Male Partner Involvement in Prevention for Mother-to-Child Transmission in Vietnam

Challenges and Opportunities for Intervention

A report based on qualitative research conducted in Vietnam

Prepared by:

Ritu Shroff Lead Consultant

With inputs from:

Bui Thi Thu Ha, Senior Researcher
Vu Van Hoan, Researcher
Dau Thi Ha Hai, Researcher
Le Lan Huong, Researcher
Pham Khanh Tung, Researcher

Technical working Group:

Nguyen Duy Khe, Director, Maternal Child Health Department, MoH
Dinh T. Phuong Hoa, Vice Director, Maternal Child Health Dept. MoH
Luu Thi Hong, Vice Director, Maternal Child Health Dept. MoH
Chu Quoc An, Vice Director, VAAC, MoH
Tran Bich Tra, IEC Department, VAAC, MoH
Hoang Anh Tuan, Maternal Child Health Department MoH
M. Tolvanen-Ojutkangas, Chief, Health & Nutrition Section UNICEF
Luisa Brumana, HIV/AIDS Specialist, UNICEF
Mai Thu Hien, PMTCT officer, UNICEF
Nguyen Ngoc Trieu, HIV/AIDS Prevention and Control Project, UNICEF

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Lastly, all errors and omissions are solely the responsibility of the lead consultant.

Từ viết tắt

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retro-Virals
BCS	Bao cao su
BLTQĐTD	Bệnh lây truyền qua đường tình dục
BPTT	Biện pháp tránh thai
BVH	Bệnh viện huyện
BYT	Bộ Y Tế
CDC	Centers for Disease Control and Prevention
CLB	Câu lạc bộ
GF	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HNMD	Hành nghề mại dâm
KHHĐQG	Kế hoạch hành động quốc gia
KT-TĐ-HV	Kiến thức, thái độ, hành vi
LIFE GAP	Dự án Sự lãnh đạo và đầu tư chống lại dịch bệnh _chương trình AIDS toàn cầu
LTQĐTD	Lây truyền qua đường tình dục
PEPFAR	Presidential Emergency Plan For AIDS Relief
PLTMC	Prevention of Mother to Child Transmission of HIV
QHTD	Quan hệ tình dục
TCMT	Tiêm chích ma tuý
TTYTDP	Trung tâm y tế dự phòng
TTCSSKSS	Trung tâm chăm sóc sức khoẻ sinh sản
TTGDTT	Thông tin giáo dục truyền thông
TTPC	Trung tâm phòng chống
TTTĐHV	Truyền thông thay đổi hành vi
TVXNTN	Tư vấn xét nghiệm tự nguyện
TYT	Trạm y tế
SDMT	Sử dụng ma tuý
SD NVP	Single Dose Nevirapine
SKBMTE	Sức khoẻ Bà mẹ Trẻ em
SKBMTSS	Sức khoẻ bà mẹ và trẻ sơ sinh
SKTD	Sức khoẻ tình dục
SKSS	Sức khoẻ sinh sản
SKSS&GT	Sức khoẻ sinh sản và giới tính
UNAIDS	United Nations AIDS Program
UNICEF	Quỹ nhi đồng liên hiệp quốc
WHO	United Nations Children's Fund
YTDP	Y tế dự phòng

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Executive summary

Background

Viet Nam is making considerable progress in institutionalizing and scaling up Prevention of Mother to Child Transmission (PMTCT) activities in the country, as well as in conceptualizing the needed linkages between Sexual and Reproductive Health (SRH), Maternal and Neonatal Health (MNH) and PMTCT. The national objective of the PMTCT Plan of Action is to achieve nation-wide reach of PMTCT services by the end of 2010—a very ambitious target that requires mobilization of services and resources. Currently, most pregnant women who are tested positive are still diagnosed at the very late stage of their pregnancy, mainly right before delivery, which prevents them from accessing timely services when needed. In several assessments and informal dialogues with health workers as well as pregnant women attending antenatal care (ANC) in Vietnam, it appeared that lack of male partner involvement in the provision and use of services, as well as in the information sharing of the importance of PMTCT, is one of the bottlenecks to improve PMTCT service intake.

Study Purpose

This qualitative study investigates the involvement of men in pregnancy and RH care more broadly, and PMTCT more specifically, and makes recommendations to improve it.

Specific aims are to:

a. Identify the knowledge, attitudes, health seeking behaviors and practices of pregnant women, their male partners and the couples and the family as a unit in respect to PMTCT in the broader context of SRH, including primary prevention in the couple prior and during pregnancy;

b. Identify behavioral and cultural determinants, barriers and opportunities for greater involvement of male partners in PMTCT and SRH;

c. Identify existing service provision , how services are linked to better prevent mother to child transmission (including primary prevention in the couple, STIs and infant and young child feeding practices), and how they allow, or don't allow, men/partners involvement.

Study Design

Data were collected through 115 focus group discussions (FGDs), in-depth and key informant interviews in 6 districts in 3 high prevalence provinces in Vietnam—Quang Ninh, An Giang and Ho Chi Minh City. One district per commune offered PMTCT services under the UNICEF project, the other did not (but may have offered services through other donors). Data were collected from positive men and women (some of whom had received PMTCT services), pregnant women and their male partners (who had either not tested for HIV or tested and were found negative), family members, community leaders and service providers at provincial, district and commune levels. Analysis was done in NVivo software.

Discussion on Key findings and Major implications

The team explored socio-cultural determinants and intra-household and inter-spousal communication and decision-making, which affects pregnant women's decision to access antenatal care at various points during pregnancy and to accept PMTCT. They also helped in providing insight on fertility decisions and communication on sexuality, contraception and health care.

Knowledge and awareness of HIV transmission is high, but knowledge and awareness of prevention of mother to child transmission is relatively superficial. Attitudes toward PMTCT among both men and women were positive, and attitudes toward care and support by providers during pregnancy are also high.

Women exercise a great deal of choice and freedom over reproductive health care decisions that ultimately affect their own bodies. These are certainly influenced to a greater or lesser extent by societal factors and by family members, but women still perceive themselves to have a degree of freedom. In particular, the decision to test for HIV during routine ANC seems to rest with women. From a women's rights perspective, efforts that diminish this right would be unethical.

On the other hand, fertility decisions (to become pregnant or to terminate a pregnancy) are jointly taken by men and women and influenced by societal and familial influences. Sexuality and sexual health, while not often discussed, are obviously also critical in PMTCT. Male involvement in primary prevention of infection in women (prong one) and in prevention of unwanted pregnancy (prong two) thus emerges as a clear need from this study. Many men are reluctant to discuss risky behaviors and possible HIV infection with wives or girlfriends, and may even be reluctant to disclose their positive status. Women are thus placed in a vulnerable position, where they engage in unprotected sexual intercourse and enter pregnancy without this information. This study shows that some women, in retrospect, might have made different decisions regarding marriage, unprotected sexual intercourse and pregnancy, even termination of pregnancy, if they had had information about their husband's HIV status.

Finally, being diagnosed as positive needs to be viewed within the larger and rapidly changing socio-cultural context in Vietnam. The legacy of the social evils campaign lingers on, with some people still associating HIV and being diagnosed as positive as being the same as being socially deviant. In a country where social norming is an extremely strong aspect of society and where the state reinforces such messages actively, women and men feel a strong pressure to be seen and to operate within such socially acceptable norms. Such norms include recognition for and positive reinforcement of certain types of families, and are closely linked with Confucian and other cultural traditions. Similarly, families and individuals that do not conform are given less support and recognition and may experience a form of socio-cultural isolation. Internalizing such messages is not uncommon, and there is a vicious cycle of shame and embarrassment reinforced by social judgment and isolation.

For men and women to make an informed choice about having a child if positive, they would need to discuss the possibility of HIV infection prior to conception and go in for testing. Stigma and discrimination of positive individuals may be one factor that contributes to reluctance of men to communicate with wives about risky behaviors, and even about their positive status. Decisions to keep one's positive status from one's wife and family members, and for mothers of positive men to support their sons into a marriage without revealing his status are better explained when examined within such social and cultural norming.

PMTCT services in Vietnam have focused to a great extent on prong three of the comprehensive approach, which is about prevention of infection in infants. This study also finds that women, men, families and service providers associate PMTCT primarily with prong three, and even more simply with two things—replacement feeding, and ARV prophylaxis. An expansion and deepening of PMTCT among service providers as well as communities seems warranted, especially when looking at male involvement. While this study reassures program managers, policy makers and service providers that, unlike other settings around the world, in Vietnam, male partners, in fact, are unlikely to prevent women from testing during pregnancy and accessing ARV prophylaxis, or even in unduly

influencing their feeding decisions, it also is a reminder that PMTCT entails much more than protecting the infant from infection.

Male involvement in infant and young child care also emerges as an area needing attention. Support for exclusive feeding (either formula or breastfeeding) is essential for women, especially since exclusive breastfeeding is not commonly practiced and replacement feeding poses its own challenges that may, inadvertently, result in mixed feeding.

Recommendations

A comprehensive approach to PMTCT requires a program that focuses on all four prongs of the recommended UN approach. In Vietnam, men can play a critical role in the first two prongs of PMTCT. General recommendations for behavior change and service provision are described. This is followed by a pilot model based on three levels of change, at the individual level (healthy behaviors), at the societal level (social support) and the policy/program level (enabling environment), with activities for each prong of the UN recommended comprehensive approach to PMTCT.

In Prong One, the most critical behavior change at the individual level is encouraging condom use among men who test positive. This requires more men to test and more men to reveal their status. As this study finds that stigma and discrimination and fear of being rejected discourage testing as well as disclosure, this model proposes community outreach and education, as well as mass media efforts to encourage men to test and disclose their status to their wives/partners. Enhanced services, such as free testing for men who are about to get married or for wives of men who test positive will also encourage testing and disclosure.

In Prong Two, the most critical behavior change is to avoid pregnancy if one does not wish to have a child. This study finds that several women either stated that they did not plan to have children, or wished that they had known their status before pregnancy in order to have prevented it. For this to be a real option, pre-pregnancy testing for the couple through packages that include wellness and general health information and testing are proposed. Early testing in pregnancy, and rapid sharing of results would make it possible for those women who wish to terminate their pregnancy to exercise that choice. For those women who wish to continue with their pregnancy, earlier uptake of ARV can help the infant. In Prong Two, strengthened couple counseling is essential to support any of the options—not to conceive, to terminate a pregnancy or to continue it, as men will play a significant role in decision-making.

In Prongs Three and Four, male involvement during pregnancy and childbirth can be of a supportive nature. It is proposed that men be invited for special days to learn about pregnancy and childbirth, as well as PMTCT, and that men be involved in counseling about infant feeding and infant care. Finally, much stronger counseling for women who test negative is recommended to avoid future transmission.

Conclusion

This qualitative study finds that male involvement in HIV testing when offered during routine ANC, and access to related PMTCT care is minimal. It also makes the case for efforts to involve men in Prongs one and two of the international approach to PMTCT, and offers the benefits and rationale for doing so. As the MOH gears up to expand its PMTCT efforts nationwide, these recommendations and findings should be useful in considerations about access, quality of care, patient rights, and ultimately, decreased HIV prevalence among women and children.

I. Background (refer to Annex 1 for a complete Literature review)

A. HIV/AIDS Globally and in Vietnam

An estimated 33.2 million people in the world live with HIV/AIDS (PLWA), of which 2.5 million are children under 15 years of age (UNAIDS/WHO 2007). National prevalence rates in Asia remain lower than some other continents, but due to the large populations of Asian countries, even low national prevalence signifies large numbers of PLWA (UNAIDS/WHO 2007 and UNICEF Vietnam 2006). The high-risk behaviors of injecting drug use and unprotected sex, mainly commercial sex, continue to fuel the epidemic in Asia (ibid). Yet prevention efforts have not sufficiently addressed these two issues (ibid). Men who are engaged in high-risk behaviors may also often be in long-term relationships with or are married to women where it is the norm to have unprotected intercourse (UNAIDS/WHO 2007 and MOH 2008a). The pressure to bear children in Asian countries is high, and most women would thus likely become pregnant, putting their children at risk of transmission from mothers during pregnancy, childbirth or breastfeeding (Oosterhoff 2008, Chapter 1). Hence many Asian countries are seeing HIV spread beyond the vulnerable populations of intravenous drug users (IDUs) and commercial sex workers (CSWs) and their clients to the wider society, including pregnant women and children (UNAIDS/WHO 2007 and UNICEF Vietnam 2006).

The epidemic in Vietnam is still considered a concentrated epidemic, with high prevalence rates among intravenous drug users, men having sex with men, and commercial sex workers. From 1990 until 2006, 106,288 HIV-infected cases have been reported in Vietnam (UNICEF Vietnam 2006 and MOH 2006), and UNAIDS estimates that the total number of people living with HIV ranges from 150,000-430,000 (UNAIDS 2007). Since the epidemic in Vietnam is fueled by IDUs, unsurprisingly, efforts have focused on reaching this population. However, Nguyen et al propose that the risk of HIV transmission among women in Vietnam has been underestimated (2003). They further state that "the reported data may represent as little as 16% of the real number (Nguyen et al 2003). Although modeling predicted that there would be 98,500 cases of HIV-infected women in 2005, only 15,633 were accounted for in reports from the health system. That could mean that in 2005, up to 83,000 women infected with HIV have not been detected by the health care system" (ibid). Data from sentinel surveillance conducted yearly shows that HIV prevalence among pregnant women has increased rapidly over ten years, from 0.02 percent in 1994 to 0.37 percent in 2005 (MOH 2006). The HIV prevalence rate was found relatively high among pregnant women in some provinces in 2005: over 1 percent in Hanoi and Quang Ninh and 2 percent in Thai Nguyen provinces (MOH 2006). There are an estimated 8500 children under 15 years living with HIV in Vietnam (MOH 2006).

Vietnam is estimated to have between 1.8 and 2 million births per year. Almost all women (90 percent) receive antenatal care, and 88 percent have skilled birth attendants during delivery (GSO, 2006). Close to two-thirds of deliveries take place in health care institutions (ibid). Breastfeeding is universal and continues well past the first year for a large proportion of infants, however, only 16.9 percent of women practice exclusive breastfeeding (ibid).

With the HIV prevalence rate of 0.37 percent among pregnant women, approximately 5,000-7,000 women living with HIV give birth each year (MOH 2006). Transmission rates from mother to child without any intervention ranges from between ranges from 15%-25% in non-breastfeeding populations and 25%-40% in breastfeeding populations (De Cock et al, 2000). Thus about 1,200-3,000 children would be infected without intervention in Vietnam (MOH 2006). With prophylactic treatment, this rate decreases to closer to 10 percent, hence the number of children infected could decrease to approximately 600 children per year (MOH 2006, De Cock 2000).

In conclusion, the epidemic in Vietnam has seen, and may continue to see increases in the prevalence and new infections in wider society, including among long-term female partners of men engaged in risky behaviors. Since childbearing is a strong cultural norm within such long-term relationships, both pregnant women and infants are a vulnerable group. Currently, with the low uptake of testing among these groups and sexual norms, there is a need to pay attention to prevention of mother to child transmission efforts.

B. International Guidelines on PMTCT

The United Nations adopted a four-prong approach to preventing mother to child transmission (WHO 2007). This four prong approach is aimed at protecting and supporting the health of both the mother and the child, and incorporates primary prevention as well as prevention of mother to child transmission (WHO 2007).

Prong 1: **Targeted primary HIV prevention among women of child bearing age**
Prong 2: **Prevention of unintended pregnancies among HIV-positive women**
Prong 3: **Prevention of infection from HIV-positive mothers to infants**
Prong 4: **Provide care and support of women, their children, and families infected and affected by HIV/AID**

C. The MOH National Plan of Action and Guidelines:

The Ministry of Health in Vietnam has prepared a national plan of action (2006 to 2010) to address PMTCT (MOH 2006). Responsibilities at the central level rest with both the Vietnam Administration for HIV/AIDS Control (VAAC) and with the Reproductive Health Department.

The overall objective of the MOH national plan of action is to bring the rate of mother to child transmission of HIV to below 10 percent by 2010 (ibid). The specific objectives are to ensure that the prevalence of HIV among pregnant women stays below 0.5 percent, 90 percent of pregnant women receive counseling, and 60 percent opt for testing, and 100 percent of registered women with HIV and their children receive prophylaxis and 90 percent receive post-delivery care and follow-up (ibid).

The Plan of Action includes social activities, technical activities, and management/ organizational activities. Responsibilities of various levels, such as provincial hospitals, district health stations, and commune health stations, as well as departments and administration units have been described. The Plan of Action states that PMTCT services will be expanded to all 64 provinces between 2008-2010.

D. Gender Issues in Vietnam and possible implications for PMTCT

Vietnam, especially in comparison with other countries in the region, shows good progress in improving gender equality (Vietnam Country Gender Assessment 2006). Health and education outcomes overall have improved, and economic opportunities have improved for both men and women. However, strong gender stereotypes prevail, which have significant implications for household decision-making, domestic work, and attitudes toward men and women in the workplace and society (ibid). The 2006 Vietnam Country Gender Assessment points to unequal workloads, with women working an average of 13 hours per day, and men working for 9 hours per day on average (ibid). This disparity can be explained by the fact that women contribute equal amounts of time to income generation activities, but bear the bulk of the responsibility for housework (ibid). During pregnancy and post-

partum, especially if dealing with the additional needs for care and support related to HIV, this has implications for the health and well-being of both mother and child.

At the household level, husbands are still seen as the major decision-makers in the home in contemporary Vietnam (Knodel et al 2004). Vietnamese culture is strongly patriarchal, with the husband and father as the head of the household (ibid). The family is the basic unit in Vietnam, and nuclear families are common (ibid). Family relationships are the most significant relationships in Vietnam, especially among the majority Kinh population, where community, tribal, and village relationships are often of secondary importance (ibid). Vietnamese families are thus independent and private, which means that husbands and wives are highly dependant on each other for moral and emotional and financial support. Husbands and wives may discuss major decisions, however, if there is a difference, the husband's opinion is usually the one that would prevail (ibid).

Vietnamese society places a high premium on family life, with marriage and childbirth (the latter usually soon following marriage) expected and strongly encouraged (Oosterhoff 2008, Chapter 1). The role of motherhood is valued, almost revered, and women enter marriage with the expectation that they will soon have a child (ibid). Mothers-in-law, mothers, and other family members encourage childbearing and may play an active role in pregnancy and childbirth, especially for younger, first time mothers (ibid). Son preference, especially in some parts of the country is still prevalent—as according to Confucian tradition, a son is needed to protect the lineage (Oosterhoff, in press Culture, Health and Sexuality). Decisions on fertility are to be seen within this socio-cultural context, where opinions and pressures of the overall family exert a powerful influence.

Oosterhoff (in press, Culture, Health and Sexuality) reveals a strong degree of pressure on women to bear children, associated with cultural constructions as well as familial pressures. She notes that being a mother elevates the status of a married woman, and that a married couple is considered incomplete without children (ibid). Son preference is strong, and in cases where the husband is the only male, the pressure to have a child may be greater (ibid). The motivation in such cases often appears to be a future grandson, to continue the family line. Her thesis also points to examples of sons who are drug users, even those whose positive status is known, that may have been encouraged to get married, sometimes in the hope that it will "straighten" the son out, and sometimes to have a grandchild. Women in these marriages may not have been aware of their husbands' HIV status, and would have unprotected intercourse. Even after knowing about their HIV status, they may decide to conceive anyway due to the social, cultural and familial constructs around marriage and childbearing (ibid).

While it is difficult to draw any general conclusions on sexual behaviors among married couples, it is not uncommon for married men to visit sex workers—some men may do so very seldom, while others are quite frequent visitors (Tran Duc Hoa et al 2007). Visits to sex workers are often undertaken with male friends, or with male colleagues in the context of business deals (ibid). In such cases, men will often drink alcohol in addition to visiting sex workers. Men state that it is difficult to refuse such invitations. It is not clear if men would consistently use condoms in such encounters, especially since they are often accompanied with alcohol (ibid).

At the same time, discussing sex openly with one's spouse is not the norm. While husbands and wives discuss children, finances, health, and their hopes for the future, sex remains a taboo topic. Men prefer to talk about sex with their friends, and women may do so as well with their friends, although topics like sexual pleasure would not often be discussed among women, compared with men (ibid). Men and women are thus caught in a cycle where neither can openly discuss sexual pleasure with each other, and it is considered normal to engage in sexual intercourse outside marriage for pleasure, and within the home for childbearing (ibid).

II. Purpose of the Study

MoH, with the support of UNICEF, WHO and UNFPA has conducted this study on the involvement of men in PMTCT program, including barriers and opportunities, as well as men's readiness to provide support to their partners on PMTCT intervention, including primary prevention prior and during pregnancy, as well as access and acceptance of VCT **(see Annex 2 for TORs).**

The study aims at:

a. Identifying the knowledge, attitudes, health seeking behaviors and practices of pregnant women, their male partners and the couples and the family as a unit in respect to PMTCT in the broader context of SRH, including primary prevention in the couple prior and during pregnancy;

b. Identifying behavioral and cultural determinants, barriers and opportunities for greater involvement of male partners in PMTCT and SRH;

c. Identifying existing service provision , how services are linked to better prevent mother to child transmission (including primary prevention in the couple, STIs and infant and young child feeding practices), and how they allow, or don't allow, men/partners involvement.

Based on the study, a set of recommendations and programmatic models for increasing male involvement are proposed.

III. STUDY DESIGN AND METHODS

The study team was composed of an international consultant with one senior Vietnamese researchers and four Vietnamese researchers (two male and two female). The four researchers were divided into 2 teams—one went to Quang Ninh and the other to the 2 provinces in the South. MOH and UNICEF provided technical support and oversight and handled all logistical arrangements.

A. Sites for data collection

Since the epidemic is a concentrated epidemic in Vietnam, some provinces have a much higher prevalence than others. HIV/AIDS services more generally, and PMTCT services more specifically, are offered in select districts in high prevalence provinces (see Annex 3 for a map on the sites where PMTCT is offered through the UNICEF-supported project). This study focused on gathering data from three high-risk but very different provinces in order to give a broad sense of the issues and concerns. Since PMTCT services are not provided in all districts in these high-risk provinces, both districts with services and those without were sampled.

These provinces included Quang Ninh in the North, which has a high prevalence of HIV primarily fuelled by drug use. Although it is both urban and rural, data in this province focused on peri-urban and rural areas. The second province was Ho Chi Minh City, a predominantly urban province, where the epidemic is drug-fueled as well as associated with commercial sex work, and where there are issues related to migration. The third province was An Giang, on the border with Cambodia. The epidemic is drug-fuelled as well as associated with sex work, and there is cross-border migration associated with labor as well as commercial sex. The three provinces are thus culturally and socio-economically diverse and thus, household decision-making, family attitudes, and spousal relationships also could be different.

Data were gathered from six districts in total. These six districts included three districts where PMTCT services had been offered since 2005 and three districts where there were no PMTCT services. The comparison between sites offering and not offering PMTCT services was useful in determining the levels of awareness of PMTCT and openness in discussing issues related to HIV.

B. Methods:

A number of qualitative methods were used, including in-depth interviews, focus group discussions (FGDs), observations of health services, and semi-structured interviews **(see Annex 4 for the Study Design and Workplan and Annex 5 for questionnaires)**.

The team developed lines of inquiry, and based on these, developed a set of questions and guides for the different groups of people to be interviewed. For assessment of health services, a set of structured questions and an observation guide was developed. These questionnaires were pre-tested in Hanoi at the Ob/Gyn hospital and revised. The full team participated in a 1-day discussion on the questionnaires to prepare for data collection.

The first site where data were collected was Quang Ninh, and two researchers, one male and one female collected the information with the international consultant. Reflection meetings were held daily and on the third day, a longer reflection was held. Another reflection was held after the first field trip for the two researchers who went to Quang Ninh and the two researchers who went to the South. The team cross-checked its findings on the health services with the findings from the end-of-project assessment, since both studies were undertaken at roughly the same time.

C. Data collected

A total of 115 interviews were conducted, of which 31 were in Quang Ninh, 40 in HCMC and 44 in An Giang provinces **(see Annex 6 for sites and list of people interviewed):**

- 29 interviews with health care providers
- 10 interviews with heads of sympathy clubs or mass organizations
- 19 interviews/group discussion with HIV positive women, some of whom had received PMTCT services
- 16 interviews/group discussions with HIV positive men (mostly partners of above)
- 12 interviews/group discussions with pregnant women who had not been tested for HIV or had been tested and found negative
- 13 interviews/group discussions with husbands/male partners of these women
- 11 interviews/group discussions with family members of positive men/women
- 5 interviews/group discussions with community members whose sons' wives/daughters were pregnant

As far as possible, the team attempted to interview a group of pregnant women, all their husbands and their parents-in-law. This was not always possible, as husbands of pregnant women were at work, or parents-in-law lived far away. Hence, in some cases, 2-3 interviews were conducted with some of the husbands/male partners or mothers/mothers-in-law of women who participated in a group discussion. In HCMC, because it was difficult to interview people who were related to each other, in some cases, positive men, women and mothers/mothers-in-law of positive people were interviewed who were not related to each other.

Interviews were recorded on tape, and transcribed in Vietnamese. These were then translated into English. After data collection had been completed, the international consultant met with each researcher individually to clarify the interviews, discuss preliminary impressions and check on data collection processes.

D. Analysis

After transcription and translation, an overall meeting was held to analyze the findings with researchers and MOH and UNICEF. Data were then entered into NVivo and coded, and then organized according to the lines of inquiry developed. Linkages and major familial factors that affected PMTCT service acceptance and use were developed.

The draft report was prepared by the lead consultant, and based on discussions with the researchers, researchers' summaries and analysis through NVivo. It was shared and revised based on comments from researchers, MOH, UNICEF and other international agencies. The models and recommendations were developed at a workshop following the presentation of a draft report, and included colleagues from UNFPA and WHO and international agencies.

E. Limitations of the study

Most data gathered in high prevalence provinces with a large amount of international support. So knowledge, attitudes and practices may be better than other areas.

One of the greatest challenges to the PMTCT program is to ensure a far lower rate of women who are lost to follow-up. As the findings reveal, approximately one-third to half of the women who test positive do not return for their results and cannot be traced. Having an in-depth understanding of the perceptions and realities of living with HIV among these women would shed great insight to help improve all aspects of the PMTCT program, including male involvement. Because these women and their families could not be interviewed, this study has had to make some assumptions about concerns and issues faced by these women based on data from women who are positive, their partners and their relatives.

The data collection processes in this study were challenging. There were two teams of national researchers rather than one team collecting all the data, and the international consultant was unable to accompany the full data collection. Further, transcription took a long time due to the volume of data collected, and translation was of mediocre quality for the same reasons.

This study focused on examination of male sexual partner involvement in reproductive health decision-making. As a result, interviews were conducted with women and men who either are currently in long-term relationships (almost all legal marriages) or had been widowed. This study therefore excluded those women who are not in such long-term relationships, and it must be noted that very different factors may influence their decision-making. Further, this study was not really able to investigate the influence of male family members such as fathers-in-law and fathers on women's reproductive health, as more data were gathered from mothers and mothers-in-law, and very little data were gathered from or about their influence.

Discussion on Key Findings and Major Implications for Male Involvement

Data were collected under this study along five lines of inquiry, which were:

1. What is the understanding of HIV among community members? How do pregnant women, their partners, and their families perceive HIV?

Những sự khác biệt giữa các địa bàn nghiên cứu:

Nghiên cứu cho thấy có sự khác biệt về phương pháp tiếp cận và nhận thức giữa miền Bắc là tỉnh Quảng Ninh và miền Nam là tỉnh An Giang và TP HCM. Dựa trên các số liệu còn rất hạn chế, thì khó có thể kết luận là do những khác biệt giữa miền Bắc và miền Nam của Việt Nam, tuy nhiên, văn hóa, các thành phần di cư và các điều kiện kinh tế xã hội có thể là nguyên nhân của những sự khác biệt này. Những sự khác biệt này được phân ra thành 3 lĩnh vực sau:

- **Vai trò và ảnh hưởng của các thành viên trong gia đình đối với việc ra các quyết định:**

Vấn đề này có vẻ mạnh mẽ hơn ở Quảng Ninh so với hai tỉnh thành ở trong Nam. Nhóm nghiên cứu cảm thấy một phần là do các cặp vợ chồng ở các tỉnh trong Nam có thể sống tương đối xa gia đình của họ, đôi khi là do nhu cầu việc làm. Ngoài ra còn có một cảm nhận khác là nhìn chung các cặp vợ chồng trong Nam sống độc lập hơn, họ thường có khuynh hướng giữ khoảng cách với hàng xóm, với cộng đồng và các thành viên trong gia đình họ và vợ chồng thường sống dựa vào nhau nhiều hơn.

- **Sự gần gũi giữa các cặp vợ chồng nhiễm HIV:**

Nghiên cứu này cũng phát hiện thấy nhiều trường hợp tại các tỉnh trong Nam, các cặp vợ chồng trở nên gần gũi với nhau hơn sau khi biết được tình trạng HIV của họ, hoặc duy trì được sự gần gũi giữa hai vợ chồng. Ở Quảng Ninh, các cặp vợ chồng nhiễm HIV khi được phỏng vấn đã bày tỏ sự buồn bã và thất vọng nhiều hơn, đặc biệt là trong các trường hợp khi mà người vợ không biết gì về tình trạng HIV của chồng mình. Ở An Giang và TP HCM, các cặp vợ chồng nhiễm HIV nói rằng họ sống dựa vào sự hỗ trợ lẫn nhau là chính và cùng trao đổi về tương lai và cuộc sống của con cái họ. Có những ví dụ về sự lo ngại và quan tâm của những người chồng.

- **Mong muốn có con của các cặp vợ chồng nhiễm HIV:**

Nghiên cứu cho thấy rằng áp lực phải có một đứa con, và chấp nhận có một đứa con, kể cả khi đã nhiễm HIV, ở Quảng Ninh cao hơn so với ở An Giang và TP HCM. Trong khi nhiều cặp vợ chồng ở TPHCM và An Giang thẳng thắn nói rằng họ không có kế hoạch sinh con, thì ở Quảng Ninh, các cặp vợ chồng đã thú nhận là họ muốn có một đứa con, hoặc đang cố gắng hoặc đang lên kế hoạch chờ đợi thêm một thời gian nữa trước khi có thai. Ngoại trừ các trường hợp các cặp vợ chồng đã có một con/nhiều con.

2. What are men's roles in pregnancy, childbirth and postpartum? How does HIV status affect this role? What is the relationship between HIV status and having a child? How do men and women feel about this? How do they communicate about it?

3. How are decisions about care and support during pregnancy, during the childbirth period, and postpartum made? How does HIV status (known, suspected, unknown) affect these decisions? Who influences them and how? What are men's opinions and feelings about these decisions and their involvement in them?

4. What are the perceptions and opinions about services available for pregnant women at risk of HIV/those who are HIV positive? How can men be involved in this time? What are the actual experiences of women who receive PMTCT services? How have they been supported or not?

5. What are the key dimensions of existing PMTCT services in actual locations offering services? How are they being offered? Who is accessing them? Who is not, and what could possible reasons be?

These areas of inquiry helped the team explore socio-cultural determinants and intra-household and inter-spousal communication and decision-making, which affects pregnant women's decision to access antenatal care at various points during pregnancy and to accept PMTCT. They also helped in providing insight on fertility decisions and communication on sexuality, contraception and health care.

Key findings are organized according to the three objectives of the study.

a. Knowledge, attitudes, health seeking behaviors and practices of pregnant women, their male partners and the couples and the family as a unit in respect to PMTCT

b. Behavioral and cultural determinants, barriers and opportunities for greater involvement of male partners in PMTCT and SRH;

c. Existing service provision issues and how they affect men/partners involvement.

A. Knowledge, attitudes, health seeking behaviors and practices of pregnant women and their male partners, as well as couples and the family

A.1. Knowledge and awareness of HIV, PMTCT and pregnancy care

a. HIV/AIDS

This study echoes others in Vietnam that show that **men and women have high knowledge about HIV transmission**, and are aware that condoms can protect from transmission. Knowledge of HIV and major modes of transmission was universal among all respondents. Of the 76 interviews and FGD conducted with people in the community, every one of the respondents had heard of HIV, and usually could list the three modes of transmission. In a few cases, individuals knew of only 2 modes.

Although the overall knowledge of HIV transmission, including mother to child transmission, is very high among men and women, and both positive and uninfected individuals, several misconceptions persist about transmission. These reveal a high level of fear and concern about contracting HIV, as well as underlying stigma associated with HIV. On being asked which activities were risky, for example, there was a range of understanding among men and women, and family members. Several people's responses revealed misconceptions, including thinking cutting hair or nails with the same instruments, washing clothes together, sharing toothbrushes, towels and soap and eating together, sharing bowls and chopsticks was risky.

- "I know HIV infected person so sometime I have to keep away from him/her, it can be risky too. Shaving and taking wax out of the ears can be risky too. If we share stuffs with infected people, we will be infected too. As far as I know, it can not be transmitted by mosquitoes. Shaving and cutting finger-nails can be dangerous so I bought my own instruments and use them at home (laugh)." *Male partner of pregnant woman, Tan Chau, An Giang*
- "…through blood transmission route, having sex with each other, contacting blood and getting infection, leading a life of debauchery, drug injecting, uncontrolled sexual activities, sharing the razor, tooth-brush, soap." *Family member of positive person, Tan Chau, An Giang*

b. PMTCT

On the other hand, **knowledge of prevention of mother to child transmission, especially among men, is not very high**, even in areas where PMTCT services were being offered. Although many men think that reproductive health decisions should be made by women, they are nonetheless very interested in and concerned about their children's future, and would be interested in learning about measures to help protect their wives and children's health.

- "I married at 22, had a baby at 23, and was widowed at 25. My husband had worked in Cambodia, he was not a drug user. But I think it's my husband who gave me the disease. Someone tells me I should have used condoms in sexual contact with my husband." *Positive woman, Tinh Bien, An Giang*

- "I have heard about it, but I do not have much understanding about it. I heard that infected mother could take drugs to prevent infection for the child. I advised my daughter to be deliberately careful of not transmitting infection to the child, to be aware of prevention for the child. When I saw her chewing and feeding porridge into the child's mouth – I did not let her do so. Health workers from the precinct health station paid home visit to explain and gave instructions on disease prevention for the child" *Mother of positive woman, District 6, HCMC*
- "To prevent HIV for child when pregnant, you need to go to the medical centre to be examined, after delivery, no breast-feeding. When bathing my baby I must wear gloves to prevent scratching my body as I may infect HIV to the child in this way because child's skin is so weak and new." *Positive man, Yen Hung, Quang Ninh*

Providers and community leaders felt that while messages on HIV and HIV transmission were widespread, messages on PMTCT were less frequent and had also only recently been introduced. While many people were aware that HIV infected women could transmit it to their infants, there was little knowledge about how to prevent it.

- "We don't know about it (PMTCT). It's a new program so we don't know. I only know that it is possible for HIV infected woman to bear a child who is not infected. The main method of prevention is by raising the child by milk powder (formulas). Mostly we know about it because of being counseled by the health care providers. But I have never seen this before here." *Husband of pregnant women, Uong Bi, Quang Ninh*

c. Pregnancy care

Women and female family members exhibited a high level of knowledge about pregnancy care. They were aware of the need to go to ANC on a regular basis, to take tests, to deliver safely, to rest and to eat well.

In general men were aware of the need for pregnant women to rest and to eat nutritious food, but were not very informed about visits to the health providers. On the whole, they had little knowledge of health services and the different components of ANC. Some wives informed them about what happened during an ANC visit, others did not.

- Some husbands are concerned, but some are not concerned. Some people are tired because of working, others get involved in drinking – show no concerns." *Family members, Tan Chau, An Giang*
- "For some couples the wives told the husbands they were going to have a prenatal check-up on that day, or asked if they could take an HIV test. But some do not ask their husbands because in this areas, most men have to go to work from early morning till evening so their wives make all the decisions and then tell their husbands the results after that. Furthermore, their husbands do not care much about such things." *Positive man, Tan Chau, AG*

A.2. Attitudes toward PMTCT

a. Attitudes about condom use if positive

The study found that among positive couples, many reported using condoms once they knew they were positive. Attitudes towards condom use were generally positive, however men said that they had less sexual desire compared to before. Using condoms to both prevent transmission as well as to avoid pregnancy if one was positive was also stated as a practice among several couples.

- "When I knew I got infected, I told my husband to use condoms to prevent bad things and he followed." *Positive woman, District 6, HCMC*

- "After marriage, I have been using condoms up to now, I advised her to test HIV many times, ultimately she tested and its result was negative." *Positive man, Yen Hung, Quang Ninh*

b. Attitudes about having a child if positive

Interestingly, **both positive men and women felt that positive couples should not have children**. This is contradictory to actual practice—as of course there were plenty of examples of positive couples having children. In many cases, women discover their status during pregnancy. Given this information that men and women do not think that positive couples should have children, it raises the question as to whether **different fertility decisions would be taken by some couples if positive status were known prior to conception**.

Some positive women and men stated clearly that they did not want to have a child because of their status.

- "I knew that I was infected with HIV so I did not want to have a baby in order to prevent my wife and child from HIV infection." *Positive man, Uong Bi, Quang Ninh*
- "Many husbands don't want to have baby because they are afraid that the baby will be infected too." *Positive woman, Tan Chau, An Giang*
- "I am afraid that I am very weak. I can not earn enough for life. I am not sure for how long more I can live, so who will bring up my baby." *Positive woman, District 6, HCMC*

Others talked about how much they wanted to have a child, and were either trying to conceive or wanted to take some more time before they conceived.

