



HIV TRANSMISSION FROM MEN TO WOMEN IN INTIMATE PARTNER RELATIONSHIPS IN VIET NAM:

A Discussion Paper

2010

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Acronyms/Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
FHI	Family Health International
FSW	Female Sex Worker
GBV	Gender-based Violence
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPT	Intimate Partner Transmission
MOH	Ministry of Health
MSM	Men who have Sex with Men
NCPFP	National Council on Population and Family Planning
PCG	Programme Coordination Group
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SAVY	Survey Assessment of Vietnamese Youth
STI	Sexually-Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary Counselling and Testing

Preface

A 2008 special report to the UN Secretary-General by the Independent Commission on AIDS in Asia drew attention to the problem of intimate partner transmission (IPT) from men who engage in high-risk behaviours to their wives or long-term intimate partners. Subsequently, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Fund for Women (UNIFEM) and the United Nations Development Programme (UNDP), in collaboration with Asian networks of people living with HIV, initiated several research studies to establish a stronger evidence base for various countries in Asia.

Building on this regional momentum, the United Nations in Viet Nam initiated a rapid assessment of the situation of intimate partner transmission of HIV in Viet Nam. The aim of this discussion paper is to provide an overview of the current situation and to highlight the correlation between gender relations and HIV, particularly between men and their spouses or long-term female partners. The paper includes recommendations for priority actions to prevent IPT.

Different UN agencies in Viet Nam contributed to this paper, with UNAIDS and UNIFEM taking the lead in formulating the final document. We are grateful for the many helpful comments and contributions received from UNAIDS and UNIFEM regional colleagues.

We hope that this paper will support policy dialogue and inform the development of the next phase of Viet Nam's response to HIV so that the issue of IPT is made more visible and is accompanied by prevention services that will address this transmission mode.

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Executive summary

Asia has seen a major increase in the number of women living with HIV over the past decade, with women making up 35 per cent of new infections, an increase of 4 per cent since 2000. Although some women acquired HIV through injecting drug use and others while selling sex, the majority were exposed while having sex with a husband or partner who had contracted HIV through injecting drug use, through unprotected sex with a sex worker or through unprotected sex with a male partner. This is known as HIV transmission in intimate partner relationships, or “IPT”.

In 2009, it was estimated that 243,000 people in Viet Nam were living with HIV, with prevalence among adults (ages 15 to 49) at 0.43 per cent of the population. HIV infection is still heavily concentrated among men who use drugs or engage in other high-risk behaviours. In 2009, the number of male adults living with HIV was three times higher than the number of female adults living with HIV, and men still make up the majority of new infections. However, it is estimated that the male-female ratio will gradually decrease, reaching 2.6 by 2012, reflecting the risk of transmission from HIV positive injecting drug users (IDUs) and clients of sex workers to their spouses or regular sexual partners.

This discussion paper, generated by the United Nations in Viet Nam, examines the current state of IPT in Viet Nam, its causes, and the historical and social context of sexuality in Viet Nam – biological drives as well as sexual norms, behaviours and practices. It also addresses avenues for preventing IPT through increased research, policy development and programme action by the Government and other stakeholders.

The ability to measure IPT to women from men with high risk behaviours (unsafe drug injection, unprotected sex work and unprotected sex with men) is limited by insufficient data. Research on male IDUs – the largest group among people living with HIV (PLHIV) in Viet Nam – has focused more on their needle-sharing behaviour and unprotected sex with sex workers rather than on their sexual behaviour with their wives or girlfriends. There is also little or no data from population-based studies on the proportion of men who visit sex workers in Viet Nam, nor on their use of condoms with their wives or girlfriends. And although behavioural surveys indicate that a significant share of men who have sex with men also have sex with wives or female partners, there is little information on sexual behaviour and risk in these relationships.

The gender norms underlying IPT risk in Viet Nam are rooted in traditional, largely Confucian beliefs that women should be subservient to men. Women are expected to be obedient, innocent in sexual matters and morally virtuous, while it is acceptable for men to seek extramarital sex. Long-held social norms stigmatize the discussion of sex between men and women, which constrains opportunities for seeking safer sex, HIV testing and other preventive actions. Gender norms also manifest themselves in physical and sexual violence against women, a fairly common and accepted practice in Viet Nam. Global research is now confirming that gender-based violence puts women at greater risk of HIV because violence or even the fear of violence strips women of the power to negotiate safer sexual practices with their husbands or boyfriends. In addition, general stigma and discrimination against PLHIV, and against those who engage in drug use and sex work, make people reluctant to seek social and health services, including HIV testing, counseling and treatment services, and therefore might contribute to an increase in IPT .

Economic development is driving men to engage in high-risk sexual behaviours. Rapid growth has increased commercial and individual sources of income, and men are more likely to spend their disposable income at establishments that use women to attract customers, such as massage parlours, karaoke bars and nightclubs, where they can often purchase sex. Economic opportunities have stimulated greater mobility, including labour migration, and migrants have a greater tendency to engage in drug use or sex work. IPT is now part and parcel of this changing universe of male power, stigma, and economic shifts that ultimately put women at greater risk.

To date no Vietnamese programmes and policies directly address IPT. HIV programmes and policies only indirectly raise the issue of IPT and they do not address male responsibility to protect intimate partners. Nor do they confront gender inequalities and norms that may increase women’s vulnerability

to infection. HIV prevention programmes tend to focus on strategies for self-protection and few address individuals' responsibility to protect their intimate partners or confront sensitive issues of gender power imbalance in sexual relationships. HIV and reproductive health laws and policies do not yet adequately challenge power relations between men and women, particularly in sexual relationships. However, there are signs within the policy environment in Viet Nam that decision makers might be ready to address IPT, such as the recent promulgation of the Law on Gender Equality and the Law on Domestic Violence Prevention and Control.

In making recommendations on these complex and culturally sensitive issues, this discussion paper takes international human rights standards, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) – to which Viet Nam is a signatory – as a guide. It calls for gender equality in political, economic, legal and social spheres, including within marriage and the family, and also recommends improving research and data related to intimate partner transmission; changing HIV, reproductive health, and gender laws and policies to better address IPT; and changing HIV programme interventions to promote a greater focus on IPT and on the particular HIV-related risks that women face.

I. Introduction

The aim of this discussion paper is to provide an overview of the situation of HIV in intimate partner relationships in Viet Nam and to highlight the correlation between gender relations and transmission of HIV, particularly between men and their spouses or long-term female partners. It explores some specific factors as well as the larger context of gender inequality and sexual relations that contribute to a growing rate of infection among female intimate partners of men living with HIV. The paper draws upon the findings of a rapid assessment that identified critical gaps in research, policies and programme interventions in response to women's increased risk of HIV infection as well as on other available literature. It also makes recommendations for priority actions for the prevention of IPT.¹

Due to the steep increase in HIV infection among women in Asia, and in line with studies on HIV transmission in intimate partner relationships in other countries in the region, the scope of this paper is limited to the transmission of HIV to women from their husbands or long-term male partners. Evidence obtained through operational research indicates that although there is some transmission of HIV from women to their intimate male partners, transmission from men to their female partners is much more common. Therefore, in this paper HIV transmission in intimate partner relationships is examined only in the context of male-female sexual relationships, whether within marriage or outside of marriage, from the perspective of female risk. In Viet Nam, as elsewhere in Asia, such transmission tends to occur because male partners contract HIV through unsafe drug injection or through unprotected sex with sex workers or other men.

