Pressure to bear: gender, fertility and prevention of mother to child transmission of HIV in Vietnam
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Economic transition

Vietnam is still a communist state with only one legal party, the Communist Party of Vietnam. The launch of Đổi mới or “renovation” in 1986 marked the beginning of the country’s transition from a centrally planned economy to a market economy, along with a range of other social and political changes. Social and health indicators, such as literacy and maternal and child mortality rates, are relatively good in Vietnam compared to the country’s level of economic development. In 2005, Vietnam ranked 109th out of 177 countries according to the Human Development Index (United Nations Development Program, 2007) - well above what would be expected from its gross domestic product (GDP) of less than USD 400 per capita per year. Life expectancy is 68 years and adult literacy has been maintained at over 90%. Maternal mortality is declining slowly, while neo-natal infant and under-five mortality were 19 and 42 per 1,000 live births respectively in 2003. (United Nations Country Team Vietnam, 2005) A number of international donors support health programs aimed at improving the coverage and quality of health services, but the main contribution to the health system still comes from the national budget.

Although studies by the national authorities and international donors do not all use the same definition of poverty (Nguyen Nguyet Nga & Rama, 2004), there is consensus that the incidence of poverty has fallen dramatically nationwide since Đổi mới. (General Statistic Office, 2007; Ministry of Foreign Affairs, 2005; World Bank, 2004) However the rate of decline and the incidence of poverty vary greatly across the different regions in the country, and are now a largely rural phenomenon concentrated in the Northern Uplands, Central Highlands and North Central Coast. Moreover, increasing migration of poor unskilled labourers from the countryside to large cities such as Hanoi and Thai Nguyen poses new challenges to urban areas to provide for these new populations of poverty-stricken settlers. Many of the rural migrants are not registered in the urban centres and therefore face barriers to accessing social services, including health care (Ministry of Plan and Investment, 2006).

In the urban areas, a range of negative side effects of the Đổi mới process are evident in burgeoning crime rates, an increase in the illicit drug trade and rates of drug addiction, and a growing sex industry. Rapid economic growth, socio-cultural changes, and the relative availability of heroin are factors which have contributed to increased drug use among young Vietnamese males in the study sites. (Tran Thu Minh et al., 2006) Further, greater use of drugs and
the spread of HIV/AIDS have been explicitly correlated with Đổi mới. (Werner & Belanger, 2002)

One study found that about half of male IDUs are employed in industries that have thrived under Đổi mới such as mining, construction, or trucking, activities which place them at particular risk for drug addiction and the contraction of HIV. (Nguyen Tran Hien, 2002)

With the advent of Đổi mới, men encountered many more opportunities for commercial extramarital sex. (Phinney, 2005b) In urban areas, various hospitality and personal care service providers, such as (karaoke) bars, hairdressers, and massage parlours also offer sexual services for men. Often the women who provide these services are migrants from rural areas. (Nguyen-Vo Thu Huong, 2002; Walters, 2004)

The study reported in this thesis took place in two urban areas which are illustrative of the changes that occurred under Đổi mới. The study was conducted in Thai Nguyen province and the capital Hanoi, both in the Northern part of Vietnam, close to the Golden Triangle, and a hub on the routes of drug trafficking to the coastal ports and China.

**Gendered inequities**

Women play a central role in the ongoing capitalist transition. The Vietnamese state, like other socialist states such as Cuba and Bulgaria, has taken strong measures to support gender equity, some of which have been very successful. For example, the proportion of female members of the National Assembly fluctuates between 26-27%, the 16th highest the world, and in the Asia and Pacific Region, only slightly below Australia with 26.5% and New Zealand with 30.8%. (Nation Master.com) An ambitious gender equity law was approved at the 10th meeting of the National Assembly in 2006 (SRV, 2006b) The gender effects of changing public expenditures, such as the privatization of state companies and the introduction of direct and indirect taxes do not appear to have been systematically measured, however. (H. Akram-Lodhi, 2002). While the 2006 gender equity law aimed to provide for actual affirmative action measures to improve the position of women, at the same time public utilities and state companies were privatized, reducing the number of jobs, especially for women, who were overrepresented in the state sector. Several authors have argued that gender inequities are increasing under Đổi mới.
mới. (Bousquet & Taylor, 2005) Others reported that the welfare of women in Vietnam has generally improved, although there are significant differences amongst women depending on their age, education, ethnicity and relationship to the market economy. (Le Anh Tu, 2006)

This study focuses on the người Việt or người Kinh people, the dominant ethnic group and culture in Vietnam originating from what is now northern Vietnam and southern China. They are the majority ethnic group of Vietnam, comprising 87% of the population, and are officially known as Kinh to distinguish them from other ethnic groups in Vietnam. (Communist Party of Vietnam, 2007) The Kinh are patriarchal and patrilocal, essential characteristics which are not found amongst all of the other ethnic groups which reside in Vietnam. Various forms and levels of matriarchy and matrilineality exist amongst a number of groups such as the Cham, Chu Ru, Ede, Gia Rai, Mnong, and Raglai, for example. (Vietnam News Agency, 1996)

Care should be taken to avoid simplifications and generalizations, but studies suggest that Vietnamese women, like women in many other countries including the Netherlands, are paid less and educated less than men in the same social circumstances, and that the gender gap is even wider among poor families. (United Nations Development Program, 2004) Women’s lack of education contributes to communication difficulties with health care workers, which are often amplified by health care staff’s limited interest in women’s concerns. Women tend to have less access to credit than men. (United Nations Expert Group on Women and Finance, 1995) Vietnamese women have fewer opportunities to borrow money from formal institutions and, indeed, are more likely to borrow from informal sources such as relatives, moneylenders or Họ/Hụi (local rotating savings and credit associations) than from formal institutions. (Fyles & Vu Thi Thao, 2001)

The amounts that can be borrowed through such self-help savings institutions are relatively small, and often short term (with loan cycles of less than one year) thus providing members with limited opportunities for investing in capital-intensive sectors or businesses which require a longer term investment to generate income.

