Pressure to bear: gender, fertility and prevention of mother to child transmission of HIV in Vietnam
Oosterhoff, P.P.J.

Citation for published version (APA):

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Summary

This retrospective explorative study examines the life trajectory of Vietnamese HIV-positive AIDS widows, living in a patrilinear and patrilocal society where HIV is highly stigmatized. Options normally available to most women, such as living with their eldest son, are not available to young HIV-positive widows. But the women in our two-year study improved their prospects following the deaths of their husbands by joining support groups, seeking new partners and strengthening relations with their families of origin. Most women who returned to live with their families found a new intimate relationship through support groups for HIV-positive persons.

Keywords: Gender, patrilocal, kinship, stigma, HIV/AIDS, widows, health and care

Introduction

The progress of the HIV/AIDS epidemic within the developing world, where PLWHIV are firmly located within a familial context, raises theoretical and practical concerns about how families are adapting to the effects of HIV/AIDS, such as the rise in the number of AIDS widows and AIDS orphans. (Rotheram-Borus, Flannery, Rice, & Lester; Williams et al., 2005) Today an increasing number of women are infected and affected by HIV/AIDS. (Dworkin & Ehrhardt, 2007; UNAIDS & WHO, 2006b) Many of the specific problems that make women vulnerable to HIV are related to the family. These include domestic violence, (Dunkle et al., 2004; Garcia-Moreno & Watts, 2000; Maman, Campbell, Sweat, & Gielen, 2000) lack of support and increased expenses for informal care givers, (Ogden, Esim, & Grown, 2004b; Smith, 1994) inequality in marriage, (S. Clark, 2004; S. Clark, Bruce, & Dude, 2006; Glynn et al., 2001; Hirsch, Higgins, Bentley, & Nathanson, 2002; United Nations, 2000) lack of protection of their property rights (Sweetman, 2006) and lack of access to education for girls. (UNDP, 2005b) Moreover, in various cultural settings where rising HIV infection rates are linked to intravenous drug use, the women in a family invariably bear the brunt of the social and financial consequences of illicit drug addiction. (S. Murphy & Rosenbaum, 1999; United Nations, 2003; Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, & Clement, 1999)
Today, in many countries, women are mobilized in the fight against AIDS, but their concerns continue to receive little attention. (Kmietowicz, 2004) Women are underrepresented in, and are sometimes noticeably absent from, the international fora where AIDS policies are decided and funds are allocated. (UNAIDS, 2006a) Women’s networks and organizations may not be recognized, reflecting the lack of value attributed to women’s work. (Cott, 1987; Dore & Molyneux, 2000; Kaplan, 1997; Koven & Michel, 1990, 1993) The documentation of women’s formal and invisible networks and the recording of their “muted” voices have formed part of a global dialogue among feminists all over the world in recent decades. (Ramusack & Sievers, 1999)

Rather than accepting victimhood, how women act and accomplish change has become central to contemporary discussions on women’s empowerment and choice. (Kabeer, 2001; Malhotra, Schuler, & Boender, 2002; Sawsicki, 1991) For several decades now, scholars have argued that marginalized persons, though weak, may have their own weapons and assume different identities in different contexts. (Craton, 1982; J. Scott, 1985; Taussig, 1993; Turton, 1986; Willis, 1981) An acknowledgment of different manifestations of resistance to political and social marginalization is attractive to feminists because women’s movements have often taken place at the community level and focused on practical issues rather than grand collective political action. (Boesten, 2004; Koven & Michel, 1993)

Recognizing HIV-infected and affected persons capacities for change can be particularly complicated because they might isolate themselves and hide their problems due to a fear of stigmatization. (de Bruyn, 2004; Shapiro et al., 2003) Health-related stigma involves social exclusion of individuals and populations identified with a particular health problem, such as HIV infection. (Weiss, Ramakrishna, & Somma, 2006) Women and men may experience HIV-related stigma differently, however. In some contexts, women may be blamed for their HIV-positive status more than men. (Paxton et al., 2005; Voluntary Services Overseas-Regional AIDS Initiative of Southern Africa (VSO-RAISA), 2005) Studies in Vietnam suggest that a woman infected with HIV is considered to have brought shame to the household. (Khuat Thu Hong, Nguyen Thi Van Anh, & Ogden, 2004; Oosterhoff, Nguyen Thu Anh, Pham Ngoc Yen, Hardon, & Wright, 2008b)

A number of authors have argued that HIV-related stigma does not just reflect fear of the transmission of HIV, but is part of a larger process that works to produce and reproduce power relations, reinforcing existing social inequalities, such as those pertaining to gender. (R. Parker & Aggleton, 2003; R. Parker, Aggleton, Attawell, Pulerwitz, & Brown, 2002) Self-exclusion or self-stigma can be seen as a psychological process that is not only related to a person’s HIV status but also to their social status and their other experiences of being excluded, due to their own or their partner’s drug addiction, for example. An acknowledgment of the individual mental processes that lead to socio-economic exclusion, including self-exclusion, is useful in un-
derstanding social change because it recognizes power as something that emerges, at least partially, from within individuals and hence is something that individuals themselves might have some ability to transform. (Freire & Macedo, 1998; Sen, 1990)

