"Because We're So in Love": The Experiences of HIV-Negative and HIV-Positive Partners in Serodiscordant Relationships in Vietnam

Khuat Thi Hai Oanh, Sally Cameron, and Lan Nguyen

Introduction

The official approach to HIV prevention in Vietnam has shifted over the last decade from a platform that blamed certain populations for the HIV epidemic to a stronger focus on public health. Emerging recognition that many women's HIV infection risk occurs within intimate relationships has triggered a shift in Vietnam's HIV prevention thinking. It is now accepted that HIV risk extends beyond the "social evils" ("tệ nạn xã hội")[1] of injecting drugs, sex between men and sex work, and that risk can arise as a result of behaviors considered socially acceptable or even desirable, that is: sex between spouses and sex between monogamous heterosexual couples. There is growing understanding of the intersection between behaviors in different contexts and a realization that primary HIV prevention measures targeting key "higher risk" populations of people who inject drugs, men who have sex with men and female sex workers directly impact a secondary group: their intimate partners. Still, relatively little is known about the many contextual factors such as culture, intimacy and gender dynamics that influence HIV transmission risk among intimate partners in serodiscordant relationships in Vietnam and the way HIV infection informs their daily lives, including plans for the future.

[1] A term institutionalised in government policy.

Khuat Thi Hai Oanh (✉)
Centre for Supporting Community Development Initiatives, Hanoi, Vietnam
e-mail: oanhkhuat@scdi.org.vn

S. Cameron
Australian Federation of AIDS Organisations, Newtown, NSW, Australia
e-mail: sallycameron@fastmail.fm

L. Nguyen
Partners in Health, Boston, MA, USA
e-mail: nguyen.phg.lan@gmail.com

© Springer International Publishing Switzerland 2017

A. Persson, S.D. Hughes (eds.), *Cross-Cultural Perspectives on Couples with Mixed HIV-Status: Beyond Positive/Negative*, Social Aspects of HIV 2,
DOI 10.1007/978-3-319-42725-6_19

Emergence of Serodiscordant Couples as a Priority for HIV Prevention

In 2014, an estimated 256,000 people were living with HIV in Vietnam (Vietnam Administration of HIV/AIDS Control 2013). The HIV epidemic is concentrated among key populations of people who inject drugs, men who have sex with men and female sex workers and their clients, with injecting drug use the primary mode of transmission. Most people living with HIV are men, however a steady increase in infections among women is being reported. In 2001, women comprised 15 % of people living with HIV (Ministry of Health data, cited in San et al. 2002). By 2013, women accounted for an estimated 32.5 % (Socialist Republic of Vietnam 2014).

While definitive surveillance data are not available, numerous studies suggest a primary source of HIV infection among women is their long term partners, and that increasing rates of infection among women likely reflect "slow but steady" transmission of HIV to women by men engaging in "highly risky behaviors" (Socialist Republic of Vietnam 2014). Intake data from voluntary counselling and HIV testing clinics between 2006 and 2010 showed 54 % of women diagnosed with HIV infection identified a husband or long-term male partner with high risk behaviors as their only possible exposure to HIV (UNAIDS and UN Women 2012). *Vietnam AIDS Response Progress Report 2014* states most women living with HIV report they were infected by a stable sexual partner who either injected drugs or visited sex workers (Socialist Republic of Vietnam 2014). The consequences of the "slow creep" of spousal transmission means that transmission from men engaging in high-risk activities to their long-term female sexual partners accounted for an estimated 28 % of *all* new infections in Vietnam in 2014 (Vietnam Administration of HIV/AIDS Control 2014). In this study (outlined below), 88 % of female participants reported they were HIV infected by their heterosexual partners.

