Faculty of Natural Resources and Agricultural Sciences
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From peasant society to manufacturing society;
How change aggravates HIV and AIDS among youth in Vietnam

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Abstract

Since the early 1990's when the first cases of HIV were found in Vietnam, the number of people infected with HIV has been increasing. Over half of the Vietnamese population is under the age of 25 and 78.9% of the reported cases of HIV are people between the ages of 20 and 39. This thesis work has been undertaken to evaluate whether there is a need to focus more on the youth in terms of prevention within HIV and AIDS related to the move from a peasant society to a more industrialised society.

To investigate this, a literature desk study was carried out supported by key informant interviews and a small questionnaire.

It was found that specifically the HIV and AIDS law, stigma, discrimination, gender roles, and risk-behaviour of migrants and the Vietnamese youth were important factors linked with vulnerability and livelihood change after *doi moi*.

Although more research on a national level on the subject is needed, the findings indicate that changes have happened since *doi moi* which influences the linkages between livelihood change and HIV and AIDS vulnerability among the youth in Vietnam.

Keywords: HIV/AIDS, Vietnam, *doi moi*, vulnerability, livelihood, youth, risk-behaviour, migration, gender roles, stigma.

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
CGFED	Centre for Gender, Family and Environment in Development
CIHP	Consultation of Investment in Health Promotion
CPCD	Center for Partnership in Community Development
EDK	Embassy of Denmark
FAO	Food and Agriculture Organization
GDP	Gross Domestic Product
GNI	Gross National Income
GSO	General Statistical Office
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IOM	International Organization for Migration
IRRI	International Rice Research Institute
NGO	Non-governmental organization
PRB	Population Reference Bureau
STI	Sexually Transmitted Infection
SOE	State owned enterprises
UN	The United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	The United Nations Development Programme
UNICEF	The United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VSO	Voluntary Service Overseas
WHO	The World Health Organization

1. Introduction

Gorbach et al. (2002) has analysed the impact of changing into a market-driven economy in terms of emerging HIV epidemics in Russia, China, and Vietnam. Their argument is that the reform Vietnam initiated in 1986, which was a great step in moving from a peasant society to a more industrialised society, created great economic growth for Vietnam as a whole. But at the same time the economic growth also created greater gaps between rich and poor, changes in the cultural environment, restructuring of the health system, and increased migration as new opportunities arose in country. These changes are then argued to be factors influencing the HIV epidemic (Gorbach et al. 2002). This can be linked with the statements from Dahlgren & Whitehead (2006) on the importance of the linkages between poverty and poor health, which can turn into a vicious circle where vulnerability increases with diseases and influences poverty and so forth.

This can also be seen in the statistics of HIV infected as since the early 1990's when the first cases of HIV were found in Vietnam; the number of people infected with HIV has been increasing. Also although the registered number of people living with HIV is greatest in urban areas, a rise in the numbers of people living with HIV can also be seen in rural areas (WHO 2008).

Thao et al. (2006) states that of all the HIV infected the percentage of people who are below 30 years old increased from 16% to 69% in the years from 1995 to 2004. So although the epidemic in Vietnam is currently considered to be concentrated among drug users and sex workers it is interesting to investigate if the Vietnamese youth will play a greater role in the HIV and AIDS epidemic in the future (UNAIDS 2008, PRB 2006, Khuat et al. 2004).

This thesis work has therefore been undertaken to evaluate whether there is a need to focus more on the youth in terms of prevention within HIV and AIDS related to the move from a peasant society to a more industrialised society.

Changes following the reform in 1986 discussed in this thesis include current socio-economic conditions in terms of migration, the financial crisis, stigma and discrimination, and gender roles together with current political situation in terms of the HIV & AIDS laws and policies and access to services. These were the most frequently mentioned factors found when doing the literature search and the key-informant interviews related to changes in livelihood and vulnerability since the reform and were therefore selected.

The target groups of this thesis are actors responsible for, or involved in, formulating the strategies, laws, and actions plans relating to HIV and AIDS prevention and control, as these influences from central to local level.

2. Background on Vietnam

2.1 Move from peasant society to manufacturing society

2.1.1 Vietnam the peasant society (→ 1975)

Until 1945, where the Democratic Republic of Viet Nam was founded, agricultural production was mainly controlled by those owning the land, including the French plantation owners and indigenous landlords, comprising only a small part of the population. In the following years steps were taken to distribute the land which previously belonged to the French, culminating in a large land reform in 1954. With the reform came also policies promoting agriculture especially benefitting the peasants, including land ownership guarantee, promotion of cooperatives and mutual aid, and permission for people to engage freely in work. These policies meant that the peasants now had more incentive to be effective in their work which improved growth rates and development, with a doubling of food production from 1939 to 1959 (Boothroyd & Pham 2000).

Despite that the change into production through cooperatives meant a food output decline from 1959 to 1960 of more than 1 million tons, policy, organisational and ideological efforts, and investments still promoted this way of production. This meant that the number of peasant households having joined cooperatives in the North were more than 90% by 1965. A few years later, 95% of the farmland belonged to cooperatives, but only produced 30-40% of the total income of the cooperative members, while the remaining 5% belonged to the members themselves, but making up 60-70% of their total income. This also concurred with the decline in production of the cooperatives which happened throughout the Vietnam War. Around the end of the war in 1975 agriculture accounted for about 50% of GDP (Boothroyd & Pham 2000).

Employment at this time was mostly related to the state, whether in government offices, state owned businesses or cooperatives. Few were fired and since the government subsidised losses in these institutions and enterprises focus was not on productivity and competence of the worker (Nguyen 2002).

2.1.2 The end of the Vietnam War (1975 - 1986)

After the end of the Vietnam War a five-year plan was initiated in the North, reorganising the cooperatives from village to commune based sizes. But the larger scale did not increase production; rather it stagnated while there at the same time was a rapid increase in the population. Although land in the South until the end of the war was owned by the peasants, and the cooperatives did not seem to be

effective in the North, the same strategy was applied in the South. This rendered many objections by the peasants and never really gained a foothold, but still influenced negatively on the overall agricultural production (Boothroyd & Pham 2000). Finally realising that this was not working, key adjustments in the socioeconomic development policies were attempted, including more autonomy to the peasants. Many of the old policies and principles though still stayed in place, including agricultural subsidies and together with among other things readjustment in wages and prices, this ended in a national crisis in the mid-1980s. This was reflected in high inflation, bad living conditions, and stagnating agricultural and industrial production (Boothroyd & Pham 2000).

2.1.3 Doi moi (1986 →)

Vietnam entered a new phase in 1986 when a new policy direction was initiated to deal with the socioeconomic crisis. This period is referred to as *doi moi* meaning renovation and was the start of many institutional and policy changes. Overall, Vietnam changed towards a more market-based economy, opening up for international investments, privatising some state-owned businesses, and opening up for more democracy for the people. For the peasants the changes meant that the households again were seen as autonomous economic units and given the right to use land over a long-term period through leases. Also the comparative advantages within agriculture and general rural economy were taken into account in the different regions. This meant a shift from focussing on self-sufficiency to commodity production. State investments in terms of direct agricultural investments and indirect investments through credit banks were made, just as produce was no longer sold to the state at a fixed price, but regulated by free negotiations or the free market (Boothroyd & Pham 2000 and Nguyen 2002).

These changes meant an increase in productivity and output and thereby increased food security, just as social and cultural aspects changed. Due to the state of rural development before *doi moi*, it was though argued that Vietnam was many years behind other countries in the region (Boothroyd & Pham 2000).

Vietnam at present

Today Vietnam has an estimated population of 87,096,000 people (2008 estimate by United Nations Population Division 2009) of which 77% live in rural areas. Of these 70% generate their income from agriculture which corresponds to more than 47 million people. This means that still more than half of the Vietnamese population makes a living within agriculture (Embassy of Denmark 2008). A survey from 2006

estimated that 21.5% of the Vietnamese population lives below the international poverty line on $1.25 per day and a total of 48.4% live below $2 per day (The World Bank 2008a). These numbers though are decreasing, indicating overall increases in income in Vietnam (ADB 2008).

Although Vietnam has long had a family policy limiting the number of children allowed per family this is not implemented in many rural areas and the increasing Vietnamese population impact on availability of arable land to sustain a livelihood. Also underemployment in rural areas is high with estimates from 1994 at about 30% of the local work force being underemployed. This makes it even harder for the rising population to make a living in these areas and thereby increases both seasonal and permanent migration. In addition, it is estimated that although Vietnam will see an increasing ratio of people in urban areas, the actual number of people in rural areas will still increase (Boothroyd & Pham 2000).

Productivity within agriculture, forestry, and fishery in Vietnam has increased much over the years, but in terms of the share of GDP it decreased from 38.7% in 1990 to 20.89% in 2005. In addition, statistics from 1994 showed that rural households still earned the main part of their income (74.5%) from these activities (Boothroyd & Pham 2000 and Consulate General of Vietnam in San Francisco 2008).

Table 1 shows the development of the Vietnamese society in terms of people employed in the different sectors with employment in agriculture falling since 2000 while the industry and service sector have seen a rise.

Table 1: Structure of the employed population in Vietnam as of 1 July 2007 (%)

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**[4]	**Δ 2000 – 2006**
Agriculture[1]	65.09	63.46	61.91	60.25	58.75	57.10	55.37	53.90	-14.9
Industry[2]	13.11	14.40	15.40	16.44	17.35	18.20	19.23	19.98	46.7
Service[3]	21.80	22.14	22.69	23.31	23.90	24.70	25.40	26.12	16.5

1) includes hunting, forestry, and fishing 2) includes mining and quarrying; manufacturing; construction; and public utilities 3) includes wholesale and retail trade and hotels and restaurants; transport, storage, and communications; financing, insurance, real estate, and business services; and community, social, and personal services 4) Preliminary numbers
Based on: GSO 2009a

The main part of the agriculture in Vietnam is still considered small-scale when comparing with other Asian countries which also influence the vulnerability of Vietnamese agriculture and food security (Sustainable Development Department 1998 & IRRI 2007). Until around the 1960s, grain crops were produced on 90% of the agricultural land to help lessen food shortages. After *doi moi* focus changed for Vietnam to meet export and domestic demand. This was done through increases in multiple and intensive crops and diversification of plants (Boothroyd & Pham 2000).

Since *doi moi* the social stratification has changed, giving some the opportunities to create higher incomes through new production possibilities and working harder. A relatively large part of the population on the other hand does not experience this improvement and some even experience a worsening socioeconomic situation. There can for example be problems in terms of getting loans for poorer people, as this generates less profit for the banks and employees therefore receives relatively smaller bonuses. Incentives incorporated in policies are therefore needed to improve livelihood possibilities for the poorer population (Boothroyd & Pham 2000).