Social support groups have stimulated the interest of academics and development practitioners partly because of their role in raising the awareness of and mobilizing and empowering individuals who are socially marginalized. (S. Evans, 1980; Gillis & Perry, 1991; Kling, Shibley-Hyde, Showers, & Buswell, 1999; Malhotra, Schuler, & Boender, 2002; Raphael, 1993; Schrijvers, 1985) Forming or joining a support group can offer opportunities for all PLHIV to improve their quality of life, by learning about accessing and coping with treatment, sharing personal experiences and accessing services such as micro-credit. (Oosterhoff, Nguyen Thu Anh, Pham Ngoc Yen, Hardon, & Wright, 2008a)

For women who have a low status in their own households, the emotional and practical support provided by such groups might be even more important than for men. The groups that could help HIV-positive women to organize themselves and pursue practical and strategic gender needs are shaped by larger contexts, however. In one-party communist states -- Laos, Vietnam, and China, for example -- the distinction between the state, civil society, and political and non-political “mass organizations”, such as the Women’s Union in Vietnam, are blurred. (Godwin, O’Farrell, Fylkesnes, & Misra, 2006; Stromseth, 1998)

In Vietnam, the locus of this study, the first support group for HIV-positive families was founded in 1999 by the Women’s Union, which is under the auspices of the Communist Party. Since then the number of state-supported groups has grown and opportunities to form both independent and supported groups, while still limited, are increasing. Groups for PLWHIV have expanded rapidly in Vietnam over recent years; the number of self-help groups not directly under state authority nearly doubled between 2006 and 2007, from 34 to 74. (Health Policy Initiative, 2007) While some HIV-positive women’s groups have been successful in developing a collective form of organization and a strategy to access the services that they and their family members need, such as access to AIDS medicines, psycho-social support and micro-credit, many HIV-positive mothers are still unwilling to appear in public, which reflects the extent of stigmatization that still prevails. (Oosterhoff, Nguyen thu Anh, Pham Ngoc Yen, Wright, & Hardon, 2008)

The national prevalence of HIV is still comparatively low, at an estimated 0.5% in 2005, and is concentrated predominantly among young male intravenous drug users (IDUs) in urban areas, border regions and seaports. (MOH, 2006b) Currently young adults between the ages of 20-29 account for 50.5% of all reported HIV infections. (Nguyen Tran Hien, 2007) Reported HIV prevalence rates among young male IDUs vary between 25-70%. (MOH, 2006c; Nguyen Duy Tung et al., 2001; Nguyen Tran Hien et al., 2001; Nguyen Tran
Hien, Le Truong Giang, Phan Nguyen Binh, & Wolffers, 2000) While antiretroviral drugs are increasingly available in Vietnam, not all patients who need these medications have access to them, often for financial reasons. (MOH, 2006e)

Vietnam’s response to the HIV epidemic has been structured by social policies implemented in the context of its national “renovation” policy, or Đổi mới, which began in 1986, shortly before HIV appeared in the country. The policy encouraged free-market reforms that revitalized the economy but it also caused rapid social change. Several authors have argued that gender inequities have increased under Đổi mới, in part because the socialist government no longer offers women the extra social benefits it once did. (Bousquet & Taylor, 2005; Werner & Belanger, 2002) Others have reported that the welfare of women in Vietnam has generally improved, although there are significant differences among women depending on their age, education, ethnicity and relationship to the market economy. (Le Anh Tu, 2006) At the same time, socio-economic shifts have been accompanied by an increased use of drugs and the spread of HIV/AIDS. (Werner & Belanger, 2002)

With a rapidly expanding economy, a significant number of men now work in mining, construction and trucking. These are all environments that are known to put workers at a greater risk of drug addiction and contracting HIV. (Nguyen Tran Hien, 2002) (Phinney, 2005b) In recent years, there has been an increase in the number of hospitality and personal care service providers, such as (karaoke) bars, hairdressers, and massage parlors that 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)

Wives and girlfriends of IDUs, many of whom have or are planning to have families, are increasingly infected and affected by HIV, but figures on HIV-positive women are greatly under reported. (Nguyen Thu Anh, Oosterhoff, Hardon, Nguyen Tran Hien et al., 2007). Although people in the community understand the difficulties of women whose husbands or children are drug users, they rarely provide them with practical help. (Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, & Clement, 1999)

According to Confucian patrilocal and patrilineal doctrine, which profoundly influence the culture of the dominant ethnic group in Vietnam, the Kinh, the status of a woman during different stages of her life is closely linked to her role in producing children. (Lang, 1968; Leslie & Korman, 1989; Mann, 1991; Marr, 1984) As in other patrilineal societies, there is strong cultural preference for male children in Vietnam. (Belanger, 2002) Women are traditionally considered part of their husbands’ family after marriage, where they occupy lesser roles than the elder women in the household, notably their mothers-in-law. (Ch’u, 1965; Yao, 1983) Historically under Confucianism the rights of widows with regards to property and independence depended on their chastity, and thus inhibited remarriage. (Sommer, 1996) Brave individuals such as the outspoken eighteenth-century concubine and poetess Ho Xuan Huong, contested these constraining Confucian roles. (Ho Xuan Huong,
2000) But until the 1959 Law on Marriage and the Family, Confucian ideas about women, kinship and marriage, such as polygamy and no protection for the property of widows, were legal. Today, marriage between a widow and a man who was not married before is still frowned upon.