**Women’s reproductive roles**

Gender roles within families may vary and change during a lifetime, but taking care of a child is considered the responsibility of women in a Vietnamese family, as is illustrated by popular expressions such as “A child becomes naughty because of his mother; a grandchild becomes naughty because of his grandmother” (con hư tài mẹ, cháu hư tài bà). Vietnamese women seek to have children for many social and family reasons, such as to cement their relationship with their husband and to bond with their mother in-law and their new family in-law. Motherhood gives a Vietnamese woman status, but infertility has serious social consequences. (Pashigian & Melissa, 2002) Viet-
Vietnamese women are expected to have children in their first year of marriage. This means that once a couple is married they will likely have unprotected sex, which increases the risk of STI and HIV among newly married women.

Son preference has a long tradition in many countries, and is particularly pronounced in South and South East Asia, where it has been well documented. (Goodkind, 1999; Gu & Zhenming, 1998; Miller, 1981, 1983; R. Murphy, 2003; Pande & Astone, 2007; UNFPA, 2005) Although the Vietnamese state has promoted gender equity, some recent research suggests that son preference is still widespread in Vietnam, and is possibly on a par with Bangladesh and China. (Haughton & Haughton, 1995) Sons are more desirable as an investment, because they provide labour and economic security to their parents, while after marriage daughters leave home to become members of their inlaws’ families. (Haughton & Haughton, 1999) According to Confucian tradition, it is sons who are responsible for ancestral offerings and continuing the family line; failure to have children, especially a son, is, therefore, a disgrace to the ancestors and considered shameful. (Handwerker, 1998) In the words of a well known Confucian saying, “If you have a son, you can say you have a descendant. But you cannot say so if you have even 10 daughters.” (Haughton & Haughton, 1995) A woman who marries the only son in a household is strongly pressured to have (male) children. In addition, in some rural areas folk beliefs hold women responsible for the sex of their children. (Bélanger, 2006) Biological children are strongly preferred over adopted children, which adds to the pressure on women to bear their own (male) child. (Phinney, 2003, 2005a)

Some cultural groups with strong son preference developed solutions for families without a son such as uxorilocal marriage among the Han in Central China. (Pasternak, 1985; A. P. Wolf, 1989) In this system, parents usually ‘call in’ a son-in-law for one of their daughters, and either the son-in-law assumes his new family’s surname as an adopted son or one of the son-in-law’s sons is assigned this family’s surname to carry on the lineage.

This solution for families without a son has also been reported in Vietnam, but it is not common and most men who agree to take on filial duties are poor and of low social status. (Bryant, 2002; Gammeltoft, 1999) Son preference is responsible for well documented sex ratio imbalances in China, Korea, Vietnam, India and Myanmar. (Goodkind, 1999; Gu & Zhenming, 1998; Miller, 1981, 1983; R. Murphy, 2003; Pande & Astone, 2007; UNFPA, 2005) For the cultural preference for sons to result in imbalanced sex ratios, women need to have access to prenatal screening technology to detect the sex of a child and have access to abortion. In many Asian countries, therefore, improved antenatal care and prenatal screening facilities, especially ultrasound technology, contribute to imbalances in sex ratio. (UNFPA, 2007) In Vietnam, sex selection is relatively easy because ultrasound and other technologies for improved prenatal screening, including sex determination, are widely available. (Gammeltoft & Nguyen Thi Thuy Hanh, 2007) While sex selective abortion is illegal, it nonetheless occurs.
Reproductive health policies in Vietnam, as in many other countries, have focused more on population control than on women’s health. (Lynellyn, Le Ngoc Hung, Truitt, Le Thi Phuong Mai, & Dang Nguyen Anh, 2000) Vietnam adopted an official policy to reduce rapid population growth as early as 1963. (Knodel, Mai Van Cam, Nguyen Van Phai, & Hoang Xuyen, 1996) Until 2003 Vietnam had a two-child policy, to curtail population growth. Although the official policy has been relaxed in recent years, families are still expected to be small and most authorities still pressure women to restrict the number of children they have.

Recent population control campaigns still recommend having only two children even if both are girls (see Figures 2 and 3).

Family planning services are widely available, and are easily accessible to married women, providing them with a number of different options for contraception. The state, often through the Women’s Union, has encouraged women to participate in reproductive health programs by linking family planning programs to micro-credit. (Committee for Women’s Development, 2006) The Intrauterine Device (IUD) is the preferred family planning mechanism in Vietnam. In some urban and rural areas an estimated 80% of women use one, although many women report side-effects. (Gammeltoft, 1999) Antenatal care is widely available in Vietnam, and includes blood testing for diseases such as HIV, although these blood tests are not universally provided to pregnant women. (Piwoz & Preble, 2002)

The burden of family planning is on Vietnamese women who, when they have problems with an IUD, and fail to convince their husband to wear a condom, end up having an abortion in order to control the timing and the numbers of children. While induced abortion is rarely discussed publicly, Vietnam has one of the highest abortion rates in the world. (Gammeltoft, 2002) Not only is abortion legal in Vietnam, but it is carried out on a large scale by married- and increasingly also unmarried women (estimates based on MOH data from 1998 suggest that unmarried women accounted for 30 percent of
the total abortions). Eighty-two percent of women of childbearing age have had at least one abortion. (General Statistic Office, 2005) Annually, 40% of all pregnancies in Vietnam end in abortion. (UNICEF, 1999) Abortion is so common that it can be safely assumed that almost all women who come for antenatal care want to have their baby, otherwise they would have gone directly to the abortion service. There are, however, exceptions. A newlywed woman can be refused an abortion if she cannot prove that her in-laws and/or husband approve, for example. Cultural constraints are thus translated into administrative barriers in public health services.

