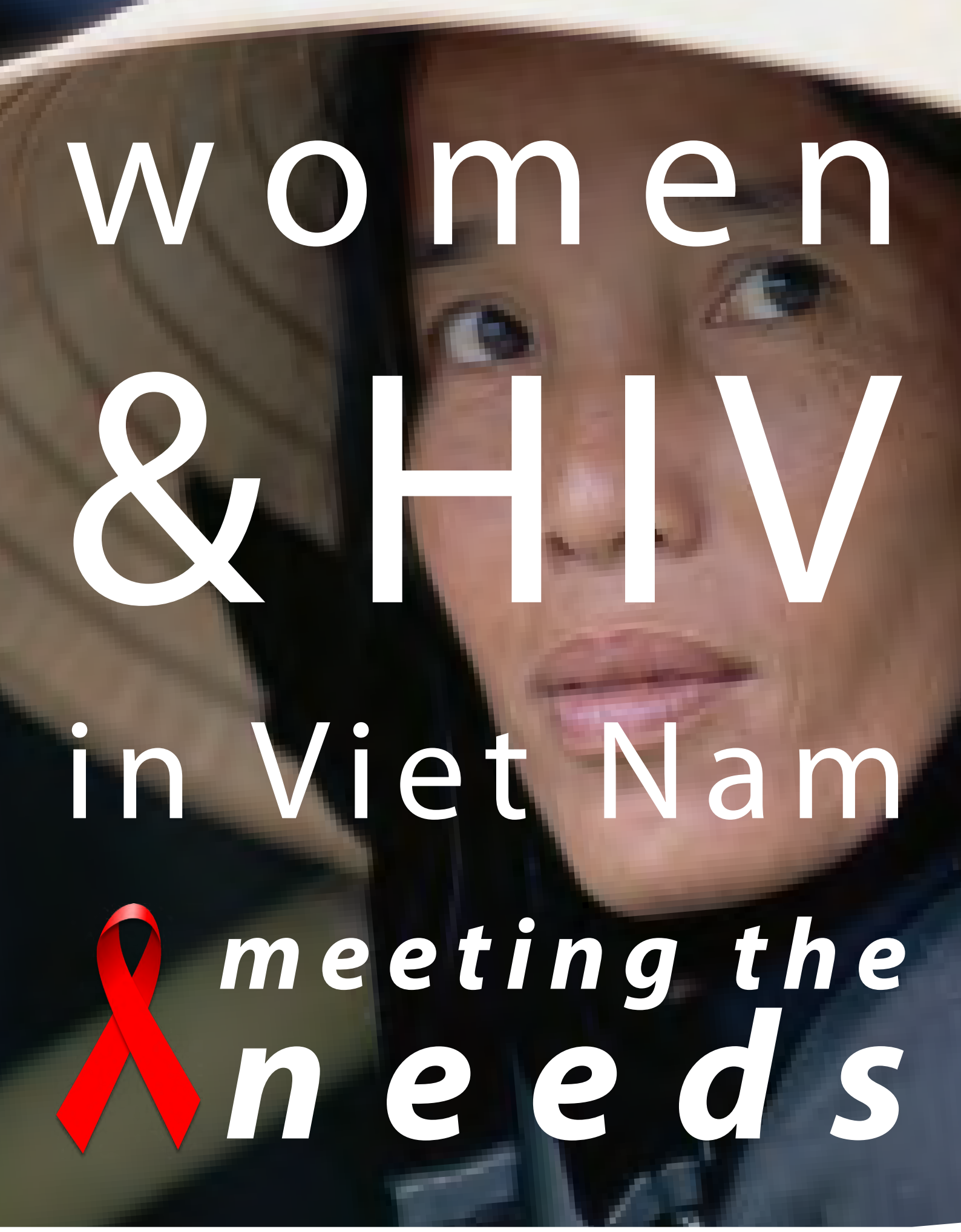

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IN PARTNERSHIP TO FIGHT HIV/AIDS

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With special thanks to

Our interview participants

Respondents living with HIV

Consultants

Abbreviations

AIDS	Acquired immunodeficiency syndrome
AusAID	Australian Agency for International Development
CCIHP	Creative Initiatives in Health and Population
CD4	Cluster of differentiation 4
CDC	United States Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CESVI	Cooperazione e Sviluppo
CHP	Community Health Promotion
CIHP	Consultation of Investment in Health Promotion
COHED	Center for Community Health and Development
CSAGA	Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents
DfID	Department for International Development (United Kingdom)
EPP	*Viet Nam HIV/AIDS Estimates and Projections 2007–2012* (Ministry of Health & VAAC, 2009)
ESD	Extending Service Delivery
FHI	Family Health International
GSO	General Statistics Office of Viet Nam
HESDI	Health and Environment Service Development Investment
HIV	Human immunodeficiency virus
ICRW	International Center for Research on Women
IBBS	*Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam 2005–2006* (NIHE & FHI, 2007)
IPPF	International Planned Parenthood Federation
ISDS	Institute for Social Development Studies
MCNV	Medical Committee Netherlands Viet Nam
MDGIF	Millennium Development Goals Achievement Fund
MOLISA	Ministry of Labor, Invalids and Social Affairs
MSI	Marie Stopes International
NGO	Non-governmental organization
NIHE	National Institute of Hygiene and Epidemiology
OSEDC	Organization for the Support and Education of Disadvantaged Children
PAC	Provincial AIDS Committee
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHAD	Institute of Population, Health and Development
SAVY	*National Survey on Adolescents and Youth in Viet Nam from 14–25 years old (SAVY)* (GSO, 2009)
SHAPC	STI/HIV/AIDS Prevention Center
SRH	Sexual and reproductive health
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economics and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNGASS	*Declaration of commitment on HIV and AIDS adopted at the 26th United Nations General Assembly Special Session in June 2001 (UNGASS). Reporting period: January 2008–December 2009* (Viet Nam, 2010)
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VAAC	Viet Nam Administration of HIV/AIDS Control
VCSPA	Viet Nam Civil Society Partnership Platform on HIV/AIDS
WHO	World Health Organization

Contents

Preface

HIV does not affect men alone in Viet Nam. It is time for stakeholders to act together on meeting women's urgent, unique needs.

This report introduces current knowledge on the particular situation that Vietnamese women face with regard to HIV. Women are a critical population within the epidemic, not only in terms of sheer numbers, but as this report emphasizes, in terms of the disproportionate toll that HIV can take on their lives. Even as the rate of infection begins to stabilize among high-risk men, transmission continues from these men to their wives and regular partners. When HIV enters the home, women confront a double burden: greater discrimination for contracting the disease and greater sacrifice as caretakers for other infected family members.

Yet policies and programs to assist women still trail behind those that target men. Part of the answer is to increase knowledge of women's complex vulnerabilities. This report specifically aims to address that need, by providing gender analysis of stigma and discrimination, prevention, treatment, caregiving and the role of men, as well as highlighting projects that addressed these in the first decade of the 2000s.

Knowledge of vulnerabilities remains insufficient, however, without complementary knowledge of women's distinct strengths. In the words of *Women and HIV/AIDS: Confronting the Crisis* (UNAIDS, UNFPA & UNIFEM, 2004):

> Women must not be regarded as victims … women and men are taking action to increase knowledge about the disease, expand access to sexual and reproductive health and educational services, increase women's ability to negotiate safer sexual relations, combat gender discrimination and violence and increase access to female-controlled prevention methods… (iv)

Vietnamese women are empowered by a relatively gender-equal society. Viet Nam's Gender Development Index is among the highest in the Southeast Asia and Asia–Pacific regions, and it is approximately on par with the country's Human Development Index for the population as a whole (CEDAW, 2007). The vulnerabilities described in this report must be coupled with a parallel understanding of women's strengths, in order to produce policies and programs that best support women to maximize their health and quality of life.

This report concludes with recommendations that can help policymakers and implementers coordinate future policies and programs that meet women's HIV needs. Increased attention to women's needs does not imply neglect of most-at-risk populations. Rather, because women's infections pass via high-risk groups, existing interventions with such groups are more urgent than ever, and they should incorporate gender to challenge the social norms that place women at risk.

Pact compiled this report based on a desk review of government, donor, academic and other documents pertaining to women and HIV in Viet Nam and worldwide; and on group and individual interviews, conducted in partnership with the Viet Nam Women's Union, that capture the voices of women living with HIV, government officials, international donors, and Vietnamese and international non-governmental organizations. It also owes an important debt to *Women and HIV/AIDS: Confronting the Crisis,* the United Nations report cited above, which guided the selection of topic areas and offered an indispensible global background on women and HIV. The Ford Foundation provided generous support, as did the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Aid (USAID).

We hope this document will serve as an advocacy and policy tool to help meet the HIV-related needs of women in Viet Nam, and thereby contribute to a strengthened national HIV response.

Pact, May 2011

Women and HIV in Viet Nam: What are the needs?

In Viet Nam, the proportion of women living with HIV is growing steadily closer to that of men – and the disease takes a heavier toll on women. According to *Viet Nam HIV/AIDS Estimates and Projections: 2007–2012,* or EPP (Ministry of Health & VAAC, 2009), by 2012 there will be approximately 77,000 women living with HIV in the country: That equals 30% of all infected adults, up from 25% in 2002. One reason for the narrowing gap is men transmitting HIV to their regular sexual partners. Once HIV is brought inside the home, women bear a disproportionate double burden: greater discrimination for contracting the disease, and greater sacrifice as caretakers for other infected family members.

Young women have lower HIV-related knowledge than do young men. *The National Survey on Adolescents and Youth in Viet Nam from 14–25 years old* (SAVY) (GSO, 2009) finds that fewer young women have high knowledge of HIV than do men: 63% compared to 69% in urban areas, and 50% compared to 59% rural.

Female sex workers, one of the highest-risk groups in Viet Nam, require more effective interventions with them and their male clients to help protect against HIV. According to *Results from the HIV/sexually transmitted infection Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam 2005–2006* (NIHE & FHI, 2006), female sex workers register rates of infection as high as 18% for venue-based sex workers in Ha Noi and 23% for street-based sex workers in Hai Phong. A comparison of the published IBBS figures from 2005 and preliminary IBBS data from 2009 finds that female sex workers' overall consistent condom use was revised downward in Can Tho, Ha Noi and Ho Chi Minh City.

Interventions targeting women and tailored to their specific needs remain few and far between. Communication materials tend to target men (injecting drug users and men who have sex with men) or female sex workers, because these are the groups at highest risk of HIV. Peer outreach for high-risk women who inject drugs is virtually nonexistent (CIHP, 2008), and low-risk women have not received adequate communication and education, despite the growing numbers who contract HIV through their partner.

Power dynamics enforced by Viet Nam's social norms make it challenging for women to protect themselves against HIV when they negotiate sex. In a survey of married couples in Nghe An, Luke et al. (2007) found that most people believed a woman should respect her husband's supremacy and defer to his judgment.

Women who disclose their status, attempt to access services or publicize their condition to raise awareness among those not yet infected risk stigma and discrimination. Because women are held to high standards of "purity," those who become infected through sex work or drug use can be blamed and condemned (Khuat, Nguyen & Ogden, 2004). And regardless of the source of infection, a wife or mother will almost always care for a man living with HIV, but if a woman contracts HIV, her in-laws may abandon her or separate her from her children. To date, however, few efforts to reduce stigma and discrimination have targeted women explicitly.

Care and treatment services are often offered to women with a tone of judgment. Providers assume women have acquired HIV through practices thought of as "social evils." Nguyen et al. (2008) surveyed 52 women living with HIV who accessed well-resourced maternity services in Ha Noi, and found that they experienced discrimination during counseling, antenatal care visits, abortion, delivery and post-delivery care. Many of the women did not want to revisit the hospital where they had delivered.

Services are needed to help caregivers and children living with or affected by HIV, as well as innovative ways to raise men's awareness of and sensitivity to women's needs. Women living with HIV face added burdens of strained budgets, loss of property – which is often not in their name – and caregiving responsibilities. Three-quarters of all HIV caregivers in Viet Nam are women (UNESCAP, 2010). They must learn how to support and care for the other person's physical, medical, nutritional and emotional needs, while sacrificing their own financial security, educational opportunities and health. For this reason, community- and home-based care is critical for women who cannot come to clinical facilities themselves.

Microcredit most often supports women's finances, although it has not explicitly targeted women living with HIV. Viet Nam has limited experience with microcredit and other initiatives to support the income of women affected by HIV. Initial efforts include some positive results (e.g., Oosterhoff et al., 2008; also anecdotal experience from small businesses under local organizations that receive PEPFAR funding from USAID via Pact).

1. Stigma and discrimination

HIV compounds the hardship that women may already experience in their communities. Stigma and discrimination deter individuals from learning their status and rights, and they inhibit those who know they are infected from sharing their diagnosis, taking action to protect others and seeking treatment and care for themselves. Stigma and discrimination can also discourage acknowledgment and timely action at the level of policy.

In Viet Nam, discrimination against women living with HIV is based on moral judgments, conservative social values and a poor understanding of infection routes, which generates fear of casual infection. Early mass media campaigns exacerbated the situation by strongly linking AIDS with drug use and sex work – activities officially defined as "social evils" – and failing to identify ways in which HIV *cannot* be transmitted. The official response reinforced the link between HIV and social evils, by tying HIV agencies to those responsible for drugs and prostitution.

Discrimination against women living with HIV largely reflects the degree to which they are perceived to have transgressed beyond acceptable social boundaries. In Viet Nam, women are expected to conform to higher moral standards and be less promiscuous than men, and HIV infection implies a breach of these standards. Women infected via sex work or drug use are harshly judged because they "deserve" blame and social opprobrium (Khuat, Nguyen & Ogden, 2004). Women infected through marital sex or blood transfusions are also stigmatized, although they are considered unlucky rather than blamed outright.

> *To say frankly, if men are still young and they indulge in play and get [HIV] infected, that's the general story of society. If a girl gets this disease, no one would like to get close to her, because it is a problem of her conduct and her morality. It is not tolerated in females compared to males.*
>
> – Female community counselor (Ogden & Nyblade, 2005)

Even when not infected themselves, mothers, wives, daughters and other female family members of people living with HIV may be stigmatized by association. Social norms put pressure on women to manage caregivers' stress without indulging in activities that men rely on as outlets for anger or grief. This puts women at risk of anxiety and depression and reduces their ability to care for family members – an especially arduous task if the caregiver herself is living with HIV or suffering from AIDS.

Discrimination in the community and among health care providers, inadequate psychological support, and a lack of regard for the dignity of HIV-positive women remain common.

> *At the hospital, when we come, everyone knows who we are…there is a room reserved for patients [with HIV]. Waiting outside the room, we will be identified as infected.*
>
> – Woman living with HIV, Ho Chi Minh City

Stigma within the family and community

Some women living with HIV receive emotional support from their husbands and love, support and care from their families, despite the stigma attached to HIV. But for many others, discrimination within the family can be substantial.