Household composition and traditional Confucian gender roles in both urban and rural areas are changing, however. (Hsieh, 1985; Knodel, 2003; Le Thi Nham Tuyet, 1996; Nguyen-Vo Thu Huong, 2002; Walters, 2004; Xiao, 1999; Yao, 1983; Yeh, 1997) Yet research has shown that son preference remains widespread in Vietnam, and is possibly on par with Bangladesh and China. (Belanger, 2002; Haughton & Haughton, 1995; Johnsson, Hoa, Le Thi Nham Tuyet, & Mai Huy Bich, 1996) A practical reason for son preference is the cultural norm that sons should take care of their parents, which is particularly important for widows who live with their in-laws. (Knodel, Friedman, Truong Si Anh, & Bui The Cuong, 2000) A son can secure the widow’s livelihood because of the traditional right of parents to remain living with their sons. However, AIDS widows tend to be young mothers with small sons who cannot provide such practical caring.

HIV-positive AIDS widows face diverse challenges, many of which are related to their gender. (H. Akram-Lodhi, 2002; Bousquet & Taylor, 2005; Werner & Belanger, 2002) They tend to be young women living under the authority of their in-laws (Hirschman & Vu Manh Loi, 1996); they hold the low status traditionally borne by widows; (Knodel, Friedman, Truong Si Anh, & Bui The Cuong, 2000) some bear the burden of reproductive responsibilities; (Gammeltoft, 1999; Lynellyn, Le Ngoc Hung, Truitt, Le Thi Phuong Mai, & Dang Nguyen Anh, 2000) and they face a diagnosis of AIDS. (Khuat Thu Hong, Nguyen Thi Van Anh, & Ogden, 2004) In many cases, given the IDU-driven epidemic, they often bear the real burdens of drug addiction, (Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, & Clement, 1999) as well as the stigmatization stemming from the popular association of HIV infection with heroin addiction. (CSIS, 2006b) However, they might also have different options from other Vietnamese widows because they tend to be younger, and enjoy access to resources such as support groups for HIV-positive persons. Currently there is a lacuna in the social science literature on the actual status and experiences

4 Clauses 7 and 8 in the Law on Marriage and Family in 1959 protect widows: Clause 7 clarifies that to be in mourning is not an obstacle for getting remarried. Clause 8 gives widows rights to remarry while guaranteeing their rights to children and property. These rights are reaffirmed by more recent decrees such as decree 32/2002/NĐ-CP (March 27th 2002).

5 A popular Vietnamese expression holds that a widow is “a very bad dish”, which is for example reiterated in the following popular folk song:

"Trai tỏ o hời tri tỏ
Để đâu mất với mà vàng
Na dòng lấy được tri tỏ
Bèm nám hi hưng nhor ngo duec vàng
Tri tỏ vớ phải na dòng
Nhu nước mắm thì chăm lòng lợn thiu"

“Hey, unmarried man
Why do you go so fast, to catch that married old woman
Married old women who can get married with that unmarried man
Beside herself with joy at nights as if catching the gold
Unmarried man who gets married with married old woman
Like rotten fish sauce with putrid puddings.”
of widows in contemporary Vietnam, which may be a reflection of their perceived low social status.

In order to discover their responses to the challenges they faced, we explored the life trajectories of a sample of Vietnamese HIV-positive AIDS widows in detail over a two-year period. We examined their experiences as they started new lives as widows, and the choices they made. Specifically, we sought to learn where and how they lived when their husbands died; whether having a son influenced their options; and how they used existing kinship networks and new support groups to cope with the double stigma of being a widow and HIV positive.

**Respondents and methods**

For this explorative study we collected qualitative data in a number of locations in northern Vietnam: the urban areas of Hanoi and Thai Nguyen City, as well as Dai Tu District, a rural mining area in Thai Nguyen province.

All of these locations have relatively high HIV prevalence rates for Vietnam, are experiencing rapid economic growth and heroin is rather easily available. Data collection began in 2005 and follow-up interviews continued until the end of 2007, until the researchers had followed the experiences of each widow for two years. Three researchers worked directly as advisors with support groups, which helped pregnant HIV-positive women and HIV-positive mothers to get access to medical, social and economic services. In these support groups they met the widows on a regular, sometimes a weekly, basis.

The research team consisted of four members with medical backgrounds (all Vietnamese) and three with social science backgrounds (three Vietnamese and one foreigner). The team also included one local translator and one field administrator. The study was linked to an operational program run through a women’s group jointly managed by the Vietnamese Red Cross and the HIV-positive women since 2004. In Hanoi, the intervention provided social, economic and medical support to HIV-positive mothers, including free access to anti-retroviral therapy (ART) for themselves and their family members. The support groups in Thai Nguyen also had access to ART, but did not offer income-generating activities for members until 2006.

