world, not at least in 'this country'. He ordered some additional blood tests. He made me feel calm but before leaving his office he asked me if I was being cautious during sex. I told him I was a Chemsex user and that in the last intake I didn't used a condom. His attitude changes immediately. He looked confused, so I explain calmly about the drugs and ways I was consuming. He was speechless and said he was going to look up into it before our next appointment." Jonas remember feeling judged, but he thought he deserved it.

"After that I knew I needed to tell my parents, I went to their home. When my mom opened the door, I brook up in tears. She stood by the entrance and hug me. Then, I told her I was HIV positive. We both cry for half an hour. She started asking question, how? How did this happen? Weren't you being careful? Did you use condoms every time?" Jonas roll his eyes while he remembers the episode. "I knew she was concerned and worried, I guess like any mom would be" Jonas take a deep breath before continuing the story." I hug her and remain silent. I was exhausted. She insisted me to stay but I wanted to go home. I wanted to be alone in the comfort of my place. I didn't tell her I was doing Chems, I was too weak emotionally to take it. When I went home I felt even lost, I wanted to cry but cry was not an answer. I ask myself, 'how did I let this to happen to me?' I knew the answer I just didn't want to face it."

"I took some days at work to take care of myself." Jonas sees his phone ringing and take some time to answer. After a while he hangs up and continues, "I thought that was it, but my GP called two days after and asked me to go to his office. When I did he was looking worried. He asks me again about the drugs I was consuming. I told him I preferred GHL but had tried once Crystal Meth. It took me around 30 minutes to explain my GP what Crystal Meth was. He seemed surprised and disappointed. Especially in my condition as 'A HIV+ gay male'. I was so frustrated. I just remember saying that HIV is not who I am. I never felt comfortable again talking to him about this."

Coming out, Coming down

Hector

We met for the first time in a coffee place he likes. He presents himself in Spanish but says he would rather practice his English whenever we are meeting. I agree. We drink coffee and talk about the nice weather. After a while he asks me if it is possible I called him "Hector" in my research, he says it reminds him of a Latin actor who is always 'hooking up' with everyone. I smile and nodded.

Hector woke up early that morning, he said he had some nightmares with a guy he doesn't see anymore. "I thought I was only going to stay some months in the Netherlands while I was doing an exchange program with my university. But then I found a job in a company and decided to stay. At work I met a consultant working for the company. He was this beautiful Dutch man and we immediately had this powerful sexual chemistry. I started to arrive early in the mornings to the office, just to have time to speak to him before the daily activities commenced. We started dating after a while, but he was 15 years older than me and that became a problem." He stops and ask me if it's okay he gives me so many details about his life, I said he could talk as much as he wanted, I was happy to hear it.

"Well, he was older, and I liked that, he had all this experience in the gay world and I had just started to enjoy the night life in the city. He took me to a club called Church, is a place where queer men can do almost everything they want. I felt like I was coming out to the world, like embracing my 'gayness.' But then things begun to change. He was never available anymore and I even beg him once to let me come to his place. Now that I think about it, I think I was also pretty young. I was 22 back then and was still receiving money from my parents, back in Ecuador, to keep myself floating. Now that I am 26, at least I can maintain myself financially." He reflects for a moment and continues.

"We stop dating, However, wherever I went I saw him, after all he was the one that had shown me the gay scene in Amsterdam. Some of his friends told me he was consuming Chems and hanging out with guys he met on Grindr. He had asked me to do Chems with him for a while, but I never said yes. I felt sad because I thought that was the reason he ended everything. To say the truth, I think I was very naïve too." Hector looks at me, he stops to ask me questions about my research and my life. I respond to all his questions calmly and ask him if he wanted to have some carrot cake. He agrees and makes some jokes in Spanish about the weather, which is now getting rainy.