> *Women in Viet Nam are expected to be the "last" in the family, and any family failure is borne by the woman.*
>
> – Director of Vietnamese NGO
>
> *A husband's family may blame the wife for the infection if both spouses are infected, and if the husband dies the wife might be driven away or her children may be taken away from her.*
>
> – Greater Involvement of People Living with HIV volunteer, Hai Phong

Discrimination can take many forms, such as separate household items, verbal abuse, forced removal of a child from an HIV-positive mother, physical separation of an HIV-positive woman from the rest of the household, and total rejection and abandonment. Men living with HIV/AIDS are almost always cared for by their mothers and wives, but if a woman becomes HIV-infected, her in-laws may neglect or abandon her, or separate her from her children (Khuat, Nguyen & Ogden, 2004).

Community isolation of people living with HIV is common, especially of women who are said to have failed to maintain the high moral standards expected of them. This isolation can affect friendships, community relationships, and livelihoods. Nguyet, who lives in Quang Nam province, used to run a food stall, a key source of income for her family when her husband was dying of AIDS, but it was boycotted once clients discovered she was living with HIV. Some positive women are dismissed from their jobs and others avoid seeking work because they fear their status will be uncovered or more broadly known if potential employers follow up references or require testing. Boston University, COHED & Life (2010) find that 33% of women living with HIV in Hai Phong and Ho Chi Minh City had experienced a change in their employment situation since discovering their positive status: 15% had lost their jobs and 12% reported unfair treatment at work.

Women who publicly disclose their status to advocate for change may find that discrimination grows rather than diminishes. Brickley et al. (2009) note that a woman who actively supported people living with HIV was forced to move repeatedly because her landlords would not accept her as a tenant. Boston University, COHED & Life (2010) find that 8% of the women they interviewed had been evicted from their homes due to their positive status.

Stigma in medical settings

HIV-related stigma and discrimination are often highest in medical settings, especially those that do not specialize in HIV-related care. Care providers and other staff may fear transmission or may be reluctant to offer limited medical supplies to "uncurable" patients. Women report that they are denied certain reproductive health services (such as Caesarean sections because doctors fear infection), offered other services reluctantly, and coerced into accepting procedures (such as abortion or sterilization) that they do not want. Boston University, COHED and Life (2010) find that 12% of women interviewed had been refused health or social services because of their positive status. ISDS and VCSPA (2011) find that 68% of 2,600 HIV-positive people surveyed believe that accessing sexual and reproductive health (SRH) services would be easier if they were not HIV-positive. In addition, 41% believe it would be cheaper, and 63% believe staff would be friendlier.

> *Doctors like to judge their patients, especially for [HIV]. They have very limited resources and don't want to divert them to people who "deserve" what they've got.*
>
> – Former director of international NGO, Ha Noi

Despite knowledge and training, some professionals continue to fear people living with HIV.

> *I am a health professional. I know that HIV is transmitted only in three main ways. But when I come into contact with them [people living with HIV] I still worry and feel nervous … In my case it is my duty, my responsibility to work with them, to go to them. But in fact, I am fearful.*
>
> – Healthcare provider (Ogden & Nyblade, 2005)

Women living with HIV are often denied their sexual and reproductive rights and told to abstain from sex. Of those interviewed by Boston University, COHED and Life (2010), 66% said they had been advised to do so by a doctor, and 32% by a family member.

Self-stigma

Women living with HIV are well aware of the sources of stigma and the pain they can cause. As a consequence, many women living with HIV practice self-stigma, imposing stigmatizing beliefs and actions on themselves. This phenomenon reflects how deeply the experience of HIV is embedded in its socio-cultural context and community norms.

> *I am afraid of giving my disease to my family members—especially my youngest brother who is so small. It would be so pitiful if he got the disease. I am aware that I have the disease so I do not touch him—I talk with him only. I don't hold him in my arms now.*
>
> – Woman in Viet Nam (Ogden & Nyblade, 2005)

> *I thought I deserved it because I have in my body an infectious disease that scares people away. I shouldn't complain about it. People believe that engaging in bad behaviors will result in having the infection. So those who have HIV like us must have done something shameful … The feelings weighed me down and I thought I was not going back to the hospital anymore.*
>
> – 26-year-old pregnant woman (Brickley et al., 2009)

Isolation can lead to depression and limit a woman's access to essential services. It may also prevent her from participating in empowering activities such as group advocacy for rights of people living with HIV. By perpetuating the wall of silence and shame surrounding the epidemic, self-stigma can also hinder efforts to respond effectively.

Economic disparities

Economic disparities between men and women are diminishing in Viet Nam and the country has achieved relative equality between men and women on basic development indicators (CEDAW, 2005), yet gender differentials still exist. In 2004, for example, Vietnamese women earned an average of 15% less than men (World Bank, 2006) and most Vietnamese women remain reliant on men for their economic wellbeing. However, while Viet Nam's Land Law requires that both husband and wife be named on land titles, in practice many women are not named. This prevents women from using land as collateral against bank loans, or retaining assets if they leave their marriage (World Bank). Lower earnings among women and their obligation to perform unpaid family care reduce their ability to make independent financial choices.

Women's economic dependency within marriage likely influences their decision-making power. Globally, many women are unable to leave unhappy or abusive marriages and cannot enforce personal choices – such as condom use – that might reduce their risk of HIV infection (e.g., UNAIDS, UNFPA & UNIFEM, 2004). When a woman's family member is infected with HIV, she faces arduous financial challenges associated with the family and societal expectations that she will be responsible for the economic and physical demands of caregiving (Oosterhoff, 2008).

Meeting stigma and discrimination needs

> *Giving HIV a human face is important. We must show that it's not just about death and that "good," ordinary people can have HIV and live well with it. If we don't change the "social evils" campaign, it will make working on HIV very difficult.*
>
> – Co-director, Vietnamese NGO

Stigma and discrimination reduction are a critical part of Viet Nam's efforts to address the epidemic. However, the association of HIV and "social evils" remains, limiting the effectiveness of HIV prevention and care initiatives. This association is still embedded in existing information, education and communication materials, as well as within government structures that link HIV with highly stigmatized drug use and sex work. Until the link between "social evils" and HIV is broken, it is unlikely that stigmatizing attitudes and discriminatory practices will disappear. While the government recognizes the need for programs to eliminate stigma, efforts have been limited both in quantity and effectiveness – and largely gender neutral.

One of the most significant contributions to stigma reduction has been made by ISDS, which has been working in partnership with ICRW and with the Central Commission for Ideology and Culture. ISDS and ICRW's study between 2002 and 2004 greatly enriched awareness and understanding of AIDS-related stigma and discrimination in Viet Nam (Khuat, Nguyen & Ogden, 2004). Subsequently, ISDS developed a package of stigma reduction tools to address the key drivers of stigma, which is now used in community interventions with positive results (Nyblade et al., 2008). ISDS's work also supported the development of *Guidelines on IEC Activities to Eliminate HIV/AIDS Related Stigma and Discrimination* (Central Commission for Ideology and Culture, 2006).

There are signs that the government is considering further changes to its information, education and communication approach, to depict drug use and sex work in a less stigmatizing way, and separation of HIV from these in mass media campaigns. Women who sell sex are now officially called "sex workers" rather than "prostitutes," and UNAIDS is working with lawmakers to decriminalize sex work. In cooperation with UNICEF and Save the Children, the Ministry of Education and Training is updating the country's high school curriculum, which represented HIV as dangerous and frightening, and emphasized the criminalization of drug injection and sex work, by integrating HIV/AIDS and modern

sexual and reproductive health education. The Government campaign, during the 2008 National Month of Action for HIV/AIDS Control and Prevention called for grassroots support toward people living with HIV.

Beginning in 2006, the Asian Development Bank funded a five-year, $20-million multimedia HIV behavior change communications campaign, co-sponsored by the Government of Viet Nam. Co-developers of the campaign include Government television and provincial radio stations, and the British Broadcasting Corporation World Service Trust. The purpose of the campaign is to raise sensitivity toward people living with HIV. While the government is making stronger efforts to build public advocacy for people living with HIV, audiences may be confused so long as these efforts run parallel to the social evils campaign. Explicit demonstrations of people accepting others who live with HIV would do much to reduce stigma: for example, high-profile meetings between senior officials and people living with HIV, upbeat media depictions of people living with HIV, or depictions of celebrities actively engaging with people living with HIV.

> *We'll solve this problem … when the first celebrity says, "I'm positive."*
>
> – Director, international NGO

Community-based organizations and self-help groups throughout Viet Nam can serve as an important mechanism for advocacy activities. These groups are growing and gaining support from international NGOs and Government. Many are sponsored by the Women's Union, which is uniquely positioned to mobilize women to address stigma within their communities. Global experience on stigma demonstrates that changes in attitudes toward people living with HIV often come when people realize someone they know is living with HIV. Community-based efforts can be powerful complements to mass media campaigns and other programs.

> *Networks of people living with HIV are growing and their voice is getting stronger. This will change the way people see them.*
>
> – Director, Vietnamese NGO

Projects that combine mass media and community outreach hold much promise. PSI's high-profile New Horizon campaign, which strategically uses mass media to promote voluntary counseling and testing and condom use, was one of the first to address stigma directly.

To date, only a few stigma and discrimination reduction efforts have explicitly targeted women. The ISDS/ICRW study, while not specifically focused on women, investigated the ways in which gender relates to HIV stigma. As a result, the ISDS stigma-reduction toolkit, based on the study, is designed to address women's particular needs. Widespread use of the toolkit could help reach women in settings where they receive maternity or SRH services. The Boston University, COHED and Life (2010) assessment of the needs of women living with HIV also highlighted discrimination that women living with HIV face in employment and SRH service contexts. Some community and home-based care and treatment services, such as those provided by FHI, and integrated reproductive health by Pathfinder, have piloted integration of stigma reduction counseling into their service packages.

2. Prevention

Prevention programming includes a combination of elements that encompass behavior change communication, educational materials, SRH services, access to free or affordable condoms, lubricants and needles, voluntary counseling and testing, and life-skills and job-skills training opportunities. This section presents the factors that influence vulnerability to and prevention of HIV among women in Viet Nam.

Awareness of risk and access to information

Awareness of HIV risk and access to information that can help reduce risk are key factors in vulnerability, and are different for women and men. In Viet Nam, as in many traditional cultures, both the discussion of and education about sexual matters are sensitive. As a result, girls and women in Viet Nam may lack critical knowledge about their SRH and HIV/AIDS.

According to SAVY data (GSO, 2009), between the ages of 14 and 25, 69% of the urban male interviewees exhibited high overall knowledge of HIV compared to 63% of urban female respondents; the levels among rural males and females were 58% and 50%, respectively.

While the SAVY report shows an improvement in overall knowledge of HIV transmission compared to the 2005 SAVY report, and that the knowledge gap between males and females has significantly narrowed, ethnic minority women remain the least knowledgeable overall.

Similarly, an early study carried out in Quang Ninh and An Giang by the Women's Union, the United Nations Development Fund for Women (UNIFEM) and the United Nations Development Programme (UNDP) (2000) found that only 12% of women surveyed knew that women who were not sex workers or injecting drug users were at risk of HIV infection, and 42.2% believed that HIV infection could be prevented by engaging in a monogamous relationship. To complicate matters, information campaigns target mostly at-risk males or sex workers; most women do not consider themselves at risk of infection; and those who do wish to learn are often concerned that seeking such information might lead people to question their morality.

Even when women are aware of the risks they face, social norms can inhibit their ability to negotiate sexual interactions, protect themselves from unsafe sex, or challenge behaviors that might threaten their safety. Traditional female virtues, still widely accepted by both sexes, include sexual purity, submissiveness, and the sacrifice of women's individual wishes and needs (e.g., Hoang et al., 2002). In a survey of married couples in Nghe An province, Luke et al. (2007) found that most people supported traditional roles for husbands and wives, and that they believed women should respect their husband's supremacy and defer to their husband's judgments.

Because it is important to maintain the appearance of virtue and family harmony in Viet Nam, women are encouraged to remain silent when faced with husbands who are engaging in risk behaviors or are HIV-positive. Women who engage in activities perceived as immoral, such as drug or alcohol consumption, or who are divorced or economically more successful than their husbands, risk social rejection. Luke et al. (2007) found that 93.1% of wives and 83.7% of husbands surveyed in Nghe An province believed that it is best for everyone if the husband is the breadwinner and the wife takes care of the home and family.

Sexual transmission

Women become infected through unprotected sex with infected husbands or boyfriends (who are most often injecting drug users or clients of sex workers), or male clients (via sex work). Women face far greater vulnerability to sexual transmission of HIV due to biological, economic, educational, social and physical reasons. Biologically, women are almost twice as likely as men to contract HIV during unprotected sex (e.g., Lavreys et al., 2004).

Physically, women face much greater risk of gender-based violence and unwanted sex, which carries with it higher risk of transmission of sexually transmitted infections including HIV. Migrant women are at heightened risk because they may engage in sex work for economic survival. They are also are more likely to be concentrated in the service and entertainment industries, which often serve as entry points to sex work (e.g. Yang & Xia, 2006).

Why are women more vulnerable to HIV infection than men?

Biologically: almost twice as vulnerable

Economically: less economically independent

Educationally: less aware of HIV transmission risks

Socially: expected to maintain sexual innocence until marriage and submissiveness to male family members after marriage

Physically: at greater risk of gender-based violence and unwilling unprotected sex

Transmission via sex work

Women engaged in sex work are particularly vulnerable to HIV transmission because of the nature of the sex, frequency, and the number of sexual partners. According to the IBBS, HIV prevalence among female sex workers was highest in Ha Noi (18% for venue-based sex workers) and Hai Phong (23% for street-based sex workers). The IBBS found that rates of consistent condom use among female sex workers varied widely, from 21% to 86%. Overall consistent condom use among female sex workers has reportedly increased from 2005 to 2009 in most surveyed provinces, but decreased in Ha Noi, Ho Chi Minh City, Da Nang and Can Tho for venue-based sex workers, and in Ha Noi, Ho Chi Minh City and Can Tho for street-based sex workers.

In addition to facing increased risk of transmission, sex workers must avoid arrest or harassment by public security, making them more reluctant to seek health services. Women may also avoid treatment for sexually transmitted infections because of the stigma associated with being viewed as immoral or "bad" women. This avoidance increases risk for HIV infection because preexisting sexually transmitted infection infections, especially those long untreated, increase the likelihood of co-infection with other bacterial or viral infections, including HIV (e.g., Laga, Nzila & Goeman, 1991).

Sexual transmission through regular partners

Women who are in committed relationships may still be vulnerable to HIV infection on account of their partners' risk-taking. A qualitative study of men in entertainment establishments (defined as any place, including an outdoor location, that provides members of the public with entertainment) carried out by FHI found that 60 to 70% of the married men studied reported having visited sex workers, usually in the company of peers (Tran et al., 2006). Married men more commonly reported having multiple sex partners than single male respondents.

