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

Health services around the world offer many guidelines for HIV positive women who are pregnant or who want to become pregnant, and for women with HIV infected partners. These guidelines are addressed to women and increasingly also to men but pay little or no attention to the role of other members of the family in fertility decisions. This study looked at factors influencing decisions about fertility in families with an HIV positive member. In Vietnam, the whole family takes a crucial role in deciding whether a woman should become pregnant and whether she will keep her child. This decision is taken in the context not only of the close family but also under the influence of ancestors and the weight given to them within the culture. Key in this regard is the need for parents and grandparents to have male offspring. Health workers share these ideas about preferred family composition and support men and women in the quest for male offspring. Policies and guidelines should take into account these additional family factors and goals as a basis for the design of appropriate programmes to reduce HIV transmission.

Keywords: child desire, HIV, family, ancestors, Vietnam

Introduction

Academics and health practitioners increasingly recognize the role of men and their desire for children in the reproductive health decisions of women. (Sauer, 2003) Many authors have argued that men need to be more involved in reproductive health programmes and HIV in order for these programmes to be effective. (Chant & Gutmann, 2002; Doyal, 2001; Greene & Biddlecom, 2000; Hawkes & Hart, 2000; Mane & Aggleton, 2001; Ostlin, George, & Sen, 2001) In Vietnam, men have important symbolic roles within the family. In the Confucian tradition that has influenced Vietnamese culture, sons make the ancestral sacrifices, pray to the ancestors and carry on the family line; failure to have children, especially a son, is a disgrace to the ancestors and therefore shameful (Handwerker, 1998). Sons guarantee the continuity of the family line and support in old age (Belanger, 2002). In Vietnamese families, women’s lives are usually considered incomplete if they have not produced at least one child, preferably male. A woman who marries the only son in a household is strongly pressured by the family to have male children to continue the lineage.
Injecting drug use among men has been an important factor fuelling the HIV epidemic in Vietnam. Since the first HIV case was reported in 1990, the HIV epidemic has continued to grow, albeit slowly compared to other countries. In 2005, an estimated 263,000 people were living with HIV nationwide and 22,000 children were orphaned when one or both parents died of AIDS. (UNGASS, 2005)

Injecting drug users account for 53% of all reported HIV infection cases, but the HIV epidemic in Vietnam is moving into the population more generally. Indicators of this shift are the rising infection rates among women at antenatal clinics. The first HIV positive pregnant Vietnamese women were identified in 1993; HIV prevalence among pregnant women has subsequently increased from 0.03% in 1994 to 0.37% in 2005. The latest sentinel surveillance for 2005 showed that HIV prevalence among this population in the Northern provinces of Thai Nguyen, Hanoi, and Quang Ninh had reached 2.0%, 1.25%, and 1.0%, respectively (VAAC, 2005). Nationwide, 16.5% of women were tested for HIV at antenatal care visit antenatal care (GSO, NIHE, & ORC Macro, 2006). Although voluntary counseling and testing (VCT) is available, most pregnant women are identified as HIV positive in state hospitals by routine blood tests that include a HIV test in the last trimester of their pregnancy.

The mean age of people living with HIV in Vietnam is decreasing: young adults 20 to 29 years of age account for 50.5% of HIV infections. Many of these young people will either want children or will be strongly encouraged to have children by their families who are concerned about continuing the lineage. Anti-retroviral therapy is increasingly available in Vietnam. Studies in other countries on the fertility desires of infected couples have shown that having access to anti-retroviral therapy influenced the choices made. (Panozzo, Battegay, Friedl, & Vernazza, 2003) The prevention of mother to child transmission is therefore strategically important in Vietnam to slow both the spread of HIV and the shift from a concentrated to a more generalized epidemic.