II. Current trends in HIV

Globally

There has been a rapid increase in HIV infections among women over the last decade and now, of the 33.4 million PLHIV in the world, 15.7 million are women.² The greater incidence and prevalence of HIV among women have brought into focus gender inequalities between women and men in terms of their social, economic and decision-making status. Evidence has shown that women, particularly women at risk of HIV, are in need of greater attention from policymakers and those creating and implementing HIV prevention programmes.

¹ Hoang, T. H., Nguyen, N. T., Nguyen, V. T., *Spousal Transmission of HIV among Married Women in Viet Nam: Review of policies, research, interventions and IEC materials* (Ha Noi: UNAIDS and CIHP, 2009).

² Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an effective response* (New Delhi: Oxford University Press, 2008).

Regionally

The HIV epidemic in Asia has long been concentrated among “key populations at higher risk”, i.e. IDUs, female sex workers (FSWs) and their clients, and men who have sex with men (MSM). However, the epidemic in many parts of Asia is steadily expanding into groups with lower-risk behaviours, such as the sexual partners of those most at risk.³

In 2008, an estimated 4.7 million people in Asia were living with HIV, including 350,000 who contracted HIV in 2007. The proportion of women living with HIV in the region increased from 31 per cent in 2000 to 35 per cent in 2008.⁴

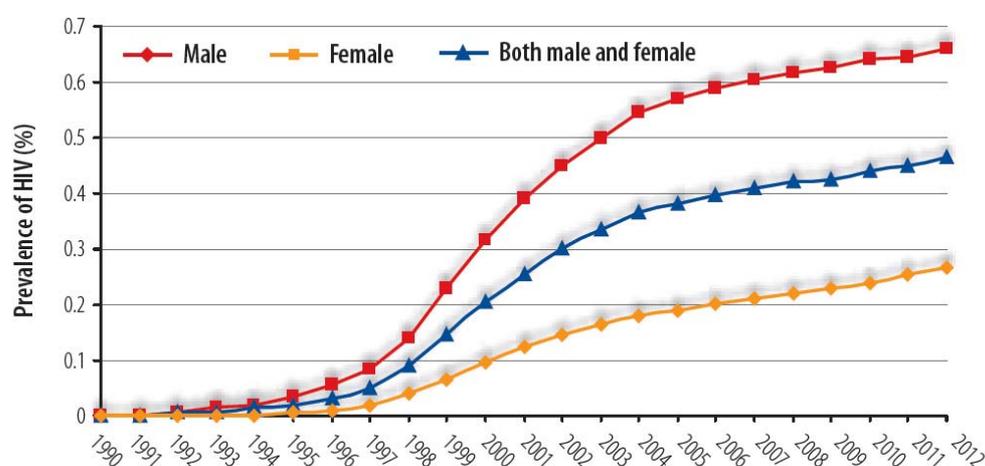
Evidence from many countries in Asia also indicates that most women are acquiring HIV not because of their own sexual behaviours but because their partners engage in unsafe behaviours. It is estimated that more than 90 per cent of women living with HIV acquired the virus from their husbands or from their boyfriends while in long-term relationships.⁵

The Independent Commission on AIDS in Asia concluded recently that men who buy sex are the single most important driving force in Asia’s HIV epidemic. Approximately 75 million men in the Asia-Pacific region purchase sex from a population of about 10 million sex workers. In addition, approximately 4 million men inject drugs and 16 million men have sex with men, and there is considerable overlap between these behaviours. For example, some men paying for sex also engage in injecting drug use.⁶ Individuals from any of these populations could pass HIV on to their wives or partners, a population of women estimated at 50 million.

In Viet Nam

The HIV epidemic in Viet Nam is currently concentrated among key populations at higher risk, mainly IDUs, FSWS, and MSM. According to the Viet Nam HIV/AIDS Estimates and Projections 2007-2012, produced by the Ministry of Health of Viet Nam, 243,000 people were living with HIV in 2009, with prevalence among adults aged 15 to 49 estimated at 0.43 per cent (Figure 2).

Figure 2. HIV prevalence among adults, Viet Nam, 1990-2012, disaggregated by sex



Source: Ministry of Health - Viet Nam Administration of HIV/AIDS Control (2009) *Viet Nam HIV/AIDS Estimates and Projections 2007-2012*: 69.

³ Ibid

⁴ Joint United Nations Programme on HIV/AIDS, World Health Organization, *AIDS epidemic update* (unpublished data), November 2009.

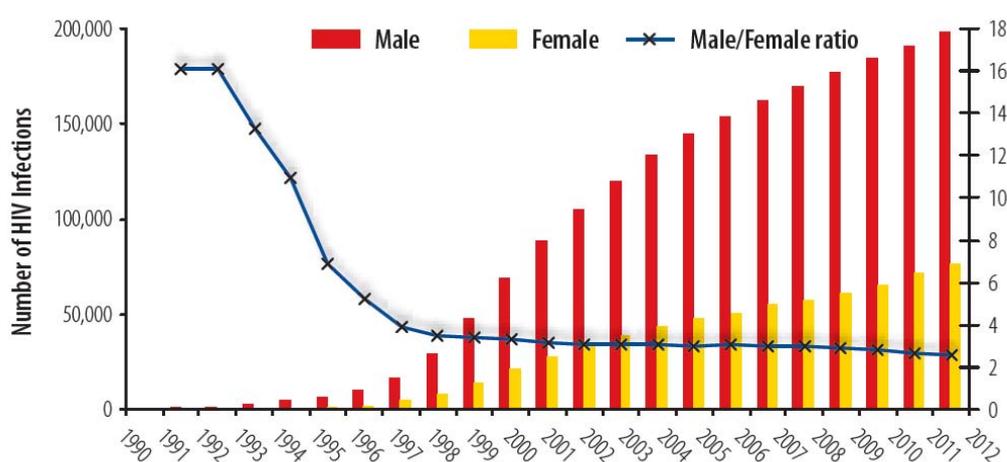
⁵ Joint United Nations Programme on HIV/AIDS, *HIV transmission in Intimate partner Relationships in Asia* (Geneva, 2009).

⁶ Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an effective response* (New Delhi: Oxford University Press, 2008).

Currently, the group with the highest HIV prevalence in Viet Nam is IDUs, who represent approximately 44 per cent of all reported cases. According to the HIV Sentinel Surveillance by the Ministry of Health (MOH), in 40 of Viet Nam's 63 provinces prevalence among IDUs decreased from 29 per cent in 2002 to 18.4 per cent in 2009. Surveillance also found that prevalence among sex workers in the 40 provinces decreased from 5.9 per cent in 2002 to 3.2 per cent in 2009.