Condom taboos

According to interviews conducted for this report, condom use in "attached" relationships (between spouses or unmarried regular partners) can have negative connotations due to social taboos. The request from one partner to another to use a condom in a relationship that is presumed to be monogamous can raise questions regarding fidelity. Besides challenging trust, condoms play a strong defining role in a relationship. Not using a condom may be thought to convey that the partners are serious about each other and trust each other. Condoms are so firmly associated with sex work or "dirty" sex, suggesting that their use can be considered insulting, as expressed by these young women:

> *My friend has a very beautiful, young girlfriend. When they [first] had sex, he used a condom – she was very upset. She asked him why they had to use condom. He didn't dare tell the truth; he said it was to avoid pregnancy. But she was still upset because she said he was not serious with her, he just wanted to play.*
>
> – Director, Vietnamese NGO
>
> *My husband was a transient worker, only home two months a year. When I asked him to wear a condom he refused, saying I didn't trust him.*
>
> – Woman living with HIV, Thai Binh

Formal data on the use of the female condom in Viet Nam are lacking. Female condoms have been promoted and distributed internally among UN staff under the UN Care Program. UNFPA and PSI are in the process of designing a survey on condom use (including female condoms). Information gathered from PSI outreach reports suggests that sex

workers use female condoms when clients refuse to use a male condom, during menstruation, and some with regular partners. PSI estimates that it distributes approximately 30,000 to 35,000 female condoms annually (PSI, personal communication).

Sexually transmitted infection

Women face additional vulnerabilities when they discover they have a sexually transmitted infection, even if obtained from their regular partners. Qualitative interviews and focus groups with general-population men and women in northern Viet Nam (Go et al., 2002) show that sexually transmitted infections are strongly associated with promiscuity and, as a result, several men said they would beat their wife and/or divorce her if she became infected with a sexually transmitted infection. In addition, many women expressed panic at the idea their husband might discover they had a sexually transmitted infection. Both men and women said that wives, in contrast, should accept their husband's sexually transmitted infection.

Voluntary counseling and testing

Access to voluntary counseling and testing in Viet Nam has steadily increased, with support from PEPFAR, the Global Fund and the World Bank. Among most-at-risk populations, the highest rate of testing and the greatest increase between 2006 and 2009 was among female sex workers. The IBBS reports that voluntary counseling and testing rates among most female sex worker groups have increased substantially, particularly in Hai Phong (75% among venue-based sex workers, 79% among street-based sex workers. However, most provinces are still under 50% for testing among female sex workers. Only 36% of female sex workers and 18% of injecting drug users tested; thus, much remains to be done.

Sexual and reproductive health (SRH) and HIV

A number of documents within the Viet Nam legal framework jointly address SRH and HIV, including the National Strategy for Reproductive Health Care 2001–2010 (Ministry of Health, 2001), the National Standards and Guidelines for Reproductive Health Services (Ministry of Health, 2003), the National Strategy on HIV Prevention and Control until 2010 with a Vision to 2020 (National Committee for AIDS, Drug and Prostitution Prevention and Control, 2004) and the Law on HIV/AIDS Prevention and Control (National Assembly, 2006). All of these include the provision of SRH services for HIV-positive individuals, especially via prevention of mother-to-child transmission programs.

However, the government health system is still vertical in its approach, and linkages between services are limited. In addition, capacity for referral and follow up is also limited, and people still face heavy stigma and discrimination from service providers, especially within the sexual/reproductive health system. The private sector plays a significant role in provision of SRH services, especially fertility assistance and to a lesser degree family planning, but the sector is not yet officially recognized as a key player in the network of services, and monitoring and regulation are still lacking (ESD, 2010).

In order to understand and respond to the SRH needs of people living with HIV, a review of PEPFAR/Pact partners was carried out in July/August 2009 in Ha Noi and Ho Chi Minh City (Pact, forthcoming). The review included in-depth interviews with fifty-five respondents including program managers, field supervisors, and service providers from PEPFAR/Pact partner organizations, and mapping of referral services. The review found that sexual/reproductive health care provided to people living with HIV/AIDS by most programs under this review is mostly limited to sexually transmitted infection prevention, diagnosis and treatment, and prevention of mother-to-child transmission. All programs reviewed report high, unmet demands from clients for information, care and support for SRH, including sexual dysfunction, sexual rights, sexual pleasure, and assisted fertility. Most programs reviewed do not provide these services because they feel it is beyond the scope of their program's objectives:

> *We rarely talk with drug users about sexual issues. We do not discuss family planning or child care either. Yes, it is necessary to pay attention to sexual and reproductive health issues, however, our first priority is harm reduction. We talk with drug users mostly about … issues related to injecting, how to inject safely. Harm reduction is our project goal and objective.*
>
> – Field supervisor

When clients ask me to give them advice on having a child, I do not dare advise them. We as home-based care workers do not have that function. We are not required to do so. I send them to the doctors for counseling. We do not dare to counsel on this very important issue. There would be consequences for the child. Who would take care of the child in the future?

– Staff member of community-based organization

There is strong support and willingness among program staff to begin to think about how to better meet the SRH needs and rights of and of most-at-risk populations, but preconceptions on fertility among people living with HIV still need to be addressed (CCIHP, New Care & Pact, 2009). People living with HIV have particularly limited access due fear of stigma and discrimination from health care providers and economic barriers. Many most-at-risk populations face similar concerns, especially regarding stigma because of their sexual orientation, drug use, or occupation as sex workers.

Before, women with HIV did not think about this issue because carrying HIV meant carrying a death sentence. Nowadays, due to antiretrovirals, they see the opportunity to live, and to have babies to maintain the family line.

– Service provider

Transmission via injecting drug use

There is increasing evidence in Viet Nam that drug use among women is growing, especially among sex workers. In a recent study focusing on women living with HIV in Hai Phong and Ho Chi Minh City (Boston University, COHED & Life, 2010), over half of women living with HIV reported having had sex with a partner who injects, and 16% reported ever injecting drugs themselves. Of those, 41% reported having shared equipment, about one third of them within the last month.

High HIV infection rates among female drug users can be associated with gender-specific vulnerabilities to both injection and sexual infection routes, as well as gender-specific obstacles to accessing harm reduction services. International studies suggest that women are more likely than men to use a needle after someone else has used it (Burns et al., 2009). Anecdotal evidence from FHI suggests that women in Viet Nam are generally introduced to drug use by their male partners (except in the case of female sex workers). Some may also access their drugs and equipment from male partners, and there is a tendency for women in intimate partnerships to share injecting equipment with their partners as a demonstration of trust (Baldwin, personal communication).

Additional research is needed to clarify how women initiate drug use, especially among drug users who do not sell sex. Programs that target male injecting drug users may be missing opportunities to extend harm reduction to female partners of injecting drug users if they do not specifically address this potential interaction.

The situation is most alarming for sex workers who also inject drugs. With multiple compounding risk factors, it likely that female sex workers who also inject are among the highest-risk groups in Viet Nam: The EPP estimates 60% prevalence among injecting female sex workers in Ho Chi Minh City.

According to the IBBS, drug use among venue-based sex workers in Ha Noi rose from 4% in the 2006 report to 26% in preliminary data for 2009, and in Ho Chi Minh City from 15% to 28%. Among street-based sex workers during the same period, drug use in Hai Phong rose from 8% to 23% and in Ho Chi Minh City from 8% to 30%. The 2006 IBBS report notes that female sex workers who also inject drugs are more likely than male injecting drug users to share needles; the 2009 preliminary data show that 30% of female sex workers in Ha Noi had shared needles in the last six months, compared to just 7% of male injecting drug users.

According to a nationwide survey of female sex workers aged 18 to 35 (PSI, 2008), female sex workers who injecting drugs are likely to have more clients than non-injecting sex workers – although consistent condom use by the two groups is almost identical (80% for female sex workers and 81% for female sex workers who inject drugs). PSI qualitative research also indicates sex workers who inject drugs are most likely to be introduced to drugs by fellow sex workers. PSI found that most injecting female sex workers inject every day (87%) and that heroin is the most commonly injected drug among female sex workers (98%). Female sex workers who inject drugs most often inject alone (71%), but sharing practices are otherwise similar to male injecting drug user practices. When sharing needles and syringes, more than half injecting female drug users share with other sex workers (52%). The remainder inject

with a partner (26%), with another non-partner or non-sex worker (16%), or with a sibling or friend (7% each). Drug use among female sex workers is mostly initiated by other sex workers (48%) and female sex workers usually help each other to inject the first time (59%). More than a third of female sex workers inject in front of non-injectors (37%) and more than a third of female sex workers reported on the benefits of injecting to non-injectors (36%).

Slipping through the cracks

While a number of interventions provide drug-related harm reduction services for most-at-risk populations (injecting drug users, sex workers and men who have sex with men), peer outreach targeting female injecting drug users is rare. Fear of stigmatization and arrest, as well as responsibilities at work and at home, can deter women from becoming peer educators, which limits access to services for female injecting drug users.

A needs assessment in Hai Phong and Ho Chi Minh City examined programs targeting sex workers and injecting drug users and identified gaps and needs specific to injecting sex workers in HIV prevention (CIHP, 2008). The findings suggest that there are no specific services for female sex workers who also inject drugs, and that the compound risk of HIV transmission among injecting sex workers is not being addressed. The study also found that while some peer educators provide needles and syringes to sex workers who inject drugs, their interventions do not include behavior change communication for risky sexual behaviors. Alarmingly, CIHP suggests that the proportion of sex workers who inject drugs may be significantly underestimated in the IBBS surveys.

A few programs address this nexus. In 2007–2008, PSI received funding to design an outreach intervention pilot program targeting sex workers (both injecting drug users and non-injecting drug users) in Hai Phong province. PEPFAR also funded PSI to pilot an intervention for sex workers in six PEPFAR provinces (Hai Phong, Ha Noi, Quang Ninh, Ho Chi Minh City, Can Tho and An Giang) with a focus on injecting sex workers in Hai Phong and Can Tho.

To date, drug-counseling and treatment options for women are relatively limited (outside of Government-run rehabilitation centers). Programs tend to focus on abstinence as the ultimate treatment goal, with relapse the principal indicator of program success (or lack thereof). This approach tends to ignore the fact that drug treatment requires provision of a variety of treatment options, quality counseling, on-going support, and room for lapse and relapse as part of the recovery process.

Transmission from mother to child

Mother-to-child transmission is the most common cause of HIV infection among children under 15 years of age. HIV can be transmitted from mother to child during pregnancy, delivery or breast-feeding. The likelihood of mother-to-child transmission is between 20% and 45% without treatment, and can fall to approximately 1–2% if comprehensive prevention of mother-to-child transmission services are provided (WHO, 2007).

The need for prevention of mother-to-child transmission continues to grow. Prevalence rates among pregnant women in Viet Nam stood at 0.02% in 1994, rose to 0.37% in 2005. According to the Ministry of Health summary report on HIV/AIDS in 2009 and key missions for 2010, cited in the 2008–2009 United Nations General Assembly Special Session (UNGASS) report (Viet Nam, 2010), the 2009 prevalence rate in Viet Nam was 0.28%, up from 0.21% in 2008. The EPP projects that by 2012 the number of pregnant women living with HIV in Viet Nam will be 4,800, up from 4,100 in 2007.

The response to Viet Nam's concentrated HIV epidemic focuses on most-at-risk populations, and prenatal HIV testing among Vietnamese women remains limited. In a study of 52 self-help group members who had accessed well-resourced maternity services in Ha Noi (Nguyen et al., 2008), only 20% had received comprehensive prevention of mother-to-child transmission services, against 44% who had received minimal services and 17% who had received none. Many women do not test until labor, when prophylaxis less effective and health staff are less likely to provide counseling on infant feeding options or post-partum follow-up care for mothers, babies and sexual partners. In Nguyen et al., 29% of the women did not test until labor; this percentage rose to 55% in a Hai Phong study (Nguyen, Christoffersen & Rasch, 2010), which found that residence more than 15 km from the hospital is significantly associated with testing at labor; low education, low income and occupation as a farmer or worker are not.

According to the *Vietnam Population and AIDS Indicator Survey 2005* (GSO, NIHE & ORC Macro, 2006), knowledge of mother to child transmission varies greatly by transmission mode. Knowledge of transmission during pregnancy

and delivery was high among both women and men, while knowledge of transmission through breastfeeding was less commonly known. Specifically:

- Three-quarters of all respondents knew that HIV can be transmitted during delivery, and 90% of respondents knew that HIV can be transmitted during pregnancy.
- While only two in 10 women and men knew about anti-retroviral drugs to reduce the risk of mother to child transmission, 21% of women and 18% of men knew that there are special drugs that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby.
- About four in 10 women and men of reproductive age knew that HIV can be transmitted from a mother to her child by breastfeeding (43% of women and 39% of men).

The combined indicator shows that only about 15% of women and men of reproductive age knew both that HIV can be transmitted through breastfeeding *and* that the risk of mother to child HIV transmission during pregnancy can be reduced with medication. Women and men were about equally knowledgeable with regard to the risk of HIV transmission.

Ministry of Health data in the UNGASS report indicate that the number of pregnant women who received HIV pre-test counseling, were tested and know their results doubled between 2008 and 2009, and the number of those who were tested for HIV (560,930) nearly tripled. UNGASS also records that in 2009 approximately one-third of HIV-positive pregnant women received antiretroviral prophylaxis to prevent mother-to-child transmission – more than double the rate in 2007. A total of 96% of children born to HIV-positive mothers received treatment.

Despite these achievements, the UNGASS report also states that only one-quarter of pregnant women tested for HIV in Viet Nam in 2009; the Viet Nam National Strategy and Action Plan aims for 54%. Increasingly, Vietnamese women who give birth in provincial and larger district medical facilities routinely test for HIV in the seventh or eighth month of pregnancy (Hardon et al., 2009; Nguyen et al., 2009). However, the UNGASS report suggests that diagnosis through antenatal clinics remains relatively low, especially in rural areas, because the majority of women receive antenatal care at commune health stations where HIV testing is not available. Nguyen et al. also find that 42% of pregnant women are tested without their knowledge or consent: This is an issue that calls for further investigation.

Data on prevention of mother-to-child transmission coverage are inconsistent. According to the Ministry of Health summary report on HIV/AIDS in 2009 and key missions for 2010, cited in the 2008–2009 UNGASS report, 96 sites served pregnant women with comprehensive prevention of mother-to-child transmission services nationwide and 127 sites provided voluntary counseling and testing and referral. PEPFAR supports 600 sites that provide prevention of mother-to-child transmission services, 85 of which provide comprehensive services (PEPFAR, 2010).

Viet Nam established a legal foundation for prevention of mother-to-child transmission in 2003. The law states that prevention of mother-to-child transmission should be made available to all women who need it. To put the law into practice, Viet Nam launched the National Plan of Action for Prevention of Mother to Child HIV Transmission (PMTCT), 2006–2010 Period. Plans are underway to implement newly developed prevention of mother-to-child transmission guidelines that are consistent with the four-pronged WHO approach: *1)* primary prevention of HIV infection among women of childbearing age and their sexual partners, *2)* prevention of unintended pregnancies among women living with HIV, *3)* prevention of HIV transmission from women living with HIV to their children, including provision of prophylactic antiretroviral therapy and safer delivery techniques, and *4)* provision of care, treatment and support to women living with HIV and their children (WHO, 2010).