After a while he continues by saying "I tried Chems because I was still heartbroken and wanted to feel what it was like. It wasn't the right reasons, but I didn't care. I try it with a Mexican guy who was used to consumed Mephedrone. I loved it, I remember feeling without inhibitions, willing to try and do everything. And we did, we had the most passionate sex for hours. Next day however, when I was coming down, I felt anxious and apprehensive."

Hector told me he talks with some friends after that who explained to him where and how to get the drugs online. "I was suspicious at first, I have heard some dealers changes the drugs with other chemicals. But I decided to contact a dealer and we developed a relationship of trust through the months. I started consuming Mephedrone although everyone kept talking of T (Crystal Meth)." He stops some minutes to answer some messages in Grindr and then he continues saying "I love Mephedrone, is not the most common right now but whenever I am with a sexual partner each of us bring our own drugs. I love how Mephedrone

makes me be this 'badass' men, fearless and empower with my sexuality. But the coming down is always hard and you have once in a while cravings to consume the drug. However, I have make the commitment to only take drugs during sex and without sex no drugs." He stops and laughs. He says, "Well you can imagine how my body craves for sex now".

After we met for that first time, Hector asked me to accompany him to a health Centre just outside the city center, to take an HIV test. It his first time doing it since he lives in the Netherlands and I could not help noticing his concern. I tried to distract him by talking about everyday things, but he insisted on talking about his last medical appointment. He told me his family doctor was very concerned when he told him he was doing Chems. "He said that is why gay men end up with HIV. I told him MSM get HIV because many different things even when they don't consume Chems. However, his words got me concerned and I decided to look for a STI Centre to get tested". When we arrived to the STI Centre the nurse asked me if I also wanted to get tested, I haven't considered it, but I agree.

Some days after the results were out and Hector felt calmer. "I was feeling nervous because I've been screwing around like a bunny." He said while laughing and moving enthusiastically beside me. He called my attention to a rainbow flag outside a Coffee shop and starts to tell me he has created a Support group for Chem users. "I had thought about it for a while, but after we met the first time I thought about the number of things I don't know about chems. For example, I haven't try Tina again because someone told me it produces cancer. I also wasn't aware that we can also get Hepatitis C, no one talks about hepatitis C they just talk about HIV and AIDS". Hector stopped, and I was curious and amazed by how passionate he was with this new project.

"I want to be more active and contact others to join and get informed. Someone told me there are support groups for Chemsex users but all the places that I had contact, told me they are only in Dutch, and we don't speak Dutch." I listen carefully to Hector and told him to look in other close cities, where other participants had told me peer support groups were provided. I received an email of him a week after, telling me that he went to GDD in The Hague, but their support group is only for Dutch speakers. He also contacted someone in Rotterdam, but they told him there were not meetings program that month.
Hector seem genuinely worried about some of his friends and said he had managed to get some nurses to teach them how to use slamming more responsibly. He said he is still looking for a name for the group "Well in the end, I can't call everything Hector."

‘Please let me know’

Daniel

I saw Daniel, 32, from a block away. He looks radiant with a red shirt and black skinny jeans. He says red highlights his strong “Moroccan features”. We sat for a moment in a café, but he suddenly changed his mind and said he prefers to walk for a while. I agree, and we start walking besides the canal. Is the third time we met and by then I have already learned to distinguish his sudden mood changes.

He walks close to me and I often feel his hand pointing to attractive men in the street. I blush when occasionally some of them turn to see what we are doing. But Daniel is fearless and I can’t imagine him feeling uncomfortable ever.

We recall a conversation we have had some days before when he told me he when to a drug treatment therapist to talk about Chemsex. “When I went to a consultation with the drug treatment therapist and I told him that I used crystal meth he told me that he did not have much experience with this drug but that he had treated many cocaine users.” He looks at me, trying to see if I am surprised.

