



Engaging HIV positive ethnic minority mothers in Vietnam

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Modern medical institutionalised birthing facility, with stirrups and sterilised medical equipment.

Maternal and child health (MCH) services are critical for prevention of mother-to-child transmission (PMTCT). Throughout Vietnam, HIV-positive pregnant women and mothers are increasingly using these services to access HIV care and treatment for themselves and their children. But while ethnic-majority Kinh women use such services frequently, use of MCH services among Vietnam's 53 ethnic minority groups is low (UNFPA 2007).

The result is maternal mortality four times higher among minorities than among the Kinh. Minority women's poor use of antenatal care (ANC) and delivery services is often blamed on low education, geographical isolation, household income, or adherence to 'traditional customs', with little effort made to understand possible reasons behind low usage, including

minority ethnic groups' dissatisfaction with the services.

Most Vietnamese HIV-positive pregnant women and mothers are partners of intravenous heroin users who discovered after marriage that their husbands used drugs (Oosterhoff 2008, Socialist republic of Vietnam, 2010). As most ethnic groups

in Vietnam expect women to get pregnant within a year of marriage, recently-married women cannot use condoms, hence at higher risk of HIV infection.

Vietnam's fastest-growing HIV epidemic is in Dien Bien, a mountainous province bordering Laos, near the famous "golden triangle" of the heroin industry (Cao Kim Thoa 2010). Black Thai ethnic minorities — a subgroup of the Thai (or Tai) people of mainland Southeast Asia and southern China — are the dominant population.

Intravenous drug use (IDU) increase coincides with Vietnam's introduction of the "Doi Moi" (modernisation) policy, marking a transition from a communist to a



market economy. The resulting cross-border trade included heroin export from Laos to Vietnam and China, creating large numbers of IDUs along the trade routes. Harm reduction programmes were not available when heroin started coming in, hence most HIV-infected people are young men who inject drugs (Rapin et al. 2005).

The action research described here was part of the scaling up of a successful mother-focused PMTCT programme based around a support group for HIV-positive mothers, the Sunflowers (Le Thi Huong and Morch-Binnema 2008). The initial groups launched by a Dutch international NGO in 2004, comprised ethnic-majority Kinh women, mainly in urban areas. They were linked to a range of governmental medical, social, legal and economic services. However, reaching ethnic-minority women in rural areas was a challenge.

Dien Bien had established infrastructure for ART, with trained and motivated staff, supported by international programmes such as the United States President's Emergency Plan for AIDS Relief (Pepfar) and the Global Fund. But members of the local HIV-positive support group were mainly male IDUs, whose female partners were hiding and dying alone.

The scaling up initiative supported HIV-positive mothers and authorities in starting Sunflower support groups, and linking members to treatment and services. The research sought to learn how state services could meet the needs of HIV-positive ethnic minority mothers and pregnant women in PMTCT programmes.

Study methods

Participatory observation was used, with additional qualitative and quantitative data collection in October 2009, in three villages of Dien Bien. HIV prevalence among IDUs in the area is a high 57.5 per cent.

A team of five Vietnamese researchers and an international specialist did the study in two weeks. Selected villages are roughly comparable in terms of geographical access to key local PMTCT health services. Focus group discussions (FGDs) were held separately with men and women of mixed ages.

In-depth one-on-one interviews were held with 92 women of reproductive age (15-49 years). Additional one-on-one interviews



Traditional Black Thai home birthing environment, near the fire and with use of a hung cloth.

were held with 10 Sunflower support group members in Muong Ang Town (eight Thai and two Kinh women) to gain insight into the background experiences and situation of HIV positive women and their families. In-depth interviews were also carried out with health staff at the commune and district level (ANC, delivery and VCT). The Provincial AIDS Committee (PAC) and local health staff supported the activities.

IDU epidemic and decline of protective premarital arrangements

Almost half of the women reported that at least one male family member was using or had used heroin. Respondents reported that from the late 1990s, a shift occurred from traditional opium use, largely by older men, to injection of heroin among younger men. A quarter of the respondents said a male family member had died from heroin use, resulting in marital separation, financial

stress on families and stealing within communities.

Due to the government's *Doi Moi* policies that promote patrilocal and patrilinear cultural norms of the Kinhs, the study found a decline of the traditional Black Thai practice of temporary matrilocality¹ (*Zu kuay*).

Zu kuay (literally 'in-law staying') is a premarital arrangement among Black Thai. After engagement (*pay vay*) there is a 'small marriage' (*xu noi*) after which the groom moves to live with his wife and parents-in-law, to work for them and prove his suitability before the 'big marriage' (*xu o*). Traditionally, *zu kuay* lasted several years, enabling women to avoid risks associated with hasty marriages, such as marrying IDUs.

Zu kuay declined during *Doi Moi*, partly due to the decollectivation of land as



part of the market transition. Extended multigenerational households working common lands were discouraged. Truck drivers and construction workers — kingpins of the market economy — could now pay their future brides' families in cash rather than in labour, thus avoiding *kuay*. Increasing drug use and decreasing traditional cultural protection made some Thai women vulnerable to marriages with HIV-positive IDUs (Oosterhoff, White and NguyenThi Huong 2011).

Low HIV awareness

Awareness of modes of HIV transmission was low, with less than a third of respondents aware that HIV could be spread through sex. Only one-sixth knew that needle-sharing could transmit HIV, and less than five per cent knew about mother-to-child transmission. None of the respondents who reported that their husband was a drug user ever used a condom with him. Condoms are freely available at family planning programmes and target married women. They are expected to have sex until they have produced the state promoted maximum two children. Unmarried women are not supposed to have sex. Less than a fifth of all respondents had ever been tested for HIV.