In 2007, the number of male adults (age 15 and older) living with HIV was three times higher than the number of female adults living with HIV, and men still make up the majority of new infections. Yet this gap is expected to gradually decrease to a ratio of 2.6 by 2012, which translates to an estimated number of 198,000 adult men and 76,700 adult women living with HIV (Figure 3). This declining gender ratio reflects the risk of transmission from people with high risk behaviours to their female spouses or regular sexual partners.⁷ In addition, the number of HIV-positive pregnant women in Viet Nam will continue to increase to an estimated 4,800 women by 2012, another possible indication of a rise in IPT.

Figure 3. Number of adults aged 15 and older living with HIV, by sex, and male-to-female ratio in Viet Nam 1990-2012



Source: Ministry of Health-Viet Nam Administration of HIV/AIDS Control (2009), *Viet Nam HIV/AIDS Estimates and Projections 2007-2012*: 70-71.

III. High-risk behaviours among men and intimate partner transmission

Insufficient data and research hampers efforts to measure the risk of IPT from men in Viet Nam who engage in high-risk behaviours – unsafe drug injection, unprotected sex with FSWs and unprotected sex with men – to their female partners. Although a periodic national behavioural survey measures the rate of condom use among FSWs and male IDUs, it does not extend to other groups likely to engage in high-risk behaviours, such as the male clients of female sex workers and male migrant workers. In addition, there are no national-level data on the number of individuals among these key populations at higher risk who are married, and no data on their condom use habits or other sexual behaviours with their wives or intimate partners, though some small-scale studies have addressed these issues.

Not all official national HIV data has been sex-disaggregated, making it difficult to measure differences among men and women. The Government of Viet Nam did recently adopt a decision requiring sex-disaggregated data at the national, provincial and district levels, but concerns remain that the decision lacks enforcement. When studies do collect sex-disaggregated data, reports often do not present the breakdown by sex but instead re-aggregate the data for official publication.⁸

⁷ Ministry of Health - Viet Nam Administration of HIV/AIDS Control, *Viet Nam HIV/AIDS Estimates and Projections 2007-2012* (Ha Noi, 2009).

⁸ Nguyen, T.L., *Mapping Sex Work and HIV in Viet Nam* (Ha Noi: UNFPA, 2009).

Male injecting drug users

Studies show that significant numbers of male IDUs are involved in unprotected sex with different partners, including female sex workers. In An Giang Province, for example, 43 per cent of IDUs reported having had sex with FSWs in the previous 12 months.⁹ Also, 28 per cent of IDUs in Hai Phong and 60 per cent in Ha Noi reported having had sex with a regular female partner in the previous 12 months. Few of these IDUs (16-36 per cent) reported using condoms consistently with their regular partners.¹⁰

A rapid assessment of other research on IDUs also suggests that most studies have focused on needle sharing and unprotected sex among IDUs or between IDUs and sex workers, rather than on their sexual behaviours with intimate partners.¹¹

Male clients of female sex workers

Male clients of FSWs are significant agents in the transmission of HIV, yet a rapid assessment of current research on this population indicates that most studies have focused only on their behaviours with female sex workers rather than their bridging behaviours with intimate partners.¹² There is also no national data from population-based studies on the proportion of men who visit sex workers in Viet Nam or on their use of.¹³ However, a study in Ha Noi in 2002 indicated that one-third of men aged 18-55 had had sex with an FSW at least once in their life and 45.3 per cent of these had visited sex workers more than five times. But only 36.4 per cent of this group reported that they used condoms "always".¹⁴ Findings from the IBBS 2005-2006 also indicated that few sex workers reported consistent condom use with their regular partners. In almost all provinces the rate was 30 per cent or less.¹⁵

Men who have sex with men

In 2006, the IBBS found that 90 per cent of HIV-positive MSM were unaware of their status and only 16 per cent reported having had a voluntary HIV test in the last year.¹⁶ The IBBS also found that only 29 per cent of MSM in Ha Noi and 37 per cent in Ho Chi Minh City reported the consistent use of condoms with non-commercial partners in the previous month.

This combination of a lack of awareness of HIV status and inconsistent condom use presents a clear risk to intimate partners. Again according to the IBBS, in the 12 months prior to the survey about 40 per cent of MSM had had sex with a female partner and up to one-third (of all surveyed) self-identified as "straight". A rapid assessment of available literature indicated that there is little information available on these relationships or behaviours, or the risks that female partners of MSM and female intimate partners of male clients of MSM face.¹⁷

Male migrant workers

The growing phenomenon of domestic and international migration, and especially migration from rural areas to urban areas for employment, is another factor contributing to HIV high-risk behaviours. Young male migrants who work in the construction, industrial or manufacturing sectors far away from home are more vulnerable to HIV because they have a tendency to engage in unprotected sex with

⁹ Viet Nam Ministry of Health *Integrated Biological and Behavioural Surveillance [IBBS]*, 2006: p.50.

¹⁰ *ibid*, p.25.

¹¹ Hoang, 2009.

¹² Hoang, 2009.

¹³ Nguyen, T.A. et.al., A hidden HIV epidemic among women in Viet Nam, *BMC Public Health*, 8 (2008):37.

¹⁴ *ibid*

¹⁵ Viet Nam Ministry of Health [IBBS], 2008, p.27.

¹⁶ *ibid*, p.71.

¹⁷ Hoang, 2009.

more than one partner as well as a tendency to use injecting drugs.¹⁸ Their intimate partners are thus vulnerable to IPT from them.

A behavioural survey carried out in 2000 with about 2,500 migrant workers in Viet Nam found that 60 per cent of respondents were married. Nevertheless, in Hai Phong 20 per cent, and in Can Tho 7 per cent, had had at least one commercial sex partner in the previous 12 months.

Consistency of condom use among these respondents varied depending on the location and the type of partnership, but with wives/regular partners it was less than 3 per cent.

IV. The gender context of intimate partner transmission in Viet Nam

HIV transmission in intimate partner relationships in Viet Nam is best understood from a broader social context wherein gender inequality and the inadequate fulfilment of human rights are recognised to have contributed to the vulnerability of women. In this context, the dynamics of HIV transmission are understood to be shaped by gender and sexuality¹⁹, perceptions in intimate relationships, gender-based violence and stigma and discrimination related to HIV.

Evolution of gender and sexuality norms

Historical records show that in the earliest ages in the area that has become Viet Nam, attitudes and practices toward sexuality were based on the belief that sex is a wholesome human activity in harmony with the universe.²⁰ The arrival of Buddhism with Chinese rule then gradually encouraged the control of passion and desire. Integration of Confucian principles in public administration, coupled with a thousand years of patriarchal ideology, established a social hierarchy with embedded gender values. Sexuality became redefined and administered along the lines of social class and gender, with a clear set of hierarchical values and expectations for men and women's sexual behaviours which over time evolved into social norms regarding masculinity and femininity.

This set of values demanded that men and women should not have bodily contact until marriage.²¹ A good woman was to maintain the "four virtues": good management of domestic activities, pleasant appearance, polite speech and moral virtue.²² Men's responsibilities were to reproduce progeny, build families and continue their ancestors' lines.²³ Men were also believed to have uncontrollable sexual urges that needed to be satisfied regularly and quickly; thus when they were away from home, sexual outlets such as sex workers were justified. Over centuries these values were transformed into a

¹⁸ United Nations Population Fund (UNFPA) Viet Nam. (Forthcoming). *Internal migration: Opportunities and challenges for socio-economic development in Viet Nam*. Ha Noi.