Reproducing the happy family

Women play essential roles in the family as mothers, enjoying thiền chức, a “sacred motherhood mandate”. There are many national policies designed to protect this role and support women as wives and mothers. (SRV, 1984, 2002) thiền chức provides women with some policy benefits that men do not enjoy, such as extended maternity leave and leave to take care of sick family members, but also brings with it many familial, collective duties which are not borne by men. Vietnam’s early population policy, like that of China, linked family planning policy to socialist development policies. Families who complied were rewarded with material and immaterial rewards such as being able to borrow money through “clubs for families with two children” or “good mother clubs”, while those with larger families would face barriers or restrictions such as being unable to become a member of the Communist Party.

The ideal “happy” family was understood to be composed of two parents and two children, an older daughter and a younger son, all leading productive lives and abstaining from what are considered “social evils”, such as gambling, drugs, theft, prostitution and pornography. The preference for an older daughter was so that the daughter could help to raise her younger brother.
The *gia đình văn hóa*, or cultural family concept, is still important for the communist party and for some members of the older generation, it may have less relevance for young people, for whom early marriage and family life may have less importance. While pre-marital sex is generally frowned upon by the older generation, for example, one in three single urban males (33.4%), aged 22-25, reported premarital sex (compared to 3.7% of their female counterparts), while 26% of rural males aged 22-25 reported pre-marital sex (compared to 3.3% of their female counterparts). (Ghuman, Vu Manh Loi, Vu Tuan Huy, & Knodel, 2006) If young Vietnamese couples are having sex before marriage, sex counselling for young sexually active people would seem logical from a public health perspective. This is however not the practice as it remains culturally unacceptable for young people to have sex before marriage.
The National Health care system: strong vertical public health policy approach

Vietnam’s health system is far stronger than those in many other countries already highly impacted by HIV/AIDS. As in many Asian countries it is the state and not civil society or national or international non-governmental organisations (NGOs) that provides most social and health services. (Levine, 2004) Vietnam has a strong vertical health care system that reaches the village level.
(see diagram below). (MOH, 1996) The Vietnamese state has an excellent track record in implementing policies once leaders have agreed on health priorities, which was demonstrated in the successful combating of outbreaks of SARS and avian flu, or behaviour change interventions such as the promotion of helmet-wearing on motors and scooters. However, foreign funding for HIV/AIDS interventions is considerably larger than national investment. The President’s Emergency Plan for AIDS Relief (PEPFAR) provided around USD 67 million in 2007, for instance, compared with a little over USD 6 million which the national government invested in the same year. Multi-sectoral collaboration and coordination across the various vertical programs (such as the HIV/AIDS and the family planning programs, for example), in order to establish a more comprehensive approach, are weak.

Figure 5: Vietnam’s health system structure

National level
- Policy, rules and regulations
- Universities, teaching hospitals

Provincial level
- Preventive medicine, medical schools, provincial hospitals, local supplies
- Coverage: 8-12 districts; 1.2 million people

District level
- Primary and 1st level curative and preventive services
- Team of hygiene and epidemiology (8-15 staff, medical doctors, assistant doctors, nurse) supporting vertical programs, disease surveillance and prevention in the districts
- Coverage: 10-20 communes; 100,000-150,000 people

Commune level
- Primary health care services, including maternal care
- In general: 3-4 health staff: medical doctor, assistant doctor, nurse, midwife or pharmacist
- Policy: each centre headed by a medical doctor, reality: 40%
- Coverage: average of 6,000 people

Decentralization and socialisation of health

At first glance, it might appear that the well-established hierarchy and lines of authority in the Vietnamese state system would conflict with decentralization, including the participation of patients in the health care system. However,
there have been many significant changes in the national health policies for and at the grassroots level over the past decade. A hallmark resolution was passed at the 4th conference of the Central Party Committee in 1993, stating that health care is the collective responsibility of the whole society and that a focus on the grassroots level of health care, as well as a multisectoral approach, was needed to strengthen the health care system as a whole. This meant that increasing attention was paid to the health needs of the population, including the rural population, outside the hospitals.

The vision of primary health care was subsequently developed further through a series of decrees and decisions. (SRV, 1995c) Primary health care fits with what is known as the “socialisation of health” in Vietnam, which originates from the idea that several sectors should be involved in the provision of health services. (SRV, 1989) Further, a number of decrees and circulars support a multi-sectoral approach to health. (SRV, 1999) These decrees reflect international discourses and developments in public health such as the Alma Ata declaration of 1978 which emphasized the importance of primary health care. To a certain extent they also mirror a communist vision of the relationship between the state and society, and the utopian ideal that the state is responsible for creating absolute equality between all citizens.