To improve our understanding of how and why the HIV transmission rates among young women continue to increase, it is important to understand the socio-cultural factors underlying child desires and their role in unprotected sex. It is also necessary to understand how decisions are made about having a child, in order to design appropriate programmes to reduce HIV transmission. In the Vietnamese context, this requires an investigation into how not only women and men, but also whole families respond to the desire to have children of their infected sons, daughters and daughters-in-law. This study provides some preliminary answers to this question and shows the importance of the family’s role in decision making about childbearing by HIV infected and affected women.
Respondents and methods

Qualitative and quantitative data were collected in Hanoi and in Thai Nguyen City, two urban areas in Northern Vietnam with relatively high HIV prevalence rates for Vietnam. Two Hanoi hospitals have offered prevention of mother to child transmission treatment since 2000; there are several free anti-retroviral therapy sites. In Hanoi, women planning to deliver their baby in a state hospital are routinely tested for HIV at 7-8 months of pregnancy.

Thai Nguyen is 80 km north of Hanoi; an anti-retroviral therapy programme for adults free at the point of delivery was started in 2005. Hospitals in Thai Nguyen test women just before delivery but may offer earlier testing when they suspect HIV infection. At the time of the study, anti-retroviral therapy prophylaxis was not available there.

HIV infected pregnant women, HIV positive mothers, their partners, family members, and health workers were interviewed about child desire, HIV infection, the family, prevention of mother to child transmission, anti-retroviral therapy, health care and social support. In each district, the study interviewed staff providing services for the prevention of mother to child transmission, resulting in 275 semi-structured interviews with health care workers. Because of the vertical organization of the health care system, samples included all levels from the national to the commune level. Inclusion criteria for health workers were (1) being responsible for and/or directly involved in services for women with HIV or women seeking prevention of mother to child transmission and (2) having at least one year of experience in their current job. Health officials were also interviewed as stakeholders and key informants.

In Hanoi and Thai Nguyen, we also interviewed 56 HIV seropositive women using semi-structured questionnaires. Fifty were mothers, two had had repeated abortions, two had miscarried, one was infertile and one did not yet have children. Most HIV positive women interviewed in Hanoi were detected late in pregnancy during routine HIV testing, while in Thai Nguyen most had discovered their status only after the illness of their child.

All respondents were recruited from support groups and through health sites offering routine testing prior to delivery. HIV positive women at health sites were invited to join the groups, where they could receive medical and social support, including access to highly active anti-retroviral therapy for themselves and their family members. The first interviews with women took place at the support group office outside the hospital, after they had signed consent forms. The following interviews took place either there, or during group activities in different locations around the two cities. The mothers in Hanoi had access to loans, vocational training, conflict mediation and legal support through a women’s group since 2004, while the support groups in Thai Nguyen were of
mixed sex and did not receive any economic support. The health and economic status of the women interviewed in Thai Nguyen was lower; five were abandoned widows, while in Hanoi, almost all of them lived with in-laws or their own family. In 42 cases, the woman’s partner or a relative of her choice was interviewed separately. The other women, all widows, had no new partners or family members able and willing to be interviewed. Participatory observation was continued through two years of programme activities. All respondents were Kinh, the largest ethnic group in Vietnam; their social and economic backgrounds were diverse.

Forty-six of the women were aged 20 to 30 years old, eight were between 30 and 35 and two were over 40 years of age. Twelve women had been widowed as a result of AIDS.

Only three had a history of sex work or injecting drug use; most were probably infected by their husbands or former boyfriends. All the husbands had a history of injecting drug use, visits to sex workers, or both. Six women had been to university; only two were not fully literate.

As part of the study, and to provide contextual information, the researchers also interviewed policy makers, social service providers and other key informants and reviewed popular media.