¹⁹ Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors. (WHO draft working definition 2002 from http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html)

²⁰ Khuat, T. H., *Sexuality in Viet Nam: The known and unknown issues* (Ha Noi : Population Council, 1998).

²¹ *ibid*

²² Kelly, P., What is known about gender, the constructs of sexuality and dictates of behaviour in Viet Nam as a Confucian and socialist society and their impact on the risk of HIV/AIDS epidemic," In E. Micollier (ed.), *Sexual cultures in East Asia - the social construction of sexuality and sexual risk in a time of AIDS* (London and New York: RoutledgeCurzon, 2004): p.107.

²³ Blanc, M-E., *Social construction of male homosexualities in Viet Nam: Some keys to understanding discrimination and implications for HIV prevention strategy* (Oxford: Blackwell Publishing Ltd., 2005): p.664.

popular construct of masculinities characterised by smoking, drinking, gambling and patronising sex workers.²⁴

Economic reform in the 1990s brought drastic changes to lifestyles, values and perceptions about sexuality in Viet Nam. Economic diversification helped to accelerate development, creating more employment opportunities and increasing both commercial and individual sources of income. Under these conditions individual freedom and women's positions markedly improved. Women do still have a tendency to place sexual relations within the family context but, compared to the past, they tend to stress more the importance of a satisfying sexual relationship in ensuring domestic happiness.²⁵ Despite these changes, women's innocence in sexual matters is still highly valued, especially before marriage.²⁶ As far as men are concerned, it is still socially acceptable for men to seek premarital and extramarital sexual relations.

The market economy has played a role in shaping men's access to, and personal motivations for, extramarital sex, effectively producing a new male identity that links consumption to sexual activity.²⁷ Men today are more likely to spend their disposable income at establishments that use women to attract customers, such as massage parlours, karaoke bars and nightclubs, where they can often purchase sex.

This dynamic places women at risk of HIV infection in marriage or in long-term partnerships even though they may not engage in any risky behaviour themselves. Sexual and reproductive health services, which women are likely to access more regularly than men, might not adequately address HIV risk, the importance of condom use in certain situations or ways to empower women to negotiate safer sex. Gender-based violence, or just the fear of it, only further limits women's power to negotiate condom use or safer sex, to request that their partner seek testing if they suspect infection or to demand that the partner remain faithful.

Condom use in intimate relationships

The rate of condom use in Viet Nam remains very low, at around 9 per cent of the 79 per cent of women who are either married or in committed partnerships and are using birth control methods.²⁸ The rate of condom use among groups with high-risk behaviour is also low, as mentioned above.

Prevailing Confucianist and patriarchal ideologies have allowed men both control over decision making and freedom from responsibility in their sexual behaviours. Results of the nation-wide survey 2006 Household Family and Living Standards Survey found more tolerance for men having extra-marital and pre-marital sex than for women doing so.²⁹ Although women are widely perceived as being responsible for contraception, they are unable to negotiate effectively on reproductive issues because of their low status within the household and the strong cultural preference for sons that prevails in Viet Nam.³⁰ These cultural attitudes make it difficult for men to admit to gaps in their knowledge about sex and to practice safe behaviours.³¹

Research shows that men's reasons for using or not using condoms in their sexual relationships varies according to the context. One study by FHI of male clients of sex workers throughout Viet Nam

²⁴ Kelly, 2004:105.

²⁵ Khuat, 1998.

²⁶ San, P.B. et.al., *Report of the evaluation of the national AIDS program January 1996 - June 2001 in Viet Nam* (Ha Noi: Market and Development Research Center, 2002): p.56.

²⁷ Phinney, H. M., Rice is essential but tiresome, you should get some noodles: Doi Moi and the political economy of men's extramarital sexual relations and marital HIV risk in Ha Noi, Viet Nam, *American Journal of Public Health*, 98. (2008): 650-660.

²⁸ General Statistics Office (GSO) Viet Nam, *The 2008 Population Change, Labour Force and Family Planning Survey: Major finding* (Ha Noi, 2009): table 16-17.

²⁹ Ministry of Culture, Sport and Tourism (MOCST), General Statistics Office, Viet Nam, UNICEF, Institute for Family and Gender Studies, *Results of a Nationwide Survey on the Family in Viet Nam 2006* (Ha Noi, 2008).

³⁰ United Nations Development Fund for Women (UNIFEM) East and Southeast Asia, *Women, Gender and HIV/AIDS in East and Southeast Asia* (2002).

³¹ ibid

found that men don't view sex outside marriage as being irresponsible toward their families. These men blamed HIV infection on sex workers not requiring condoms rather than recognizing their own decision not to use condoms. They expressed concern that girlfriends' previous relationships could pose a risk for them, but not a concern that they might be responsible for infecting their girlfriends or their wives.³²

Research on the dynamics of HIV risks and sexual relationships among injecting drug users found that most drug users who were intimate partners already shared needles, and therefore they assumed that they were already infected and thus did not need to use a condom.³³ These individuals felt that condom use might indicate infidelity or arouse the suspicion of their partners.

A rapid assessment of literature relevant to intimate partner transmission found only two studies specifically designed to investigate intimate partner transmission among sero-discordant (where one partner is HIV-positive) or concordant (where both are HIV-positive) couples in Viet Nam. These studies both found that in a significant number of cases, couples adopted consistent condom use after notification of a positive HIV test result.³⁴

Research exploring attitudes about extramarital relationships reveal that many married women consider infidelity among their husbands to be common, especially when they work far from home. Nevertheless, they rarely used condoms with their husbands, citing men's resistance because condoms aroused suspicions about their own behaviour and fidelity.³⁵

The frequency of condom use is influenced by the level of openness in discussing sexuality and the ability to negotiate sex. When questioned, most men and women in Viet Nam express reluctance to talk about sexuality with their partner. Men and women in one study said that it was extremely difficult to discuss sexual issues with partners.³⁶ Both men and women thought that it was the man's job to initiate any discussion on sex. In addition, women were believed to have less sexual desire and expected to know nothing about sex before marriage. A wife was expected to obey and satisfy her husband's sexual desires, to bear the problems and troubles the husband created for her, and to keep harmony in her family.³⁷

The ability to initiate discussions about sexuality and negotiate condom use again varies according to the context. Research with female sex workers found that they usually talk about sexuality with their clients but not with their husbands because it is not considered appropriate within marital relationships.³⁸ These findings suggest that communication messages in policies and programs which call for condom use for HIV prevention and protection are insufficient, because they overlook the sensitive issues of trust and communication between partners.

Government approaches toward condom use also influence men's and women's attitudes. The male condom was introduced as a contraceptive method in the 1960s, when family planning programmes began.³⁹ The Government of Viet Nam organized strong campaigns in the 1980s to promote

³² Family Health International, *Behind the pleasure: Sexual decision-making among high-risk men in urban Viet Nam* (Ha Noi, 2006): p.4.

³³ Nguyen. T.L., *Injecting drug users in Viet Nam: The dynamics of AIDS risks and sexual relationships* (Ha Noi: CIHP, 2005).

³⁴ Hoang, T. A., 2009.

