



## HIV/AIDS in Vietnam: A Gender Analysis

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### Abstract

Global statistics of HIV/AIDS infection reveals the disastrous effects of discrimination against women in the area of human health. Women's vulnerability to HIV/AIDS reflects their wider social, economic and sexual disadvantages compared to their male counterpart. Although the gender context of HIV/AIDS has received a considerable attention recently, however, in case of Vietnam gender aspects of the epidemic have still been a neglected area of research. Little is known about how gender affects the epidemic as well as how the epidemic affects the life of women. This paper reveals that the gender context of HIV/AIDS epidemic in Vietnam has a much complex reality. Institutions, social norms and opportunity structures, of which "Doi Moi" [Renovation] has become an integral part, combine to create new norms and conditions put women more vulnerable to HIV/AIDS. A gendered strategy is crucial in order to successfully fight against the growing HIV/AIDS epidemic.

**Keywords:** Vietnam, HIV/AIDS, Gender, Gender Analysis, Institution, Opportunity Factor

### 1. Introduction

Despite much effort, HIV/AIDS epidemic continues to grow in many parts of the world, threatening developmental process. On a global scale, a total of 30 million HIV/AIDS cases were documented in 1997 (Cohen 1998, p.1) and by the year 2005, an estimated 40.3 million "people living with HIV/AIDS" (PLWHA), close to 5 million of them have been newly infected and 3.1 million died from AIDS within that year, pervading every part of the world (UNAIDS & WHO 2005). The UNAIDS projections reveal an upward future trend, with about 14,000 newly-infected cases everyday, 95% of which ravage poor and developing countries (Swiss Centre for International Health 2005). A rising huge number of HIV/AIDS carriers are challenging the humanity to combat it.

Almost as many women as men are now suffering and dying of HIV/AIDS, and the infection mechanism of this epidemic is increasingly becoming a gendered one. HIV/AIDS epidemic was largely prevalent among men in most nations in its earlier stages, but now it has a women's face as mostly women are bearing the brunt of the epidemic and they make up almost half of the HIV/AIDS infected population globally (WHO 2003; UNAIDS 2004, p.3). Ample evidence suggests that populations most affected by HIV/AIDS are those who have been socially and/or economically marginalized by income, employment, education, culture, power, gender and other socio-economic aspects (Commonwealth Secretariat 2002, p.4). Inequalities as a consequence of this marginalization put more people at risk of infection, isolation and bearing heavy responsibilities for caring for themselves and others which ultimately result in early death. HIV/AIDS, thus, is evidently a disease which could ravage every aspect of people's lives, from the most private to the most public sphere, affecting both human health and process of societal development.

The importance of the interaction between gender, poverty and health has been acknowledged during the last decade, but

has still only been recognised in research and policy making to a limited extent (Vlassoff & Bonilla 1994, p.26). Research on gender aspects of HIV/AIDS has so far also been limited and little is known about how gender factors affects the epidemic as well as how the epidemic affects the life of women in Vietnam. This paper brings forward the significant publications relating to HIV/AIDS in Vietnam published during 1994-2006 to provide a gender analysis and illuminates areas where gender and related factors have an impact on the epidemic as well as where the epidemic does so on the life of women.

## **2. Prevalence of HIV/AIDS in Vietnam**

HIV/AIDS epidemic in Vietnam so far gives a pessimistic picture with a rapidly growing number of infections and deaths over past decades, despite certain intervention efforts. Since the first case reported in 1990 (McNally 2002, p.1), each subsequent year saw about 1,500 new cases, spreading to all 61 provinces of Vietnam within nine years, bringing the total to a cumulative 76,180 PLWHA by the end of year 2003 (Hien et al. 2004, p.141). However, an actual cumulative number was estimated to soar to 160,000 cases (Policy Project Vietnam 2003). By the end of 2003 there were 11,659 AIDS cases and 6,635 AIDS-related deaths (Hien et al. 2004, p.143). Young adults at working age of 20-39 years have been the biggest group of victims, most of whom are found among sex workers and injecting drug users (IDUs), occupying 21.6% (Agence France-Presse 2001) and 32% (Hien et al. 2004, p.137), respectively. While HIV infection among IDUs dominantly ravages men, that among sex workers is found mainly in women, implying a gender disparity in HIV/AIDS rate among these groups. Although HIV is originally prevailing among males, it is ever-increasing among females. Rather, HIV rate among female sex workers rose from 2.8% in 1998 to 21.6% in 2001 (Agence France-Presse 2001). The number of women suffering from HIV was from below 50,000 cases in 2001 but rapidly increased nearly to 100,000 cases by 2005 (Hien et al, 2004, p.143). The above disturbing picture of HIV/AIDS in Vietnam, thus, should be regarded as an issue with utmost concern.