He continues, “Is silly how even drug specialist treated Chemsex users as regular addicts. I am not saying we are not addicts; although most of my friends would disagree; I am saying we share a different type of addiction. One that is linked to sex. Sex with men. Suddenly, in the country of the ‘tolerance’, I can see the face of disapproval in the doctor’s face. Suddenly, in the country of the ‘tolerance’, I am treated as a sexual pervert. Oh! but it is not sudden, is just sudden for me. Is not only for my sexual orientation, although that doesn’t seem to help, is because the color of my skin and my nationality and my language. For some reason, people here found every part of me offensive. I may be as well a professor or an activist but whenever I went to the doctor all they seem to see is a sexual pervert”. Daniel stops a moment to take some air, and before I can keep up with him he continues talking. I am used to his passionate speeches.

“And then I went to talk to LGBTQ+ organizations, but It seems I am not worthy of their time. You know what they usually say? That I should go to an NGO for LGBT refugees. I explain to them that I am not a refugee, I am a migrant. So, then they tell me to go to an LGBT organization for migrants. They say it with hypocrisy and one might think LGBT organizations in the Netherlands are only for Dutch men, but no! They are full of Germans, Belgians and French. So, they do like migrants, they just preferred their migrants to be white. That infuriates me.” He takes some air again and I try to take him back to discussing Chems, but he is unstoppable.

“I know sometimes I might come to aggressive, but people need to listen. Homophobia, transphobia, islamophobia and racism are real. I’ve lived in the Netherlands for 6 years and people seem to think that the health system in this country is the same for everyone. But as a black gay migrant, I learned quickly that is not the true, that the system is full of vices.” We stopped in a corner to buy some drinks and he smokes a cigarette. Shortly after he seems calmer.

He continues by saying "Did I ever told you I went to a peer support group?" I briefly shake my head.

"At first everything was great, I felt comfortable and because I was there everyone agree to speak in English. Then I had the opportunity to speak, I shared my experience using Chem-sex for the first time and how it had given me a sense of belonging when I have needed it. Everyone seemed annoyed by my comment."

When I ask Daniel, why he thought they were upset, he said that some of the participants had approached him at the end of the session to talk to him about how he cannot let other people influence him to take drugs, and that it was a personal decision and not an imposition. He tried to explain to them that, that was not what he meant. He was indeed responsible for his actions but what he intended to say is that he felt as an outsider in the MSM networks because he wasn't doing Chems.

We sat beside a canal, and he pointed out a handsome man seating in a boat. He then told me he had been feeling depressed lately. I look surprised. I ask him if that had something to do with the visit to the support group. "Maybe" he said.

"To tell the truth, I haven't been feeling well since some months ago, I think it has to do with the Chems, but also with me missing my family and feeling alone in this city. The hardest part is that I just found out the guy I am seeing has HIV and although we try to always use a condom, there is a part of me that is scared. And is not even because the HIV, is because… I don't want to be this stereotype of black gay men with HIV that all the NGO campaigns talk about! I don't know if you can understand me, but I don't want to feel like that, like a burden." He claimed. I look at him in silence and nodded sympathetically.

Daniel told me he had a breakdown the day before our meeting. "Some days ago, I went to an STI clinic, to do a regular blood test. I went back yesterday to ask for the results and the nurse said he couldn't give me the results until a practitioner was there to read them. I got scared. I wait for about an hour until I asked again for the doctor. The nurse told me to wait ten more minutes. I did. In the mean time I saw many persons enter and leave the clinic that morning, but I stood there waiting. Finally, a practitioner came to see me. I told him I was waiting for almost two hours, and he said it was a busy day and that I should be grateful that they open a space for me. I didn't want to delay more the consultation, so I stood quietly. The practitioner opened the results and before saying anything he received a call and left the room for other ten minutes. When he arrived, I beg 'Please just let me know, let me know', I just need to know. He sat in his desk calmly and said the results for HIV were negative. The practitioner told me he had detected something else in my blood but didn't seem serious. I am on antibiotics for two weeks."

Daniel went back home and cried, in part because he was upset for the long waiting and in part because of the relief.