The importance of children and son preference

Vietnamese people consider a marriage without children as sad and unfulfilled. Vietnamese women want children for many social and family reasons, such as to confirm their relationship with their husband and to bond with their mother in-law and their new family in-law. Infertility has serious social consequences for Vietnamese women (Pashigian & Melissa, 2002). Vietnamese couples are expected to have children within the first year of marriage. Vietnam, like China, has a strong family planning policy linked to socialist development policies. Until 2003, families were allowed only two children, to curtail population growth. More recently, the state has promoted the ‘happy’ family with two parents and two children, one daughter and one son, leading modern productive lives and abstaining from ‘social evils’ such as gambling, drugs, prostitution and pornography. Compliant families are rewarded with material and intangible rewards, such as a ‘cultural family certificate’, while larger families are frowned upon.2

The state has tried to counter cultural long standing preference for boys by actively discouraging sex preference. Sex selective abortion is illegal; urban areas are full of billboards of a smiling family with two girls in front of modernist flats, with texts that discourage families from having more children just to have a son. However, sex selective abortion is relatively easy because ultrasound and

2 The cultural family certificate is given to families who fulfill a number of social criteria including a maximum of two children, abstaining from quarrels and from drugs. Wards with high concentrations of these ‘cultural’ families are praised.
other technologies for improved prenatal screening including sex determination are proliferating (Gammeltoft & Nguyen Thi Thuy Hanh, 2007). In practice, it is difficult for authorities to monitor (ab)use of ultrasound by health workers and families, partly because health workers might agree and understand the family’s preferences. Although induced abortion is not discussed publicly, Vietnam has one of the highest abortion rates in the world (Gammeltoft, 2002).

Many families especially in urban areas do stop at two children, partly because of government family planning policies. It is common for Vietnamese to grade each other on their family composition; the ideal, worth ten points, is a girl followed after five years by a boy. Girls are appreciated, but families having two daughters are considered ‘unlucky’ because daughters cannot continue the lineage. In a Confucian cultural context, families with two sons are not unlucky because they have ‘ensured’ their lineage. Biological children are preferred over adopted children (Phinney, 2003, 2005a).

Uxorilocal marriage, a solution for families without a son, exists in China and Vietnam3 (Pasternak, 1985; A. P. Wolf, 1989) But most men who agree to take on these filial duties are poor and have low social status (Bryant, 2002; Gammeltoft, 1999). In traditional and popular Vietnamese culture, many stories tell how infertile women or women with only daughters try to solve their lineage problem by finding a second wife for their husband. In the stories, the wife hopes to avoid a divorce and gain her in-laws’ respect if she manages to find one, but usually ends up divorced if the other woman produces a son (Mai Hoa, 2004) (Quang Hoan, 2004). If for any reason the son in a family does not have children, it is considered a great tragedy for the preceding generations. Every household has an altar for the ancestors, continuously reminding the members of their trans-generational duties.

HIV infected and affected men and women, health workers, and all other authorities responded with surprise or annoyance when we asked them why HIV positive people want children. Especially in smaller modern families, sons are under great pressure from their parents to perform well socially; this includes providing healthy male grandchildren. The HIV epidemic is concentrated in urban areas where families are smaller; here there is often only one son to carry on the family line. The authorities are aware of the challenges for the state to discourage HIV positive people from having children in this cultural context. As one health professional put it:

‘There is no way to persuade people not to have a child. In the past, the state tried to discourage drug users and HIV infected persons from having children. This failed because of the culture and the concept of a happy family, which means having parents and kids.’ (Senior level male health professional, 52 years-old, district level, Hanoi)

3 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
Findings

Familial reproductive processes

The couples in our study do not make decisions about reproduction on their own. The HIV positive man’s parents play a key role in encouraging him to have children. This can lead to much anxiety, because both the male and female partners need to consider not only their own future health and that of their children, but also the views of members of their extended families.

The situation is most dramatic for families who have only one son to continue the lineage and he is a drug user infected with HIV. Not only do these families fear that their own desire for grandchildren will not be satisfied, they also fear that all their ancestors will become lost spirits without the nourishing care of a male descendant. The wife of the HIV positive son is expected to produce a male heir as soon as possible, while she and her husband are still alive.