Because HIV prevalence in Vietnam is low, we interviewed a convenience sample of 24 widows, all infected with HIV. They were recruited from six support groups, four of which were under the umbrella of the Vietnam Women’s Union (“Sympathy Clubs”) or the Vietnam Red Cross (“Sunflower and Cactus Blossom Support Groups”) and two of which were independent groups that were not affiliated with the government (“Bright Futures”). The first interviews took place at the support group offices. Hence, a bias of the sample is that all the women interviewed were active in their organizations, in the sense that they had sought the help of a support group for treatment and care. Of these 24 women, 17 were interviewed in Hanoi, where they had joined sup-
port groups offering medical and social support. Six of these women lived in nearby provinces, and travelled to the capital to join the support group and access medical services. Of the seven widows interviewed in Thai Nguyen city, five hailed from the city and two were from rural areas and had come to live in the city to access AIDS-related services. All had been members of their respective support groups for fewer than six months.

With the exception of one respondent, all were Kinh, the largest ethnic group in Vietnam, and were still young when their husbands died. Nineteen women were 20 to 30 years old, four were between 30 and 40 years old, and one was in her early forties. All had been widowed for less than four years. In three cases, we knew the women while their husbands were still alive and witnessed their last months together. Six women had a history of sex work or injecting drug use; most were probably infected by their husbands or former boyfriends, all but one of whom had a history of using drugs. Only one of the women could not read or write.

We used semi-structured questionnaires to ask about HIV, the desire to have children, family situation and livelihoods, romantic love and familial support for HIV-positive women and their health.

In 16 cases, the woman’s current sexual partner or a relative of her choice was also interviewed separately in order to learn more about familial and romantic desires and capacities to provide care and support to widows. The other women had no new partners or family members able and willing to be interviewed. The one-to-one interviews took place either at the support group offices, or during group activities in different locations around the two cities. Prior to starting any interview, researchers invited the respondent to read and sign the consent form, and asked their permission to record the interview on tape. All interviewees were informed that they could stop the interview at any time. Almost all respondents agreed for their interview to be recorded; those who did not were all males with a self-reported history of drug use. Notes were also taken during each interview. At the end of the interview, the tape recorder was stopped and researchers invited interviewees to ask questions and provide comments.

Researchers shared interviewing experiences, their analyses and note-taking skills in bi-weekly team meetings. All tapes were transcribed and NVivo software was used for further in-depth analysis. Respondents were not asked their full names, addresses or any other identifying information, in order to ensure privacy and confidentiality. All data sets, questionnaires, and tapes were stored in a secure office. All first names have been changed to protect confidentiality.

The researchers also interviewed social and health service providers who work on drug addiction and HIV/AIDS about the households with male HIV-positive IDUs, and the capacities and needs of HIV-positive AIDS widows to rebuild their lives. The study proposal was reviewed to ensure the protection of human subjects by the ethical review board of Hanoi Medical University.
Results

Family situation for women married to HIV-positive men prior to widowhood

To fully understand what happened to the HIV-positive women after their husbands died of AIDS, we needed a clearer picture of gender and power relations in the households when the husbands were alive. It was found that the family situations of the women in the study had been dominated, often for years, by the illicit drug addiction in their husband’s households. In addition to their husband’s drug use, in eight cases there were other IDUs in the family: brothers, uncles or fathers living in the household, in prison, or at government-run rehabilitation centers for drug users.

Few women had independent sources of income. Before widowhood four women had been employed outside the family, all in the private sector. Three described themselves as unemployed. Three managed small businesses at their in-laws using their own capital and two assisted their own families

<table>
<thead>
<tr>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanoi</td>
<td></td>
</tr>
<tr>
<td>Inside the city</td>
<td>11</td>
</tr>
<tr>
<td>Nearby province</td>
<td>6</td>
</tr>
<tr>
<td>Thai Nguyen</td>
<td></td>
</tr>
<tr>
<td>Inside the city</td>
<td>5</td>
</tr>
<tr>
<td>Rural area</td>
<td>2</td>
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</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>20-30 yrs old</td>
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</tr>
<tr>
<td>30-40 yrs old</td>
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</tr>
<tr>
<td>&gt; 40 yrs old</td>
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<thead>
<tr>
<th>Education</th>
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</tr>
</thead>
<tbody>
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<td>23</td>
</tr>
<tr>
<td>Illiterate</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Used to be member of a support group before joining current group</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>6</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinh</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>Widowed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>5</td>
</tr>
<tr>
<td>1- &lt; 4 years</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 1: Demographic features of the sample
with a business. The 12 others described their work as assisting their in-laws in household work, small businesses or farming. Most widows had not been aware of their husband’s addiction when they married; 18 of the 23 had found out after marriage that their husband was an IDU while the others reported that their husbands started using drugs after marriage. Women learned about their husbands’ HIV-positive status either because he became ill or they tested positively themselves during antenatal care (ANC). Most widows supported their husbands until they died.