With the economic development came also better infrastructure and thereby access to heroin and knowledge about how to use it effectively; through injecting rather than smoking. This has influenced the number of injecting drug users and their risk-behaviour therefore influencing most parts of the country including transmission of HIV (Eligh 2009). Since more and more young people in Vietnam seem to use drugs, the issue of HIV and youth seem to be interlinked (Appelboom 2009).

Current economic situation

Vietnam has experienced great development, with GDP growth on 6.8% or more since 2000 and an average of 7.4% from 1990-99 (IMF 2008a). But throughout 2008 and the first of 2009 the media have been telling the story about the global economic and financial crisis and how the recession is affecting both high-income and low-income countries (World Bank 2008b). The crisis might turn into a social crisis in some countries and thereby impact on basic development. As Chan (2008) states, some countries might have to cut on things such as health and education, which are important factors in fighting HIV in many countries. This crisis links with the reform in 1986 and the move from peasant society to a more industrialised society as the effects of it would not have been as great if Vietnam had not opened up to the rest of the world.

With the influence of the financial crisis GDP growth in Vietnam in 2008 fell to 6.23% (GSO 2009b, Bo 2008). Table 2 show projections made in April 2008 and October 2008. The most resent projections give a new picture with projections for 2009 down by almost 2 percentage points to 5.5% (IMF 2008a).

Table 2: Vietnam's GDP and Inflation, including projections (Annual % Change)

	2004	**2005**	**2006**	**2007**	**2008**[1]	**2009**[1]	**2013**[1]
Real GDP Growth	7.8	8.4	8.2	8.5	7.3/6.3	7.3/5.5	8.0/7.5
Inflation	7.7	8.3	7.5	8.3	16.0/24.0	10.0/15.0	6.0/6.0

1: Projections from April 2008 and revised data from October 2008, respectively
Based on: IMF 2008a & 2008b

The Asian Development Bank (ADB) revised their target for Vietnam to be 4.5% for 2009 and projections for 2010 and 2011 from ADB and Standard Chartered Bank lie under or around 6% (VietnamPlus 2009). The Vietnamese government have lowered expectations from 6.5% to 4.8 – 5.6% for 2009 after seeing GDP at 3.1% in the first quarter of 2009 compared to last years rate on 7.5% (GSO 2009c & Folkmanis 2009). Also worrying for Vietnam is the high inflation rate with new projections from IMF for 2008 and 2009 up from 16.0% to 24% and 10.0% to 15%, respectively. This is supported by the rates for the first quarter of 2009 on 14.47% (GSO 2009c & IMF 2008a). Compared with the first quarter in 2008 imports fell 45% in the first quarter of 2009 and this indicate lowered imports from both enterprises and individuals. If excluding re-exportation of gold, exports fell 15% while Foreign Direct Investments (FDI) decreased by 40.1% compared to the first quarter of 2008 (GSO 2009c).

After *doi moi* employment is seen more as a commodity which is not a right and therefore there is more focus on productivity and skills. This also means that there is less security and thereby a heightened vulnerability. Few young people want to work for the Government, but prefer working for an international company where the work environment is more challenging, where they can obtain more work related responsibilities, and earn more money (Nguyen 2002).

Currently job losses are already being seen in larger enterprises and industrial zones and it is expected that on a national basis underemployment and unemployment in 2009 will be 7.7%. Although this might not be critical it is a significant increase from 2008 where the percentage was 4.65% (GSO 2009b & 2009c).

With the financial crisis there is a danger of the poorest loosing out as the Government will be focused on measures directly related to growth. Therefore poverty issues, diseases, and similar issues will recede into the background, but by not focusing on for example HIV and AIDS it might affect development in the longer term as HIV and AIDS increases inequality, deepens poverty, and could impact on the macroeconomic situation (Barnett & Whiteside 2002 and Cornia & Zagonari 2002). Asian Development Bank (ADB 2009) support this, stating that the economic methods the Vietnamese government can use will one way or the other, in the short term or long term affect the gains Vietnam had made within unemployment, underemployment, and poverty.

Through focus group discussions and in-depth interviews Go et al. (2002) found that economic hardship was given as the reason for the increasing social evil behaviour. The changes which have happened after *doi moi* and the financial crisis

could mean that inequality and vulnerability is increasing, because more people are either forced or driven by economic incentives to change the way they make a living. This could lead to new livelihood strategies for a large group of people, with possible increased risk-behaviour and thereby vulnerability in terms of HIV.

2.2 HIV and AIDS in Vietnam

The 2007 estimate show that around 280.000 adults (15 – 49 years of age) are infected with HIV in Vietnam and that the rate has increased from 0.3 to 0.5 percent of the population from 2001 to 2007 (WHO 2008). Table 3 show the estimated number of people infected with HIV including high and low estimates. The table also includes the number of people receiving and needed antiretroviral therapy showing that only a small part of those needing treatment actually get it.

Table 3: HIV estimates in Vietnam for 2007

	Age group 15 – 49	Age group 15 – 49 (%)	Age group 15 – 24 (%)	People receiving ART	People needing ART
Estimate	280,000	0.5	0.3	17,000	67,000
Low	170,000	0.3	0.1	16,000	41,000
High	470,000	0.9	0.5	18,000	110,000

Based on: WHO 2008

In 2007 a law on HIV and AIDS came into force in Vietnam, addressing things such as the need for information, education, reduction of stigma, discrimination, and risk-behaviour. The groups prioritised in terms of prevention and control firstly include people infected with HIV or other STIs, drug users, sex workers, and homosexuals as HIV in Vietnam is still mainly seen as a problem related to sex workers, injecting drug users, and to some extent sex between men (UNAIDS 2008, PRB 2006, Khuat et al. 2004). But with increases in HIV-rates among these groups the general population will also be more at risk. This for example can happen through high-risk behaviour in marriages where one is a previous or current injecting drug user or in cases of premarital and/or extramarital sex, putting themselves and the partner at risk of getting HIV (UNAIDS 2008 & HIV/AIDS Information Gateway 2009).

The law is not specifically targeting the youth, which here is defined as the population born from around the end of the Vietnam War in 1975, but their attitude towards reproductive health and their risk-behaviour are factors which might be very important in influencing the HIV epidemic in Vietnam. The number of people aged 15 – 24 is increasing and data from 2005 show that around 24% of the population is within this age group and in total 53% of the population is under

the age of 25 (UNAIDS 2006, Dang et al. 2005 & Linh et al. 2006). Around 25% of this age group is living in urban areas due to urbanization and rural-urban migration and this number has until now been increasing (Dang et al. 2005).

Also, about one third of registered HIV infected is between the age of 15 and 24 which can cause concern as they are Vietnam's future workers. This is supported by UNAIDS Vietnam (2008a) stating that people with HIV are becoming younger with 78.9% of reported cases being people between 20 and 39 years old and the majority of reported HIV infections being male.

3. Objectives

The overall objective was to investigate whether there are linkages between livelihood change and HIV and AIDS vulnerability among the youth in Vietnam.

Specific objectives

1. to evaluate whether migration, current economic conditions, the HIV & AIDS law and policies, access to services, stigma and discrimination, and gender roles are factors linked with livelihood change that could aggravate HIV and AIDS in Vietnam
2. to characterise the vulnerability of youth in Vietnam in terms of reproductive health and risk behaviour

4. Literature review and theoretical framework

4.1 Literature review

4.1.1 Changes following doi moi

Since the change in management processes, laws, and policies links to the changes in quality of and access to services, it thereby also links to the overall vulnerability of the population needing these services and is therefore addressed in this section. This is especially important in terms of access to healthcare for those with little financial means.

According to the party doctrine in Vietnam, the party should lead while the state should manage, but in reality the party still intervenes in the management processes and controls the processes for example in state owned enterprises (SOE's) as it sees fit. This links with the issue that corruption at high levels generally to go unpunished, which makes it difficult to advocate no corruption strategies on all levels of the political system in Vietnam. Low salaries contribute to this problem and

in the end this benefit those with power and money, leaving a large part of the population at a disadvantage (Painter 2003).

Green (2007) states that although the state is loosening its grip on some things, it is still important for the state to support institutions to sustain growth which for example can be done be securing property rights, gender equality, and through respect of human rights. But formal institutions cannot be changed without also changing informal institutions and change or conflicts between formal and informal institutions can be difficult to see in the period where it is happening.

Liquidating or restructuring SOE's was part of the reform initiated in 1986 and this meant that from 1990 to 2000 the number of SOE's declined from around 12,000 to 5,300. Despite efforts to restructure management of the remaining enterprises, they still heavily rely on favourable conditions, such as tax breaks and credit with low interest. In addition, good relations with the people at high positions in the Government or the party are still very important and therefore some private companies also benefit from this, creating an unequal distribution of advantages and goods. This also influences the tax paid to the state, which after the reform also had to come from other than the SOEs. It has shown to be difficult to collect fixed taxes which influences on the economic situation of Vietnam where more services now are paid through user fees or insurance (Painter 2003).

As of 1998, 80% of the health spending came directly from the households, leaving average household spending on health care at 7% of the total consumption. Health shocks are found to generally have an effect on earned income and in many cases on medical spending. It can also influence on food consumption of the household affected. Also, as rural households are often larger than urban households the impact of a health shock tends to be less on the rural households (Wagstaff 2007).

4.1.2 Factors influencing livelihood, vulnerability, and risk

Vulnerability of a household or individual refers to "*a high degree of exposure to risk, shocks, and stress*" (Ellis 2000 p.62). Pain (2007b) emphasises that vulnerability combines susceptibility and exposure to a threat, while risk refers to vulnerability combined with hazards which both includes predictable and non-predictable elements. On a micro level hazards or shocks can be caused by for example ill health and unemployment, while it on a macro level can be influenced by the national or international economic situation.

Ellis (2002) and Pain (2007b) differentiate between risk management or ex-ante risk mitigation and ex-post coping strategies. Risk management refers to strategies which are adopted before any real failures have occurred. Coping strategies on the

other hand are strategies which are done as a response to some kind of failure and therefore are often initially short-term responses.

Beckman (2006) mention that when looking at vulnerability one needs to understand how political processes and socio-economic factors influence the situation of the household at all times and not only in the case of a hazard. In other words, vulnerability is present at any time, but becomes clear when the household is exposed to shocks. Beckman (2006) also links poverty and vulnerability, saying that poverty can influence the ability to cope and recover from shocks or increase exposure to shocks. This can also be seen through statistics which imply that one third of non-food spending goes to health care in the poorest quintile in Vietnam.