The results in Table 1 show the relationship between the responsibility for carrying on the lineage and the pressure on HIV positive women to have a male child.

<table>
<thead>
<tr>
<th>Responsible for lineage Married to the eldest and/or only son</th>
<th>Pressure from family for a male child</th>
<th>No pressure from family for a male child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Had boy before HIV</td>
<td>Had no boy before HIV</td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
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In this complex arena, a clear pattern emerges: if a family does not yet have a male heir, there is pressure on the couple to produce a male offspring, regardless of the HIV status of the man and the woman. This applied in 18 of 20 cases who experienced pressure from family for a male child among the total group of 56 women interviewed.

When the couple was responsible for the lineage. If they already had a boy, they did not feel that pressure (9 cases). Couples who were not responsible for the lineage also felt little pressure to produce a male child, whether or not they already had one.

Two women were under pressure to have a child even though the couple was not responsible for the lineage. In one case, the husband was a farmer who wanted a son to keep the land that he hoped to inherit from his parents. In the other case, the woman was an artist who belonged to the family’s performing troupe; they said they hoped that if she had a child, she would stay and take care of their son. That is, they wanted her to have a child to bind her to the family, for her services.
How notions of lineage shape the fertility decisions of couples and their families is illustrated by the following three cases who were chosen from the 56 women interviewed. These cases represent the fertility issues and choices related to the lineage that we found in our study. The first case is a family with two unmarried sons.

Both sons became infected with HIV because they were sharing needles and drugs. The younger son died of AIDS, leaving only the elder son to continue the lineage. Because it is difficult to attract a woman to marry an HIV infected man, the family hid this fact from prospective brides. He had taken an HIV test before marriage, but he claimed that health workers had told him he was negative.

‘I think my husband tried to hide his HIV status. But I don’t blame him because I understand that he was ashamed. I asked my husband directly about his HIV test results in Bac Ninh Hospital and he confirmed it was positive. But he also said that his HIV test result in Hanoi was kept by my mother-in-law.’ (HIV positive mother, 25 years-old, with one infected and one uninfected son, Hanoi)

Health workers mentioned that in some cases that they felt that the family, especially the mother, should inform the individual members about their HIV positive status. Health workers explained that many young injecting drug users are male and still living at home; their mothers should be informed about HIV status so that they could take care of their sons. Mothers on the other hand considered it reasonable to conceal the status of their son until he was married. The bride-to-be in the family described above chose to believe the most optimistic scenario, which was that her husband could not possibly be HIV infected.

‘I thought, how could my young, handsome husband die of AIDS?’ (HIV positive mother, 25 yrs with one infected and one uninfected son, Hanoi)

When she found out he was HIV positive, she believed that his mother had hidden his results from her son so that he could not inform her. She thought that he would not do that, but his mother would, to be sure that the girl would marry her son and have a child. This same couple held rather different perspectives on his past. He claimed that his wife knew what kind of person he was – a man with experience in life.

‘I was a wild boy. I am a truck driver. I did a lot of drugs and had women all along the highway.’ (HIV infected father, 33 years-old, one infected and one uninfected son, Hanoi)
When the husband fell in love with his wife who he saw as ‘one of the most beautiful women in town’ her parents were, he said, ‘not enthusiastic because of my reputation’. He therefore took an HIV test, which according to him was negative, and then the marriage took place.

His wife offers a more sedate account, ‘My husband was not a serious drug user. Maybe he tried some. He may have had a girlfriend before’.

Whether he told us a wilder story to make an impression, or his wife tried to protect them both from the public shame of being HIV positive, we do no know.