³⁵ Vu, S.H. The harmony of family and the silence of women: Sexual attitudes and practise among rural married women in Northern Viet Nam, *Culture, Health and Sexuality*, Vol 10, Supplement, 163-176 (2008).

³⁶ Family Health International, *Behind the pleasure: Sexual decision-making among high-risk men in urban Viet Nam* (Ha Noi, 2006).

³⁷ Vu, S.H. The harmony of family and the silence of women: Sexual attitudes and practise among rural married women in Northern Viet Nam, *Culture, Health and Sexuality*, Vol 10, Supplement, 163-176 (2008).

³⁸ Doreen, R. and Tran, T.K.O., *Listening to female sex workers in Viet Nam: Influences on safe sex practices with clients and partners* (Ha Noi: Consultation of Investment in Health Promotion, 2006).

³⁹ San, et.al, 2002: 53.

intrauterine devices (IUD) and in the mid-1990s to promote sterilization.⁴⁰ Information and services have mostly targeted women and their physical reproductive functions, with the purpose of reducing fertility and controlling population growth.

Men are encouraged to use condoms as a contraceptive method, but the rate of use among married couples is low, about 9 per cent, as mentioned above.⁴¹ The IUD (44 per cent) and birth control pills (10 per cent) are still the most common forms of contraception among married women aged 15-49.⁴² From a family planning perspective, men hardly see the necessity of using contraceptives and discussing their needs, experiences and expectations. For them, male sexual drive and greater decision-making power is taken as a given. In addition, abortion and the IUD are completely subsidized by the Government whereas other contraceptives like condoms must be purchased.⁴³

Perceptions about condoms and sexuality are found to have a strong influence on condom use rate. Notably, the second national Survey Assessment of Vietnamese Youth (publication forthcoming) has found a positive change among young people in their attitudes toward condoms, compared with the same survey undertaken five years earlier.⁴⁴ According to the survey, 45 per cent of young men and 64 per cent of young women said that condoms reduced sexual pleasure (compared with 76 per cent of men and women in the 2004 SAVY). Nevertheless, nearly 95 per cent of young people understand that condoms help to prevent pregnancy, STIs and HIV. Only 15 per cent of females and 17 per cent of males in the latest survey thought that condoms are only for people who buy sex or are unfaithful, down from 26 per cent and 34 per cent of females and males, respectively, in the previous survey.

Gender-based violence within intimate partner relationships

The national prevalence of gender-based violence (GBV) in Viet Nam is not yet known. One study conducted in 2006 indicated that 21.2 per cent of married couples experienced at least one form of domestic violence, including verbal, emotional, physical or sexual violence.⁴⁵ Other small-scale studies estimated the rate of GBV at anywhere from 16 per cent to 37 per cent for physical violence, 19 per cent to 55 per cent for emotional violence and 6.6 per cent to 33 per cent for sexual violence.^{46, 47, 48, 49}

Gender-based violence is likely to be under-reported because victims are reluctant to talk out of fear and shame, or because their adherence to traditional values requires quiet acceptance for the sake of family harmony. Research in rural communities has confirmed that violence against women is not discussed openly and women subjected to violence keep silent and avoid seeking help in order not to reveal it. However, when it comes to prevention, members of the community studied did strongly

⁴⁰ Nguyen, M.T., Dang, N.A., Accessibility and use of contraceptives in Viet Nam, *International Family Planning Perspectives*, 28.4 (2002):218.

⁴¹ General Statistics Office (GSO) Viet Nam, *The 2008 Population Change, Labour Force and Family Planning Survey: Major findings* (Ha Noi, 2009).

⁴² GSO, 2009: table 16-17.

⁴³ Anh, H.T. et al., *Impact of Cairo POA - Women's empowerment and reproductive health in four Viet Namese communities* (Ha Noi: Consultation of Investment in Health Promotion, 2002): p.78.

⁴⁴ Viet Nam Ministry of Health, *Survey Assessment of Vietnamese Youth 2* (Ha Noi, 2009).

⁴⁵ Ministry of Culture, Sport and Tourism (MOCST), General Statistics Office, Viet Nam, and UNICEF, Institute for Family and Gender Studies, *Results of a Nationwide Survey on the Family in Viet Nam 2006* (Ha Noi, 2008).

⁴⁶ Vung, N. D., Per-Olof, O. and Gunilla K., Intimate partner violence against women in rural Viet Nam – different socio-demographic factors are associated with different forms of violence: Need for new intervention guidelines? *BMC Public Health*, 8:55 (2008).

⁴⁷ Vu, M. L., Vu, T. H, Nguyen, H. M, Clement, J., *Viet Nam Gender-based Violence*. World Bank (1999).

⁴⁸ Luke, N., Sidney R. S., Bui T. T. M., Pham V. T., Tran, H. M. Exploring Couple Attributes and Attitudes and Marital Violence in Viet Nam. *Violence Against Women* 13(1): 5-27, (2007); United Nations Population Fund (UNFPA) Viet Nam, *Gender based violence: Program review* (Ha Noi, 2007).

⁴⁹ For a detailed discussion of gender-based Violence in Viet Nam, see "Gender-based Violence Issues Paper" by Diane Gardsbane, Vu Song Ha and Kathy Taylor, United Nations Viet Nam (2010).

support messages to educate people and improve the enforcement of laws designed to protect women.⁵⁰

Global and regional studies have found links between increased rates of gender-based violence, unprotected sex and HIV infection. According to this research, sexual violence against women, including within marriage, places them at higher risk of HIV infection if the male perpetrator is infected, not only because forced sex is almost always unprotected sex, but also because violent sex can result in abrasions, which are more likely to facilitate HIV transmission. Even physical and emotional abuse, or simply the fear of abuse, put women at risk since these limit their ability to negotiate safer sex with their intimate partners. Furthermore, research indicates that women who experience sexual or physical violence are more likely to engage in risky behaviours that can lead to HIV infection, including having multiple partners, engaging in sex in exchange for money or goods, earlier sexual initiation and low rates of condom use.⁵¹

What limited evidence does exist on sexual violence suggests that it is common in Viet Nam. A survey of eight provinces and cities conducted in 2006 by the Viet Nam National Assembly's Committee of Social Affairs indicated that 30 per cent of female respondents were forced to have unwanted sex with their husbands.⁵² A review of reports on 137 calls to a domestic violence hotline found that more than half of the women calling knew that their husbands were having extramarital sex (a risk factor for HIV infection) yet callers reported that asking a husband to use a condom could lead to increased physical violence.⁵³

Sexual violence is seldom recognized when it occurs within marriage, however, due again to prevailing cultural attitudes. Some in the community simply blame women for not meeting their husband's sexual needs while others blame men's use of alcohol or drugs. Often, women simply acquiesce to their husband's demands for sex because they view it as their "duty" and maintain an outward posture of silence about abuse.⁵⁴

The high rates of intimate partner violence indicated by these studies, and the silence that surrounds it, suggest that many Vietnamese women face harm if they attempt to refuse sex, to insist on monogamy or to protect themselves from HIV infection by insisting on condom use.