## **3. Institution, gender and HIV/AIDS**

In Vietnam, a paradox exists within the current institutional system which has been putting several marginalised groups such as female sex workers and drug injecting users more vulnerable to HIV/AIDS infection. The legal policies see sex work and drug abuse as “social evils”, the behavioural acts which have long been regarded as a degradation of morality, a threat to both familial traditions (Tung et al. 2000; Rekart 2001, p.48). As it is viewed as a “social evil”, its solutions generated pay much concern about fighting against such “social evils”, whilst prevention and care services have not received enough attention and focus. Police are actively mobilised to capture IDUs and female sex workers when finding these groups injecting drugs or having sex with clients, and then confine them in rehabilitation centres (Markus & Liselotte 2001). This heightens the vulnerabilities of these groups to risky behaviours, because they must carry out these risky behaviours quickly before being discovered by police (Hien et al. 2004, p.149). For those groups with injecting drug, pressure to inject rapidly before being observed by police means they pay less attention to cleaning injection equipment, thereby sharing needles. Paradoxically, a number of men working as police who themselves perform their task of arresting IDUs and female sex workers are clients of these female sex workers (Tung et al. 2000; Rekart 2001, p.49). It appears that the vulnerability of these groups to HIV/AIDS infection could not be reduced, despite the introduction of legal institutions.

## **4. Culture, gender and HIV/AIDS**

According to Eckersley (2001, p.69), a variation in culture can amplify and/or moderate social determinants of health. In Vietnam, some cultural norms and stigma as well as unequal power and bargaining position women, especially among those working as sex workers are making them socially vulnerable to HIV/AIDS transmission. Like in many other developing countries, gender discrimination, repressive culture norms and power disparity in a contemporary Vietnamese society has led to marginalisation of groups like IDUs and female sex workers. At community level, female sex workers, IDUs and PLWHA in Vietnam are frequently stigmatised and socially excluded (Rekart., 2001, p.48; McNally 2002, p.7), since they are construed as social evils. Sex workers and HIV/AIDS carriers are socially seen as violating human morality and destroying familial traditions. They are challenged by a phenomenon of victim blaming, since their behaviors are thought as responsible for disease they suffer. At both levels – community and household, women working as sex workers are labelled as “not virgin”, and are challenged to lead a happy life. Most men expect to marry much younger girls who are “virgins”, while it is socially acceptable for men to have extra and multiple sex partners both before marriage and during spousal life (Rekart 2001, p.49). But, community has not recognized that accepting multiple partner relationships for men is a gender norm that increases women’s vulnerability to HIV infection, since men are risky to be infected by HIV when having sex with numerous partners outside their home, and spread HIV to their wives. The gender inequalities have direct impact on the rise of men’s extramarital sex and married women’s risk of HIV infection (Werner & Belanger 2002). Women sex workers try to hide their prostitution status as otherwise they would not be able to get married. However, women’s prostitution status, if known by their husbands after marriage, could threaten a familial breakdown. Their survival would be more difficult if they suffered from HIV/AIDS and subsequently considered being unacceptable or denied to stay home by their husbands. At community level, since they fear being arrested by police and stigmatised by their families and friends, sex workers tried to stay “invisible” and “out of reach”. Consequently, sex workers and PLWHA have been discouraged from seeking and accessing HIV/AIDS prevention and treatment services. Further, as gender norms rooted in the family, women are often expected to carry out reproductive roles like domestic care while men mainly perform productive tasks like generating income. But, when poverty dominates their life, women conventionally take both roles, thus bearing double burden and having limited time to

access health services. Once women suffer from HIV/AIDS, they face triple jeopardy – dismissed by their husbands, unaccepted by community, and discouraged from accessing health care. As such, in both groups of women – female sex workers and women living with HIV/AIDS, familial and social vulnerabilities heighten the risks of HIV/AIDS infection for female cohort, and reduce survival opportunities for women with HIV/AIDS.