Tina is my favorite Girl

Heydar

"We are all in love with her [Tina], but is a suicidal form of love, we all love her until she destroys us."

Heydar was born in Cape Coast, Ghana in 1987. He missed his country and family. He remembers fishing in the early mornings with his dad. When he feels alone, he dreams with the salty smell of the breeze and the cracking sound of the wooden boat tearing the waves apart.

In 2012, however, Heydar ran away from his country, and ask for asylum in the Netherlands.

"I was with a friend. We spent the afternoon with some Portuguese tourists in the harbor. After that, my friend and I walk through the port. The night was warm, and we found a small space within two ships. We kiss. But, someone saw us kissing and called a police officer who detained us. My friend was liberated after some hours because his family was close to the Christian church. I, however, did not deserve the same faith because I am a Muslim. I stood in the station for four days until my brother manage to get me out and take me home. Sexual acts between same-sex people are illegal in Ghana and staying could have ended up with me in prison or dead." He says.

"Sometimes people think I am being over dramatic, but some days after I received asylum in the Netherlands, my mom called to say three men had come to our house looking for me to kill me." He stops the story there, like taking some air between his words. "I haven't go back home since then. My mom still calls me through the phone often, but my dad hasn't dealt well with me being queer."

Heydar has deep brown eyes, and a kind smile. He has been working in a postal office for a year. His Dutch is good, but he says he still get nervous every time he needs to speak in public.

"I run away from home not because I didn't love my home, but because I love myself more. I think I am a rebel. How else could I describe myself? Love, especially self-love is always disruptive. Is anti-social and revolutionary." Heydar is a romantic.

Heydar has however, found a new love. "I love Tina. Tina is my favorite girl." He says. "Well, is my only girl."

We talk about Chems for a while, he says is easy to find them online or in social apps. He shows me his Grindr profile and laugh before I can say anything. His bio has a passage from a famous British poet and all the T's of the poem are in capital letters.

Heydar tells me he has been doing Chems for two years. He started with poppers and progressively change to Tina. He says he likes the flavor of it. "At first I did it just to make sex last longer. From 'her' I get the excitement, the strength to say and do what I usually can't; but I respect 'her', she is fearless, and you can easily cough up and lose yourself. I don't want

that, I love myself too much to risk it. But I can tell is getting harder to quit." Heydar reflects for a while. "Tina is not jealous, she doesn't judge, she doesn't discriminate. We are all in love with her, but is a suicidal form of love, we all love her until she destroys us."

"I went to the ER once, it was not because of me, it was because a Dutch friend from work had an overdose with Mephedrone and he needed someone to bring him some things to the hospital. When I arrived, the personnel of the place was very inquisitive. They ask me if I knew where he got the drugs, or if I knew his dealer. I was confused and said, I didn't know. It was the truth, but his doctors didn't seem to believe me, they didn't believe him either when he said I wasn't his dealer." Heydar stops and arranges the bottom of his shirt.

He looks at me while I ask him, "why did they thought you were his dealer?" He takes some breath and answer "I guess because… I am black?" His answer is also a question. "The truth is that I don`t know, I am used to see people in the street walking away from me, like they were afraid of me. For some time, I thought it was because I was doing something weird, the way I walk, the way I dress. I try to hide myself and assimilate the European 'ways', but I can`t hide the color of my skin. As I live in the city, I recognized small forms of racism. I thought I was projecting my fears of being different, because I have always been different. But when I started to learn Dutch, I was impressed by the amount of comments around my skin color." Heydar get distracted briefly by the sound of the rain outside.

