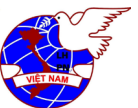


women
& HIV
in Viet Nam
*meeting the
needs*



REPORT SUMMARY



This publication was made possible thanks to generous funding from the Ford Foundation, and from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID).

This summary presents key findings from *Women & HIV: Meeting the needs*, a comprehensive overview of current knowledge on the situation that Vietnamese women face with regard to HIV.

Pact compiled the report based on a desk review of government, donor, academic and other documents pertaining to women and HIV in Viet Nam and worldwide; and on group and individual interviews, conducted with the Viet Nam Women's Union, that capture the voices of women living with HIV, government officials, international donors, and Vietnamese and international non-governmental organizations.

This report summary is designed to anchor discussion at the Gender & HIV Multi-Stakeholder Forum cohosted by USAID, Pact and the UN in Viet Nam on May 11, 2011, in Ha Noi. The forum seeks to highlight recent research, raise awareness and facilitate dialog, and assist in advancing the agenda for gender and HIV in terms of programming and policy. As such, the summary opens with a reference list of key findings on women and HIV in Viet Nam, followed by a series of condensed briefings on the forum's central topics.

We hope this document will serve as an advocacy and policy tool to help meet the HIV-related needs of women in Viet Nam, and thereby contribute to a strengthened national HIV response. The full *Women & HIV: Meeting the needs* report will be available at www.pactworld.org/cs/vietnam as of May 2011.

Pact

May 2011

What are the needs?

In Viet Nam, the number of women living with HIV is growing steadily closer to that of men – and the disease takes a heavier toll on women. By 2012 there will be approximately 77,000 women living with HIV in the country: That equals **30% of all infected adults, up from 25% in 2002**, according to *Viet Nam HIV/AIDS Estimates and Projections: 2007–2012* (Ministry of Health & VAAC, 2009). One reason for the narrowing gap is **men transmitting HIV to their regular sexual partners**. Once HIV is brought inside the home, women bear a **disproportionate double burden**: discrimination for contracting the disease, and sacrifice as caretakers for other infected family members. Yet knowledge and programs targeting women's unique HIV needs continue to trail behind those of men. HIV can no longer be considered an epidemic that infects men alone.

It is time to act together on meeting women's urgent needs.

- The 2009 National Survey on Adolescents and Youth finds that **fewer young women have high knowledge of HIV** than do men: 63% compared to 69% in urban areas, and 50% compared to 59% rural.
- **Female sex workers are one of the groups most at risk of HIV** in Viet Nam, registering rates of infection as high as 18% for venue-based sex workers in Ha Noi and 23% for street-based sex workers in Hai Phong (Ministry of Health, 2009). The Ministry of Health's Integrated Biological and Behavioral Surveillance (IBBS) found **female sex workers' overall consistent condom use decreased** in Can Tho, Ha Noi and Ho Chi Minh City from 2005 to 2009.
- Communication materials tend to target men (injecting drug users and men who have sex with men) or female sex workers, because these are the groups at highest risk of HIV. **Peer outreach for high-risk women who inject drugs is virtually nonexistent** (CIHP, 2008), and low-risk women have not received adequate communication and education, despite the growing numbers who contract HIV through their partner.

Bien was nine months pregnant when she discovered she had HIV. Her husband was suffering the last stages of AIDS. Bien was forced to “work and do everything” for her husband and child.

– Case story from Thai Binh

When Yen's husband fell ill with AIDS, her in-laws told her to give up her job to care for him, even though other people in the house might have taken on the responsibility.