Stigma and discrimination

Cultural norms regarding gender and sexuality have also increased stigma against women, sex workers, drug users, men who have sex with men and PLHIV. Several studies on HIV have confirmed that stigma and discrimination based on gender, sex, ethnicity, sexual orientation and HIV status put people in Viet Nam at risk of infection from HIV and other sexually-transmitted infections (STIs).⁵⁵ Due to the fear of stigma and discrimination, many people hesitate to seek information and services for HIV prevention, care and treatment if they know they are HIV-positive, and many also hesitate to tell their partners.

⁵⁰ Jonzon, R. et al., Violence against women in intimate relationships: Explanations and suggestions for interventions as perceived by healthcare workers, local leaders, and trusted community members in a northern district of Viet Nam, *Scandinavian Journal of Public Health* 35 (2007); 640.

⁵¹ Harvard School of Public Health, Program on International Health and Human Rights, *HIV/AIDS and Gender-Based Violence (GBV) Literature Review* (Boston: Harvard School of Public Health, 2006).

⁵² Nguyen, T.A., Nguyen T. N., Nguyen T.V., *Intimate Partner Transmission of HIV in Viet Nam - Findings from a Review of Policies, Research, Interventions, IEC/BCC Materials and a Qualitative Study in Ha Noi and Hai Phong* (2008).

⁵³ *ibid*

⁵⁴ *ibid*

⁵⁵ International Center for Research on Women (ICRW) and the Institute for Social Development Studies (ISDS), *Understanding HIV and AIDS-related stigma and discrimination in Viet Nam* (Washington D.C., 2004); Oanh, K. T. H. et.al., Improving hospital-based quality of care in Viet Nam by reducing HIV-related stigma and discrimination, *Horizons Final Report* (Washington, DC: Population Council, 2008); United Nations Office of Drugs and Crime (UNODC), Center for Social Development Studies, *Men fly to heaven, women go to hell: Findings of qualitative research in Hai Phong* (Ha Noi, 2003).

HIV-positive women, IDUs, sex workers, MSM and transgender individuals suffer from layered stigma as well due to their various identities, and women living with HIV in general experience even greater stigma. In Vietnamese culture, women are expected to devote themselves to their families; men are not under such pressure. Men who are living with HIV seem to be more easily accepted by society than women. If a man contracts HIV through drug use he is often regarded as a “victim of social evils”. However, if a woman contracts HIV, she is criticized as having violated a core moral norm of society. As evidence of this bias against women, many respondents in one study rated sex work by women as a greater “evil” than drug use by men.⁵⁶

Gender differences in the expression and experience of HIV-related stigma come sharply into focus when the experience of married couples in Viet Nam is considered. In general, cultural norms dictate that women should offer forgiveness and accept their husbands’ mistakes while husbands are almost expected to abandon their wives if they find out that their wives are HIV-positive.

Disparities in care are also common. Men living with HIV are almost always cared for by their mothers or wives but if a woman becomes HIV-positive, her in-laws may neglect or abandon her, or may force her to remain isolated from her children.⁵⁷

Such stigma and discrimination and the pressure to operate within socially acceptable norms also serve as an avenue for further transmission when couples want to have children. If one prospective parent is HIV-positive, they need to discuss the possibility of infection prior to conception and go for testing. Yet men in this situation may be reluctant to communicate with their wives about their risk behaviours and even about their HIV-positive status.⁵⁸

V. Laws, policies and programmes related to IPT

Legal and policy context: international human rights standards

The human rights principles essential to effective state responses to HIV are found in existing international instruments, such as the Universal Declaration of Human Rights, International Covenants on Economic, Social and Cultural, Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child – all of which have been ratified by Viet Nam.

Of these, CEDAW, to which Viet Nam became a signatory in 1982, is the main instrument related to IPT concerns. The UN committee reviewing CEDAW implementation among nations has consistently expressed deep concern about the spread of HIV among women.⁵⁹

⁵⁶ *ibid.*

⁵⁷ *ibid.*, p.35.

⁵⁸ Viet Nam Ministry of Health and UNICEF, *Male partner involvement in prevention of mother-to-child transmission in Viet Nam - challenges and opportunities for intervention* (Ha Noi, 2008): 7.

⁵⁹ United Nations, *Report of the Committee on the Elimination of Discrimination Against Women: Ninth Session, General Recommendation 15*, art. 12, para. 1, *Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, U.N. Doc. A/54/38/ (Part I) (1999).

STIGMA IN VIET NAM: ONE WOMAN’S PERSONAL ACCOUNT

When my son was 18 months old, I got a job in a seafood company. The company had a policy to provide workers with a health check every year, including tests for HIV. After the manager discovered I was HIV-positive, she moved me ... even though I was very good at my job. Then she told me she knew I was HIV-positive and she was worried that if my blood spilled onto the seafood they could not export it to Japan and she did not want to lose money because of me. Then without my consent she told other workers about my HIV status. They spread the gossip around and my co-workers began to avoid touching me or talking to me.

-Huyen in Asia-Pacific Network of People Living with HIV, Diamonds: Stories of Women from the Asia Pacific Network of People Living with HIV (Bangkok: APN+ and UNIFEM, 2009).

Although CEDAW does not directly address HIV, it condemns violence within marriage and sets out a broad framework for gender equality in political, economic, legal and social spheres, including within marriage and the family. Recommendations accompanying the convention call upon states to provide women with access to a full range of health care, including sexual and productive health services, and to conduct a gender analysis of the HIV epidemic. It also asks states to increase public awareness, especially among women and children, about the risks and effects of HIV.

The 2001 Declaration of Commitment of the United Nations Special Session on HIV/AIDS further includes a provision calling upon governments to advance women's human rights, to eliminate all forms of discrimination and gender-based violence, to "promote shared responsibility among men and women to ensure safe sex" and to "empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection". A subsequent political declaration by the UN in 2006 repeated these commitments and made a strong statement on ending violence against women, also noting the "importance of the role of men and boys in achieving gender equality". Although the Declaration of Commitment is not binding, all governments signed it and agreed to monitor progress toward the commitments on a bi-annual basis. As a result, there is pressure on governments to demonstrate adherence to the goals.

Gender equality laws and policies in Viet Nam

The 1992 Constitution of Viet Nam guarantees women equal rights in all spheres, including in the family, and bans discrimination against women and acts that are "damaging to women's dignity". More recently, significant improvements were made to the gender equality legal and policy framework in Viet Nam with the 2006 passage of the Law on Gender Equality and the 2007 Law on Domestic Violence Prevention and Control. The Law on Gender Equality aims to "eliminate gender discrimination" and establishes the principle of gender equality in politics, the economy, labour, education and training, science and technology, culture, information and sport, public health and the family. Article 17 of the law further specifies that "Man and woman are equal in . . . deciding on contraceptive measures, measures for safe sex and for preventing and protecting against HIV/AIDS."⁶⁰

The Domestic Violence Law does not directly address HIV risk but does provide explicit protection from violence within the family. It also covers a wider range of acts, including physical, emotional and psychological abuse, infringing on custody and visitation rights, sexual abuse including forced sex in marriage, forced marriage and divorce, property damage, "economic abuse" and forced eviction of family members.⁶¹

A set of guidelines known as the Gender Mainstreaming Guidelines on National Policy Formulation and Implementation further provide comprehensive information and approaches to gender issues. They encourage institutional change and male involvement in tackling gender inequality.⁶²

Laws and policies on HIV and AIDS

While prevention of HIV transmission in intimate partner relationships is not explicitly addressed in the 2006 Law on HIV/AIDS Prevention and Control, the issue is indirectly raised in provisions stating that people living with HIV have an obligation to inform their spouses or fiancées of their status and that spouses shall be informed of positive test results. However, subsequent guidelines clarify that in order to protect confidentiality a positive test result will not be released without the HIV-positive person's consent.⁶³

Viet Nam's National Strategy on HIV goes further, making several references to the need to raise gender awareness among educational institutions, youth and policymakers. It aims to reach 50 per

⁶⁰ Socialist Republic of Viet Nam, *The Law on Gender Equality* (Ha Noi: 2006).