Impediments to success

Nguyen et al. (2008) collect qualitative evidence that women experience stigma and discrimination at all stages of service of Ha Noi: counseling, antenatal visits, abortion, delivery and post-delivery care. Low levels of client confidentiality have impeded the effectiveness of prevention of mother-to-child transmission programs: 30% of participants discovered that their results were not kept confidential. Regardless of efforts to improve confidentiality at voluntary counseling and testing sites, sites are required to report HIV-positive cases to the government, which may dissuade some women from testing. For women who test positive, antiretroviral therapy and other prevention of mother-to-child transmission services are less widely available at medical facilities below the provincial level.

There is a general lack of adequate referral for follow-up care for HIV-positive women (e.g., Tarantola et al., 2009). This is related in part to gaps in the referral networks, inadequate counseling, travel costs (especially for poor women in rural areas) and women's reluctance to return to the hospital after giving birth because of discriminatory treatment they experience during delivery and post-partum care. This reluctance also adversely affects post-partum HIV testing for infants, which is conducted between 12 to 18 months after birth. Stigma also limits access to prevention of mother-to-child transmission services, because these usually require visits to provincial facilities, which may attract unwanted attention to the woman's condition. According to Nguyen et al. (2008), many women worried that differences in care and treatment would make it more difficult to keep their HIV status confidential, by alerting family and friends that something was wrong.

Women who do access care after delivery, including counseling, provision of milk formula, and on-going antiretroviral therapy for themselves or their child, may suffer community stigma when government and non-government support staff visit their homes. Home visits may reveal to community members that care recipients are HIV-positive. Additionally, women who choose not to breastfeed to protect their child from HIV transmission risk stigmatization in a culture where breastfeeding is the norm.

Ethnic minority women

While it is suspected that ethnic minority women are more vulnerable to HIV and experience greater challenges in accessing services than do women of the Kinh majority ethnic group in Viet Nam, research in this area is limited.

For example, Dien Bien province, where the largest ethnic group is of the Thai minority, is experiencing the fastest growing HIV epidemic in Viet Nam. HIV prevalence among both high- and low-risk groups is many times the national average (PAC Dien Bien, 2010).

Oosterhoff, White and Nguyen (2011) identify a number of factors that may increase Thai women's vulnerability to HIV. According to the report, Black Thai women are particularly vulnerable to HIV due to widespread injecting drug use by male villagers, low levels of condom use, low levels of prevention of mother-to-child transmission uptake, and reduction in the time period for *zu kuay* (a period during which a male suitor lives in the female family's home to allow the family to determine his viability as a husband). Osterhoff suggests programs targeting high risk groups found in urban areas may be overlooking this predominantly rural population.

According to the Viet Nam Health Economics Association (VHEA, 2010), 14.6% of women deliver at home nationwide. In mountainous areas, this number can be much higher. The data for Dien Bien in first quarter of 2010 (PAC Dien Bien, 2010) indicates that only 46.75% of women delivered at health facilities and 61.8% delivered with the care of health care workers, while in Yen Bai, the corresponding numbers are 82.1% and 88.8%. According to lessons learned from current intervention programs, a high percentage of ethnic minority women do not come to health facilities for antenatal care or delivery, and therefore, they do not get prevention of mother-to-child transmission services.

In provincial hospitals supported by the United States Centers for Disease Control and Prevention program, staff report that there are few to no interpreters who can understand and speak minority languages. As a result, minority women may not receive comprehensive counseling during a visit to a voluntary counseling and testing or prevention of mother-to-child transmission site. Staff also report cultural barriers that hinder minority women from making decisions on their own (i.e., they need to ask their husband's permission to get an HIV test).

Meeting prevention needs

Sexual transmission prevention programs in Viet Nam must reflect increasing infection rates among youth and women, and the complex interplay between drug use and sex work.

Critical elements of an effective response to HIV in Viet Nam include access to condoms and female-controlled methods of prevention; information, education and communication materials; behavior change communication interventions that target wives, girlfriends and sex workers who inject drugs; integrated sexual/reproductive health and HIV programs; and programs that address norms of gender inequality. Referral between facility-based and community-based services should be strengthened within the prevention-to-care network. Outreach services should

be expanded via community-based organizations and mass organizations (e.g., the Viet Nam Women's Union) to reach traditionally overlooked groups, such as girlfriends and wives.

Funding for interventions

Viet Nam has the support of a number of bilateral, multilateral and international donors and organizations in HIV prevention. The primary donors include PEPFAR, the United Kingdom's Department for International Development (DfID), the Global Fund, the World Bank and the Asian Development Bank. National spending on prevention in 2009 constituted 37% of the government HIV budget – almost equal to the 39% of spending on care and treatment (UNGASS, 2010). Programs focus on reducing infections among high-risk populations via behavior change communications; information, education and communication; harm reduction; voluntary counseling and testing; and prevention of mother-to-child transmission. Most programs that aim to serve women target female sex workers, prevention of mother-to-child transmission and, more recently, sexual partners of injecting drug users.

Sexual transmission

Peer outreach approaches have proven most effective for identifying and reaching communities at risk through networks of rapport and shared identity. Social marketing is critical to increase demand for condom use. PEPFAR, DfID and the World Bank primarily support social marketing and distribution of condoms. PEPFAR-funded PSI has been a leader in condom social marketing. In addition to conventional outlets and provision during peer outreach, marketers are recognizing the need for non-traditional outlets such as tea shops and entertainment establishments.

As women in committed heterosexual relationships account for an increasing proportion of HIV infections, prevention efforts will need to design condom social marketing to focus on prevention within primary sexual relationships. Programs should increasingly sensitize men who visit sex workers or inject drugs to the risk of infecting their primary sexual partners, as well as target their female partners directly. As prevalence among men who have sex with men increases, it may be necessary to invest more resources in research and programming that serve the female partners of men who also have sex with men.

Sexual partners of injecting drug users

Abt Associates and ISDS have spearheaded interventions with female sexual partners of injecting drug users by working with women whose male partners are active drug users or are living in or recently released from rehabilitation centers. They use an empowerment approach and focus on women who are HIV-negative, building knowledge, skills and self-esteem necessary for them to remain uninfected. A needs assessment for this target group indicates that a great deal remains to be done to support counseling, referral and outreach to these women (Nghiem et al., 2009).

In a 2008 baseline survey of sexual partners of injecting drug users at Ha Noi peer-based HIV prevention locations, Hammett et al. (2010) revealed an HIV prevalence of 14% among sex partners. Only 27% reported condom use with their primary male partners half the time or more, 69% were in sero-discordant or unknown HIV-status relationships. Condom use was not more frequent in these relationships than in concordant partnerships. Many sexual partners feared angry or violent responses if they requested condom use. These fears were higher in sero-discordant and unknown-status relationships. Sexual partners also reported limited access to HIV prevention services.

Young men

Programs need to take into account the role men can play in protecting their partners. One program that uses a gender-based approach is Project NAM, a Save the Children HIV prevention program that targets young men in vocational schools and on the streets in Ho Chi Minh City. The program has demonstrated an increase in gender equitable attitudes related to sexual health among targeted young men. Save the Children uses youth clubs as venues for peer-led education.

Save the Children and MOLISA provide comprehensive HIV prevention education to male and female students aged 15–24 in the vocational school systems of six provinces, under PEPFAR funding from USAID via Pact. The program promotes awareness and reflection on gender norms and HIV risk practices for young men and young women. Trained teachers and peer educators facilitate an extracurricular course for a core group of students each semester using a gender-based risk reduction curriculum adapted to the Vietnamese context from Brazil. Most sessions involve single-sex discussion, and selected sessions are intended for joint male and female discussion groups. The young people, in turn, reach out to individual and small groups of peers to share learning and negotiate risk reduction. In 2009 they

reached more than 75,000 young men. They also organize school-wide events to reinforce key themes such as the links between gender and HIV.

> *Young people enjoy very much to learn about gender roles; they learn not only about themselves but also their relationships. It helps men think about men's sexual health, men's roles. They realize that in order to have healthy relationships, they should respect themselves as well as their partners.*
>
> –Program manager, Save the Children

Teachers who reflect on gender norms during trainings to support peer educators also report substantial changes in their relationships with wives, girlfriends and their children.

Using an adaptation of the Gender Equitable Men scale to measure gender attitudes, a 2008 baseline survey of male students in the MOLISA vocational schools project classified respondents into three categories based on distribution of scores: highly inequitable (33%), moderate (39%) and highly equitable (28%). Findings show significant associations between more equitable attitudes and preventive practice, including less and safer sex with sex workers and casual partners, as well as higher intention and confidence to respect and remain faithful to a spouse after marriage. In the post-intervention survey, inequitable gender attitudes reduced to 15% and highly gender equitable attitudes increased to 56%.

Integration of sexual and reproductive health (SRH) and HIV

Family Health International, Pathfinder International, Marie Stopes International (MSI) and Pact are currently involved in efforts to integrate sexual/reproductive health and HIV services for women and men. Activities include training on HIV for district and commune health center providers and on SRH for providers in HIV clinics, including counseling for sero-discordant couples and dual method promotion. However, results from an evaluation of interventions to improve access to and quality of health and social services for women living with HIV in Hai Phong and Ho Chi Minh City (Boston University, COHED & Life, 2010) reveal that although there was significant improvement in knowledge, use of and referral to SRH services, there was no improvement in the level to which women living with HIV felt that SRH service providers understand the particular needs of women living with HIV. For detailed recommendations on integration of SRH and HIV services, see Section 3.

Drug-fuelled transmission

Women who both inject drugs and sell sex are at especially high risk of HIV. Given the dual stigma of sex work and drug use, and public security measures to eliminate both behaviors, this population of at-risk individuals is one of the most highly marginalized and most difficult to reach. As the number and proportion of female drug users increase, interventions will need to target programs specifically to the needs of female drug users.

At a minimum, programs must provide targeted behavior change communications with appropriate information, education and communication materials and consistent access to condoms, lubricants and clean needles and syringes. In addition, female drug users must have access to voluntary, community-based drug counseling and treatment programs with a variety of treatment options including methadone maintenance therapy. Community-based programs should link with Government rehabilitation centers to ensure that female detainees receive follow-up counseling and treatment options upon return to their communities. Female drug users need access to quality referral services, including SRH, treatment of sexually transmitted infections, HIV care and treatment, and self-help support groups (both HIV- and drug use-related, as appropriate).

Because of the severity of the stigma that female injectors face, it is critical that outreach teams be comprised of women, and that outreach approaches are engendered with female-appropriate messaging. For example, behavior change communication must take into account how women typically inject, how they engage with male partners who inject drugs, and the kinds of referral services that apply specifically to women. In order to determine how to cater services to women's needs, programs should research how drug use is initiated for various female sub-groups and conduct needs assessments to learn what beneficiaries want. In addition, programs must take into account the role that male partners who inject drugs play in introducing and supplying women with drugs and injecting equipment, and programs should extend prevention and harm reduction communication through male injecting drug users to their female partners.

Needle and syringe programs

Viet Nam's needle and syringe programs expanded from 21 provinces in 2005 to 60 in 2009 (UNGASS, 2010). Despite provisions in the 2007 Law on HIV that enable greater access to prevention services for most-at-risk populations, Viet Nam still faces considerable policy barriers in establishing and scaling up effective interventions such as needle/syringe programs and 100% condom use programs at the local level. There are contradictory priorities between public security measures to control drug use and sex work on the one hand, and public health measures to reach the populations engaged in these activities on the other. The "social evils" campaign against drug use and sex work marginalizes and stigmatizes most-at-risk populations, which impedes their access to prevention, treatment, care and support services. As an example, the reinforcement of the current policy of compulsory confinement of drug users and female sex workers causes these populations to avoid public services. While it is not yet possible to implement needle/syringe programs or condom promotion in closed settings, the Ministry of Public Security and MOLISA are making additional efforts to ensure that HIV treatment, care and support services are available in prisons and rehabilitation centers.

There are four major donor-funded harm reduction interventions in Viet Nam: the Australian Agency for International Development (AusAID), Global Fund, PEPFAR and World Bank/DfID. The major interventions that work with rehabilitation centers are supported by UNODC, PEPFAR, the World Bank and Global Fund.

Drug treatment

Drug treatment options remain limited for all injecting drug users, and for women in particular. Detoxification at rehabilitation centers is currently the only service available in many areas, although a small number of community-based drug treatment initiatives now offer wider alternatives. Female injectors must have access to a variety of drug treatment options, including regular counseling, follow-up care and methadone maintenance therapy. The last of these is relatively new in Viet Nam. Pilot methadone maintenance therapy programs supported by the U.S. Government through FHI launched in Hai Phong and Ho Chi Minh City in 2008 and are now expanding. A methadone clinic opened in Ha Noi in December 2009, three new sites opened in 2010, and two more are expected to open in 2011. The Ministry of Health has set a goal to have 80,000 drug users on methadone maintenance therapy by 2015, according to a decree cited by UNGASS (2010).

Drug treatment programs with methadone maintenance therapy must take into account the increased risk of transmission by female sex workers who also inject, and ensure that they set aside a proportion of enrollment slots for this population, balanced according to local epidemiology. Access to methadone for pregnant women must also be prioritized because of the danger that traditional detoxification poses to fetal health. Drug treatment programs must also reframe their measures for success to reflect that abstinence is one of a series of milestones, and that relapse is a part of the recovery process.

Sex workers who use drugs

PSI has developed an innovative program in Viet Nam targeting sex workers who also use drugs. Based on extensive qualitative research, PSI learned that most sex workers are introduced to drug use via fellow sex workers. PSI determined that sex workers need to be reached often, and with dynamic messaging catered to their particular needs. For example, inhaling drug users need different kinds of outreach than injecting drug users, especially to prevent inhalers from graduating to injection. Using a unique identifier code, PSI outreach teams know exactly how many sex workers they work with, what kinds of users they are, what messaging they need to receive and how often they have been reached. This enables the teams to cater behavior change interventions to the specific needs of each individual. PSI also distributes sterile injecting equipment in both private and public sectors to reduce needle sharing, and facilitates the distribution of the drug naloxone to prevent overdose death. In addition to reducing drug-related harm with these programs, PSI works to prevent the initiation of injecting drug use through the Break the Cycle model, and promotes methadone maintenance therapy for female sex workers who wish to stop using heroin.

Self-help groups

MCNV has supported an intervention led by female injecting drug users in Ha Noi since 2005. At the core of the program is a self-help group, the Cactus Blossom Group, comprised of both sero-positive and sero-negative women released from rehabilitation centers. They receive training and assistance in order to organize themselves to demand access to the medical, social and economic services they need to rebuild their lives, avoid drug relapse, prevent HIV infection, and obtain and adhere to antiretroviral therapy.

Voluntary counseling and testing

For many women, voluntary counseling and testing is the entry point for in-depth counseling on HIV prevention, and for care and support in the event of infection. Referral to quality counseling and testing is a critical part of the prevention-to-care continuum. Some organizations, such as PSI, Médecins du Monde, Family Health International and CDC/LIFE-GAP, provide testing at the clinical sites that they support. PSI promotes LIFE-GAP voluntary counseling and testing services through its New Horizon campaign, which combines mass media and behavior change communication outreach to encourage female sex workers and their male clients to test at its branded sites.