Serodiscordant relationships are not unusual, particularly relationships involving an HIV-positive man and an HIV-negative woman or woman of unknown HIV status. In 2012, a UNAIDS and UN Women's data triangulation exercise examining intimate partner transmission found that between 53,000 and 160,000 women were potentially exposed to HIV by a high-risk long-term male partner between 2006 and 2010. Broken down by exposure category, this means up to 41,327 women living with an HIV-positive person who injects drugs; up to 11,017 women living with an HIV-positive man who have sex with men; and up to 107,652 women living with an HIV-positive client of sex workers. A recent study of HIV-positive married men registered at an HIV clinic in northern Vietnam also found a high proportion of HIV serodiscordance among HIV-affected married couples. Among the 163 HIV-positive men enrolled in the study, 63 % had wives who were HIV-negative (Sawada et al. 2015).

Limited progress in primary HIV prevention measures is placing serodiscordant sexual partners at significant risk, particularly when the HIV-positive partner is undiagnosed. HIV testing remains low among priority populations. In 2013, only 29 % of MSM and 24 % of people who inject drugs reported an HIV test in the

previous 12 months (Socialist Republic of Vietnam 2014). Vietnam's national AIDS Law of 2006 provides that sexual partners of people who inject drugs and other key populations are entitled to access the condom promotion program (Socialist Republic of Vietnam 2006). There is recent official recognition of serodiscordant couples as a priority population for prevention (Ministry of Health 2014:15) and a growing understanding that additional measures are required to specifically address the HIV prevention needs of intimate partners of people with HIV. Prevention for serodiscordant couples is implemented through behavior change communication, HIV testing and counseling, and "treatment as prevention" (TasP). Even so, coverage of HIV testing and counseling services was very limited among female long-term partners of men at higher risk of HIV infection when this study was conducted in 2009; such remains the case in 2015.

The Study

This chapter is based on a 2009 multi-arm study documenting the sexual and reproductive health (SRH) needs of people with HIV (Oanh et al. 2011). The study was undertaken by the Institute for Social Development Studies in partnership with Vietnam Civil Society Partnership Platform on AIDS. The study was given ethics approval by the Institutional Review Board of the Institute for Social Development Studies.

The study's first arm comprised a survey of 2599 people living with HIV (PLHIV) associated with PLHIV groups in 22 provinces: 1300 women, 1297 men and two transgender people (referred to as "the core PLHIV study"). The self-administered questionnaire required Vietnamese literacy. The second arm involved 307 HIV-negative partners of some of those who participated in the first arm of the study (referred to as "the negative partners study"). The negative partners study grew out of feedback from the core PLHIV study, during which many participants suggested that sero-negative spouses should also be involved as they are an "integral part" of the sexual and reproductive health of people with HIV (Oanh et al. 2011). Negative partners of people with HIV were defined as those living with a positive person (regardless of marital status) and whose latest HIV test indicated they were HIV-negative. The majority of negative partners who participated in the study were women (87.6 %). Of those women, 58.2 % had been with their HIV-positive partner for five years or more and 29.4 % had been together for two to five years.

A qualitative arm was also conducted, spread evenly across seven geographic regions: Northwest, Northeast, Hanoi, Red River Delta, Central, Ho Chi Minh City and Mekong Delta. Efforts were made to ensure representation of men and women as well as representation across key populations. The qualitative arm included 21 focus group discussions (seven for men with HIV, seven for women with HIV, two for HIV-positive drug users, two for HIV-positive sex workers, and three specific to HIV-negative partners). It also included 72 in-depth interviews with people living with HIV and their regular (primary) sexual partners. "Regular (primary) partner"

was defined as someone either living with the participant as husband or wife, or someone with whom the participant had sex on a regular basis and with whom the participant had had a strong emotional attachment for at least three months. Finally, 88 in-depth interviews with SRH service providers were conducted. This paper focuses on the qualitative interviews with HIV-negative partners and in-depth interviews with people living with HIV and their regular sexual partners.