Mai, for example, was born and raised in the south of the country and came to Hanoi to live with the parents of her husband with no warning about her husband’s drug addiction. During ANC, she tested HIV positive. The situation in her in-laws’ household was physically and emotionally abusive and she wanted to escape. When she was elected leader of a support group, she used her stipend to move in with a lover in another district, switched off her cell phone, and asked the support group and its related project to explain her actions to her husband and his family. For days her husband sat on his scooter in front of the support group’s office, hoping for her return. She left her lover and returned to the house of her in-laws, taking out a loan to establish a scooter-washing business, hoping that capital assets and a job for her husband would improve the situation. But her husband spent the money she earned, and beat her - with the approval of his mother.

“When my husband fell ill with AIDS I had to earn money to cover the hospital fees for my husband, other expenses for our daughter and for myself. But the hospital could not save him. His liver could not manage the ARVs.” (HIV-positive widow, 24 years old, Hanoi)

The widows interviewed described having tried to change their situation, but reported feeling socially stigmatized in their neighborhoods because of both illicit drug use and HIV infection in the family. Women -- mothers, sisters, wives, grandmothers and aunts -- contributed funds to buy drugs for the addicted men in their household, trying to keep them at home. When this didn’t work, some female household members paid for rehabilitation; the husbands of ten of the women had been in state rehabilitation centers for drug users. Interviews and observations revealed that as long as the drug-using husband was alive, much of the women’s lives revolved around catering to his many needs. Both widows and other female members of their households who were interviewed reported feeling guilty about spoiling their husbands, sons or grandsons by buying them what they wanted, including drugs. Others argued that a loving mother or wife has the duty to do whatever is needed to prevent the IDU from committing crimes and causing tensions in the household.

“It is not fair to say that I spoiled my son. I kept him off the streets and in our house, so that he did not have to go out and steal.” (Mother-in-law of HIV-positive widow, 54 years old, Hanoi)
No matter who made sacrifices for the male addicts in the family, the wives of addicted husbands were expected to share the burden. Quy, for example, lived with her in-laws after her husband’s death. Her husband was the eldest son of the family, had started using drugs after their marriage, and was addicted for eight years.

“His mother usually paid for his drugs, but he also beat me to get money for his habit. My husband had TB but he refused to go for treatment. I had to buy him drugs. When he was high I could persuade him to go to the TB hospital to prevent him infecting our son. He had resistant TB and already had AIDS. I spent all my money on his treatment to try to keep him alive.” (HIV-positive widow, 32 years old, Hanoi)

Addiction experts who were interviewed as part of the study considered the family not just as part of the solution to drug abuse, but also as part of the addiction problem.

“It is the family that has learned to accept paying for the drug addiction, and addicts know exactly what to say to which member to get what they want. In this way families enable the addictive behavior.” (Psychiatrist specialized in addiction, national-level hospital, Hanoi)

Partly because of the difficulties of living with an IDU, not all of the women were living with their in-laws at the time they were widowed. In two cases, widows had not lived with their husband at their in-laws prior to his death. They lived instead with their family of origin because their in-laws rejected their drug-using HIV-positive son. In another case, the husband’s family was very wealthy and did not want their son to damage the family image and thereby the family business. They paid for his drugs as long as he was out of the house. In another case, the family was too poor to finance the husband’s expensive addiction.

**Options for the widows**

When the women became widowed, they had to make decisions about where they would live. All were HIV positive when they were widowed; most did not want to want to be a burden or an embarrassment to their elderly parents and other relatives.

“I have a younger brother and sister who are not married yet. We live in a rural area. If I move back to my parents’ they might have more difficulty in marrying if somebody finds out that I am an HIV-positive widow.” (HIV-positive widow, 26 years old, Hanoi)

The women reported wanting to be in a stable family situation; most were actively seeking male companionship.
“I want somebody to share my life with, with a good job and a place to stay. It’s easy to meet men if you look for them, but it is difficult to find a good one, especially when you are HIV infected. (HIV-positive widow, 26 years old, Hanoi)

Because of their health status, the HIV-positive widows needed to live near urban areas to access specialized medical care and support. The cost of living in Hanoi and Thai Nguyen city was too high for most women who were single, and most of these women had worked in their in-laws’ family businesses but lost that income when they left their in-laws’ households. HIV-positive widows without family need to find other sources of support. In some cases a woman who leaves her in-laws might be able to count on the support of her family of origin, but when her family lives far away, or is not able or willing to help because of HIV-related stigma, she might have to rely on the favors of strangers, especially men.