Both parents and their eldest child were infected with HIV. Because their first son’s health was very weak, the couple decided to have another child to continue the lineage:

‘I need to give my parents a drop of my blood. I have to continue the family line. You know the story of our older son. He is a wonderful child but he’s infected, it’s a catastrophe.’ (HIV infected father, 33 years-old, one infected and one uninfected son, Hanoi)

They decided to try again after they knew they could receive treatment for the prevention of mother to child transmission and thereby reduce the risk of having an HIV positive child. They were both very happy with their decision and the man adores his wife, ‘I feel very lucky to have two sons. I feel lucky to have my wife. My wife is my best care and treatment.’ The couple has, however, moved away from the house of the mother in law and a younger sister-in-law of the wife, not the mother-in-law, has agreed to care for the children in case the parents die.

A second case study illustrates how some women may be particularly vulnerable to the pressure to ensure a male heir. One local support group member, a woman from outside Hanoi widowed as a result of AIDS, was living by herself with help of boyfriend(s). She escaped from the mistreatment of her former in-laws in Hanoi who agreed to care for her daughter but then expelled her from the household. Her rent is 300,000 VN dong per month, which is exactly what she can earn undertaking community outreach work to other infected women. In the course of her outreach activities, she met the family of a male injector living with HIV, the only son of a wealthy family. The family offered to pay her to produce a child for their lineage because they know that with current medical technology she has a very good chance of producing the healthy child they need.

‘I don’t know what to do. I am so worried about my health. His family is kind and he is willing to marry me and I can live in their house when he will die, but I will have to have a baby. I know that I can probably have a healthy baby, but what about my own health? What will happen to me?’ (HIV positive widow, 24 years-old, one daughter, Hanoi)
When the family knows their son is HIV positive, his wife’s status in the household depends on whether or not there is another man in the family who can or who has already continued the lineage. The pressure on HIV-infected sons to have children can come from their own mothers and/or from their grandmothers. These women in turn may be under real or imagined pressure from their husbands. It has been argued that traditional ideas about the ‘three submissions’ (tam tôn) influence many aspects of Vietnamese women’s social lives today.

The three submissions divide a woman’s life into childhood, marriage, and widowhood; she is commanded to obey three masters in sequence – father, husband, and eldest son (Marr D, 1984).

In some contexts, men have been shown to play a key role in Vietnamese couples’ decisions on abortion, (Johansson, Ngo Thi Nham Tuyet, Nguyen The Lap, & Sundstrom, 1996; Johansson, Nguyen Thu Nga, Tran Quang Huy, Doan Du Dat, & Holmgren, 1998) but the male partners of the women in this study did not seem to have much power to decide about fertility issues. None of the women respondents mentioned older males (father-in-law or father) having any role or responsibility in the couples’ reproductive health decisions.

Both male and female respondents described aunts, sisters, mothers, and grandmothers as having an important influence on fertility decisions. Older men were also not observed as visitors in the hospitals and did not figure in conversations with family members. Yet from their photographs on the family altars they clearly watch over their descendants’ actions and are accepted as having responsibilities as well as expectations for the family. In the third case study, the mother told us that she had found a poor woman from the countryside to marry her son shortly after she discovered that he was infected.

‘There is a lot of stigma in Vietnam against HIV infected men. I decided to fight it. I was not going to abandon my son. I went to look for a bride for him. No, I did not tell her that he was infected - but I protect her health. She is pregnant now. I make sure she gets good antenatal care and HIV test every two months to make sure she is still not infected and everything is normal.’ (Mother, a Party official, of HIV positive son, 27 years-old, who has one son, Thai Nguyen)

This family had three sons but only one was considered a social failure due to his history of drug use, crime and HIV infection. The family’s need to rehabilitate themselves, especially for the sake of two respectable sons, underlay the pressure on their youngest child to marry and have a child. Herself under pressure from the community for her failure to keep her son off drugs, the mother in turn put pressure on the son to marry a girl that she has found for him. The son argued that he was doing both his wife and his mother a favour. He was not greatly interested in his marriage, sex or his child.
‘My wife is very poor. I helped her to escape from a poor household into my urban family which is very nice. She does not need to have sex with me any more now that we have a child. I don’t need to get married for sex. When I use drugs I lose interest in sex. Now my mother has somebody to talk to and a grandson. I am very lucky. My life looks normal now.’ (HIV positive man, 27 years-old with one son, Thai Nguyen).