In this thesis vulnerability both refers mostly to vulnerability of the general population but also to those who are already infected with HIV. Those infected with or somehow linked with HIV might have a higher vulnerability to begin with compared to the general population due to stigma and discrimination.

With the economic change after *doi moi* and the current global financial crisis the people vulnerable to HIV might change which can bring new scenarios to the fight against HIV and AIDS. As stated in the introduction Gorbach et al. (2002) analyses the impact of changing into a market-driven economy in terms of emerging HIV epidemics in Russia, China, and Vietnam. There seems to be similarities between the three countries including the epidemic so far being largely contained to drug users and sex workers. But with highly mobile populations especially in China and Vietnam there is a risk that the HIV epidemic could spread to the general population. In addition, it is highlighted that registered HIV and AIDS cases in all three countries are estimated to be far below actual rates.

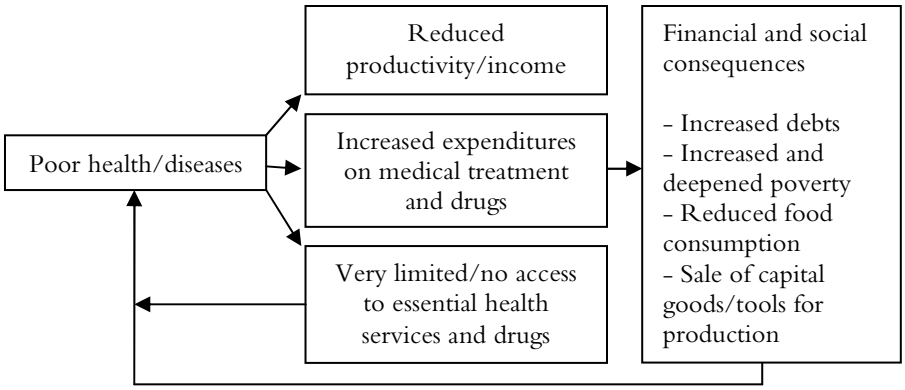
The changes which happened in connection with the reform, also mentioned in the introduction when referring to Gorbach et al. (2002) mean that generally the population has more money which they can spend on for example entertainment such as sex workers and drugs. Opening up the country also means more influence from mass media and therefore a possible change in the cultural environment (Gorbach et al. 2002 & Nguyen 2008c).

4.1.3 HIV and AIDS in Vietnam

As in many other Asian countries the HIV epidemic in Vietnam is considered to be concentrated (UNAIDS 2008, PRB 2006, Khuat et al. 2004) which is defines as *"if HIV transmission is primarily attributable to HIV-vulnerable groups and if protecting HIV-vulnerable groups would protect the wider population"* (Wilson 2006 p.4). Statistics show

that all provinces in Vietnam have HIV cases; of the 659 districts, 96% have HIV cases and in the 10,732 communes/wards, above 66% have HIV cases (UNAIDS Vietnam 2008a). On a national level 28.6% of the registered HIV infected is injecting drug users while prevalence for female sex workers is 4.4%. There can be large differences between provinces, from 40 – 80% of drug users infected and with estimates that 50-60% of all HIV infected having ever injected drugs (HAARP 2009, Nguyen et al. 2001 & Thao et al. 2006). UNAIDS Vietnam (2008a) also state that transmission between heterosexuals is becoming a more important way of transmission (UNAIDS Vietnam 2008a). Local health officials argue that despite current estimated HIV rates, the next couple of years are critical in the fight against HIV and AIDS as it might otherwise spread to the general population. This is based on the fact that the number of drug users and sex workers infected with HIV is currently high and rising. It could therefore be argued that effort to combat HIV and AIDS in Vietnam should not only be concentrated within high-risk groups, but also include the general population and maybe more specifically the youth, as they make up a large part of the newly infected (The World Bank 2007).

Figure 1: Linkages between poor health and poverty



Based on Dahlgren & Whitehead (2006) p.52

Figure 1 shows linkages between poor health, social, and financial consequences, turning into a vicious circle where vulnerability increases with diseases and influences poverty. This in turn influences on the susceptibility to diseases and so it continues and could therefore help explain what happens to vulnerability when an individual or household experiences HIV infections (Dahlgren & Whitehead 2006). This also links with risk-behaviour as reduced productivity occurs at the same time as expenditure on treatment and drugs are increased, with less money available to sustain a livelihood. As this happens some people will have to change their coping strategies to be able to cope with the new situation. In some instances changing

coping strategies might lead to a higher risk-behaviour, because as they argue there is a greater impact on the health in a negative way the deeper the poverty is (Dahlgren & Whitehead 2006).

4.1.4 Youth and reproductive health

According to UNESCAP (2000) 75% of drug users are adolescent and youth, with around 49% between the age of 15 and 29, and in Hanoi specifically adolescent and youth amount to 93%, reasons being: *"a lack of knowledge and experience in life combined with curiosity; a lack of regular attention and care from parents and relatives who are preoccupied with earning a living; and a lack of attention provided by teachers"* (UNESCAP 2000). These high rates are also supported by Thao et al. (2006).

Compared with other countries, many studies have until now shown that the 15 – 24 year olds engage less in premarital sex and it could therefore be argued that the youth is not one of the most important groups to target when it comes to HIV and AIDS campaigns. A pilot study on reproductive health using different methods to collect data questions this, as the study shows that depending on the method of retrieving data, there are large differences in the data. The most anonymous way of retrieving data (Audio Computer Assisted Self-Interview - ACASI) proved to reveal the highest percentage of premarital sex and highest levels of risky sexual relations compared with face-to-face personal interview and pencil-and-paper self-administered interviews. In addition, lack of knowledge about correct condom use was higher with ACASI than with the other methods, indicating that they felt more comfortable with displaying their lack of knowledge in the ACASI (Linh et al. 2006). Although this sample is only taken from one community it might be an indicator that previous studies can be misleading and that there is a higher prevalence of premarital sex and risk-behaviour than expected (Linh et al. 2006). This might also be supported by Gammeltoft (2002) who writes that unofficial numbers from Ho Chi Minh City and Hanoi show that young unmarried women account for 30% of the abortions. Her study also showed that unprotected sexual intercourse is quite common among Vietnamese youth with only 15% of the participants reporting use of condoms or contraceptive pills. Most relied on withdrawal (45%) and safe periods (35%), while 37% reported never using any type of contraception. One reason was given as "*using contraception is a proof that in your heart you do not trust the other person and he does not trust you, and then why would you sleep with each other?*" (Gammeltoft 2002 p. 492). Another stated that since she and her boyfriend were not married they did not prepare for it and therefore did not use

condoms. Others end up denying that they have had sexual intercourse to live up to the social norms and values. Some women also perceived sexual intercourse to be something beyond ones self-control and rational planning (Gammeltoft 2002).

Especially also the risk-behaviour of female sex workers in Vietnam needs to be evaluated as it is estimated that around 30% of young Vietnamese men (15-29 years old) who are sexually active, have at least once visited a female sex worker. Also around 6% of participants in one study said that their first sexual experience was with a sex worker (Duong et al. 2008a & Nguyen et al. 2008a).

4.2 Theoretical framework

4.2.1 Livelihoods framework

Ellis' (2000) defines livelihood as *"[comprising] the assets…, the activities, and the access to these (mediated by institutions and social relations) that together determine the living gained by the individual or household"* (Ellis 2000 p. 10). A livelihoods framework is a tool to analyse livelihoods with the advantage of it taking into account most sectors, just as it is possible to look at the livelihood at different levels (Pain 2007a).

Experiences from Africa show how great effects interactions between the surrounding environment and diseases can have on households, linking gender issues, vulnerability and resilience of the household, migration and urbanisation. Lack of action to understand and deal with these linkages might mean that the response is not as effective as it otherwise could be (du Guerny & Hsu 2004).

A livelihoods framework is built around different capitals or assets which the household or individual own, claim, control, or access. These are believed to be essential when trying to understand what options the households or individuals have, how they form their survival strategies, and how vulnerable they are to different situations (Ellis 2000). According to Bebbington (1999) assets are what gives households or individuals capabilities and meaning to life instead of just being simple resources or things necessary to make a living.

Most livelihoods frameworks use the same asset base including human, social, natural, physical, and financial assets (Hussein 2002). Human capital concerns the labour available to the individual or household and can include investment health, education, and skills. It is especially important to those who have little or no saving and therefore rely heavily on their own labour for their livelihood. Financial capital is about access to the supply of money or credit, including savings and loans. Social capital is about family, friends, communities, and other kinds of networks where

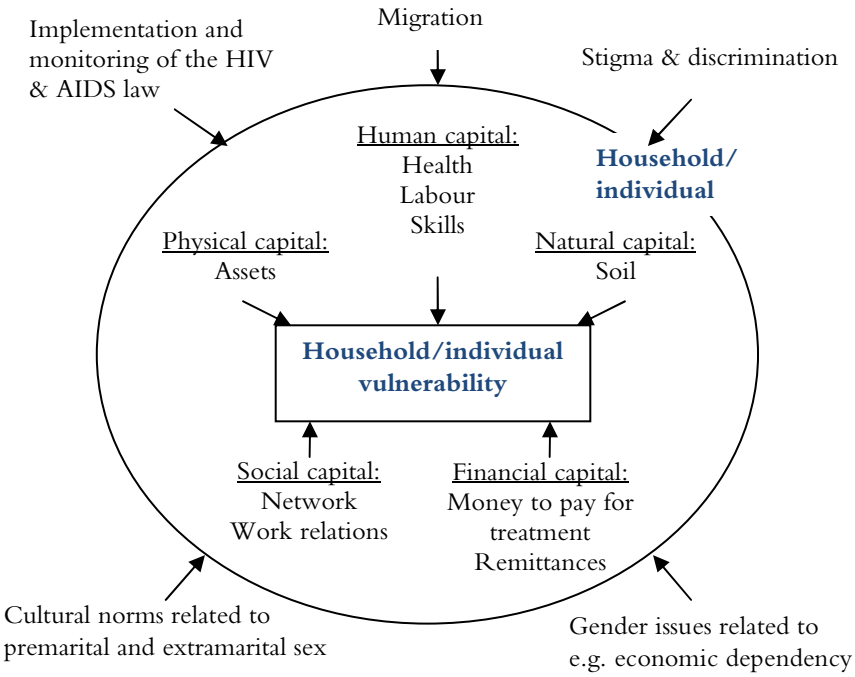
some being more important than others in terms of strengthening the household or individual capital. Natural capital includes things such as water and land resources. Physical capital is derived through the economic productions processes undertaken and includes for example machinery and tools for production, buildings, and roads. It can be a substitute for natural capital especially when going from agricultural based society to industrialised society where inputs are of more technological kind. All of these capitals are changeable and influence each other, thereby determining internal vulnerability of a household or individual. (Ellis 2000).