Then he continues, "Maybe is just because in Ghana, I never thought about my skin color. It was irrelevant for me to say, 'I am black', it was more important to say, 'I am gay' and sometimes to say, "I am Muslim." Naively, I thought that when I move to the Netherlands those denominations were going to be forgotten. But now… now I am a gay, black Muslim migrant." Heydar looks at me as if he wants to stop the conversation there, but he abruptly continues, "I am a gay black Muslim man in the Netherlands, and no one seems to matter…Oh! well unless I go to the doctor. Then being gay means, I am victim. Being Muslim means I have a close mind to progress. Being black means I must be uneducated. Then, the doctor doesn't need to ask me why I consume Chems, because no matter what I respond he has already assumes that is because I live in the margin of what is socially acceptable."

Is not about the bottom

Hans

"I felt an energy rush after the first dose of G (Street name for GBL), but the effect lasted only a couple of hours. That's when I decided to consume a second dose of GHB. After that I only remember a quick euphoric effect. Then I started having trouble breathing until I completely lost consciousness. My partner, whom I had met only a few days before, had to drag me to his car and take me to the ER." Hans said.

Hans, 40, was remembering the time he had an overdose with GHL and GHB in 2017.

"When I woke up the first thing I saw was my mom sitting at the foot of the bed. I could see that she had not slept in the last days and I regret that at her age she had to go through this. Then I saw my boss and lifelong friend on my right side." Hans served my tea while I ask him, how long was he in the hospital? He lowered his eyes and responded "When I woke up, I had already spent four days in a coma. They left me in the hospital for some days more.

Hans looks back at me and ask, "Do you drink it with sugar?" I said "yes" in a thin voice. I am felling shy today.

He continues his story. "I wasn't feeling great you know, when these things happen when you are forty, you feel you have failed in life. But I try to stay positive. In the ER, a nurse practitioner told me that when I arrived there, my vital signs were very low and that my partner (who did not speak Dutch) was not sure of the name of the drugs we were taking. He told me that when he explained to them, the doctors though he had an intoxication with ecstasy." Hans said. "I've always felt attracted for Latin men, I do not know why, but they just seem more likely to say yes and less likely to say no, especially in relation to chems. The guy who took me to the ER was from Costa Rica, he went to the hospital every day until I went out of the coma. When I was feeling better I send him flowers with a note that said, 'thanks for saving my life'. He wrote later an email to me saying he was glad I was ok but that we should continue seeing each other. I understood and never contact him again."

"Days later, my boss sat with me in the office, he hugged me and told me that I could not continue working if I did not have control over my consumption. He was honestly worried about me, about this other side of my life he didn't knew. I quit my job that day. I knew I couldn't lie to him, and in that moment in life I wasn't in control." Hans look at me curious, I am still drinking my coffee and taking notes. When I look back he is staring at my notebook. He asks if he can see my notes before I leave. I smile back and agree.

He continued his story by saying he was seeing a therapist. "I tried to look for a sexologist, but my insurance wouldn't cover it. The therapist has help me see other issues, but when it is about Chemsex, I don't feel he really gets it. He says I need to stop consuming drugs, and I agree, but doing so means I need to stop seeing most of my friends who are also into Chems. I don't think my therapist understands Chems are what keeps me connected to my social network." He stops to poor some more tea into my cup. He looks at me and asks about my personal life. We talk about my studies in the Netherlands and my decision to start researching about Chemsex. Hans says, "one I was younger I wanted to experiment every-thing I could, but I grew up in the south of The Netherlands, were people is still very

conservative and religious. Everyone seem good with me being gay, but drugs were another thing. When I move to Amsterdam I was already in my thirties, and for the first time I was able to live as free as I could. Amsterdam is one of those cities where you can be whoever you want. I had fun, the type of fun you can only have when you are a gay man. But when I was 36, I discovered I was HIV positive, I wasn't happy, but I felt it was not the end of the world. Around the same time, I started to Chems. I met a guy who was always bragging about being positive and not needing to use a condom anymore. I started to practice bare-backing (Anal sex without the use of a condom) during Chemsex, only with other HIV positive men. Since then, I developed regular sexual partners with HIV. Recently however, a friend of mine was diagnosed with Hepatitis C, we realized we never considered that as a risk." I heard him carefully, writing down every bit.