The daughter in-law said that she would not have got married if she had known her husband was HIV positive. She says that she married him because of her desire to help him stop using drugs. This may reflect both the ancient ideal of the self-sacrificing woman who cheerfully takes on the care of others, but also modern prescriptions on female behaviour.

Once the couple was married, the mother attempted to limit the risk for her new daughter-in-law by advising her to use condoms. At first, the girl did not understand or appreciate the advice. Ten days after the marriage, the newlywed husband became sick and hospital staff told his mother, that he had AIDS and that if he had a wife she should be informed. The mother-in-law informed his wife of the result. The young woman then had herself tested and was found to be negative. The risk of contracting HIV did not stop her from wanting children.

‘I wanted to have a baby and I became pregnant one month later. My mother in-law advised me to abort, but I felt sorry for my baby. I tested HIV again at six and at eight months.’

Her decisions to accept the risk of infection in order to become pregnant, and to keep the baby reflect the importance of having children for women.

It is tempting to draw cynical conclusions about the attitudes of the mothers-in-law towards the health of their daughters-in-law that would also fit with local stereotypes. But this mother-in-law also tried to stop her daughter-in-law from having a child. Her daughter-in-law chose to have a child in order to establish a relationship with her (uninterested) husband and his family and to establish herself in her new community. The young mother also reported having a good relationship with her mother-in-law.

**Individual desire to have a child**

HIV-positive women and men may experience a lack of autonomy in issues of reproductive health of interest to the family. The lack of pressure on women who already had a son suggests that women who have a male child may have more reproductive freedom than women who do not. But while some men and women have more independence than others, all of them display agency and make their own choices. All of the childless HIV positive men and women interviewed wanted children, but only if the child could be healthy and grow up. Both men and women were very concerned about both the physical health risks for their children and their emotional well-being in an
environment where HIV is stigmatized. They were all aware of the risks of transmission from mother to the child.

HIV seropositive men and women were concerned about their own and their child’s health and mentioned both in relation to their desire to have children. Their responses also suggested that having access to medicines and feeling healthy were important for future parents. HIV seropositive men with a seronegative wife in a family that had a male grandchild were vocal about their priority to protect their wives.

‘I really want children. I am willing to sacrifice a lot, also financially, but I would never risk the relationship with my wife. She loves me even though she knows I am positive. I would not want to risk losing her.’ (HIV positive man, 32 years-old, childless at first interview, Hanoi)

Some HIV negative men mentioned that they were not sure that they should stay with their infected wife. Only one man was willing to support his wife, who tested HIV positive at seven months into her pregnancy - if she was able to deliver a healthy child. He took an almost obsessive interest in the medical details of prevention of mother to child transmission and anti-retroviral therapy before the delivery and afterwards through breastfeeding. After the birth of the child, the couple rushed out of the hospital to avoid being seen.

In interviews after the delivery the husband talked of the stress of being caught between his loyalty to his wife and child and his fear of ‘losing face’ to his parents for having married a women who probably became infected because she had had sex with another man before marrying him. He also feared losing customers in his business if anybody should find out his wife’s HIV status.

All seropositive women dreamed of having healthy children that they could raise themselves. The desire for children is a standard topic at the group support meetings in Hanoi, attended weekly by the authors for two years. Women in the support group could see encouraging examples of other women who were HIV infected but gave birth to healthy children and had access to anti-retroviral therapy. Especially older, well-informed women in a support group in Hanoi for women who had a husband but no children were very vocal in their desire. In practice, though, the women were hesitant to take the risk for the sake of their future child’s health.