The framework has been criticised for not including gender issues and political capital, but since focus in this thesis is on external factors, it is possible to include these issues in relation to the vulnerability and risk-behaviour of individuals or households (Hussein 2002).

Linking vulnerability and HIV

Figure 2 below shows a theoretical framework which includes components from Livelihoods Framework, adjusted and supplemented with relevant issues specific to the topic of linking HIV and the surrounding environment.

Figure 2: Internal and external vulnerability of households



Based on aspects of a Livelihood Framework (Ellis 2000)

The circle represents the household or individual and the components inside the circle are the different kinds of internal capitals mentioned above which might influence the vulnerability. For example, if the human capital is affected e.g. if a

household member gets HIV, the other capitals could also be influenced. HIV might for example influence the financial capital, diminishing the capital available for other things if relatively much money is spent on treatment. Similarly, physical capital might be diminished if assets are sold to pay for treatment.
In terms of social capital, this might be influenced by stigma and discrimination. Ellis (2000) is also talking about social exclusion and the importance of understanding conditions relating to why people become "outsiders" and "insiders" and that generally there is not enough emphasis on this maybe due to complexity.
Specific emphasis in this thesis is given to the concepts surrounding the circle (See Figure 2) which are external factors or environmental factors that can influence the vulnerability of the household or individual. This is especially important as external factors are much harder for the individual or household to influence than internal factors. It is argued that especially institutions and social relations are important mediating factors as these can facilitate or inhibit actions of the individual or household. Also these are processes that changes over longer periods of time and might not influence vulnerability and livelihood strategies right away (Ellis 2000).

Although this study is done on a macro level, livelihoods framework as a tool for analysis is still relevant as there are linkages between macro level policies and micro level outcomes. Policies are needed both at a national and local level with overall policies on a national level that can help change and remove barriers to more context specific efforts on a local level. Understanding vulnerability on a household and individual level is important to understand what livelihood strategies are being applied in the context of HIV, risk-behaviour, and environmental factors and what response should be put in place to better the conditions at this level (Ellis 2000).

5. Methodology

5.1 Study area

The thesis was carried out as literature-based research complemented by empirical research. The research was undertaken from 1st of February to 14th May 2009 in Hanoi, Vietnam, but the field was extended to include more than Hanoi as two people outside Hanoi, Thai Nguyen and Dak Lak Province, were also reached by e-mail. During the stay in Hanoi data was collected for the literature desk study and to complement this analysis, key informant interviews were undertaken with relevant informants and a questionnaire was created and distributed.

5.2 Data collection methods

The following questions were used as a starting point for the literature desk study and discussion during interviews. They should therefore not be seen as covering all issues related to this thesis.

Initially a brainstorming was done to find possible questions and as the thesis process developed some were eliminated as they were not found to be as relevant as the questions stated below. Also questions were added as these were found to be of some significance but had not been in the initial brainstorming, for example questions on the HIV and AIDS law and on how the communities influence the attitude towards HIV and AIDS.

Some questions also seemed to render more interesting answers than others and so these were prioritised if there was a time constraint. These included the questions on important environmental factors, and the influence of stigma, discrimination, internal and external migration on HIV and AIDS.

The Vietnamese situation

- Why have the HIV and AIDS epidemic not spread more in Vietnam?
- Is it still relevant only to focus on high risk groups in Vietnam?
- How helpful is the HIV and AIDS law in Vietnam?
- Which environmental factors are important in the context of HIV and AIDS and the youth?

The youth

- What role does the youth play in spreading HIV and AIDS?
- Some young people in Vietnam associate condoms with something only prostitutes use. Is this a trend among young people?
- The youth in Vietnam is getting married at a later age compared to previously. Does this influence their attitude towards premarital sex?
- A pilot study show that when using a more anonymous way of gathering data, more young people say they have premarital sex, multiple partners, and unprotected sex. Could these factors be drivers for HIV and AIDS?

Cultural aspects & stigma and discrimination

- Are male more promiscuous than female in Vietnam and why?
- How does stigma and discrimination affect the HIV rates?
- How has public information on HIV and AIDS influenced stigma?
- How do communities influence the attitude towards HIV and AIDS?

Financial crisis & migration

- How does the global financial crisis influence Vietnam and the youth?
- How is vulnerability of people affected by the financial crisis?
- How is internal and external migration influencing HIV and AIDS rates of the youth?

5.2.1 Literature desk study

A literature desk study was undertaken between the 1st of February and 14th May 2009 to examine research done related to the questions stated above. Keywords such as HIV and AIDS, Asia, Vietnam, youth and young, migration, sex workers, discrimination, culture, gender, condom, behaviour, premarital, vulnerability, and *doi moi* where used to find relevant material. This was done on Google and Google Scholar search engines and the SLU database. Also relevant journals were found by searching journals in the SLU database using keywords such as HIV, AIDS, Asia, and culture and then using the above keywords to search inside the specific journals. In total, 22 journal articles, 5 web based documents, and one book were used in the literature desk study.

5.2.2 Key informant interviews

Semi-structured interviews with key informants were undertaken between the 10th of February and the 21st of April. The reason for doing semi-structured interviews mostly consisting of open-ended questions was that the researcher was not well trained in doing interviews and according to Hughes (1979) doing more structured interviews will be an advantage to untrained interviewers. At the same time the researcher also needed it to be flexible enough so that it would be possible to follow up on anything interesting the respondents said in order to develop the thesis in the most relevant direction.

The questions mentioned above were used as a base for most of the interviews with key informants, although more specific questions were asked to some informants as some had specific knowledge within one field for example migration or drug use.

The first interviews served as a tool to narrow down the thesis topic and develop the questions asked for the following interviews. In total 11 people were interviewed; 9 people in face-to-face interviews and 2 done via e-mail. The face-to-face interviews mostly took place in offices and cafés and generally it was up to the interviewee to choose the setting. For the most part face-to-face interviews were recorded and key points were written down after the interviews.

Table 4: Key informants

Name	Title & place of work
Brøndum (2009)	Embassy of Denmark
Mørch (2009)	The United Nations Children's Fund (UNICEF)
Eligh (2009)	United Nations Office on Drugs and Crime (UNODC)
Poulsen (2009)	Embassy of Denmark
Appelboom (2009)	Organisational Capacity Building Officer in HIV & AIDS, VSO
Nguyen (2009)	International Organization for Migration (IOM)
Le (2009b)	Center for Partnership in Community Development (CPCD)
Le (2009a)	Centre for Gender, Family and Environment in Development (CGFED)
Tran (2009)	Consultation of Investment in Health Promotion (CIHP)
Phan (2009)	Joint United Nations Programme on HIV/AIDS (UNAIDS)
Okuku (2009)	Voluntary Service Overseas (VSO)

2 of the 11 interviewees were working as advisers for the Embassy of Denmark and contact was established through the Embassy. For 5 of the interviewees, details were obtained through the snowball effect through either one or two people which were either also interviewees or intermediaries. Contact details for the remaining 4 interviewees were found on the Internet when searching for relevant NGOs in terms of the thesis topic. In total, 3 represented local NGOs while the rest worked for international organisations including 3 UN organisations. Of the 11 interviewees, 6 were women and 5 men, all probably over the age of 30 and 7 probably over the age of 45. 5 were Vietnamese of origin.

It is important to note that the views expressed in this report from the people interviewed do not necessarily represent the views of the organisation they represent. In addition, it has to be emphasised that not all the things told by the interviewees are supported directly by articles, reports, statistics etc., but might be experiences obtained through work and general life in Vietnam or things told by colleagues or friends.

5.2.3 Questionnaire

A small questionnaire regarding reproductive health and HIV was distributed to a part of the youth in Vietnam to get a sense of what their attitude towards issues related to sex was. This was done to triangulate with information from the literature desk study and key informants on the subject as triangulation of methods is important to ensure the validity of the study (Johansson 2007).

In total the questionnaire consisted of 22 questions of which 6 questions related to demographics. Of the 16 questions which were not demographics, 1 was open-ended, 4 were yes/no questions, 10 had between 4 to 9 answer options, and 1 was age related and therefore had over 10 options. The questions were both related to facts about HIV and own experiences related to reproductive health.

They survey was open from the 17th of March to the 2nd of May. Distribution was done electronically through two different workplaces in Hanoi – Embassy of Denmark and Esoftflow - together with 19 universities in Vietnam.
In total there were 33 respondents to the questionnaire of which 10 were male and 23 were female. The average respondent was born in 1982 but it ranged from 1972 and 1998. 63.6% were unmarried and around 82% had at least a bachelor's degree. Almost 70% of respondents were born in the North, with 45% in Hanoi.

5.2.4 Validity

A challenge was to get certain detailed information as some information was only available in Vietnamese and research documents from the Government, some local researchers, and NGO's rarely was available electronically. Since the researcher was not fluent in Vietnamese a translator would have had to be used to obtain these types of information. Not utilizing this option could profoundly influence the type of data collected. To insure that the data was valid, triangulation between the literature desk study, key informant interviews, and the questionnaire was done. This should enhance the validity of the findings.

With regards to the key informant interviews, it was clear that some respondents where very specialised and this could in some instances be seen as a restraint in terms of them not seeing other issues as just as important as the one they were working with. Also it was important to consider whether they had their own agenda in terms of only telling me what they wanted me to be aware of and write about. In addition, my little experience in doing interviews could mean that I unintentionally asked leading questions.
Since the informants both were found on the basis of the snowball effect, through the Embassy of Denmark, and through the Internet it should give a somewhat broad and diversified sample of key informants. On the other hand the methods may have left out relevant people and/or organisations which were not represented in English on the Internet or did not have much contact with the international organisations that were contacted. Although this thesis was related to the Vietnamese youth, only few of the key informants were in this category. On the other hand, input from the Vietnamese youth on some of the issues was obtained through the questionnaire.

The questionnaire was distributed via e-mail to several universities and two different work places where people were asked to forward it to friends and family. Distribution through universities might not have reached the students as there might

not be ways of distributing them electronically. The relatively low number of respondents could be due to the fact that the questionnaire dealt with sensitive issues on HIV and sex. In addition, the questionnaire was in English which limited the group reached, just as it might have been a problem in terms of understanding the full context of some of the questions.

Despite these factors the quality of data was still found to be trustworthy. This was obtained through the triangulation of methods between the questionnaire, key informant interviews, and the literature desk study.