- "I hope to have a baby but I have lost 2 already (2 miscarriages). It is my dream, but I am so worried about the future. I hope it can happen." *Positive woman, Uong Bi, Quang Ninh*
- "We often talk to each other about sexual matters, usually if it's necessary to use some pregnancy prevention methods. But we really want to have a child now, so we don't use anything. We just talk to make love in the exact period, so that we can have a baby." *Positive man, District 6, HCMC*

A few women who discovered their status when pregnant said that they would have aborted the child if they had discovered their status early enough. Sometimes, husbands or families pressured them to keep the child.

- "Frankly, I did not want to have a baby with him, because he had one stepchild, we also had one girl; when I was one month pregnant, I wanted to have an abortion. Initially he agreed with me, after that, he said that it was immoral. When I was going to hospital for an abortion, he ran after me and said "stop, my father tell you to keep our child, we have 2 girls, it is better if we have one boy." *Positive woman, Yen Hung, Quang Ninh*
- "If I knew about this matter earlier, I would have an abortion. I am sorry, I only knew about it when I was 5 months gone." Positive woman, District 6 HCMC

Attitudes toward ANC

Almost all men and women and family members expressed a great deal of support for ANC. According to one person, it was the "civilized" thing to do. In this study, there was little resistance to receiving advice, guidance, medication or tests during pregnancy, and the general sense was that pregnancy care and childbirth were of good quality.

- "Health workers are good, enthusiastic, and smart. Women come for free ANC and free vaccination." *Mother of positive woman, District 6, HCMC*

- "The health care providers provide good services, but sometimes in health station there are some cases that they can't deliver and have to send to Province Hospital. The health care services for pregnant woman are good." *Husband of pregnant woman, Yen Hung, Quang Ninh*
- "To tell the truth, my wife goes for pregnancy tests very frequently. The medical station's officers are very kind-hearted." *Husband of pregnant woman, Tinh Bien, An Giang*
- "This is the 1st time my wife gets pregnant so I do not know. I just take my wife for pregnancy tests, I just follow whatever doctors told me to do." *Husband of pregnant woman, District 6, HCMC*

Attitudes toward testing during pregnancy

Most men, women, and family members expressed a great deal of support for HIV testing during pregnancy.

- "Most husbands support HIV testing. But we should test HIV with other tests when we are pregnant but should not during other times because the husband will think that we do not trust and believe him." *Pregnant woman, Uong Bi, Quang Ninh*
- "I think everybody needs to take HIV test, so we can know whether we are infected or not. All pregnant women should go to take the test to know the way of prevention for their children." *Positive woman, Uong Bi, QN*

Possibly the most surprising finding in this study is the extent to which women expressed having control over their decision to test for HIV during pregnancy. By making HIV testing as part of ANC, it is perceived as part of the normal set of services that everyone has to avail of during pregnancy, and there is little stigma attached to it. Further, making it a part of ANC firmly places it in the decision-making arena of women, which means that women can decide whether or not to get tested. This study strongly suggests that most husbands and family members are supportive of routine testing for HIV during ANC for pregnant women, which may not be the case for VCT.

- "For some couples the wives told the husbands they were going to have a prenatal check-up on that day, or asked if they could take an HIV test. But some do not ask their husbands because in this areas, most men have to go to work from early morning till evening so their wives make all the decisions and then tell their husbands the results after that. Furthermore, their husbands do not care much about such things." *Positive man, Tan Chau, AG*

Attitudes toward infant feeding

All mothers and most fathers interviewed were very conscious of the need to protect their children's health and state that they follow instructions as given by doctor very carefully. They are aware that they need to follow instructions carefully to benefit and protect their children. Both men and women accepted replacement feeding, and went to some trouble and expense to adhere to it. Family members also accepted replacement feeding.

A.3. Health-seeking behaviors and practices of pregnant women and their male partners:

This study finds that men's role in decisions around antenatal care and childbirth as well as infant feeding, including routine testing for HIV during pregnancy, is not very significant. However, men's role in fertility and sexual health decisions, including communicating about risk behaviors, contraception, decision to have (or not have) a child, and decisions to terminate a pregnancy, are significant.

This study finds, as have many others conducted in Vietnam, that women's decisions around fertility, contraception, childbirth, and health seeking behaviors during pregnancy, childbirth and postpartum, both with regards to their own health as well as that of their children, are influenced by a rather complex set of factors which, in turn, shape and influence women's preferences and desires. These preferences and desires interact with some of those same factors, manifesting themselves in women's behaviors and actions around their own health and that of their children.

In this study, women, men, community members and health professionals stated over and over again that **reproductive health care decisions were made by women by themselves**. It is critical to note that these decisions mostly related to those around antenatal care and childbirth, and were the end-result of interactions and influences in a woman's life outside of the health center. Further, this study finds that the high regard and trust place in health providers by Vietnamese women (and often their family members as well) may affect the degree of real choice exercised—women are reluctant to oppose the advice of health providers. In a context where the words for counseling, consulting and advice are almost synonymous, and where the line between helping a woman make a choice and advising her on the perceived right choice is blurry, it is not clear that women make full choices. Finally, some reproductive health services are free (PMTCT services are free for example). Decisions that involve expenditure, especially major expenditure, would need to be taken up with a husband. For example, one of the reasons cited for women not accepting tests was concern about the costs of such a test. As long as services are free, women are more comfortable making a decision on their own.

a. Male Involvement in sexual health and fertility decisions

Decisions about sexuality, sexual health and fertility need to be distinguished from decisions around antenatal care and facility-based delivery. Such decisions are hugely influenced by husbands and family members. Decisions on contraception are discussed between husband and wife, especially with regards to the decision to start or stop its use in relation to the decision to have (or not have) a child.

- "We seldom talk about that (sex and related matters such as contraception) but before having a baby we did talk to each other, and when we wanted to have a baby, we stopped it (contraception)." *Husband of pregnant women, Tan Chau, An Giang*

Conversations around STIs may or may not take place between couples. Unsurprisingly, men do not discuss STIs with their wives for concern that they may be accused of infidelity. Men report discussing issues related to sexuality with friends including concerns about contracting a disease, rather than their wives. They may choose to self-medicate or go on their own to a doctor. Some do feel comfortable discussing issues related to sexual health with their wives, but largely, it is still a taboo issue. Discussions on sexual health are related to issues of disclosure as well as decisions such as couple testing.

- "For example, when I went out and had sex with a prostitute and I was not so clear about that then I told my friends I had just slept with a prostitute but I hadn't used a condom; yet I had ejaculated outside not inside. So, would I be infected? That sort of thing." *Husband pregnant woman, Tan Chau, AG*
- "As for personal issues related to sex, men often talk with their friends first, then if they can not work out any solutions, they will tell their wives later. They do not tell their wives right away about their problems. The last resort is they go to see doctors or buy medicine to take. I suppose it is not quite good, but it is nature of men." *Farmers Association, Tan Chau, An Giang*

Further, the decision to terminate a pregnancy could not be taken unless the husband and family approved. Sometimes, husbands or families pressured them to keep the child even when they wanted to have an abortion (also see Case Study 2).

- "Frankly, I did not want to have a baby with him, because he had one stepchild, we also had one girl; when I was one month pregnant, I wanted to have an abortion. Initially he agreed with me, after that, he said that it was immoral. When I was going to hospital for an abortion, he ran after me and said "stop, my father tell you to keep our child, we have 2 girls, it is better if we have one boy." *Positive woman, Yen Hung, Quang Ninh*

b. Male involvement during pregnancy and childbirth

Many couples and family members reported that husbands accompanied wives for ANC visits although it varies based on proximity and employment. It appears that most men went with wives for at least 1-2 visits, especially in the first pregnancy. Men did not actually go into the facility often, but waited outside or at a nearby coffee shop. Some dropped their wives off and went to work. Several men also stated that they had a role to play in reminding their wives to go for ANC visits and to take care of themselves.

- "They (women) are more confident when being with the husband. If they are lazy for ANC visit and be reminded by the husband, they will go more often – the husband is their support, you know." *Husbands of pregnant women, District 6, HCMC*
- "Many husbands do not take their wives to pregnancy tests just because they have to go to work, but not because they do not care for their wives. However, with limited intellectual level, husbands in farming, poor households know to love their wives by trying as much money as possible, not know how to take care of, encourage their wives as highly intellectual husbands. *Tan Chau Health staff, An Giang*

One man acknowledged the need to support his wife, but stated

- "I'm poor so I have to go to earn money whole day, so do others. We are not the same with rich people who always stay at home to take care of their wives. Of course, we want to take care to our wives (his voice is sad)…" *Husband of pregnant man, Tan Chau, An Giang*

As has been mentioned earlier, reproductive health care decisions are in the domain of women. The third prong of PMTCT is therefore focused on the interaction between the pregnant woman and the provider primarily. Husbands, even if they accompany their wives to ANC or the delivery room, wait outside. There were a few situations where providers mentioned that husbands may have prevented their wives from obtaining a test, and a few where women were afraid of being told their status, but this was an exception. Some women are afraid that their status will be made public, however, and those that are concerned about confidentiality may resort to providing false addresses, or moving after a test.

In spite of the fact that most men and women stated that decisions around pregnancy and childbirth were the domain of women, they also stated that were a husband to express an opinion, or request his wife to access or not access a certain health service, she would likely agree. They also said that since husbands had a key role to play in supporting wives, encouraging them to get tested or to follow any health practices would significantly influence a woman

- In Vietnamese tradition, the men are in major and women are in minor position. When the husband decides, the wife must follow. So it's difficult for the women to propose the new things. *Positive woman, Yen Hung, Quang Ninh*

- "The husband plays an important role in health care and shares with the wife to bring up children, take/remind each other to take drugs regularly, love each other." *Positive man, District 6, HCMC*
- "In discussions, the husband raises his opinion and wife should listen to him and should not be too stubborn when discussing." *Pregnant woman, Hoc Mon, HCMC*

c. Male Involvement in decision to take an HIV test

Many people said that men were considered to have a critical supportive role in encouraging women but ultimately the decision is the woman's. People also supported it as being only in the interest of the child.

- "If I want to take a test, I can decide on my own without asking for my husband's opinion. And even if I do ask him, my husband will agree. These days, both the husband and wife make money." *Pregnant woman, Tinh Bien, An Giang*
- "I think the woman decides herself, the husband has a little impact, he does not hinder if that's good for his wife and child. Some husband can say: why taking the test when there is not disease, so much blood loss for test, but the decision is made by the wife, it's unusual to hinder the wife to take the test." *Positive woman, Uong Bi, QN*
- "I independently decided to take the test because it was good for me. After I took the test I told my husband, he said it was good to do so. I see no husband objects to that." *Pregnant women, Tan Chau, AG*

In a few cases, men and women were opposed to testing in general and HIV testing more specifically. Reasons given included fear of blood loss, pain, costs associated with testing, and so on. This is consistent with the findings of the end-of-project assessment.

- "No (my wife is not afraid of finding out that she has a disease). She is only scared about blood sampling. She is my wife so I understand her. I did encourage her. But she did not want. What else can I do? I told her that there is nothing to be scared of. But my wife described to me how blood sampling is. It is like this (he showed 2 fingers as an example) so she is scared." *Husband of pregnant woman, Tan Chau, An Giang*

In addition, men would tell their wives that they did not need to get an HIV test because they were "good men," however, this was the exception rather than the norm.

- I mean we are very serious, decent so why should we go for tests, which is a waste of effort. Anyone who indulge in pleasure should go to know how to treat the disease. *Husband of pregnant woman, Tinh Bien, An Giang*

Some providers thought that in a few cases, women had refused testing because they were afraid of knowing about their status, or their husbands did not want them to learn of their status.

- "Of course, many people in my group persuaded their wives to take HIV test but there was also a case where the husband persuaded his wife to take test but the wife did not agree. I also asked he why she did not go to take a HIV test, he said that "I have persuaded her many time but my wife did not go to take HIV test", I am dispatching a person to go to their house for counseling what is good and harm for her to encourage her to take HIV test, I predict that she do not dare to face the truth, she is afraid of HIV infection when her husband is very thin." *Sympathy club leader, Yen Hung, Quang Ninh*

There are a few places where providers and individuals revealed that where someone was suspected of being positive and refused a test, the health workers would come to their home, sometimes with a needle to draw blood.

- My husband didn't go, they came to my house to take the blood. At that time, I prepared to bear my child. They let me take the test when there was 1 month until my child's birth. I didn't know that I was infected, I only knew some days before giving birth. *Positive woman, Uong Bi, Quang Ninh*

d. Disclosure of positive status and men's responses to it

Case Study 1:

Huyen and Minh live in Tan Chau district with Huyen's parents. They have been married for several years, she is HIV positive, and he is possibly infected through her, but did not reveal his status. Minh states that he loves his wife and only child—he does not want her to work as she gets tired easily. Nor does he blame her for infecting him, from his perspective, they are husband and wife, and he loves her. He defends her and cares for her. His greatest joy is his three-year-old son. Huyen and Minh use condoms while having intercourse.

Minh cannot tell his family that his wife is infected—he is positive that his family will ask him to leave his wife, but he wants to live with her. His approach is to live joyfully for as long as he can, and to work and save money while he is still healthy.

This study finds that the **majority of women reveal their status to their male partners almost immediately**. However, men do not always reveal their status to women, and in some cases, have successfully hidden risky behavior from their wives. This study also found many **examples of men who were supportive and loving towards their positive wives**, and in a few cases, were supportive even though their wives were infected and they were not (See Case Study 1). It appeared that in the Southern provinces especially, positive couples were greatly reliant and emotionally dependent on each other, and gave each other a considerable amount of support.

Interviewed women who tested during pregnancy usually did not know about their status. Most women who tested positive informed their husbands about their status. There was no reported violence, as in most cases, the women had been infected by their husbands. In many cases, women already suspected that their husbands had engaged in high-risk behaviors and were already mentally prepared. In a few cases, the women recall being extremely shocked. In general, women stated that they reacted by being upset and angry with their husbands, but ultimately accepted this as reality.

- "I was so sad. When my husband knew, he was even more depressed than I. He could not bear that. I had to come after to console him". *Positive woman with uninfected husband, Tinh Bien, An Giang*
- "I was shocked to hear that my husband was positive. I was sure I was infected as well, as I knew we had not used a condom. At that time, I did not think about anything other than the future of my older child. I was pregnant and all I could think about was my older child, as I was sure I was going to die and also my husband and also my unborn child." *Positive woman, Uong Bi, Quang Ninh*

In some cases, their husbands had already undergone a test and knew they were positive or were aware that they had engaged in risky behavior and were possibly positive. There were a few cases where the husband was positive, and his status was kept from his partner by his family or by him (see Case Study 2). In such cases, the woman usually discovered her status during pregnancy.

- "He had the test before he got married. He did not tell his wife at first, but this could not be hidden for long so he then told his wife about that. *Mother-in-law positive woman, District 6, HCMC*

- There is one case of a man that does not want to let his wife know because he's afraid that she maybe worried, sad. He said that since he got to know about his HIV status, he has used condoms when having sex with his wife. His wife asked him "why do you use condom?" and he answered that he still young and does not want to have baby early. I have taken him here for counseling so that he can tell the truth to his wife, but he said that" If I tell my wife the truth, I will be broken-hearted and may die" *Sympathy club leader, Tinh Bien, An Giang*

e. Male support for positive wives

In most cases, wives had been infected by their husbands. There were many examples of husbands giving support, encouragement and caring for their wives. It appeared as though, according to providers as well as community members, positive couples in the South exhibited greater degrees of closeness and support, with the caveat that this is a small sample and it is difficult to draw conclusions about such differences. There were 4 cases in the South where the wife was infected and the husband was not or was infected by his wife. In 2 of these cases, the husband either abandoned or intended to leave his wife once his child was born. In the other two, the husbands were very supportive and loving towards their wives *(See Case Study 1)*.

f. Male involvement in infant care

Most positive couples (and people in general) were informed that positive mothers should not breastfeed their children, but give them formula. Messages that any mixed feeding puts infants at the highest risk, and that exclusive breastfeeding is a safer option than mixed feeding, do not appear to have been given. Neither men nor women mentioned the risks of mixed feeding, and only 1 woman stated that she exclusively breastfed for the first four months, which was against the advice of health providers. All men and women seemed to be under the impression that breastfeeding was not recommended. Guidance on infant feeding did not seem to have included information on the higher risks of mixed feeding versus exclusive breastfeeding. Some women breastfed along with formula saying that it was because the provided formula is not enough. Others exclusively breastfed initially because they were not aware of replacement feeding in time, or because they wanted to.

- "They said that, I have to prevent for my child, have not give the breast to him, but I still breastfed him exclusively for 4 months. They gave me milk, after 4 months I let him drink formulas milk (powder milk)." *Positive woman, Uong Bi, Quang Ninh*
- "I suckled my child, and fed him with my milk, because my knowledge at that time is not enough. I suckled my child totally for 3 months, after that, I fed him with formula milk. He took the examination 2 times, but he wasn't infected. He is now more than 4 years old." *Positive woman, Yen Hung, Quang Ninh*

Most women stated that they were given one can of formula on being discharged from hospital in most places where the PMTCT services have been established. They are referred to another department or facility to get additional formula. Mothers are usually asked to return once a month. Most women, especially in HCMC, reported no difficulties in obtaining milk. A few said it was a difficult process.

- "I did not feed my child formula. I was advised to, and first they told me I could get it for free from the District PMC. Then they told me that I could get it from the Sweden-Uong Bi hospital. But I could not get it from either place. Then they told me to get it from the Women's Union, but in fact, they did not have the formula." *Positive woman, Uong Bi, Quang Ninh*

Men do know about the fact that their children were replacement fed, and revealed that they knew which formula, and whether it was enough. Women are thus informing and involving men in infant care, even if decisions are taken by women. The women who had received PMTCT claimed that they formula fed exclusively. Their male partners confirmed this, and were accepting of this decision, as both felt it was in the best interest of the child. Other studies have revealed, in fact, that mixed feeding may be more common, and it is certainly possible that respondents were telling researchers what they knew they were supposed to do. **Men are not involved in decisions about infant feeding**. However, given that many men express concern for their children's health, and given that infant feeding and follow-up especially appears to be challenging, increasing men's knowledge and awareness on appropriate practices may be useful.

Replacement feeding is associated with having HIV, as breastfeeding is the norm, and many people, especially in areas where PMTCT services are offered, are aware that HIV positive women are recommended formula feeding to avoid infection.

- "They (other people who are positive or have family members who are positive) also keep secret like me. But I know one way to find out HIV infected people. The mother who doesn't give a baby breast-feed is infected with HIV." *Mother in law positive woman, District 6, HCMC*

Women thus come up with alternate explanations for formula feeding

B. Behavioral and cultural determinants that affect for male involvement

B.1. Inter-spousal communication

Most men and women said that they spoke to each other about a range of things, and were the first ones that they would confide in if there was a problem. Topics such as health, health care, work, money and having and raising children were often discussed, including contraception, contraceptive methods and stopping contraception when one wants to have a child. Topics such as sexuality and sex were considered taboo. Men expressed a range of responses when asked who they discussed sexuality with. Some said that they spoke with friends, others said they spoke with no one, and still others said they would speak with their wives. Husbands and wives rely a great deal on each other as most live in nuclear families.

- "In our life, we always talk together, with so much love. We ask together to agree or not for everything. If he wants to go somewhere, he asks me, not like another people." *Positive woman, Uong Bi, Quang Ninh*
- "For example, when I went out and had sex with a prostitute and I was not so clear about that then I told my friends I had just slept with a prostitute but I hadn't used a condom; yet I had ejaculated outside not inside. So, would I be infected? That sort of thing." *Husband of pregnant woman, Tan Chau, AG*
- "Yes, I can only talk about those issues with my wife, not anybody else. I talk with her everything that happens to me." *Husband of pregnant woman, District 6, HCMC*

Men are still expected to earn money and be the primary bread-winner. Most of the families interviewed in this study are relatively poor—they have a certain amount of income insecurity or are just above the poverty line. The pressure to earn money seems considerable, especially if the family is young. Many men stated that they worked very hard as they felt a strong sense of responsibility to

earn money for their families, and, as they worked long hours, some said they were too tired to discuss things with their wives.

- "For many people – the wife stays at home to do the house work, and the husband works to support the wife and children. Most husbands work as bread winner for the family, and the wife mainly do the housework in the family." *Family members of pregnant women, Tan Chau, An Giang*
- "He works harder all the day from having a baby, and the work seems much more. Formerly, he used to work several days in a month, the rest days are day-off before giving birth. But it now is totally different. He works at operation sites and seems not to rest." *Mother-in-law positive woman, District 6, HCMC*
- "She didn't tell anything, I felt tired the evening, and go to bed immediately, each one on the opposite side in bed." *Positive man, Tan Chau, An Giang*

At the same time, husbands' opinions and ideas are still highly regarded. Women do seek their husbands' opinions on a range of topics.

- The husband's role is very important. Most of women here ask their husband, they discuss everything. Normally women follow their husband ideas. *Family members positive woman, Hoc Mon, HCMC*

B.2. Household-level decision-making

Although men are supposed to be the traditional "heads of households" and major decision-makers, this study reveals that younger couples in Vietnam make decisions jointly. Over and over again, men and women interviewed stated that they discussed and made decisions jointly, or based on who was "right".

- "We are in good harmony, he never dominates things. I am not sure about the others." *Pregnant women Tan Chau, An Giang*
- "She decides some by herself, for other issues, she talks with me. We discuss and decide." *Positive man, Hoc Mon, HCMC*
- "Wife is equal with husband, she doesn't depend on him." *Pregnant women, District 6, HCMC*
- "We both talk and listen to the one that is right." *Positive woman, District 6, HCMC*

B.3. Expectations around childbearing

The expectation that a married couple would have a child is quite high. Not having a child would certainly be noticed and speculated on in a community, and women are under pressure in some families to produce a male heir to continue the lineage. However, while the desire to have a child is universal, some positive couples have decided or may prefer not to have a child (even if they want one) because of their concern about infection and their own inability to raise a child. In such situations where women would have preferred not to have a child, pressure exerted by family members is difficult to resist. Examples from this study show that women who might have chosen to not get pregnant or have an abortion were pressured into having a child.

Most people, men and women, do not think that positive couples should have children. They expressed concern about both the child getting infected, as well as care and support for the child after his/her parents died.

- "Women should not do so. If she is lucky that the child is not infected, but she cannot prolong her life to raise the child. If she is not lucky and dies soon, then the child may become a street child. Moreover, infected women are not healthy so they have difficulty in earning money for their life, and this burden maybe doubled when taking care of the child." *Sympathy Club, Tinh Bien, An Giang*
- "In general infected people should not have children. Now they are more knowledgeable. They know they will die soon because of HIV infection then the children will be orphans, unhappy, without care. They therefore decide to not have children." *Family members pregnant women, Uong Bi, QN*
- "I think they shouldn't. If the baby is given drug does not get infected, it will be very good. But what about the parents? Without any property, when the parents die, the baby will be left behind without adequate care. No one, including direct relatives, can take care of your children as good as you do. The baby will grow and lack of lots of things. I do think that the woman should not have children unless she has good health and wealth." *Wife of positive man, Uong Bi, Quang Ninh*

At the same time, several people, especially in Quang Ninh, stated how they would understand if a woman chose to have a child, even if she was positive, as women were expected to bear children—and the value of one's life was increased if one had children.

- "I think if she doesn't have yet a child and she has a good condition, she can bear child, because there is now the vaccine." *Positive woman, Uong Bi, Quang Ninh*
- "The community will not object to an infected woman for this action." *Family member, pregnant woman, Uong Bi, Quang Ninh*
- "In my opinion, if they still have not children, as you know, the expectation is that a couple must have children, their children are the family ties and bring the best happiness to them. If they want to have baby, they should go to counseling office to know how to take care for yourself." *Sympathy club leader, Yen Hung, QN*
- "In many cases, both wife and husband have HIV and they both want to have babies. Particularly, the husband is the unique son in his family, they necessarily have babies." *Health Staff, Quang Ninh*.

A decision to not have a child is easier in families where there has been open discussion on HIV status, and where there may be other grandchildren. In other situations, women are seen as a "vessel" for producing a grandchild, even at the expense of her own health.

B.4. Expectations of male partners during pregnancy and childbirth

Men and women all recognized that pregnancy was a special period, where women required extra attention and support. They stated that women were more tired, more emotional and needed more support during pregnancy and expected husbands to play an important role.

- "Pregnant women are more susceptible to be angry, so not everybody can please his wife. We shouldn't be angry too, because we will make them be more tired. They are not as fine as when they aren't pregnant." *Husband of pregnant woman, Uong Bi, Quang Ninh*

Men and women also reported that they helped their wives during pregnancy with housework.

- "Our couple is living alone. All the heavy works are done by husband. When the wife is pregnant, he buy more food for her. Just doing the lightly works like laundry, prepare the meals…Other heavy works are done by husband." *Pregnant woman, Yen Hung, Quang Ninh*

- "(You have to help a pregnant wife) so much (everybody laugh loudly) I don't let her do hard work when she is pregnant, and I help her to do work like cooking. *Husband of pregnant women, Tan Chau, An Giang*

In some cases, where the couple was living with parents, husbands did not help as much. Women said that they expected men to provide financial support and emotional support during pregnancy. Many women also said that their husbands asked them how they felt, about what they would like to eat, and if they had eaten enough.

- "Besides economy, sentiment is very important. Most important, the husband must be concerned about his family. Giving birth with out your relatives concern is terrible." *Pregnant woman, Uong Bi, Quang Ninh*
- "Yes, he has. He cares and he does heavy work, I do light work only. When I did this and that, he told me to rest and asked if I would like to eat anything then he would buy for me but I said I did not want to. When I am pregnant he asked whether I vomitted or not but I said I didn't." *Pregnant woman, Tinh Bien, AG*

B.5. Disclosure of positive status

Being diagnosed as positive needs to be viewed within the larger and rapidly changing socio-cultural context in Vietnam. The legacy of the social evils campaign lingers on, with some people still associating HIV and being diagnosed as positive as being the same as being socially deviant. In a country where social norming is an extremely strong aspect of society and where the state reinforces such messages actively, women and men feel a strong pressure to be seen and to operate within such socially acceptable norms. Such norms include recognition for and positive reinforcement of certain types of families, and are closely linked with Confucian and other cultural traditions. Similarly, families and individuals that do not conform are given less support and recognition and may experience a form of socio-cultural isolation. Internalizing such messages is not uncommon, and there is a vicious cycle of shame and embarrassment reinforced by social judgment and isolation.

- "There is a constrained outlook that still exists in the community: they think infection lies in somebody who indulges in pleasures or involves in evils, but not them and their families, so they do not want to have tests as they do not think they are infected. We have to offer consultancy, then they agree to have tests." *Health Worker, Tan Chau, An Giang*
- "Yes you should do more propaganda on HIV. But if you show photos of HIV infected people who are skinny, and weak, then people will be afraid of them, and infected people like us (he has tears welling up). But if you tell them the three ways of HIV transmission, they will not be scared, but to know how to prevent transmission as well. That's why you shouldn't give us leaflets with such scary pictures, that's no good at all because they will keep far away from infected people. And they may think that we are more like such people in the pictures, not our real appearance in life. (pointing himself)." *Positive man, Tan Chau, An Giang*

For men and women to make an informed choice about having a child if positive, they would need to discuss the possibility of HIV infection prior to conception and go in for testing. Stigma and discrimination of positive individuals may be one factor that contributes to reluctance of men to communicate with wives about risky behaviors, and even about their positive status. **Decisions to keep one's positive status from one's wife and family members, and for mothers of positive men to support their sons into a marriage without revealing his status are better explained when examined within such social and cultural norming**. Clearly, some mothers-in-law are aware of the ethical issues with hiding their son's status from their wives, but do so anyway out of love and

affection for their sons, a hope to see them "settle down", and a desire for a grand child—all powerful images of a happy, normal family *(see Case Study 2)*.

- "My husband was infected before married me, but he didn't let me know, all his family hide his status from me, only me who didn't know anything, it's miserable. I think he intentionally hid (his status) from me because he took the test several times. I think he knew but he hid from me. I realized just after I bore the child, but it's too late. If I have known before, I would never have had a child." *Positive woman, Uong Bi, Quang Ninh*
- "There are families that know their sons having risk behaviors and know that the sons might have acquired with HIV, but they do not want to take their sons for HIV test. When the sons get married and their wives get pregnant, then they want to bring the women for HIV test to see whether their daughters in law and their grandchildren infected or not. When the wives were detected with HIV and the wives refused to keep the pregnancy, they were transferred to the Center for HIV/AIDS Control for consultation because we did not have PMTCT program then. We knew that the families still reserved good treatment toward their daughters-in-law." *Health staff, An Giang*

In such a context, the decision to test for HIV may appear daunting to most women. Routine testing, where an HIV test is part of a "normal" package of ANC, is appealing to both providers and to women. However, for many women, concerns about others finding out about their status are a disincentive. This study was obviously not able to interview women who had tested positive during pregnancy but were lost to follow-up. A significant reason for loss to follow-up appears to be that women who already suspect their status give false addresses, for fear of having their status known, or having health visitors come to their homes (which draws attention to oneself). Other women may just move back to their mothers' homes for the period of the delivery. **Confidentiality and disclosure of results only to the woman, if practiced uniformly, would go a long way in increasing women's confidence in testing.**

- "Some mothers declared wrong addresses because they do not want their status to be known." *Health staff, HCMC*
- "According to regulations, they must go to the health centre to take HIV test, although they went to other center for HIV test or anonymous, wrong address. I think it very difficult when the government allows HIV carriers to have anonymous right, they can give true first name but wrong family name or address. Someone even swore at us when we came." *Sympathy club leader, Yen Hung, Quang Ninh*

Further, disclosing one's status, even to other positive individuals (e.g. sympathy clubs) requires a great deal of courage and self-esteem. This study found only one woman who spoke in public with confidence about being positive. Based on descriptions of joining sympathy clubs, it seems that positive individuals go through a process of accepting their status, rebuilding a sense of self-worth and overcoming the feelings of shame and internalized stigma before declaring one's status. The actual act of disclosure also brings a sense of freedom and greater self-acceptance.

B.6. Living with HIV

Many respondents, positive, not positive, health providers and community leaders, stated that compared to the past, discrimination had decreased. Certainly, communities seem to be aware that the government had sent out strong messages to NOT discriminate against PLWA. Knowledge of transmission has increased, which has contributed as well to allaying fears and concerns.

- "I don't know any infected people in the village. But I know that the government is trying to convince people not to discriminate infected people. The doctors in the medical station also consult people about HIV transmission so that we can protect our self and treat infected people normally." *Husband of pregnant woman, Tan Chau, An Giang*

However, several other people also reported that discrimination persists. It is not clear that the IEC efforts, both on increasing knowledge about HIV and on the inappropriateness of discrimination have been internalized.

- "In general, people do not like to access HIV infected people. We also feel afraid of getting closer to them because more or less harm could come. If they are not our loved ones, we may feel scared and do not want to get close. Even we know that HIV is not transmitted through shaking hands or kissing, we still feel afraid" *Family member of pregnant woman, Quang Ninh*
- "There is a constrained outlook that still exists in the community: they think infection lies in somebody who indulges in pleasures or involves in evils, but not them and their families, so they do not want to have tests as they do not think they are infected. We have to offer consultancy, then they agree to have tests." *Health Worker, Tan Chau, An Giang*

This study interviewed women in or who had been in long-term relationships with men that were legally recognized marriages. While some couples were contemplating or already separated and some individuals were widowed, in most cases, the researchers interviewed women and men who were both alive and together. For positive women, the support received by their male partners (emotional as well as otherwise) cannot be overstated. Women who were diagnosed as positive expressed feeling socially isolated from their communities, and even their families at times. In such situations, **wives do rely on husbands for emotional strength.**

Economic prosperity, in the wake of the relatively recent policy changes in Vietnam, and the related pressure to earn a living seems to be immense, especially for those who are just above the poverty level. Competition for work is fierce, and individuals who may experience illness may not be able to ensure a steady income. Many positive individuals interviewed in this study were already poor, and thus experienced both social exclusion and marginalization, as well as economic uncertainty and difficulty.

A few people mentioned that women who were infected by their husbands, especially if pregnant, were to be sympathized with. They were seen as innocent victims, and people felt that they needed to be treated with care.

- "A woman is infected, her husband is infected. The neighbors feel sorry about them and hire her to wash clothes and pay her monthly - she is a such gentle girl and they feel sorry for her." *Family member of pregnant woman, Tan Chau, An Giang*

Free ARV, whether as prophylaxis for protection of the infant, or for men and women, is a very powerful motivator. Men and women who are diagnosed as positive appear to quickly find out about where and how to obtain free ARV. This study found interviewed 11 women who received ARV prophylaxis during pregnancy—and one of them shared her medicine with her husband—to protect him. While knowledge about SD NVP is limited, and women who have received it may not even remember getting it, knowledge about ARV is much higher and is a powerful draw.

B.7. Family support and influence:

There was a strong sense that parents and parents-in-law advised, but could not make decisions for couples. In most cases, families saw their role as that of giving advice and encouragement to the young couple. Most family members said that they would encourage their daughters/daughters-in-law to follow the advice of health providers. There were no examples where a mother-in-law or mother prevented a woman from getting an HIV test, or from accessing care and support. Many mothers-in-law quietly accepted replacement feeding, recognizing that it was in the best interest of the child

- "I am a mother, I encouraged my daughter-in-law to do HIV test. If it is positive she will receive medicine. I will not maltreat. All women decide on their own, other people just encourage them. Nobody is opposed by their husband or mother-in-law." *Mother-in-law of positive woman, district 6, HCMC*
- "My son wants to have a baby but his wife says that they are both infected so the baby will also be infected. Moreover, they need to have money to raise the child and they do not know how long can they live. If they have a baby and then die, the baby will be so miserable, and what his/her future will be, it is not so simple for them to have a baby (tears is running down on her cheek)….Let's leave it there until they can earn a better living but not now." *Mother-in-law, Positive woman, District 6, HCMC*
- "They directed us that the baby must be not breast-fed. They fed him according to regulations of a medical hospital, bottle-feeding with clean hands because mother milk contains many bacteria. At the beginning, I do not know anything and ask them why the newborn baby is not fed on mother's breast and must use bottle-feeding. A nurse tell me all things about that, I thought that it must be all right, there is a need to separate the baby from his mother to be fed on bottle-feed, because mother milk contains many bacteria, is it not?" *Mother-in-law, positive woman, Quang Ninh*

Family influence seemed stronger in Quang Ninh than in HCMC and An Giang. This is partly explained by the fact that in both the southern provinces, couples seemed to be living further away from their parents. This is especially true in HCMC, where many people are migrants from outlying provinces. There were a few cases where mothers-in-law had a strong influence over the decision to marry and subsequently, put pressure on the couple to have a child in cases where the husband was positive. In such cases, mothers-in-law played an active role in pregnancy and post-partum (see Case Study 2).

Case Study 2

Loan lives in Quang Ninh with her HIV positive son, his wife and their son. She openly admitted that her son was diagnosed with HIV before he was married, as he was a drug user. Her grandson tested negative. She keeps their status from her neighbors, as she is concerned that they will ostracize her and her family. When her son was diagnosed, he had a girl-friend, and she encouraged them to get married, and did not tell the girl-friend that he was positive. Her daughter-in-law was diagnosed at delivery and was shocked to learn of her status. .

Her daughter-in-law Nhung, realizes that there is not much point in assigning blame, but is angry that no one in her husband's family told her that he was positive. She feels that were she to have known about his status before she got pregnant, she would never have had a child. Her mother-in-law, on the other hand, said she would not have let her had an abortion, and that assumed that she would have understood that since she was married, she would have a child..

Family behaviors toward a positive couple ranged from extremely supportive and loving to tolerant with great caution taken over infection, especially when living together. Many positive individuals reported receiving a great deal of support and care from their families. This support included significant financial support in some cases, especially where the man was unable to bring in a steady source of income, usually in cases where drug use occurred. Some family members also participated in clubs, in order

to better support and be aware of how to help their positive family members. There were also several PLWA who reported that they had kept their status from family members, and some where the family either ignored or had cut ties with the couple.

- One positive man *(Tan Chau, An Giang)* said that he had not told his parents that he and his wife were infected "Because I am afraid that my parents are worried and separate us, so no-one will take care of my wife and child…(hís voice is choked by tears). So I have to keep silence until now and not let anybody know, absolutely. He said his wife's family, on the other hand, knew that they were infected and their behavior toward them was, "So kind, the normal attitude as before. In general, when my wife ant to eat something, anyone among her brothers and sisters, even her mother, can goes out to buy it for her"
- Hien (infected woman) and her brothers now are living with me. The youngest brother loves her so much. He always buy things that she likes. They understand and love each other, because their sister died of HIV. I love her and her son. I am her mother so I am responsible for them. The son was infected with HIV and cannot prolong his life. Her husband's family does not pay attention on them. They does not love their son, so they can not love his wife. They know the situation, sometimes give 2,000 – 3,000 VND to their grandson." *Mother, positive woman, Tan Chau, An Giang*

Family support seemed tremendously important to positive couples, especially women, since most people admitted that neighbors and members in the community were not likely to be asked for help.

C. Existing service delivery issues and their effects on male involvement

C.1. Coverage

PMTCT services are only offered in select districts in high-risk provinces in Vietnam. Three things stand out with regards to service provision in this study, which are likely because the sites mostly do offer PMTCT services. First, all pregnant women are offered testing (and in many cases agree to it) relatively early in pregnancy in these sites, especially in the last several months. Second, the quality of post-test counseling for positive women appears high. Third, formula is recommended, is available (although women have to travel to a facility to get it) and is free of charge, although of insufficient quantity for most babies.