⁶¹ Socialist Republic of Viet Nam, *The Law on Domestic Violence Prevention and Control* (Ha Noi: 2007).

⁶² National Committee for the Advancement of Women in Viet Nam (NCFAW), *Gender mainstreaming guidelines in national policy formulation and implementation - toward gender equality in Viet Nam through gender-responsive national policy and planning* (Ha Noi: Women's Publishing House, 2004).

⁶³ Socialist Republic of Viet Nam, *The Law on HIV/AIDS Prevention and Control* (Ha Noi: 2006).

cent of women of reproductive age with education about prevention of STIs, including HIV, an effort that could help prevent IPT.⁶⁴

However, the national strategy still does not directly address an individual's responsibility to protect his or her intimate partner, nor does it confront gender inequalities and norms that may increase women's vulnerability to infection even when women may be well informed about HIV prevention methods. An anticipated gender analysis of the National Strategy on HIV in 2010 could yield deeper understanding of the extent to which the strategy takes into account different needs and issues faced by different groups of men and women.

Elsewhere in the policy environment, materials related to prevention of mother-to-child transmission (PMTCT) in the case of pregnant women and in policies related to sex work imply prevention of IPT. These policies aim to promote women's access to HIV testing during pregnancy and safer sex among women of reproductive age, and they encourage HIV testing before marriage.

In the case of sex work, the Ordinance on Prostitution Prevention and Control stipulates that "those who buy sex with minors or who, though being aware of their HIV infection, deliberately transmit the disease to other persons shall be examined for penal liability." While gender power imbalances prevail and sexual violence within marriage is seldom recognized, it is difficult to expect women to protect themselves or to bring charges against someone who knowingly transmits the disease through unprotected sex.

Other relevant laws and policies

In the current population strategy, men are generally encouraged to share responsibilities with women in reproductive health, family planning, housework and child rearing and to create more opportunities for women to access education and training.⁶⁵ However, there is no concrete information on the practice of safer sexual behaviours among men and women, which might contribute to HIV prevention, and again this strategy fails to address gender stereotypes and unequal power relations.

In the larger reproductive health context as well, men are rarely seen as agents of change and policy approaches to men and women are influenced more by the bio-medical model of sexuality coupled with prevailing cultural norms. Men are seen as assertive and sexually active and women as passive, with a declining sexual urge after childbearing. This has only reinforced stereotypes in communication messages on population and reproductive health.⁶⁶ Moreover, despite calls for men's involvement, population and reproductive health policies still target women, as mentioned earlier. These policies call on women to protect themselves from coerced or unsafe sex and to learn and "work hard" to heighten their own position in the family and society, after which they will ultimately be able to make decisions about their reproductive life.⁶⁷

Research by Phinney (2008) indicates that two specific policies have shaped marital lives in Viet Nam: the 1986 Law on Marriage and the Family, which garnered public discussion and acknowledgment that women's identity is first and foremost grounded in being a mother, and the Happy Family Campaign, a population policy that linked the nation's efforts to modernize to couples' ability to create "happy, wealthy, harmonious, and stable families". Yet these policies make individuals dependent on the marital unit for survival in the new market economy, which renders economic stability the benchmark of a successful marriage and induces women to acquiesce in their husband's extramarital sexual activity to maintain economic and social status. They also encourage a gendered division of marital labour, which reinforces patriarchal norms. The Vietnamese "happy family" policy is determined by the success of social reproduction and economic stability, not an individual's or a couple's satisfaction.

Thus, a "happy family" and marital fidelity are ultimately defined not in terms of sexuality but in terms of economics, and these policies overlook the health and related risks that extramarital relations

⁶⁴ Socialist Republic of Viet Nam, *The National Strategy on HIV/AIDS prevention and control in Viet Nam to 2010 with a vision to 2020* (Ha Noi, 2004): 63.

⁶⁵ Ministry of Education and Training (MOET), *Population Strategy* (Ha Noi: 2000): 26.

⁶⁶ National Committee for Population and Family Planning, 2002: 89

⁶⁷ *ibid*, p. 36.

present to married couples. If a man provides for his family, he is fulfilling his familial obligations regardless of whether he is having extramarital sex. By failing to address men's responsibility for engaging in risky sex, the Government and society have allowed men to continue conceptualizing their marital fidelity in economic rather than sexual terms.⁶⁸

Therefore, although HIV programmes and policies in Viet Nam indirectly raise the issue of IPT, they do not address male responsibility to protect their intimate partners. Nor do they confront gender inequalities and norms that may increase women's vulnerability to infection as well as adequately challenge power relations between men and women in sexual relationships. Yet with the recent Law on Gender Equality and Law on Domestic Violence, the policy environment in Viet Nam has shown signs that decision makers might be ready to address IPT.

Current programmes on HIV transmission in intimate partner relationships

A rapid assessment by the research team reviewed 24 HIV interventions implemented by international and local NGOs. These programmes targeted key populations at higher risk (IDUs, FSWs, MSM) as well as their partners, PLHIV and their families, migrant workers and youth. The research team also assessed interventions at the national level through project proposals and reports available online.⁶⁹

Overall, the rapid assessment found that interventions tend to emphasize information and services for disease prevention, protection, and treatment. Given the earlier rapid escalation of HIV infection among key populations at higher risk (IDUs, FSWs, and MSM), the great majority of prevention interventions have understandably focused on strategies for self-protection.

To date, the reviewed interventions have rarely addressed individuals' responsibility to protect their intimate partners. For example, interventions for IDUs have tended to focus on harm reduction, such as needle exchange, and general condom use. However, they overlook any specific discussion about transmission to intimate partners. The interventions aimed at MSM did not recognize that some MSM have wives, meanwhile, and overlook the issue in prevention approaches. The few interventions that were aimed at FSWs did not distinguish between married and unmarried sex workers, and the one intervention aimed at male clients of FSWs addressed only their risk of sex with FSWs, not sex with their wives or intimate partners. Similarly, projects aimed at migrant workers focused on safer sexual behaviours when they were away from home rather than their sexual behaviour and how to communicate about sexual matters with their wives or husbands when they returned home.

The rapid assessment also found that interventions have in many cases reached not only key populations at higher risk but also the general population. However, most of these interventions had a single focus on promoting safer sexual behaviour without adequately tackling larger issues of sexuality, including gender power imbalance in sexual relationships, communication about sex or strategies for negotiating safer sex. Nor did programmes prioritize addressing gender inequality issues that affect sexual behaviour, such as gender-based violence or economic dependency.