To some extent qualitative research in Vietnam is seen as problematic as one need to understand all filters when looking into these issues including research which might be written with an unofficial agenda. On the other hand there could be problems with learning from experiences of other countries as there might be other things influencing their knowledge than can be seen in Vietnam (Eligh 2009).

6. Findings & discussion

The overall objective of this study was to investigate the linkages between livelihood change and HIV and AIDS vulnerability among the youth in Vietnam. This has been done through studying relevant literature, doing key informant interviews, and through a questionnaire. The findings together with a discussion of the findings will be presented in this section.

6.1 Changes following doi moi

6.1.1 The influence of Government laws and policies

After *doi moi* a lot of new laws and policies have been initiated. There is a supportive framework for this in Vietnam, like the HIV and AIDS law on prevention and control, however implementing the laws is a challenge and most laws exist merely on paper (Mørch 2009, Appelboom 2009, Brøndum 2009, Phan 2009, & Le 2009b). The reason being that little monitoring is in place and few are punished for breaking the law (Phan 2009).

This also links with the way the work is coordinated within and between Government and donors which was argued by several of the key informants to be challenging, for example with conflicting laws between ministries and disagreements between donors (Appelboom 2009, Eligh 2009 & Le 2009b). Eligh (2009) argues that with Vietnam's communist history there are little benefits from cooperating freely between government departments, leading to a politically competitive

environment. Data is seen as currency and unless there is a clear advantage by sharing data or people are directly ordered to do so, this is not done.

Although these issues are not directly linked with the aggravation of HIV, they are factors which influence the households or individuals indirectly. The HIV and AIDS law should protect against stigma and discrimination, but since it is not enforced, social vulnerability will keep on being high for those who are infected with HIV or take an HIV test, but not infected. This essentially increases vulnerability of both HIV infected and the general population.

In the HIV/AIDS strategic plan 2006-2010 the Government use a large part of their funds on control while prevention is downplayed (Nguyen et al. 2008c). This also means that the targeted groups mostly are drug users, sex workers, and people already infected with HIV where relatively high HIV rates are already seen (PRB 2006, Khuat et al. 2004). Le (2009a) stress the importance of increasing and improving information and education both through educating the parents and teachers as the current effort is not seen as effective enough. Currently most education and information seems to emphasise consequences of HIV, but not ways to prevent it. Reducing stigma and discrimination is also seen as one of the ways to prevent a larger HIV epidemic, but an issue which the Government is not prioritising. Also the need for better disseminating of information related to HIV and AIDS was mentioned by two informants, both in terms of good, broad public information and information specifically targeted at schools and young pupils (Mørch 2009 & Le 2009b).

In terms of making effective laws to prevent the spread of HIV from drug users, who are the largest group infected with HIV in Vietnam, it is argued that the recent drug law does nothing to increase access to services or increase the ability of people to deliver services to injecting drug users. Rather it encourages them to hide and avoid services and contact and drives people to more risky behaviour and increases general vulnerability in communities with a relatively large number of drug users. It is also stated that drug users do not see themselves as a separate group from the rest of the population which supports that caution is needed when separating the response to HIV through high-risk groups (Eligh 2009).

Le (2009a) does not perceive treatment of drug addiction in Vietnam as effective enough. Firstly, there is not enough capacity to take them in. Secondly, there is no help when they return to society after treatment, leaving them few possibilities to get a new start. The effort of the Government focusing on control and treatment is not seen as doing enough to rehabilitate drug users as this is less sustainable.

Also since *doi moi*, visiting sex workers has been linked with social status and masculinity and free time is seen as a time for men to socialise with other men. In addition, it is argued that clients of public and private businesses are treated to services of a sex worker as a part of doing business (Phinney 2008). Tran et al. (2006) confirms that changes have happened socially and culturally with effects unequally distributed between men and women, leading some women into prostitution to make a living.

In the study by Phinney (2008) all married men knew of other men who had extramarital sex, indicating that maybe more than the men reporting extramarital sex were actually engaging in this. Extramarital sex with sex workers was not seen as a threat to the stability of the family and many of the participants (both male and female) actually said that men had a right to engage in extramarital sex if he was not satisfied by the women. Phinney (2008) criticises the Government for only focusing on sex workers, leaving the men not to feel responsible for their actions.

In addition, specific gender roles have been accentuated by government policies, for example with the Happy Family campaign, launched as a part of the *doi moi* reform. Here economic stability and children is in focus, while actual satisfaction and happiness of the family is of less importance, leaving women to do most of the domestic work, being dependant on their husband. This also leaves more free time for the husband than for the wife (Phinney 2008).

The Vietnamese government also launched a Social Evils Prevention Campaign in the 1990s aimed at preventing drug use and sex work. Since the first cases of HIV and AIDS also were found in this period they ended up being associated through for example posters showing linkages between drug use, sex work, and HIV and AIDS. This created stigma and discrimination of people living with HIV or AIDS. The Government has to some extent realised the problem and among other things has put up posters which are less discriminating although old posters are also still

Drugs and Sex services - the roadmap to HIV and death. Source: Mette Holst

present. Changing the attitude of the population regarding this will take time and it is therefore expected that stigma and discrimination will continue to be a problem until there is enough knowledge and understanding about HIV and AIDS in the general population (Phinney 2008 & Dixon-Mueller 2009).

Most of the key informants to some degree agreed that stigma and discrimination in relation with HIV and AIDS in Vietnam is a problem. One informant specifically said that stigma is the reason for the spread of HIV as it makes people more vulnerable (Le 2009a). The social evils campaign was also mentioned by three of the informants in terms of linking drug users, sex workers, and HIV and AIDS and resulting in stigma and discrimination (Mørch 2009, Eligh 2009 & Tran 2009).

With their social evils campaign after *doi moi* the Vietnamese government has not handled stigma and discrimination of HIV and AIDS infected very well. Eligh (2009) states that the posters which were a part of this campaign relate to moral codes and inclusion or exclusion in the community. By engaging in the activities which are displayed on these posters, one could be excluded from the community. This social exclusion can have a large effect of possible livelihood strategies and thereby both income and health of a household. These issues of exclusion through stigma and discrimination can be seen both in rural and urban areas (Le 2009a & Appelboom 2009). Mørch (2009) though emphasises that Vietnam has moved forward as some 3½ years ago HIV infected people would be arrested for meeting in groups more than 5, but they are allowed to meet through various organisations. The problem is that the changes have not been large and fast enough.

Social vulnerability

Beckman (2006) mentions the importance of social vulnerability which among other things includes access to social capital and social security. She specifically mentions that kinship ties and family have become more important after *doi moi* as user fees for many services now is a reality. It was found in the questionnaire that many respondents attributed family norms and values and friends much value when making the decision of having sex, whereas religion was of little importance. The question given was "*Which of the following (if any) have an influence when you make the decision to have sex?*". In total 27 respondents answered the questions of which 14 respondents (52%) reported that neither, religion, family norms and values, behaviour of friends, or alcohol have any influence, 9 respondents (33%) reported that family norms and values was of importance, while 4 respondents (15%) reported that behaviour of their friends as important. This also shows the importance of social networks and social vulnerability and links with the problems

of social exclusion. There is therefore a larger dependency on others in terms of providing social safety nets which also mean that there are differences in how households can cope with shocks including illnesses such as HIV.

Since *doi moi* the health care system in Vietnam has been transformed with more privatisation and services mainly paid through health insurance held by the individual or through users fees (Gorbach et al. 2002). Although health insurance should guarantee good health care, those who pay in cash will be first in line while those with insurance will be queued due to the bureaucratic system of getting the money back for treatment (Nguyen 2009 & Tran 2009). It is argued by Adams (2005) that although fees are meant to be waived for poor this is not happening and people willing to pay fees in advance is favoured over people with health insurance or no insurance. This leaves the most vulnerable waiting for treatment with poor quality medicine, or even without treatment. Potentially this leaves them with poor health and therefore fewer possibilities to make a living ending with coping strategies which might include high-risk behaviours in terms of contracting HIV (Nguyen 2009 & Tran 2009). The theory of this thesis also support this, as it is described that especially health issues are important to the poorer part of the population who depend mainly on their own labour to make a living. This also tie in with stigma and discrimination which in the literature desk study and key informant interviews also is seen as very much present in Vietnam and might increase barriers to disclosure and treatment, thereby increasing overall vulnerability in the society.

HIV testing facilities are in many cases in separate buildings making it easy to associate those getting tested with social evil behaviour (Binh 2009 & Appelboom 2009). Also few people want to get tested as there is little help afterwards in case one is found to be HIV positive (Mørch 2009). There is also a problem in terms of access or knowledge of access to testing facilities (Eligh 2009), just as the capacity to test and counsel both in terms of equipment and expertise of health staff might not be available. It could therefore be questioned whether the actual rates of people living with HIV and AIDS are too low (Mørch 2009, Phan 2009 & Tran 2009).

6.2 Factors influencing livelihood, vulnerability, and risk

6.2.1 Economic changes

The Economist Intelligence Unit expects that 400,000 people in Vietnam will loose their jobs in 2009. The same trend as is happening in China, with people moving

back to the areas where they came from after loosing their job, might therefore also happen in Vietnam creating more vulnerable people (Anh 2009 & Keane 2009).
Few of the informants wanted to predict the future in terms of the influence of the financial crisis. Poulsen (2009) argued that there are a lot of young men with relatively affluent parents who become trapped in unemployment as they do not want the available public sector jobs with little prestige and pay and might end up having a hard time coping with responsibilities which eventually could lead to drug abuse. One informant said to the question on the influence of the financial crisis that probably many migrants would be sent back (Phan 2009). One informant also mentioned that due to the urbanisation, there is now less land for cultivation and therefore a need for income diversification for example through seasonal migration (Le 2009b). Job losses due to the current crisis and the problem of underemployment could be linked with livelihood coping strategies. Poulsen (2009) says that the effects are already present with urban-rural re-migration, just as international migration will decrease. In addition, the crisis will increase vulnerability in terms of for example lack of jobs, decreasing prices of agricultural products, increased competition on water and land, and difficulties getting capital for investments (Poulsen 2009). This means that many individuals and households will have to adapt and are maybe forced into less wanted employment such as sex work or driven into drug use as a way out of their misery.
In Vietnam more and more women work in places such as hotels, coffee shops, beer cellars, and karaoke bars where they end up as both regular workers and sex workers for the clients. Especially poorer women without many other job opportunities or any forms of safety nets have no other choice than to do what is asked by the employer even though they did not initially intent to be sex workers. Female students are also seen working in this business as it is a way to pay for things such as accommodation, food, and clothing while studying (Le 2009b). This connects with the arguments of Gorbach et al. (2002) who states that the overall outcome of the economic and political transformation in terms of HIV and STIs, are increasing numbers of infected people which is also the case for Vietnam. As reported, HIV infections have been increasing and according to the WHO & Ministry of Health (2000) there were more than 100,000 reported cases of STI annually from 1998 to 2000. Since reporting from health services is expected to be incomplete, projections are much higher with estimates of up to 1 million cases of STI infected every year.