PSI has developed a number of recommendations to improve voluntary counseling and testing in Viet Nam, based the findings of on a qualitative study (PSI, 2005). Women-specific items include the following:

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

MSI, which works primarily in reproductive health and family planning, advocates for greater research on access to and utilization of voluntary and counseling services by women. MSI notes the importance of addressing the needs of women in violent homes. It works with women on disclosure to partners and encourages couples testing when appropriate. In addition, the organization conducts mobile activities in places frequented by women, such as markets, factories, restaurants and karaoke bars. It also works with Women's Union to access community groups at the commune and district level, has developed women-specific information, education and communication materials and workshops, and has integrated voluntary counseling and testing services into reproductive health and pregnancy services.

Integrated services for sexual and reproductive health (SRH) and mother-to-child transmission

Several pilot programs have demonstrated that coordination of prevention of mother-to-child transmission and SRH services can improve program effectiveness. FHI (2006b) suggests that integration of services for family planning and prevention of mother-to-child transmission may double efficacy of the latter by reaching potential mothers earlier. FHI offers integrated services at its family-centered care clinics. Similarly, Pathfinder, with funding from the Ford Foundation, offers prevention of mother-to-child transmission services at its sexual/reproductive health centers in Soc Trang, Can Tho, An Giang and Quang Ninh provinces, with plans to increase coverage. The Ministry of Health in partnership with UNICEF has also piloted integrated services at antenatal care clinics. For further details on these projects and integration of SRH services with prevention of mother-to-child transmission, see Section 3.

A number of pilot projects also address counseling and service provision gaps in prevention of mother-to-child transmission. A Save the Children project funded by PEPFAR features prevention counseling for negative women, in addition to treatment for those who test positive. PSI promotes early HIV testing among pregnant women who seek antenatal services through its New Life campaign, which supports CDC/LIFE-GAP project sites with communication to increase use of prevention of mother-to-child transmission services. The Clinton Foundation works with VAAC to expand polymerase chain reaction coverage at six weeks, as well as with Save the Children to provide a comprehensive prevention of mother-to-child transmission program in Thai Nguyen.

Since 2007, MCNV has collaborated with national and provincial partners on pilot prevention of mother-to-child transmission programs based on the WHO model (Le & Morch-Binnema, 2008), initially in Ha Noi, Quang Ninh, Thai Nguyen and Cao Bang provinces, and as of 2009 in Dien Bien, Yen Bai and Ha Giang as well. The project takes into account the cultural and epidemiological context of the epidemic in catchment areas, tailoring support groups for women living with HIV to provide care and support services and build a referral system for prevention of mother-to-child transmission.

3. Treatment

Women living with HIV have specific care and treatment needs that differ from those of men, as do women in households affected by HIV. Best practices in engendering HIV services demonstrate that comprehensive care and treatment programs targeting women must address the greater stigma and discrimination that girls and women face, and preferential care for boys and men when resources are limited. They should encompass economic and livelihood support for women who are less likely to have money to care for themselves and their families, and for those who wish to leave sex work. Counseling, testing and other HIV-related services should be integrated with reproductive health centers to increase reach.

Greater efforts must be made to provide outreach to women who are not yet pregnant, as well as those who are, to address HIV-related complications associated with pregnancy, and to provide much-needed family planning services for HIV-positive women who wish to raise a family. Prevention of mother-to-child transmission services must be widely promoted and available, and antiretroviral therapy for mothers must be a part of the service package to ensure that they live healthy lives and can raise healthy, productive children. Systems must be in place to prevent, detect and address gender-based violence.

Evidence suggests that women living with HIV in Viet Nam have significant health and social service needs that are not being met because the services either do not exist, or because women lack knowledge of or access to existing services. Boston University, COHED and Life (2010) find that women interviewed prioritize the following needs: advice on nutrition and other health issues, antiretroviral therapy (including adherence support), women-focused health care, employment opportunities, psychological support, family support, support to cope with stigma and discrimination, drug counseling and safe drug treatment, and housing. Access to these services among those interviewed was fairly limited: 38% had received adherence counseling, 46% said they could access antiretroviral therapy, and 29% said they could access nutrition counseling. Employment support was said to be lacking by 33%, and 29% noted inadequate access to reproductive health services.

Clinical care and sexual health

HIV affects all dimensions of women's sexual and reproductive health: pregnancy, childbirth, breastfeeding, contraception, abortion, sexually transmitted infection and exposure to sexual violence. Doctors who work with women living with HIV require specific skills and knowledge to address women's needs. For example, HIV infection accelerates the progression of some reproductive illnesses, increases the risk of cervical cancer and increases the severity of illnesses such as pelvic inflammatory disease, which can lead to infertility (UNFPA & WHO, 2006).

Sex also plays a role in prescription of medication. For example, the antiretroviral nevirapine is contraindicated in women with CD4 counts over 250, due to an increased risk of nevirapine hypersensitivity reaction. This can impact on the choice and availability of antiretroviral therapy for a woman's own health, as well as affect the choices of antiretroviral therapy for prevention of mother-to-child transmission. Another example is that the antiretroviral efavirenz should be avoided when women wish to become pregnant because of its association with birth defects.

> *Doctors need to have firm knowledge of HIV and related illnesses, but they don't know much, and in some cases they give medication based on appearances or a quick examination…but there's no questioning about health (or other factors) that might influence medical needs.*
>
> – Woman living with HIV, Ho Chi Minh City

Because of discrimination, limited health care resources, and poor understanding within the medical community of the reproductive health care rights and needs of women living with HIV, medical practitioners may deny HIV-positive women the information and options they need to make informed reproductive health decisions. In addition to health-related consequences, a positive diagnosis can lead to various changes in a woman's life. HIV can change the way women view their sexuality. Some women may choose to continue to have sex, but others may forego sex because of their HIV status or because of the stigma associated with it. For example, ISDS and VCSPA (2011) find that 16% of female interviewees had abstained from sex since learning they were positive. However, HIV infection does not stop women from having sexual feelings (Esplen, 2007). Women wishing to conceive, or those who discover they are HIV-positive during pregnancy or childbirth, may be judged harshly, pressured to undergo sterilization, or told to terminate

their pregnancies. Few women living with HIV are offered advice or counseling regarding their reproductive options or the options available to prevent mother-to-child transmission.

Many women may choose to forfeit pregnancies of their own volition, fearing that the health or future happiness of their child may be compromised by their positive status. Oosterhoff (2008) found that healthcare workers believed unanimously that HIV-positive women should not have babies. ISDS and VCSPA (2011) note that 17% of the 1,297 HIV-positive women interviewed had had an abortion because of their positive status. Boston University, COHED and Life (2010) find that 46% of women living with HIV had had legal abortions and 43% had had an unwanted pregnancy. These percentages tend to be significantly higher than estimates of the percentage of HIV-negative women who abort in the general population, which have been estimated to be between 22% (National Committee for Population, Family and Children Population and Family Health Project, 2003) and 33% (Le, 2006).

> *I wanted children and it was a big internal conflict. After a lot of thought, I decided not to have any.*
>
> – Woman living with HIV, Hai Phong

Women living with HIV who choose to have children face multiple obstacles. Sexual and reproductive health services for HIV-positive women are seldom integrated with HIV/AIDS services. Under the current structure, most women living with HIV wishing to access antenatal services, prevention of mother-to-child transmission and antiretroviral therapy must visit several different clinics from pregnancy through birth. Siloed donor funding modalities indirectly contribute to a lack of integration. As discussed in Section 2, mothers who learn of their HIV status close to childbirth miss out on opportunities to abort if desired, to increase the efficacy of prevention of mother-to-child transmission, and initiate timely training on postnatal care for their babies and themselves. The lack of integrated services also poses time and cost obstacles for women living with HIV, in addition to increased likelihood of discrimination in the healthcare setting.

> *We need [doctors to have] just one thing – a heart.*
>
> – Woman living with HIV, Ho Chi Minh City

The sexual/reproductive healthcare system in Viet Nam extends from province to district to commune levels. Services include reproductive health counseling, family planning, safe abortion, diagnosis and management of sexually transmitted infection, and maternal and child health care, but these vary by type and level of facilities. Limited efforts have been made to build the capacity of the SRH network to address HIV/AIDS. Because of the lack of coordination and integration between SRH and HIV services, many women who suspect HIV or sexually transmitted infections defer treatment rather than face stigma associated with accessing care at provincial AIDS centers.

Barriers to accessing services

A substantial proportion of women living with HIV in Viet Nam either do not know about or have trouble accessing services. Fear of stigma and discrimination can convince women living with HIV and those at risk of infection to avoid seeking services. These include counseling, testing, returning for test results, care and treatment, and other services that provide clinical or psychological support, and for pregnant women, those that reduce their risk of transmission to their child. HIV-positive women who do attempt to access services may be deterred from doing so "by the judgmental attitudes of health workers, who sometimes deny women the opportunity to give informed consent to HIV testing and treatment, violate their confidentiality, treat them with disrespect, deny them services, or push them to access services without providing comprehensive information about alternatives" (Esplen, 2007). For details on stigma and discrimination, which further complicate access to services, see Section 1.

Among participants in the study by Boston University, COHED and Life (2010), nearly half of women in Ho Chi Minh City and nearly one-third of women in Hai Phong indicated that services were not sufficient to meet their needs. Roughly one-third of these women indicated the need for more employment and credit-related services: 29% wanted more SRH services and 22% wanted greater access to outpatient services. Shortcomings were also identified in the availability of psychological, legal, nutritional and sexually transmitted infection-related services. Roughly half of the women living with HIV interviewed wanted more information on services related to HIV, SRH and social support.

Where services are available, evidence suggests that women benefit from those services to a lesser degree than men. ISDS and VCSPA (2011) find that 70% of men interviewed reported access to antiretroviral therapy, compared to 61%

of women. Information, education and communication materials tend to target men or female sex workers and are typically distributed at venues frequented by most-at-risk populations.

Time, money and transportation issues pose major constraints to access to services for women living with HIV. Many women in Viet Nam face a double burden common to women worldwide, as caregivers and homemakers, and as income generators. When required to care for a sick family member, the demands are such that women may not have the time and energy to care of themselves (Esplen, 2007; Oosterhoff, 2008). In some cases, women who are forced to give up income generation to care for family members sell their own antiretroviral medication to feed their families, or sacrifice the cost of transportation to access care services.

Furthermore, women living with HIV may face significant difficulty in obtaining credit from government microcredit schemes. When asked to identify areas in which service provision for women living with HIV could be improved, women in Hai Phong and Ho Chi Minh City highlighted credit services (Boston University, COHED & Life, 2010). Some widowed women living with HIV report being unable to borrow money because they were deemed to be at higher risk for loan default by loan officers. It is challenging to prove credit worthiness when one is infected with a potentially life-threatening virus.

> *I heard about a program offering microcredit to positive families in difficulty, but when I tried to access it, the ward [officials] asked, "Who will repay the loan if you die?"*
>
> – Woman living with HIV, Ho Chi Minh City

Meeting care and treatment needs

Gender plays an important role in determining a woman's vulnerability to HIV and can also impact health-seeking behavior related to care and treatment. Women living with HIV require care and counseling that is specifically tailored to their needs, particularly as it relates to sexual and reproductive health. In order to address gender differences in care and support for women living with HIV in Viet Nam, the response will need to ensure that women have both information on and access to quality voluntary counseling and testing, support with disclosure, and appropriate and effective referral to non-stigmatizing clinical care and support – including prevention of mother-to-child transmission, treatment of sexually transmitted infection, drug counseling and treatment, and integrated HIV and SRH services with a focus on women's specific needs. Women also need greater access to social support services that take into consideration the specific challenges women face, including the compound burden of domestic duties, income generation, family health management and cultural expectations.

Clinical care and sexual health

HIV counseling and testing and prevention of mother-to-child transmission are entry points for HIV-related care and support, including antiretroviral therapy. Women must know their HIV status as early as possible in order to tailor healthcare and counseling to their needs. This will also assist them to make decisions on self-care; contraception; methods, number, spacing and timing of pregnancies; and infant feeding practices. Healthcare services must take into consideration the reality that many women living with HIV continue to have sexual relationships (Esplen, 2007). Integrated SRH and HIV services are critical to ensure that HIV is addressed early and appropriately, and that women have access to a full range of counseling, care and treatment services. In addition, appropriate and prompt case management of sexually transmitted infections will help reduce the risk of transmission to sexual partners, as well as reproductive tract and obstetric complications associated with sexually transmitted infection (UNFPA & WHO, 2006).

Providers must understand how to manage potential HIV-related complications before, during and after childbirth for women living with HIV. Comprehensive postpartum follow-up and care for women living with HIV and their infants must extend beyond six weeks, and it must include assessment of maternal healing after delivery, evaluation for postpartum infections and ongoing counseling and support on infant feeding. Antiretroviral therapy programs must be sensitive to women's needs, particularly in relation to their sexual and reproductive health. Selection of antiretroviral therapy regimens for women should take into account the possibility of planned or unplanned pregnancies. As the health and well-being of women improve with antiretroviral therapy, women may reconsider previous decisions regarding their sexuality and reproduction. Healthcare providers should be aware of this and anticipate that women need counseling and support to make decisions according to their wishes (UNFPA & WHO, 2006).

Community and home-based care is critical to ensure that women are not lost to follow-up and remain adherent to treatment regimens. Such initiatives are particularly critical to assist women who are unable to come to clinical settings due to domestic responsibilities, lack of access or funding for transportation. Special care must be taken to avoid revealing HIV status and community stigmatization on home visits. Homecare teams and their clinical counterparts must effectively refer beneficiaries to local self-help groups that focus specifically on women living with HIV.

Integration of HIV and SRH, and linkage with prevention of mother-to-child transmission

There are many benefits to integrated HIV and SRH services. Integration improves access to and uptake of key HIV and SRH services and provides services that are better-tailored to the needs of women living with HIV. Family planning can function as a key HIV prevention strategy, at far less cost than clinical prevention of mother-to-child transmission. Integrated HIV and family planning services are more likely to reinforce dual protection and less likely to stigmatize women. Similarly, if condoms are promoted for both HIV and family planning, this key dual protection device will be subject to reduced stigma as well, expanding women's options for negotiating condom use. Integrated services can decrease duplication of efforts and competition for resources, and they can enhance program effectiveness and utilization of scarce human resources for health.

As introduced in Section 2, in 2008 Pathfinder International set out to integrate HIV/AIDS services into reproductive healthcare settings in Viet Nam, through the capacity building of providers within Reproductive Health Care Centers at the provincial level and health facilities at the district level. The program covered four high-prevalence provinces: An Giang, Can Tho, Quang Ninh and Soc Trang. It focused on strengthening service capacity and referral systems within existing networks of facilities, and on supporting related policy and outreach interventions. Pathfinder's approach included strengthening HIV/AIDS counseling and services at provincial and district level; enhancing the policy environment for service integration by supporting the development of provincial policies and national guidelines; and raising local communities' awareness of risks and prevention related to SRH and HIV, with a particular focus on youth. The program successfully integrated HIV counseling and related services within Reproductive Health Care Centers and health facilities in many provinces and districts. It integrated HIV risk assessment and prevention counseling into several existing reproductive health services, including family planning, abortion care, gynecological testing and treatment services.