Notably, the rapid assessment found that interventions aimed at PLHIV and their families often do address wives or long-term partners as groups susceptible to HIV infection. Yet they again tended to promote safer sexual behaviour only without raising larger issues such as barriers in sexual communication and gender inequity between husbands and wives. In addition, most projects targeted women only and failed to involve men, thus placing more responsibility for protection on women.

Most messages communicated through HIV programmes targeted at young people also encouraged them to "say no" to sex and warned them about "harmful consequences". They encouraged restraint and emphasized making "responsible decisions" for their future.⁷⁰ Nevertheless, several interventions aimed at youth did train male and female participants on their sexual and reproductive rights, including their right to protection from violence and sexual abuse. One also addressed the different cultural expectations for sexual behaviour between boys and girls. However, these did not address prevention of HIV in future marriages and did not urge testing and counselling before marriage.

⁶⁸ Phinney, 2008.

⁶⁹ Hoang, T. A. et.al., 2009.

⁷⁰ National Committee for Population and Family Planning, 2002:50.

This study also reviewed 91 pieces of material used for information, education and communication about HIV (IEC) to examine whether and how intimate partner transmission is addressed. These materials were produced either by national and provincial government departments, by Communist Party organizations working with key constituencies such as women, youth and farmers, or by non-governmental organizations.

Many of these materials targeted key populations at higher risk such as MSM and sex workers, and provided good basic information about preventing HIV transmission. Some of them also addressed the biological and gender factors that contribute to risk of infection. Most of the communication messages associated with these materials encouraged key populations at higher risk to inform their sexual partners about their HIV risks or results, though they did not necessarily address the specific risks of wives and intimate partners. In addition, there was little to suggest that IEC communicators were trained to effectively explore the complex nature of sexual relationships and imbalance in gender relations in order to facilitate behaviour change among men.

VI. Recommendations

In order to more effectively recognize and address HIV transmission in intimate partner relationships in Viet Nam, action should be taken to improve research efforts and the development and implementation of national policies and programmes, as outlined below.

A. Improve research and data related to intimate partner transmission

Several steps should be taken to strengthen the body of evidence in Viet Nam on the extent and nature of HIV transmission in intimate partner relationships:

- Ensure that Government regulations requiring that national- and provincial-level HIV prevalence data be disaggregated by sex and age are fully implemented and that official Government reports standardize the use of this disaggregated data.
- Prioritize operations and behavioural research on HIV transmission from key populations at higher risk to their intimate partners. This should include: 1) population-based studies investigating intimate partner transmission among IDUs, MSM, male and female sex workers, male clients of sex workers, male migrants and their intimate partners; 2) more qualitative studies on sexual behaviour and communication among those at higher risk of HIV and their intimate partners, exploring gender differences that affect their behaviour and communication; and 3) qualitative studies to investigate risk behaviours among pregnant women who test positive for HIV.

B. Make changes to HIV, reproductive health and gender-related laws and policies

The issue of HIV transmission in intimate partner relationships should be made more visible in Viet Nam's laws and policies. This can be accomplished through the following steps:

- Conduct a gender analysis of the national AIDS response and use the results to inform the new phase of the National HIV Strategy.
- Raise awareness of high-risk behaviours and the importance of testing and communication between partners regarding their HIV status in AIDS policies and strategies. In addition, provide all the support and counselling needed in order to encourage people living with HIV to voluntarily reveal their positive status to their female partners/wives. This in turn calls for a strategy to give greater emphasis to reducing stigma and discrimination against all PLHIV and behaviours associated with HIV infection.
- Demonstrate stronger commitment to promote positive attitudes toward widespread condom use, not only for prevention of HIV and other sexually transmitted diseases but also for family planning purposes. Behaviour change communication messages should link the use of condoms to men's greater responsibility to protect their wives and all sexual partners, and this should be coupled with strengthening women's skills for negotiating safe sex.

- Expand HIV prevention strategies to target male clients of sex workers and migrant workers, including expanding SRH and HIV services, information, and voluntary counselling and testing (VCT) to these groups.
- Prioritise the elimination of gender and sexual stereotypes in all national policies by creating stronger linkages between Viet Nam's National Strategy for Population, National Reproductive Health Strategy and National HIV Strategy. These policies should target men as well as women and should go much further to recognize the gender norms and gender power dynamics that affect sexual behaviour and communication.
- Fully implement the gender equality and domestic violence laws, including giving greater emphasis to reducing sexual violence within marriage and intimate partner relations. Implementation strategies and programmes should directly address the risk of HIV infection as a result of gender-based violence and gender inequality. Ministries charged with overseeing the implementation of gender equality, domestic violence and HIV laws should also establish coordination mechanisms.

C. Make changes in HIV programme interventions to promote greater focus on intimate partner transmission

Addressing intimate partner transmission in programmes requires the expansion of many existing HIV interventions. Recommendations include the following:

- Expand prevention programmes directed at key populations at higher HIV risk to directly address intimate partner transmission and initiate programmes directed at intimate partners who might be at greater risk in venues where they can be more easily targeted (e.g., spouses of migrant workers, spouses or partners of those detained in closed settings).
- Expand training for HIV counsellors, reproductive health workers and other health workers so that service provision is gender-sensitive and can address the issues of HIV transmission in intimate partner relationships. Such counselling should promote the open discussion of sexual relationships with their intimate partners and encourage preventive behaviour among individuals who test positive for HIV.
- Strengthen operational linkages between HIV and sexual and reproductive services, integrating family planning and reproductive health into HIV policies and vice-versa, with particular emphasis on HIV-positive couples who want to have children. All of these initiatives should target men as well as women.
- Integrate education about the risk of HIV transmission into programmes addressing violence against women, with particular emphasis on sexual coercion and violence within marriage and intimate partnerships. Such programmes should target health providers, counsellors and shelters for women victims of domestic violence as well as community groups involved in violence prevention campaigns.

VII. Conclusion

Asia has seen a major increase in the number of women living with HIV over the past decade. Most of these women were exposed to HIV while having sex with a husband or partner who had contracted HIV through unsafe drug injection, through unprotected sex with a sex worker or through unprotected sex with a male partner. Although Viet Nam has a concentrated epidemic, the male-to-female ratio of people living with HIV is decreasing. As such, HIV transmission from men to women in intimate partner relationships should be considered an important element in the national response to HIV.

Insufficient data is one of the main challenges in measuring the scope of this issue and its impact on different groups of men and women. This in turn has limited the policy and programme responses. HIV programmes and policies only indirectly raise the issue of IPT and tend to focus on strategies for self-protection with few addressing an individual's responsibility to protect their intimate partners or the sensitive issue of gender power imbalance in sexual relationships. Nor do they confront the gender inequalities and norms that may increase women's vulnerability to infection.

We strongly encourage various key stakeholders involved in the national HIV response to adopt the recommendations of this paper regarding improving research and data related to intimate partner transmission; changing HIV, reproductive health, and gender laws and policies to better address IPT; and changing HIV programme interventions to promote greater focus on IPT and the particular risks that women face.

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