“I never have enough money. Luckily my boyfriend supported me, but he left me and I have to do it all by myself. I hope to meet another man” (HIV-positive widow, 24 years old, Hanoi)

Staying with the in-laws

One practical reason why women in patrilineal Vietnamese communities prefer sons is that they expect their sons to care for them when they are old and/or widowed. Moreover, only sons can be responsible for the family lineage and provide care to the ancestors. Three of the four widows who bore a son to the eldest or to the only son in the family, and therefore had a son responsible for the lineage, stayed with their in-laws following the death of their husbands. (Table 2) Although the numbers are small, it appears that lineage can play a role in the options available to widows; those who had provided a lineage-bearing son before the death of the husband were more likely to be able to remain living with their in-laws after they became widowed than those who had not. Grandparents who have an eldest son want their grandsons to stay and continue the lineage.

<table>
<thead>
<tr>
<th>Responsible for lineage</th>
<th>Returned home</th>
<th>Stayed with in-laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married to and had son with eldest/only son</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Not responsible for lineage</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

**Table 2: Relationship between child’s responsibility for family lineage and changes in residence of 22* widows following the death of their husbands**

**Two couples had always lived with the wife’s family and the women stayed there after the death of their husband.**
If women who have given birth to a lineage-holder remain with their in-laws it does not mean that they are satisfied with the situation, however. They may stay out of necessity. Two women were rejected by their families of origin, which were unwilling and/or unable to take care of them, for example.

“Now I and my twin sons live with my mother-in-law, but we do not have a good relationship. She said she will raise and feed her grandsons. I have to earn for myself. My four older sisters are all married but they cannot support me. My parents are old. My father is afraid that if the mosquitoes bite me, then bite other people that they will become infected.” (HIV-positive widow, 31 years old, Hanoi)

In another case, one widow did not want to live and raise her son with her family of origin because of their criminal activities, including drug use. She met another man whom she married, and left her son with his grandparents (her in-laws).

**Living Alone**

Living alone is an option in many countries but not an easy one in the social context of Vietnam. Six of the 24 women lived without a male sexual partner or other family members. Five rented a room and one slept on a bench in a food shop. Living alone is not only financially difficult but makes women even more vulnerable; single HIV-positive widowed women encounter stigma related both to the disease and to being a young widow living alone.

The five women who rented rooms all received financial support from married men/or single male IDUs to supplement their income. Three reportedly had their rent paid by married men whom they met outside the networks of HIV-positive persons and groups. They said they wanted a respectful and reliable man with a good social position, and they claimed to use condoms to prevent transmission of HIV. These women also said that convincing a man to wear a condom was quite problematic, as their partners would wonder why they felt the need to use a condom. They were fearful of disclosing their status in case their partners left them.

“He’s married and lives abroad most of the year with his wife and family. I need him. I’m so afraid of losing him if he knows my status. We have sex with a condom sometimes. He prefers without so I tell him he should be careful. I ask him not to trust anybody, even me. But he just smiles.” (HIV-positive widow, 26 years old, Hanoi)

All widows who lived alone had left their children with their own parents or their in-laws because they could not afford to support them even if they had employment.
“I had to leave my daughter with my mother so that I can work in town. I miss her so much but it is better for her.” (HIV-positive widow, 41 years old, Thai Nguyen)

**Living with their own families**

Six women had been living at their in-laws’ homes but had returned to live with their families of origin after their husbands’ deaths, while two had already lived with their spouses at the homes of their own parents prior to becoming widowed. All six women who returned home described being pressured to leave by their in-laws. They found that their family of origin provided a more supportive environment. Two former IDUs reported feeling unable to make a living in their in-laws’ households because nobody trusted them, whereas they were able to live and work with their families of origin, together with their children. From the various stories a picture emerged of emotional neglect by their in-laws. Uyen’s case illustrates the isolation women experienced after their husbands’ deaths: Uyen said that she loved her husband in spite of his drug addiction. They lived with his family, and had a son. When her son was two-and-a-half years old both he and her husband became ill with AIDS. Within a month she lost both of them. She was mourning their deaths, but her in-laws did not talk to her and made her sleep on a separate floor of the house.

“I moved back in with my own family because I could not call my parents-in-law for help when I was sick, because I am just a daughter-in-law. If I fell down in that house no one would know. My mother told me it served no purpose to stay with my in-laws. Therefore I went back to my family.” (HIV-positive widow, 26 years old, Hanoi)

After some months of care from her mother and sister, Uyen joined a support group where she met her new boyfriend Duc, an ex-IDU who is also HIV-positive and wants to marry her. Uyen works as a peer educator and helps her family with household work. Duc and Uyen plan to live by themselves and have children of their own.

**Recreating kinships**

Seven of the eight women who ended up living with their parents after being widowed had found new male partners. Because of the predominantly male HIV epidemic in Vietnam, it is relatively easy for a young HIV-positive woman to find a new partner at one of the mixed-gender HIV support groups.

Most members are male former or active IDUs who would encounter difficulties in finding a partner who is not also HIV positive. HIV-positive men, who also live in difficult circumstances, seek partners, preferably HIV-positive
women, with whom they can live positively. None of the women wanted to marry an active drug addict again, having lived with one already. All the new partners of the widows were ex-IDUs. In five cases, these men had not used hard drugs for more then a year, suggesting that they had strong motivation to stay clean. They all had some income, mostly through an existing family business. Four women received stipends for their work as peer educators, which they found through HIV-positive women’s support groups.