Voluntary counseling and testing and prevention of mother-to-child transmission have been integrated into Reproductive Health Care Centers, with a focus on testing clients who exhibit sexually transmitted infections and pregnant women. At the centers participating in the Pathfinder project, there has been a marked increase in counseling on HIV testing among clients who exhibit sexually transmitted infections, from an average of 4% in early 2008 to 100% in late 2009. Approximately 91% of pregnant women who access antenatal clinics within provincial Reproductive Health Care Centers received counseling on HIV testing, and 67% of these agreed to be tested. Pathfinder has also worked with the Ministry of Health to develop national guidelines on sexual/reproductive healthcare for people living with HIV. Pathfinder is assisting the Government to develop guidelines based on the findings of the large-scale needs assessment by ISDS and VCSPA (2011) on sexual/reproductive health rights and needs of people living with HIV.

To integrate public and private services, the Provincial AIDS and Tuberculosis Center in An Giang Province, with support from Pathfinder (funded by PEPFAR and the World Bank), has piloted a voucher scheme through which selected private clinics can provide subsidized sexually transmitted infection services to most-at-risk populations. The Provincial AIDS Committee (PAC) of An Giang has begun scaling up the model. A second pilot allows antiretroviral therapy provision by private clinics that meet certain quality control criteria in Ha Noi.

Efforts to integrate HIV and SRH services should draw on the strengths and resources of both systems, without sacrificing the quality of existing services. See Section 6 (Recommendations) for additional analysis.

Initiatives in clinical care and treatment

Viet Nam is making efforts to scale up antiretroviral therapy, using national treatment guidelines that follow WHO standards. The approach attempts to link clinical treatment through health delivery systems at district, provincial and central levels with home-based care and support. With continuing expansion of services, the percentage of adults living with HIV who receive antiretroviral therapy has grown from 30% in 2007 to 53% in 2009 (UNGASS, 2010). Related initiatives led by the VAAC and its partners, such as adherence counseling and a uniform drug management system,

have further improved Viet Nam's capacity to meet the clinical care and treatment needs of people living with HIV (Tarantola et al., 2009).

In light of barriers limiting women's access to clinical services, some programs are responding by increasing service convenience and comfort, and decreasing stigma. For example, in choosing specific locations for its clinics, Médecins du Monde considers women's accessibility. In Ha Noi, where the majority of female clients are infected via marital sex, Médecins du Monde located its clinic in Tay Ho district, a middle class area not known for heavy drug use. In Ho Chi Minh City, where female clients are mainly sex workers and injecting drug users, clinics are located in districts with greater concentrations of these populations. Médecins du Monde also works with women's self-help groups to advertise its services and increase access.

MCNV supports local self-help groups to provide appropriate care for women living with HIV. For example, the Sunflower Group Network for HIV-positive mothers launched in 2004 and has grown to six groups in four provinces. It provides members with access to free medication for women living with HIV and their families. Members also receive services for prevention of mother-to-child transmission and follow-on treatment for mothers.

Social services

Social support services can improve women's adherence to antiretroviral therapy and help women care for themselves and their families. For female injecting drug users, strong support networks and access to addictions counseling and methadone are critical to recovery. Community involvement in care and support can create a "reinforcing cycle in which those who benefit from treatment become living testimony that AIDS need not destroy lives, and those who gain more knowledge about HIV/AIDS can support friends and family, learn to live with a chronic disease, as well as prevent HIV from spreading further" (UNAIDS, UNFPA & UNIFEM, 2004).

Programs should aim to integrate clinical and social services in a continuum-of-care model that recognizes the specific needs of women living with HIV. The continuum-of-care model links antiretroviral therapy and other clinical services with social support and a host of relevant services, including adherence counseling. FHI supports continuum-of-care services in 16 clinics in Viet Nam, six of which offer services to children as well as their parents. The "family-centered care model" uses case managers to ensure integrated care. This approach improves service delivery, patient welfare and efficiency. Médecins du Monde also integrates social support and home care with medical care, based from three outpatient clinics in Ho Chi Minh City and Ha Noi, and employs peer educators to offer a range of services designed to benefit patients and caregivers.

The community- and home-based care model complements integrated clinical care by providing palliative care, nutritional support, counseling for psychological and spiritual support, adherence support, and referrals to other relevant services, all in the home or community setting. A growing number of NGOs deliver community- and home-based care services with PEPFAR funding under USAID, via Pact. These NGOs include CARE, COHED, CHP, CESVI, HESDI, HealthRight International, Médecins du Monde, Mai Hoa Center, OSEDC, Pastoral Care, PHAD, SHAPC and World Vision.

Community- and home-based care programs assist women in particular because women tend to serve as caregivers of family members living with HIV. These programs help them cope with the emotional, physical and economic stress of caregiving, as well as meet the needs of those who are HIV positive themselves. The Women's Union has led the way in "care for caregivers" with its Empathy Clubs. With AusAID funding, the Women's Union also hopes to establish a psychological support center for women living with or affected by HIV in Ha Noi. PEPFAR has recognized care for caregivers as a benchmark for program assessment, by adding an indicator to its monitoring framework to track this.

Serving women in closed settings

Until recently little has been done to improve access to HIV-related services in rehabilitation centers and prisons, or to help former detainees (both women and men) reintegrate into their communities. The Government now recognizes that follow-on HIV prevention, care and treatment for these residents in the community is critical to mitigation of the epidemic. Little is known of the specific needs of women leaving closed settings.

HIV care and treatment services are limited or non-existent in rehabilitation centers and prisons, and they are unequally distributed where they do exist. Responding to service needs in closed settings remains a serious challenge. Well-funded rehabilitation centers, such as Ba Vi in northern Viet Nam, provide vocational training in addition

to medical examinations and treatment, but HIV counseling, testing and referral are not usually performed in rehabilitation centers due to lack of specialized staff (Tarantola et al., 2009).

In 2009, 15 rehabilitation centers nationwide provided voluntary counseling and testing and information, education and communication services; 14 of these also provided antiretroviral therapy. Additional centers are currently receiving assistance to provide counseling support for detainees living with HIV (UNGASS, 2010). However, there remains a lack of continuum-of-care linkages between centers and the community. This lack of follow-up and service provision increases the likelihood of problems associated with antiretroviral adherence post-release.

AIDS patient/residents who become seriously ill are usually sent to hospitals for treatment but are returned to the center once they show signs of recovery. With little or no access to continued care, they often become ill and are sent away again, exacerbating the "revolving door" of HIV and AIDS in and out of closed settings.

> *If you get AIDS (in a center) you'll probably die.*
>
> – Greater Integration of People Living with HIV volunteer and former rehabilitation center resident, Ho Chi Minh City

While some incipient drug-related services are now available in rehabilitation centers in a bid to lower the extremely high relapse rate among those released back into the community, women who inject drugs seldom benefit from these. A substantial number of female detainees are sex workers who inject drugs (although they usually admit to drug use rather than sex work because the internment period is shorter). Drug-related services in these centers are almost always unavailable.

Women released from rehabilitation centers face particular stigma, discrimination and family rejection. Interviewees for this study noted that men more easily return to their families and that stigma associated with HIV is stronger among women. As a result, women who return to their community disappear almost immediately and are lost to follow-up. Without access to drug rehabilitation or vocational training within rehabilitation centers, and fearful of accessing services on release, many return to drug use or sex work.

The Ha Noi Department of Social Evils is collaborating with MCNV on one project to support reintegration of female injecting drug users into their communities following release. The Cactus Blossom group uses peer support to enhance access to social and health services.

4. Caregiving

Although government antiretroviral therapy and clinical management of opportunistic infections are available in urban centers in most provinces, families and community groups must meet a host of other care needs. These impose substantial burden on families, and particularly women, since it is the wives and mothers of men and children living with HIV who bear the brunt of caregiving responsibilities. Approximately 75% of Vietnamese HIV/AIDS caregivers are women (UNESCAP, 2010), and since most of these have occupational responsibilities outside the home, caregiving can increase daily workloads by one-third (Measham, 2007). Women who are poor suffer the greatest impact, and those who are widowed by AIDS and become female heads of household may become more susceptible to poverty as a result.

Because of the demands of their care responsibilities, women caregivers may be forced to forego paid employment, social lives, education and, if HIV-positive themselves, attention to their own health and welfare. The stigma associated with HIV within a family must also be borne by the caregiver, who may be the most visible link between society and the people living with HIV for whom she cares.

Caring for people living with HIV involves a variety of different tasks, many of which caregivers must conduct with little or no training or support. These include: catering to patients' physical needs (bathing, feeding, etc.), ensuring adherence to antiretroviral therapy, monitoring and balancing nutrition, and offering emotional support.

Why are women more vulnerable in addressing their care needs?

Socially and culturally, women often put the needs of other family members above their own, sometimes foregoing personal care. Because of the workload they assume, they may also lack time to care for themselves.

Economically, women may lack the financial resources needed to pay for ancillary care and treatment services (e.g., CD4 testing) or may prioritize their family's financial needs over their own health.

Stigma and discrimination – or the fear of stigma, which is often greater for women than for men – prevent many women from seeking care and treatment.

Poor coordination between healthcare providers makes it harder to access care and treatment services that may be more complicated for women, especially given their multiple obligations.

Women caregivers make significant sacrifices in order to provide care for loved ones living with HIV:

Financial security. Loss of income can exacerbate poverty at a time when antiretroviral therapy and other care needs increase family expenses.

> *When Yen's husband became ill with AIDS her parents-in-law told her to give up her job in order to care for him even though there were other people in the house who might have taken on the responsibility.*
>
> – From interview in Thai Nguyen

Educational opportunities. Women may be forced to give up or postpone their education in order to care for sick relatives. This can negatively impact their self-esteem, earning potential and future independence.

Time. Individuals caring for people living with HIV may find they have no time to do anything but earn income or provide care.

> *Bien lives in Thai Binh province and was nine months pregnant when she discovered her own positive status. Her husband was suffering the last stages of AIDS. Bien was forced to "work, and do everything" for her husband and child.*
>
> – From interview in Thai Binh

Physical health. In poor families where more than one infected individual requires antiretroviral therapy, men will often be treated before women.

> *Hien, herself living with HIV, works with women living with HIV in Bac Ninh. She describes a client who is often confined to her home by her caring duties and lacks the time needed to access the tests and treatment she needs to keep her HIV in check.*
>
> - From interview in Bac Ninh

Emotional health. The trauma of watching loved ones die, stigma attached to families of HIV/AIDS sufferers, and huge workloads placed upon caregivers that prevent them from accessing information or support, create emotional pressures for which few are able to find a release. Many such women suffer feelings of helplessness.

Voice. The time and energy required to care for a family member, often on top of other family duties traditionally carried out by women, leave caregivers little time to participate in community meetings or events in which their own needs may be discussed.

Meeting caregiver needs

Caregivers have a range of specific needs: technical, financial, psychological and social. Because women are usually the primary caregivers in a family, they have increased need for support services. The stress of caregiving can increase the negative impact on their own health, and if women living with HIV fall ill because of unmet medical needs, all family members who rely on their care will be affected.

Technical and medical advice. Non-professionals caring for people living with HIV need training to ensure adherence to antiretroviral therapy, to understand and monitor possible side effects, to provide appropriate nutrition, and to meet the basic hygiene needs of patients.

Financial assistance. Because of high medical costs and other expenses associated with caring for people living with HIV – often at a time when the caregiver has forgone her own work in order to dedicate herself to caring – caregivers need access to financial resources and quality nutrition. Those who continue to work while caring may benefit from microcredit and financial planning services and advice.

Psychological support. Networks that link caregivers and offer them and their families tailored counseling can also provide emotional support and an outlet for feelings and frustrations that caregivers may seldom air at home.

Support from men. Greater involvement of men in caregiving or household work would relieve female caregivers of some of the pressures they now bear. Male caregivers could also care for the many women living with HIV who need assistance and have no other family member to help.

Meeting financial needs

Because women often give up work to care for an ill family member at the same time that they face financial burden to care for themselves, financial assistance such as microcredit is critical. International experience (e.g., Kim & Watts, 2005; IPPF, UNFPA & Young Positives, 2007; Ashburn, Kerrigan & Sweat, 2008; Hargreaves et al., 2009; Ashraf, Karlan & Yin, 2010) suggests that microcredit and other livelihoods schemes can meet more than financial needs alone, but can improve women's ability to meet a range of challenges presented by HIV. Participation in these initiatives improves women's self-confidence, value in the family and household decision-making authority. Experience in Viet Nam is limited but shows initial positive results.

Increased leverage within the family can translate into an increase in a woman's ability to protect her health (IPPF, UNFPA & Young Positives, 2007). However, care needs to be taken to ensure that microfinance schemes take into consideration sensitivities in relationships between women and their partners. Despite evidence from the International Planned Parenthood Federation (IPPF), UNFPA and Young Positives that participation reduces the likelihood of gender-based violence, some women experience increased mistreatment from husbands as they gain economic power and assertiveness (Measham 2004; Kim & Watts, 2005; Dworkin & Blankenship, 2009).

Being in a women's credit group gives women the opportunity to exchange many other experiences besides financial information, which can contribute to empowerment in other spheres of life.

– Oosterhoff, 2008

A growing range of programs support income-generating activities, including microfinance, for people living with HIV in Viet Nam. While most do not specifically target females, women make up the majority of beneficiaries in these programs. The Women's Union is mandated to engage in programing that economically empowers women. This has resulted in a central role in many microcredit schemes targeting women living with HIV. MCNV provides microcredit specifically targeting women living with HIV through the Women's Union (Oosterhoff et al., 2008) in a program which focuses on building self-esteem along with careful planning skills, and accessing additional resources. UNAIDS, through the Women's Union, has supported microcredit for female caregivers. The Vietnamese Tinh Thuong One Member Limited Liability Microfinance Institution fund, created by the Women's Union, has recently engaged more closely with women living with HIV.

USAID has provided PEPFAR funding, via implementing partner Pact, to support several livelihoods initiatives that focus on women. For example, Pastoral Care provides shelter and income generating opportunities for women living with HIV through three social ventures: a flower shop, a garment factory and a wedding dress factory. Through the Women's Union, World Vision provides loans mainly to women, and it has also provided vocational training. COHED's work on income-generating activities serves women primarily by providing small groups of people living with HIV with capital to develop businesses.

Irish Aid has also shown significant leadership in enterprise development support for people living with HIV. For example, it has supported Life's partnership with COHED in Ho Chi Minh City on enterprise opportunities for women living with HIV, involving beading and flower shops. COHED has also used Irish Aid funding to support networks of people living with HIV with microfinance and to fund social enterprises run by self-help groups, a significant portion of whose beneficiaries are women.