Lack of consensus and even rivalry between sectors, such as that which exists between the Ministry of Health (MOH) and the Ministry of Labour and Social Affairs, and rivalry within the health sector (such as that between the reproductive health and HIV departments in the MOH), can pose obstacles to a coordinated multi-sectoral and decentralised approach. The State Budget law of 2002 provided the National Assembly (at central level) and People’s Committees (at local levels) authority to decide on the budget allocation among different sectors. (SRV, 2003a) In addition, the primary role of the People’s Committee at all levels makes it hard for specific sectors, such as the health sector, to call meetings or coordinate activities involving other sectors.

Public/private mix: The commodification of health services

In spite of the extensive state health system, most health costs in Vietnam are paid for privately. As part of liberalization efforts, the state health sector is under reform and health care services increasingly require user fees. The introduction of user fees has generated substantial additional income for the public health sector, to the tune of US$ 0.40 per capita per year in 2001, for example. (United Nations Country Team Vietnam, June 2003) The use of new medical technologies, such as ultrasound and other prenatal screening technologies, and the use of private services are both proliferating. They fulfil the needs of both patients and health care providers for reassurance, and also provide health services with extra income. (Gammeltoft & Nguyen Thi Thuy Hanh, 2007)
The introduction of indirect taxes such as user fees for education and health services reportedly affects women disproportionately, as in their gendered roles of caretakers women are considered responsible for the payment of such fees. (Tran Tuan, 2001) Moreover, a study on HIV/AIDS-related expenditures and income losses found that the total health care expenditure for households having a person or people living with HIV (PLHIV) was 13 times higher than the average household’s spending on health. (United Nations Development Program, 2005)

In many provinces in Vietnam, ARV are increasingly available for free especially through internationally funded programs, but anti-retroviral treatment (ART) also requires expensive tests. As a result, ART is still too expensive for most people with HIV (MOH, 2006e), as it requires the payment of formal user fees such as routine testing and CD4 tests, informal payments to public and private service providers, self-medication, and prescribed medicines.

Characteristics of the HIV-AIDS epidemic in Vietnam

The first HIV case was reported in Vietnam in 1990, four years after the introduction of Đổi mới. Since then the HIV epidemic has continued to grow in all population groups under surveillance. (Avert, 2006) Although the national prevalence of HIV is low, at an estimated 0.5% in 2006, prevalence
rates increased from 0.02% in 1994 to 0.37% in 2005. Some provinces such as Hanoi and Quang Ninh have reportedly higher rates, at more than 1%, while the province of Thai Nguyen has a prevalence rate of approximately 2%. (MOH, 2006d) By international standards a prevalence rate of more than 1% is considered a generalized epidemic. However, it seems clear that the mean age of PLHIV in Vietnam has been decreasing; currently young adults between the ages of 20-29 account for 50.5% of all HIV infections. (Nguyen Tran Hien, 2007) Sixteen percent of reported HIV cases were among females including sex workers and drug users. (UNGASS, 2005) The overall prevalence rate among female commercial sex workers in 2005 was 6.5%, but many female sex workers (FSW) are also IDUs and have much higher infection rates. (SRV, 2005) Moreover, figures on HIV+ women are greatly under reported. (Nguyen Thu Anh, Oosterhoff, Hardon, Nguyen Tran Hien et al., 2007) Wives and girlfriends of IDUs, many of whom have or are planning to have families, are increasingly infected and affected. Many of these women are not using drugs and have not worked in prostitution.

Similar to other countries in South East Asia such as Thailand and Indonesia, HIV prevalence has risen rapidly among IDUs in Vietnam. (Birowo, Djoerban, & Djauzi, 2003) The epidemic is still concentrated predominantly among young male IDUs in urban areas, at borders, and in seaports. (MOH, 2006b) Needle-sharing among drug users is common, with rates ranging from 20-70%. (UNAIDS & WHO, 2004) Although the use of heroin strongly reduces the sexual drive and IDUs have much lower levels of sexual contact than their non-IDU peers, male IDUs have sex, including unprotected sex. A study among IDUs aged 16-29 in Hanoi indicated a low proportion of condom use in the 30 days previous to the study: 35.8% reported using condoms during vaginal sex. (Nguyen Tran Hien & Nguyen Minh Son, 2005)

Additional, concentrated HIV epidemics among IDUs are located in rehabilitation camps, which are Soviet-style reeducation centres for IDUs and commercial sex workers (camps are numbered O6 and O5, respectively, for these two social groups). A significant proportion of the IDU population in Vietnam, spends time at one of these camps. Persons are confined for mandatory periods as a result of judicial/police action, family and community referrals and in some cases voluntary enrolment. The total number of persons residing in such rehabilitation centres in Vietnam is unclear; estimates range between 40,000 and 80,000 persons. (CSIS, 2006b) The 05-06 centres in Ba Vi, the catchment area for Hanoi, accommodate 7-8,000 residents, 10% of whom are female. Thai Nguyen has two 05-06 camps which can accommodate around 1,000 residents. The conditions in the camps vary; some provide vocational trainings and sport and recreational activities while others are rather basic and lack activity programs. Screening for HIV is compulsory for residents; and between 30-60% of the camp populations may be infected. The health facilities in the camps are generally poor. (CSIS, 2006b) This may partly be because these facilities lack the technical support of the MOH as they fall under the jurisdiction of the Ministry
of Labour, Invalids and Social Affairs (MOLISA). Relapse rates amongst former IDUs released from the centres are high, at between 70-90%. (Crofts, 2005)

Most residents in 06 camps are male. As camp residents move in and out of their local communities, HIV and other infectious diseases such as tuberculosis (TB) move with them. Inadequate TB and HIV control in such institutionalized settings, combined with lack of integration and follow up in the community, has resulted in well known international public health risks, such as multi-drug resistant TB. (Kazionny, Wells, Kluge, Gusseynova, & Molotilov, 2001)