– Case story from Thai Nguyen

- Power dynamics enforced by Viet Nam's social norms make it **challenging for women to protect themselves against HIV** when they negotiate sex. In a survey of married couples in Nghe An, Luke et al. (2007) found that most people believed a woman should respect her husband's supremacy and defer to his judgment.
- Some women living with HIV have their family's love and support, but others face substantial discrimination. Because women are held to high standards of "purity," those who become infected through sex work or drug use can be blamed and condemned (Khuat, Nguyen & Ogden, 2004). And regardless of the source of infection, **a wife or mother will almost always care for a man living with HIV, but if a woman contracts HIV, her in-laws may abandon her or separate her from her children.** To date, however, few efforts to reduce stigma and discrimination have targeted women explicitly.
- Women living with HIV face added burdens of strained budgets, loss of property – which is often not in their name – and caregiving responsibilities. **Three-quarters of all HIV caregivers in Viet Nam are women** (UNESCAP, 2010). They must learn how to support and care for the other person's physical, medical, nutritional and emotional needs, while sacrificing their own financial security, educational opportunities and health. For this reason, community- and home-based care is critical for women who cannot come to clinical facilities themselves.
- Viet Nam has **limited experience with microcredit** and other initiatives to support the income of women affected by HIV. Initial results are both positive (e.g., Oosterhoff et al., 2008; also anecdotal experience from small businesses under local organizations that receive PEPFAR funding from USAID via Pact) and negative (see quote below).

"I heard about a program offering microcredit to HIV-positive families in difficulty, but when I tried to access it, the ward asked: 'Who will repay the loan if you die?' "

– Woman living with HIV, Ho Chi Minh City

In a study of services for women living with HIV in Hai Phong and Ho Chi Minh City, supported by USAID with PEPFAR funds via Pact (Boston University, COHED & Life, 2010), the women named the following priority needs:

- Advice on nutrition and other health issues
- Antiretroviral treatment (including adherence support)
- Women-focused healthcare
- Employment opportunities
- Psychological support
- Family support
- Support to cope with stigma and discrimination
- Drug counseling and safe drug treatment
- Housing

Sexual & reproductive health rights of women living with HIV

“When clients ask me to give them advice on having a child, I don’t dare advise them ... We don’t dare to counsel on such an important issue. There would be consequences for the child. Who would take care of it in the future?”

– Community-based organization supported by CARE

“We rarely talk with drug users about sexual issues. We don’t discuss family planning or childcare either ... our first priority is harm reduction.”

– Field supervisor, anonymous organization

Several Vietnamese legal documents, such as the Law on HIV and the National Standards and Guidelines for Reproductive Health Services, cover sexual and reproductive health services for people living with HIV – especially programs that help expectant mothers prevent transmission to their unborn children.

In Ha Noi and Ho Chi Minh City, a review of PEPFAR-supported organizations, including Pact civil society partners, revealed that most services for people living with HIV were limited to sexually transmitted infections and mother-to-child transmission, leaving high, unmet demand related to sexual dysfunction, sexual rights and pleasure, and assisted fertility (CCIHP, New Care & Pact, 2009). Most women living with HIV must visit multiple clinics for antiretroviral treatment, antenatal services and prevention of mother-to-child transmission.

Women often receive treatment delivered with a judgmental tone, because providers assume they acquired HIV through practices thought of as “social evils.” For women affected by HIV, their options as parents are similarly limited by family, community and medical discrimination. Boston University, COHED and Life (2010) note that 12% of women living with HIV in Hai Phong and Ho Chi Minh City had been refused health or social services. Oosterhoff (2008) found that health workers unanimously believed HIV-positive women should not bear children; Boston University, COHED and Life report that 66% of their respondents who abstained from sex were told to do so by their doctor, and 46% had undergone an abortion. Khuat (2009) found that 17% of 1,297 women interviewees living with HIV had had abortions nationwide.

“Women with HIV didn’t think about this issue before, because HIV was a death sentence. Nowadays, thanks to antiretroviral treatment, they see the opportunity to live and have babies to continue the family.”

– Service provider, anonymous organization

Prevention of mother-to-child transmission can reduce the likelihood of a newborn contracting HIV from 20%–45% to 1%–2% (WHO, 2007). In 2009 about one-quarter of pregnant women tested for HIV in Viet Nam. Nguyen et al. (2003) found that many women refuse free HIV testing in local antenatal health stations because of lack of privacy: The sites must report positive cases to the government, and as a result testing only occurs during labor in 90% of cases. Family Health International (2006) reports that services to prevent mother-to-child transmission can double their effectiveness if combined with family planning services, which places them in contact with potential mothers earlier.