Findings and Discussion

Marital or Partnership Status

Data from the core PLHIV study reveal a number of gendered differences among respondents living with HIV. Women tended to be younger, have fewer years of schooling, and were more likely to be responsible for providing economic support to at least one other person. Men were far more likely to have never been married/ lived with anybody (Men 24.6 %: Women 3.0 %). Women were far more likely to have "ever lost a spouse to AIDS" (Men 6.9 %: Women 48.8 %). Women were also far less likely to have remarried following the death of a spouse, identifying current marital status as "widowed" (Men 1.3 %: Women 34.5 %). According to the participants, being known as the widow of someone who had HIV or was a drug user was considered a great disadvantage to women, undermining the likelihood of finding a new partner. Their experiences of personal loss also seemed likely to impact the nature of intimacy in future relationships.

The majority of HIV-positive participants (67.3 %) described themselves as having a regular partner (68.7 % of men and 63.2 % of women), however only a minority were formally married (46.0 % of men and 36.5 % of women). These rates were far lower than the general population, where 61 % of men and 77 % of women among those aged 25–29 years, and 84 % of men and 86 % of women among those aged 30–34 years are married (General Statistics Office of Vietnam 2005). This difference is notable, since formal marriage brings enhanced social standing and access to services. Unmarried partners also confront practical challenges, such as difficulties dealing with legal issues regarding children and inheritance outside of marriage. This finding suggests the importance of developing responsive interventions that recognize that the majority of people with HIV are in a relationship although many are not married.

Ninety-seven percent of respondents in relationships were in a heterosexual relationship. Of those people with HIV who had only one regular partner, 60.2 % (52.7 % men and 84.3 % women) had a partner who had tested positive for HIV, while 31.1 % (37.4 % men and 10.6 % women) had a partner who had tested HIV-negative, and 8.8 % (9.9 % men and 5.1 % women) had a partner whose status was unknown.

The research showed highly gendered patterns of serodiscordance. Almost half of all partners of men living with HIV were HIV-negative or of unknown serostatus. By comparison, only 15 % of partners of women living with HIV were HIV-negative or of unknown serostatus. Most serodiscordant respondents reported their relationships were either committed and/or loving, however many also struggled with fear of transmission and fear of losing their partner for a variety of reasons (outlined below).

Disclosure

HIV-negative partners came to be in a relationship with their HIV-positive spouse in a number of ways: they were unaware that their partner was HIV-positive when they first partnered; their partner was infected *after* they had formed a relationship; or they knew *beforehand* that their partner had HIV and made a commitment regardless. The majority of HIV-negative respondents had not been informed of their partner’s HIV status before committing to the relationship. For a range of reasons, it not uncommon for people with HIV to have sex without disclosing their HIV status to their sexual partner. Although Vietnam’s Law on AIDS stipulates that people with HIV must disclose their status to their spouse or fiancé (Socialist Republic of Vietnam 2006), in this study 26 % of men and 20 % of women who had had sex since being diagnosed HIV-positive had not disclosed to at least one partner before having sex.

Participants described multiple barriers to disclosure of HIV-positive status. Many people with HIV reported difficulties in disclosing although they wanted to disclose. The most common reasons for not disclosing were fear of being stigmatized or isolated (85.4 % men and 95.3 % women), fear of confidentiality being breached (86.2 % men and 86.9 % women) and fear that their partner would refuse to have sex with them (88.2 % men and 79.3 % women). Positive women were more fearful of being stigmatized or isolated than their male peers, which is perhaps not surprising given evidence many women become victims of abuse, violence or abandonment following disclosure (Eyakuze et al. 2008).

For some people, fear of the consequences of disclosure was so great that they chose to give up a relationship rather than disclose:

> That girl is really sweet. I like her a lot but I didn’t know how to tell her [I have HIV]. If I had continued, I would have needed to let her know, but I didn’t know how she would react. I am afraid that she would have looked at me with different eyes. Maybe she would tell other people … so I’m giving up (HIV-positive man).

One man had decided to stop three different relationships:

> It is like there is a wall, a wall in front. Every time I start dating someone I think, how can I say it … if I say I am diseased like this? So after some time, I give up.
>
> Interviewer: So why do you start dating these people?
>
> Well, at the beginning, because we are human, we have feelings. Having feelings, we want to date. After dating I feel … I feel if I am not going to tell her, I would of course feel

> guilty. I have to decide. Telling her is like killing; not telling her is also like killing. Then I think, it's better to withdraw myself (HIV-positive man).