C.2. Testing

The end-of-project assessment found that, on average, 100 percent of pregnant women are offered tests, 62 percent agree, and of those who text positive, 62 percent receive treatment and counseling. This means that approximately one-third of women refuse tests, and one-third of those who test positive, are lost to follow-up. **This study finds that male partners' disapproval or refusal to let wives test, or fear of violence or abandonment are not a significant reason for either refusal to test or loss-to-follow-up**. Rather, issues of fear of blood tests, fear of being publicly declared as positive, or concern about community stigma are stronger disincentives.

a. Routine testing works

Provider-initiated testing during routine antenatal care has been the right move in Vietnam for PMTCT services. Trust and confidence in health care providers, especially related to pregnancy

care, is high. Facility-based deliveries, regular attendance of antenatal care visits, and receiving counseling and testing during pregnancy and childbirth are familiar to Vietnamese women.

A range of "choice" is perceived by women in terms of opting out—many think they should test because that is what the provider is asking them to do. Only a few actively choose to get tested, and fewer still ask for the tests themselves. In some cases, women are told it is a blood test, not that it was a test for HIV. Providers admit that they do not always tell women why their blood is being drawn. Many women are not aware of being tested for HIV during labor, they may think the blood test is for any diseases.

- "Many women were afraid when hearing about HIV testing at first, but they agreed to take the test after hearing the health staff explained about that." *Health Staff, Tan Chau, An Giang*
- "Apart from prenatal checkups, I had 2 blood tests at the request of the doctor. Doctor said to have blood tests to check if I got any disease with no further explanation." *Pregnant women, District 6, HCMC*
- "The Staff members at the Health Station told me to go for a pregnancy check-up, blood test and mentioned nothing about HIV Testing." *Positive woman, district 6, HCMC*
- "Testing is given during the labor – just the suspected case, taking blood for testing. No pre-test counseling is given because we do not want to say it frankly with the indication of HIV testing. We just say about the need to take blood for testing." *Health staff, Tinh Bien, AG*

b. Confidentiality of test results is a major disincentive

In places where there are no PMTCT services, providers may encourage women who they think are drug users, sick, or deemed "suspicious" to get tested. This associates HIV testing with socially-unacceptable behaviors, and increasing stigma associated with taking the test, as well as with being diagnosed as positive.

- "Suspected HIV infected patients are given encouragement to take the test. If they agree, we can let them do HIV testing. If they agree we charge the fee. No signature for the commitment prior to the test. The staff of the clinic takes blood to do the test." *Health staff, Tinh Bien, AG*
- "If the pregnant woman has a husband who is involved with risky behavior like drug addiction, going with prostitutes, we will advise them to ask the husband to take HIV test. Last year, we advised one couple like that, but the results were negative. Risky behaviors include drug addition, working as drivers who are often far from home, going with prostitutes… managing restaurants or hotels." *Health staff, Uong Bi, Quang Ninh*

Other studies have pointed out to challenges with confidentiality of test results in Vietnam. The findings of this study are consistent, that perceived or real fear of others finding out about their status is a big concern. In addition, there were some examples of results being shared.

- "I receive HIV test results from the center of higher levels." *Sympathy club leader, QN*
- "The authorities at the commune level receive a piece of paper with all the people in the commune who are HIV positive." *Positive woman, Uong Bi, QN*
- "Positive results will be sent to the planning bureau of the municipal preventive health care center. We provide names, addresses and results, and have a monthly meeting to discuss loss to follow up" *Health staff, HCMC*

c. Getting male partners to test

There were no examples of couples coming in for tests together during ANC. Even after the woman's result was known, few men agreed to come in for testing to the health service. In many cases, the

husband knew his status already (see section on being diagnosed with HIV and revealing positive status). Some men agreed to be tested but not at the ANC centre and not with their wives.

- "For positive cases, during post-test consultancy, we always mobilize those women to take their husbands to tests, but none of them takes their husbands to the surgery for tests yet. They all go to other places for test, perhaps they hesitate to go to pregnancy testing wards." *District PMC, Hoc Mon, HCMC*
- "Many pregnant women are taken to the center for pregnancy tests by their husbands, but none of these husbands has a test with his wife." *Health staff, CHC staff, district 6 HCMC*

Some men refused to go for tests themselves, most likely out of a sense of denial.

- "Yes, I did tell him to go for a test, but he did not follow my advice. At the time, he was very upset, but he still encouraged me and I encouraged him. But then when I delivered the birth, I did not have time to take care of him, he got addicted to scag again. I told him but he did not listen to my advice." *Positive woman, district 6, HCMC*

d. Post-test counseling

It appears that quality post-test counseling has been practiced relatively recently and only in select locations. Individuals who were diagnosed as positive a few years ago or in places where there has been no training, did not receive sensitive and appropriate post-test counseling.

- "They didn't tell me anything. Even after she gave birth, they didn't care about us, they left us alone. (speaking to others): They left us alone there in the hospital. After my wife gave birth, they didn't give her any medicines to take; until I asked them what medicine she had to take, did they tell me, then I had to go to the drugstore to take her some. The doctor didn't (do a blood test). He just stood there saying this and that. I listened to other people telling me to ask them for a test. Then they called me for the result before we left there. They didn't do any counseling or advice, anything at all." *Positive husband, District 6, HCMC whose wife delivered a baby at a non-PMTCT hospital*

More recently, individuals stated that providers were sensitive, caring and sympathetic during post-test counseling and more generally.

- "Healthcare staff at the community health station also provide me with counseling. I think they were friendly… Yes (it was) very useful. These counseling sessions help me understand that we should not stigmatize persons living with HIV. In addition, we know how HIV is transmitted and how to prevent contracting HIV." *Wife of positive man, Uong Bi, Quang Ninh*
- "Every time I go to the commune health station, I always stay to talk with people there for hours. They encourage me a lot." *Positive woman, Tan Chau, An Giang*

Service providers in Vietnam are usually overburdened. For example, it is not uncommon to see women sharing beds in hospitals post-delivery. Service providers thus make their own decisions with regards to use of time and resources, given the constraints that they operate under. They may, for example, choose to forego individual pre-test counseling due to the large numbers of women that attend ANC, especially if facilities offer ANC only on certain days in a month. They may either choose to do group education, or very quick individual information sharing. With regards to post-test counseling, great care is given (in facilities that have received training) to follow good practices for women or men who test positive. In the case of routine testing, however, **the vast majority of women, even in high-risk provinces, test negative. Limited counseling is given to these women, or even information about future protection**. Again, this is a provider judgment based on time

and resources available. Women thus are lulled into an even greater sense of security—they have been tested, and found "okay" or "normal". Therefore, their husbands are "normal" and "good""—they are not "playboys". **Negative status is seen as a stamp of fidelity and good behavior**. There is a lost opportunity to counsel women who test negative and their partners about primary prevention of HIV infection and about the window period.

C.3. ARV prophylaxis for PMTCT and ARV for adult men and women:

Many women are counseled on testing the first time they come for ANC in locations where PMTCT services are established, which varies by individuals. If positive, and if ARV is available in the places where they live, they receive free ARV after 28 weeks. Positive women get referred to places where ARV is provided. This study interviewed 11 women who received ARV prophylaxis during pregnancy, some receiving it for just a few weeks, and others for 2-3 months. A few places provide free CD4 testing, but it is not free in all places. The most consistent support has been SD NVP during labor and to the infant after birth. Most women and their husbands have little memory of SD-NVP, and their babies receiving it after delivery.

- "No medicine was given pre and during laboring." *Positive woman who received PMTCT, Hoc Mon, HCMC*

Getting free ARV is one of the greatest motivators for testing and seeking care.

- "(Our hopes are that) when we give birth to our child, she/he won't be infected with HIV. We are poor, so we hope to be helped like to take free medicine." *Positive man, District 6, HCMC*
- "The doctors give medicine to extend my life, I'm very lucky. I don't have money to buy it outside." *Positive man, Tan Chau, An Giang*
- "If they (pregnant women) are infected with HIV, health centre gives them medicine to protect their children from HIV." *Sympathy club leader, Yen Hung, Quang Ninh*

C.4. Infant care:

Formula was widely recommended as the preferred method for infant feeding for infants born to positive women. However, women and men have to travel to select facilities to receive it, once a month. It is usually insufficient, and sometimes only provided for six months.

- "Secondly, at present, the commune level is not permitted to provide medicine, milk to infected, pregnant women so those women have to go up to the suburban district/district level to get milk, medicine. It means they have to pay cost for going there though they do not have money because most of them are poor." *Health staff, HCMC*

Exclusive breastfeeding does not seem to be recommended as an option. None of the men or women interviewed mentioned it, and all mentioned formula feeding as being the only suitable option.

- "I don't know, 3 days after the birth, they separated me and my child, didn't allow me suckle, then the doctor talks to me and let me know (about her status)." *Positive woman Uong Bi, Quang Ninh*

Follow-up and testing for infants proved more challenging. It was not clear from this study whether men and women were fully informed about when to test babies for HIV—some tested quite early, others much later. Testing for babies was done at various times, at 2 months, at 6 months, or at 18 months.

D. The rationale for greater involvement of male partners/husbands, and barriers and opportunities for male involvement

D.1. Rationale for male involvement

Women exercise a great deal of choice and freedom over reproductive health care decisions that ultimately affect their own bodies. These are certainly influenced to a greater or lesser extent by societal factors and by family members, but women still perceive themselves to have a degree of freedom. In particular, the decision to test during routine ANC seems to rest with women. From a women's rights perspective, efforts that diminish this right would be unethical.

PMTCT services in Vietnam have focused more on prong three of the comprehensive approach, which is about prevention of infection in infants. This study also finds that women, men, families and service providers associate PMTCT primarily with prong three, and even more simply with two things—replacement feeding, and ARV prophylaxis. An expansion and deepening of PMTCT among service providers as well as communities seems warranted, especially when looking at male involvement. While this study reassures program managers, policy makers and service providers that, unlike other settings around the world, in Vietnam, male partners, in fact, are unlikely to prevent women from testing during pregnancy and accessing ARV prophylaxis, or even in unduly influencing their feeding decisions, it also is a reminder that PMTCT entails much more than protecting the infant from infection.

On the other hand, fertility decisions (to become pregnant or to terminate a pregnancy) are jointly taken by men and women and influenced by societal and familial influences. Sexuality and sexual health, while not often discussed, are obviously also critical in PMTCT. Male involvement in primary prevention of infection in women (prong one) and in prevention of unwanted pregnancy (prong two) thus emerges as a clear need from this study. As mentioned in the key findings, many men are reluctant to discuss risky behaviors and possible HIV infection with wives or girlfriends, and may even be reluctant to disclose their positive status. Women are thus placed in a vulnerable position, where they engage in unprotected sexual intercourse and enter pregnancy without this information. This study shows that some women, in retrospect, might have made different decisions regarding marriage, unprotected sexual intercourse and pregnancy, even termination of pregnancy, if they had had information about their husband's HIV status.

Finally, male involvement in infant and young child care also emerges as an area needing attention. Support for exclusive feeding (either formula or breastfeeding) is essential for women, especially since exclusive breastfeeding is not commonly practiced and replacement feeding poses its own challenges that may, inadvertently, result in mixed feeding.

Factors Affecting women's RH decisions

D.2. Barriers to men being more involved

a. Reproductive health is women's domain

The biggest disincentive for men playing a more active role in women's care during pregnancy and childbirth is that it is seen as women's domain, and therefore not of interest or of importance to men. Men see their role as passive, which may range from offering active support and encouragement to indifference.

Also, couple counseling, and partner testing through the antenatal care system is almost non-existent. Husbands who do get tested after learning of their wives' status do so at other facilities, where there is greater anonymity and assurances of confidentiality.

b. Reproductive health services target women

Female service providers, calling the services maternal and child health services, hours of operation, lack of space for men, poor understanding of men's own needs for sexual and reproductive health—these were some of the reasons cited by men, women and providers for men not participating actively in health services during pregnancy and childbirth. Service providers, while acknowledging the importance of men in the household, do not see men as active agents and participants in the health care setting. Some service providers assume that certain types of men are responsible for infecting women, and do not have a great deal of respect for them.

c. IEC efforts target women

IEC materials and information about PMTCT solely focuses on preventing transmission in the infant, and is targeted to women and their female family members. It is available through the health centre, and seldom a topic of discussion at more male-focused events or meetings. The main messages that have been taken away are about prophylaxis and replacement feeding rather than breastfeeding. Both of these involve intervention by health providers and by women—and are communicated as such. Avery few individuals are aware that higher-level facilities offer better protection—which is a decision that may be taken jointly by husband and wife, especially since it involves resources. All of the above approaches reinforce the message that PMTCT is a) only about protecting the newborn and b) only the responsibility of women.

d. Men are focused on earning money

It is well known from research in a number of countries that men feel an extra pressure to ensure that the household finances and income security is assured during pregnancy. Vietnamese men, based on this study, appear to be no different, and feel an immense pressure to earn money. In families where couples decide that want wives should work less or stop working, there is an increased pressure on men. Further, this study interviewed families who were relatively poor, and in the context of Vietnam's strong economic growth, felt an even greater pressure to be able to compete and reap some of the benefits of such growth. This pressure leads to long working hours and difficult working conditions and results in men being unable to find much time and energy to devote to women's or children's health.

e. . In some families, mother-in-law plays a strong influence

In a few families, especially where the man was a drug user, the mother-in-law exerted a much stronger influence on the woman's reproductive health behavior than the husband himself. Husbands in such situations seemed disengaged, and were uninterested in their wives' future or even their children. Mothers-in-law were very strong in such situations in caring for the infant and the young

mother. It appeared as though all the emotional investment was in the infant, and the father was excluded from decision-making and active support—almost as though he was not as relevant. In other families, mothers and mothers-in-law played a significant role in protecting their daughters-in-law, caring for the infant, and caring for the health of the couple.

D.3. Opportunities for male involvement

a. Men do support and influence their wives and their opinions do count

Although there is wide range in how male partners are involved in pregnancy and childbirth, it is clear that men's opinions and recommendations, when given, are taken seriously. A number of respondents stated how important their partners' support was during pregnancy and in the post partum period. While earning money for the family seems to be the number one priority, other types of support, including helping with household chores and paying attention to one's wife's health were also expected from men. It was also clear that were a husband to express interest or an opinion, his wife was unlikely to go against it. Further, there is social endorsement in many ways for men to support their wives during pregnancy—several respondents stated that men who did so got praised and commended by their neighbors. Such involvement can include attending ANC visits with women (which happens very seldom) and also supporting women in the decision to test and in infant feeding practices.

The pressure to earn money stems from a desire to provide the best for one's family—and men acknowledge their roles as the heads of households, and therefore assume responsibility for overall well being for the whole family. Responses given by men and women, as well as providers all implied that, if PMTCT messages were conveyed in the context of family well-being and family responsibility and taken out of the health care setting, men might pay them greater attention.

b. Men's involvement is much more critical in the first two prongs of PMTCT

The current PMTCT efforts in Vietnam have focused less on the first two prongs of the UN comprehensive approach to PMTCT. The first two prongs, which relate to primary prevention among women, and prevention of unwanted pregnancy, offer great potential in protecting and enhancing women's health in Vietnam. There is acceptance, in a very broad sense, for using condoms—but to introduce their use in couples where there is no perceived risk is tantamount to assuming infidelity or other socially frowned upon behaviors. Post-test counseling for women who test negative is nonexistent. This is an opportunity to reach out to women and their partners about the importance of primary prevention.

According to this study, many positive couples do not wish to have a child, and may need support and explicit social endorsement for such decisions; especially given that they may experience equally strong pressure to have a child. While most individuals stated that positive couples should not have children, in reality, there is also a tacit understanding that women want to be mothers and hence may choose to have children. While any actions must carefully ensure that childlessness is not associated with being positive (as that would create further stigma and a sense that positive individuals are socially "deviant"), increased support for deciding not to have children may be warranted.

Condoms are acceptable for both disease prevention and for pregnancy prevention, if status is disclosed and accepted. Sympathy clubs seem to play an essential role both in increasing acceptance of condoms and in increasing access to condoms. It is not clear from this study whether, in couples where a woman tests negative, condoms would be acceptable, or indeed even their acceptability more generally in long-term relationships where neither partner was disclosed as positive.

Further, this study interviewed several positive individuals where a husband had kept his status from his wife. In one case, health workers were counseling and encouraging the husband to disclose his status to his wife. However, as long as there is a great deal of stigma associated with being positive, men may continue to feel little incentive to disclose their status. Men, and their families, need to be encouraged to disclose their status to their partners so that decisions about marriage, childbearing and sexual intercourse can take place with full informed choice.

There were a few individuals that expressed support for mandatory HIV testing prior to marriage. Interestingly in An Giang, some couples were under the impression that it was mandatory to undergo a test, and while one couple interviewed did so, others found ways to "avoid" it. One person expressed disapproval for mandatory testing, on the basis that two people who loved each other would be heartbroken if one of them was found to be positive right before a wedding. Based on these examples, mandatory testing may not prove to be a successful strategy. Further, this would not offer any protection individuals who have sex outside of marriage or before marriage, the latter of which is supposedly on the rise.

c. . Opportunity for improved spousal communication

Post-test counseling and follow-up for women who test positive during pregnancy are an entry point for partner testing, counseling on decisions related to pregnancy termination as well as protection for women who test negative from possible infection. (Add more)

d. Women look to men after learning about their status for support and empathy

Given the considerable stigma associated with being positive, in conjunction with issues related to poor health and income insecurity, mean that positive women are much more likely to depend on their husbands for financial and emotional support. Women who are positive experience both internalized stigma and shame, as well as discrimination from neighbors if their status is known or suspected. While it may be true that such discrimination is not as overt as it may have been in the past, many women in this study said they were depressed, sad, and unable to function for days after receiving their diagnosis. In such situations, husbands can play a powerful supportive and motivational role.

IV. RECOMMENDATIONS

A comprehensive approach to PMTCT requires a program that focuses on all four prongs of the recommended UN approach. In Vietnam, men can play a critical role in the first two prongs of PMTCT, and indeed, as one service provider stated,

- "We can not wait until when women get married (to start with PMTCT efforts). It will be too late if their wives get pregnant already; they (men) must be supported early; IEC must be carried out in the society, with special importance given to schools (at present, IEC in schools is ignored), they must have sex education and education of men and women's roles." *Health worker, HCMC*

Women and men need information and support prior to conception, even prior to marriage.

A. General recommendations on behavior change communication (BCC)

1. Develop and implement a strategy for BCC that focuses on primary prevention and avoidance of unwanted pregnancy:

A framework that includes key messages that are focused on the first two prongs of PMTCT and identifies a range of approaches to reach men as well as women, is a first step to reaching out to men and increasing their sense of responsibility for PMTCT. In such a framework, one major challenge that needs to be addresses is early disclosure of HIV status by men and communication on risky behavior. Since disclosure is so closely linked to existing stigma of being positive, the messages and communication approaches must portray being open about one's status with a potential/existing partner keeping this in mind. Such messages thus need to convey emotionally rewarding benefits of disclosure.

Men, as well as their family members (especially potential mothers-in-law) need to be targeted for these messages. The pressure live up to the image of the ideal "married with two children" family is tremendous. These messages also need to be conveyed to the larger community to generate support, positive reinforcement and sympathy for disclosure and the decisions that may follow such disclosure, rather than social isolation and judgment for making choices that differ from these social norms.

Another set of messages needs to focus on early diagnosis, preferably before conception. There is a great deal of support for routine testing during pregnancy. It may be therefore be possible to introduce voluntary counseling and testing for HIV as part of a pre-pregnancy or "wedding" health package (since most women try to have a child quite soon after marriage, as that is the social norm). While any sort of mandatory testing would be unethical, not to mention most likely unsuccessful, messages on the benefits of testing for HIV and other health issues prior to conception may be effective.

Another critical set of messages needs to focus on condom use. This study finds that men and women do accept condom use in long-term relationships. It also finds that men are aware of the need to protect and interested in the health of their wives. These can be powerful incentives and images of strong men who care for their wives by using condoms may be effective. It is also important to include in these messages protection for women who test negative from future infection—as currently most women who test negative assume that they are "safe" from HIV.

A fourth set of messages needs to focus on social endorsement and acceptance for the decision not to have a child. This is a difficult "sell" in Vietnam, where children are highly valued, and a childless couple also faces a great deal of ostracism. For many women especially, the decision to not become a mother is contradictory to both personal as well as social expectations. However, this study finds that enough women who learn that they are positive during their pregnancy would have preferred not to have had a child. Early detection, if practiced well, can help women in making a decision about continuing a pregnancy once diagnosed. Diagnosis pre-pregnancy, however, and support for the decision to not have children also need to be made more acceptable than they are now. Care must be taken not to associate being without children as a declaration of HIV status, and also not to create additional social stigma for couples who are positive who do decide to have children.

While mass media and print media remain options for BCC on these above messages, interpersonal communication and community-based education may be more effective in communicating some of

the nuance of the issues above. Positive images of HIV positive individuals—portraying strength and courage and making strong courageous decisions (e.g. early testing, decision to not have children) in mass media seem important—both to decrease stigma and to bring hope and strength to PLWA. Mass media efforts will unlikely be sufficient in really bringing about some of the behavior change—such as pre-pregnancy testing and disclosure and hence interpersonal communication and peer education would be effective as well. In this study, several individuals mentioned that men found it difficult to find time to attend meetings, and hence using mass organizations to provide information through seminars or meetings may only reach a proportion of men. Sympathy clubs appear to make a big difference, and one option would be to ask members of sympathy clubs to educate community members, especially young married men and women, about HIV.

2. Ensure men are included in IEC efforts for prevention of transmission to the infant:

This study does show that most men do not attend ANC and even those who do accompany their wives may wait for them at a close-by venue. However, there are a few men who are actively involved in their wives' antenatal care and most men do accompany their wives for delivery. Positive images of men supporting their wives in attending ANC and obtaining HIV testing, in following ANC regimens and in adhering to ARV regimens would reinforce existing positive health seeking behaviors. Further, messages that show men supporting women in exclusive feeding, either replacement feeding or breastfeeding are urgently needed.

B. General recommendations for service provision

1. Improve PMTCT services focused on Prong three to encourage men who want to be involved

Men interviewed in this study stated that the care and protection of the health of their children was of a high priority. While men may think of reproductive health care and decisions around ANC to be the domain of women, they are much more interested and engaged in decision-making around child rearing. Positive women who are counseled about infant feeding would benefit from additional support from their husbands, and their husbands would benefit from accurate information given directly to them. There are two specific actions to consider. First, the current policy on not permitting men to attend the birth of their child could be changed. Some men may want to attend the delivery (and many do accompany their wives) and in doing so, may be more aware of their wives and newborn infants receiving SD NVP. The second, more important action, is to actively engage men in information on infant care and infant feeding. This study found several misconceptions on infant care, particularly an exaggerated sense of risk of transmission from parents to infants after birth, which are unnecessary and would simply deny essential physical contact and affection between parents and newborns. This study also found a possibly inadequate understanding about the risks of mixed feeding. While this can be addressed by targeting women with more accurate messages about infant feeding, men can play a powerful supportive role, and should also be targeted.

2. Increase opportunities for couple counseling/education

The study found no examples of couple counseling. Men and women who are unsure about their status and who may wish to test or remain child free if positive will need a considerable amount of emotional support, given the norms for childbearing. Women, if supported by their husbands, are far more likely to be able to exercise such a choice. The study revealed sufficient possibilities for

couples to make such choices—there were examples of positive couples who had decided not to have children, and sufficient numbers of men felt sadness at having infected their wives. While some men may be reluctant to go in for couple counseling before or even after knowing about their HIV status, especially to a health service that was not private, others may be willing. Having some male counselors would increase the comfort level of men, and having couples as community peer educators may also be an effective model.

3. Improve counseling services to ensure that men support women in making healthier decisions:

Pre-pregnancy packages would need to include counseling for couples that choose to test before conception. Such pre-test and post-test counseling would need to be done with great sensitivity, as most couples would be hoping to have children, and may not be mentally prepared for a positive test result.

Several women stated that they would have either not conceived or terminated a pregnancy had they known about their positive status earlier than they did. Decisions to terminate a pregnancy if a woman is detected early enough would be taken jointly by men and women. In most cases, even if a woman agrees to test relatively early, by the time she receives her result, it may be too late for a termination. Improved testing practices, along with partner counseling, may support women in their desire to terminate a pregnancy.

C. A possible pilot model for increasing male involvement in all four prongs of PMTCT.

Below is described a pilot model that can be tested in the pilot UNICEF-supported districts for 2-4 years, and assessed for its impact on male involvement prior to expansion. It is based on the Communication for Development model of JHU/CCP, and identifies the three areas of change that need to be addressed for PMTCT: the individual level (behavior change), the community level (social support) and the program/policy level (enabling environment).

In Prong One, the most critical behavior change at the individual level is encouraging condom use among men who test positive. This requires more men to test and more men to reveal their status. As this study finds that stigma and discrimination and fear of being rejected discourage testing as well as disclosure, this model proposes community outreach and education, as well as mass media efforts to encourage men to test and disclose their status to their wives/partners. Enhanced services, such as free testing for men who are about to get married or for wives of men who test positive will also encourage testing and disclosure.

In Prong Two, the most critical behavior change is to avoid pregnancy if one does not wish to have a child. This study finds that several women either stated that they did not plan to have children, or wished that they had known their status before pregnancy in order to have prevented it. For this to be a real option, pre-pregnancy testing for the couple through packages that include wellness and general health information and testing are proposed. Early testing in pregnancy, and rapid sharing of results would make it possible for those women who wish to terminate their pregnancy to exercise that choice. For those women who wish to continue with their pregnancy, earlier uptake of ARV can help the infant. In Prong Two, strengthened couple counseling is essential to support any of the options—not to conceive, to terminate a pregnancy or to continue it, as men will play a significant role in decision-making.

In Prongs Three and Four, male involvement during pregnancy and childbirth can be of a supportive nature. It is proposed that men be invited for special days to learn about pregnancy and childbirth, as well as PMTCT, and that men be involved in counseling about infant feeding and infant care. Finally, much stronger counseling for women who test negative is recommended to avoid future transmission.

The desired changes at each level are described with strategies and activities for implementation, by each prong.

Objectives	Strategies	Target Audience	Where and who implements
Prong One: Primary prevention among women of RH age			
To increase condom use among couples at risk of HIV or where partner is positive			
Sub-objective: To raise awareness on high-risk behaviors, the importance of testing, and communication with partners about positive status	-Offer peer education to men on the importance of testing to prevent infection among wives through community outreach.	Men	Sympathy club/mass organization peer educators/CHC staff
	-Counsel men who test positive about prevention of infection about bringing their partners in for testing and disclosing status	Positive men	VCT centers at various levels of health service
	-Use mass media to promote positive images about disclosing status and using condoms to prevent infection	Community and family members	Mass media (television, radio, billboards, and print media)
Sub-objective: To improve services focused in primary prevention	-Hold male reproductive health days once or twice a year in communes, where men are informed about STIs and HIV and protecting female partners. This should be linked with referrals to VCT sites. Ensure male doctors are the service providers	Men	CHCs
	-Offer free voluntary testing for men who are about to get married at VCT sites	Men	VCT centers
	-Offer free voluntary testing to partners who come in	Women	VCT centers
	-Offer couple counseling and family education on PMTCT and on primary prevention as an approach to PMTCT.	Positive men/ sero-discordant couples	VCT centers
	-Promote condom use through social marketing and other BCC approaches	Positive men/ sero-discordant couples	Mass media, print media, community outreach
Sub-objective: To encourage family members and communities to support testing and to reveal positive status of men to wives/partners	-Use mass media and community awareness campaigns (through mass organizations) to raise awareness about all prongs of PMTCT and to promote positive images of positive individuals	Men and women of reproductive age	Sympathy clubs, CHCs, mass organizations and mass media

	-Promote the benefits of disclosure by portraying positive responses from partners and communities to men who disclose their status to partners and protect them	Men and women of reproductive age	Mass media, sympathy clubs, community outreach
	-In situations where a mother is aware of her son's positive status, provide information and education to her about PMTCT, including primary prevention (CHC staff).	Mothers of positive men	CHC/District PMC staff
Prong Two: Prevention of unwanted pregnancies			
To encourage women and men to make an informed choice about child bearing if HIV positive			
Sub-objective: To encourage testing pre-conception and decision-making about childbearing if positive	-Offer pre-pregnancy health packages that include HIV testing. These should include a high quality component on pre and post-test counseling for positive, sero-discordant and uninfected couples. For positive couples, discuss childbearing preferences and offer condoms if no intention to have children. If intending to try to conceive, offer information on prongs three and four. For sero-discordant couples, discuss prevention of primary infection as well as childbearing preferences. For couples who test negative, offer information about risks of HIV for future protection.	Couples intending to conceive	District PMC/CHCs
Sub-objective: To support women who test positive in exercising their childbearing preferences	-Offer HIV testing in early pregnancy and ensure positive results are also shared rapidly -Modify policy/guidelines on testing and sharing of results to enable more rapid response	Pregnant women	MOH Central/ Disrict PMC/ CHCs/Provincial hospitals
	-Provide post-test counseling, including information on childbearing preferences. Support women in pregnancy termination if it is their preference. If they choose to continue with the pregnancy, offer information on Prongs three and four. Invite male partners for a counseling session	Pregnant women who test positive and their male partners	Health staff at testing sites
Prongs Three and Four: Prevention of infection in the infant and care and support for the mother and infant			
To encourage husbands/male partners to support women's decisions on RH and infant feeding	-Hold male partner days at CHCs to provide information about pregnancy care, including PMTCT	Male partners of pregnant women	CHC
	-Strengthen couple counseling services for women who test positive, sending invitations to male partners at the post-counseling session to come for a meeting to understand PMTCT	Positive couples who are expecting a child	CHC/District PMC

	-Use mass media and community outreach to provide information about ARV prophylaxis, SD NVP and the importance of exclusive breastfeeding.	Positive couples who are expecting a child, community and family members	Mass media, sympathy clubs, mass organizations
	-Consider a policy to allow men to attend deliveries and offer counseling to men after birth on postpartum support and care of the newborn	Male partners of pregnant women	MOH Central
	-Strengthen infant feeding and infant care counseling, especially in the post-delivery period and ensure that male partners are included in information about infant care.	New parents (mothers and fathers)	MOH Central/ Disrict PMC/ CHCs/Provincial hospitals
	-Strengthen post-test counseling for women who test negative	Pregnant women	Health staff at testing sites
All four prongs			
To reduce self-perceived stigma and community discrimination against PLWA	-Promote more positive and optimistic images of PLWA	All communities	Mass media, community outreach

V. Conclusion

This qualitative study finds that male involvement in HIV testing when offered during routine ANC, and access to related PMTCT care is minimal. It also makes the case for efforts to involve men in Prongs one and two of the international approach to PMTCT, and offers the benefits and rationale for doing so. As the MOH gears up to expand its PMTCT efforts nationwide, these recommendations and findings should be useful in considerations about access, quality of care, patient rights, and ultimately, decreased HIV prevalence among women and children.

Annex 1:

Male involvement in Prevention for mother to child transmission in Viet Nam

Review of the literature

I. Background Information

A. HIV/AIDS globally

An estimated 33.2 million people in the world live with HIV/AIDS (PLWHA), of which 2.5 million are children under 15 years of age (UNAIDS/WHO 2007). In 2007, UNAIDS estimated that 2.5 million people were newly infected with HIV, of which 420,000 were children under 15 years of age (ibid). Most new infections in children occur during pregnancy, childbirth and breastfeeding. AIDS-related deaths among children under 15 years were estimated at 330,000 (ibid).

National prevalence rates in Asia remain lower than some other continents, but due to the large populations of Asian countries, even low national prevalence signifies large numbers of PLWHA (UNAIDS/WHO 2007 and UNICEF Vietnam 2006). The high-risk behaviors of injecting drug use and unprotected sex, mainly commercial sex, continue to fuel the epidemic in Asia (ibid). Yet prevention efforts have not sufficiently addressed these two issues (ibid). Men who are engaged in high-risk behaviors may also often be in long-term relationships with or are married to women where it is the norm to have unprotected intercourse (UNAIDS/WHO 2007 and MOH 2008a). The pressure to bear children in Asian countries is high, and most women would thus likely become pregnant, putting their children at risk of transmission from mothers during pregnancy, childbirth or breastfeeding (Oosterhoff 2008, Chapter 1). Hence many Asian countries are seeing HIV spread beyond the vulnerable populations of IDUs and CSWs and their clients to the wider society, including pregnant women and children (UNAIDS/WHO 2007 and UNICEF Vietnam 2006).

Considerable progress has been made in reducing both the numbers of new infections as well as in providing treatment and support to those infected, thus improving their health and lengthening lives (UNAIDS/WHO 2007). However, in many countries, barriers due to resources, health care infrastructure and stigma and discrimination persist.

B. HIV/AIDS in Vietnam

The epidemic in Vietnam is still considered a concentrated epidemic, with high prevalence rates among intravenous drug users, men having sex with men, and commercial sex workers. From 1990 until 2006, 106,288 HIV-infected cases have been reported in Vietnam (UNICEF Vietnam 2006 and MOH 2006), and UNAIDS estimates that the total number of people living with HIV ranges from 150,000-430,000 (UNAIDS 2007). A recent study showed remarkably high prevalence rates among risk groups—between 13 percent to 66 percent among IDUs in certain provinces and between 5 and 22 percent among street-based CSWs (MOH 2008a). A significant proportion of IDUs (between 14 and 43 percent) report having sexual intercourse with CSWs, sometimes unprotected (MOH 2008a). Many CSWs may also be injecting drug users (MOH 2008a).

Since the epidemic in Vietnam is fueled by IDUs, unsurprisingly, efforts have focused on reaching this population. However, Nguyen et al propose that the risk of HIV transmission among women in Vietnam has been underestimated (2003). They further state that "the reported data may represent as little as 16% of the real number (Nguyen et al 2003). Although modeling predicted that there would be 98,500 cases of HIV-infected women in 2005, only 15,633 were accounted for in reports from

the health system. That could mean that in 2005, up to 83,000 women infected with HIV have not been detected by the health care system" (ibid). It appears that a significant number of these women would be women in long-term relationships with men who may be IDUs and/or engaging in sexual intercourse with CSWs. About 30 percent of IDUs in a recent survey reported having unprotected intercourse with their female partners/wives (MOH 2008a).

Data from sentinel surveillance conducted yearly shows that HIV prevalence among pregnant women has increased rapidly over ten years, from 0.02 percent in 1994 to 0.37 percent in 2005 (MOH 2006). The HIV prevalence rate was found relatively high among pregnant women in some provinces in 2005: over 1 percent in Hanoi and Quang Ninh and 2 percent in Thai Nguyen provinces (MOH 2006). There are an estimated 8500 children under 15 years living with HIV in Vietnam (MOH 2006).

Vietnam is estimated to have between 1.8 to 2 million births per year. With the HIV prevalence rate of 0.37 percent among pregnant women, approximately 5,000-7,000 women living with HIV give birth each year (MOH 2006). Transmission rates from mother to child without any intervention ranges from between ranges from 15%-25% in non-breastfeeding populations and 25%-40% in breastfeeding populations (De Cock et al, 2000). Thus about 1,200-3,000 children would be infected without intervention in Vietnam (where breastfeeding is nearly universal) (MOH 2006). With prophylactic treatment, this rate decreases to closer to 10 percent, hence the number of children infected could decrease to approximately 600 children per year. (MOH 2006, De Cock 2000)

In conclusion, the epidemic in Vietnam has seen, and may continue to see increases in the prevalence and new infections in wider society, including among long-term female partners of men engaged in risky behaviors. Since childbearing is a strong cultural norm within such long-term relationships, both pregnant women and infants are a vulnerable group. Currently, with the low uptake of testing among these groups and sexual norms, there is a need to pay attention to prevention of mother to child transmission efforts.

II. The response to prevent mother to child transmission of HIV

International Guidelines on PMTCT

The United Nations adopted a four-prong approach to preventing mother to child transmission (WHO 2007). This four prong approach is aimed at protecting and supporting the health of both the mother and the child, and incorporates primary prevention as well as prevention of mother to child transmission (WHO 2007).

Prong 1: **Targeted primary HIV prevention among women of child bearing age**

Prong 2: **Prevention of unintended pregnancies among HIV-positive women**

Prong 3: **Prevention of infection from HIV-positive mothers to infants**

Prong 4: **Provide care and support of women, their children, and families infected and affected by HIV/AIDS**

In 2006, WHO issued revised guidelines on ARV drugs for PMTCT, using a public health approach (WHO 2006). These guidelines provide regimens that are recommended, alternative (for example in lower-resource settings) and minimum (WHO 2006). For women who are identified as HIV positive

during pregnancy, they recommend ARV prophylaxis be started, where possible, in the 28th week of pregnancy, and that SD-NVP be administered to the mother during labour and the infant post delivery, as well as ARV for both mother and child after delivery for 7 days (WHO 2006). The minimum is SD-NVP to mother during labour and infant post-delivery (WHO 2006).

In addition to ARV prophylaxis, pregnant women may require ARV for themselves based on diagnosis and testing (WHO 2006). Further, mothers require counseling on infant feeding, as the international recommendations are to encourage replacement feeding where it is acceptable, feasible, affordable, sustainable and safe (WHO/UNICEF/UNAIDS/UNFPA 2003). Where not possible, it is to recommend exclusive breastfeeding (ibid).