Most HIV+ women in Vietnam do not have a known history of drug use and have probably been infected through heterosexual contact with male IDUs. They have recurring health problems that bring extra expenses, and suffer from different forms of HIV related stigma from within the family and the society. (Khuat Thu Hong, Nguyen Thi Van Anh, & Ogden, 2004) Vietnamese women are reported to have less access to ART than men. (WHO, 2006)

Characteristics of the HIV epidemics in the study sites

The trends in HIV prevalence at the study sites in Thai Nguyen and Hanoi province are comparable. The highest prevalence of HIV is found among IDUs; in both provinces about a third of IDUs are infected (Tables 2 and 3). The tables

| Table 2: HIV prevalence among sentinel populations in Hanoi (%) |
|-------------------|----------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| IDUs              | 2.39 | 3.25 | 13.25 | 17.50 | 22.25 | 25.25 | 30.50 | 31.25 | 27.50 |
| Female sex workers| 0.84 | 3.75 | 6.50 | 10.00 | 11.50 | 14.50 | 15.00 | 15.50 | 13.00 |
| Pregnant women    | <0.1 | <0.1 | <0.1 | 0.50 | 0.38 | 0.38 | 0.63 | 0.25 | 1.25 |
| Military recruits | -    | 0.13 | 0.25 | 0.75 | 0.50 | 0.75 | 0.50 | 0.50 | 0.00 |
| STD patient       | <0.1 | <0.1 | 0.75 | 3.00 | 7.00 | 3.00 | 4.00 | 3.50 | 4.75 |
| TB patient        | <0.1 | <0.1 | 1.50 | 1.00 | 2.50 | 7.00 | 0.63 | 8.25 | 7.75 |


| Table 3: HIV prevalence among sentinel populations in Thai Nguyen (%) |
|-------------------|----------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| IDUs              | 12.27 | 6.71 | 7.97 | 9.70 | 27.49 | 28.40 | 29.20 | 32.00 | 33.25 |
| Female sex workers| <0.1 | 0.24 | <0.1 | <0.1 | <0.1 | 0.88 | 1.95 | 1.67 | 2.95 |
| Pregnant women    | <0.1 | <0.1 | <0.1 | <0.1 | <0.1 | 0.50 | 1.13 | 1.38 | 2.00 |
| Military recruits | <0.1 | 0.10 | 0.44 | 1.60 | <0.1 | 1.25 | 0.99 | 1.25 | -    |
| STD patients      | <0.1 | 0.10 | <0.1 | <0.1 | 2.99 | 9.75 | 6.50 | 8.25 | 9.64 |
| TB patients       | <0.1 | <0.1 | 0.75 | 1.73 | 3.00 | 2.98 | 10.50 | 11.25 | 12.54 |

presented below also show a rapid increase in the percentage of HIV infections among high risk groups and an overall trend of rising infection rates among women over the past decade. The large differences between the HIV prevalence rates among sex workers in the two provinces can be explained by the distinct methods of administration at the two locations. In Thai Nguyen sex workers who use drugs are registered as IDUs while in Hanoi they are registered as sex workers. In both provinces the trends among pregnant women are clear, and indicate that there is little room for complacency in implementing the PMTCT program.

**National response: competing discourses in HIV policy**

Although the Communist Party, the National Assembly and the government are paying increasing attention to HIV/AIDS, a closer examination of the history of the institutes and policies pertaining to the epidemic in Vietnam over the last 25 years reveals a dynamic of competing policy discourses on HIV/AIDS and social deviance. These conflicting policy dynamics reflect Vietnam’s attempts to control criminal activities, especially illicit drug use and sex work, to contain the HIV/AIDS epidemic, and to provide care and treatment to persons infected and affected by HIV/AIDS.

The use of illicit drugs and working in prostitution are considered to be “social evils” that undermine the “moral and traditional customs and habits of the nation, which bring negative influences on the health, offspring, material and spiritual life of the people and social security, and which cause serious consequences for subsequent generations. All forms of these social evils should be prevented, and violating persons should be severely punished.” (SRV, 1995b) As noted earlier, the best-known and controversial punishment for drug addicts and prostitutes is compulsory “rehabilitation” in isolated 05-06 centres outside the cities. Many HIV information, education and communication (IEC) campaigns linked engagement in “social evils”, notably drug use and sex work, with HIV, propagating the notion that increased control over drug abuse and sex work could increase control over the HIV epidemic. (Khuat Thu Hong, Nguyen Thi Van Anh, & Ogden, 2004)

Among the nine objectives of the Vietnamese HIV/AIDS strategic plan 2006-2010, harm reduction accounts for nearly 20% of the total funds of the government HIV/AIDS budget, while PMTCT is allocated approximately 8% and the program to prevent sexually transmitted infections (STIs) is scheduled to receive only 5% of the funds allocated. (MOH, 2006a) As the HIV epidemic has evolved in Vietnam, the government has prioritized prevention and surveillance activities.

HIV/AIDS policy and programming practice aims first and foremost to control the spread of the virus, and are less concerned with providing care and treatment to individuals already affected. This emphasis on the containment
of epidemics has worked for the health system in the past in the combating of other infectious diseases such as polio, SARS and, more recently, avian flu. (SRV, 2005) Although the national response has evolved over time, and PLHIV have also been involved in important policy changes, such as the development of the new HIV/AIDS law of 2007, an important element of both public AIDS and drugs campaigns is “shock tactics” regarding drug use, as illustrated by the billboards below (Figures 6 and 7).