HIV-positive women receive inadequate referrals for health and social services (Tarantola et al., 2009), due to gaps in the referral network and discrimination from health staff. In response, Pathfinder is promoting a model that integrates HIV services into provincial reproductive health care centers and district health facilities, and it has increased counseling on HIV testing for clients with sexually transmitted infections from 3.5% in early 2008 to 100% in late 2009; 91% of pregnant women at the provincial centers also receiving HIV counseling, and 67% agreed to testing. Ethnic minority women are especially vulnerable to HIV (e.g., Oosterhoff, White & Thi, 2011): Factors include cultural taboos and limited outreach from the health system, for example in the form of interpreters to facilitate counseling in minority languages.

“Doctors like to judge their patients, especially for this. They have very limited resources and don’t want to divert them to people who ‘deserve’ what they’ve got.”

– Former Médecins du Monde director, Ha Noi

“Doctors need to have firm knowledge of HIV and related illnesses, but they don’t know much, and in some cases they give medication based on your appearance or a quick examination.”

– Woman living with HIV, Ho Chi Minh City

In 2005, PSI carried out a qualitative study on motivations and barriers related to voluntary counseling, which informed a series of recommendations for improvement. Women-specific recommendations include:

- Signs should clearly identify sites as VCT clinics, but should not contain the words “HIV” or “AIDS.” They should be easily recognizable to those wishing to access services, but most sex workers preferred generic signs that do not make the purpose of the facility explicit.
- Increase coverage and effectiveness of outreach by enrolling peers. Partners of injecting drug users require separate outreach efforts, perhaps involving local Women’s Union networks.
- Many sex workers avoid HIV testing to avoid losing earnings: Visiting a center can raise suspicions of infection.
- Increase variety of voluntary counseling and testing sites available. Many women want clinics that are located anonymously in large health facilities.

Women & drug injection

Drug injection is becoming more common among Vietnamese women, especially those who engage in sex work. Yet in comparison with drug-related harm reduction services for other groups at highest risk of HIV, peer outreach for women who inject drugs is virtually non-existent.

Female sex workers who also inject drugs represent one of the highest-risk groups for HIV in Viet Nam: The Ministry of Health (2009) estimates that as many as 60% of these women will be living with HIV in Ho Chi Minh City by 2012, and their numbers are rising sharply across the country. Between 2006 and 2009, the IBBS has revised its drug injection figures from 4% to 26% for sex workers based at Ha Noi venues, 15% to 28% at Ho Chi Minh City venues, 8% to 23% for those based on the street in Hai Phong, and 8% to 30% on the street in Ho Chi Minh City. According to Boston University, COHED and Life (2010), over half of women living with HIV in Hai Phong and Ho Chi Minh City had had sex with a partner who injects drugs; 16% reported having injected themselves, and 41% of those had shared equipment.

The 2009 IBBS found that in Ha Noi 30% of female sex workers had shared needles in the past six months, compared to just 7% of male injecting drug users. A nationwide survey, supported by USAID with PEPFAR funds via Pact, found that 13% of injecting female sex

workers shared needles in the past month (PSI, 2009). This study also finds that female sex workers who inject drugs have more clients than non-injecting sex workers – although condom use among the two groups is identical at 80%–81%.

Female sex workers who inject drugs have particular habits that may differ from men's. For example, it is other sex workers who usually initiate them in drug use (48%): 37% of female sex workers inject in front of non-injectors, and 36% have told non-injectors about the benefits of drug use. PSI has used the results to pilot tailored outreach in Hai Phong and Can Tho, helping distribute clean needles and overdose medication, tracking inhaling drug users to reach them before they graduate to injection, and more.

The need, however, remains great. A 2008 needs assessment in Hai Phong and Ho Chi Minh City (CIHP, 2008) found no specific services that addressed the compound risk of female sex workers who also inject drugs. Programs that target men may not reach these female drug users effectively, and the treatment available at rehabilitation centers tends to focus on abstinence rather than proven methods, such as varied treatment options (including methadone), quality counseling, ongoing support and room for relapse as part of recovery.