The Vietnamese context also implies a gender inequality in bargaining powers both within and beyond family between men and women. Women frequently keep silent, not able to negotiate safer sex and powerless to ensure safety for their survival (McNally 2002, p.135; UNAIDS 2004). They fear losing their clients when trying to negotiate with clients to use condoms, since it is men who make decisions on safe sex or on types of sexual relations - mostly unsafe sex. Since women are voiceless and less powered to bargain sex behaviors, they become submissive to follow decisions of men in community and of their husbands at their home. When women try to persuade clients to use condoms, they may risk losing the opportunity of earning income. More formidably, some women sex workers are forced to inject drugs by brothel owners or mediators so they can be easily exploited and controlled (UN 2001, p.53). Ironically, when sex workers are found as HIV/AIDS-positive, brothel owners would dismiss them, depriving them of their livelihood (UNAIDS 2004). In that case, women living with HIV/AIDS may face “double jeopardy” because of discrimination regarding gender and health. Therefore, lack of bargaining power makes it more difficult for women sex workers to avoid risk behaviours of HIV/AIDS infection.

## 5. Opportunity factors, gender and HIV/AIDS

### 5.1 Macro opportunity factors

There has been a wide assertion among research community that the spread of HIV/AIDS in Vietnam is related with *Doi Moi* (Reform policy). The presence of gendered disparities, socio-economic and cultural change, which are part of *Doi Moi*, combine to transform old sexual desires and create new ones to produce a situation in which some married men’s extramarital relations are no longer considered entirely socially unacceptable (Phinney 2003, pp.220-230).

In 1986, the Vietnamese government transformed the Vietnamese economy from a centrally planned economy to a market economy with a socialist direction. In addition to transforming its agricultural based cooperatives in favor of household production, the state removed most welfare subsidies (Craig 2002), closed state factories in favor of promoting private enterprise, enabled the expansion of export markets, and loosened restrictions on domestic and foreign migration. *Doi Moi* policies have had the most impact on urban areas and their surroundings. Changes have had a profound influence on reshaping sexual norms and created an emergence of social stratification, gender disparities and the commercialization of women’s bodies (Mangat 2003).

Although more women have access to economic opportunities and politically empowered than before *Doi Moi*, there has been a significant increase in gender disparities. Because of the poverty, many young women from rural areas have left their homes to seek employment in the sex industry (Hong et al. 2000, p.179; Thuy et al. 2000, p.67). The consequence of this has led to a dramatic increase in both the number of sex workers (Phinney 2006) and the number of men clients frequenting the latter groups due to men’s leisure and changing norms and attitudes toward sexuality and sexual relations (Ha 2002). It is with *Doi Moi* that a series of social, cultural and economic changes have intertwined to create a set of opportunity factors that promote men’s access to extramarital sex in specific ways. Opportunity factors here mean the political and socio-economic conditions that enable a behavior to occur and become common or normalized. The extramarital opportunity factors that have contributed not only to the rise in men’s extramarital sex as part of the process of *Doi Moi*, but also have increased married women’s risk of HIV include the commodification of sexuality, the prevailing presence of modern masculinities and transformed male prestige desires. Together these have made extramarital sex a widespread urban phenomenon that must be understood as a product of a changed social organization and political economy.

### 5.2 Micro opportunity factors

Micro opportunity factors favoring men’s sexual practice both before and beyond marriage have been attributed to four key factors namely drinking alcohol, financial status, peer pressure, and ability to refuse commercial sex (FHI, 2006, pp.1-2). According to Family Health International (FHI 2006, pp.1-2), 100% of the young men surveyed reported that alcohol plays a significant role in heightening sexual desire and lowering the ability to control oneself (respondents said that 90% of the time they visited female sex workers, the evening began with drinking alcohol). Education and money play no role in whether or not a man purchases commercial sex. Respondents came from all socio-economic backgrounds. Education ranged from primary school to university. Nearly all working class respondents and day construction laborers in particular, said money does not influence whether or not one goes for commercial sex. Rather, money influences only what type of sex and what level of sex worker one can afford and the frequency of visiting female sex workers. Laborers mentioned that if they have little money, they would pool funds to buy service from sex workers. Pressure from business ties is also another factor that drives men buying sex. Men might refuse to go with friends, but never refuse to go with a boss or business partner, since defectors risk not receiving future invitations, job promotions or business deals.