Figure 6: Hanoi Billboard, “Drugs, AIDS, do not try drugs, not even once”

Figure 7: Hanoi Billboard, “Drugs are the devil”

National PMTCT policy

Vietnam’s national PMTCT policy dovetails with both international political and medical developments. Vietnam has been remarkably swift in its recognition of the need to prevent HIV transmission to children. The PACTG trial 076 showed a reduction of MTCT of HIV-1 by 70% with Zidovudine. (Connor et al., 1994) To assess the safety and efficacy of Zidovudine for the prevention of maternal-infant HIV transmission, the Pediatric AIDS Clinical Trials Group conducted a multi-centre clinical trial (Protocol 076) in the United States and France. The results of the trials resulted in important public health policy recommendations regarding the integration of prevention of mother-to-child transmission of HIV using Zidovudine within the basic health and MCH services of selected countries. (Dabis et al., 2000) Within a year of the publication of the results of this ground-breaking trial, Vietnam established a PMTCT sub-committee located in the National Obstetric Hospital.
But the Zidovudine regime was costly and complex, which might be one of the reasons why there were no directives for the operation of the PMTCT sub-committee. (SRV, 1995a) In 1999, the HIVNET 012 trial in Thailand demonstrated that a single dose of Nevirapine lowered the risk of HIV-1 transmission during the first 14–16 weeks of life by nearly 50% in a breastfed population. The policy conclusion was that this simple and inexpensive regimen could decrease mother-to-child HIV-1 transmission in less-developed countries. (Guay et al., 1999) A year after this landmark trial, Vietnam issued the “Guideline on diagnosis and treatment of HIV/AIDS”, the first legal document which directly addressed PMTCT. (SRV, 2000) The guideline provided instructions on prophylactic treatment, procedures for birth attendants and postnatal treatment for mothers and children in obstetric departments at the provincial or national level. (SRV, 2000)

In June 2001 the Vietnamese government signed up to the international agreement to “reduce the proportion of infants infected with HIV by 20% by 2005, and by 50% by 2010” in the United Nations General Assembly. (UN-GASS, 2005) In 2003, the Prime Minister issued a Directive instructing the MOH to improve the quantity and quality of PMTCT. (SRV, 2003c) PMTCT was included as one of nine core action programs for the National Strategy on HIV/AIDS Prevention up to 2010. (SRV, 2004) PMTCT was described as a comprehensive program that included: (1) raising awareness among women of reproductive age about the risk of HIV transmission and the possibility of mother-to-child transmission; (2) raising the capacity of the system engaged in PMTCT; (3) intensifying activities related to early PMTCT; (4) care for HIV-infected and affected children. Men and fathers are not mentioned in this document.

The Vietnamese government has faced a challenge deciding who should coordinate the whole PMTCT process, as well as who should be assigned the responsibility and authority to implement the different elements of the program. Is PMTCT largely an HIV/AIDS intervention or is it part of the reproductive health program? The Department of Reproductive Health in the MOH was assigned responsibility for developing a detailed action plan for PMTCT and this was finalized in 2006. However, the PMTCT guideline was only finalized in 2007, partly because the department dealing with HIV/AIDS, the Vietnam Administration of Aids Control (VAAC), and the Department of Reproductive Health were not clear about their respective rights and duties.¹ The National Strategy on Reproductive Health for the period 2001-2010 aims for a reduction of sexually transmitted infections, including HIV/AIDS, but does not specifically mention PMTCT.

¹ I followed these discussions closely because I was personally involved in the development of these procedures.
Civil society involvement

In the one-party communist state the distinction between the state and civil society and political and non-political organisations is unclear. Vietnam has a system of mass organisations which are linked to the People’s Committee of the ruling party. Several decrees and policy documents stipulate that all mass organisations have to be mobilised in the fight against AIDS at all levels. (SRV, 1995c, , 2006a) In Vietnam and Laos, which have similar political systems, mass organisations such as the Youth Union, the Women’s Union and even the National Red Cross are referred to as both NGOs and part of the state although non-governmental organisations are usually not considered state bodies. (In China, this ambiguous relationship between the state and civil society is captured in the term “GONGO”; Government Owned Non Governmental Organisations). Founded in 1930, as a women’s section of the Vietnamese Communist Party, the Women’s Union has more than 13 million members, a significant proportion of the population of 84 million, and thus possibly representative of most adult Vietnamese women. (WU’s website, 2007)

Mass organisations, especially the Women’s Union, have been very active in efforts to control HIV/AIDS. One role of the National Women’s Union is to preserve and improve the moral values, (good) traditions of the nation and Vietnamese women and to lead and assist women to organise equal, modern and happy “cultured families”. (WU’s website, 2007) The Women’s Union and the Red Cross, have not only worked on IEC under the guidance and with the support of the Vietnamese government, but they have also been involved in care and support activities at the community level, mostly with international financial support.

The participation of clients or patients in health and health care, including the establishment of self-help groups of HIV infected and affected persons, is consistent with recent national policies on the democratization and socialisation of health. (SRV, 2003b) From the perspectives of health care providers, donors and policy makers, it can be attractive to promote patients’ associations. If the growth of such groups leads to the increased self-reliance of individuals, it could reduce some of the burden on the state, for example.