Both men and women in these couples wanted to share their lives but none lived as a traditional family with the woman moving in with her in-laws. At the time we met them, the men and women were each staying with their families of origin, as the following cases illustrate.

Lam, an unmarried HIV-positive man, was the boyfriend of HIV-positive widow Nguyet. Lam was an ex-miner, unemployed at the time we met him, and living with his grandmother. He became a drug user while working in abandoned mines, leading a group of others digging illegally for gold. They shared drugs and needles to give them the stamina to keep working. Never married, he found Nguyet through the HIV-positive support group.

“We are a group of lonely men. We love it when a new female member comes and joins us. All the men in our HIV support group want to find love and have a family. I was one of the lucky men who found a woman who wants to marry me.” (HIV-positive male, 31 years old, Thai Nguyen)

Nguyet lived with her young daughter at her own mother’s house, where she was making an adequate living raising chickens. Nguyet knew about Lam’s past but was ready for a new relationship.

“I really want to marry again and have another child with my new boyfriend. He has had an unhappy life, as his mother died young. I want him and his grandmother to have a baby to hold.” (HIV-positive widow, 29 years old, Thai Nguyen)

Their families approved of their relationship, but they did not know if they will live together after they marry because of Nguyet’s responsibilities for her daughter and her business.

None of the families reportedly protested against the unusual arrangement where widows with children stayed with their families of origin while having a relationship with a new man; on the contrary, they seemed relieved. Linh, a widowed mother with a young daughter, also met her current boyfriend Dung, an ex-miner, in a support group for HIV-positive persons. She described wanting to raise her daughter in the stable environment of her family of origin, who are happy that she has a relationship with a man who loves her. Her boyfriend’s mother, a war widow, was happy about the support Linh offered to her son.
“He joined the support group where he met his new wife a year ago. At first I was worried that if they cannot practice family planning, they will probably have children. I do not want to have HIV-positive grandchildren. But if it is just because they love each other, then I agree with their choice. I know my daughter-in-law’s status and I love her as my daughter. She is very kind and she can change my son for the better. He has not used drugs for a year. She is very strict. Her first husband was a drug user but she is not. Her daughter is a good girl. If they are happy, I am happy.” (Mother-in-law of HIV-positive widow, 58 years old, Thai Nguyen)

Linh and Dung were both volunteers in support groups. Dung was supporting Linh practically and emotionally, and was proud of and grateful to her.

“I am who I am because of her. She gives me strength.” (HIV-positive widow, 32 years old, Thai Nguyen)

Only one widow, herself also a recovering IDU, who returned to her family of origin, appeared to have stopped looking for love and protection from men outside her family. Her father is a member of parliament. She had a stable and intimate relationship with a woman, also an HIV-positive former IDU. With the benefit of a good education, energy and people skills, she joined and became a leader of a support group.

“Now I want to spend my life fighting drugs and helping other female addicts. I want my family to be proud of me, and I want to show them that even though I used drugs and became infected, I can still be useful.” (HIV-positive widow, 32 years old with a son, Hanoi)

**Living with the double stigma of HIV and widowhood**

We interviewed 19 respondents when they were newcomers to their support groups. At first, all women reported very low self-esteem and feelings of isolation and helplessness. They looked ill, poorly dressed, and neglected. Even just asking how they were often started their tears flowing. They said that they had sacrificed care for themselves by remaining silent about their HIV status. They had no plans for the future. They described being subject to cruel treatment from their in-laws. For example, during our first interview with Anh Thu, a widow in Thai Nguyen, she described the stigma she had experienced:

“I feel sick and weak. I came to the group for help. I could not stay with my in-laws, because my mother-in-law sold the land where I used to live. I used to cook at village parties and people used to help me with the rice harvest. Now that my husband has died of AIDS and they suspect that I am infected, nobody wants to work with me anymore.” (HIV-positive widow, 41 years old, Thai Nguyen)
Being in a group enabled the widows to tolerate the double stigma of HIV and widowhood, and to regain confidence in themselves and in others. After some months, Anh Thu’s perception of her situation had become more optimistic:

“I can share my feelings with others in the group. Some are in a worse situation than I am. They have nobody, but I have my daughter and my mother. I now see that my mother-in-law is in a very difficult situation herself, having three drug addicted, HIV-positive sons.” (HIV-positive widow, 41 years old, Thai Nguyen)

Two years later, Anh Thu was running a food shop and had become a very active, cheerful member in the group, conducting outreach work with other rural women.

Another example is Tuyet, who had just returned to live with her family of origin with her three-year-old daughter. She reported that after her husband’s death her family-in-law made her feel invisible.