In sum, from both the perspective of a National AIDS Authority or Ministry of Health in any country that is responsible for implementing the four-prong approach, the challenges of coordination, collaboration, and outreach are considerable. Finding adequate resources (in poor countries most people cannot afford to pay for these services) is another major challenge. For families in developing countries, the first and foremost barrier is resources to pay for services. Even where services are near free, accessing information, testing, treatment, care and support can be formidable, as it may require going to different places for different types of services, adhering to regimens that may be difficult or complicated to follow, and initiating feeding practices that may not be the cultural norm. Finally issues of confidentiality and stigma and discrimination against positive people continue to challenge comprehensive care and support, especially in Vietnam (Morch et al 2006, and Oosterhoff [in press AIDS Care]).

The MOH National Plan of Action and Guidelines:

The Ministry of Health in Vietnam has prepared a national plan of action (2006 to 2010) to address PMTCT (MOH 2006). Responsibilities at the central level rest with both the Vietnam AIDS Coordinating Committee (VACC) and with the Reproductive Health Department.

The overall objective of the MOH national plan of action is to bring the rate of mother to child transmission of HIV to below 10 percent by 2010 (ibid). The specific objectives are to ensure that the prevalence of HIV among pregnant women stays below 0.5 percent, 90 percent of pregnant women receive counseling, and 60 percent opt for testing, and 100 percent of registered women with HIV and their children receive prophylaxis and 90 percent receive post-delivery care and follow-up (ibid).

The Plan of Action includes social activities, technical activities, and management/ organizational activities. Responsibilities of various levels, such as provincial hospitals, district health stations, and commune health stations, as well as departments and administration units have been described.

The Plan of Action states that PMTCT services will be expanded to all 64 provinces between 2008-2010.

Existing service delivery models in Vietnam

PMTCT services are currently only provided in select high-risk provinces, including Hanoi, HCMC, Quang Ninh, An Giang, and Lang Son, and within these provinces only in select districts (MOH 2006 and Morch et al, 2006). Three major projects are providing support, UNICEF, Centers for Disease Control through the Life-GAP project, and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) (ibid).

PMTCT services are provided as follows in these select areas (Morch et al 2006 and MOH 2008b):

Service Delivery Point	Commune Health Station	District Hospital	Provincial Hospital	PAC
Counseling and testing	Maybe routine for all pregnant women. Actual lab work done at district or provincial levels. Positive results and post-test counseling sometimes done through CHS, sometimes through district	Offered during ANC (opt-out) and done during labor. Results provided on site	Offered during ANC (opt-out) and done during labor. Results provided on site	VCT sites in major provincial towns. Lab work done in provincial hospitals. Results provided on site
ARV prophylaxis during pregnancy	Referral	Maybe provided after 28 weeks of pregnancy,		Referral: pregnant women who are known to be positive are referred to provincial hospitals
ARV prophylaxis during labor and postpartum	No	Yes	Yes	NA
Infant care counseling	Not usually	Yes through Pediatrics Department, WU or Preventive Health Department	Yes through pediatrics department	No
Replacement feeding supplements	Not usually	Yes through Pediatrics Department, WU or Preventive Health Department	Yes through pediatrics department	No
Infant checkup and treatment of OI	Yes, sometimes	Yes	Yes	No
Testing at 18 months	No	Not usually	Yes at Pediatrics Department	No
ARV for mother if eligible		Not usually	Yes at OPD	Yes through provincial hospitals

As can be seen from the above, PMTCT services require considerable collaboration and coordination between departments and levels of services. For women and men who wish to access these services, the number of places and departments to go to for different services can be daunting (Oosterhoff 2008 Chapter 1).

A rapid assessment of existing PMTCT service delivery models was undertaken in 2006 (Morch et al 2006). The assessment's major findings were that testing for HIV was nearly universal in large hospitals in areas where there were services, and that positive women received prophylaxis and their infants received SD NVP. However, confidentiality of test results was a major issue, and many women provided incorrect addresses or changed the place of delivery for fear of stigma and discrimination (ibid). Further distribution channels and subsidies for replacement feeding supplies were not well organized and counseling and information provided on replacement feeding was inadequate (ibid).

Furthermore, PMTCT services are only being offered in select districts and provinces. In a country of low prevalence which nonetheless plans to expand services to the whole country, cost-effective models are a challenge (ibid). With coordination already being a challenge in these select areas, any models for expansion would also bring greater challenges for coordination.

III. Male Involvement in PMTCT

A. Globally:

Male involvement in PMTCT and in reproductive health has traditionally been low (Kidyomunda 2003, Cullinan 2002, Mbizvo & Bassett 1996 and Mullany et al, 2007). However, men play a key role in household decision-making and can support or discourage women in childbearing, health and childrearing decisions (Mbizvo & Bassett, 1996, Mane & Aggleton 2001, Horizons report 2003, Peacock 2003 and Sauer 2003). The Horizons report on an evaluation of PMTCT states that "involving male partners means that they are far more likely to support women at critical turning points: deciding whether to take an HIV test, returning for test results, taking antiretroviral drugs, and practicing safer infant feeding methods."

The recently-held High-Level Global Forum on PMTCT (Consensus Statement, 2007) identifies 15 challenges to scaling up quality, comprehensive PMTCT programs. These challenges include, in addition to the need for greater male engagement, an acknowledgment that there has been:

- Inadequate support for infant feeding, which remains a complex issue;
- Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants;
- Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services; and
- Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;

Many of these could be addressed through increased male partner engagement and by embedding approaches to involve them in the uptake of health services. Men play a critical role in all four prongs of the comprehensive approach to PMTCT (UNAIDS/IATT Fact Sheet and Horizons Report 2003).

Why then, is male involvement so low, in spite of the acknowledgment and broad consensus on the need for it? First, many of the efforts undertaken to prevent mother to child transmission have focused on prophylaxis and protection for the newborn (UNAIDS/IATT Fact Sheet). It is only recently that efforts have expanded to include the mother, and slowly also the family and the community (UNAIDS/IATT Fact Sheet and WHO 2007). The four-prong approach proposed by WHO provides the framework for a more integrated and comprehensive approach and represents a shift from focusing only on protecting the neonate from transmission to recognizing the need to also pay attention to the mother, as well as the father and to preventing transmission to the mother and pregnancy among infected women who do not wish to have children (WHO 2007).

Second, in most countries, women's biological roles in pregnancy and childbearing, combined with traditional norms for masculinity, have meant that PMTCT is seen as the domain of women (Cullinan 2002). Service provision has reinforced this message by targeting women for PMTCT services. The concept that PMTCT requires the active participation of both men and women, and that it may be a useful entry point to combat the epidemic more broadly is slowly gaining ground (Montgomery et al 2006). But this requires challenging and changing gender roles, and redefining masculinities, which can be done (ibid).

Third, when discussing gender roles globally, men as a group are often referred to as the dominant sex. Authors of a recent publication argue that men's behaviors are a 'product' of the ideas and no-

tions on how they should act, and what may be called the dominant, hegemonic masculinity influences men's behaviour and actions (SIDA/Lunds University 2007). Some men and boys may not depart at all from such influences, while others struggle to find different identities. In other words, they state that "masculinities are collective, sustained not only by individuals but also by groups and institutions (for example through workplace, sport and military cultures) (ibid). They are actively constructed through social interaction, and they are dynamic – they change over time (ibid). Masculinities are also tied to hierarchy and power relations; there are dominant and more subordinate forms of masculinities (ibid). Examples of social constructions of masculinities that play a central role in HIV-transmission are (ibid):

- That men should be strong – leading to not visiting health clinics as it is a sign of weakness
- That homosexuality does not conform with 'being a man' – leading to silence and stigma around homosexuality
- That men's sexuality drives them to have multiple partners, or drives them to abuse and rape women/men

Such dominant, hegemonic masculinity influences men's behaviors and attitudes toward PMTCT.

All of these are manifest in the lack of engagement with all four prongs of PMTCT, and are reinforced by a number of factors described below:

A. Male involvement in primary prevention of HIV infection among women of childbearing age

Women who are in long-term relationships with men who are aware of their positive status or aware that they have engaged in high-risk behavior can protect themselves from infection by using condoms during intercourse. However, **men may not be willing to use condoms or to abstain to prevent infection**. Within long-term relationships, men and women may not want to use condoms (UNAIDS/IATT Fact sheet and Burke et al 2004). In Cambodia, the condom use campaign has been enormously successful in increasing condom use in transactional sex, but at the same time, is frowned upon in long-term relationships, as it is associated with commercial sex (Walston 2005). In cultures where women are not expected to have intercourse during pregnancy, men may seek sex elsewhere. Abstinence is seen as being difficult, as men say they cannot control "irresistible urges" (Smith and Rapkin 1996 and Burke et al 2004)

B. Male involvement in prevention of unwanted pregnancy

Women who may be ambivalent or unsure about having children, especially in cases where HIV positive women or female partners of positive men, may nonetheless, be reluctant to avoid pregnancy due to the strong cultural and social pressure to bear a child. Couples need to communicate openly about the risks and challenges to having a child when one or both partners are positive—as women on their own are unlikely to opt against pregnancy. (Burke et al 2004).

C. Male involvement in prevention of infection from mothers to infants

In places where they are offered, at a minimum, PMTCT services include counseling testing, routine or voluntary, during pregnancy or labor, the administration of ARV prophylaxis, also during pregnancy and/or labor for the mother and to the newborn, and guidance on infant feeding and care.

Men's role in testing during pregnancy:

The sooner in pregnancy a woman is diagnosed, the sooner she can take ARV prophylaxis. Husbands/ male partners can either encourage or discourage their wives from taking an HIV test. Whatever their decision, women are unlikely to take a test if their husbands are opposed to it, and may be persuaded to do so if their husbands encourage them (Chandisarewa et al 2007). There is also an opportunity during pregnancy for both partners to be tested and counseled. A study in Uganda (Bajunirwe et al 2005) demonstrates that male partners' attitudes are important in a woman's reported willingness to accept HIV testing. In some circumstances women have tested for HIV without their husbands consent and have suffered domestic violence (De Paoli et al 2004). In this survey, the perception that the husband would approve of a woman's decision to test for HIV was the strongest predictor of whether the woman had the intention of testing or not.

Men can support women in taking ARV prophylaxis

Husbands can play an important role in supporting their wives in taking ARV prophylaxis during pregnancy, and for infants just after delivery. As women are recovering from childbirth, husbands/ male partners can take responsibility to administer ARV. Men are highly motivated by access to ARV, even if it is only for the child, or even mother and child (Burke et al 2004).

Several factors have been documented that lower men's engagement in accessing, or helping their female partners to access these services:

Men's lack of knowledge about PMTCT and maternal health.

Men are often not targeted for information on maternal health or even PMTCT (Mullany, B. 2006 and Munene &Gathenya 2004). They may thus be unaware of services, benefits to their partners and their children, and especially, the approaches to avoid transmission of HIV to their child (ibid).

Culturally, men are not expected to be involved in pregnancy care:

Studies undertaken in Cambodia and Nepal show that men are reluctant to be involved in pregnancy as it is not considered the norm. Men who are seen helping their wives with housework are afraid of being ridiculed by the community and accused of being "henpecked" (Peacock 2003). Further their wives may be afraid that they themselves are seen as lazy or incompetent if they let their husbands do domestic work. Pregnancy is considered a women's affair, and mothers and mothers-in-law play an important role, more so than husbands. (Walston 2005 and Mullany, 2006)

Men do not go to ANC services where women are offered testing and counseling

Integration of PMTCT services as a routine part of ANC and MCH services has been critical in expanding access and making it easier for women to use these services (WHO 2007). In particular, routine testing for HIV during pregnancy (with opting out) is now considered to be good practice (WHO 2007 and Chandisarewa et al 2007). ANC and MCH services have long been seen as the domain of women, and hence, involving male partners through ANC poses a set of challenges (Mullany 2006).

1. ANC targeting women: In KwaZuluNatal, a study with over 1000 men found that men were willing to go to ANC services, but were not sure they had the necessary skills (Peacock 2003). In Cambodia, men said that RH services were women-oriented, with predominantly female clients and female service providers, which does not welcome men (Walston 2005). Timing and hours of ANC services may also not be suitable for men.
2. Providers mostly female: Most RH providers are women, and men do not feel comfortable discussing intimate issues around sexuality with women (Burke et al). Health information

needs to come from a trusted source, preferably a male: A study undertaken in Tanzania reveals that men prefer to get information and advice from other men (Burke et al 2004). While they may trust information coming from a male or female health provider, they are not likely to open up with female providers. Female providers are also seen as suitable for treating women.

Men may not want female partners to get tested, especially during pregnancy.

A study in Tanzania revealed that a positive result for a female partner or a child was a proxy for one's own status (Burke et al 2004). If the child or mother were negative, so was the partner. Men, especially if they are aware that they have engaged in high-risk behaviors may thus be extremely reluctant for their partners to get tested and women who do get tested may not reveal positive results to their husbands for a number of reasons:

- Fear of abandonment, violence or rejection: Women who learn of their positive status may not share their results with their husbands as their husbands may reject them or abandon them, or respond with violence (Medley et al, 2004)
- Fear of being "found out": Women who learn of their HIV status may accuse their husbands of infidelity or of going to see CSWs. Men usually will go to CSWs without wanting their partners to know, and hence may oppose testing or may not want to be exposed if the wife has been tested (Medley et al 2004).
- Fear of learning about own HIV status: In Zimbabwe, a study done among male partners of women receiving routine testing during pregnancy revealed that only 7 percent of men came in for testing on learning that their partners were positive (Winfreda et al, 2007).
- Fear about stigma and discrimination. A concern that test results will be shared within the community is one of the most important barriers to men getting tested and to encourage their partners to get tested. A study in Tanzania showed that men preferred to be tested in sites that were away from home (Burke et al). In Cambodia, studies have found that people prefer to go to the private sector as they are more assured of confidentiality (Walston, 2005).
- Denial about behaviors that put one at risk: Men may be in denial that ID use or unprotected sexual intercourse can lead to HIV—and may not want to be confronted with the reality of their behaviors (Vermund and Wilson 2002).
- Guilt and concern about the child: Female partners diagnosed during pregnancy can transmit HIV to their infants, and men may feel a sense of guilt and concern about their wives' and children's health and well-being.

Women may not want to reveal results to men for fear of being abandoned or of violence

Several studies show that women who have been tested without their partners' knowledge are reluctant to reveal these results, either positive or negative (Cullinan 2002, De Paoli et al 2004 and Nuwagaba-Biribonwoha et al 2007). Sharing a negative result may reveal suspicion about a man's behavior or imply that the woman herself has engaged in risky behavior (ibid). Sharing a positive result may result in abandonment, in the male partner blaming the woman, or denying his own behavior (ibid).

D. Male involvement in provision of care and support to women, children and their infants

a. Men's role in care and support during pregnancy

Men can support women during pregnancy by sharing domestic work, joining women for ANC, and helping them eat well and stay healthy.

b. Men's role in infant care

Infant feeding remains a complex issue, with access to replacement formula, safe and healthy practices when using bottles, and social stigma attached to formula feeding all posing challenges (Leshabari et al 2006, Buskens et al. 2007) The greatest support can be offered in making and adhering to the decision on infant feeding, either exclusive breastfeeding or replacement feeding, especially if neither are the cultural norm (Waweru et al 2004). Administering ARV prophyalxis, obtaining infant formula and infant feeding if the choice is to feed formula—all these activities can be supported and done by men (ibid).

- Women may not be able to access healthcare, treatment, and drugs for children without male partner support (UNAIDS/IATT Fact Sheet). As mentioned above, the range of services that a pregnant woman or new mother has to access can be formidable, especially if provided in different locations. Partner support, when available, can help women access the full-range of services.
- Women do not feel supported in strategies such as replacement feeding or exclusive breastfeeding (Buskens et al, 2007). In many developing countries, breastfeeding is the norm, but longer-term exclusive breastfeeding is not (UNICEF Child Info Statistics, 2007). Supplements are introduced as early as 2 months in some countries (ibid, Buskens et al, 2007). Replacement feeding poses its own challenges (Leshabari et al, 2006). Women may not have the resources to buy formula, and even where it is provided for free, may not have the resources to ensure safe bottlefeeding (Wanyu et al 2007). Where men do not support these options, women may well give up and revert to mixed feeding.
- Replacement feeding is associated with increased visibility of positive status. A study conducted in Tanzania revealed the men and women expressed their concern that, in a setting where breastfeeding was the norm, and people were aware that replacement feeding was recommended to positive women; by replacement feeding, families were as good as disclosing their HIV status (Burke et al 2004).

B. Gender Issues in Vietnam and possible implications for PMTCT

Vietnam, especially in comparison with other countries in the region, shows good progress in improving gender equality (Vietnam Country Gender Assessment 2006). Health and education outcomes overall have improved, and economic opportunities have improved for both men and women. However, strong gender stereotypes prevail, which have significant implications for household decision-making, domestic work, and attitudes toward men and women in the workplace and society (ibid). The 2006 Vietnam Country Gender Assessment points to unequal workloads, with women working an average of 13 hours per day, and men working for 9 hours per day on average (ibid). This disparity can be explained by the fact that women contribute equal amounts of time to income generation activities, but bear the bulk of the responsibility for housework (ibid). During pregnancy and post-partum, especially if dealing with the additional needs for care and support related to HIV, this has implications for the health and well-being of both mother and child.

At the household level, husbands are still seen as the major decision-makers in the home in contemporary Vietnam (Knodel et al 2004). Vietnamese culture is strongly patriarchal, with the husband and father as the head of the household (ibid). The family is the basic unit in Vietnam, and nuclear families are common (ibid). Family relationships are the most significant relationships in Vietnam, especially among the majority Kinh population, where community, tribal, and village relationships are often of secondary importance (ibid). Vietnamese families are thus independent and private, which means that husbands and wives are highly dependant on each other for moral and emotional and financial support. Husbands and wives may discuss major decisions, however, if there is a difference, the husband's opinion is usually the one that would prevail (ibid).

Vietnamese society places a high premium on family life, with marriage and childbirth (the latter usually soon following marriage) expected and strongly encouraged (Oosterhoff 2008, Chapter 1). The role of motherhood is valued, almost revered, and women enter marriage with the expectation that they will soon have a child (ibid). Mothers-in-law, mothers, and other family members encourage childbearing and may play an active role in pregnancy and childbirth, especially for younger, first time mothers (ibid). Son preference, especially in some parts of the country is still prevalent—as according to Confucian tradition, a son is needed to protect the lineage (Oosterhoff, in press Culture, Health and Sexuality). Decisions on fertility are to be seen within this sociocultural context, where opinions and pressures of the overall family exert a powerful influence.

Oosterhoff's (Chapter 1, 2008) draft thesis reveals a strong degree of pressure on women to bear children, associated with cultural constructions as well as familial pressures. She notes that being a mother elevates the status of a married, and that a married couple is considered incomplete without children (ibid). Son preference is strong, and in cases where the husband is the only male, the pressure to have a child may be greater (ibid). The motivation in such cases often appears to be a future grandson, to continue the family line. Her thesis also points to examples of sons who are drug users, even those whose positive status is known, that may have been encouraged to get married, sometimes in the hope that it will "straighten" the son out, and sometimes to have a grandchild. Women in these marriages may not have been aware of their husbands' HIV status, and would have unprotected intercourse. Even after knowing about their HIV status, they may decide to conceive anyway due to the social, cultural and familial constructs around marriage and childbearing (ibid).

While it is difficult to draw any general conclusions on sexual behaviors among married couples, it is not uncommon for married men to visit sex workers—some men may do so very seldom, while others are quite frequent visitors (Tran Duc Hoa et al 2007). Visits to sex workers are often undertaken with male friends, or with male colleagues in the context of business deals (ibid). In such cases, men will often drink alcohol in addition to visiting sex workers. Men state that it is difficult to refuse such invitations. It is not clear if men would consistently use condoms in such encounters, especially since it is accompanied with alcohol (ibid).

At the same time, discussing sex openly with one's spouse is not the norm. While husbands and wives discuss children, finances, health, and their hopes for the future, sex remains a taboo topic. Men prefer to talk about sex with their friends, and women may do so as well with their friends, although topics like sexual pleasure would not often be discussed among women, compared with men (ibid). Men and women are thus caught in a cycle where neither can openly discuss sexual pleasure with each other, and it is considered normal to engage in sexual intercourse outside marriage for pleasure, and within the home for childbearing (ibid).

IV. Lessons learned from programs that have involved male partners in HIV/AIDS and RH/FP programs

Below are some elements of success from programs that have promoted male involvement in PMTCT:

A. A. Outreach efforts directly to men improves women's uptake of PMTCT service (Horizons Report 2003):

An evaluation of PMTCT services revealed that men providing education and information to men outside of the ANC/MCH setting is most effective. This evaluation gives examples, where "in rural Keemba and Monze, Zambia, program staff approached male leaders to promote PMTCT among the men in their communities, which has led to higher levels of male involvement in PMTCT decision-making and in uptake of VCT services." It further states that "providing men directly with information confirms their important role in such decisions and removes the onus of responsibility from women for bringing up PMTCT."

B. Involving men in reproductive health using innovative strategies can improve partner testing (USAID Success Stories Rwanda, 2005).

In Rwanda, a program to integrate partner involvement activities with PMTCT services led to gains in the rate of partner testing in a short period of time. The three strategies used were to invite partners directly and discreetly to accompany their wives for ANC visits to the health service, actively involving them in the services provided to their wives, and developing a community-provider partnership, where families and health care providers could dialogue about norms and values, as well as attitudes and behaviours.

This program saw an increase in partner testing from "10 percent in December 2002 to 88 percent in September 2004." They also report that it is now the norm for men to accompany their female partners to PMTCT counseling sessions without letters.

C. C. Involving men in reproductive health using innovative strategies can improve maternal health and well-being (Waweru et al 2004, and Mullany et al 2007).

In another study in Kenya, a Saturday ANC clinic was started, and the women were given two letters; one to the partner's employer requesting permission for the man to attend the clinic and another to the partner inviting him to come to the clinic. After the introduction of the letters, the number of male partners attending the clinic almost doubled (from 8% to 14%), and for about half the men, the Saturday clinic provided a suitable time.

In Nepal, a randomized-control trial was done to see if involving men in ANC services made any difference to maternal health outcomes. Women who received education with husbands were more likely to attend a postpartum visit than women who received education alone or no education Women who received education with their husbands were also nearly twice as likely as control group women

to report making >3 birth preparations. These data provide evidence that educating pregnant women and their male partners yields a greater net impact on maternal health behaviors compared with educating women alone.

D. Provide testing as a routine procedure to women during pregnancy.

Many studies have revealed that routine antenatal HIV testing is both feasible and acceptable for pregnant women. Reasons given for an increase in the number of women who test if it offered as a routine procedure, rather than opting in, are many. Women are less fearful of participating in routine HIV testing because this approach may be perceived by her partner and family as "standard of care" offered to all ANC clients, thereby reducing the risk of stigma and other adverse social consequences when compared to the opt-in VCT policy (Winfreda et al 2007). A program in urban Zimbabwe showed that "almost 100% of women opted for HIV testing and there were overall significant improvement in quantitative PMTCT service statistics" after routine testing was introduced (ibid). They attribute, "in addition, community sensitization, counselling sessions involving highly motivated community counsellors and availability of on-site rapid HIV testing" as well to increasing HIV testing rates among women in this particular study (ibid).

While the study in Zimbabwe revealed that almost all women (98%) returned for their results, this is not consistent in other locations where routine testing is offered (ibid). The same authors contrast the Zimbabwe experience with Botswana and Kenya, where studies showed that 29% and 31%, respectively, of women who tested did not return for their results (ibid). This is consistent with the experience in Vietnam, where a significant number of women who test are lost to follow-up (Morch et al 2006).

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Annex 2:

Terms of reference

Study on men/partners involvement in sexual and reproductive health including pmtct

Background

Viet Nam is making considerable progress in institutionalizing and scaling up Prevention of Mother to Child Transmission (PMTCT) activities in the country, as well as in conceptualising the needed linkages between Sexual and Reproductive Health (SRH), Maternal and Neonatal Health (MNH) and PMTCT.
The national objective of the PMTCT Plan of Action is to achieve nation-wide reach of PMTCT services by the end of 2010- a very ambitious target that requires mobilization of services and resources.

Nonetheless, in the sites that are already providing PMTCT services, the overall uptake of services is often quite low. Women who attend antenatal care services are often opting out from the offer of taking a HIV test , despite the fact that knowing their status could facilitate receiving services to avoid HIV transmission to their newborn in case positive. Most of pregnant women who are tested positive are diagnosed at the very late stage of their pregnancy, mainly right before delivery, which prevent them from accessing timely services when needed. Some studies shown that when male partners are actively involved, positive health seeking behaviours and acceptance of HIV testing are most likely to be higher for women. As a result, women and also their male partners could be able to access to HIV treatment and avoid HIV transmission to their newborn in case positive.

In several assessments and informal dialogues with health workers as well as pregnant women attending antenatal care (ANC) in Vietnam, it became evident that lack of male involvement in the provision and use of services, as well as in the information sharing of the importance of PMTCT, is one of the bottlenecks to improve PMTCT service intake. Women alone often cannot make the decision of accepting a HIV test, and couple counselling and testing is still very limited in the country.

Experiences in other countries demonstrate that men's support and involvement, as well as their access to services including basic ANC will promote the effectiveness of PMTCT services and contribute to the primary HIV prevention for both men and women, especially during pregnancy and breastfeeding, and secondary prevention of MTCT and, in the longer run, to reduce the incidence of HIV infections in children. Furthermore, it is globally recognized that men's involvement and support will help women in adhering to ARV prophylaxis and treatment regimens as well as to prevent unintended pregnancy.

Purpose of the study

MoH, with the support of UNICEF, WHO and UNFPA plans to conduct a study on the involvement of men in PMTCT program, including barriers and opportunities, as well as men's readiness to provide support to their partners on PMTCT intervention, including primary prevention prior and during pregnancy, as well as access and acceptance of VCT.
The study will provide a better understanding about the current attitudes and practices of pregnant women and their male partners towards the PMTCT program and know how best to have encourage the greater involvement of men in every program' steps.

The result of this study will be used for developing an intervention model for greater involvement of men in SRH/MNH including PMTCT in Viet Nam.

Scope and Focus

This formative study aims at:

a. Identifying the knowledge, attitudes, health seeking behaviours and practices of pregnant women, their male partners and the couples and the family as a unit in respect to PMTCT in the broader context of SRH, including primary prevention in the couple prior and during pregnancy;

b. Identifying behavioural and cultural determinants, barriers and opportunities for greater involvement of male partners in PMTCT and SRH;

c. Identifying existing service provision , how services are linked to better prevent mother to child transmission (including primary prevention in the couple, STIs and IYCF practices), and how they allow, or don't allow, men/partners involvement.

Geographical locations for the study will be chosen in provinces of higher HIV prevalence, including both a district where PMTCT has already been implemented, and a second without exisiting PMTCT services. The selection includes HCMC, Quang Ninh, An Giang.

The analysis of the findings should help identify effective measures to promote men's involvement. Recommendations from the study will help develop interventions to increase meaningful men involvement, as well as support related revision of relevant policies, guidelines and training curricula on PMTCT.

Evaluation methods and process

Descriptive, cross-sectional study with 2 methods

- **Quantitative methodologies:** the data will be collected through face to face interview in the community, using a questionnaire. The interviewers will be trained carefully to familiarize with the questionnaire.
- **Qualitative method:** In depth interviews, focus group discussions are proposed to be conducted to assess deeply on involvement of men in PMTCT

Study subjects will include different groups of stakeholders including men, pregnant women, health care provider, community leaders, members of community organisations.

Within this initial broad outline, the study team will further develop the study methodologies, data collection tools, sampling approaches and analysis framework and methodologies.

Participatory study methods are generally effective and are encouraged.

Stakeholder participation & accountabilities

The research will use a participatory process and involve a team/advisory group composed of independent consultants, project counterparts at central level, sub-national counterparts and community beneficiaries. UNICEF and other key international organisations (i.e. WHO, UNFPA and others) will also provide support.

The following structure is proposed:

- A study team will be set up, composed of one international and two national researchers consultants, and a study manager from RHD/MoH
- Project counterparts at central level (RHD, VAAC): liaison, coordination of assessment plan, technical advisory. They will also be involved along with the external consultant in data collection, analysis, recommendations, dissemination and follow up.
- Sub-national counterparts: input to refine evaluation tools, support during data collection process and dissemination
- The study team will be encouraged to involve primary stakeholders (male partners of pregnant women (PW), PW themselves, HIV(+) mother and their family members, HWs, community leader, IEC collaborator, Mass organisation) in the design of study plan and tools
- UNICEF:
  - Health & Nutrition: Technical assistance throughout the assessment process as well as support to coordination (including necessary logistical support)
  - M&E Network: Technical assistance in the evaluation design and process, as appropriate
- Other international organisations (WHO and UNFPA): technical assistance throughout the process, through an extended consultative group to be coordinated by RHD/VAAC

Procedures and logistics

Once the consultants are identified, the specific working arrangements and task division will be decided.

Below are the expected tasks and outputs for the consultancy. It is proposed that three qualified consultants are identified, one international and two national consultants, to provide technical leadership and coordination for the assessment process. UNICEF staff and project team will actively engage in the research process, and UNICEF's evaluation procedures and guidelines will be strictly followed.

Task 1: Literature review on men involvement in SRH/MCH and PMTCT (international +national)
Output 1: Succinct literature review report available
Tentative time: 4 days

Task 2: Development/conceptualisation of the detailed research objectives, methods, data collection and analysis plan, study tools
Output 2: Research proposal, methodology and study tools developed
Tentative time: 3-5 days

Task 3: Training workshop for assessment team, pre-testing of tools and finalization of tools
Output 3: Tools revised and finalised.
Tentative time: 3 days

Task 4: Data collection
Output 4: Field work, including group discussions, interviews and observations, conducted and data collected.
Tentative time: 15 days

Task 5: Data entry, analysis and draft report
Output 5: Data entered and analysed and draft report produced.
Tentative time: 5 days

Task 6: Consultative process to collect comments and recommendations from relevant stakeholders on the draft report, incorporation of comments and finalisation of study report
Output 6: Final report with clear recommendations in both Vietnamese and English are ready to use.
Tentative time: 3 days

Tasks 7: In consultation with relevant stakeholders, development of a feasible pilot model for men involvement with recommended necessary materials, and guidelines
Output 7: Pilot model for men involvement is suggested/developed with clear outlines
Tentative time: 4 days

Research team composition and proposed competencies of consultants

International consultant researcher- expected competencies

- Advanced academic degree in social studies or other relevant field
- Good knowledge and understanding of reproductive health, maternal, neonatal health HIV and PMTCT
- Good knowledge and experience in undertaking similar type of research, preferably on HIV and PMTCT
- Good knowledge of human rights and child rights and participation.
- Excellent communication skills including writing skills (English); knowledge of Vietnamese an asset
- Ability to work with various counterparts, including government agencies, NGOs, PLHIV, and children.
- Working experience and/or knowledge of Viet Nam is an asset.

National Consultants researchers- expected competencies:

- Advanced academic degree in social studies or other relevant field
- Good knowledge and understanding of reproductive health, maternal, neonatal health HIV and PMTCT
- Good knowledge and experience in undertaking similar type of research, preferably on HIV and PMTCT
- Good knowledge of human rights and child rights and participation.
- Excellent communication skills including writing skills (English and Vietnamese)
- Ability to work with various counterparts, including government agencies, NGOs, PLHIV, and children.

Study focal point: RHD /MoH

Advisory group: will include members from RHD, VAAC, UNICEF, WHO, UNFPA, other relevant experts.

Tentative time frame and workplan:

The evaluation will take place as per the tentative schedule:

Key tasks and Time	Sep	Oct	Nov	Dec	Jan08
Task 1: Literature review					
Task 2: Development of the conceptualization of the research objectives, study question, methods, plan and tools.					
Task 3: Training workshop for assessment team, pre-testing of tools and finalization of tools					
Task 4: Data collection.					
Task 5: Data entry, analysis and draft report					
Task 6: consultations on draft report and preparation of final report					
Tasks 7: Development of models for men involvement, materials, guidelines					

8. Time Frame and Work Plan from 10 Dec. 2007 to 29 Feb 2008

Tasks	Time Allocation	Tentative Dates	Place	Person responsible
Task 1: Literature review	**4 working days**		Consultant's home country	Int consultant
Task 2: Development study design, plans and tools	**6** days	10 Dec-15 Dec 07	Hanoi	Whole team
Task 3: pre-testing, training and finalization of research tools	**2** days	16-17 Dec	Hanoi*	Whole team
Task 4: Data collection Tentative schedule: - 6 days in HCMC+ 1 days for traveling - 6 days in AG + 1 days for traveling - 6 days in QN +1 day for traveling	**IC: 4 days** NC: 21 days	18 Dec -24 Dec 07 25 Dec – 31 Dec 07 4 Jan -10 Jan 08	Ho Chi Minh* An Giang* Quang Ninh*	Whole team in part, national consultants in part The int' consultants will involve in **3 days for data collection and 1 day of reflection (18 Dec- 21 Dec)** in HCMC

Task 5: Data entry, analysis and draft report	**IC: 12 days** (2 days in VN and 10 days in BKK) NC: 12 days	21 Jan- 1 Feb 08 (for Int'consultant, including 2 days in VN and 10 days in BKK) 11 Jan-22 Jan 08 (for National consultant)	Hanoi, BKK Hanoi	Whole team in part, national consultants in part. National consultants to transcribe data and to do prelim analysis by Jan 20 The international consultant will involved **2 days in Hanoi (around 21-22 Jan) and 10 days in BKK** for drafting repot
Task 6: Development of recommendations for models to increase men involvement	**IC: 3 days** NC: 3 days	12-14 Feb. 08	Hanoi	The international consultant will involved **3 days in Hanoi** for finalizing and presenting draft and developing record
Task 7: Consultative process for comments seeking and finalization of report and model	**IC: 11 days** (5 in country, 6 in BKK) NC: 5 days	18-23 Feb for finalize report in BKK 3-7 March for consultative process, writing the final report and workshop in Hanoi	Hanoi	The int' consultant will involved - 6 days to finalize report in BKK - **5 days** for consultative process and writing the final report and workshop in HN The national consultant: **5 days** for consultative process and writing the final report in HN
	Total: **IC: 42 days** NC:49 days			

For International consultant: 42 days: 20 days at home in BKK and 22 days in Vietnam

Annex 3:

Study guide and workplan for primary data collection Male Involvement in Prevention of Mother to Child Transmission Efforts

Data collected from HCMC, An Giang, and Quang Ninh Provinces và Quảng Ninh

A. Areas of Inquiry

The MOH in Vietnam is currently piloting PMTCT services in several districts in Vietnam. Husband/ partner involvement is not a significant component of this intervention, but is sensed to be critical in order to ensure that women access these services. For improvement of PMTCT services, and to inform scale-up, the MOH wishes to develop models for intervention that will include activities to reach male partners and families of pregnant women

The study objectives as per the TORs are to:

a. Identify the knowledge, attitudes, health seeking behaviours and practices of pregnant women, their male partners and the couples and the family as a unit in respect to PMTCT in the broader context of SRH, including primary prevention in the couple prior and during pregnancy;

b. Identify behavioural and cultural determinants, barriers and opportunities for greater involvement of male partners in PMTCT and SRH;

c. Identify existing service provision , how services are linked to better prevent mother to child transmission (including primary prevention in the couple, STIs and IYCF practices), and how they allow, or don't allow, men/partners involvement.

Based on these objectives, the five areas of inquiry that this study attempts to cover are as follows:

1. What is the understanding of HIV among community members? How do pregnant women, their partners, and their families perceive HIV?

2. What are men's roles in pregnancy, childbirth and postpartum? How does HIV status affect this role? What is the relationship between HIV status and having a child? How do men and women feel about this? How do they communicate about it?

3. How are decisions about care and support during pregnancy, during the childbirth period, and postpartum made? How does HIV status (known, suspected, unknown) affect these decisions? Who influences them and how? What are men's opinions and feelings about these decisions and their involvement in them?

4. What are the perceptions and opinions about services available for pregnant women at risk of HIV/those who are HIV positive? How can men be involved in this time? What are the actual experiences of women who receive PMTCT services? How have they been supported or not?

5. What are the key dimensions of existing PMTCT services in actual locations offering services? How are they being offered? Who is accessing them? Who is not, and what could possible reasons be?

These areas of inquiry have been selected to help deepen our understanding of how socio-cultural determinants and intra-household and inter-spousal communication affects pregnant women's decision to access antenatal care at various points during pregnancy and to accept PMTCT. It is to be noted that although Vietnam is a low-prevalence country for HIV, rates among pregnant women have been increasing in the past five years. Increased uptake of testing, and subsequently, of more comprehensive care and support for women who are seropositive, is part of the MOH's plan for PMTCT. In order to achieve these goals, this study will provide critical insights to reach both the general population of pregnant women, as well as pregnant women who are at risk of HIV or are already positive and their partners.

B. Proposed Methods and rationale for target groups:

In order to investigate these five areas, three provinces with high prevalence of HIV have been selected. In these three provinces, data will be gathered both from districts with PMTCT services and from those without. Qualitative methods have been selected, as this study explores underlying attitudes, values and opinions that affect health-seeking behavior. In addition, some quantitative information from the health centers/hospitals will be collected.

Semi-structured questionnaires within broad, open-ended lines of inquiry have been developed for the in-depth interviews and FGDs. A structured questionnaire and observation checklist has been developed for the information on the existing health services.