He asks again about my research, I tell him I am writing about the policy aims in the health system and how it can be more sensible to Chemsex users. He thinks about it and then says, well "when you reach the bottom is terrible, but the hardest part is actually the fear. The fear of being judged, the fear of disappointing everyone, the fear of being treated as less just for being gay."

We talk for about an hour that day. We saw each other again almost a month after. This time we met in a small bookstore besides the canal. Hans said he goes there on the weekends to read and get out of his house. He has been working as a consultant for some months and is doing better. We talk for some hours that day, he looks happy and calm. On the train home I receive a message that says, "Is not about the bottom, is about all that happens before and after."

High in the Method

Ali

Our first meeting was short, but after a brief round of presentations, he said, "The first thing you need to know is that the effect is determined by the method" His words echoed in my head days after we said goodbye. "What do you mean?", I asked him impatiently when we met two days after in Dam square. He said to me "well it means the same drug can have different effects, depending on how you use it. That's why we need to treat them we respect. Today a dose of GBL may make you feel happy, tomorrow it can be your torture."

Ali is a Kenyan and Dutch citizen who moved with his parents to The Netherlands in 2003 looking for better economic opportunities. Since then Ali has lived in different parts of Holland. However, as he says it was only through Chems where he "found a community where he belongs". Ali has engaged in Chemsex practices for the past three years. "Drugs empower me to enjoy my body, to feel pleasure." He stops an add "I thought for many years that I didn't had the right to feel pleasure. Because queer pleasure is always stigmatized and tear apart. But when I started consuming drugs it was like I finally had the right to own my body and my sexuality."

Ali always looks serious, but I discovered that he cannot help but smile when he thinks of his family. His parents do not ask much about his love life, they are aware that Ali is gay, but they often ignore the issue when they are together as a family. Ali is very close to them although he confesses that since he consumes Chems he lives in fear of what his family would think if they ever found out. However, Ali has not missed any family celebration in the recent years, he says he is always there for his friends, he never misses work and he has diner regularly with his sister.

Six month ago, Ali men an Ethiopian man, who had move recently to the Netherlands. "The first think I notice were his arms. Oh my god, I though who could be the lucky one to be with that guy?" Ali laughs nervously. "Anyway, I saw he was alone drinking a beer in one side of the bar. I ask him if I could sit with him and he nodded nervously. We talked for hours that night and before the bar closed I invited him to my house. We came to the small apartment I share we two other flat mates. We had sex that night, but after almost an hour of trying, I realized I couldn't cum. He said it wasn't a big deal, but I knew I haven't had sex without Chems for a long time, and that was probably the reason behind. I finally decide to tell him I was into Chems, he said I should do whatever made me happy, so we stopped for a while and I took a rectal dose of GBL. The night was perfect after that." Ali says with a proud glance in his eyes.

"We had been dating for six months now and he has started to do chems with me occasionally. We usually use GBL and GHB and we have promised we won`t try Crystal meth for now. I have also taught him to take just one dose of GBL at a time, because I feared an overdose while we are having sex. Things seem to look good for now, but I think he is getting more hook up with the drugs." We talk some more hours about his new boyfriend and he promise to present him to me during Pride week in Amsterdam.

I met Ali two weeks after. He was late, and I wait for him about an hour. When he arrived, he apologized for being late, but he told me he could not stay long because he had to go to

an appointment in the immigration office later that afternoon. We talk for a while and he told me that his boyfriend was having problems with immigration and he was trying to help as much as he could. I offered to come with him to immigration. He refused at first, but when the time came to say goodbye he told me to accompany him to his appointment. The immigration office was almost empty when we arrived. However, we wait half an hour before they attended Ali. When it was his turn, I waited for him outside in the waiting room. After some minutes Ali got out and we took the tram back to central station. On the way there, he told me he was worried about his boyfriend and his legal status in the Netherlands. He suggested he could try to marry him, but he quickly seemed to regret sharing that idea out loud. After that he said his boyfriend was insisting on trying Crystal meth with him, but he didn't want to mess with meth. "To be honest, I don't think I like drugs that much, what I really like is to experiment with the method. My boyfriend like to take 'G' (GBL) orally but I preferred the sensation of booty bumping it."