Children living with or affected by HIV

UNGASS estimates that roughly 283,000 children under 18 in Viet Nam were affected by HIV in some way as of 2009, and almost 69,000 had lost one or both parents to AIDS. For the same year, the EPP estimates the number of HIV-positive children at 4,720, and UNGASS records 1,987 children who were receiving antiretroviral therapy.

Mothers and mothers-to-be need medical, social and psychological support to ensure that they can exercise their right to raise children. Many women living with HIV worry that by having a child they risk exposing that child to HIV-related discrimination, illness and orphanhood, should they die of AIDS. Some women living with HIV who give birth to healthy children may be forced to give them up by their families.

After my child's birth, my mother-in-law said, "If you keep him you may infect him." Then she kept the baby … I haven't been allowed to hold him. She doesn't allow him to live with me.

– Woman living with HIV (Brickley et al., 2008)

We have to think about who will take care of our children if we die.

– Woman living with HIV, Hai Phong

Infected and affected children, whether healthy or ill, often suffer discrimination. Schools may refuse to admit them: 10.4% of women living with HIV interviewed by Boston University, COHED and Life (2010) said their child was denied schooling because of the status of either the mother or child. Other schools may separate children living with or affected by HIV from other students, who then bully and taunt them.

My kids have to use separate stuff at school. Other kids shout "SIDA" at them.

– HIV-positive mother of twins, one HIV-positive and one negative, Hai Phong

In an effort to recognize and address the needs of children infected and affected by HIV/AIDS, Pact, UNICEF and other international organizations have assisted the Government of Viet Nam to develop the National Action Plan for Children affected by HIV and AIDS until 2010 with a Vision to 2020 (MOLISA, 2009). Children affected by HIV

are defined as children up to 15 who are HIV-positive, who have lost one or both parents to AIDS, who live with HIV-parents or guardians, or are a member of one of the following most-at-risk groups: orphans due to all causes, street children, child drug users, children who engage in commercial sex work or are sexually exploited, children of commercial sex workers or drug users, and trafficked children.

The action plan notes challenges such as difficult access to basic services, failure to identify and assist children in need, lack of adolescent- and child-focused care, and limited availability of alternative care. See Section 6 (Recommendations) for action plan objectives that will benefit from additional support.

5. The role of men

Efforts to engender Viet Nam's HIV prevention response must involve men by addressing their assumptions, needs and desires. HIV was formerly transmitted in Viet Nam primarily via male-to-male needle sharing, from male injecting drug users to female sex workers, and from female sex workers to male clients. High-risk activities such as drinking, multiple sex partners and drug use appear to be increasing among younger men, suggesting that marital infection will continue to rise (Tarantola et al., 2009). Yet HIV/AIDS policy and programs still focus heavily on men as drug users, rather than as responsible partners to their wives and girlfriends, and on women as female sex workers, rather than as wives or girlfriends at risk of infection.

Gender norms

Just as women must negotiate gender stereotypes and social norms that define their roles as mothers and caregivers, men also experience pressure to conform to male gender norms: to earn for their families, sometimes by working or studying away from their communities. Pressure comes from friends, colleagues and family members. Men questioned on their visits to female sex workers (FHI, 2006a) said they seldom go alone and often feel obliged to join a group of friends or colleagues. Many said they felt unable to decline if invited by their boss.

> *If you refuse … they'll think you're 1) afraid of your wife; or 2) don't have any money.*
>
> – Married man, Ho Chi Minh City (FHI, 2006a)

Risk-taking is an accepted – and often expected – social norm for men. Discussion of sex and sexuality is often viewed as unmanly and may deter men living with HIV from informing their sexual partner or partners of their status. Because sexual and reproductive health issues are widely viewed as the responsibility of women, men may often be shut out of parenting or nurturing roles (WHO, 2003) and are ill at ease with sexuality and its role in a relationship.

> *School textbooks discuss women's reproductive health, but not men's. [Men] don't understand their own bodies.*
>
> – NGO worker involved in integration of HIV and sexual/reproductive health in high school curricula

The Viet Nam Committee on Human Rights (2007) notes that gender stereotypes affect policy and legislation, and cast family planning and reproductive health as a purely female responsibility. Programs run by the Women's Union are almost exclusively "women only" and fail to target men and boys.

While sociocultural expectations that shape men's behavior increase their risk of HIV infection as well as the likelihood of male-to-female transmission, there is little awareness of the harmfulness of masculine norms for men and boys (AusAID, 2007). These social norms affect men's relationships with women and their attitudes toward sex, marriage, fidelity, women's rights and other dynamics that impact HIV risk.

Gender-based violence

Gender-based violence can increase women's risk of HIV infection, both within sexual partnerships and commercial sex transactions. This increased vulnerability is tied to several issues:

- *Lack of control.* Condom negotiation is all but impossible during violence (Nguyen, Khuat & Nguyen, 2008), and it is compromised when a woman who sells sex feels compelled to forego a condom for higher pay.
- *Physiological susceptibility.* Abrasions and cuts commonly occur during forced vaginal penetration, facilitating the entry of the virus through the vaginal mucosa (WHO, 2002). Gender-based violence also affects women's health as a whole: Across Viet Nam, women who experience consistent partner violence are more likely than women who have never experienced partner violence to report poor or very poor health, with specific symptoms ranging from pain and distress to miscarriage (MDGIF et al., 2010).
- *Fear of gender-based violence can deter women from seeking services,* or returning to a clinic for test results.
- *HIV infection can exacerbate gender-based violence,* as beating or verbal abuse may result from a woman's disclosure of her status to her husband or partner. Gender-based violence can be physical, sexual, verbal or emotional and may be committed by sexual partners or family members.

The national study on domestic violence against women finds that 34% of ever-married women reported physical or sexual violence by a husband (GSO, 2010). According to the UNFPA (2007), men and women still mention Confucian norms, under which some consider it acceptable for a man to use violence to "teach his wife" if he feels she has done something wrong. UN Viet Nam (2010) cites a 2009 presentation by the Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents (CSAGA) that claimed approximately half of its 137 female counseling clients knew their husbands were having extramarital sex, including with sex workers, yet the women feared violence if they requested condom use.

Luke et al. (2007) found that of women who admitted having been hit by their husbands (37% of those surveyed), 80% believed the beating was justified in at least one circumstance and 66% did nothing in response; 63% of men believed their violence toward their wives was justified. The study also found that having a husband who expresses equitable attitudes is not in itself protective against violence: The benefit of such a husband greatly increases when the female partner's own gender attitudes are more equitable.

Luke et al. (2007) noted that Vietnamese men often use violence when they feel unable to fulfill their own traditional responsibilities of supporting the family. There may be increased spousal violence by men who are unable to fulfill these responsibilities due to AIDS, which would increase their partner's risk of HIV infection.

Sexual coercion within marriage is also common in Viet Nam. Studies have found that 30 to 50% of women in Viet Nam have been forced by their husbands to have sex (Nguyen, Khuat & Nguyen, 2008). If a woman is forced to have sex, or fears a violent response if she refuses, she is unlikely to ask her husband or partner to wear a condom, raising her risk of HIV infection.

> *Sometimes a husband will come home at midnight, drunk, and force sex on his wife.*
>
> – Woman living with HIV, Ho Chi Minh City

Severe physical violence (sexual and otherwise) is relatively easy to confirm, and a woman may bring it to the attention of the authorities if she is willing to take such a risk. Verbal and emotional abuse may be very difficult to confirm or punish, however, particularly given cultural taboos. In one study of intimate partner violence in northern Viet Nam, Krantz et al. (2005) found that such violence involves the entire family, but because it is considered a private matter within the home, only in very serious cases of abuse would women seek healthcare or dispute resolution. Community-based resolution, if sought, usually attempts to reconcile couples, denying women who wish to leave an abusive relationship the support they need.

> *We prefer to suffer than go to dispute resolution. We'd rather keep quiet.*
>
> – Woman living with HIV, Hai Phong

The government has shown its commitment to address violence against women through the approval of the law on Domestic Violence Prevention and Control in 2007. Nevertheless, the decrees needed to ensure that the law is implemented have not been approved and clear guidelines to manage gender-based violence at the community level have not been developed. Several projects to prevent and manage gender-based violence have been implemented on a pilot bases. They focus mainly on increasing awareness among women and community of women's rights, and on educating young people to adopt new gender norms. Few programs focus on integrating gender-based violence within the health and legal sectors, or provide information and referral for counseling and other services.

Examples of efforts to integrate gender-based violence screening and responses into existing service delivery systems include capacity building activities by a range of organizations, although the number of facilities offering such services remains limited. The Ha Noi Health Service and Duc Giang Hospital, along with the Population Council and UNFPA, are among the pioneers in this field. Population Council activities have demonstrated results in developing the capacity of counselors, improving the standard of medical care provided for women who suffer abuse, raising community awareness, and fostering equitable attitudes on gender and household conflict (Nguyen et al., 2005).

The Medical Services Administration of the Ministry of Health is overseeing scale-up of initiatives to provide screening and treatment for gender-based violence at district hospitals. In some pilot communities, law enforcement and women's unions are also engaged in the effort. CSAGA runs a telephone hotline and provides advocacy, community mobilization and counseling to assist affected women (Nguyen, Khuat & Nguyen, 2008). CSAGA has teamed with ISDS

and the Harvard School of Public Health to explore the link between sexual violence and HIV infection. A case booklet and toolkits to guide sensitization discussions and trainings were produced and disseminated. The tools have been used successfully in various ActionAid projects.

In addition, CIHP has conducted research on an integrated response model for gender-based violence in clinical and community settings. Funding for this program is provided by the Ford Foundation. COHED has incorporated gender-based violence explicitly into its HIV/AIDS care and treatment programs, by conducting screening for abuse and support services to assist women in need.

Involving men in meeting the needs

Because women's vulnerabilities to HIV/AIDS are inextricably linked to their relationships with men, responding to women's needs requires the engagement of men.

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

Programs aimed specifically at improving women's lives often focus exclusively on women and fail to target men and boys (Viet Nam Committee on Human Rights, 2007). Programs are beginning to change this within the spheres of clinical care, education and community outreach. Some HIV clinical service providers, such as Médecins du Monde, FHI and Pathfinder, are trying to encourage male participation in women's sexual and reproductive health decisions.

> *We're not expecting men to walk into reproductive health clinics in any large numbers.*
>
> – Leader of a program to increase male participation in women's sexual and reproductive health

The Ministry of Education and Training, with Save the Children and UNICEF, is revising the high-school curriculum to address gender norms, sexuality and HIV. Sex and gender education is also offered through peer educators, youth groups, labor unions and other organizations with access to large male populations. Such programs can help men to question gender norms and increase their understanding of women's needs. Pathfinder is beginning to reach young men before or as they become sexually active, offering sexual messaging via football clubs that advocate responsible behavior. Save the Children's Project NAM has developed peer education in universities and vocational schools and found that young men are willing and able to alter their attitudes. SHAPC, a Vietnamese NGO, is also building peer education networks, focusing on male students at Ha Noi University. Other HIV prevention programs aim to reach at-risk individuals together with their sexual partners, such as those that target injecting drug users and their female partners discussed under Section 2 above. The Center for Population, Social and Environment Affairs is implementing a project with coal miners and their primary and commercial sexual partners. Such programs hold promise because they address women's needs explicitly in the context of existing gender dynamics and, if scaled up, may help alleviate the gender imbalances that exist in Viet Nam.

6. Recommendations

Policy makers and program implementers need to ensure that HIV-related policy and practices include gender as a part of their approach, in order to address the specific needs of both women and men, and to ensure effective HIV prevention, care and support. Women and girls must be engaged in their design and implementation to ensure that they cater appropriately to their needs. Programs must address compound stigma and discrimination related to HIV and gender inequality. They should also encompass strategies to overcome complex social and cultural barriers that make it difficult to discuss sexuality and insist on protection.

The underlying causes of women's vulnerability to HIV in Viet Nam must be addressed to help women take charge of their health and well-being: factors that drive women into sex work, drug use or make them susceptible to trafficking; poor access to prevention and sexual/reproductive health information; and disempowering gender norms.

The following recommendations are provided as a starting point for government and non-government agencies wishing to examine how comprehensively they are addressing the specific needs of women as they relate to HIV prevention, care, support and treatment. These recommendations are based on the findings of this report and international best practice – specifically following the guidance set out in UNAIDS, UNFPA and UNIFEM (2004), and adapted to the Viet Nam context.

Stigma and discrimination

Support Government and grassroots efforts to reduce stigma associated with HIV, sex work and drug use

1. **General**
   a. Efforts must be made to delink HIV from "social evils," especially as they pertain to women. This could entail decriminalization of sex work and modification of outdated, stigmatizing information, education and communication materials and national, provincial and local campaigns against HIV, sex work and drug use.
   b. Government should step up efforts to portray positive images of women living with HIV in the media and encourage high-level officials and prominent spokespeople to support HIV-related advocacy for women living with HIV and their children.
   c. Programs should support free or affordable legal services, including training of paralegals, to protect the rights of women and girls affected by HIV/AIDS.
   d. Government country reports to the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) should include information on violations of women's human rights in relation to HIV/AIDS and measures taken to redress such violations.
   e. Support should be provided for gender analyses at every stage of policy design, implementation and evaluation to ensure that all forms of gender discrimination are eliminated, and to protect and promote women's human rights.
2. **Stigma in medical settings**
   a. Additional resources should be allocated to scale up existing models that have demonstrated positive changes in reducing stigma and discrimination in medical settings, such as that developed and piloted by ISDS and ICRW. The government should consider institutionalizing stigma reduction modules in all major health care settings and as part of its training for doctors, nurses, orderlies and hospital administrators.
3. **Self-stigma and stigma in the community**
   a. Additional program support should be provided to local NGOs and community-based organizations to help build a stronger network of self-help groups for women living with HIV, with advocacy from government-led initiatives, such as Empathy Clubs under the Women's Union.
4. **Economic disparities**
   a. Women and girls should be empowered economically by providing them with access to credit and training on business and leadership skills.

b. Efforts should be made to protect women's property and inheritance rights and to provide of alternate shelter and livelihoods for those in need.