Many HIV-negative respondents recognized their HIV-positive partners' decisions not to disclose or to delay disclosure were not straightforward and often involved considerable anxiety and guilt.

Staying Together

Clearly not all serodiscordant couples stay together. For example Sawada and colleagues' (2015) data show 4 % of men in their Northern Vietnam study sample had divorced since their HIV diagnosis. In this study, HIV-negative partners, including those who found out their partner's HIV positive status before or after getting together, gave a variety of reasons for staying with their HIV-positive partner (Fig. 1).

The importance of marital ties and/or romantic attachment frequently outweighed HIV-related concerns when deciding to continue the relationship. The majority of negative partners felt strong emotional attachment to and compassion for their positive spouses. When asked if they would like to have a new partner, 92 % of negative partners responded "no". Many of those who made a commitment to their partner after learning of their partner's HIV-positive status told stories of love and compassion.

> Because we were so in love … Well, when you are so in love, there is no fear anymore (HIV-negative, male).
>
> That day when I married him, many people said I am mad or that kind of thing. The day we decided we want to live together, I only thought 'if our love can protect and help each other, it is good' (HIV-negative, female).

In addition to love and commitment, both positive and negative partners in serodiscordant relationships often also experienced a range of different fears. For example, some positive partners spoke of their fear of losing their negative partner because of

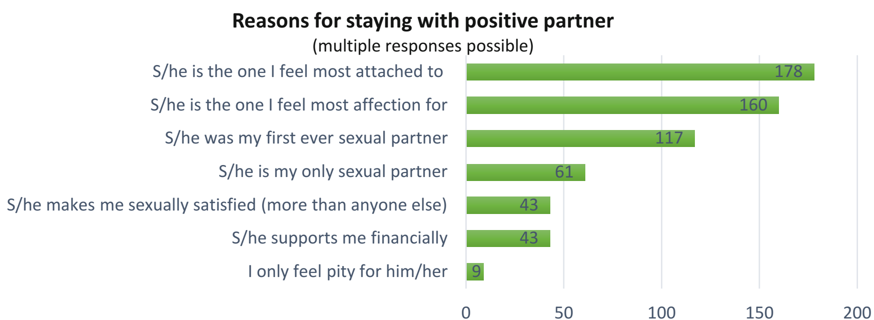

Fig. 1 Reasons given by (307) HIV-negative partners for staying with HIV-positive partner

the additional burden that living with a person with HIV may bring, or because partners and family members also experienced HIV-related stigma and discrimination. Indeed, the study uncovered cases where fear of a partner leaving the relationship may have contributed to cruel behavior, including gender-based violence:

> It is truly because of the pressure … Every time we start to have sex, my husband feels pressure so he becomes scornful. His personality has changed. Before he was 10 times sweet. Now he is 10 times cruel (HIV-negative, female).
>
> I know this guy. He is positive. His wife was not but he forced her to have sex without a condom. He kind of tried to infect her because he was afraid she would leave him. He even said to her that he would infect her so that when he dies she won't be able to go with another guy. She knelt in front of him asking him to save her so that she can take care of the children. Many people spoke to him but he insisted. Now she is positive (HIV-positive, female).

HIV-positive respondents also reported that their fear of transmitting HIV impacted their physical relationship:

> I am an infected person so our (sexual) relationship is not as enjoyable as it was at the beginning. I am always afraid and try to prevent transmission to my wife (HIV-positive, male).

Some negative partners also spoke of their fear of transmission:

> Sometimes while we are [having sex], I stop and check the condom. I am so afraid (HIV-negative, female).

In some cases, this fear was so severe that negative partners took extreme measures to avoid sex:

> We have our own beds. I have a 'security guard' so I am not afraid. The 'security guard' is my son [who sleeps with his father]. Going to sleep he uses a scarf to tie his wrist to his father's, and says to his father 'you should not go anywhere' (HIV-negative, female).