Looking not only at the current economic situation, but at the development since *doi moi*, there is now no longer any compensation in terms of agricultural

production as there was before *doi moi*. This and more focus on a household level compared to cooperatives means that there is a need for many to supplement their income to sustain their livelihoods. This together with the economic incentive has meant an increase in migration (Boothroyd & Pham 2000). This is supported by Ellis (2000) who talks about the reasons for people migrating with two overall motivators: push factors which include lack of jobs in the area, risk, and seasonality and pull factors which include higher pay for migrants. Migration will be discussed more below.

6.2.2 Migration

Migration in Vietnam

Although migration in itself is not a direct risk factor for HIV, the risk-behaviour of migrants is and this can leave both themselves and their partners at higher vulnerability to HIV (Eligh 2009). According to Mørch (2009) in-country migration is a phenomenon which is becoming more and more important in Vietnam. This is supported by UNDP (2008) which states that migration is high within Vietnam and between Vietnam and its neighbouring countries. Phan (2009) emphasised that in addition to the high-risk groups that the Government is targeting, UNAIDS is now also acknowledging that migrants are a high-risk group in terms of contracting and spreading HIV as their vulnerability to HIV is higher than the population not migrating.

Relatively few journal articles specifically address Vietnamese migrants and their vulnerability to HIV. One that addresses the issue is by Wolffers et al. (2002) talking about "migrant identity" as a separate identity due to less social control in migrant areas. The argument is that most migrants are in their reproductive years and therefore still has a need for sex and intimacy which then cannot be with their regular partner and a sex industry therefore develops in the migrant areas.

This study takes up Vietnamese migrant workers in South Korea and Cambodian rural-urban migrants. Both with internal (in-country) and external (between countries) migration there can be differences in the known and new culture with the result that the migrant will have to redefine him/herself to somehow fit into the new culture. The Vietnamese and Cambodian migrants both expressed that life in their new culture was freer and they end up adapting somewhat to this. One Vietnamese migrant state: "*Coming here, we live far from our country, our family and relatives. We feel sad and have to look for pleasures*" (Wolffers et al. 2002 p. 463). Many migrants are introduced to sex workers by other migrants and also relationships arise between Vietnamese male and female migrants in South Korea especially because

women need support to get by, which is then exchanged by other favours. Despite the fact that many migrants are married they regard themselves as single when away from their community (Wolffers et al. 2002).

Although few Vietnamese migrants admit homosexual relations themselves, they talk about others who engage in this. One reason for engaging in this is that male migrants have little contact with female migrants and generally there is little social control and after finalising this work they might never see each other again. The migrant identity therefore becomes something which in the case of Vietnamese migrants is less socially strict and arguably could lead to denial of behaviour and therefore also less acknowledgement of risk-behaviour. This leaves migrants and their partners more at risk for contracting HIV (Wolffers et al. 2002). This is supported by studies from Kenya and China where migrants tend to have more extramarital sex than non-migrants (Voeten et al. 2002 & Hu et al. 2006). The same was argued by three of the informants which could lead to increased vulnerability (Okuku 2009, Nguyen 2009 & Phan 2009). Since migrants have a higher risk-behaviour than non-migrants, there is a larger risk that they have HIV and returning to their wife or girlfriend can therefore also put them at risk.

Another problem in terms of migrants and HIV in Vietnam is access to health care. Access through health insurance is tied to one or a few health facilities, which becomes problematic for migrants as they do not reside in only one place (Mørch 2009 & Nguyen 2009). This is problematic both in terms of discovering new HIV cases and thereby limiting the vulnerability of others and in terms of getting antiretroviral therapy to those who need it (Nguyen 2009).

Le (2009a) argues that migrants are the reason for spreading HIV to the rural areas and now that more women migrate it could also affect the HIV epidemic. These women meet risks and challenges when migrating which make them more vulnerable to sexual violence and engaging in risk-behaviour than what might have been the case had they not been migrating.

Okuku (2009) agrees that migrants have a large influence on the HIV epidemic spreading into the general population as sexual lust and peer influence contribute to a changed sexual behaviour. In addition, sex workers see areas with many migrants as good places to earn money and so they become mutually reinforcing (Okuku 2009). But few large scale surveys have been done on migration and HIV as the Government do not see it as a major problem. It seems that there is an attitude of "No evidence – no problem" which is the case with this issue (Nguyen 2009 & Tran 2009).

Migration in other countries

Experiences from mobile population groups in Kenya also show the attitude towards extramarital sex. One truck driver told of his experiences with sex workers when out driving for several months: *"I cannot sincerely survive all this time without having a woman along the routes, so I have a sex worker in Mombasa, one in Kisumu, and one in Kampala"* (Voeten et al. 2002 p. 449).

In a study from China comparing sexual behaviour of migrants and non-migrants, 11.8% of the migrants reported multiple sexual partners, and 61.9% reported premarital sex. The corresponding numbers for non-migrants was 5.8%, 51.5%, respectively. Just around 70% of both migrants and non-migrants perceived both own and spouse vulnerability to HIV as unlikely. Also around 33% were unsure about whether consistent condom use would prevent HIV thereby showing a lack of knowledge about HIV and how it can be prevented (Hu et al. 2006). Another study among young migrant workers aged 14 – 19 was undertaken in Nepal and it was found that 20% of the male and 12% of the female who were unmarried had had sexual intercourse. Some female migrants reported having to exchange sex with employees to get their payment, making them very vulnerable. Although knowledge about HIV and AIDS was high, few reported using condoms and more than 65% did not perceive being at risk of getting HIV; reasons other than condom use being infrequent sex and trust in the other partner. This can also be seen together with the fact that 26% of the girls had experienced a minimum of one unintended pregnancy and the belief that having sex with girls from villages is not a risk factor (Puri & Cleland 2006).

The attitude of wives of Mexican migrant workers in the United States show that although most women knew many migrant men would engage in extramarital sex while away many reported that their husband was a good man and therefore did not engage in this. Therefore they did not believe they were at risk of getting STIs. These women also perceived sex with a condom as taking away pleasure and being less intimate. Asking the husband to use a condom was also seen as acknowledging or possibly approving infidelity of the husband and therefore the women end up fairly vulnerable. Only 6 out of 26 said they would leave their husband in the case of infidelity and all of them were economically independent, giving them both more power to negotiate safe sex, but maybe also more possibility to have multiple partners during their lifetime (Hirsch et al. 2002). Multiple sexual partners is not really supported by the findings from the questionnaire where over 50% of the respondents only had one sex partner during the last 6 months, while only 6% (2

respondents) reported having 2 or more partners. Around 40% reported not having had any sexual partner during the last 6 months.

6.2.3 Gender roles

Estimates done regarding African women with HIV show that 60 – 80% are likely only to have had one partner, leaving the cause of the infection to come from their partner (Barnett & Whiteside 2002). This also relates to statistics from Thailand and Cambodia which shows that more than 50% of the new HIV infections are among married women. Vietnam does not have this kind of statistics, but UNAIDS is currently advocating to include spousal transmission prevention in the overall HIV effort (Phan 2009).

Lack of access to land is one of the things which can make women vulnerable as it makes it hard for them to become independent. According to the most recent Land Law in Vietnam women should be registered alongside their husbands on the Land-Use Right Certificate, but in reality the percentages of shared or single ownership by women vary between provinces from 6.3% to 83.0% (The World Bank 2006).

It was estimated in 2005 that 33% of HIV infected in Vietnam were women compared to the registered 16%. In addition, estimates show that only 11% of women infected could be related to female sex workers and over 50% of the HIV infected women were predicted to be in rural areas (Nguyen et al. 2008c). Low-risk women are at risk of contraction HIV for example if they have a partner who is or has been an injecting drug user or one who visits sex workers or have other forms of extramarital sex. Although it is found that many women are aware of how to contract HIV, sex is rarely talked about between husband and wife or boyfriend and girlfriend and since condom use between a couple is considered to be showing less trust and emotion, women feel ashamed to talk about it (Nguyen et al. 2008c). To understand how many women are at risk, Nguyen et al. (2008a) calculated that with low estimates of men visiting sex workers, up to 3,850,200 women could be at risk of contracting HIV and/or STIs. With higher estimates the number would be 7,682,000. Despite possible problems with social bias and an assumption that girlfriends and wives are actually in the low-risk group, this study gives an indicator of how many women are actually at risk of being HIV infected.

Phinney (2008) argues that men's possibility to engage in extramarital sex has increased much since *doi moi* through commercialization of men's free time, linking consumption to sexual activity, and through an increase in money and time for leisure. This could be looked at together with the fact that 1 out of 3 couples in

Vietnam experience domestic violence. This might together with the problems of access to land have an influence on the women's ability to object to unsafe sex and infidelity. Also domestic violence together with the large discrimination might make women refrain from going to the doctor to be checked and it might therefore be difficult to avoid the spread of HIV to a larger degree (UNAIDS Vietnam 2008b).
13 of the respondents in the questionnaire (39%) partly agreed that only promiscuous people contract HIV. But as the examples above shows, spousal transmission seems to be an important way of transmitting HIV and only requires that one person in the relationship has been promiscuous.

Through in-dept interviews and focus group discussions Go et al. (2002) studied gender issues both rural and urban areas in Vietnam. According to the Confucian belief, women should be hard-working, have an attractive physical appearance, and speak appropriately, while accepting imperfections of their husband. Not following the traditions, the community can exclude her and her family leaving them highly stigmatised. Especially a women's virginity is important, but participants also acknowledged that things were changing and that they to a larger degree had to accept premarital sex. Men are seen as naturally being tempted by social evils and therefore it is to some degree accepted and connected with much less stigma. Especially in urban area unemployment was seen as leading to social evils such as stealing, drug use, and women taking jobs which are less respected out of necessity (Go et al. 2002).
These traditions are supported by a traditional Vietnamese proverb, saying that it is okay for men to have extramarital sex while this is not true for women: "*A real and heroic man can have five wives and seven girlfriends but a virtuous woman only has one husband in her life*" (Go et al. 2002 p. 474). There though seemed to be a difference between having a love affair and visiting a sex worker, as visiting a sex worker was not seen as relating to love and emotions (Go et al. 2002).
In terms of STIs, this was associated with women being dirty and not taking care of themselves or them having extramarital sex and therefore they were seen as personally responsible (Go et al. 2002).
It is also argued that younger women are becoming more assertive there are still clear gender roles including it not being uncommon for guys to have their first sexual experience with a sex worker, while women should stay virgins until marriage (Appelboom 2009). As mentioned this is something rooted in the society through Confucianism which is built on patriarchy where women are very passive, including in sexual relationships where men seem to have nothing to loose by

loosing their virginity, while women have very much to loose. This is still very much present in rural societies while in the urban areas on the other hand things are changing and more young women have premarital sex although it is still not socially accepted (Phan 2009 & Tran 2009).