Specifically:

1. To gather information about the health system:

We will collect information from three levels of health services—provincial, district and commune. Commune health centers provide ANC. In communes where PMTCT is offered, they provide pre-test counseling, draw blood for the test, and do post-test counseling. District and provincial hospitals are higher levels of care, and women are tested for HIV in the 7th or 8th month routinely, and are offered prophylaxis and other support. Information will be gathered through structured questions about the actual services, observation of an actual service, and a set of semi structured questions about community attitudes, compliance, and follow-up. This information will be triangulated by asking questions to women and men who have used PMTCT services. This includes ANC, labour and delivery, lab services and the pediatrics department.

2. To gather information on community attitudes:

We will collect information from family members and leaders of self help groups for positive women (Women's Union Sympathy groups). This will be done using in-depth interviews. This information will be used to deepen and triangulate the information gathered from men and women directly.

3. To gather information on men and women's perceptions, attitudes and health-seeking behaviors:

We will collect information from pregnant women who have not yet received PMTCT and their partners, pregnant women or new mothers who are receiving/have received PMTCT and their partners, and HIV positive women and their partners. It is to be noted that MOH plans to provide PMTCT services eventually to all pregnant women, hence, it is important that we not restrict ourselves to interviewing only positive women, or even women who are known to be partners of positive men. Therefore there is a need to discuss these issues with pregnant women who have not yet received services. At the same time, analysis of the numbers of women who test positive shows that a significant proportion of them are lost to follow-up as soon as they get tested. This group of women represents a marginalized group that is possibly of the greatest need for high quality confidential PMTCT services, but is outside of the health system. Ideally, it would be useful to interview some of these women, but they will not be easy to track to interview. Hence, we propose that instead, we interview positive women, regardless of whether they have ever been pregnant, and their partners. These women may, at some point, become pregnant, and will give us a useful insight into some of the attitudes and chal-

lenges to involving men in PMTCT interventions. We will use a combination of FGDs and in-depth interviews for these groups. Triangulation is ensured by visiting at least 2 communes where PMTCT is offered, and further, 1 commune from a district where no PMTCT services are available. Since HCMC offers PMTCT services in all districts, a non-UNICEF supported district will be chosen.

C. Basic Set-up

Data will be collected from three provinces: Quang Ninh, HCMC and An Giang. More specifically, data will be collected from 2 districts per province; 1 in which UNICEF-supported PMTCT services are being provided, and 1 in which they are not being provided. In those districts where PMTCT services are provided, 2 communes will be visited. In districts with no PMTCT services, 1 commune will be visited. These are:

Dates: 25 – 31 December
Quang Ninh: Provincial Level
Quang Ninh: Uong Bi District with PMTCT
Quang Trung Commune
Thanh Son Commune
Quang Ninh: Yen Hung District without PMTCT
Quang Yen Commune

Dates: 4-10 Jan
HCMC: Provincial Level
HCMC: District 6 with PMTCT
Commune #8
Commune #11
HCMC: District Hoc mon
Commune Ba Diem

Dates: 11-17 Jan
An Giang: Provincial Level
An Giang: Tan Chau District with PMTCT
Tan Chau Commune
Long Phu Commune
An Giang: Tinh Bien District without PMTCT
Commune (TBD)

D. Target groups:

Where?	Who?	What methodology?	How many people?
Central level	Key informants in government and/or int'l organization working on HIV/AIDS)	Interview	
Provincial Level	RH provincial center	Interview	PMTCT person*
	Provincial Hospital: Ob/Gyn Department or OB/GYN hospitals	Interview and Observation	Head of delivery dept*

District with PMTCT	District Hospital Maternity Ward	Interview and Observn of ANC	Head*
	District center of preventive medicine (in QN and HCMC) and District Hospital (in AG)	Interview	PMTCT person*
	District Farmer Association (for Tan Chau and Uong Bi) or Youth Union (for HCMC)	Interview	Head
Commune A	Commune Health Center Head and Midwife	Interview and Observn of ANC	Head and midwife
	Pregnant Women not received PMTCT	FGD	8
	Husbands/Partners of pregnant women	FGD	8
	Family members of those women	FGD	6
	Women receiving/received PMTCT	In-depth interview	1-2
	Husbands/Partners of above	In-depth interview	1-2
	Positive women not receiving/recd PMTCT	FGD/In-depth interview	6-8
	Husbands/Partners of above	FGD/In-depth interview	6-8
	Family of those women	FGD/In depth interview	4-6
	Positive women's self help group leader	In-depth interview	1
Commune B	CHC Head and midwife	Interview	
	Pregnant Women not received PMTCT	FGD	8
	Husbands/Partners of pregnant women	FGD	8
	Family members of those women	FGD	6
	Women receiving/received PMTCT	In-depth interview	1-2
	Husbands/Partners of above	In-depth interview	1-2
	Positive women not receiving/recd PMTCT	FGD/In-depth interview	6-8
	Husbands/Partners of above	FGD/In-depth interview	6-8
	Family of those women	FGD/In-depth interview	4-6
	Positive women's self help group leader	In-depth interview	1
Commune C in district w/ out PMTCT	Commune Health Center Head and Midwife	Interview	
	Pregnant Women	FGD	8
	Husbands/Partners of pregnant women	FGD	8
	Family members of those women	FGD	6
	Positive women not receiving/recd PMTCT	In-depth interview	1-2
	Husbands/Partners of above	In-depth interview	1-2
	Family members of those women	In-depth interview	1-2
	Positive women's self help group leader	In-depth interview	1

* Please provide names and exact titles ahead of time to the research team

Summary:

- Health Professionals: 7 X 3 interviews and 3 X 3 observations
- Community men and women and family: 9-15 X 3 FGDs, 7-16 X 3 in-depth interviews
- Community Informants: 3 X 3 in-depth interviews
- **Total: 21 interviews, 9 observations, 30-48 in-depth interviews and 27-45 FGDs**

E. Note to MOH and sub-departments on setting up these interviews, observations and FGDs

It would be very useful to have the names of the people at the health departments and hospitals with whom the team will meet ahead of time.

1. **At provincial level:** The team would like to meet with key person or team responsible for PMTCT services at the RH Provincial Center. The team would also like to meet with the head or deputy head of the Obstetrics Department of the Provincial Hospital (or in the case of HCMC—at one of the two Ob/Gyn hospitals)—who would know about women getting testing for HIV during labour and about administering SD NVP during labour and post-partum. If possible, it would be useful to also talk with the providers of ANC, but this is not critical at this level. Also, team would like to see the ANC room, the lab services and the pediatrics department. If possible, it would be good to observe some PMTCT services—possibly testing?
2. **At district level:** The team would like to meet with The team would like to meet with key person or team responsible for PMTCT services at the RH District Center. The team would also like to meet with the Head of the Ob/Gyn dept and some key colleagues at the District hospital—this group of people should be able to tell us about women getting testing during ANC, but also during labour. If possible, it would be useful to observe ANC services offered at this level in 7th or 8th month, when testing is also done. Also, team would like to see the ANC room, the lab services and the pediatrics department.
3. **At the commune level where PMTCT is offered:** First the team would like to meet with the CHC Head and the midwife (s) providing ANC. Second, the team would like to, if possible, observe ANC services in one commune where PMTCT services are being offered. Third, the team would like to hold a FGD with pregnant women, and a separate one with their partners, and their family members, particularly mothers-in-law. Fourth, the team would like to hold a FGD with positive women, and a separate one with their partners and their family members, particularly mothers-in-law. Fifth, the team would like to conduct in-depth interviews with women who have received PMTCT and their partners. Finally, the team would like to conduct an interview with a leader of a self-help group for positive women.
4. **At the commune level where no PMTCT is offered:** First the team would like to meet with the CHC Head and the midwife (s) providing ANC. Second, the team would like to hold a FGD with pregnant women, and a separate one with their partners, and their family members, particularly mothers-in-law. Fourth, the team would like to conduct in-depth interviews with positive women, and a separate one with their partners and their family members, particularly mothers-in-law. Finally, the team would like to conduct an interview with a leader of a self-help group for positive women.

If the number of FGDs seems excessive, it is possible to do in-depth interviews with positive women, their partners and family members in 1 of the 2 communes where PMTCT is offered, and FGDs in the other. This would reduce the FGDs to 36 in total, and the in-depth interviews would increase to 39.

F. Ethical considerations.

Some small compensation for pregnant women, their partners, and family members to participate in FGDs and interviews is planned, and should be given out during the meetings themselves. In addition, we must protect confidentiality—and hence, if participants are asked to sign names to

receive the compensation, these must not be disclosed to researchers. Researchers do not need to know names and addresses, only first names and ages of participants. It is recommended that participants sign a confidentiality and consent form. Further, It is recommended that some information (brochures or leaflets) on PMTCT services be provided to participants, which will be given when the meetings are finished.

Annex 4:
Questionnaire guides

Note to researchers: For the in-depth interviews and FGDs with community members, please do not follow the questionnaire exactly. Let the conversation flow more naturally and organically, but make sure you cover all themes and probe for information where you can. Warm-up is very important—chat for a few minutes, talk about yourself, and ask general questions about the interviewees. Ask for real-life examples wherever possible

1A. In-depth interview for women who have received PMTCT

Introductions, first name and age only of respondent. Introduce the purpose of the research.

1. What is your understanding about HIV, how it is transmitted, and how you can take care of yourself if you are HIV infected?

(Probe if needed) What is your understanding about HIV? How can one prevent transmission? What can you do to take care of yourself if you are HIV infected?

What do people consider to be high-risk behaviours that can increase HIV transmission? What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT. How is mother to child transmission best prevented? What do people know about PMTCT?

2. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

3. What was your experience with testing?

(probe if needed) Where did you go for HIV testing? At what point during the pregnancy did you find out? What are the challenges to women going in for HIV testing? Who can influence such a decision (probe who in the family influenced)? How will such a decision be made? What was the role of your husband/male partner in the decision to get a test? Did he also get a test? How much does it cost? Was it easy to get the test? What were the attitudes of the providers? Did you receive any advice/counseling from the health care providers? If yes, when did you receive this advice? Was it useful? Did you get the HIV test results? Who gave you the result? What was his/her attitude? Did you receive any advice/counseling from the health care providers when receiving the test results? If yes, when did you receive this advice? Was it useful? Did other people find out about the result? How did they find out?

4. What was your experience with receiving treatment, and care and support once you found out you had HIV, both for yourself and your baby?

(probe if needed) Did you receive medicine to help protect you and your baby from HIV? If so, what was this treatment? Did you have to pay money to receive it? If yes, how much? Any other expenses? Where did you receive this medicine? Was it difficult to get it? Was it difficult to follow the instructions? Did you follow the instructions? What were the challenges in following the instructions? How

did you deal with these challenges? Did you get any advice/counseling with the medicines—on how to take the medicine, what food to eat, how to take care of your baby? How often you get this? What kind of advice did you get—any advice on feeding the baby? Was it useful? Did you find it easy or difficult to follow the advice?

5. What are the attitudes in your community toward HIV infected persons? What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

How does the community behave with a woman who is HIV positive, especially if she becomes pregnant? How will her husband respond? Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child?

What are the general perceptions and attitudes toward HIV testing? Who should go for testing? Should all pregnant women get the test? Who should influence/decide if a pregnant woman should get a test? How did your husband react when you found out you were positive? How did your family respond? What about the community?

6. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is the opinion of your husband/male partner with regards to MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your husband's role?

What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? When you received PMTCT, did you get any support from the community? What about from your family? And your husband? Who else supported you? How did they support you (money, time, moral/emotional support, sharing workload)? Who was encouraging and helped you? What else helped to motivate you and keep you healthy?

Did you feel a lack of support or criticism from anyone in the community? Your husband? Your family? How did you respond to such criticism?

7. How do you and your husband discuss personal issues?

Do you and your husband talk about many things openly? What are the kinds of things you discuss openly with him? What are some things which are difficult to discuss with him? Do you discuss your health? Your husband's health? Your children's health? The future? What about more personal issues?—such are sexual relations, etc.

Is it easy for a wife to know if her husband is engaging in some high risk behaviour, or usually she will not find out? Do many men engage in some high risk behaviour in the community?

Do you think it is possible to talk about sex? If you do, who do you think you should discuss it with? Who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? In what way do you talk about sex with your husband/partner? (probe on several issues)

Do you discuss your health with your husband/male partner? What are the issues that you discuss? What issues are more difficult to discuss? Do you discuss you own HIV status and your baby's? Did you and your husband plan to have a child? ? Before you got pregnant, did you think there was a chance that you or he may have HIV? If yes, what did you discuss about this issue with each other and how?

8. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get tested and receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives? What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

1B. For men whose wives received PMTCT

Introductions, first name and age only of respondent. Introduce the purpose of the research.

1. What is your understanding about HIV, how it is transmitted, and how you can take care of yourself if you are HIV infected?

(Probe if needed) What is your understanding about HIV? How can one prevent transmission? What can you do to take care of yourself if you are HIV infected?

What do people consider to be high-risk behaviours that can increase HIV transmission? What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT. How is mother to child transmission best prevented? What do people know about PMTCT?

2. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

3. What was your experience with testing, both for yourself and your wife? Ask first if they have been tested. Then ask about wife getting tested

(probe if needed) Where did you go for HIV testing? Where did your wife go for testing? At what point during the pregnancy did she find out? What are the challenges to women going in for HIV testing? Who can influence such a decision (probe who in the family influenced)? How will such a decision be made? What was your role in the decision to get a test? How much does it cost? Was it easy to get the test? What were the attitudes of the providers? Did she receive any advice/counseling from the

health care providers? If yes, when did she receive this advice? Was it useful? Did she get the HIV test results? Who gave her the result? What was his/her attitude? Did she receive any advice/counseling from the health care providers when receiving the test results? If yes, when did she receive this advice? Was it useful? Did other people find out about the result? How did they find out? What was your reaction when you found out she was positive? What did you do?

4. What was your experience with receiving treatment, and care and support once your found out she had HIV, both for herself and your baby?

(probe if needed) Did your wife receive medicine to help protect her and the baby from HIV? If so, what was this treatment? Did you have to pay money to receive it? If yes, how much? Any other expenses? Where did she receive this medicine? Was it difficult to get it? Was it difficult to follow the instructions? Did she follow the instructions? What were the challenges in following the instructions? How did you/she deal with these challenges? Did she get any advice/counseling with the medicines—on how to take the medicine, what food to eat, how to take care of your baby? How often you get this? What kind of advice did you get—any advice on feeding the baby? Was it useful? Did you find it easy or difficult to follow the advice?

5. What is your role in terms of your wife's pregnancy, especially when you found out she was HIV positive?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is your opinion about MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your role?

What are your perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? When your wife received PMTCT, did she or you get any support from the community? Did she get support from you? What about from your family? Who else supported her? How did they support her (money, time, moral/emotional support, sharing workload)? Who do you think most encouraged and helped her? What else helped to motivate her and keep her healthy?

In your opinion, did she feel a lack of support or criticism from anyone in the community? From you sometimes? Your family? How did she respond to such criticism?

6. What are the community attitudes toward HIV infected persons, particularly in the local community? What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

How does the community behave with a woman who is HIV positive, especially if she becomes pregnant? How will her husband respond? Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child?

What are the general perceptions and attitudes toward HIV testing? Who should go for testing? Should all pregnant women get the test? Who should influence/decide if a pregnant woman should get a test? In your situation, how did the community respond to your wife's HIV status?

7. How do you and your wife discuss personal issues? With whom do you discuss personal issues

Do you and your wife talk about many things openly? What are the kinds of things you discuss openly with her? What are some things which are difficult to discuss with her? Do you discuss your health? Her health? Your children's health? The future? What about more personal issues?—such are sexual relations, etc.

Is it easy for a wife to know if her husband is engaging in some high risk behaviour, or usually she will not find out? Do many men engage in some high risk behaviour in the community?

Do you think it is possible to talk about sex? If you do, who do you think you should discuss it with? Who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? In what way do you talk about sex with your husband/partner? (probe on several issues)

Do you discuss your health with your husband/male partner? What are the issues that you discuss? What issues are more difficult to discuss? Do you discuss you own HIV status and your baby's? Did you and your husband plan to have a child? ? Before you got pregnant, did you think there was a chance that you or he may have HIV? If yes, what did you discuss about this issue with each other and how?

8. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get tested and receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives? What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

2A. FGDs/In-depth interview for positive women who have not received PMTCT.

Introductions, first name and age only of respondent. Introduce the purpose of the research.

1. What is your understanding about HIV, how it is transmitted, and how you can take care of yourself if you are HIV infected?

Probe if needed) What is your understanding about HIV? How can one prevent transmission? What can you do to take care of yourself if you are HIV infected?

What do people consider to be high-risk behaviours that can increase HIV transmission? What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT. How is mother to child transmission best prevented? What do people know about PMTCT?

2. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

3. What was your experience with testing?

(probe if needed) Where did you go for HIV testing? What are the challenges to women going in for HIV testing? Who can influence such a decision (probe who in the family influenced)? How will such a decision be made? What was the role of your husband/male partner in the decision to get a test? Did he also get a test? How much does it cost? Was it easy to get the test? What were the attitudes of the providers? Did you receive any advice/counseling from the health care providers? If yes, when did you receive this advice? Was it useful? Did you get the HIV test results? Who gave you the result? What was his/her attitude? Did you receive any advice/counseling from the health care providers when receiving the tests? If yes, when did you receive this advice? Was it useful? Did other people find out about the result? How did they find out?

4. What are the community attitudes toward HIV infected persons, particularly in the local community?

How does the community behave with a woman who is HIV positive? How will her husband respond? What are the general perceptions and attitudes toward HIV testing? Who should go for testing? How did your husband react when you found out you were positive? How did your family respond? What about the community?

5. What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child? Have you been pregnant/had a child or know of anyone who is pregnant/had a child and HIV postive? How did the community treat you and your child?

6. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is the opinion of your husband/male partner with regards to MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your husband's role?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

7. How do you and your husband discuss personal issues? With whom do you discuss personal issues

Do you and your husband talk about many things openly? What are the kinds of things you discuss openly with him? What are some things which are difficult to discuss with him? Do you discuss your health? His health? Your children's health? The future? What about more personal issues?—such are sexual relations, etc.

Is it easy for a wife to know if her husband is engaging in some high risk behaviour, or usually she will not find out? Do many men engage in some high risk behaviour in the community?

Do you think it is possible to talk about sex? If you do, who do you think you should discuss it with? Who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? In what way do you talk about sex with your husband/partner? (probe on several issues)

Do you discuss your health with your husband/male partner? What are the issues that you discuss? What issues are more difficult to discuss? Do you discuss you own HIV status and your baby's? Did you and your husband plan to have a child? ? Before you got pregnant, did you think there was a chance that you or he may have HIV? If yes, what did you discuss about this issue with each other and how?

If you and your husband decide to have a baby, will you discuss it? In what way will you discuss it? Who else would you discuss it?

8. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get tested and receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives? If you get pregnant, how will you and your husband respond?

What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

2B. FGDs/In-depth interviews with men whose wives are positive

Introductions, first name and age only of respondent. Introduce the purpose of the research.

1. What is your understanding about HIV, how it is transmitted, and how you can take care of yourself if you are HIV infected?

(Probe if needed) What is your understanding about HIV? How can one prevent transmission? What can you do to take care of yourself if you are HIV infected?

What do people consider to be high-risk behaviours that can increase HIV transmission? What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT. How is mother to child transmission best prevented? What do people know about PMTCT?

2. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

3. What was your experience with testing, both for yourself and your wife? Ask first if they have been tested. Then ask about wife getting tested

(probe if needed) Where did you go for HIV testing? Where did your wife go for testing? What are the challenges to men an women going in for HIV testing? Who can influence such a decision (probe who in the family influenced)? How will such a decision be made? What was your role in the decision to get a test? How much does it cost? Was it easy to get the test? What were the attitudes of the providers? Did she receive any advice/counseling from the health care providers? If yes, when did she receive this advice? Was it useful? Did she get the HIV test results? Who gave her the result? What was his/her attitude? Did she receive any advice/counseling from the health care providers when receiving the tests? If yes, when did she receive this advice? Was it useful? Did other people find out about the result? How did they find out? What was your reaction when you found out she was positive? What did you do?

4. What are the community attitudes toward HIV infected persons, particularly in the local community?

How does the community behave with a man or woman who is HIV positive? How will husbands respond when they find out that their wife is positive? What are the general perceptions and attitudes toward HIV testing? Who should go for testing? How did your husband react when you found out you were positive? How did your family respond? What about the community?

5. What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child? Has your wife been pregnant/had a child or know of anyone who is pregnant/had a child and HIV postive? How did the community treat your wife, you and your child? In general, how does the community respond to pregnant HIV positive women?

6. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is your opinion about MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what would your role be?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward HIV positive pregnant women who are receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

7. How do you and your wife discuss personal issues? With whom do you discuss personal issues

Do you and your wife talk about many things openly? What are the kinds of things you discuss openly with her? What are some things which are difficult to discuss with her? Do you discuss your health? Her health? Your children's health? The future? What about more personal issues?—such are sexual relations, etc.

Is it easy for a wife to know if her husband is engaging in some high risk behaviour, or usually she will not find out? Do many men engage in some high risk behaviour in the community?

Do you think it is possible to talk about sex? If you do, who do you think you should discuss it with? Who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? In what way do you talk about sex with your husband/partner? (probe on several issues)

Do you discuss your health with your husband/male partner? What are the issues that you discuss? What issues are more difficult to discuss? Do you discuss you own HIV status and your baby's? Did you and your husband plan to have a child? ? Before you got pregnant, did you think there was a chance that you or he may have HIV? If yes, what did you discuss about this issue with each other and how?

If you and your wife decide to have a baby, will you discuss it? In what way will you discuss it? Who else would you discuss it?

8. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get tested and receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives? If you get pregnant, how will you and your husband respond?

What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

3A. FGDs with pregnant women who have not been tested

Introductions, first name and age only of respondent. Introduce the purpose of the research.

1. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is the opinion of your husband/male partner with regards to MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your husband's role?

2. How do you and your husband discuss personal issues? With whom do you discuss personal issues

Do you and your husband talk about many things openly? What are the kinds of things you discuss openly with him? What are some things which are difficult to discuss with him? Do you discuss your health? His health? Your children's health? The future? What about more personal issues?—such are sexual relations, etc.

Is it easy for a wife to know if her husband is engaging in some high risk behaviour, or usually she will not find out? Do many men engage in some high risk behaviour in the community?

Do you think it is possible to talk about sex? If you do, who do you think you should discuss it with? Who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? In what way do you talk about sex with your husband/partner? (probe on several issues)

Do you discuss your health with your husband/male partner? What are the issues that you discuss? What issues are more difficult to discuss?

Had you planned to have a child? Did you and your husband discuss it beforehand? In what way will you discuss it? Who else did you discuss it with?

3. What is your understanding about HIV, how it is transmitted, and how you can take care of yourself if you are HIV infected?

(Probe if needed) What is your understanding about HIV? How can one prevent transmission? What can you do to take care of yourself if you are HIV infected?

What do people consider to be high-risk behaviours that can increase HIV transmission? What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT. How is mother to child transmission best prevented? What do people know about PMTCT?

4. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

5. What are the community attitudes toward HIV infected persons, particularly in the local community?

How does the community behave with a woman who is HIV positive? How will her husband respond? What are the general perceptions and attitudes toward HIV testing? Who should go for testing?

6. What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child? Do you know of anyone who is pregnant/had a child and HIV postive? How did the community treat her and her child?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

7. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get HIV tested? If she is positive, how should he support her to receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives?

What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

3B. FGDs with male partners of pregnant women

Introductions, first name and age only of respondent. Introduce the purpose of the research.

1. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/

partner? What is your opinion about MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your role?

2. How do you and your wife discuss personal issues? With whom do you discuss personal issues

Do you and your wife talk about many things openly? What are the kinds of things you discuss openly with her? What are some things which are difficult to discuss with her? Do you discuss your health? Your wife's health? Your children's health? The future? What about more personal issues?—such are sexual relations, etc.

Is it easy for a wife to know if her husband is engaging in some high risk behaviour, or usually she will not find out? Do many men engage in some high risk behaviour in the community?

Do you think it is possible to talk about sex? If you do, who do you think you should discuss it with? Who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? In what way do you talk about sex with your husband/partner? (probe on several issues)

Do you discuss your and your wife's health with your husband/male partner? What are the issues that you discuss? What issues are more difficult to discuss?

Had you planned to have a child? Did you and your wife discuss it beforehand? In what way do you discuss her pregnancy? Who else do you or she discuss it with?

3. What is your understanding about HIV, how it is transmitted, and how you can take care of yourself if you are HIV infected?

(Probe if needed) What is your understanding about HIV? How can one prevent transmission? What can you do to take care of yourself if you are HIV infected?

What do people consider to be high-risk behaviours that can increase HIV transmission? What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT. How is mother to child transmission best prevented? What do people know about PMTCT?

4. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

5. What are the community attitudes toward HIV infected persons, particularly in the local community?

How does the community behave with a woman who is HIV positive? How will her husband respond? What are the general perceptions and attitudes toward HIV testing? Who should go for testing?

6. What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child? Do you know of anyone who is pregnant/had a child and HIV postive? How did the community treat her and her child?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

7. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get HIV tested? If she is positive, how should he support her to receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives?

What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

4. In-depth interviews with family members where appropriate

1. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

2. What are the community attitudes toward HIV infected persons, particularly in the local community?

How does the community behave with a woman who is HIV positive? How will her husband respond? What are the general perceptions and attitudes toward HIV testing? Who should go for testing?

3. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is the opinion of your husband/male partner with regards to MCH/FP services in

health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your husband's role?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

4. What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child? Do you know of anyone who is pregnant/had a child and HIV postive? How did the community treat her and her child?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

5. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get HIV tested? If she is positive, how should he support her to receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives?

What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

5. Interviews with community leaders (depends who these are):

Introductions, first name and age only of respondent. Introduce the purpose of the research.

For leaders of Sympathy Clubs:

When did the club start? Who supports it? How many members? How many people working to run the club? What activities do you do? How often do you meet? What are the attitudes of the community toward the club? Health workers? What is difficult about running the club? What is rewarding and motivating?

1. What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women?

(probe if needed) Where are services available? How much do they cost? What does the MOH/government health service offer?

2. What are the community attitudes toward HIV infected persons, particularly in the local community?

How does the community behave with a woman who is HIV positive? How will her husband respond? What are the general perceptions and attitudes toward HIV testing? Who should go for testing?

3. What support, or lack of support, do pregnant positive women experience?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What is the opinion of your husband/male partner with regards to MCH/FP services in health centers? Can men go there? Should they? What are suitable levels of involvement for men during pregnancy? In your home, what is your husband's role?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

4. What are the attitudes towards pregnant women who are HIV positive, or who learn about their HIV status during their pregnancy?

Does the community feel that a woman who is HIV positive or married to a man who is HIV positive should have a child? Do you know of anyone who is pregnant/had a child and HIV postive? How did the community treat her and her child?

In your opinion, should all pregnant women get a HIV test? Who should influence/decide if a pregnant woman should get a test? What are the general perceptions and attitudes toward a HIV positive pregnant women who is receiving treatment and counseling to protect her health and her baby's health? Will they get support from their families? Their husbands? Do you think they feel a lack of support or criticism from anyone in the community?

5. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get HIV tested? If she is positive, how should he support her to receive treatment? What should the men do/what are the ways in which they should be supportive? In reality, do they support their wives? If yes,

what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives?

What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

6. Interviews with Health Personnel at various levels

Name of Health Centre:
Name of person being interviewed
Position of person being interviewed

A. Describe the Antenatal Care

1. Do you offer ANC services at your center?
2. On average, how many pregnant women come each month for ANC to your centre?
3. What proportion of the pregnant women in the commune/district/province come to you center for ANC?
4. On average, how many ANC visits do most pregnant women make?
5. On average, how many months pregnant is a woman when she comes in for ANC to your center?
6. On which day(s) do you offer ANC?
7. In the last month, how many women came for ANC on those days? If significantly different from response to 1, prob why
8. What ANC services are available for women at this centre:
    a. Counseling on women's health
    b. Iron tablets
    c. Folic acid tablets
    d. Urinalysis
    e. Blood tests (what are these for?)
    f. Taking height, weight, blood pressure
    g. Tetanus toxoid immunization
    h. Testing for STIs
9. Do you offer HIV testing at your center for pregnant women?
10. If yes, describe the process for offering the test? Is it done for all pregnant women? Do you ask them if they want to? Do they have to ask for it (i.e. you do not offer it)? Do you offer pre-test counseling?
11. On average, at what point during the pregnancy are women tested? In your health centre in the last six months, how many women were a) given pre-test counseling, tested, given results, and given post-test counseling? At what point in their pregnancy were most of these women?
12. Do you perform the actual tests at your center? If not, where is the blood transported?
13. What sort of tests do you/the referral place do for HIV? Rapid test or ELISA or WB
14. Between the time the blood is drawn, how many days does it take to get a result?

15. How is the result given to the woman? Who gives it? Is the result shared with anyone else, e.g. leaders in the commune where she lives?
16. Do men and women come in together for testing? If not, do you ask the women to bring their husbands in for testing?
17. Do you give results to a) the woman b) someone in the family (state who), c) the husband, d) someone else?
18. Do you offer post-test counseling? Is post-test counseling offered to a) woman only, b) woman and her mother-in-law or close relative, c) the couple?

B. Describe labor and delivery

1. Do women deliver at your center?
2. On average, per month, how many women deliver at your centre?
3. Last month, how many women delivered?
4. Do you handle all cases of delivery? If not, what cases do you refer? Where do you refer them to?
5. Can you do c-sections at your center?
6. Do HIV positive women deliver at your center? If not where do they deliver?
7. Do you test women for HIV during delivery?
8. Do they sign a consent form? Do you keep copies of the consent form? If yes, ask if possible to see a few.
9. What tests do you do at the center? Rapid test, ELISA, WB
10. Do husbands and/or family members have to agree for the woman to get a HIV test?
11. Do you give the woman the result? If not, what are the reasons? Do you give someone in the family the result? Who do you normally give the result to?

C. Describe PMTCT services offered post testing

For Ob-Gyn department

1. On average, when do you find out that a pregnant woman is positive? Is it during pregnancy or during delivery?
2. What services do you offer to pregnant women who are HIV positive? Do you offer
    a. post-test counseling?
    b. ARV during pregnancy at 28 weeks? At 36 weeks?
    c. C-sections?
    d. ARV during labour?
    e. ARV after the baby is born?
    f. Infant feeding counseling? Infant formula?
3. Describe the protocols you follow once you know a woman is positive
4. Are there guidelines from MOH on testing and treating pregnant women for HIV? Do you have these guidelines? Do you follow these exactly or do you face some challenges in following them? If not exactly, how deviate and what reasons?

5. How do you involve husbands in the post-test period and for care and support?
6. In the last six months, how many HIV positive women did you treat and what did you give them?

For the pediatrics department:

7. Do you give formula and is it free of charge?
8. How does a woman receive it? How often does she have to come back?
9. Do you test the child at 18 months?
10. In the last year, how many children born to HIV positive women have you taken care of? How many tested at 18 months? What happened to the others?

D. Overall

1. What are the direct costs for your services?
2. Are there any indirect costs? If so, what are these and how much?
3. What are the linkages and integration between MCH and PMTCT services?
4. At the commune level, do you also offer VCT?
5. At all levels, how do you link PMTCT, VCT, ANC, labor and delivery, and well-baby care services?
6. What are the major challenges to providing these services to HIV positive women? What are the opportunities?

E. Lab services if available

1. Do you do tests for HIV? Which tests do you do? How many per year?
2. Do people have to pay for the tests?
3. Do the patients come to you directly? Do some places also send you blood? Where do you receive the blood from?
4. How do you give results, both when you have taken the blood yourself, and when you get it from another place?
5. If another place, how do they give the results? Are the results shared with the community leaders?

F. What levels of awareness exist within the community on HIV and PMTCT?

What are the sources of information on HIV prevention and care and support? What are the places where services are available for HIV positive women? For HIV positive pregnant women? Where, other than your center does a woman go for HIV testing? How much does it cost? Is it easy to get the test? What do people know about PMTCT?

G. What are the major community and intra-household factors that encourage or discourage acceptance of PMTCT services?

For women in the community, who is it easy/comfortable to talk to about sex? Who is it difficult to talk to about sex? Do husbands and wives talk about sex with each other? In what ways do they talk about sex?

What sort of support is available to pregnant women? From whom can support be expected? How will this support be given? What is suitable for a man to do during pregnancy to support his wife/partner? What are suitable levels of involvement for men during pregnancy?

What are the general perceptions and attitudes toward HIV testing? Who do you think should go in for testing? What are the general perceptions and attitudes toward pregnant women getting a test? Who should influence/decide if a pregnant woman should get a test?

What happens in the community if it is known that one is positive? Do you know of pregnant women who are positive? How does the community feel about women who are positive who are pregnant/want to have a child? What are the general perceptions and attitudes toward receiving PMTCT services? When a woman receives PMTCT, does she usually you get any support from her family? What about her husband? In what ways do they support her? What else helps to motivate her and keep her and her baby healthy?

H. What do you know about the health-related behaviors among pregnant women

What prevention practices are people familiar with and actually use to prevent a baby from getting HIV? Probe on safer sex, needle use, PMTCT

What factors influence a pregnant positive woman to follow/accept PMTCT? What are some of the challenges? Probe on male partners? (any cases where men stopped or supported—explain more—reasons, motivations, cultural barriers)

I. How do men support or discourage their wives to get testing and medicine to protect their own health and that of the baby? What can be done to encourage men to be more involved?

In your opinion, how important is it for a husband/male partner to support his wife to get tested and receive treatment? What should the men do/what are the ways in which they should be supportive? Should the husband also go for testing? In reality, do they support their wives? Do they go for testing? If yes, what motivates them? If not, what do you think are the reasons that they cannot/do not support their wives? What, in your opinion, can be done to reach out to men who are with pregnant positive women to encourage them to support their wives/female partners?

If you have no time to go through the whole questionnaire, focus on Sections A-E, F and H

7. Observations of the PMTCT service

Observe and respond to the following questions. Do not ask questions to the providers unless you are unsure, just observe.

A. Commune Health Center during ANC services

Are HIV tests being offered?
Do any women accept?
Is pre-test counseling offered?
Is this offered in a private room?
Is the male partner or a family member present? If yes, state who it is.
Is the pre-test counseling offered to the woman with this person?
What do you think are the attitudes of the provider?
Has the woman been singled out and offered a test or are tests being offered to all women?
Was blood taken from the woman? If so, did it appear that infection prevention procedures were carried out?

B. District Hospital during ANC services

Observe and respond to the following questions. Do not ask questions to the providers, just observe
Are HIV tests being offered?
Do any women accept?
Is pre-test counseling offered?
Is this offered in a private room?
Is the male partner or a family member present? If yes, state who it is.
Is the pre-test counseling offered to the woman with this person?
What do you think are the attitudes of the provider?
Has the woman been singled out and offered a test or are tests being offered to all women?

C. Provincial Hospital during labor and delivery (if possible)

Are women being asked to take an HIV test?
Are all women being asked, or just some? If just some, can you tell why only some are asked?
When women are asked, do they or their family members have to sign a form?
Are they allowed to refuse to take a test?
Are they tested without asking their permission?
Who is informed of the result?
If positive woman: What medicines are given to the woman during labour and delivery to prevent the baby from getting HIV?
What are the attitudes of the provider?

D. Provincial or district hospital after birth for positive women

Does the woman know she is positive?
Did she choose to get a test?
Has her husband been tested?
Did she and her baby receive medicine? If yes, what medicine and when?
Was she given any counseling on feeding her baby? Any formula?
What is the attitude of the providers toward her?