Prevention

Ensure that women and girls have the knowledge and means to prevent HIV infection; increase involvement of men and boys in prevention efforts

1. **Sexual transmission**
   a. Sexual transmission prevention programs must account for increasing infection rates among youth and women, and the interplay between sex work and drug use. Interventions should include life skills training and skills building on decision-making and negotiation, both in and out of school, to foster mutual respect and equality between boys and girls. Programs must ensure that school curricula remove gender stereotypes, promote girls' leadership and self-esteem, and include age-appropriate information on sexual/reproductive health and HIV/AIDS. They must also take into account the role of young men by addressing gender awareness and reflecting on gender norms as they relate to HIV risk practices.
   b. Social marketing of condoms must be extended beyond core risk groups and focus on normalizing condom use within regular sexual partnerships. Programs must increasingly target women who are partnered with men who visit sex workers, have sex with men or inject drugs.
   c. Programs should promote integration of sexual/reproductive health and HIV interventions, via training on HIV for district and commune health center providers and sexual/reproductive health training for providers in HIV clinics, including counseling for serodiscordant couples and promotion of dual protection. (Further recommendations on service integration under Treatment below.)
   d. Programs should promote zero tolerance of violence against women and girls, and sexual harassment policies with strong and swift penalties. These should be implemented both in and out of schools.
   e. Prevention interventions for sex workers must ensure that female sex workers are reached often and with dynamic messaging adapted to their particular needs.
2. **Drug-fuelled transmission**
   a. Programs must increasingly target female drug users with tailored behavior change communications; appropriate information, education and communication materials; and consistent access to clean needles, syringes, condoms and lubricants. Outreach teams should be composed of women, and outreach approaches must be engendered with female-appropriate messaging (i.e., behavior change communications that take into account how women typically inject, how they engage with male partners who inject drugs, and specific referral services that apply to women).
   b. Female injecting drug users must have access to voluntary, community-based drug counseling and treatment programs with a variety of treatment options, including methadone maintenance therapy. Drug treatment programs need to set aside a proportion of enrollment slots for sex workers who also inject, based on local epidemiology. These community-based programs must be well-linked to rehabilitation centers to support women upon release.
   c. Female injecting drug users in the community need access to quality referral services, including sexual/reproductive health, sexually transmitted infection treatment, HIV care and treatment, and self-help support groups.
3. **Ethnic minorities**
   a. Programs must take into account the increased risks faced by ethnic minority women. Where possible, efforts must be made to improve access to public sector services, with specific provision of interpretation for counseling services, or hiring of ethnic minorities to provide counseling that targets ethnic minorities who do not speak Vietnamese.

Treatment

Ensure equal and universal access to treatment services

1. **General**
   a. Women must be provided with information and access to quality voluntary counseling and testing, support with disclosure, and appropriate and effective referral to non-stigmatizing clinical care and support, including prevention of mother-to-child transmission, treatment of sexually transmitted infections, drug counseling and treatment, and integrated HIV and sexual/reproductive health services.
   b. Programs should facilitate access to social support services that take into consideration the specific challenges that women face, including domestic duties, income generation, management of family health and cultural expectations.
2. **Clinical care and sexual health**
   a. Health providers must receive specific training on management of HIV/AIDS-related complications before, during and after childbirth.
   b. Comprehensive postpartum follow-up and care for women living with HIV and their infants must extend beyond six weeks and include assessment of maternal healing after delivery, evaluation for postpartum infections and ongoing counseling and support on feeding preferences.
   c. Selection of women's antiretroviral therapy regimens should take into account the possibility of planned or unplanned pregnancy, and providers should be trained to provide appropriate counseling and support.
   d. Home- and community-based care (based on a continuum-of-care model and utilizing case managers) should be provided as a complement to clinical care and support. This will ensure that women who are unable to make regular clinical visits because of domestic duties can receive appropriate care and support, as well as referral to social support groups that cater to the needs of women.
3. **Integration of HIV and sexual/reproductive health services and linkage with prevention of mother-to-child transmission**

   The following summary of guidelines for integration is based on the large-scale needs assessment conducted by ISDS and VCSPA (2011) and a small-scale rapid assessment of sexual/reproductive health services provided by PEPFAR partners (CCIHP, New Care & Pact, 2009). The recommendations are divided according to high and low HIV-prevalence locales, with greater focus on general populations in high-prevalence areas, and greater focus on people living with HIV and most-at-risk populations in low-prevalence areas.

   a. High-prevalence locales:
      i. Sexual/reproductive health services should be made available within HIV clinics and should encompass family planning, prevention and management of sexually transmitted infections, and counseling on sexual health.
      ii. HIV services should be made available within the sexual/reproductive health system. At the provincial level, Reproductive Health Care Centers should provide a wider range of services, including HIV counseling and testing, prevention of sexually transmitted infection, and support for safe conception. At the district level, such centers may focus on voluntary counseling and testing and management of sexually transmitted infection. At all levels, efforts should be made to reduce stigma among sexual/reproductive health service providers, and to promote the establishment of youth-friendly services.
      iii. Referral systems should be formally organized between and within the HIV and sexual/reproductive health systems. Mapping of existing services will support the establishment of formal linkages between providers in each system and facilitate referral among services.
      iv. Resources from both systems should be employed to promote integration of services. Sexual/reproductive health trainers should support capacity building for HIV providers, and vice versa.
      v. Efforts should be made to ensure integration within outreach and education services. Peer educators, self-help groups and community-/home-based care teams can play key roles in addressing sexual/reproductive

health needs of women living with HIV at the community level. Outreach workers active in sexual/reproductive health should be empowered to address HIV issues with their clients.

b. Low prevalence locales
   i. Sexual/reproductive health services should be made available at HIV/AIDS service sites. As primary entry points for at-risk individuals and people living with HIV, clinics, voluntary counseling and testing sites, and outreach clubs can help address sexual/reproductive health needs for women.
   ii. Efforts should be made to reduce stigma among sexual/reproductive health providers in order to increase access for women living with HIV.
   iii. Community workers active in sexual/reproductive health should be equipped with HIV knowledge.

c. General
   i. A deeper analysis of the private sector and its role in the provision of sexual/reproductive health and HIV services should be conducted to explore potential areas of integration and support. A considerable number of people living with HIV seek care within the private sector, mainly because of greater confidentiality and less judgmental attitudes among providers. The need for identity or residency papers to access public health facilities may further hinder utilization of services by individuals most at risk of HIV infection.
   ii. Prevention, recognition and management of gender-based violence should be widely available within HIV and sexual/reproductive health systems, to protect the human and sexual rights of women living with HIV and women in the general population.
   iii. Youth-friendly sexual/reproductive health services should be widely available within HIV and sexual/reproductive health systems, to ensure that young couples are informed and counseled on sexual health issues.

The following are key recommendations distilled from FHI's Study of Family Planning and HIV Integrated Services in Five Countries (Adamchak et al., 2010a):

a. The base service must be strong enough to absorb the new service. If it is not, decision makers must determine how to improve the base service before considering the needs and costs of the added service.
b. Programs must improve training to ensure that providers can apply WHO medical eligibility criteria for contraceptive methods to all clients, regardless of HIV status.
c. Screening for unmet family planning needs must become a standard element of HIV services, and should be routinely updated in client records.
d. In many settings family planning services provide an excellent opportunity to discuss HIV risk assessment and to offer rapid, on-site testing for those in need.

FHI (2010) has also produced 10 essential steps on strengthening integration of family planning and HIV services, summarized below:

1. Generate demand for integrated services. Advertise to clients using posters, brochures and leaflets. Encourage community health workers, volunteers and local support groups to tell others.
2. Organize services. Learn how clients move through the facility. Draw a diagram of the available space; reduce costs by offering services in different rooms, modifying waiting areas or rearranging moveable fixtures. Determine how services can be changed to reduce waiting time and client costs.
3. Ensure commodity security. Register the facility with the appropriate authorities to receive contraceptives and HIV supplies. Develop a plan for a reliable supply system within the local network and within the facility.
4. Train providers. Provide information and training in basic counseling skills to lower level cadres and community health workers. Learn WHO medical eligibility criteria for contraceptive use by people living with HIV. Access free training materials on the Internet, organize in-house study groups and use peer-to-peer support.
5. Screen all clients for an unmet need for contraception. All women of child-bearing age and all men should be asked about their sexual activity, desire for pregnancy in the near future and current contraceptive use. Screen clients at regular intervals and update information in their records.

6. Foster dual protection and dual-method use. Develop counseling strategies to encourage male and female clients to use condoms correctly and consistently, and to use condoms with another contraceptive method. Stress the importance of preventing both pregnancy and sexually transmitted infections.
7. Challenge provider bias. Address the tendency of providers to emphasize condoms and neglect other contraceptive methods. Correct the false belief that some contraceptive methods are inappropriate for people living with HIV. Support the right of people living with HIV to enjoy healthy sexual relationships and to become pregnant if desired.
8. Reinforce referral systems. Map all available sources of contraceptive methods not provided on site (public and private facilities and those operated by nongovernmental organizations). Develop a contact list with phone numbers and e-mail addresses. Institute a monthly follow-up system to track completed referrals.
9. Strengthen skills for supportive supervision. Update documents (supervision protocols, monitoring forms, provider job descriptions, checklists) for consistency with the provision of integrated services. Make sure these documents address contraception and challenges in promoting dual protection and dual-method use.
10. Monitor and evaluate performance. Determine whether the family planning service or the HIV service is responsible for reporting the delivery of integrated services. Collect relevant service data during an appropriate time frame, using standard indicators and reporting systems. Review the data as a team and use that information to improve the services you provide.

Additional FHI resources related to integration of family planning and HIV services are available at *www.FHI.org/en/topics/FPHIV.htm.*

4. Meeting economic needs

a. Programs should increase access to women-focused livelihoods initiatives for women living with HIV and caregivers, taking into consideration the specific needs of women and the potential harm they may face in relationships where domestic violence is prevalent.

Caregiving

Recognize and support community- and home-based caregivers of people living with HIV and orphans

1. Caregivers

Programs and interventions should:

a. Provide medical and psychosocial training to caregivers to help them ensure adherence to antiretroviral therapy, understand and monitor possible side effects, provide appropriate nutrition and meet basic hygiene and psychological support needs of clients.
b. Provide financial assistance directly or through microcredit schemes to support medical and other costs associated with caring for people living with HIV.
c. Provide psychological support via networks that link caregivers and offer counseling for them and their families.
d. Encourage men to provide care and support for household chores, to relieve women caregivers of some of the pressures they now bear.
e. Provide social protection mechanisms for caregivers, to help relieve women's burden of caring for sick and dying family members or orphans.
f. Undertake campaigns that raise the visibility of the burden of care on women, and encourage equitable sharing of household and care-giving responsibilities.

2. Children

a. Government and civil society agencies should take steps to operationalize the National Action Plan for Children affected by HIV and AIDS until 2010 with a Vision to 2020. Activities should support the following objectives established for MOLISA, the Ministry of Health and the Ministry of Education and Training:
    i. Increase accessibility to and adequacy of healthcare and education services and social policies for children affected by HIV.

ii. Ensure that services specifically required by children affected by HIV/AIDS are available, of good quality and child-oriented.
iii. Improve mechanisms for providing information, education, care, treatment and counseling for children affected by HIV/AIDS.
iv. Create an enabling social environment for the protection and care of children affected by HIV/AIDS.
v. Improve systems for supervision, monitoring and evaluation of the situation of children affected by HIV/AIDS.

The role of men

Programs must recognize the critical role men can play in reducing their own vulnerability and that of their partners

1. Involving men in the response

a. Support should be provided to scale up models that encourage boys and men to question established gender norms and increase their understanding of women's needs. Programs should be implemented both in and out of schools and employ peer-driven approaches to ensure messages are delivered in a targeted and effective way.
b. Programs should examine ways to extend critical behavior change communication interventions and messaging from most-at-risk women to their male partners, including partners of injecting drug users, as well as regular partners and clients of sex workers.

2. Gender-based violence

a. Government should expedite the development and approval of appropriate decree(s) to support and enforce implementation of the 2007 Law on Domestic Violence Prevention and Control. This should be coupled with an aggressive nationwide campaign to ensure that women and men know their rights and how the law can protect them.
b. Additional resources should be mobilized to scale up pilot models that have successfully trained providers in the health system to recognize and counsel on gender-based violence, and provide referral to quality supportive services including community support groups. Programs should ensure that all rape victims have access to free post-exposure prophylaxis within 24 to 72 hours.
c. Government should target men in broad-based media campaigns to combat gender-based violence at the community and household level, by addressing masculine norms and behaviors that heighten the risk of both male and female infection.

General recommendations

1. The role of civil society

a. Government should consider increasing the role of civil society organizations and the private sector in providing prevention, counseling, care, support and treatment services targeting women. Expanding the civil society contribution will depend in part on the passage of the Law on Associations. Without this law, the difficult registration process for new NGOs and other civil society groups will remain a barrier to entry for potential civil society implementers.

2. Participation of women living with HIV in program implementation and policy making

a. Programs should support women living with HIV to engage in national and local policy making and program implementation efforts. Civil society organizations and mass organizations such as the Women's Union can support the presence of grassroots representatives of women living with HIV and female caregivers at local and national fora that inform policies and programs.

3. Coordination between policies, laws and agencies responsible for improving the lives of women

a. Government and civil society should continue to focus efforts on improving coordination among the six ministries responsible for HIV/AIDS (Ministry of Health, MOLISA, Ministry of Public Security, Ministry of Education and Training, Ministry of Finance, Ministry of Planning and Investment) and organizations

engaged in supporting women and their needs. At the provincial level, coordination is required between departments of public security, health and labor to ensure that prevention efforts for female most-at-risk populations are not obstructed, and that women feel safe and confident in accessing public sector services. Coordination is also critical to ensure that women receive quality follow-up service in their communities following release from rehabilitation services, particularly with regard to HIV prevention, care and support, livelihood support and drug treatment.

4. Research and data gathering to identify and address women's needs

a. Funding should be allocated to assess and evaluate the success of pilot programs that focus on women's needs, preferably as part of the development of new models.

b. Programs should develop peer educators' capacity for regular data collection and analysis on harm reduction programs, to improve targeting and approaches that focus on most-at-risk women (e.g., PSI's approach for female injecting drug users). Similarly, programs should support care and treatment service providers to examine the degree to which female clients are effectively supported and referred within the continuum of care.

c. Organizations should focus on developing research skills beyond conventional qualitative in-depth interview and focus group formats, to build a knowledge base that will allow for more refined and effective responses.

Annex: Methodology notes

The desk review for this report covered a range of documents related to HIV, women's rights and other relevant issues: Government laws and decrees, academic papers, donor and NGO reports, and analysis of the effectiveness of HIV interventions in Viet Nam.

The interview process, which ran from December 2008 to February 2009, gathered qualitative data through group and individual interviews with 45 women living with HIV, selected as representatives of support groups in their communities. Five of these women were interviewed in Ha Noi, 13 in Hai Phong and 15 in Ho Chi Minh City. The remaining 12 represented other provinces and were interviewed in Ha Noi while attending a conference in the city in January.

Individual interviews were conducted with an additional 12 participants, including Government representatives, foreign donors, international and Vietnamese NGOs, and the academic community working and based in Viet Nam.

Interviewees discussed the following issues:

- The role of women in Vietnamese society: how gender stereotyping, educational and employment opportunities, and gender-based violence can impact women's vulnerability to HIV/AIDS and their ability to access care and treatment if infected.
- Viet Nam's policy and legal environment for HIV/AIDS and ways it may be adjusted: effectiveness of current legislation in protecting people from HIV/AIDS and addressing the specific needs of women.
- Funding and programs: programs that currently protect women from HIV/AIDS in Viet Nam and that may be needed in future; ways in which future programs may be more sensitively tailored to women's needs; and how Viet Nam can meet the substantial overall funding needs associated with its HIV/AIDS response while seeking to meet the needs of women infected and affected by the disease.
- Children and caregivers: how their specific needs can be met as their numbers increase.
- Men: gender norms that may prevent them from helping protect women from HIV/AIDS and ways in which this may be combated.

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