Among all women interviewed, only those HIV positive women married to the eldest or only son actually took the risk of having a child; they all delivered boys. With a small sample like this, care should be taken in drawing general conclusions, but it is noteworthy that these women could learn the sex of the foetus by ultrasound and boys were required in the family situation. It might be that families that need a son are willing to take the risks to have one, and that they decide to continue the pregnancy when they know the foetus is male, a risk they might not take for a girl child.
**Few rights for the wife**

A male child, especially the oldest grandson, secures a woman’s position in the household of her in-laws and establishes good relationships between her biological family and her in-laws. Without a husband, a child and land rights to protect her, a woman can be expelled from the house by her in-laws, or simply ignored after a husband dies.

> ‘Since my husband died and I cannot work to contribute food to my family-in-law, they treat me with a cold heart. I cannot live there anymore. I still visit them sometimes. They do not care about me because I am childless. My mother-in-law sold the house that my husband and I built because it was not registered in our name.’ (HIV positive woman, 30 years-old, childless, Thai Nguyen)

Even when a woman has a son, she can be expelled from the house of her in-laws if the child is HIV-infected. She might also not be welcomed by her own family because of enacted stigma by the family or the community, or she might herself choose to protect her family from possible stigma by the community by avoiding them.

> ‘My family-in-law blamed me for my husband’s HIV infection. My husband was a drug user but he died without telling his family why he was infected. He did nothing to protect me; he did not register land in my name. I have a good relationship with my own family. They love me but they do not want me at home because they are afraid of discrimination by the community. I have some younger siblings who need to be clean to get married. I don’t know yet what to do and where to live. My son lives with my mother-in-law. I couldn’t bring him to the city, but they don’t take good care of him because he is HIV-infected. I don’t want to burden my own family and I don’t think I can get any support from the in-laws.’ (Widowed mother, HIV positive, 27 years-old Hanoi)

Because of family and lineage duties, a husband may leave an infected woman while she is pregnant, even if he infected her.

> ‘He infected me, but when I was almost ready to give birth, he took another women home and told me that he would marry her instead. My parents and grand parents-in-law seemed happy to have a new daughter-in-law. That woman even came to my room and said that I shouldn’t be selfish and should leave him to make him happy.’ (HIV positive woman, 26 years-old, 1 daughter, Hanoi)

One woman said her own mother pressured her to have a second child because her first child had been a girl.
I found out that my husband was a drug user after my marriage. I wanted to divorce him right away but my mother said that I am a woman and I should have a child so I had my daughter. I am not sure whether my husband was already HIV-infected at that time, but when I was pregnant again with the second child his habit was very serious, he was infected and I wanted to abort. My mother told me that I had to have another child so I should complete my duty to the household. I was diagnosed as HIV-positive just before the delivery of my son. I am not angry with my mother because she has no power in her own or in my in-laws household... I just do what I have to do.’ (HIV positive mother, 31 years-old, two children, Hanoi)

Women accepted such advice and acted on it, because they knew that their own family would not accept them back anyway. Only a few women reported being directly coerced or faced with concrete demands, but all reported feeling that they could not refuse to have male children. Having a child, in spite of the health risks, was often a response to many issues, including continuing the linage.

Professionals’ assumptions

None of the policy makers or the 275 health workers questioned the patients’/clients’ desire to have a family, whether or not they are HIV-infected. Health workers knew families pressured women to have a child and they in turn feel pressured by their families.