In many countries there has been a shift from hospital based care to community and family based care, notably palliative care reflecting both the cost concerns of the state and the desires of patients and their families. (British Columbia Centre of excellence for women’s health, 2003; Greaves et al., 2002; Hendrick, 2000; Ogden, Esim, & Grown, 2004b; Smith, 1994; Timery et al., 1994) Patient associations can also be attractive for prevention activities; members can be mobilised for preventive strategies among the general population through “outreach” or “peer education.” For international health workers, often working with funding for a limited duration, an emphasis on self-reliance can also be related to the need for sustainability and associated “exit strategies”. Within a context of economic liberalization, however, ironically the socialization and democratization of health can end up burdening
families and communities, who may or may not be organised in civil society groups, with new financial and practical responsibilities.

PLHIV support groups in Vietnam have rapidly expanded in number and membership over the last few years. The number of self-help groups that are not directly under the authority of the state has more than doubled between 2006 and 2007, from 34 to 74. (Health Policy Initiative, 2007) Some are supported through international organisations as part of international efforts for the Greater Involvement of People Living with HIV/AIDS (GIPA), while national mass organisations, especially the Women’s Union, have also actively supported families with HIV infected members. For example, the Women’s Union supports over 300 sympathy groups (câu lạc bộ đồng cảm) with over 6,000 members, mostly mothers or caregivers (grandmothers) with HIV-infected sons. (CSIS, 2006a) There is considerable variation among these groups in terms of their aims, their size, the level of control by the group itself, and members’ backgrounds.

**International response to HIV**

Vietnam has received generous international support from the UN system, the World Bank, the Asian Development Bank, and many bilateral donors including PEPFAR, AUSAID, and DGIS. Prevention, IEC and surveillance have been priorities, but care and treatment now receive increasing funding. Care and support is a priority under PEPFAR, which is the largest international donor, providing USD 67 million in 2007 and an estimated USD 84 million in 2008.

In 2001, there were few opportunities for anyone in Vietnam to be tested for HIV but by 2006 national and local health authorities were supporting more than 50 VCT sites with trained counsellors who have provided services to thousands. (CSIS, 2006a) Antiretroviral therapy was unavailable in 2001, while in 2007 a reported 10,678 PLHIV are being treated with ARV. (MOH, 2007) In addition, small-scale harm reduction pilots reported a reduction in the use of shared needles by 50%. (The PSI Dashboard, 2005) Several smaller programs focus on GIPA in the development, implementation and evaluation of HIV/AIDS policies and programs. This dovetails with an overall increased attention to civil society and democratization by donors and bilateral agencies working in developing countries and former communist states.

But these positive developments of increased focus on and funding for treatment, care and support, in addition to prevention, are counterbalanced by a national policy that continues to criminalize sex work and drug use and by an increasingly conservative international climate, typified by (but not limited to) PEPFAR policies that restrict the activities of HIV programs working with sex workers and IDUs. There is ample international evidence on the effectiveness of harm reduction to reduce the spread of HIV and the failure of the “war on drugs” or criminalizing approaches. (Wood, Montaner, & Kerr, 2005) But international and bilateral donors and NGOs have to respond to their own individual and international collective constituencies. It is a considerable challenge
for each of these actors to conceptualize rational interventions that not only address drug use, sex work and 05-06 centres, but are also politically acceptable. National and international coordination is a serious problem in this area.

In the current international and Vietnamese political climate women are particularly appealing in their role as mothers. Pregnant women have an additional advantage that they often have increased contacts with health services during pregnancy, which has contributed to the recent focus by large international organisations such as the Global Fund, the Center for Disease Control and Family Health International (FHI) on offering, respectively, HIV testing as part of antenatal care (ANC), highly active anti-retroviral treatment (HAART) for pregnant HIV+ women, and infant feeding advice, including free formula, for six months. Identifying HIV+ pregnant women and offering them antiretroviral prophylaxis and infant feeding advice is politically acceptable and fits with disease-specific programs such as the Global Fund for Malaria, HIV and Tuberculosis. A focus on secondary prevention, however, conflicts with the need to strengthen and promote synergy between the various parts of the health system. (D. B. Evans et al., 2005)

There is now international agreement that a PMTCT strategy should have four pillars: 1) primary prevention of new infections; 2) the prevention of unwanted pregnancies in HIV infected women; 3) the prevention of transmission from HIV infected mothers to children and 4) the provision of care and support for HIV-positive mothers and their children and families. What should be included in each pillar is not yet specified, however.

What needs to be done to ensure primary prevention of new infections depends on the context. Drug-fuelled epidemics centred on injecting drug use, such as those in Indonesia and Vietnam, require different primary prevention strategies than epidemics centred on commercial sex work, such as that in Cambodia. Both of these scenarios require very different prevention strategies than those usually employed in a generalized epidemic situation. IDU-fuelled epidemics concentrated among young men require harm reduction interventions such as clean needle distribution and exchange and the provision of substitution drugs. Epidemics related to commercial sex work require the prioritizing of condom use among sex workers and their clients. Generalized epidemics caused by multiple, long-term partners demand a focus on increased condom use among long-term partners or reducing the number of partners.

If the different steps in a four pillared PMTCT process are already complex and context-bound, it should be clear that the whole PMTCT process is by no means a simple program to implement. It requires collaboration between prevention and care programs, and between HIV/AIDS, family planning and reproductive health programs.

A key question for national and international policy makers in Vietnam, as in other countries, is where to draw the conceptual boundaries around “PMTCT”. (Holmes, 2005) There is agreement that the prevention of HIV infection in men and women is the best way to prevent infection in children, but
also that HIV+ mothers need care and that the focus on secondary prevention has had limited results. (McIntyre, 2005) Adherence to and attendance of PMTCT programs that focus on secondary prevention without making clear links to mothers’ own treatment care and support is oftenlow.