After a while he said he was thinking on going to an addiction therapist, referred to him in the STI clinics. Nevertheless, his boyfriend said he would rather go to a peer support group. We look online and found out Mainline and GDD had some Chemsex groups. However, his boyfriend, was discouraged by the fact that the group wasn't in English. I told him we should try anyway, but at the end I went alone to the group.

"How was it? How did you feel?" I asked.

Ali said he didn`t like it. "Some of my friends don't go because they don't speak Dutch. But I speak Dutch and I didn't feel comfortable either. All of the other participants were 'Dutch white', I was the only black men in the room." He took a look to me and said, "I felt different, I think I couldn't relate to the other Dutch guys, even though we were all there because of chems."

I asked him about what made him feel more uncomfortable and he answered that some of the participants where curios about how he paid for the drugs. "I was a weird question, but I try not to take it personally and answered that I had a well-paid job in Amsterdam. The other guys laughed at me and I couldn't know what they were laughing about. After that the man seated beside me said I must have many "well-paid clients" suggesting that I was a sex worker. That really got me upset and I never went back to the group." Ali was upset, he said he felt Dutch after 15 years in the country, especially after receiving his citizenship. But he said he was never going to be "Dutch enough, because he wasn't white enough". We walk in silence for some time and sat in a bench.

We talk some more time that day, he showed me his niece who had recently born in Utrecht. We said goodbye with a small hug, he looked serious as always, but whisper "I would invite you if there is a wedding". I laugh.

Ali has recently told me he is HIV positive.

Appendix 2 - Overview of Research Participants

RESEARCH PARTICIPANTS OVERVIEW										
No. Code	**Name**	**Age**	**Nationality**	**Identify as**	**Chemsex drugs use**	**How often use Chems in sexual context?**	**Use in non-sexual contexts?**	**Has had a negative experience with chemsex?**	**Where do you found sex partners with the same interests?**	**HIV +?**
1	Jeremy	31	Ecuatorian	gay	Crystal meth/GHB	Every time he has sex	No	Yes	Chat Online	Yes
2	Eric	28	dutch/german	gay	Crystal meth/Extasis	Every time he has sex	No	Yes	Grindr	No
3	Jonas	35	Dutch	bisexual	Crystal Meth/GBL/GHB/	Ocasionally during sex	Yes	Yes	Grindr	Yes
4	Hector	26	Ecuatorian	gay	Mephedrone	Ocasionally during sex	No	Yes	Chat Online	No
5	Daniel	32	Moroccan	gay	Crystal meth/ GHB	Every time he has sex	No	Yes	Grindr	No
6	Rud	39	Poland	Fluid	Crystal Meth/ Poppers	Ocasionally during sex	No	Yes	Grindr	No
7	Heydar	32	Ghana	gay	Crystal meth/Poppers	Every time he has sex	Yes	Yes	Grindr	No
8	Hans	40	Dutch	gay	GBL/GHB /MDMA	Every time he has sex	No	Yes	Scruff/Grindr	Yes
9	Ali	26	Dutch/kenian	gay	GBL/GHB/ Extasis	Ocasionally durng sex	Yes	Yes	Grindr	Yes

Appendix 3 – Locations of Participatory Observation

Locations visited with Research Participants		
Location	***Partici-pant***	***Date***
Visit to an STI Centre	Rud	June
Visit Immigration Office	Ali	June
Walk through the city looking for Grindr dates	Jonas	July
Meeting after AIDS workshop	Heydar	July
Visit to Albert Heinz market to buy food for the week	Jeremy	July
Medical Appointment	Jonas	August

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Notes