“My family-in-law saw me as nobody. My child was not allowed to play with other children. I felt isolated and lonely so I came home and now live off my family’s kindness. I do not have a future plan. I want to give my child away, because I cannot care for her.” (HIV-positive widow, 27 years old, Thai Nguyen)

But a few months later the friends she had made through the support group had helped her to obtain medical care. She had gained weight, started to work at the market selling various goods, and was more positive:

“I am lucky. I have medicines, I feel much better. I am very busy with my business and can care for my child without my backward, rural in-laws. I don’t believe in fate. I believe in taking care of my daughter.” (HIV-positive widow, 27 years old, Thai Nguyen)

When we first met Hong, a recovering drug user, she was pregnant and had just married the father of her child, also an ex-IDU as well as being HIV positive. It was difficult to convince his family to accept the marriage and let her move in with them; they thought she was not a good match. But her husband became ill and died from AIDS-related complications. Hong moved back to her family of origin with her daughter after his death.

“I feel sad for my husband. But I am relieved to escape my in-laws’ criticism. I don’t need a man or in-laws who do not accept me. I am a widow and HIV-positive but I feel pretty good, I work hard and stay clean. I run a business now with my mother at our house. I help members in the group who need and deserve my help.” (HIV-positive widow, 26 years old, Hanoi)
All of the women who were interviewed emphasized that the support groups had helped them to overcome the low self-esteem and lack of confidence related to being an HIV-positive infected person and a widow, and that this made an important difference to their ability to start new lives.

“Talking to others and learning from their experiences has really helped me and given me hope. My partner, whom I met through the group, had the same experience and this has made our love stronger.” (HIV-positive widow, 28 years old, Thai Nguyen)

Discussion

Feminist authors have suggested that lack of self-esteem can lead to behavior that continues to marginalize and disempower women. (Malhotra, Schuler, & Boender, 2002; Schrijvers, 1985). A study in India found that the actual stigma experienced by those infected with HIV was much less than the stigma HIV-positive people feared they would experience, or that they perceived themselves to experience. (B. E. Thomas et al., 2005) HIV-infected persons’ negative perceptions of themselves might thus be as significant a problem as others’ negative perceptions of them. Low self-esteem can change over time and our findings suggest that widows’ negative perceptions of themselves changed due to their membership of a support group. Both female and male members of support groups reported important psychological benefits due to the release of emotional pressure by sharing their status openly in a peer group. This effect might be what has been labeled as the ‘paradox’ of coming out openly as an HIV-positive person: though subject to AIDS-related stigma, one finds psychological release – liberation from the burdens of secrecy and shame. (Paxton, 2002)

Studies in other countries have shown that many people who are aware of their HIV status change their behavior to diminish the risk of infecting other people. (Cleary et al., 1991; Colfax et al., 2002; Otten, Zaidi, Wrotten, Witte, & Peterman, 1993). Several of the women who participated in our study failed to undertake such protective behavior towards others. Their behavior can be partially explained by the social pressures they experienced. These women were economically vulnerable and received financial support for sexual favors from various men, which they were afraid of losing if they disclosed their HIV-positive status. They might be deemed sex workers but did not see themselves that way. They emphasized that they felt emotionally close to their boyfriends. Almost all women looked for infected partners in HIV-positive support groups. This confirms findings in studies in the United States showing that HIV-positive people are unlikely to choose a partner who is HIV negative. (Wiktor et al., 1990)

Current evidence indicates that there are no linear connections between the different spheres of life in which women are disempowered. Greater economic freedom, for example, does not always equate with greater reproduc-
ative freedom. (Beegle, Frankenberg, & Thomas, 2001; Hashemi, Syed, Schuler, & Riley, 1996; Kabeer, 2001; Kishor, 2000; Malhotra, Schuler, & Boender, 2002; Oosterhoff, Nguyen Thu Anh, Pham Ngoc Yen, Hardon, & Wright, 2008a) The HIV-positive widows in our study illustrate some of the complexities of disempowerment. It is likely that most were infected by their husbands, which suggests that they were not able to protect their reproductive health. They lacked individual economic autonomy when they lived with their in-laws because they were part of a family business. The women who had made investments in the business of their in-laws lost these financial assets when they moved out after their husband’s death. But the widows who left their in-laws and returned to their families of origin were able to earn and keep income from their own families’ businesses. Some women received stipends because of their work as peer educators; a source of income that is not available to poor women who are HIV negative.

Because of the demographics of the epidemic and the increasing number of support groups, women were able to access new networks, which helped them to learn about their disease and to interact with their peers. The groups also helped these HIV-positive women find HIV-positive male sexual partners. HIV-positive widows reported no fear of being discriminated against by HIV-positive men; their HIV status actually connected them. Hence for some women, widowhood and HIV — as devastating as these are — brought new options and several modest social benefits. Their husbands’ deaths freed them from the problems of living with an HIV-positive drug user. In addition, the women who returned to their families of origin reported feeling released from at least some of the stress of living in the household of their in-laws. Those who resided with their families of origin had the option of seeking a new sexual partner, and a third of them enjoyed a new, intimate relationship while living with their family of origin, with or without their children. While almost all of the partners the women had become involved with were also recovering drug users, and it is possible that these new partners will relapse and that the widows will be in the same situation as in their first marriage, most of them had been clean for more than a year when they met the women. For the time being, therefore, these women had established new living arrangements, in which they had an intimate relationship with a man and a stable environment for themselves and their children in their family of origin.