‘If a recently married woman comes here for an abortion, I am reluctant to do it until I know whether her in-laws approve.’ (Female health worker, 34 years-old, district level, Hanoi)

Health workers reinforced the role of the family, for example, by not always notifying the individual about an HIV test result, but leaving that responsibility to the mother (-in-law). Again, there was diversity in practice. Senior health staff in wards where HIV positive women delivered, reported counseling family members to support the young mothers, but also mentioned that some families did not want to talk. According to official health policy (SRV, 2006c), all pregnant women are encouraged to go for early HIV testing and counseling. This in principle should allow women to make informed choices about the risks to their child. In practice, however, informed choice is almost impossible because pregnant women are not routinely tested until the 7th or 8th month, which is too late for them to receive a legal abortion. Besides practical obstacles to abortion by HIV positive pregnant women, health care staff and people living with HIV interviewed, stressed that remaining childless is simply not a realistic option for many HIV-infected couples.
‘Most HIV positive women did not know that their husband was HIV positive or used drugs. After marriage they get pregnant and they find out too late that they have also been infected.’ (Female health worker, 51 years-old, national level, Hanoi)

When asked whether HIV-infected women should have children, almost all health workers responded with statements like ‘A woman really wants a child, you know’, giving the idea that all women want children as almost an immutable and universal verity.

Infected women, whether or not they had children, made very similar comments such as, ‘We are all women, you know, and we all want to be mothers.’

Health staff, patients and families shared a cultural discourse concerning the importance of having children and continuing the lineage even when this conflicts with official medical guidelines, their knowledge about HIV prevention and their commitment to healthy children. No one ever said that HIV positive women did not have the right to have children. Everyone emphasized the interests of the child to have parents or the more general ‘suffering’ that should be prevented.

‘HIV positive pregnant women should not have a baby, but most Vietnamese women want to have a baby. The decision should be based on her point of view, her knowledge about HIV, and whether medication is available or not.’ (Doctor, female, national level, 37 years-old, Hanoi)

Health care workers and patients agreed about the medical risks. Some health workers tentatively suggested that HIV-infected couples should adopt a child or become informal caretakers. But their voices were always soft and lacked conviction; they knew that these options did not solve the problem of continuing the lineage. Other voices were indignant but convinced.

‘It’s hopeless to try to stop HIV-infected men from having their own children. If they do not accept our advice they will just hide from us. Their family might find them a nice poor rural girl who is happy to come to the city and have a baby for them.’ (Doctor, male, 48 years-old, district level, Hanoi)

Conclusion

A medical intervention for the prevention of mother to child transmission, in the Vietnamese cultural context, can also be used as a tool by families wanting to realize their lineage needs, even when this might conflict with the health interests of the mother. Study findings suggest that the HIV positive men are not the main person making fertility decisions in families. Couples more usually make these decisions within the context of the lineage needs of a family. An HIV positive couple who is responsible for the lineage and decide
to have a child are not just trying to make a difficult mother-in-law happy; they are aiming to serve the invisible but always present ancestors. Both living relatives and the ancestors to whom the men are responsible shape the behaviour related to childbearing.

To understand the fertility choices of HIV-infected couples, and the willingness of individuals in a family to risk HIV infection of female members, it is necessary to understand these familial lineage obligations.

Women who become HIV positive are in a vulnerable position, being at risk of being abandoned if they fail to have male heirs. Public health messages or interventions that aim to ‘involve’ men as sexual partners in reproductive health might fail to address the situation of couples in a Vietnamese family where the male might have little say in decision making. The mothers-in-law who pressure daughters-in-law to have children do not seem to consult their husbands about the continuation of his families’ lineage.

Health workers are willing to talk with the family, but pregnant women in Vietnam are routinely tested for HIV only at 7-8 months, too late for a legal abortion. In future work it will be worthwhile trying to target younger men through VCT and harm reduction programmes, before they have a child. It is also important that HIV positive young men are able to protect their female partners when they find a woman who wants to be the mother of their child. This requires that HIV serodiscordant couples can access new technologies such as sperm washing, which HIV positive men can at this moment not legally access in Vietnam. Our results suggest that it would also be useful to learn more about how the mothers and fathers of these men can be reached with information about prevention of mother to child transmission, so that their influence can be used to the benefit of the HIV positive women as well.