Annex 5:
List of interview of miv study

Provincial level:	
1	Interview health worker of RHC
2	Interview Head of Ob/gyn Department of Provincial Hospital
3	Interview- observation Ob/gyn Dept. of Provincial Hospital
4	Interview health staff of Quang Ninh PAC
Uong Bi District	
5	Interview health staff of PMC of Uong Bi
6	Interview lead of Farmer Association
7	Interview health staff of Ob/gyn Dept., Uong Bi Hospital
Quang Trung Commune	
8	GD family member in Quang Trung
9	GD husband of pregnant women in Quang Trung
10	Interview 2 husband of 2 positive women in Quang Trung
11	IDI 2 positive women in Quang Trung
12	Interview leader of community in Quang Trung
13	Interview health staff of Quang Trung Commune
14	Interview pregnant women with no HIV testing in quang Trung
Thanh Son Commune	
15	GD PW without HIV testing in Thanh Sơn
16	Interview lead of community
17	Interview 2 husband of positive women in Thanh Sơn
18	Interview 2 women who have positive husband in Thanh Son
19	Interview positive women in Thanh Sơn
20	Interview health staff of Thanh Son Commune
Yen Thanh Commune	
21	Interview positive women in Yên Thanh
22	Interview mother in law of positive women in Yên Thanh
Phuong Dong Commune	
23	Interview husband of positive women, Phuong Dong commune
24	Interview positive women, Phuong Dong Commune
Quang Yen Commune (without PMTCT)	
25	GD PW without HIV testing
26	Interview health staff of Quảng Yên Health Station
27	Interview 3 husbands of positive women
28	GD mother in law of PW in Quảng Yên
29	GD husband of PW without HIV testing, Quảng Yên
30	Interview lead of peer group in Quảng Yên
31	Interview positive women in ARV treatment in Quang Yen Commune
Provincial level	
1	Interview with Provincial RHC
2	Interview health worker of PAC
3	Interview Tu Du Hospital
District 6	
4	Interview with Youth Union of District 6

5	Interview health worker of Medical Preventive Center of District 6
6	Interview health staff of Hospital of District 6
Commune 8, district 6	
7	Indepth interview husbands of PW without HIV testing
8	Indepth interview mother in law of PW without HIV testing
9	Indepth interview husbands of PW without HIV testing
10	Indepth interview mother in law of HIV positive PW received PMTCT service
11	Indepth interview husband of HIV positive PW received PMTCT service
12	Indepth interview mother in law of HIV positive PW received PMTCT service
13	GD husband of positive women in Commune 8, district 6
14	GD PW without HIV testing, commune 8, district 6
15	Interview positive women received PMTCT services
16	Interview husband of PW with PMTCT services
17	Interview positive women, no PMTCT services
18	Interview health staff of Commune 8, district 6
Commune 11, district 6	
19	Indepth interview husband of PW
20	Group discussion with health workers of 11# CHS, 6# District
21	Group discussion of HIV positive PW received PMTCT service
22	Group discussion with staffs and Head of Sympathy club, #6 District
23	Interview mother of positive women
24	Interview pregnant women
25	Interview family member of positive women
26	IDI of husband of positive women with PMTCT services
27	IDI positive women
28	GD family member of positive women
29	IDI family member of positive women
30	IDI husband of positive women
An Hoa Clinic	
31	Group discussion husband in Outpatients clinic An Hoa
32	GD positive women
33	GD family member of positive women
Hoc mon District (not under UNICEF project)	
34	In depth interview husband of PW
35	In depth interview mother of HIV positive mother received PMTCT services
36	In depth interview health workers of Hoc Mon Medical preventive Canter
37	IDI health staff of Hocmon Hospital
38	GD pregnant women
39	IDI positive women with PMTCT services
40	IDI health staff of CHC
Provincial level	
1	GD health staffs of An Giang RHC
2	Interview Health staff of An Giang Hospital
District level	
3	IDI Head of Farmer Association of Tan Chau District

4	GD health staff of PMC of Tan Chau
5	IDI health staff of Tan Chau Hospital, OPC of FHI, member of Sympathy Club of Hospital
6	IDI health staff of Tan Chau Hospital: staff of VCT site of FHI
7	IDI leader of Sympathy Club, Small Rose Club
Tan Chau Town	
8	GD husband of PW
9	GP husband of PW
10	IDI husband of positive women received PMTCT service
11	GD member of Sympathy group of Tan Chau Hospital
12	IDI positive PW received PMTCT services
13	GD member of Sympathy club of Tan Chau district
14	IDI husband of positive PW, received PMTCT services
15	DI husband of positive PW, received PMTCT services
16	IDI family member of pregnant women
17	GD family member of positive women
18	GD pregnant women, no PMTCT services
19	IDI positive women received PMTCT
20	GD positive women, no PMTCT services
21	IDI health staff of CHC
Long Phu Commune	
22	IDI husband of positive PW, received PMTCT services
23	IDI husband of PW without HIV testing
24	IDI husband positive PW, received PMTCT services
25	IDI positive PW, received PMTCT services
26	GD health staff of Long Phu Health Station
27	GD husband of PW
28	IDI staff of Farmer Association of Long Phú
29	IDI positive women, no PMTCT services
30	IDI family member of positive women
31	GD family member of pregnant women
32	GD pregnant women
Tinh Bien District (no PMTCT services)	
33	IDI of health staffs PMC of Tinh Bien District
34	Interview pregnant women
35	IDI staff of Sympathy club of Tịnh Biên
36	GD husband of PW
37	GD the couple of PW
38	IDI husband of PW
39	IDI health staff of Tinh Bien Hospital
40	IDI positive women received PMTCT
41	IDI pregnant women
42	IDI positive women
43	IDI pregnant women, no HIV testing
44	IDI health staff of CHC

Annex 6:
Detailed findings

A.Inter-spousal communication and decision-making on reproductive health.

Summary of the findings related to male involvement:

This study finds that men's role in decisions around antenatal care and childbirth, including routine testing for HIV during pregnancy, is not very significant. However, men's role in fertility and sexual health decisions, including communicating about risk behaviors, contraception, decision to have (or not have) a child, and decisions to terminate a pregnancy, are significant.

This study finds, as have many others conducted in Vietnam, that women's decisions around fertility, contraception, childbirth, and health seeking behaviors during pregnancy, childbirth and postpartum, both with regards to their own health as well as that of their children, are influenced by a rather complex set of factors which, in turn, shape and influence women's preferences and desires. These preferences and desires interact with some of those same factors, manifesting themselves in women's behaviors and actions around their own health and that of their children.

In this study, women, men, community members and health professionals stated over and over again that **reproductive health care decisions were made by women by themselves**. It is critical to note that these decisions mostly related to those around antenatal care and childbirth, and were the end-result of interactions and influences in a woman's life outside of the health center. Further, this study finds that the high regard and trust place in health providers by Vietnamese women (and often their family members as well) may affect the degree of real choice exercised—women are reluctant to oppose the advice of health providers. In a context where the words for counseling, consulting and advice are almost synonymous, and where the line between helping a woman make a choice and advising her on the perceived right choice is blurry, it is not clear that women make full choices. Finally, some reproductive health services are free (PMTCT services are free for example). Decisions that involve expenditure, especially major expenditure, would need to be taken up with a husband. For example, one of the reasons cited for women not accepting tests was concern about the costs of such a test. As long as services are free, women are more comfortable making a decision on their own.

Decisions about sexuality, sexual health and fertility need to be distinguished from decisions around antenatal care and facility-based delivery. Such decisions are hugely influenced by husbands and family members. Decisions on contraception are discussed between husband and wife, especially with regards to the decision to start or stop its use in relation to the decision to have (or not have) a child. Conversations around STIs may or may not take place between couples. Unsurprisingly, men do not discuss STIs with their wives for concern that they may be accused of infidelity. Men report discussing issues related to sexuality with friends including concerns about contracting a disease, rather than their wives. They may choose to self-medicate or go on their own to a doctor. Some do feel comfortable discussing issues related to sexual health with their wives, but largely, it is still a taboo issue. Discussions on sexual health are related to issues of disclosure as well as decisions such as couple testing.

The expectation that a married couple would have a child is quite high. Not having a child would certainly be noticed and speculated on in a community, and women are under pressure in some families to produce a male heir to continue the lineage. However, while the desire to have a child is universal, some positive couples have decided or may prefer not to have a child (even if they want one) because of their concern about infection and their own inability to raise a child. In such situations where women would have preferred not to have a child, pressure exerted by family members

is difficult to resist. Examples from this study show that women who might have chosen to not get pregnant or have an abortion were pressured into having a child.

A1. Inter-spousal communication

Most men and women said that they spoke to each other about a range of things, and were the first ones that they would confide in if there was a problem. Topics such as health, health care, work, money and having and raising children were often discussed, including contraception, contraceptive methods and stopping contraception when one wants to have a child.

- "In our life, we always talk together, with so much love. We ask together to agree or not for everything. If he wants to go somewhere, he asks me, not like another people." *Positive woman, Uong Bi, Quang Ninh*
- "We often talk to each other when we have health problems, maybe our problems or our child's problems. Other matters we seldom talk about." *Positive man, District 6, HCMC*
- "We often confide in each other about our job. If we have problems, we will talk together." *Pregnant women, District 6 HCMC*
- "Talking on everything with the husband, nothing difficult to tell him. But we rarely talk about sex, don't mention it." *Positive women, District 6, HCMC*
- "In most families, married couples talk with each other about issues of pregnancy tests and HIV tests. But wives are still people who put forward these issues whereas husbands only give out their opinions and take their wives to pregnancy tests. There are many women who decide to go for pregnancy or HIV tests by themselves. Others ask their husbands for advice in advance." *Health Staff, Tan Chau, An Giang*
- "We seldom talk about that (sex and related matters such as contraception) but before having a baby we did talk to each other, but when we wanted to have a baby, we stopped." *Husband of pregnant women, Tan Chau, An Giang*

Topics such as sexuality and sex were considered taboo. Men expressed a range of responses when asked who they discussed sexuality with. Some said that they spoke with friends, others said they spoke with no one, and still others said they would speak with their wives.

- "For example, when I went out and had sex with a prostitute and I was not so clear about that then I told my friends I had just slept with a prostitute but I hadn't used a condom; yet I had ejaculated outside not inside. So, would I be infected? That sort of thing." *Husband pregnant woman, Tan Chau, AG*
- "As for personal issues related to sex, men often talk with their friends first, then if they can not work out any solutions, they will tell their wives later. They do not tell their wives right away about their problems. The last resort is they go to see doctors or buy medicine to take. I suppose it is not quite good, but it is nature of men." *Farmers Association, Tan Chau, An Giang*
- "I talk mainly to my friends (if I have delicate problems such as problems concerned with sex)"
- "I conceal this kind of problem. Who can tell this to the parents? (all are smiling). Mostly I am afraid that my parents think I had the unprotected sex, and it's difficult to tell them clearly about this problem. Talk to my friends, and they will help if they can."
- "It's funny to tell them about this. (smile)." *Husbands of pregnant women, Tan Chau, An Giang*

Husbands and wives rely a great deal on each other as most live in nuclear families.

- "Actually, when we women get pregnant, we find that we are leading a hard life already, not until the time we know we get infected. In those times, we just want to rely on our husbands, who else can we rely on? If husbands do not help, encourage us, we have to stand up with the situation, from whom we can ask help for?" *Positive woman, District 6, HCMC*
- "Yes, I can only talk about those issues with my wife, not anybody else. I talk with her everything that happens to me." *Husband of pregnant woman, District 6, HCMC*

Men are still expected to earn money and be the primary bread-winner. Most of the families interviewed in this study are relatively poor—they have a certain amount of income insecurity or are just above the poverty line. The pressure to earn money seems considerable, especially if the family is young. Many men stated that they worked very hard as they felt a strong sense of responsibility to earn money for their families, and, as they worked long hours, some said they were too tired to discuss things with their wives.

- "Yes, of course. Since I have been married, I have to do everything. I have to earn enough money to support my family, I have to take care about this and that." *Husband of pregnant woman, Tan Chau, An Giang*
- "For many people – the wife stays at home to do the house work, and the husband works to support the wife and children. Most husbands work as bread winner for the family, and the wife mainly do the housework in the family." *Family members of pregnant women, Tan Chau, An Giang*
- "My wife and I leave the morning and go back home the evening to earn money for our children. We have no time for discussion, sometime we don't see each other all the day." *Positive men, Tan Chau, An Giang*
- "We often talk to reassure each other, and how to take care of our kids, we do not know how long our lives last. I am worried about the health of my wife and my children. She always encourages me. I collect rubbish thing (waste, junk) everyday and she helps me to earn our living." *Positive man, District 6, HCMC*
- "He works harder all the day from having a baby, and the work seems much more. Formerly, he used to work several days in a month, the rest days are day-off before giving birth. But it now is totally different. He works at operation sites and seems not to rest." **Mother-in-law positive woman, District 6, HCMC**
- "Some do not ask because of tiredness after returning home from work." *Pregnant woman, Hoc Mon, HCMC*
- "She didn't tell anything, I felt tired the evening, and go to bed immediately, each one on the opposite side in bed." *Positive man, Tan Chau, An Giang*

At the same time, husbands' opinions and ideas are still highly regarded. Women do seek their husbands' opinions on a range of topics.

- The husband's role is very important. Most of women here ask their husband, they discuss everything. Normally women follow their husband ideas. *Family members positive woman, Hoc Mon, HCMC*

Many men and women said that they discussed their readiness to have a child and plans for children.

- "We must plan it (to have a baby). Nowadays, we are not allowed to have many babies. We also have to plan how to bring them up in advance."
- "When we want to have babies, we also have to plan how to bring them up."
- "I even have a detailed plan." *Husbands of pregnant women, Tan Chau, An Giang*
- "I just think I am concerned about our baby's health. I just wish our baby will be born in a healthy state." *Positive man, Hoc Mon, HCMC*

A2. Household-level decision-making

Although men are supposed to be the traditional "heads of households" and major decision-makers, this study reveals that younger couples in Vietnam make decisions jointly. Over and over again, men and women interviewed stated that they discussed and made decisions jointly, or based on who was "right".

- "Husband and wife discuss together and then make the decision." *Pregnant woman, Hoc mon, HCMC*
- "We are in good harmony, he never dominates things. I am not sure about the others." *Pregnant women Tan Chau, An Giang*
- "She decides some by herself, for other issues, she talks with me. We discuss and decide." *Positive man, Hoc Mon, HCMC*
- "I take care of and decide everything."
- "Everything is discussed together."
- "Everything is discussed and shared joyfully. I am not dependant on my husband."
- "Everything is discussed together."
- Positive women, Tan Chau, An Giang
- "Wife is equal with husband, she doesn't depend on him." *Pregnant women, District 6, HCMC*
- "We both talk and listen to the one that is right." *Positive woman, District 6, HCMC*

A3. Expectations of male partners during pregnancy and childbirth

Men and women all recognized that pregnancy was a special period, where women required extra attention and support. They stated that women were more tired, more emotional and needed more support during pregnancy and expected husbands to play an important role.

- "Pregnant women are more susceptible to be angry, so not everybody can please his wife. We shouldn't be angry too, because we will make them be more tired. They are not as fine as when they aren't pregnant." *Husbands of pregnant woman, Uong Bi, Quang Ninh*
- "When wife is pregnant, husband must do all heavy works, let her have a rest, eat enough food and not be on a diet, help her have best health." *Mother in law of positive woman, Uong Bi, QN*
- "They take care of their wives so much, take their wives to see doctor, to give birth, they help with anything, they are getting closer. Whenever she gives birth, he must take her to hospital, solace her, when she get tired, he take her to see doctor, to take pills and do housework for her. But in many families, husbands have to work all day, only get back home at night, they can't take their wives to have pregnancy examination. There are not many people that take their wives to have pregnant examination here." *Family member of pregnant woman, District 6 HCMC*

Men and women also reported that they helped their wives during pregnancy with housework.

- "Our couple is living alone. All the heavy works are done by husband. When the wife is pregnant, he buy more food for her. Just doing the lightly works like laundry, prepare the meals…Other heavy works are done by husband." *Pregnant woman, Yen Hung, Quang Ninh*
- "(You have to help a pregnant wife) so much (everybody laugh loudly) I don't let her do hard work when she is pregnant, and I help her to do work like cooking
- "With me, I have to do everything such as washing dishes, washing clothes, cooking. When I finish my work, I help my wife. Everybody around me says that: it's happy to live with parents, and it's a little bit miserable to live with your wife (everybody laugh together)
- "When I help her, my pregnant wife will avoid having any problem.
- "When they are pregnant, they are weak, so they aren't allowed to do hard work. Hard work is for man. *Husbands of pregnant women, Tan Chau, An Giang*

In some cases, where the couple was living with parents, husbands did not help as much.

- "I lived with my mother in law only (father in law is passed). Husband is mine worker under shift work. When he back from work, he is tired therefore he could not help much. Last time I got sick and admitted hospital for 12 days, my husband had off work for taking me to the hospital, during time of in patient, my mother in law help me mostly since my own parent is living far from me." *Pregnant women, Uong Bi, QN*

Women said that they expected men to provide financial support and emotional support during pregnancy. Many women also said that their husbands asked them how they felt, about what they would like to eat, and if they had eaten enough.

- "That women need to be supported most is sentiment and then finance." *Health staff, Uong Bi, Quang Ninh*
- "Besides economy, sentiment is very important. Most important, the husband must be concerned about his family. Giving birth with out your relatives concern is terrible." *Pregnant woman, Uong Bi, Quang Ninh*
- "Yes, he has. He cares and he does heavy work, I do light work only. When I did this and that, he told me to rest and asked if I would like to eat anything then he would buy for me but I said I did not want to. When I am pregnant he asked whether I vomitted or not but I said I didn't." *Pregnant woman, Tinh Bien, AG*

A4. Reproductive health care decision-making

Reproductive health care decisions are clearly seen as the domain of women. Men and women stated quite confidently and openly that women could make decisions on their own with regards to health care **(See more under section "testing during pregnancy and delivery")**.

- "I did not ask my family, I can decide on my own. The staff at the Health station advised me to go for a pregnancy check up. When I came to the station, I was advised to take the test to know about my infection and heath. I agreed immediately." *Positive woman, district 6, HCMC*
- No one (influenced my decision to get a test). I just decided by myself and went to the Swedish Hospital to get tested. My husband did not object to it

- I decided by myself. I did talk to my husband and he agreed. He said I should go to get to know the status. *Positive women, Uong Bi, Quang Ninh*
- "What is usual is that wives decide rather than husbands. Husbands mainly listen to results reported by their wives. They even don't listen. They just entrust their wives to those issues." *Sympathy club leader, District 6, HCMC*
- "Perhaps it is mainly the wife who makes all the decisions about family health, such as taking prenatal check-ups, having vaccinations, giving birth to babies, because the husband usually does not care for such things (smiled)."
- "The wife is the decision-maker. But for using condoms I guess there must be a consensus between them (smiled)."
- "For some couples the wives told the husbands they were going to have a prenatal check-up on that day, or asked if they could take an HIV test. But some do not ask their husbands because in this areas, most men have to go to work from early morning till evening so their wives make all the decisions and then tell their husbands the results after that. Furthermore, their husbands do not care much about such things." *Positive men, Tan Chau, AG*
- "In this area, wives also make decision on their own for health related issues and the husbands would agree to. Some families where the couples discuss health matter together but this only happens to families with high education level. For farming families, only wives are concerned on health care matters, husbands just play role of earning money." *Health Staff, An Giang*
- "Many men consider that health care for women and for pregnant women is women's business." *Sympathy club leader, Tan Chau, An Giang*

In general men had little knowledge of health services and the different components of ANC. They were aware of the need for pregnant women to rest and to eat nutritious food, but were not very informed about visits to the health providers. Some wives informed them about what happened during an ANC visit, others did not. Many couples and family members reported that husbands accompanied wives for ANC visits although it varies based on proximity and employment. It appears that most men went with wives for at least 1-2 visits, especially in the first pregnancy. Men did not actually go into the facility often, but waited outside or at a nearby coffee shop. Some dropped their wives off and went to work. Several men also stated that they had a role to play in reminding their wives to go for ANC visits and to take care of themselves.

- If there are chairs there, I sit on, if not, I go to wait in the hall
- There are chairs there for the family.
- My wife asked me to go, she said that she wanted to go there to examine
- I remember that I took her to hospital for inoculating 2 times, in about the fourth, the fifth month. *Husbands of pregnant women, An Giang*
- I suppose that men should encourage their wives to go for pregnancy, HIV tests because pregnant women hesitate to go as they are tired of the fetus already. They will not go if their husbands do not encourage or remind them. So whenever, pregnant wives are advised to go for pregnancy tests by their husbands, of course, they will go because this is good for them and their babies. This is actually quite simple because you just need to tell pregnant women to take care of their babies' health, they will go immediately. *Farmer's Union, Tan Chau, An Giang*
- They (women) are more confident when being with the husband. If they are lazy for ANC visit and be reminded by the husband, they will go more often – the husband is their support, you know. *Husbands of pregnant women, District 6, HCMC*

Others could not take their wives because of employment. Providers were clear that men who did not accompany their wives to ANC were likely detained due to work, and it was not due to any lack of concern for their wives.

- Husbands take their wives for pregnancy tests. Husbands in this area love and indulge their wives a lot. Many husbands do not take their wives to pregnancy tests just because they have to go to work, but not because they do not care for their wives. However, with limited intellectual level, husbands in farming, poor households know to love their wives by trying as much money as possible, not know how to take care of, encourage their wives as highly intellectual husbands. *Tan Chau Health staff, An Giang*

One man acknowledged the need to support his wife, but stated

- "I'm poor so I have to go to earn money whole day, so do others. We are not the same with rich people who always stay at home to take care of their wives. Of course, we want to take care to our wives (his voice is sad)…" *Husband of pregnant man, Tan Chau, An Giang*

Men almost always accompany their wives to the hospital during delivery, although with the presence of mothers and mothers-in-law, do not seem to play a very active role.

- More husbands take their wives for birth delivery. They do not often take their wives for medical checks, pregnancy tests as they are very busy. *Sympathy Club, Tan Chau, An Giang*
- Only my wife should know (about delivery), as even if I know, I am not allowed to be in labor ward by doctors, so why do I bother. Is it right, brother? So only my wife should know about it. *Husband of pregnant woman, Tinh Bien, An Giang.*

Others openly expressed that they did not have time or interest in their wives' pregnancy

- I don't care about health issues. It's enough for me to work to earn money and food for my family. I don't know how to do anything for health.
- Here we are too busy day and night to earn the food for the family, so there is no time to care about that. *Positive men, Tan Chau, An Giang*
- Some husbands are concerned, but some are not concerned. Some people are tired because of working, others get involved in drinking – show no concerns." *Family members, Tan Chau, An Giang*

In spite of the fact that most men and women stated that decisions around pregnancy and childbirth were the domain of women, they also stated that were a husband to express an opinion, or request his wife to access or not access a certain health service, she would likely agree. They also said that since husbands had a key role to play in supporting wives, encouraging them to get tested or to follow any health practices would significantly influence a woman

- In Vietnamese tradition, the men are in major and women are in minor position. When the husband decides, the wife must follow. So it's difficult for the women to propose the new things. *Positive woman, Yen Hung, Quang Ninh*
- In the community, the role of a husband in a family is quite important. They have strong power to decide everything in family. When there is a health problem of any members in the family, women usually wait for their husbands' decision. *Health staff, An Giang*
- The husbands always play critical role in their families, so they have great influence over their wives. Thus, if they express their support toward taking HIV test, their wives would fee more free to take it. *Health staff, An Giang.*

- "The husband plays an important role in health care and shares with the wife to bring up children, take/remind each other to take drugs regularly, love each other." *Positive man, District 6, HCMC*
- "In discussions, the husband raises his opinion and wife should listen to him and should not be too stubborn when discussing." *Pregnant woman, Hoc Mon, HCMC*

Some men were interested in learning more about women's health, and were keen to learn about PMTCT but expressed their concerns that they may not have much time.

- I also want to know more.
- Knowing more is better for us.
- We all have to go to work so it would be more convenient for us to read the leaflets when we have free time.
- I would prefer talking in person.
- We have to go to work so we do not take part in clubs.
- We also go to work all day so we do not attend meetings. *Husbands of pregnant women, Tan Chau, An Giang*

A5. Hỗ trợ và ảnh hưởng của gia đình đối với việc ra quyết định:

There was a strong sense that parents and parents-in-law advised, but could not make decisions for couples. In most cases, families saw their role as that of giving advice and encouragement to the young couple. Most family members said that they would encourage their daughters/daughters-in-law to follow the advice of health providers. There were no examples where a mother-in-law or mother prevented a woman from getting an HIV test, or from accessing care and support. Many mothers-in-law quietly accepted replacement feeding, recognizing that it was in the best interest of the child **(see section infant care for more information).**

- "I am a mother, I encouraged my daughter-in-law to do HIV test. If it is positive she will receive medicine. I will not maltreat. All women decide on their own, other people just encourage them. Nobody is opposed by their husband or mother-in-law." *Mother-in-law of positive woman, district 6, HCMC*
- "The younger generation is smart and can do a lot of things. Husband discusses with the wife. Few husbands force the wife to follow their will. We take care of them, telling them the good things, but we should not have a deep intervention into their affairs." *Mother-in-law positive woman, Tan Chau, An Giang*
- "In terms of family member' influences, mothers in law and aunts do not make large influences as families are now economically independent, so families just make suggestions whereas young married couples decide by themselves. Mothers-in-law of today are much different to those in the past. They treat their daughters in law in a more equal manner. They love their daughters-in-law more." *District PMC, Tan Chau, An Giang*

- Family influence seemed stronger in Quang Ninh than in HCMC and An Giang. This is partly explained by the fact that in both the southern provinces, couples seemed to be living further away from their parents. This is especially true in HCMC, where many people are migrants from outlying provinces. There were a few cases where mothers-in-law had a strong influence over the decision to marry and subsequently, put pressure on the couple to have a child in cases where the husband was positive. In such cases, mothers-in-law played an

active role in pregnancy and post-partum **(see section under "revealing positive status" for more information)**.

- "Meanwhile, while she was pregnant, she did not know she was HIV infected so she was very happy like other women. It was only at delivery that she clearly knew every thing. I think even if she had known about her status before, she would not have changed her mind. She would not think about something like that because, after all, she agreed with him to get married, and to have a pregnancy, no abortion. And he always care for her to have strong pregnancy. I strongly let them not have abortion" Mother-in-law positive woman, Uong Bi, Quang Ninh
- "My son wants to have a baby but his wife says that they are both infected so the baby will also be infected. Moreover, they need to have money to raise the child and they do not know how long can they live. If they have a baby and then die, the baby will be so miserable, and what his/her future will be, it is not so simple for them to have a baby (tears is running down on her cheek)….Let's leave it there until they can earn a better living but not now." Mother-in-law, Positive woman, District 6, HCMC

B. Knowledge, awareness and understanding of HIV in the community:

Summary of the findings related to male involvement:

This study echoes others in Vietnam that show that **men and women have high knowledge about HIV transmission**, and are aware that condoms can protect from transmission. On the other hand, **knowledge of prevention of mother to child transmission, especially among men, is not very high**. Although many men think that reproductive health decisions should be made by women, they are nonetheless very interested in and concerned about their children's future, and would be interested in learning about measures to help protect their wives and children's health.

Although the overall knowledge of HIV transmission, including mother to child transmission is very high among men and women, and both positive and uninfected individuals, several misconceptions persist about transmission. These reveal a high level of fear and concern about contracting HIV, as well as underlying stigma associated with HIV. Further, knowledge of prevention of mother to child transmission is superficial at best, even in sites where PMTCT services have been established.

The government of Vietnam has, in the past 3-4 years, significantly changed its messages about HIV infected and affected individuals. There are campaigns to educate people about how HIV is transmitted, and there has been a gradual delinking of messages of social evils and HIV. However, the messages from the past have left their legacy, and attitudes and behaviors have been slow to change. These changes have led to shifts in both perceptions and aspirations among PLWA, as well as attitudes and behaviors toward PLWA in the community. While this study was not attempting to investigate such shifts, it is to be noted that the data gathered do reflect them.

Most people, men and women, do not think that positive couples should have children. This would require that men and women discuss the possibility of HIV infection prior to conception and go in for testing. Stigma and discrimination of positive individuals may be one factor that contributes to reluctance of men to communicate with wives about risky behaviors, and even about their positive status.

B1. Knowledge and awareness of HIV transmission:

Knowledge of HIV and major modes of transmission was universal. Of the 76 interviews and FGD conducted with people in the community, every one of the respondents had heard of HIV, and usually could list the three modes of transmission. In a few cases, individuals knew of only 2 modes.

On being asked which activities were risky, however, there was a range of understanding. Several people's responses revealed misconceptions, including thinking cutting hair or nails with the same instruments, washing clothes together, sharing toothbrushes, towels and soap and eating together, sharing bowls and chopsticks was risky.

- "You must use a condom with prostitutes, but not with your wife at home." *Husband of pregnant woman, Hoc Mon, HCMC*
- "It (HIV) is not transmitted through eating, hand-shaking, or talking or normal activities in the family. You should not share a toothbrush, nail cutters, or tweezers with other people. You should not use any objects which are likely to get blood on them. You should not touch other people when you have a scratch on your hand. Use your own belongings, to avoid transmission to other people. Use condoms when having sex." *HIV positive woman, District 6, HCMC*
- "I was infected recently, so I have just learned about this. I did not know about this beforehand. HIV infects human body through injection and unprotected sex. Free casual sex is unprotected. I heard on the radio that if two people who have scratches on their bodies come in contact, there can also be an infection. I think that drug injection poses the highest risk, for unprotected sex, transmission just happens 0.4% of the times, and blood transfusion is also risky." *Positive woman, Uong Bi, Quang Ninh*
- "Eating together, touching, normal contact, sharing food are the activities that do not spread and transmit the disease. Sexual contact can transmit the disease. Toothbrushes should not be shared." *Mother of positive woman, District 6, HCMC*
- "HIV is transmitted through blood, from mothers to her children, and through sexual intercourse. HIV infected people should live separately, infected people in a family are isolated. If an infected person's finger bleeds, he infects." *Pregnant woman, Tinh Bien, An Giang*
- "It is possible to live together with HIV infected people. Sharing meals, shaking hands, kissing will not transmit infection. Husband needs to use condoms. If you have contact with an infected person when they are bleeding, you will get the infection through the blood route." *Family member of pregnant woman, Tan Chau, An Giang*
- "I know HIV infected person so sometime I have to keep away from him/her, it can be risky too. Shaving and taking wax out of the ears can be risky too. If we share stuffs with infected people, we will be infected too. As far as I know, it can not be transmitted by mosquitoes. Shaving and cutting finger-nails can be dangerous so I bought my own instruments and use them at home (laugh)." *Male partner of pregnant woman, Tan Chau, An Giang*
- "…through blood transmission route, having sex with each other, contacting blood and getting infection, leading a life of debauchery, drug injecting, uncontrolled sexual activities, sharing the razor, tooth-brush, soap." *Family member of positive person, Tan Chau, An Giang*
- "HIV is not transmitted through talking, shaking hands, hugging. Do not share the bathtub, or the bath towel." *Pregnant woman, Tan Chau, An Giang*
- "I have heard a lot about HIV. As far as I understand, there is a high risk to be infected if

someone has sex with stranger without using condom. We should use glove if we have contact with infected people." *Pregnant woman, Tan Chau, An Giang*

- "Living together with the infected person should not be done because it is easy to get the infection. It is possible to live together with HIV infected people. sharing the meals, shaking hands, kissing will not transmit infection. Husband needs to use condoms." *Family members of pregnant women, Uong Bi, Quang Ninh*
- "According to television, newspaper, if a couple having sex without condom, with blood on their teeth and or with toothaches kiss each other, it can result in HIV infection." *Family members of positive people, Yen Hung, Quang Ninh*

Some infected individuals increase their knowledge of HIV transmission after infection.

- "I married at 22, had a baby at 23, and was widowed at 25. My husband had worked in Cambodia, he was not a drug user. But I think it's my husband who gave me the disease. Someone tells me I should have used condoms in sexual contact with my husband." *Positive woman, Tinh Bien, An Giang*

B2. Knowledge and Awareness of PMTCT:

Knowledge of PMTCT, however was comparatively low, even in areas where PMTCT services were being offered. Providers and community leaders felt that there while messages on HIV and HIV transmission were widespread, messages on PMTCT were less frequent and had also only recently been introduced. While many people were aware that HIV infected women could transmit it to their infants, there was little knowledge about how to prevent it.

- "We don't know about it (PMTCT). It's a new program so we don't know. I only know that it is possible for HIV infected woman to bear a child who is not infected. The main method of prevention is by raising the child by milk powder (formulas). Mostly we know about it because of being counseled by the health care providers. But I have never seen this before here." *Husband of pregnant women, Uong Bi, Quang Ninh*
- "I still do not know how to prevent HIV transmission to my baby." *Positive woman, Tan Chau, An Giang*
- "I know a little. It is said that HIV women can still have non-infected children. Pregnant women with HIV have to take some preventive medications and the babies must not be breast-fed." Positive woman, Tinh Bien, An Giang
- "I do not know how the pregnant women can prevent infection to the child. I have not heard about pregnant women infected with HIV." *Family member of pregnant woman, Tan Chau, An Giang*

In some cases where knowledge is higher, people may have incomplete or inaccurate information.

- "There is now the prevention vaccine. If the HIV infected pregnant woman uses this medicine, there is only a 5 percent possibility of mother to child transmission. When the child is born, don't suckle the child because the transmission might be through this as well." *Positive woman, Yen Hung, Quang Ninh*
- "To prevent HIV for child when pregnant, you need to go to the medical centre to be examined, after delivery, no breast-feeding. When bathing my baby I must wear gloves to prevent scratching my body as I may infect HIV to the child in this way because child's skin is so weak and new." *Positive man, Yen Hung, Quang Ninh*

- "An Infected mother should give birth at provincial hospitals or district hospitals so as to get instruction for prevention of the infant's infection." *Family member of pregnant woman, Tan Chau, An Giang*
- "I have heard about it, but I do not have much understanding about it. I heard that infected mother could take drugs to prevent infection for the child. I advised my daughter to be deliberately careful of not transmitting infection to the child, to be aware of prevention for the child. When I saw her chewing and feeding porridge into the child's mouth – I did not let her do so. Health workers from the precinct health station paid home visit to explain and gave instructions on disease prevention for the child" *Mother of positive woman, District 6, HCMC*
- "We have learnt from the local medical station that communicates about the measures of prevention against HIV that HIV mother infected shouldn't conduct breast feeding and should not sharing injection needle or expose her blood to her baby. The HIV-negative child may be infected due to her mother scratching her." *Family members of pregnant women, Yen Hung, Quang Ninh*
- If the mother is infected, she should go to the medical station in order to be instructed. They should give birth at big hospital, not private hospital. Because there is support in big hospital in order to avoid HIV infection to the infants. The infants can be infected if there are any small mistakes. When the baby is born, there must not be any suckling otherwise the virus can be transmitted from the mother to the baby. They will provide some medicines for the baby as well. In that case, only one out of ten babies will be infected. If we don't go to the hospital or take medicines, the infected case will be higher. Something like 4 to 5 (this man looks very proud of himself as he knows about these things). For the infected pregnant women, she should not do any hard work. Because is she does anything hard, the fetus can be peeled off." *Husband of pregnant women, Tan Chau, An Giang*

This study did gather data from three communes that had no PMTCT services supported by the UNICEF project. However, two of those three districts offered PMTCT services through other donors, and hence it was difficult to see any differences in knowledge and attitudes between those communes where services were offered and those where they were not. There was also little difference in knowledge between men and women—although of course women, and their male partners, who had already received the full range of PMTCT services were better informed about it than those

With regards to PMTCT, a major motivator is the health of the unborn child, and men and women, both PLWA and those who are not positive, reported a great deal of interest and support for services to protect the child from infection.

B3. Community attitudes towards PLWA:

Many respondents, positive, not positive, health providers and community leaders, stated that compared to the past, discrimination had decreased. Certainly, communities seem to be aware that the government had sent out strong messages to NOT discriminate against PLWA. Knowledge of transmission has increased, which has contributed as well to allaying fears and concerns.

- "I don't know any infected people in the village. But I know that the government is trying to convince people not to discriminate infected people. The doctors in the medical station also consult people about HIV transmission so that we can protect our self and treat infected people normally." *Husband of pregnant woman, Tan Chau, An Giang*

- "The community used to see HIV infection as a social evil but now they are concerned about the risks for getting HIV infection. Stigma exists but not much." *Health worker, District 6, HCMC*
- "Every one stayed away from infected people before. Nowadays, people have a better understanding about HIV so it is different now." *Husbands of pregnant women, Tan Chau, An Giang*
- "The fact is that drug addiction causes the lack of money, the status of lack of money makes people always think of drug. In addition HIV infection makes people pessimistic; pessimist turns people toward behaviors mentioned. Before, we feel frightened when we heard about AIDS. It created a discriminated point of view toward infected people. However, nowadays mass media talks much about the disease, so it no longer frightens us. We know about prevention methods with blood or body fluid. We therefore no longer keep away from infected people, even that we want to be close to them." *Family members, Yen Hung, Quang Ninh*
- "In the past there was a big discrimination, people stay away from HIV infected persons. Now, the people in my village know that I am HIV infected, but they do treat with me normally as with others, if there is a wedding party, I can come to participate normally as the other villagers. At the beginning, they had fear of me, did not buy the stuff from my shop. Recently, for the last half year, the people in community have changed their attitude and behavior. At the beginning, they (the husband's family) did not allow me to hold my baby who is negative with HIV infection. Now, things have been changed, I myself and my child can visit my husband's family to have food and drink normally." *Sympathy club manager, Tan Chau, An Giang*
- "I heard that there are infected people who have been tested as HIV positive in my village, but they receive instructions from CHC health workers. When they died, neighbors have come to help with the funeral. The family has normal treatment. I do not hear about infected women or HIV infected women being rejected by the husband or husband's family." *Family member of pregnant woman, Tan Chau, An Giang*
- "A woman is infected, her husband is infected. The neighbors feel sorry about them and hire her to wash clothes and pay her monthly - she is a such gentle girl and they feel sorry for her." *Family member of pregnant woman, Tan Chau, An Giang*

However, several other people also reported that discrimination persists. It is not clear that the IEC efforts, both on increasing knowledge about HIV and on the inappropriateness of discrimination have been internalized.

- "In general, people do not like to access HIV infected people. We also feel afraid of getting closer to them because more or less harm could come. If they are not our loved ones, we may feel scared and do not want to get close. Even we know that HIV is not transmitted through shaking hands or kissing, we still feel afraid" *Family member of pregnant woman, Quang Ninh*
- "There is a constrained outlook that still exists in the community: they think infection lies in somebody who indulges in pleasures or involves in evils, but not them and their families, so they do not want to have tests as they do not think they are infected. We have to offer consultancy, then they agree to have tests." *Health Worker, Tan Chau, An Giang*
- Generally, people dislike to contact with HIV infected people, I am myself afraid of contact with them, but my relationship, even if I know HIV is not infected through shaking hand and kissing, but I still be afraid of." *Uong Bi, pregnant woman, Quang Ninh*

- "I do not hear about any HIV infected person at my place. Such kind of evil is not worth my emotion." *Family member of pregnant woman, Tan Chau, An Giang*

Sympathy club managers reported that discrimination had decreased slowly, giving examples where community members were opposed to starting clubs, or thought they were a waste of time, and had to be convinced of their value.