It is therefore important to note that opportunity structures and social norms in favour of men enable them to engage in numerous extramarital and multiple sex which put them more risky to HIV/AIDS infection, and consequently put women in general and married women in particular vulnerable to HIV/AIDS transmission. Men can be seen as a bridging group

between women, their wives and their lovers in HIV/AIDS transmission.

## 6. Social consequences of HIV/AIDS on women

The impacts of HIV/AIDS in Vietnam are multilevel and multidimensional. In the family sphere, since women are expected to fulfill all productive, reproductive, and community task, their burden is triple, especially when their family members suffer from HIV/AIDS. Most (74%) of women in Vietnam took the bulk of care giving to their family members with HIV/AIDS (UNDP 2004). For women suffering HIV/AIDS, their burden is multiplied, as they shoulder both disease burden and familial and social tasks. They have the added pressure of being ill themselves and having to provide care for their husband, family members, and/or sick child (Tallis 2002). For a woman living with HIV, such an increase in workload often means that she does not have time to adequately care for herself as well as attend to her own needs. In this case, they face “time poverty” which potentially affects their health. The opportunistic infections, such as tuberculosis and pneumonia also heighten their disease burden and death risk. Families whose members suffering HIV/AIDS are more likely to be poor, since their household earnings decline and medical expenses increase (Policy Project Vietnam 2003). In 2004, about 126,000 Vietnamese people who have either become newly poor or fell deeper into poverty trap because of HIV/AIDS, and this trend continues to increase over time (UNDP 2004). For women-headed households or families with both parents with HIV/AIDS, their poverty burden would be multiplied, because of loss of their work. Around 50% of HIV carriers working reported losing their job as a result of HIV status known (UNDP 2004). Poverty and disease multitude apparently become a tremendous challenge facing them.

In communities where stigma and discrimination prevail, both female sex workers and PLWHA, and, even their family members face such multiple disadvantages as stress, social isolation and unemployment. Only one-third of PLWHA are accepted by their communities, and stigma is a significant barrier to their participation in supportive groups (Policy Project Vietnam 2003). Fifty percent of non-HIV/AIDS workers did not want a relationship with an infected worker and believed that the infected workers must be responsible for their own sin behavior (Global Nomads Group 2003). The impacts of HIV/AIDS affect not just adults, but children and youth. They are required to stay home or stop their education to care for AIDS-infected family members (Policy Project Vietnam 2003). There are about 22,000 orphaned children in Vietnam as a consequence of their parents died from AIDS. Once orphaned children become the heads of households at a very early age, it adversely affects their behavioural development and future opportunities. The situation is worse for female children.

The social and economic burden at national level is believed to be heavy when women get HIV/AIDS, since women are socially convened as both the important work force of the society and the main party to perform reproductive tasks at their home— childbearing and family caring. Their absenteeism and costs of replacing workers with HIV/AIDS would reduce economic productivity of both public and private workplaces (Policy Project Vietnam 2003). The deaths from HIV/AIDS among women also add to the loss of labour force of the nation. Huge costs for HIV prevention and AIDS care for both male and female cohorts are also a remarkable barrier to the social development.

## 7. Conclusion

The gender analysis provides a lens to reflect a dynamic and complex picture of HIV/AIDS epidemic in Vietnam. Poverty, gender, institutions, cultural norms, and opportunity structures are not only persuasive explanatory factors for, but a good reflection of the consequences of this epidemic. This review will hopefully lead to an increased awareness of how gender and related factors affects the epidemic as well as how the epidemic affects the life of women in Vietnam. In searching for responses to the epidemic, Vietnam needs to take a gendered strategy into account which could address such several emerging gender issues as gender inequalities (in power, bargaining position, rights), and other gender-related factors favoring men (institutions, cultural norms, and opportunity structures). Such a strategy should stand high on a scientific research or policy analysis agenda in order to inform gendered responses. It calls for the effort of the whole society - Vietnamese government and community to make this strategy become possible in reality. Given the recent progress in socioeconomic achievement and a gendered initiative suggested, Vietnam has still substantial opportunities to prevent the spread of HIV/AIDS, depending on its commitment, determination, and effort.

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