Intimate partner transmission

Luke et al. (2007) provide one example of the deep-rooted tradition of male dominance in Viet Nam: In Nghe An, they found that most married men and women support traditional roles for husband and wife, which encourage women to submit passively if their husbands engage in high-risk behaviors or are infected with HIV.

“Frankly, if a young man fools around and gets infected, that’s the same old story. If a girl gets this disease, no one wants to get near her, because the problem is her conduct and morals. It isn’t tolerated in women the way it is in men.”

– Community counselor (Ogden & Nyblade, 2005)

“A husband’s family may blame the wife if both spouses are infected, and if the husband dies the wife could be driven away or her children taken away from her.”

– Volunteer, Hai Phong

The expectations placed on wives stand out even further among couples in which the husband injects drugs. In one Ha Noi study, 14% of female sexual partners of injecting drug users tested positive for HIV (Hammett et al., 2010); 69% of the women were of different HIV status than their primary partner or did not know the partner’s status, yet only 27% reported condom use with their partner half the time or more. Rates of condom use were no higher among couples with differing rather than matching HIV status.

“Young people really enjoy learning about gender roles ... It helps men think about men’s sexual health, men’s roles. They realize that in order to have healthy relationships, they should respect themselves as well as their partners.”

– Program manager of HIV curriculum at vocational schools, Save the Children

Save the Children has now handed over its gender-sensitive HIV education program for vocational schools to the Ministry of Labor, Invalids and Social Affairs for nationwide expansion. In 2008, Save the Children’s baseline survey of male vocational students found that 33% had highly inequitable gender attitudes and 28% highly equitable attitudes, the latter associated with safer sexual behavior. A follow-up survey after the program found that highly inequitable attitudes had dropped to 15% and highly equitable attitudes had climbed to 56%.

Men as partners & potential allies in the response

High-risk activities such as drinking, drug use and multiple sex partners appear to be increasing among young men, suggesting that infection of their primary partners will continue to rise (Tarantola et al., 2009). The HIV response must begin to focus on men as responsible partners to their wives and girlfriends, not only on men as part of certain high-risk populations; and on women as wives and girlfriends, not only on those who are sex workers.

Men's social norms pressure them to take risks – such as joining groups of friends or colleagues to visit sex workers (FHI, 2006) – and there is little awareness of the harm these norms may pose for them (AusAID, 2007).

The Viet Nam Committee on Human Rights (2007) finds that gender norms also affect policy, by casting family planning and reproductive health as purely women's responsibility. It notes, for example, that Women's Union programs have generally not targeted men and boys. The Ministry of Education and Training, with Save the Children and UNICEF, is revising the high school curriculum to address gender norms, and several local organizations have developed projects that address men directly in meeting women's needs.

“We prefer suffering over going to dispute resolution. We'd rather keep quiet.”
– Woman living with HIV, Hai Phong

Gender-based violence obstructs women's ability to negotiate safe sex. Nguyen, Khuat and Nguyen (2008) note that such violence makes condom negotiation all but impossible, and it increases the risk of open wounds that facilitate HIV infection. UN Viet Nam (2010) cites a 2009 presentation by the Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents (CSAGA) that claimed approximately half of its 137 female counseling clients knew their husbands were having extramarital sex, including with sex workers, yet the women feared violence if they requested condom use. Gender-based violence also affects women's health as a whole: Across Viet Nam, women who experienced consistent partner violence were more likely than women who never experienced partner violence to report poor or very poor health, with specific symptoms ranging from pain and distress to miscarriage (MDGIF et al., 2010). Breakthroughs have included sensitization toolkits prepared by ISDS (Nguyen et al., 2005) and by CSAGA with ISDS and the Harvard School of Public Health, as well as the Ha Noi Health Service and Duc Giang Hospital's collaboration with the Population Council and UNFPA on improving medical and counseling standards to foster more equitable gender attitudes.

“We need to promote men's involvement to improve our own empowerment.”
– Woman living with HIV, Hai Phong

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