It is not yet clear how PMTCT should be organised in Vietnam, which national agency should have what kind of responsibility, for example, and how national and international efforts can best be linked. Who should be the main “PMTCT agency” is not just a difficult question for the Vietnamese national authorities but also for international organisations. Should UNICEF be involved in ARV treatment for mothers and blood safety for emergency deliveries, or are these activities more appropriate for WHO? Can harm reduction be conceptualized as part of the first pillar of PMTCT or is it part of the work of the United Nations Office Against Drugs and Crime (UNODC) on drug control?

These issues are related to organisational mandates and budgets and thus to politics that divide donors’ and recipients’ attention and time in the many coordination meetings and fora which have been established in Vietnam. Should PMTCT be discussed at the Technical Working Group on HIV/AIDS, the Gender and HIV Sub-group, the Care and Support Sub-group or the GIPA Sub-group or in the context of the National Plan of Action on Children and HIV/AIDS, or all of these?

**Coverage of PMTCT programs**

Despite the existence of routine testing and notification procedures in ANC, relatively few women seem to be actually detected in the current system. In 2005, 659 HIV positive women were detected by the health care system, while the number estimated from surveillance data was 7,000-8,000. (MOH, 2006b) Nationwide, 16.5% of women were tested for HIV during antenatal care visits. (General Statistics Office 2006) This reflects not only a lack of material and human resources in the health care system, but also the distribution of these resources. Whatever the underlying reasons for this distribution, the consequence is that HIV+ women in need of care and support are both lost to and under-reported in the present health care system.

The governmental response has focused on high risk populations (IDUs, sex workers), paying limited attention to both the risks of exposure to HIV of women not identified as high risk, and the needs of HIV+ women who are neither IDUs or sex workers. (Nguyen Thu Anh, Oosterhoff, Hardon, Pham Ngoc Yen et al., 2007) According to the 2007 AIDS law all pregnant women should get free HIV testing, but HIV testing is not yet offered universally. It is, however, provided to women who come for delivery at provincial and national obstetric hospitals and clinics, and in some districts.

Usually, testing only takes place at a late stage of pregnancy, in the 7th or 8th month. (Nguyen Thu Anh, Oosterhoff, Hardon, Pham Ngoc Yen et al., 2007) Late HIV testing limits women’s choices of treatment but it is still in time to reduce the risk of transmission of the virus to the child and to inform
and prepare health workers who are assisting with the delivery. However, most women go to commune health stations for antenatal care, and testing is not available at this level. District hospitals and clinics use rapid tests, and all positive tests have to be confirmed, which can only take place at higher level hospitals and national institutes.

It is unlikely that the Vietnamese state can afford free universal testing for pregnant women, and this may not be cost-effective in a low-income country where the epidemic is not generalized. The national budget for HIV is around one hundred billion VND (6,250,000 USD). Testing costs are around 50,000 VND a test, and with some 2 million women who deliver each year, a rough calculation shows that the state would have to allocate half of its national budget for HIV/AIDS to HIV testing as part of ANC. With support of the Global Fund and PEPFAR free testing is available at some sites in 20 provinces, but these tests are also to be used for blood donors, health staff and military recruits. When free tests are not available, which is still the case in most of the 64 provinces of the country, HIV test costs the user 30,000 – 50,000 VND (2-3 USD) fee.

The first Vietnamese program offering a standard single dose of Nevirapine at the time of delivery started in 2000. In 2002, an estimated 25.4% of the estimated total of 4,900 HIV positive pregnant women received Nevirapine for PMTCT, of whom 2.35% received HAART. (UNGASS, 2005) HIV infected women receive subsidized ARV prophylaxis but they have to pay full hospital fees. HIV+ pregnant women also need to have access to CD4 tests, to determine whether they need ART themselves. These tests and the ART they may need are expensive, although increasingly, due to international funding, free testing and ARV medicines are available.

Current PMTCT programs in Vietnam aim to save the lives of children; treatment, care and support for the mothers receive less attention. Until 2007 there were no explicit procedures for PMTCT but in November 2007 the government approved new procedures which clearly mention mothers’ rights to (postnatal) care and support in line with the four-pillared PMTCT process.

On World AIDS day 2007 the Vice-president of Vietnam together with a number of high-level policymakers from the MOH, the Ministry of Social Affairs, the National Red Cross and the Secretariat of the People’s Committee visited the Sunflower group and their national counterparts that this thesis describes in more detail. Impressed with their strength, beauty and evident health the Vice-president declared that this model that had been introduced in Hanoi, Thai Nguyen, Quang Ninh and Cao Bang should be introduced nationwide. Given the capacity of Vietnam to implement policies once they are agreed upon, and once leadership decides to prioritize implementation, it is possible that postnatal care and support of HIV+ women will improve in more provinces. However, women still encounter many problems in accessing postnatal care and support and interventions relating to the first three pillars, such as the provision of: clean needles, substitution drugs, HIV testing for pregnant women in the first trimester, condoms for teenagers etc., remain
limited. Moreover, how can a woman realistically avoid infection when she is supposed to get married, premarital HIV testing is frowned upon, and she cannot control her (future) husband’s sexual behaviour? How can youth, including drug-using youth, protect themselves against STIs (including HIV) and unwanted pregnancies? How can an HIV-infected couple make an informed decision on pregnancy when HIV testing is currently only offered to pregnant women at 7-8 months? A number of these issues will be explored in detail in the empirical chapters of the thesis.