- "Many people still have discriminated attitude towards HIV. It even happens with me. When people saw me going to the club they said "what a fool woman! Her family is good, for what reason does she lead the club?" But I replied them "You do not understand. The society does not discriminate against HIV positive people anymore. Are you sure that your husband and children are not infected, are you sure that you are not infected when you tattoo or undergo other surgery". After that and when seeing how happy we are in the STAR, they change their attitude," *Sympathy Club leader, Uong Bi, Quang Ninh*
- "Before, when I established the group, some people say "My God, all of them are addicted, what do they get together and sing for?". People living around here always blame them when they loose something. But gradually, they find that the group is useful as all members help with collecting rubbish, needles… The evaluation is good, so they stop complaining." *Sympathy club leader, Uong Bi, Quang Ninh*

Officials gave several examples where there was a change in attitudes due to their support.

- When the children go to nursery school, other kids told each other "She is infected with HIV, do not play with her". We have to intervene so that she can go to school normally. *Women's Union, Uong Bi, Quang Ninh*

A few people mentioned that women who were infected by their husbands, especially if pregnant, were to be sympathized with. They were seen as innocent victims, and people felt that they needed to be treated with care.

- "A woman is infected, her husband is infected. The neighbors feel sorry about them and hire her to wash clothes and pay her monthly - she is a such gentle girl and they feel sorry for her." *Family member of pregnant woman, Tan Chau, An Giang*

B4. Societal approval for positive couples to have children

Community members generally felt that women who were positive should not have children. They expressed concern about both the child getting infected, as well as care and support for the child after his/her parents died.

- "Women should not do so. If she is lucky that the child is not infected, but she cannot prolong her life to raise the child. If she is not lucky and dies soon, then the child may become a street child. Moreover, infected women are not healthy so they have difficulty in earning money for their life, and this burden maybe doubled when taking care of the child." *Sympathy Club, Tinh Bien, An Giang*
- "In general infected people should not have children. Now they are more knowledgeable. They know they will die soon because of HIV infection then the children will be orphans, unhappy, without care. They therefore decide to not have children." *Family members pregnant women, Uong Bi, QN*
- "I think they shouldn't. If the baby is given drug does not get infected, it will be very good. But what about the parents? Without any property, when the parents die, the baby will be

left behind without adequate care. No one, including direct relatives, can take care of your children as good as you do. The baby will grow and lack of lots of things. I do think that the woman should not have children unless she has good health and wealth." *Wife of positive man, Uong Bi, Quang Ninh*

At the same time, several people, especially in Quang Ninh, stated how they would understand if a woman chose to have a child, even if she was positive, as women were expected to bear children—and the value of one's life was increased if one had children.

- "I think if she doesn't have yet a child and she has a good condition, she can bear child, because there is now the vaccine." *Positive woman, Uong Bi, Quang Ninh*
- "The community will not object to an infected woman for this action." *Family member, pregnant woman, Uong Bi, Quang Ninh*
- "In my opinion, if they still have not children, as you know, the expectation is that a couple must have children, their children are the family ties and bring the best happiness to them. Now, with all the care from scientists, health centre and Funds, if 100 women take medicine, only 5 children will be infected HIV from their mother, the infection rate is small. If they feel that they are still healthy, they should have a child but we cannot predict anything. It is the same as gambling, but now the rate is small. A couple must have awareness, taking HIV test before getting married. If they are infected HIV, they understand what they should do. If they want to have baby, they should go to counseling office to know how to take care for yourself." *Sympathy club leader, Yen Hung, QN*
- "In many cases, both wife and husband have HIV and they both want to have babies. Particularly, the husband is the unique son in his family, they necessarily have babies." *Health Staff, Quang Ninh.*

C. Living with HIV in Vietnam

Summary of findings related to male involvement

Living with HIV and being diagnosed as positive needs to be viewed within the larger and rapidly changing socio-cultural context in Vietnam. The legacy of the social evils campaign lingers on, with some people still associating HIV and being diagnosed as positive as being the same as being socially deviant. In a country where social norming is an extremely strong aspect of society and where the state reinforces such messages actively, women and men feel a strong pressure to be seen and to operate within such socially acceptable norms. Such norms include recognition for and positive reinforcement of certain types of families, and are closely linked with Confucian and other cultural traditions. Similarly, families and individuals that do not conform are given less support and recognition and may experience a form of socio-cultural isolation. Internalizing such messages is not uncommon, and there is a vicious cycle of shame and embarrassment reinforced by social judgment and isolation.

Economic prosperity, in the wake of the relatively recent policy changes in Vietnam, and the related pressure to earn a living seems to be immense, especially for those who are just above the poverty level. Competition for work is fierce, and individuals who may experience illness may not be able to ensure a steady income. Many positive individuals interviewed in this study were already poor, and thus experience both social exclusion and marginalization, as well as economic uncertainty and difficulty.

Decisions to keep one's positive status from one's wife and family members, and for mothers of positive men to support their sons into a marriage without revealing his status are better explained when examined within such social and cultural norming. Clearly, some mothers-in-law are aware of the ethical issues with hiding their son's status from their wives, but do so anyway out of love and affection for their sons, a hope to see them "settle down", and a desire for a grand child—all powerful images of a happy, normal family.

In such a context, the decision to test for HIV may appear daunting to most women. Routine testing, where an HIV test is part of a "normal" package of ANC, is appealing to both providers and to women. However, for many women, concerns about others finding out about their status are a disincentive. This study was obviously not able to interview women who had tested positive during pregnancy but were lost to follow-up. A significant reason for loss to follow-up appears to be that women who already suspect their status give false addresses, for fear of having their status known, or having health visitors come to their homes (which draws attention to oneself). Other women may just move back to their mothers' homes for the period of the delivery. **Confidentiality and disclosure of results only to the woman, if practiced uniformly, would go a long way in increasing women's confidence in testing.**

Further, disclosing one's status, even to other positive individuals (e.g. sympathy clubs) requires a great deal of courage and self-esteem. This study found only one woman who spoke in public with confidence about being positive. Based on descriptions of joining sympathy clubs, it seems that positive individuals go through a process of accepting their status, rebuilding a sense of self-worth and overcoming the feelings of shame and internalized stigma before declaring one's status. The actual act of disclosure also brings a sense of freedom and greater self-acceptance.

Similarly, **a decision to not have a child is easier in families where there has been open discussion on HIV status, and where there may be other grandchildren.** In other situations, women are seen as a "vessel" for producing a grandchild, even at the expense of her own health.

C1. Diagnosis

Many people admitted that initially, their reactions at being diagnosed themselves or a having partner diagnosed with HIV were that they had been handed a death sentence.

- "I was so sad. When my husband knew, he was even more depressed than I. He could not bear that. I had to come after to console him". *Positive woman with uninfected husband, Tinh Bien, An Giang*
- "When I found out my husband was positive, I cried for a long time. I did not go out of the house, I thought my life was over." *Positive woman, Uong Bi, Quang Ninh*
- "I was very sad. I did not know why. I had never thought I was infected. I am trying not to think much and not to blame anyone." *Positive woman, Hoc Mon, HCMC*
- "I was shocked to hear that my husband was positive. I was sure I was infected as well, as I knew we had not used a condom. At that time, I did not think about anything other than the future of my older child. I was pregnant and all I could think about was my older child, as I was sure I was going to die and also my husband and also my unborn child." *Positive woman, Uong Bi, Quang Ninh*
- "After I knew the result, I drove like crazy on streets, I nearly hit a truck. When I came home and took my wife to the hometown for a feast, I let her know, she came to a room and cried a lot. At that time, I went to the garden and was going to drink a bottle of pesticide; but I didn't because I thought if I died, it would be easy for me, then who would take care of my wife and

my children. (crying). That's why I didn't want to die, and decided that I had to do something good for the society." *Positive man, District 6, HCMC*

- "In Tropical Hospital, when doctors told me that I was infected with HIV, I was so shocked I almost went crazy. It's true. I was paralyzed at that time, and doctors said it was hard for me to recover, but on hearing the news, I suddenly stood up and ran for few meters then I fell. *Positive man, District 6, HCMC*
- "Honestly, I do not know how much longer I will live. When I first heard I was infected (when she was pregnant) I thought I would die at the time that my child started to walk and talk." *Positive woman, Yen Hung, Quang Ninh*

It took a great deal of counseling and support for individuals to regain hope.

- "The doctor in the hospital spoke to us and encouraged us. He told us not to lose hope, about ARV, and about the importance of staying healthy to take care of our children." *Positive woman, Uong Bi, Quang Ninh*
- The doctors knew that and they consoled and encouraged me. They told me to think about my children to overcome that. *Positive woman with uninfected husband, Tinh Bien, An Giang*

Some individuals especially drug users, already had suspected that they might be infected.

- "I went to test for HIV when my friends died with HIV infection. I was of course shocked as soon as I knew my positive HIV test. I had injected drugs and have weaned it for a long time." *Positive man, Uong Bi, Quang Ninh*
- "I was mentally prepared for the positive result for a long time because I knew I had indulged in pleasure." *Positive man, Yen Hung, Quang Ninh*.
- One individual commented, "Well, I knew I might be positive as I had indulged in pleasure. But as a chronic disease, I thought it was better and I should be happier to have HIV than cancer." *Positive man, Yen Hung, Quang Ninh*

Most women who were diagnosed when pregnant or who had a child immediately started to think about their children.

- "I was very sad and worried about my child." *Positive women, District 6, HCMC*
- "I need to accept the fact and try to live to care for my baby." *Positive woman, Hoc Mon, HCMC*
- "Very sad, but no choice – try to live and take care of the child." *Positive women, District 6, HCMC*
- "I look after my children while washing clothes, I do all things by myself. I am determined to take care my children as well as other children. I thought that it would be a disadvantage for my child when I can not feed him by breast milk, but luckily, he is healthy." *Positive woman, Yen Hung, Quang Ninh*
- I was concerned that when being born, the baby was infected. I had nobody to blame but myself, the child did not do anything, s/he would blame me in future. *Positive man, Uong Bi, Quang Ninh*

C2. The difference ARV makes:

The recent increase in access to ARV has made a huge difference—as PLWA hear about the availability of ARV and the prospects they offer for healthier and longer lives, hope is increased.

- "HIV is a disease like others diseases. It affects the body, but now there is the medicine that can hold back the development of virus, so it can bring a little hope to the patient. Don't be pessimistic." *Positive woman, Yen Hung, Quang Ninh*
- "They gave me the result, but I didn't pay attention, because my spirit decreased and went into shock. I felt my life improving once I started getting the medicine (ARV)." *Positive woman, Yen Hung, Quang Ninh*

C3. Internal feelings of shame and guilt

HIV positive individuals were mixed on how they were perceived in their communities and how they felt about themselves.

- "They do not know. They don't know how this disease transmits. If they knew about it, they would not fear it. They know my husband died of AIDS, so I have suffered discrimination and stigma. I will not get married again, I will not have another baby. My disease will bring unhappiness and misery to other people. I married at 22, had a baby at 23, and was widowed at 25." *Positive woman, Tinh Bien, An Giang*

In some cases, it appeared that there was a great deal of resentment and anger at being part of a category of individuals that are still viewed as "socially-deviant" or engaged in socially-deviant behaviors.

- "They feel a complex about their sense of honor. None of them is afraid of death. They are afraid of being ignored or treated without warmth by other people or deserted by them." *Mother of positive individual, Hoc Mon, HCMC*
- "Most of them still have an inferiority complex. They have been given counseling on HIV so they are aware of HIV. They do not want to be shown on television or radio. They are still ashamed." *Sympathy club leader, Tan Chau, An Giang*
- "Yes you should do more propaganda on HIV. But if you show photos of HIV infected people who are skinny, and weak, then people will be afraid of them, and infected people like us (he has tears welling up). But if you tell them the three ways of HIV transmission, they will not be scared, but to know how to prevent transmission as well. That's why you shouldn't give us leaflets with such scary pictures, that's no good at all because they will keep far away from infected people. And they may think that we are more like such people in the pictures, not our real appearance in life. (pointing himself)." *Positive man, Tan Chau, An Giang*

Many PLWA reported some form of stigma or of being treated indifferently in the community, which resulted in them being very afraid to share their status. One positive woman explained that her husband was reluctant to go the CHC for testing as "He says that he is afraid of meeting some known people there. He is really worried about people finding out." She expressed that her family and neighbors already suspected that she and her husband were infected, and that, due to her concerns about people finding out, she said "I don't dare to talk loudly with people from the commune health station. I am afraid that somebody could hear me talk about it." She said that her reasons for wanting to keep her status to herself were her observations on how infected people were treated.

- "Sometime they say this and that about infected people. I am afraid that it is even worse if they know that I am infected (her voice was almost strangled). So I don't want anybody know. Only me and my husband." *Positive woman, Tan Chau, An Giang*
- "When the community around me know that someone is infected, I see a discrimination between the infected and no-infected person, they don't want to have any contact with the

infected person. But they have their life, I have my life. But they always avoid me (tears in his eyes, his voice is choked). But even if they avoid me, I have to live and keep my health. If I am not happy, I will get ill and die shortly."

- "If they know that I am infected, they avoid me. When I go to work, they avoid me because they are afraid of the spread. But I don't care."
- "Among the people who know that I am infected, 70% avoid me, 30% have no discrimination, they said they aren't afraid, there is no problem, they can eat together with me. And me, I have to continue my life." *Positive men, Tan Chau An Giang*
- An HIV test can be taken at An Hoa Clinic, but the place is too near my family, so it is very easy to be found out by neighbors. And then, I was counseled by doctors working at the consulting room to take my children to go to doctor in Dist. 1. I advised my daughter-in-law and son that they should catch a taxi to go to see a doctor in Dist.1 which is far from home so that nobody discovers the problem. *Mother-in-law, positive woman, District 6, HCMC*
- At times, I watch television, seeing images of skinny, weak HIV-infected people, I am scared. When those images are shown, I dare not see as I think later I will be like them. Those images should not be shown on television any more. Every time, I see it, I get crazy as I am anxious for my and my baby's future. Other people who are not infected will get more afraid of us when they see those images (crying). It is all right if I do not see my child around, but when I go to pick my child up from school, whenever I think of those images, I am worried about who will bring my son up when I am dead and what he will think at seeing such images of his mother." *Positive woman, District 6, HCMC*
- "Neighbors do not contact with me when they know I am infected with HIV."
- "We stay at home, we do not go out. We close the door. We do not want to go out. Neighbors look at us. Whenever we are back home, we go inside and close the door at once." *Positive women, District 6, HCMC*
- "It is true that I keep it in mystery (at the moment, both my son and daughter in law are infected with HIV but one grandchild over 2 years old tested HIV negative). Our neighbors do not know any thing because I hide it, so do medical workers of the station and centre. If they know, they will keep away from us and not let their children play with our children therefore it is better to keep this disease in mystery. They asked why our child was usually sick, I answered that he suffered from bronchitis. They often talked that "how odd, Loan's family is frequently visited by medical workers!" I just explained that my grandchild was born prematurely, that is true therefore they came to visit, care and treat for him." *Mother-in-law positive woman, Uong Bi, Quang Ninh*

C4. Sympathy Clubs

Participation in sympathy clubs seems to have contributed a great deal to increased knowledge, self-esteem, hope and a stronger sense of well-being among PLWA.

- "At the beginning, I am really scared. I can't even eat or sleep. My neighbors are really scared about being infected. It was really sad. After joining Binh Minh Club and Muon Sac Mau Club, I feel a lot better." *HIV positive woman, Tan Chau, An Giang*
- "Some new arrivals feel to be reluctant and ashamed, now they become happier, many people feel better because they are treated with medicines and encouraged, and motivated." *Sympathy club leader, Tan Chau, An Giang*

- "Initially, all the participants wore masks to disguise when they attend the meeting of the club, after one year, they remove the masks, then step by step the club members feel normal." *Sympathy Club Leader Tan Chau, An Giang*

Positive individuals stated that they derived a great deal of support from members in the clubs.

- "At the current time, we participate in the club FOR THE FUTURE organized by Women's Union. The club has 40 members who are HIV positive. It is like a home to share thoughts, to help each others emotionally and materially. We assist each other when one is sick." *Positive man, Uong Bi, Quang Ninh*
- "Until I joined the club, I found everybody around me was the same, we never shared anything with anybody. After I joined the club I made some friends. Sometimes, when I needed them, I had to make an appointment at a cafeteria to talk, and I encouraged them a lot. It was really a hard work. I really felt sorry for them. Sometimes I even had to go to their homes and pick them up." *Positive man, District 6, HCMC*

C5. Family attitudes toward positive individuals

Family behaviors toward a positive couple ranged from extremely supportive and loving to tolerant with great caution taken over infection, especially when living together. Many positive individuals reported receiving a great deal of support and care from their families. This support included significant financial support in some cases, especially where the man was unable to bring in a steady source of income, usually in cases where drug use occurred. Some family members also participated in clubs, in order to better support and be aware of how to help their positive family members. There were also several PLWA who reported that they had kept their status from family members, and some where the family either ignored or had cut ties with the couple. Family support seemed tremendously important to positive couples, especially women, since most people admitted that neighbors and members in the community were not likely to be asked for help.

- One positive man (Tan Chau, An Giang) said that he had not told his parents that he and his wife were infected "Because I am afraid that my parents are worried and separate us, so no-one will take care of my wife and child…(hís voice is choked by tears). So I have to keep silence until now and not let anybody know, absolutely. He said his wife's family, on the other hand, knew that they were infected and their behavior toward them was, "So kind, the normal attitude as before. In general, when my wife ant to eat something, anyone among her brothers and sisters, even her mother, can goes out to buy it for her"
- "Both my husband's family and mine know. They give me money because we have not been able to do anything since we fell sick." *Positive woman, District 6 HCMC*
- "In some cases, couples lived with either the woman's parents or the man's parents. They paid more attention to us. I don't have a job, so they give me money with kindness. No scolding, they are not angry. I live with my sisters, my 3 sisters, I am aware of how to prevent infecting my family." *Positive woman, District 6 HCMC*
- "My husband told to my family and my mother in law. When I gave birth, the doctor explained and my mother knew. My mother in law knows but she loves me very much. She loves me even more than before, she takes care of my diet regime. When I had flu she persuaded me to take medicine. She loves my child more than other grandchildren. When children play together she upholds my child. Sometimes she holds my child in her arms and cries so much." *Positive woman, District 6, HCMC*

- "Both of my sister's children got infected with HIV. One time, when coming to our house, her mother in law said to me "I am lucky that they live independently. If they stayed and I would have to take care of the children and might get HIV from them". I was sad and reacted to her. I said "You are not fair. You can not say that. You should take care of the kids. You know how it is transmitted, right?" See, you know, even people in their family are like that." *Family member of positive woman, Uong Bi, QN*
- "The mother-in-law does not sit down to have the meal with me. The father-in-law asked me to go away from home, giving me a bowl of rice to eat separately. Now we are still under one roof, but there is no emotion to each other. I am not allowed to go into my parents-in-law's room. My father-in-law scolds me. My child has been given to his aunt (his father's younger sister) for fostering. My child was HIV negative after the test. I am afraid of transmitting infection to the child. My blood mother stays with my aunt. My blood father was shocked and died when hearing of my infection." *Positive woman, District 6 HCMC*
- "He took drug injection only once, but got HIV infected and took the test in 1999 when he had tuberculosis treatment. His father, mother and relatives do not pay any attention to him anymore. His niece likes him very much and he often drove her to school and back home. But when they knew he was infected, they prohibited him to touch her. He had to eat and live separately. When I came to counsel the family, they said that: "HIV is transmitted easily and has no treatment. His niece is small, HIV will transmitted if he kisses her or the mosquito bites him and then bite her". I kept counseling them for some time. Then the family treats him better. They bought a house for him for selling knife. He is quite rich now. A girl from Vang Ranh loved and married him. They have a child. She is infected with HIV but the child is healthy." *Sympathy Club leader, Uong Bi, Quang Ninh*
- Hien (infected woman) and her brothers now are living with me. The youngest brother loves her so much. He always buy things that she likes. They understand and love each other, because their sister died of HIV. I love her and her son. I am her mother so I am responsible for them. The son was infected with HIV and cannot prolong his life. Her husband's family does not pay attention on them. They does not love their son, so they can not love his wife. They know the situation, sometimes give 2,000 – 3,000 VND to their grandson." *Mother, positive woman, Tan Chau, An Giang*

D. HIV and inter-spousal relationships

Summary of findings related to male involvement

This study finds that the **majority of women reveal their status to their male partners almost immediately**. However, men do not always reveal their status to women, and in some cases, have successfully hidden risky behavior from their wives. This study also finds that men and women who are positive (mostly in sympathy clubs) expressed that they used condoms and were comfortable with their use. This study also found many **examples of men who were supportive and loving towards their positive wives**, and in a few cases, were supportive even though their wives were infected and they were not. It appeared that in the Southern provinces especially, positive couples were greatly reliant and emotionally dependent on each other, and gave each other a considerable amount of support.

This study interviewed women in or who had been in long-term relationships with men that were legally recognized marriages. While some couples were contemplating or already separated and some individuals were widowed, in most cases, the researchers interviewed women and men who were both alive and together. For positive women, the support received by their male partners (emo-

tional as well as otherwise) cannot be overstated. Women who were diagnosed as positive expressed feeling socially isolated from their communities, and even their families at times. In such situations, **wives do rely on husbands for emotional strength.**

Interestingly, **both positive men and women felt that positive couples should not have children**. This is contradictory to actual practice—as of course there were plenty of examples of positive couples having children. In many cases, women discover their status during pregnancy. Given this information that men and women do not think that positive couples should have children, it raises the question as to whether **different fertility decisions would be taken by some couples if positive status were known prior to conception.**

D1. Revealing positive status:

Interviewed women who tested during pregnancy usually did not know about their status. Most women who tested positive informed their husbands about their status. There was no reported violence, as in most cases, the women had been infected by their husbands.

- "He did not believe when I first told him. He just thought I was joking. I said it is true and ask him to have HIV tested. He agreed at once and it turned out that my husband was positive. Before married me, he had worked in restaurant and had sex contact. He do not use or inject drug." *Positive woman, District 6, HCMC*

In many cases, women already suspected that their husbands had engaged in high-risk behaviors and were already mentally prepared. In some cases, their husbands had already undergone a test and knew they were positive or were aware that they had engaged in risky behavior and were possibly positive.

- "I was drug addicted and I saw my peers who were also drug addicted get sick and died. I 1997, my family knew about my addiction. My mom and other family members encouraged me to take HIV test at Uong Bi Sweden Hospital. After 10-12 days, the doctor phoned my mother to come to the hospital to inform the result and counseled her how to counsel and take care of me. My mother kept secret, only encouraged me. But I was suspicious that I was infected because I was weak gradually. Only until 2001 did my mother tell me. I was suspicious but could not believe. At that time, I was puzzled, disgusted and still addicted. In 2003, I want to Bach Mai Hospital in Hanoi for take HIV test. In the afternoon, the doctor called me in. He counseled me and then informed that I was HIV positive. I was very weary and regretted about being addicted. But it was too late. One month after, I decided to get married but did not inform anything to my wife. Only until one year later when I was prepared and ready, I informed my wife (during that time we did not use condom when having sex). But my mother had informed her already, I did not know when. My wife was sad and put the blame on me. But she still took good care of the family. After that, I took her to Uong Bi Sweden Hospital for HIV test. After one week, the doctor called us come to counsel and inform the result, but did not provide any treatment drug." *Positive man, Uong Bi, Quang Ninh*

In a few cases, the women recall being extremely shocked. In general, women stated that they reacted by being upset and angry with their husbands, but ultimately accepted this as reality. There were a few cases where the husband was positive, and his status was kept from his partner by his family or by him. In such cases, the woman usually discovered her status during pregnancy.

- "When I tested, they advised me how to prevent the disease, then I told it to my wife about using condoms, it is better to prevent not only HIV but also other diseases. Of course, the first time to talk is very difficult but it is a good decision, I must tell her, do not keep it from her

forever, if not that maybe it will be dangerous. If it dangers her and my child's life, it will be a huge shock. I told her all my indulgence in pleasure that I was careless, unlucky, not aware clearly. I told her at one night, it was good time to talk because she would not be too shocked and did not argue loudly and was not overheard by neighbors. At that time, she was shocked and broke down and cried so much. In addition to others, I also told my parents, other family members, boy and also girl friends about my disease." *Positive man, Yen Hung, Quang Ninh*

- "I do not discuss with my wife about private problems, doctors did provide counseling to both of us, sometimes we discuss about that if having rest time, when going to bed we do not do that. In my family, all members talk about this very little." *Positive man, Yen Hung, Quang Ninh.*
- "The pregnant women's attitude at the very first is reactive. They do not believe to be infected. Their husbands have no reaction." *Health worker, An Giang*
- "At that time, he did not get married but have a darling girl friend to whom he got married after 3-4 months. The first child they had was always sick with respiratory illness and then died. At that time, when she was pregnant, she was examined and tested but was negative. Now she is recently pregnant and her test was HIV positive, so she just discovered that she was HIV infected. She asked me " Mom, maybe when I was pregnant the time before, he had had sex with a call-girl and infected, did he not?" I knew all along that he was positive, but I thought they loved together, so we arranged wedding for them. My son, he did not know that his wife was infected with HIV. During her second delivery, she was exceedingly astonished to know that she was infected because on day 3 after delivery, nurses asked me to bathe and clean the baby's skin well. The next day she told me the truth about the disease. At that time in hospital, I did not speak any thing." *Mother-in-law of a positive woman who discovered her status after her second child was born, first child died, Uong Bi, Quang Ninh*
- He had the test before he got married. He did not tell his wife at first, but this could not be hidden for long so he then told his wife about that. *Mother-in-law positive woman, District 6, HCMC*
- There is one case of a man that does not want to let his wife know because he's afraid that she maybe worried, sad. He said that since he got to know about his HIV status, he has used condoms when having sex with his wife. His wife asked him "why do you use condom?" and he answered that he still young and does not want to have baby early. I have taken him here for counseling so that he can tell the truth to his wife, but he said that" If I tell my wife the truth, I will be broken-hearted and may die" *Sympathy club leader, Tinh Bien, An Giang*
- "My husband was infected before married me, but he didn't let me know, all his family hide his status from me, only me who didn't know anything, it's miserable. I think he intentionally hid (his status) from me because he took the test several times. I think he knew but he hid from me. I realized just after I bore the child, but it's too late. If I have known before, I would never have had a child." *Positive woman, Uong Bi, Quang Ninh*
- "There are families that know their sons having risk behaviors and know that the sons might have acquired with HIV, but they do not want to take their sons for HIV test. When the sons get married and their wives get pregnant, then they want to bring the women for HIV test to see whether their daughters in law and their grandchildren infected or not. When the wives were detected with HIV and the wives refused to keep the pregnancy, they were transferred to the Center for HIV/AIDS Control for consultation because we did not have PMTCT program then. We knew that the families still reserved good treatment toward their daughters-in-law." *Health staff, An Giang*

On learning about their wives' positive status, some men reported feeling guilty and ashamed, especially if this was during pregnancy.

- "There are HIV-infected husbands say they had rather get infected, but not want their wives and children get transmitted." *Tan Chau Health Staff, An Giang*
- "He did (tell me the reason he did not want his wife to know he was positive). He said it was his fault, and it was unforgivable, so it was hard for him to let his family know. If they knew the truth, they would be angry and wouldn't forgive him." *Positive woman, District 6 HCMC*

D2. Acceptance of condoms in long-term relationships

The study found that among positive couples, many reported using condoms once they knew they were positive. Attitudes towards condom use were generally positive, however men said that they had less sexual desire compared to before. Using condoms to both prevent transmission as well as to avoid pregnancy if one was positive was also stated as a practice among several couples.

- "When I knew I got infected, I told my husband to use condoms to prevent bad things and he followed." *Positive woman, District 6, HCMC*
- "After marriage, I have been using condoms up to now, I advised her to test HIV many times, ultimately she tested and its result was negative." *Positive man, Yen Hung, Quang Ninh*
- "My husband, for example, he is ok with using condoms. He does not say anything and is very comfortable. He knows he should think of his wife's safety and health." *Positive woman, Uong Bi, Quang Ninh*
- "When I get pregnancy my husband abstained because I am only pregnant after longtime of marriage. I said to my husband that he should careful when he go to work far from home, I bought condom and put in his pocket because now the society created such situation I can not forbid husband therefore better is carefully care." *Pregnant woman, Uong Bi, Quang Ninh*
- "Well, when I go for medical examination they tell me to use the condom while having sex and they give me a lot but I haven't used much. Since I knew that I was infected, whenever I have sex with her I still don't want to because my mind is busy thinking about that. Thus, I sleep alone for sure. Since I knew about my disease, I seemed to lose my sexual desire, I forgot as if there hadn't been for it." *Husband of infected woman, Tan Chau, AG*
- "I don't know why I don't really want that (sex), it is less often than before. I am not scared at all, but I worry that she will be tired." *Positive man, Tan Chau, AG*
- "I also talk about how to use condoms. But since I discovered that I am infected, I am much weaker, so I don't want to make love." *Positive man, An Hoa, HCMC*
- "As far as I know, the majority of men do not want to use condoms though knowing that they are infected." *Health Staff, An Giang*

D3. Care from husbands if positive.

In most cases, wives had been infected by their husbands. There were many examples of husbands giving support, encouragement and caring for their wives. It appeared as though, according to providers as well as community members, positive couples in the South exhibited greater degrees of closeness and support, with the caveat that this is a small sample and it is difficult to draw conclusions about such differences.

- "My husband has given me more care when knowing my infection status. For example, we have less argument than before. As my husband gives me great care, I share with him everything." *Positive women, Hoc Mon, HCMC*
- "Husbands accept it (wives' positive results) and were sympathetic with their wife. They feel closer. None of them divorced or left each other. I think it is the same for all the couple." *Health Staff, Tan Chau, An Giang*
- "Most of infected women's husbands die earlier than them due to AIDS, or they discovered themselves with the disease earlier so they can not scold their wives. They are worried for their wives' health." *Health worker, Tan Chau, An Giang*
- "Now we live with my wife's mother, and we don't have intention to separate them. Since my wife is infected, I let her stay at home to help her mother, don't need to do any thing else, ... only take care of the meal. After turn back from work, we have lunch together, then take the short rest, and continue to work afternoon. I have only one wife and one child, so I love them very much…" *Positive man, Tan Chau, An Giang*
- "My son knew that he infected HIV to his wife so he try to compensate her for the infection, he love her much more, encourage her mental and do everything to earn money for his wife and son." *Mother in law positive woman, Uong Bi, QN*
- "I think it's really important (to love and support my wife and take care of her health). But I've just known about that recently. I used to let my wife care about those things. I did not pay attention to anything other than working. Only after discovering I am infected with HIV, do I realize that if I am not together with my wife and encouraging her, then we will die soon." *Positive man, District 6, HCMC*
- "In my opinion, for infected couples, the husband normally helps less his wife due to his bad mood toward her. HIV infected people are normally drug users who do not have money and always look for drug. Assets are often sold, food is insufficient. These people therefore do not pay attention to taking care of his wife. It is the reality." *Family member of pregnant woman, Yen Hung, Quang Ninh*

There were 4 cases where the wife was infected and the husband was not. In 2 of these cases, the husband either abandoned or intended to leave his wife once his child was born.

- "Some time he wants to keep away from me. I think our relationship will not be as before. My husband told me that when our baby was strong enough he would move to his family's house to take care of his father. Only when my father in law dies will he reckon with his future plans later. At present, I am living with my husband as usual. I stay at home taking care of our home and doing the housework. My husband is a hired labor, so our living is quite hard." *Positive woman, husband negative, Tinh Bien, An Giang.*
- "I have transmitted infection to my husband because I was addicted to drugs. I think I was infected before the marriage, but when I was at 6 months of pregnancy I took the test and got HIV (+) result. My husband was disappointed and left me. He only comes to see the child sometimes and gives us no support." *Positive woman, husband negative, District 6, HCMC.*

In the other two, the husbands were very supportive and loving towards their wives.

- "I am not afraid (very solid voice) of living with my wife. I think that everybody has to die at one time. If we live without taking care wife and child, so that thing (CD4 count) of my wife will go down. If it goes down, my wife feel tired, and if the infection changes to the third stage, my wife will pass away. I love her so much, I care so much for my wife and child. I didn't

blame her, because I know at the beginning if my wife's sister was infected, my wife would be infected, too. Her sister passed away. I was prepared for my wife's infection when her sister got sick, so I wasn't so sad. I live joyfully in order that my wife will be happy, that we can take care the next generation. So I work hard, sometime when I recall in my mind, I said to my conscience that I cannot be sad, because if my wife know I am sad, it goes down, my child will be unhappy, so I work and work, without taking rest, and my wife stay at home, don't work. I work my best to take care my wife and child. Each time I work hard, I forget all and don't blame my wife and child ... (his voice goes down and his mind looks so far)." *Uninfected Husband of positive woman Tan Chau, An Giang*

D4. Desire to have a child if positive

The desire to have a child if one is positive seems mixed. Some women and men stated clearly that they did not want to have a child because of their status.

- "I have seen on television and known about children who get infected from their mothers. (crying). I hate the women that had given birth to those children. The children are very pitiable. Why have they given birth to those children?" *Positive woman, District 6 HCMC*
- "I knew that I was infected with HIV so I did not want to have a baby in order to prevent my wife and child from HIV infection." *Positive man, Uong Bi, Quang Ninh*
- "No, my wife is infected so we don't want to have baby. We are afraid that the baby will be infected too. My wife also says that." *Positive man, Tan Chau, An Giang*
- "Many husbands don't want to have baby because they are afraid that the baby will be infected too." *Positive woman, Tan Chau, An Giang*
- "We often talk and confide each other. We often talk about birth delivery. At present, we suffer from the disease so we are afraid that it is not good for our baby. We do not have enough to live as only my husband works to earn money."
- "I am afraid of the fact that babies will have a hard life as both of us are very sick, suffering from the disease."
- "I am afraid that I am very weak. I can not earn enough for life. I am not sure for how long more I can live, so who will bring up my baby." *Positive women, District 6, HCMC*

Others talked about how much they wanted to have a child, and were either trying to conceive or wanted to take some more time before they conceived.

- "My husband really wants to have a baby. But I am worried that the baby can be infected too so we will see. I really want to have a baby but it will take time. I am really worried that the baby will be infected too (strangled voice). It's the only thing that scares me, nothing else." *Positive woman, Tan Chau, An Giang*
- "I hope to have a baby but I have lost 2 already (2 miscarriages). It is my dream, but I am so worried about the future. I hope it can happen." *Positive woman, Uong Bi, Quang Ninh*
- "We often talk to each other about sexual matters, usually if it's necessary to use some pregnancy prevention methods. But we really want to have a child now, so we don't use anything. We just talk to make love in the exact period, so that we can have a baby." *Positive man, District 6, HCMC*

A few women who discovered their status when pregnant said that they would have aborted the child if they had discovered their status early enough. Sometimes, husbands or families pressured them to keep the child.

- "Frankly, I did not want to have a baby with him, because he had one stepchild, we also had one girl; when I was one month pregnant, I wanted to have an abortion. Initially he agreed with me, after that, he said that it was immoral. When I was going to hospital for an abortion, he ran after me and said "stop, my father tell you to keep our child, we have 2 girls, it is better if we have one boy." *Positive woman, Yen Hung, Quang Ninh*
- "If I knew about this matter earlier, I would have an abortion. I am sorry, I only knew about it when I was 5 months gone." *Positive woman, District 6 HCMC*
- "The doctor said me that if I had known before, I would have used the vaccine during pregnant to prevent the transmission from mother to child. But if left to me, I wouldn't have given birth to a child." *Positive woman, Uong Bi, Quang Ninh*

E. Women and Men's perception of services

Provider-initiated testing during routine antenatal care has been the right move in Vietnam for PMTCT services. Trust and confidence in health care providers, especially related to pregnancy care, is high. Facility-based deliveries, regular attendance of antenatal care visits, and receiving counseling and testing during pregnancy and childbirth are familiar to Vietnamese women. Indeed, many individuals stated that to attend ANC was the "civilized" thing to do.

As has been mentioned earlier, reproductive health care decisions are in the domain of women. The third prong of PMTCT is therefore focused on the interaction between the pregnant woman and the provider primarily. Husbands, even if they accompany their wives to ANC or the delivery room, wait outside. There were a few situations where providers mentioned that husbands may have prevented their wives from obtaining a test, and a few where women were afraid of being told their status, but this was an exception. Some women are afraid that their status will be made public, however, and those that are concerned about confidentiality may resort to providing false addresses, or moving after a test.

Men do not want to test in the same place that ANC is offered. Men who do decide to test on hearing of their wives' results choose to do so at different facilities.

Free ARV, whether as prophylaxis for protection of the infant, or for men and women, is a very powerful motivator. Men and women who are diagnosed as positive appear to quickly find out about where and how to obtain free ARV. This study found interviewed 11 women who received ARV prophylaxis during pregnancy—and one of them shared her medicine with her husband—to protect him. While knowledge about SD NVP is limited, and women who have received it may not even remember getting it, knowledge about ARV is much higher and is a powerful draw.

Most positive couples (and people in general) were informed that positive mothers should not breastfeed their children, but give them formula. Messages that any mixed feeding puts infants at the highest risk, and that exclusive breastfeeding is a safer option than mixed feeding, do not appear to have been given. Neither men nor women mentioned the risks of mixed feeding, and only 1 woman stated that she exclusively breastfed for the first four months, which was against the advice of health providers.