Low ANC attendance and HIV testing

Over half of the women in the study did not attend ANC during their most recent pregnancy. "Remoteness" cannot be the only reason why minority women are not attending services, because even in remote communities, there are often commune health centres within a few kilometres. Women who attended ANC for the recommended three times or more went to the commune health centre, where HIV tests are unavailable. Only a third of the women who went for ANC at provincial or district level, where HIV tests should have been offered, had the test done.

Since 2003, HIV testing has been mandatory for all operations, including delivery. The most common reason for low or non-ANC attendance was that the respondent felt the pregnancy was 'normal', or 'going well', meaning, they were not aware of the important preventive role of ANC.

Avoiding institutionalised deliveries

Most women delivered at home. Almost a quarter of those interviewed reported attending ANC three times or more during

their last pregnancy, yet delivering at home. Homebirth was described as a cultural norm that assured women of support from relatives and husbands.

Most women who delivered at home reported that this was because their labour and delivery was easy. No reference was made to health services being too "remote". A traditional practitioner attended 24 out of 79 homebirths. Only three were attended by health staff.

Dien Bien has a large and well-known Secondary Medical School that provides formal medical training to nurses, midwives and doctors' assistants. Few traditional practitioners from ethnic minority groups are able to attend the school due to the (Vietnamese) language and formal education requirements for joining.

Thai women traditionally deliver in a standing position, which is not allowed at medical facilities. Trained midwives were sympathetic to the Thai technique from the woman's perspective, as it allows them to move about and helps them to push down. However, it makes it difficult for health practitioners to support the baby as it emerges. That family members are not allowed to attend deliveries at health facilities might also deter women from using them.

HIV-positive pregnancies

None of the HIV-positive mothers in the support group had received ARV prophylaxis at district level. However, new HIV-positive mothers in the group and their children who needed ART managed to access it within three months. Almost all women reported stigma and discrimination because of their HIV status and their relationship with a drug user.

After joining the group, women reported a wide variety of positive health, social and psychological changes, such as gaining weight, ability to sleep and to share feelings

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and fears and feel friendship. When they learned about PMTCT, some members became active supporters of improved HIV testing for pregnant women, and in community outreach.

Health staff were encouraged by the good results and found it helpful to have a group attached to their services with members who spoke Thai and other minority languages and who could translate and communicate information on topics such as adherence. As a result, membership tripled in less than a year.

Use of research findings

The preliminary findings of the study were presented to HIV-positive support group members and health authorities for feedback. All agreed on the scope of the current and future IDU and HIV problems for women and their partners. Although PAC and its partners run a testing campaign targeting all pregnant women through the commune health centre in 2008, none of the women who agreed to be tested were HIV-positive. Clearly, the campaign had not reached the intimate partners of IDUs.

The maternal and reproductive health team had quarterly outreach meetings for all pregnant women, reaching hundreds of women. However, testing was not offered because the HIV tests were managed by the AIDS centres. HIV and AIDS authorities assigned trained VCT staff to the ANC outreach teams in the villages to work with Sunflower members on increasing the uptake of HIV tests. Sunflower members informed pregnant women on PMTCT, testing and about support for HIV positive women to live positively. This integrated, mobile approach seemed to bear fruit. In the first month of this campaign, more HIV-positive women were detected and referred than in the whole previous year.



Discussion and conclusions

Thai women in communities where male heroin use is prevalent and where traditional protective customs are declining are highly vulnerable to HIV. Their vulnerability is compounded by extremely low levels of awareness on HIV transmission and prevention. Poor use of ANC services at district and provincial level hampers access to HIV testing for pregnant Thai women, since HIV testing is not offered as part of ANC at commune level.

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State services could meet the needs of all Black Thai mothers and pregnant women, including those who are HIV positive, more readily, if maternal health services were more relevant and acceptable to them. The medicalised environments offered at Vietnamese state facilities are strikingly different from minority homebirth settings. The National Standard Guidelines on Reproductive Health define the delivery position as 'lying on the back' (MOH 2009), making supine delivery standard practice.

The insistence on a medicalised approach to delivery and the prohibition of husbands and relatives in delivery rooms are unlikely to be attractive to Black Thai women and their families. The upright and squatting delivery positions that Black Thai and some minorities such as the Hmong do have clinical advantages with no adverse effects on the newborn, and are increasingly offered within state maternal health services in some western countries.

In Vietnam's secondary medical training schools, where midwives and village health workers are trained, these delivery techniques are not offered even when students are expected to work in minority areas later. Offering students a range of delivery techniques that are available in Vietnam could help ethnic minority women and even the Kinh, by giving women more safe delivery options.

Awareness of modes of HIV transmission was low, with less than a third of respondents aware that HIV could be spread through sex.

Lack of husbands' involvement in delivery (and later in childcare) is a well known complaint among Kinh women: they would welcome having at least the option of having the moral support of their spouse. Ethnic minority women have less access to formal education than the Kinh, and are as a result less eligible for training at secondary medical schools even if they are the ones attending birth.

ANC could also improve by increasingly adopting technology, i.e. HIV testing but offered with counselling in local language and in villages by a mobile team that includes HIV positive mothers to demonstrate positive living. The cultural capital of these HIV-positive mothers and their experiences living with HIV and addiction are key assets in slowing one of the fastest-growing HIV epidemics in Asia.

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