Le (2009b) also sees changes after *doi moi*, especially in the more urban areas where women have more opportunities to get a good job and be economically independent. This could influence their attitude towards things such as marriage and premarital sex which could both be good in terms of them being more independent and able to demand safe sex, while it could also lead to more premarital sex and more partners through their lifetime and if engaging in risk-behaviour they could be at risk of getting HIV.

Another change which is seen in Vietnam is that divorces are becoming more common. But they are still not condoned by the community and therefore many will rather keep up the facade about the happy family than divorce. In addition, it is not uncommon for men boast about their extramarital affairs to their friends. On the other hand, women who are economically independent tend not to submit to this and in many cases end up divorcing their husband. This opens up for more partners during a lifetime, which is what to a large extent drives the HIV epidemic (Phan 2009 & Mørch 2009). A study from Mexico supports this as economically independent women state that they would divorce in case of the husband having extramarital sex whereas this is not the case for women dependent on their husband (Hirsch et al. 2002).

These issues of a changing society after *doi moi*, where culture and especially gender related issues has not developed at the same pace, vulnerability of women seem to be increased. This is supported by Duong et al. (2008a) stating that there is a clear risk that HIV will spread to the general population influenced by the Vietnamese culture and traditions. The higher vulnerability can create a vicious circle where illness leads to loss of income and coping strategies including high-risk behaviour is undertaken, endangering even more people in terms of contracting HIV.

6.3 HIV and AIDS in Vietnam

It was evident that most key informants did not think that a focus only on high-risk groups in the fight against HIV and AIDS was relevant. Explanations given were that although the epidemic is still considered concentrated these high-risk groups have links with other groups (Mørch 2009, Eligh 2009, Le 2009a, Tran 2009, and Phan 2009). Phan (2009) specifically argued that migrants should be added as a high-risk group.

6.3.1 Bridging behaviour

A study done in 20 provinces from Duong et al. (2008b) shows that risk-behaviour among people living with HIV and AIDS in Vietnam is fairly high with 20% of them having multiple partners, whereas only 1/3 consistently used condoms. The reasons stated for not using condoms were among others "dislike" (around 50%), "condom not necessary" (around 25%), and for women "partner objection" (around 22%). Around 18% (644) of 2,247 male participants reported that they had visited a sex worker during the last 12 months. This study is highly relevant in terms of the youth, as 79.3% of the participants were between the ages of 20 to 34. Of those who were sexually active in the past year consistent condom use with regular partners was 41.3% for males and 26.6% for females, while numbers for non-regular partners was 30.1% and 23.1%, respectively. From this study it seems that a relatively high number of HIV infected engage in risk-behaviour, leaving their sexual partners at risk (Duong et al. 2008b).

For people living with HIV or AIDS and reporting injecting drug use the past month before the survey, 35% also reported sharing needles and syringes including 14% who had passed his/her equipment to others (Duong et al. 2008b).

Clients of sex workers have been studied by Nguyen et al. (2008a) to assess who are active bridgers (not consistent condom use and sex with both low- and high-risk partners), potential bridgers (consistent condom use only with high-risk partners and sex with both low- and high-risk partners), and unlikely bridgers (consistent condom use with low- and high-risk partners or with only high-risk when having no low-risk partner). The findings showed 5.5% were active bridgers, 50.3% potential bridgers, and 44.2% unlikely bridgers. 58.9% of the 163 who were either potential or active bridgers had a wife, 71.8% had one or more girlfriends and 74.2% reported having casual sex partners. Of the clients not using condoms with sex workers, 38.5% did not believe they were at risk of becoming HIV positive (Nguyen et al. 2008a).

To compare a study from Kenya on clients of female sex workers show that at least 50% of the clients were between the age of 25 and 36 with the majority of all participants saying they visited sex workers one or two times a week. 42% report rarely or never using condoms with sex workers with almost 70% of clients trusting the sex workers they visit often. Besides being away from the wife or girlfriend, some also mentioned peer pressure as a reason for visiting sex workers. It has to be taken into account that this was a quite small study and therefore not necessarily representative of Kenya on a national level (Voeten et al. 2002). Another study from Peru reported much higher consistent condom use between client and sex workers

with 89.4%, while the corresponding number for sex with a regular partner was 16%. 50.4% stated the reason for not using condom as not at risk of getting STI including HIV and 38.1% that it decreases sensation. Interestingly 6.7% said that they had paid more for sex without a condom (Miller et al. 2004). As mentioned above, experiences from Thailand also show that monogamous women can be infected with HIV through their husbands who engage in extramarital sex and this scenario could also be a reality in Vietnam (Tran et al. 2006).

6.3.2 Discrimination

Stigma and discrimination happens in the community for example with the family of HIV infected loosing business income or experiences exclusion and from hospital staff with examples of staff refusing to give routine services to HIV infected. Two informants also mentioned that registered national HIV and AIDS rates could be too low which among other things could be due to the fact that some does not want to be tested because of the stigma and discrimination that follows (Mørch 2009 & Appelboom 2009). Also stigma and discrimination happens in workplaces, as many are not able to get a job and if they do, discrimination follows although the HIV law should protect against discrimination at the workplace (Mai et al. 2008). This indicates that knowledge about HIV and how it is transmitted is not good enough. It has to be taken in to consideration though that this study includes specific HIV infected people's experiences, which might not be true for other HIV infected people (Mai et al. 2008).

6.4 Youth and reproductive health

6.4.1 Premarital and extramarital sex

According to Mørch (2009) Vietnam has been controlled by many moral and ethical codes of conduct which lies deeply rooted in the society. The youth have not experienced wars and have a more materialistic view on things, where a good job in the private sector, money, a car, and other luxury goods are important. There are therefore probably things resulting from the lifestyle of the youth which could make them more vulnerable to HIV compared with the older generation (Mørch 2009 & Eligh 2009). Le (2009b) also sees a difference in the way her generation and the current youth look at premarital and extramarital sex. Although still not accepted by the majority of the Vietnamese society, premarital sex for some has become popular, making them more vulnerable. Also a change in role models was seen, moving from parents and grandparents to for example movie stars and friends.

Poulsen (2009) argues that premarital and extramarital affairs are rather frequent in Vietnam for both men and women although the rates for men are probably higher.
It is also argued that the youth is getting married at a later age, which could influence the attitude towards premarital sex (Le 2009b, Mørch 2009, Tran 2009 & Appelboom 2009). Tran (2009) though argues that through focus groups discussion with young people in many parts of Vietnam, he found that of those having premarital sex, 70-80% was with the future spouse.
Mass media including TV, movies, and books is influencing the part of the youth who has access to this and thereby also influencing attitudes towards premarital sex (Mørch 2009, Le 2009a & Phan 2009). Also there are increased possibilities to engage in premarital sex through better life conditions, for example with better nutrition (Tran 2009 & Le 2009a). This can be linked with the many abortions among young women who do not know how to protect themselves (Le 2009a, Le 2009b & Gammeltoft 2002). Adolescent down to the age of 11 are seen to have abortions, and unofficial numbers show that of 30,000 abortions, 3,000 (10%) could be attributed to adolescents between the ages of 11 and 17 of which 60% came after week 13 in their pregnancy (Le 2009a). This is also supported by a survey from Nepal where a relatively high number of young migrant workers have premarital sex and a high number of unintended pregnancies are seen (Puri & Cleland 2006).
This again links with the arguments from Dixon-Mueller (2009) stating that one should also look at adolescent (10-14 years old) to prevent HIV infections. It is emphasised that "*Behaviors that are considered shameful or taboo are likely to be underreported while those viewed as "masculine" are often exaggerated by boys, thus making gender contrasts appear sharper than they are*" (Dixon-Mueller 2009 p. 101). This not only goes for adolescent, but for the whole population and is especially interesting in Vietnam as there in the journal articles reviewed is a large difference in the reporting's on sexual behaviour and risk-behaviour between males and females. It is also highlighted that at this age there are knowledge gaps regarding transmission of HIV and STIs, safe sex, and prevention of pregnancy, which might also be linked to the relatively high number of young girls getting abortions (Dixon-Mueller 2009).
In the answers from the questionnaire first sexual intercourse was between the ages of 16 and 25, but no definite trends were seen in terms of at what age the first sexual intercourse was most common.
One issue related to prevention of HIV relates to little use of contraceptives. According to two of the informants, one could previously get arrested for carrying condoms, as it was associated with sex workers (Appelboom 2009 & Tran 2009). It

is also stated by one of the informants that young Vietnamese people still to a large degree see condoms as something related to sex workers (Poulsen 2009).
The most common contraceptive method against pregnancy used by almost 50% of the questionnaire respondents having sex was condoms, while 18% (6) used oral contraceptives and 12% (4) used interrupted sexual intercourse. Of the 23 respondents having had sex, 48% reported always using a condom when having sex, 43% reported sometimes using it and 9% never using it.

This change in premarital sex is supported by Ghuman et al. (2006) who specifically studied changes in premarital sex in Vietnam in three groups of people married between 1963-1971, 1977-1985, and 1992-2000. The study found that men in the group married last had the highest percentage of premarital sex with spouses (between 3-22%) and with other than future spouses (between 3%-17%). A relatively large difference between reporting's from male and female respondents were seen. In addition, with regards to first sexual intercourse among men with their future spouse the participants from the North in the first two groups reported this to be around 97%, while the group married between 1992 and 2000 reported this to be 84%. In the South the percentages were already lower with percentages down to 77.2%. The corresponding percentages for first sexual intercourse with girlfriends was 1.9%, 1.4%, and 13.2% for the North, while 9.4%, 16.1%, and 16.8% for the South. This indicates a rise in premarital sex among men with someone other than the future spouse (Ghuman et al. 2006).
Mensch et al. (2003) questions studies which state that young people have more premarital sex than previously. They argue that much research is built on stories rather than data or on data which is from a limited part of the population and therefore is not representative or reliable. It is though argued that Confucian traditions might distort interview responses and it is emphasised that there might be problems with underreporting in their own survey, as young people tended to be more willing to talk about friends behaviour rather than ones own. One example is drug use, where use of heroin and cocaine was only reported by around 1% for both sexes, while they reported that 9-10% of their friends used these substances.