Men do know about the fact that their children were replacement fed, and revealed that they knew which formula, and whether it was enough. Women are thus informing and involving men in infant care, even if decisions are taken by women. The women who had received PMTCT claimed that they formula fed exclusively. Their male partners confirmed this, and were accepting of this decision, as both felt it was in the best interest of the child. Other studies have revealed, in fact, that mixed feeding may be more common, and it is certainly possible that respondents were telling researchers what they knew they were supposed to do. **Men are not involved in decisions about infant care**. However, given that many men express concern for their children's health, and given that infant feeding and follow-up especially appears to be challenging, increasing men's knowledge and awareness on appropriate practices may be useful.

It must be noted that with the strong influence of providers in health care decision-making in Vietnam, decisions such as replacement feeding, and even testing, only have the appearance of choice. Most women are uncomfortable with asserting themselves with providers (and most men too) and genuinely believe that a health providers' advice is for the best. Providers also feel that they are only interested in the well-being of their clients, and in the health of the infants—and therefore counseling is often replaced with advice and recommendations.

E1. Trust and confidence in providers and health service

Most men, women and family members spoke quite highly about the care and services received during pregnancy and delivery. This was true of regardless of HIV status.

- "They encouraged, comforted and told me to take care of my health and finally informed me of the result." *Positive woman, district 6, HCMC*
- "Health workers are good, enthusiastic, and smart. Women come for free ANC and free vaccination." *Mother of positive woman, District 6, HCMC*
- "The health care providers provide good services, but sometimes in health station there are some cases that they can't deliver and have to send to Province Hospital. The health care services for pregnant woman are good. Some families have condition to call taxi to go directly to Sweden-Uong Bi Hospital for delivery, not giving birth in the health station." *Husband of pregnant woman, Yen Hung, Quang Ninh*
- "To tell the truth, my wife goes for pregnancy tests very frequently. The medical station's officers are very kind-hearted." *Husband of pregnant woman, Tinh Bien, An Giang*

There is a high regard and trust in health providers, and most individuals felt that they would follow the recommendations and advice of health providers without questioning as it was in the best interest of both mother and child to do so. Currently, PMTCT services are largely free, and this appears to be very well received.

- On being asked if she felt comfortable with having her blood drawn for a test, one woman said, "I think that the health staff created a trust in me and it helped me feel more secure." *Woman who just delivered a child, tested positive during labor with the quick test*
- "This is the 1st time my wife gets pregnant so I do not know. I just take my wife for pregnancy tests, I just follow whatever doctors told me to do." *Husband of pregnant woman, District 6, HCMC*
- "We are prestigious among the commune's inhabitants and understand their family situations, which is favorable to approach them. The inhabitants follow the instructions." *Health staff, Tan Chau, An Giang*

- "My husband and I are very happy because the state supplies us with medicine in order to extend HIV infected people's lives." *Positive woman, District 6, HCMC*
- "Now, the HIV test is free, CD4 test is free, too. It seems that the HIV infected people can get support of hundred thousand VND each year from the Global Fund." *Positive woman, Yen Hung, Quang Ninh*

E2. Testing during pregnancy and delivery:

a. Routine Testing

Possibly the most surprising finding in this study is the extent to which women expressed having control over their decision to test for HIV during pregnancy. By making HIV testing as part of ANC, it is perceived as part of the normal set of services that everyone has to avail of during pregnancy, and there is little stigma attached to it. Further, making it a part of ANC firmly places it in the decision-making arena of women, which means that women can decide whether or not to get tested. This study strongly suggests that routine testing during ANC works better than having VCT for pregnant women.

- "Most husbands support HIV testing. But we should test HIV with other tests when we are pregnant but should not during other times because the husband will think that we do not trust and believe him." *Pregnant woman, Uong Bi, Quang Ninh*
- "I think everybody needs to take HIV test, so we can know whether we are infected or not. All pregnant women should go to take the test to know the way of prevention for their children." *Positive woman, Uong Bi, QN*

Many people said that men considered to have a critical supportive role in encouraging women but ultimately the decision is the woman's. People also supported it as being only in the interest of the child.

- "Do not need to ask other people, it is possible to have self decision to go and take the test" *Family member of positive couple, Tan Chau, An Giang*
- "If I want to take a test, I can decide on my own without asking for my husband's opinion. And even if I do ask him, my husband will agree. These days, both the husband and wife make money." *Pregnant woman, Tinh Bien, An Giang*
- "I think the woman decides herself, the husband has a little impact, he does not hinder if that's good for his wife and child. Some husband can say: why taking the test when there is not disease, so much blood loss for test, but the decision is made by the wife, it's unusual to hinder the wife to take the test." *Positive woman, Uong Bi, QN*
- "Pregnant women are now more aware of having HIV tests. All pregnant women who got pre-test consultancy agreed to have HIV tests, though some refused to have tests after the first time they were counseled, but afterwards they agreed; some went to other places for tests but brought results to let us know." *Health Staff, Hoc Mon, HCMC*
- "It is more than obvious that prenatal women should take the test. They are the only ones who can make decision on whether they accept the testing or not, no one can make decision for them." *Health staff, Quang Ninh*
- "I independently decided to take the test because it was good for me. After I took the test I told my husband, he said it was good to do so. I see no husband objects to that." *Pregnant women, Tan Chau, AG*

- "Nowadays, HIV test is performed everywhere even Government staff, company, factory worker therefore there is not any shy when we go to HIV test. Before people said that there is something wrong when someone go to test but nowadays we should test because then husband and wife care for each other." *Pregnant woman, Uong Bi, Quang Ninh*
- "I would ask my husband, but I am not sure he can agree or not. If he doesn't agree, I myself go to have HIV test."
- "No one (needs to be asked), if it concerns me, I go to have HIV test."
- "I think my husband will not oppose to my decision, because it is good for my health and my baby, and the rate transmission is very high in pregnant stage."
- "I think not any one can change my decision but me, for my health condition and my family, I myself go to have HIV test. " *Pregnant women, Uong Bi, QN*

A range of "choice" is perceived by women in terms of opting out—many think they should test because that is what the provider is asking them to do. Only a few actively choose to get tested, and fewer still ask for the tests themselves. In some cases, women are told it is a blood test, not that it was a test for HIV. Providers admit that they do not always tell women why their blood is being drawn. Many women are not aware of being tested for HIV during labor, they may think the blood test is for any diseases.

- "Many women were afraid when hearing about HIV testing at first, but they agreed to take the test after hearing the health staff explained about that." *Health Staff, Tan Chau, An Giang*
- "Apart from prenatal checkups, I had 2 blood tests at the request of the doctor. Doctor said to have blood tests to check if I got any disease with no further explanation." *Pregnant women, District 6, HCMC*
- "I received pretest counseling with little information. The health staff said to have blood tests to check if I got the disease and I agreed immediately as I had heard much about HIV/AIDS." *Positive woman, Hoc Mon, HCMC*
- "Health workers at CHC gave us explanation that we need to see if you have any disease." *Pregnant woman, Hoc Mon, HCMC*
- "The Staff members at the Health Station told me to go for a pregnancy check-up, blood test and mentioned nothing about HIV Testing." *Positive woman, district 6, HCMC*
- "Testing is given during the labor – just the suspected case, taking blood for testing. No pre-test counseling is given because we do not want to say it frankly with the indication of HIV testing. We just say about the need to take blood for testing." *Health staff, Tinh Bien, AG*

b. Opposition to testing

In a few cases, men and women were opposed to testing in general and HIV testing more specifically. Reasons given included fear of blood loss, pain, costs associated with testing, and so on. This is consistent with the findings of the end-of-project assessment.

- "No (my wife is not afraid of finding out that she has a disease). She is only scared about blood sampling. She is my wife so I understand her. I did encourage her. But she did not want. What else can I do? I told her that there is nothing to be scared of. But my wife described to me how blood sampling is. It is like this (he showed 2 fingers as an example) so she is scared." *Husband of pregnant woman, Tan Chau, An Giang*
- "No, I haven't (had a test) because I'm afraid of blood. I am afraid of seeing it. The doctors explained to me this and that and told me to take a test but I was too afraid of fainting. I

have had pregnant examinations three times and all the time I was encouraged to take a blood test but I haven't taken any. During the time I had the first child I took a test in which the doctors took some blood from my ear but I was afraid of fainting so from that time on, I daren't take any blood tests. I was given explanation about taking HIV tests but I know that my husband is not kind of playboy; he gives his whole mind to his business so I don't take any tests." *Pregnant woman, Tinh Bien, An Giang*

- "There are about 5 to 10 people who rejected the HIV tests. There reasons are that, they are afraid of pain and blood loss. They are afraid of the charge. When they hear that it is free of charge, they accept. Some people say that they have done HIV test in other places but they have no result reports. Some pregnant women want to discuss with their husbands first. Some say they will decide later." *Health Staff, An Giang*
- "I think my wife has no HIV infection so it is not necessary to do that. Even if you force her to do so, she will refuse because she is so afraid of that. She is scared of taking medicine as well, as she will vomit it all up." *Husbands, pregnant women, Tinh Bien, AG*

In addition, men would tell their wives that they did not need to get an HIV test because they were "good men," however, this was the exception rather than the norm.

- I mean we are very serious, decent so why should we go for tests, which is a waste of effort. Anyone who indulge in pleasure should go to know how to treat the disease. *Husband of pregnant woman, Tinh Bien, An Giang*
- Through sample tests, we find that pregnant women are now more aware of having HIV tests. Nevertheless, there are still many people who are subjective and do not agree to have tests with such reasons as: they do not have tests as if they know about positive results, they will get more worried, so they had rather not have tests; or they are decent so they do not need to have tests. Husbands always have the largest influences on their pregnant women to decide to have HIV tests as every wife has to listen to her husband's advice. *Health staff, Tan Chau, An Giang*

Some providers thought that in a few cases, women had refused testing because they were afraid of knowing about their status, or their husbands did not want them to learn of their status.

- "There is a constrained outlook that still exists in the community: they think infection lies in somebody who indulges in pleasures or involves in evils, but not them and their families, so they do not want to have tests as they do not think they are infected. We have to offer consultancy, then they agree to have tests." *Health Worker, Tan Chau, An Giang*
- "Of course, many people in my group persuaded their wives to take HIV test but there was also a case where the husband persuaded his wife to take test but the wife did not agree. I also asked he why she did not go to take a HIV test, he said that "I have persuaded her many time but my wife did not go to take HIV test", I am dispatching a person to go to their house for counseling what is good and harm for her to encourage her to take HIV test, I predict that she do not dare to face the truth, she is afraid of HIV infection when her husband is very thin." *Sympathy club leader, Yen Hung, Quang Ninh*
- "Maybe we had better tell them that we take them for diabetes tests, so they will go. If they are told they will be taken to have AIDS tests, none of them will go. It does not mean that they are afraid of death, they are afraid of being made fun of if other people know that they are HIV-infected." *Mother-in-law positive woman, Hoc Mon, HCMC*

There are a few places where providers and individuals revealed that where someone was suspected of being positive and refused a test, the health workers would come to their home, sometimes with a needle to draw blood.

- My husband didn't go, they came to my house to take the blood. At that time, I prepared to bear my child. They let me take the test when there was 1 month until my child's birth. I didn't know that I was infected, I only knew some days before giving birth. *Positive woman, Uong Bi, Quang Ninh*

In places where there are no PMTCT services, providers may encourage women who they think are drug users, sick, or deemed "suspicious" to get tested.

- "Suspected HIV infected patients are given encouragement to take the test. If they agree, we can let them do HIV testing. If they agree we charge the fee. No signature for the commitment prior to the test. The staff of the clinic takes blood to do the test." *Health staff, Tinh Bien, AG*
- "If the pregnant woman has a husband who is involved with risky behavior like drug addiction, going with prostitutes, we will advise them to ask the husband to take HIV test. Last year, we advised one couple like that, but the results were negative. Risky behaviors include drug addition, working as drivers who are often far from home, going with prostitutes… managing restaurants or hotels." *Health staff, Uong Bi, Quang Ninh*

c. Confidentiality of test results

Other studies have pointed out to challenges with confidentiality of test results in Vietnam. The findings of this study are consistent, that perceived or real fear of others finding out about their status is a big concern. In addition, there were some examples of results being shared.

- "I receive HIV test results from the center of higher levels." *Sympathy club leader, QN*
- "The authorities at the commune level receive a piece of paper with all the people in the commune who are HIV positive." *Positive woman, Uong Bi, QN*
- "Some mothers declared wrong addresses because they do not want their status to be known." *Health staff, HCMC*
- "According to regulations, they must go to the health centre to take HIV test, although they went to other center for HIV test or anonymous, wrong address. I think it very difficult when the government allows HIV carriers to have anonymous right, they can give true first name but wrong family name or address. Someone even swore at us when we came." *Sympathy club leader, Yen Hung, Quang Ninh*
- "Positive results will be sent to the planning bureau of the municipal preventive health care center. We provide names, addresses and results, and have a monthly meeting to discuss loss to follow up" *Health staff, HCMC*

d. Getting male partners to test

There were no examples of couples coming in for tests together during ANC. Even after the woman's result was known, few men agreed to come in for testing to the health service. In many cases, the husband knew his status already (see section on being diagnosed with HIV and revealing positive status). Some men agreed to be tested but not at the ANC centre and not with their wives.

- "Only when I went there for the pregnancy test and blood test, I knew I was infected with HIV. My husband was surprised why I got infected with HIV and he went to a hospital to have an HIV test immediately and found himself positive, too. He told me that he had an unsafe sex with another woman." *Positive woman, Tan Chau, AG*

- "For positive cases, during post-test consultancy, we always mobilize those women to take their husbands to tests, but none of them takes their husbands to the surgery for tests yet. They all go to other places for test, perhaps they hesitate to go to pregnancy testing wards." *District PMC, Hoc Mon, HCMC*
- "Many pregnant women are taken to the center for pregnancy tests by their husbands, but none of these husbands has a test with his wife." *Health staff, CHC staff, district 6 HCMC*

Some men refused to go for tests themselves, most likely out of a sense of denial.

- "Yes, I did tell him to go for a test, but he did not follow my advice. At the time, he was very upset, but he still encouraged me and I encouraged him. But then when I delivered the birth, I did not have time to take care of him, he got addicted to scag again. I told him but he did not listen to my advice." *Positive woman, district 6, HCMC*

e. Post-test counseling

It appears that quality post-test counseling has been practiced relatively recently and only in select locations. Individuals who were diagnosed as positive a few years ago or in places where there has been no training, did not receive sensitive and appropriate post-test counseling.

- "They didn't tell me anything. Even after she gave birth, they didn't care about us, they left us alone. (speaking to others): They left us alone there in the hospital. After my wife gave birth, they didn't give her any medicines to take; until I asked them what medicine she had to take, did they tell me, then I had to go to the drugstore to take her some. The doctor didn't (do a blood test). He just stood there saying this and that. I listened to other people telling me to ask them for a test. Then they called me for the result before we left there. They didn't do any counseling or advice, anything at all." *Positive husband, District 6, HCMC whose wife delivered a baby at a non-PMTCT hospital*
- "In general, the discrimination was serious at that time, the doctors didn't encourage and advice me where to go to examine." *Positive woman, Uong Bi, Quang Ninh*

More recently, individuals stated that providers were sensitive, caring and sympathetic during post-test counseling and more generally.

- "Did you get any advice on health caring and birth delivering from doctors when you were informed of the result?"
- "Yes, they were very enthusiastic. They gave very careful instruction." *Positive woman, district 6, HCMC*
- "They asked me whether my husband turned to debauchery, I answered that he turned to debauchery before, but after the marriage, he took pains to work. In general, the doctors are interested in me and sympathize towards me." *Positive woman, Uong Bi, Quang Ninh*
- "Healthcare staff at the community health station also provide me with counseling. I think they were friendly… Yes (it was) very useful. These counseling sessions help me understand that we should not stigmatize persons living with HIV. In addition, we know how HIV is transmitted and how to prevent contracting HIV." *Wife of positive man, Uong Bi, Quang Ninh*
- "Every time I go to the commune health station, I always stay to talk with people there for hours. They encourage me a lot." *Positive woman, Tan Chau, An Giang*

E3. ARV prophylaxis for PMTCT and ARV for adult men and women:

Many women are counseled on testing the first time they come for ANC in locations where PMTCT services are established, which varies by individuals. If positive, and if ARV is available in the places where they live, they receive free ARV after 28 weeks. Positive women get referred to places where ARV is provided. This study interviewed 11 women who received ARV prophylaxis during pregnancy, some receiving it for just a few weeks, and others for 2-3 months. A few places provide free CD4 testing, but it is not free in all places. The most consistent support has been SD NVP during labor and to the infant after birth. Most women have little memory of SD-NVP, and their babies receiving it after delivery.

- "No medicine was given pre and during laboring." *Positive woman who received PMTCT, Hoc Mon, HCMC*
- Getting free ARV is one of the greatest motivators for testing and seeking care.
- "(Our hopes are that) when we give birth to our child, she/he won't be infected with HIV. We are poor, so we hope to be helped like to take free medicine." *Positive man, District 6, HCMC*
- "The doctors give medicine to extend my life, I'm very lucky. I don't have money to buy it outside." *Positive man, Tan Chau, An Giang*
- "If they (pregnant women) are infected with HIV, health centre gives them medicine to protect their children from HIV." *Sympathy club leader, Yen Hung, Quang Ninh*

In Yen Hung, a home based care program supported HIV patients to adhere to the ARV regimen. In Uong Bi, one woman forgot to always take her ARV, and health staff complained about this.

- "Sometimes I meet an easy one, sometimes not. When I forget to take medicine or take late, they complain, but just the nurse. The doctor who examine for me directly doesn't like do that." *Positive woman, Uong Bi, Quang Ninh*

Right now ARV is free, but there are concerns about what happens when project funding runs out.

- "Take medicine? Will we have enough medicine to take for long? I asked the surgery that question. When the project ends, will there be medicine provided to us, to the people like us or at that time, will all of us die?" *Positive woman, District 6, HCMC*

E4. Infant care:

All mothers are very conscious of the need to protect their children's health and state that they follow instructions as given by doctor very carefully. They are aware that they need to follow instructions carefully to benefit and protect their children.

- I got medications for free for one month after the test result was disclosed. 1 week after birth my baby was provided with HIV medicines. My baby is now 2.5 months old. I have not had further test. Right after delivery, I was provided with formula milk. *Positive woman, Hoc Mon, HCMC*
- The doctor provided counseling to me about how to eat, I read the leaflets and follow the instructions written in these leaflets. It is not difficult to carry out. I have to pay more attention to look after for my baby.
- I do what doctors say to care for my baby. It is not difficult to do. *Positive women, District 6, HCMC*

Most women stated that they were given one can of formula on being discharged from hospital in most places where the PMTCT services have been established. They are referred to another department or facility to get additional formula. Mothers are usually asked to return once a month. Most women, especially in HCMC, reported no difficulties in obtaining milk. A few said it was a difficult process.

- "I did not feed my child formula. I was advised to, and first they told me I could get it for free from the District PMC. Then they told me that I could get it from the Sweden-Uong Bi hospital. But I could not get it from either place. Then they told me to get it from the Women's Union, but in fact, they did not have the formula." *Positive woman, Uong Bi, Quang Ninh*

All men and women seemed to be under the impression that breastfeeding was not recommended. Guidance on infant feeding did not seem to have included information on the higher risks of mixed feeding versus exclusive breastfeeding. Some women breastfed along with formula saying that it was because the provided formula is not enough. Others exclusively breastfed initially because they were not aware of replacement feeding in time, or because they wanted to.

- "They said that, I have to prevent for my child, have not give the breast to him, but I still breastfed him exclusively for 4 months. They gave me milk, after 4 months I let him drink formulas milk (powder milk)." *Positive woman, Uong Bi, Quang Ninh*
- "I suckled my child, and fed him with my milk, because my knowledge at that time is not enough. I suckled my child totally for 3 months, after that, I fed him with formula milk. He took the examination 2 times, but he wasn't infected. He is now more than 4 years old." *Positive woman, Yen Hung, Quang Ninh*

There are a few examples where formula is brought to the woman's home. For example in one commune in Quang Ninh, CHC staff brought milk and cotrimoxazole to the positive woman's home. In HCMC, women are given a list of places offering PMTCT to get milk and drugs. Although formula milk is supposed to be free in project areas—it may not be enough for each baby, some mothers may need to buy more. Most women who received formula said it was insufficient.

- "No, I had to buy milk by myself, I received a little of milk in the hospital but I had to pay when I discharged." *Positive woman Yen Hung, Quang Ninh*
- "Doctors gave baby milk and medicine, but it's in 6 months only. And there are no much left. My husband and I are very happy because the state supplies us with medicine in order to extend HIV infected people's lives." *Positive woman, district 6, HCMC*
- "Well, they just examined and said that although the mother was infected, the child would still not. Therefore, after being born, he should not be breast-fed but be fed by other kinds of milk instead. They give me (free milk) every month. But sometimes he drinks, sometimes not. There was one month when I was given two tins of cow's milk and one tin of Dialac. We sold the Dialac milk to buy cow's milk instead because he doesn't drink Dialac." *Positive woman, Tan Chau, AG*
- "Feeding this child is much money, 3 million VND a month for milk. Sweden-Uong Bi hospital gave him 6 cans of milk a time a month for 6 months then stopped. We buy it in case not enough for him. Their uncle supports them to feed their son, as they do not have money. The hospital supports milk enough for half of month, another half of month we support." *Mother-in-law of positive woman, Uong Bi, QN*

Some health providers reported that mothers breastfeed in front of their mothers-in-law, but in private formula-fed (but not very common).

- "Infected women conducted breast-feeding in front of their mother-in-laws because they do not let mother-in-law know about their infection, they do not feed breast-milk to the baby when their mother-in-laws are not present." *Health staff, HCMC.*

Replacement feeding is associated with having HIV, as breastfeeding is the norm, and many people, especially in areas where PMTCT services are offered, are aware that HIV positive women are recommended formula feeding to avoid infection.

- "They (other people who are positive or have family members who are positive) also keep secret like me. But I know one way to find out HIV infected people. The mother who doesn't give a baby breast-feed is infected with HIV." *Mother in law positive woman, District 6, HCMC*

Women thus come up with alternate explanations for formula feeding.

Follow-up and testing for infants proved more challenging. It was not clear from this study whether men and women were fully informed about when to test babies for HIV—some tested quite early, others much later. Testing for babies was done at various times, at 2 months, at 6 months, or at 18 months.

E5. Approaching men

Many health providers and community leaders stressed the need to reach out early to men.

- "The majority of women get infected from their husbands, so if we want to educate them, we must work out strategy to reach both. We cannot wait until when they get married. It will be too late if their wives get pregnant already; they must be supported early; propaganda must be carried out in the society, with special importance attachment to schools (at present, propaganda in schools is ignored), there must have sex education, education of men and women's roles. *Health staff, HCMC*

Men made it clear that they preferred to discuss issues related to sexual health with male doctors.

- "Men always feel more comfortable whenever they are given medical checks by male doctors. You must consider this issue when you want to open the health consultancy ward for men." *District Farmers Association, Tan Chau, AG*
- "It's easier to talk to male doctor."
- "We cannot choose, but it's easier to talk to male doctor."
- "With male doctor, I have more courage, and feel it easier to talk."
- "We don't hesitate to take our clothes (off) laugh together)." *Positive men, Tan Chau, AG*

They also perceived ANC services to target only women, and while they were happy to get more information about ANC, time was a concern for many of them.

- "We also observe that male clients are getting more problems with reproductive health, but there has not been any specialized service that is highly accessible for them. Thus, the only can attend the Department of Gynecology for treatment. We also decided to have a specialized department of male health care within this center. However, per decision by MOH, the center will be recalled the Center for mother and child health protection and care, if so male clients will not be able to attend our service here. Just by its name, there is no room for men health care." *Health Staff, AG*
- "Very difficult (to involve men) as they do not care about it. If they are told a meeting is aimed at pregnancy care, they will not participate, you know."

- "That is right. Men hesitate a lot to get involved in that business." *Husbands of pregnant women, Tinh Bien, AG*

Many individuals recommended reaching out through special male-focused activities, in places where men were likely to meet anyway, and during the evening hours. For positive men, sympathy clubs were expressed as a suitable venue for providing information.

- "Club's members are very skillful, so we can approach infected men to encourage them to participate in PMTCT program." *Health staff, Tan Chau, AG*
- "According to me, the way to approach them is to involve the members of Đồng đẳng Club who have skills to deal with the infected men, encourage them to participate in the program on PMTCT." *Health Staff, Tan Chau, An Giang.*

F. Service provision to prevent mother to child transmission in Vietnam

Summary of findings related to male involvement:

PMTCT services are only offered in select districts in Vietnam. The findings from this study are skewed towards those provinces, and hence should not be generalized for the whole country. Based on other studies, three things stand out with regards to service provision in this study, which are likely because the sites mostly do offer PMTCT services. First, women are offered testing (and in many cases agree to it) quite early in pregnancy in these sites, especially in the last several months. Second, the quality of post-test counseling for positive women appears high. Third, formula is available and is free of charge, although of insufficient quantity for most babies.

Service providers in Vietnam are usually overburdened. For example, it is not uncommon to see women sharing beds in hospitals post-delivery. Service providers thus make their own decisions with regards to use of time and resources, given the constraints that they operate under. They may, for example, choose to forego individual pre-test counseling due to the large numbers of women that attend ANC, especially if facilities offer ANC only on certain days in a month. They may either choose to do group education, or very quick individual information sharing. With regards to post-test counseling, great care is given (in facilities that have received training) to follow good practices for women or men who test positive. In the case of routine testing, however, the vast majority of women, even in high-risk provinces, test negative. No counseling is given to these women, or even information about future protection. Again, this is a provider judgment based on time and resources available. Women thus are lulled into an even greater sense of security—they have been tested, and found "okay" or "normal". Therefore, their husbands are "normal" and "good""—they are not "playboys". **Negative status is seen as a stamp of fidelity and good behavior.** There is a lost opportunity to counsel women who test negative and their partners about primary prevention of HIV infection and about the window period.

F1, Coverage of services

PMTCT services are offered in a few districts and provinces in the country. From many perspectives, this choice has been strategic, since the epidemic is concentrated both in terms of populations and geographically. In some places, PMTCT services are added onto existing HIV/AIDS care and support services, in others, they have been provided through independent projects. According to the findings of this study, PMTCT services are offered primarily through collaborations/financial and technical assistance from international agencies to public sector service provision facilities. There is very little outside of these internationally-funded projects.

- "Stigma is still existing, even in the hospital – they do not want to treat the disease of infected people. At XX hospital (no PMTCT services), upon being discharged from hospital, they have a policy that such patients should not be readmitted, they may refer those patients to other hospitals immediately, they do not want them to have delivery there." *Positive man, district 6, HCMC*

PMTCT services have only been offered in the past 3 years or so. They appear to have become much more established in the places where they are offered in the past 18 months to a year or so.

- "When my wife is HIV positive, the hospital provided both of us with ARV. However, I could not remember for how long did we take the drug, we were just on and off. Only after 2006 did we take the pill regularly. My wife delivered the second child at this hospital. The child was not provided with any drug or milk. She was fed totally with breast milk. After 18 months, she was taken for HIV test and the result is positive." *Positive man, Uong Bi, Quang Ninh, whose child is now 24 months*

Therefore, there appears to be a significant shift in these places in terms of availability, functionality, awareness and acceptance of PMTCT services. The end-of-project assessment of the UNICEF-supported pilot project illustrates this improvement over the past three years. Further, free ARV and testing (provided by donors such as LIFE-GAP and CDC) appear to be more established currently compared to 2 years ago.

Table 1. Selected PMCT Indicators (MOH 2008b)

Indicator	2005	2006	2007	Total
Number of PW	14.771	14.884	9.876	39.531
Number of PW attend ANC	8.270 **(56,0%)**	12.716 **(85,5%)**	7.227 **(73,2%)**	28.213 **(71,4%)**
Number of PW received pre-test counseling	8.270 **(100%)**	12.716 **(100%)**	7.227 **(100%)**	28.213 **(100%)**
Number of PW got voluntary HIV test during pregnancy	4.040 **(48,8%)**	8.196 **(64,4%)**	5.377 **(74,4%)**	17.613 **(62,2%)**
Number of PW positive after testing in during pregnancy	22 **(0,54%)**	42 **(0,51%)**	16 **(0,3%)**	80 **(0,45)**
Number of HIV-positive PW received ARV prophylaxis.	12 **(54,5%)**	27 **(64,3%)**	10 **(62,5%)**	49 **(61,25%)**

F2. Testing

In all places where PMTCT services are offered, women are encouraged to get testing during pregnancy. They are offered the test the first time they come to the health center for ANC. Some women do refuse to get tested, in which case they are counseled repeatedly (until they agree).

- "The difficulty is that some may understand the importance of HIV test but some not. They may say "I am healthy and so is my husband, why should we take blood sample?" For such cases, we have to counsel many times for them to understand and agree to take blood sample. Others may say "why do I have to take blood test, it will affect my nutrition and health while I am very poor". There are a lot of difficulties, but we keep counseling and finally they agree to take blood sample. For blood sample taking, it is different with different people, some only agree after several times of counseling." Health staff, QN

Previous studies have shown that women get tested quite late in pregnancy, and this may well have been the case up to even a year or two ago. However, as PMTCT services are slowly established in these districts, there appears to be a gradual acceptance and understanding of the need for HIV testing in those districts where it is offered. This study finds that women get tested as early as 3-6 months in places where PMTCT services are offered.

In some centers in the South, there is a consent form introduced for all HIV testing. This is a new regulation by the MOH, and it is perceived to reduce the number of women willing to be tested. Health staff felt that it asked for a lot of private information and women may not have agreed to sign it. Most health staff did not agree with this regulation. In An Giang they may ask women to sign in a log book.

- "There is a new instruction that pregnant women must sign in a form with too much of their personal information, which is not good. This instruction needs amending because through the implementation process, we find out that the number of pregnant women who agree to have HIV tests has reduced remarkably." *Health staff, HCMC*

In larger facilities, providers may be busier and so may not do much pre-test counseling. Group counseling or even less may be the norm. Pre-test counseling varies from nothing to more of an info session on HIV or even advocacy to get a test.

- "HIV counseling at the OB-Dept is impossible because it is always too crowded." *Health staff, HCMC*
- "It can be assumed that all pregnant women receive information and counseling about HIV testing. However, it is difficult to say that pregnant women receive sufficient information about HIV/AIDS before the test because on the antenatal care day, it is always crowded and very busy with different activities such as blood taking, tetanus vaccination, etc." *Health staff, Tan Chau AG*
- "We can only offer consultancy HIV tests to 30-50 cases out of 150 pregnancy tests every month and only half of the consulted women agree to have tests." *Health Staff, Tan Chau, AG*

Although commune health centres and a range of facilities offer tests, they do not all actually have the lab facilities to test the blood. Some may be able to do quick tests, others do not even do these. Blood samples are thus transferred to the lab facility where either quick tests or confirmatory tests are done. Negative results are shared quickly with women, either by giving a piece of paper that states that the test was negative, or verbally. There is little, if any, post-test counseling for patients who test negative.

For patients who test positive during pregnancy, the quick test is confirmed in a higher level lab facility and sent back usually to the place where the blood was drawn. Test results are returned in a week in some places, but take up to a month in others. The delay in providing the test result can partly be explained by the process of transferring blood samples to lab facilities, and the time that it takes to hear about the result, and partly because some providers state that the results are provided at the following ANC visit, which is usually a month later.

Post-test counseling is done by designated providers (usually a senior doctor), and in places where PMTCT services are established, is done in a private room. Post-test counseling is provided only to women who test positive. The study could not assess the quality of the counseling, but based on self-report from service providers, it is evident that some were extremely confident about the steps, while others were much more tentative.

- "Upon maternity check up, if prenatal women are found with HIV, nurses will report the case to one of the eight physicians in the counseling team and the physician who is the head of this PMTCT clinic in order for physician to initiate counseling and giving guidance on health care to the women. I am not sure how it is in the communities, but in this OBGYN department, there is no room for discrimination. In stead, they always receive our encouragement and sympathy during their pregnancy and we encourage them to have their delivery here. We have never seen any one being shocked, fainted when knowing their HIV positive status since we did 3 steps for pretest process very well. " *Quang Ninh Provincial Hospital*
- "The process for post-test counseling is as follows. Firstly: inform test result to her. Secondly: explain HIV-related issues like what HIV is, its transmission ways, consequences and available treatment measures, etc. Thirdly: working out 2 solutions: if she wants to keep the fetus, we will give consultancy of caring for themselves and the fetus during her gestation, delivery and ways to take care of her baby later. Addresses of qualified hospitals to caesarean section for infected women are given to them. If she wants to abort the fetus, we will guide them to hospitals that are permitted to perform abortion." *Provincial RHC, HCMC*
- "It is the hardest to inform pregnant women of their test results. It is really difficult for us to inform them because we are worried that they are not psychologically firm to accept the news. Thus how we must say to make them less worried but accept the truth and care for their health." *Health staff, Hoc Mon, HCMC*
- "Among 2 cases with HIV (+), 1 was tested under different name. For this case, the hospital had to retest to confirm and correct the resident address. It is very often the people come for HIV testing do not bring ID." *Health staff, Hoc Mon, HCMC*

While most providers state strongly that results are shared only with the woman, a few admitted that family members may be informed, and others revealed that authorities are given a list of positive people in their locality.

- "It is when we give consultancy to their family members because pregnant women do not want to let their family members know, but family members must know how to prevent babies and themselves from infection." *Health staff, HCMC*

It is mandatory to test during labor at some of the larger facilities.

- "That is a must (testing during delivery). The only exceptions are those who attend our clinic for maternity care prior to their delivery and we have their records. For those coming just when making delivery, we must provide counseling and HIV testing upon their labor and delivery." *Provincial hospital, Quang Ninh*
- 100% of patients are advised to have tests." *Tu Du hospital, HCMC*

In places where the data were gathered for this study, there were very few deliveries in CHCs. Most women delivered in district hospitals or provincial hospitals. Some district hospitals do testing, others may not. Testing was done again during labor for women who had been tested before if they had been tested a while ago or if they had no record of their test. As mentioned above, women may not be aware that they are being tested for HIV during labor. Post-test counseling may be less carefully done.

However, in places where there is no PMTCT, testing is not offered as part of ANC or labor. Women who perceive themselves to be at risk may get tested, and will usually travel to different facilities to get testing. In Tinh Bien for example, there were three women that decided to go to Tan Chau hospital for pregnancy and childbirth, and continue to go there for services.

F3. ARV prophylaxis

a. During pregnancy:

ARV is available free of charge in select districts and hospitals, including in some of the districts in the provinces where this study gathered data from. Currently, PLWA receive ARV if CD4 counts are below 200. Pregnant women are also entitled to receive ARV after 28 weeks, and infants are given ARV for 7 days if born to HIV positive mothers.

Women who test positive may be offered ARV during pregnancy. The number of women who are given ARV during pregnancy still appears to be small according to this study. This may be because women need to get ARV from a different facility than where they are obtaining ANC, or it may be because women are not offered ARV in all the places where they get tested. Women who are diagnosed as positive during labor in provincial or national hospitals are referred to OPDs or other departments for follow-up. This follow-up includes a CD4 test and appropriate follow-up.

In Quang Ninh for example, Life-Gap provides ARV prophylaxis to pregnant women after 28 weeks in limited places (provincial hospital and Sweden-Uong Bi hospital). To receive ARV prophylaxis during pregnancy, the woman would have to have been referred during pregnancy to the provincial hospital (which is done by a VCT site or the PAC) or have been tested directly at the Sweden-Uong Bi or provincial hospitals. CHCs and the Uong Bi district preventive medicine centre do not send women to the Sweden-Uong Bi hospital to get ARV prophylaxis.

b. Delivery:

SD NVP is offered in all the higher-level facilities where PMTCT services are established. In facilities where SD NVP is offered, ARV for 7 days is also offered to the infant, and replacement feeding is recommended. Linkages with OPD for women and pediatric hospitals for children are also made. However, it appears that SD NVP is offered only in a few facilities, and hence women who are diagnosed positive and deliver in facilities where there is no testing and no SD NVP would not receive it. Given that women may not deliver in the provinces/towns which are their normal places of residence (due to the practice of returning to one's mother's home for the delivery, or due to migration), follow-up for women from ANC through delivery appears to be an issue.

In some places, HIV infected women are kept in separate rooms during delivery and during recovery, in others, there is no such separation. Women are not told why they are being isolated in places where they are.

- "There are separate labor wards for HIV-infected women. HIV-infected patients are entitled to be treated in special rooms and given medical checks separately." *Tu Du Hospital, HCMC*
- "In labor and delivery room, HIV infected patients are cared in the same way as non infected ones. After delivery, these babies are cared like other. The mother and her baby stay in a designated room for HIV infected patients for postnatal care but the family members do not know about it." *AG General hospital*

F4. Post-delivery care and follow-up:

Providers are quite knowledgeable about the risks associated with breastfeeding and recommend replacement feeding for positive women. Formula is given in all the districts where UNICEF is doing PMTCT work, but not through UNICEF. It is also provided through other projects unrelated to HIV/AIDS, and can be distributed through district and provincial hospitals, PMC, and RHC, as well as

mass organizations. In one commune in Quang Ninh, it was brought to the woman's home by the CHC staff. Amounts of formula given also vary from place to place, with some facilities giving one box a month, others giving more, and some giving formula for only 6 months and others for longer.

Women are encouraged to bring their infants in for HIV testing (some seem to do it at 6 or 9 months, others at 18 months) and to treat opportunistic infections. Again, there is great variance in actual practices of follow-up for infant care.