6.4.2 Bridging behaviour

In a study on bridging behaviour of people aged 18-29, 261 (41.4%) of the participants had had sexual intercourse and of those 113 (43.3%) had had premarital sex (male 78.3% & female 13.5%) (Duong et al. 2008a). Mensch et al. (2003) show a different picture with 10% of males and 5% of females reporting premarital sex.

This might be explained by differences in target group (18-29 vs. 15-22) and the number of provinces targeted. Estimates show that sexual intercourse by the age of 22 has been experienced by around 29% of unmarried men and 16% of unmarried women. Of the married women, 87% said their premarital sexual partner was the person who later became their husband (Mensch et al. 2003). This concurs with the focus group discussions done by Tran (2009) and another study stating that 27.5% of males and 83.7% of females sexually active had their first sexual intercourse with their spouse. Also 42.9% reported always using a condom with non-regular partners while the number with regular partner or spouse was 21.2% (Duong et al. 2008a). The differences between men and women could be explained by men visiting sex workers and/or that girls' underreport incidences as explained above on problems with under/over reporting (Duong et al. 2008a & Dixon-Mueller 2009).

One study in Soc Trang, has seen HIV prevalence among the sex workers at 3.3%; slightly lower than national average. This study distinguish between direct sex workers which are women who only earn an income by selling sex and indirect sex workers which are women who both earn an income by selling sex and their other employment for example in karaoke bars, restaurants, hotels, hairdressers, coffee shops, and massage parlours. This distinction is important as some women might not see themselves as sex workers if their main income comes from the other job. Indirect sex workers tended to be younger than direct sex workers with about 50% being indirect sex workers (Nguyen 2008b & Nguyen 2008c). In a study from Hanoi 35% of the sex workers reported also having other employment and with only about a quarter of the participants originally from Hanoi (Tran et al. 2006).
While 77% of the participants reported regular condom use during the last month, 33.7% reported withdrawal as the contraceptive method used. This might be effective in terms of not getting pregnant, but not in terms of preventing transmission of HIV (Nguyen et al. 2008b). In the study on sex workers in Hanoi they used three different categories when asking about frequency of condom use; Irregular clients (one-time clients), Regular clients (known by the sex worker and had had sex with more than once), and "love mates" (long-term boyfriend or husband). The condom use frequency for the last sexual intercourses with the three types of clients was 94%, 77%, and 16%, respectively. When asking about the condom use frequency over the last month the percentages are 62.6%, 41.2%, and 4.8%, respectively which gives quite a different picture. It is emphasised that social bias might be the case, as sex workers might not want to report not using condoms and consistent condom use could therefore be too high (Tran et al. 2006). Nguyen

et al. (2000) also finds higher rates of consistent condom use for the last sexual intercourse 91% than compared to the last year 46.7%.

The reasons for not using condoms with regular clients included that the sex worker knew the client and therefore was not worried, secondly, that the partner objected, and thirdly, that they did not think it was necessary. The same pattern was also seen with husbands/boyfriends. In the study of women working in entertainment services, 19.3 was the mean number of partners the participants who were having sex outside marriage or relationship had during the year before the survey. More than one third reported having more than five sexual partners. Having non-regular sex was among other things correlated with being younger than 30 years old and having a residence which was non-urban (Nguyen et al. 2000).

Phan (2009) argues that although there have been changes in condom use it is still not a habit for many Vietnamese people and what still remains a relatively large problem is that women will be criticised for offering condoms for safe sex among other things because it is an issue of trust and loss of pleasure for the man. Trust and loss of pleasure were also given as reason in studies from Kenya, Peru, and Mexico described above (Voeten et al. 2002, Miller et al. 2004 & Hirsch et al. 2002). Poulsen (2009) states that there might also still be a problem in Vietnam with associating condoms with sex workers or married couples which could increase risk-behaviour.

Also consistent condom use was generally reported less by indirect sex workers and comparing to another study showing that most young women worked as indirect sex workers, the young sex workers seem to be more at risk than the older sex workers (Tran et al. 2006 & Nguyen et al. 2008b). Generally the questionnaire, key informant interviews, and literature desk study found relatively low consistent condom use. This is worrying as it has been indicated that many young men visit sex workers although they also have a wife or girlfriend.

Although it is difficult to find statistical data on how the risk-behaviour of the Vietnamese youth was before *doi moi*, this thesis still presents indicators of a change. This is done through the survey investigating premarital sex with couples married in different time periods, through some of the key-informants who say that risk-behaviour has changed because life conditions have improved, and through Phinney (2008) how state that men have more possibilities to engage in extramarital after *doi moi*. In addition, divorce rates going up and more women are becoming independent giving more possibilities to have several partners during a lifetime.

Risk-behaviour for drug users includes sharing of needles and syringes with other drug users. Two studies reported sharing by 19-24% of participants (Thao et al. 2006 & Nguyen et al. 2001). These rates might be higher in other provinces and possibly liked with the cost of needles and syringes and as drug use is illegal in Vietnam sharing might also happen as few people will then have to carry the equipment (Duong et al. 2008b).

The survey done by Thao et al. (2006) also showed that initiation to drugs was mainly done among friends and 53% said the place of initiation was an entertainment place including karaoke bars, cafés, and restaurants. Just below 80% gave peer pressure as the main reason for trying drugs. While 87% reported the method of use at initiation as smoking, at the time of the study 57% were injecting with a mean time from initiation to starting injecting at about 14 months. Of 586 participants having had sex 20 – 37% reported having sex with female sex workers, friends in drug using group, other friends, and casual partners (Thao et al. 2006).

When asked about frequency of condom use of those who were either single or married but had extramarital sex, 285 (of 532) said they never used condoms. Especially consistent condom use with spouses was low at 6% which is especially worrying as 32% of those married and having extramarital sex stated never using condoms with partners outside marriage (Thao et al. 2006).

In a survey from Ho Chi Minh City 41% of the drug users reported using condoms. Although knowledge of transmission and prevention methods in terms of HIV was high, 43% of those injecting drugs did not believe they were at risk of getting HIV (Nguyen et al. 2001).

A study among sex workers showed that the use of illicit drugs was correlated with younger participants, having the first intercourse early, and lower regular condom use with clients. The correlation between having first sexual intercourse at an early age and HIV might indicate that knowledge about safe sex is relatively low, but also that since the girls might not be fully developed at that time they are more vulnerable in terms of HIV infection (Nguyen 2008b).

When looking at the findings from the questionnaire knowledge about transmission of HIV was quite good and all respondents knew that HIV could be transmitted through penetrative sex, while only one did not indicate that HIV could be transmitted through blood transfusions. On the other hand only just over 50% related "in the womb" with transmission risk, while the number for breast feeding was almost 25% (8 respondents). A few also thought that transmission could happen through kiss and mosquitoes. On the question "*How can you protect yourself from*

getting infected with HIV?" most respondents mentioned safe sex/condom use, while a few stated things such as "*stay away from social evils*" and "*live a healthy life*".
19 respondents (57%) stated that there is no chance (8 respondents) or only a small chance (11 respondents) they might become affected with HIV. It here has to be noted that 10 respondents reported not having had sex and this might influence the number of people stating that there is no chance of them getting infected.
So generally it was found in the literature desk study, the key informant interviews, and the questionnaire that knowledge of HIV and how it is transmitted is high. But this knowledge does not seem to be translated into low-risk behaviour.

7. Conclusions and recommendations

7.1 Conclusions

From this thesis it can be seen that great changes in policies and economic environment have the possibility to influence many other factors in the society and thereby maybe also the vulnerability to HIV and AIDS. The introduction of new policies, new livelihood opportunities, and a new economic situation has created both new coping strategies and risk management strategies. The new situation has led to an increase in migration, increasing possibilities to engage in premarital and extramarital sex, increasing access to drugs, and increasing unemployment and underemployment. At the same time inconsistent condoms use is still a reality and old cultural roles are still present and maybe even more strongly after *doi moi,* influencing both the vulnerability of young Vietnamese women and men.
Actions to cope with the current situation for some mean livelihood diversification, but with the economic crisis good jobs can be hard to find and strategies which includes high-risk behaviour therefore might be the only choice. Since the number of HIV cases is increasing in Vietnam and precautions are not always taken in terms of sexual relations and injecting drug use, the possibility of contracting HIV might be getting higher. In the cases of HIV infection, livelihood strategies to cope with the new situation are even harder due to the stigma and discrimination and the livelihood basis can erode. The fear of disclosing the disease might both mean that the registered numbers currently are too low, but also that many people might be at risk of transmitting or contracting HIV without knowing it.
The findings indicate that overall there are possible connections between livelihood change in terms of migration, current economic conditions, the HIV & AIDS laws and policies, access to services, stigma and discrimination, and gender roles and HIV and AIDS vulnerability among the youth in Vietnam.

As most of the issues addressed in this thesis are difficult to measure it means that a clear conclusion is difficult to reach. Especially a further analysis of the changes in risk-behaviour is warranted as little data was found on the issue related to the time before *doi moi*. It might be that data for this can be found in Vietnamese sources.
Also it would be interesting to follow up on the impact of the financial crisis on vulnerability to HIV, when the impacts become clearer than they currently are.
One thing which could also complement the work in this thesis is field work involving young Vietnamese people rather than mainly Hanoi-based key-informants. This could be done through for example a study using Participatory Rural Appraisal (PRA) particularly on the risk-behaviour of young migrant workers or on how gender roles influence risk-behaviour of the Vietnamese youth.
In terms of the access to services and particularly access to health care the findings indicate that especially the poorer Vietnamese people are at a disadvantage and that this might influence access to HIV and AIDS testing and treatment. Future research might involve an extension of this to more specifically understand the effect of the current access to health care and the linkages to the spread of HIV and AIDS.

7.2 Recommendations

The findings indicate that to change the current development in the HIV and AIDS epidemic, changes needs to be done when it comes to policy implementation in terms of monitoring. Also maybe an added focus should be on prevention of HIV and AIDS together with more focus on migrants, spousal transmission, and more generally the Vietnamese youth for example through dissemination of information in schools. In addition, sex workers and not their clients are punished for their illegal activities. By making men responsible for their actions, it might also have an influence on the HIV epidemic.
It might also be helpful to do campaigns on condom use, stressing that this is for the general population and not only for sex workers or married couples.
With little safety nets, a relatively large part of the population is vulnerably to small changes their asset base or the surrounding environment. It could therefore also be important for the Government to secure basic safety nets for the poorest to make sure the needed tests, treatment, and counselling is available to prevent the spread of HIV and AIDS.

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