Fear of transmission, however, was not the only fear reported by negative partners. Some were also afraid their partner may leave them to look for an HIV-positive partner, to avoid concerns about transmission or to be able to have sex without condoms:

> I am afraid that he may look for a positive woman, for example, to have freedom [having sex] or he may think that she would understand him better (HIV-negative, female).

Sexual Activity

People with HIV were much less sexually active than their peers in the general population (National Sex Survey data in Hong et al. 2009, cited in Oanh et al. 2011:30). Positive people in a serodiscordant relationship were less likely to have had sex "recently" than those with HIV-positive partners. Fear of transmission was a key reason, but other reasons were also reported (Table 1).

Table 1 Last time had sex by relationship serostatus

	Serodiscordant relationship	Seroconcordant relationship
Previous 4 weeks	65.6 %	78.7 %
1 month to 1 year ago	20.6 %	15.7 %
More than 1 year ago	13.8 %	5.6 %

Some people with HIV and HIV-negative partners believed that having sex would badly affect the HIV-positive partner's health, so they tried to constrain their sexual activities.

> We are very normal. We have sex probably twice a month, because his work is hard and his health is that of a person infected with HIV, so I think if we have sex too much it will affect his health (HIV-negative, female).

After learning they had HIV, some HIV-positive people in serodiscordant relationships were not able to regain sexual desire. Not only their sexual lives, but their overall enjoyment of life appeared to have diminished.

> Since I discovered that I got it, I have not slept with my husband. I feel frightened. My limbs became weak. Lying next to my husband I have no feeling. I live only for my children. For the last two years I have not had [sexual] feelings and I don't want my husband to have [sexual] feelings. When I shower, I don't want him to see me. When he showers or changes he always closes the door. My life is not adequate. My life is so lacking in meaning (HIV-positive, female).

When people with HIV sought advice from health services, sex was mentioned almost exclusively in relation to risk and condom use. There was rarely any discussion about pleasure, intimacy or how to negotiate decreased sexual activity or desire in serodiscordant relationships.

> Since my husband died I no longer think about sex. Here there is a lot of education saying it is ok to have sex normally. There is also education about condoms and correct use of condoms. There was even a doctor who came from central level [rather than provincial level: suggesting the importance of the education session]. I understand quite well about these things but I'm finished, with no desire for sex. No feeling. No desire (HIV-negative, female).

The survey suggests that interventions to address the sexual well-being of people with HIV are urgently required, and that they should be integrated into HIV prevention education provided to serodiscordant couples.

Condoms

Condoms were found to be widely available, with 99 % of all people with HIV reporting no difficulty accessing condoms, and 90 % of those who were sexually active in the previous three months stating that condoms were always available. However, only 62 % of those who had sex with a positive partner and 82 % of those

who had sex with a negative or status-unknown partner reported consistent condom use during the previous four weeks. Rates of condom use among *serodiscordant couples* varied by gender, with 16.6 % of positive men reporting consistent condom use with a female partner, compared to 33.9 % of positive women reporting consistent condom use with a male partner. Gendered rates of condom use among serodiscordant couples also varied by marital status. Approximately one third of HIV-positive women reported consistent condom use with their husband (37.1 %) or cohabiting, unmarried male partner (31.7 %). HIV-positive men were far less likely to report consistent condom use with their wife (11.6 %) than with a cohabiting, unmarried female partner (35.0 %).

Analysis of the qualitative data suggests condom use could be much lower, particularly among those in a non-marital cohabited relationship. The known serostatus of a partner also strongly influenced reported condom use, with condom use highest among people with HIV with a known negative partner, and lowest among those with a partner of unknown status: the latter being of considerable concern.

Regardless of their partner's HIV status, people receiving antiretroviral treatment (ART) were more likely to report consistent condom use than those who were not. Of those whose partner was known to be HIV-positive, 68 % of people on ART consistently used condoms compared to 56 % of those not on ART. Of those whose partner was known to be HIV-negative, 93 % of those on ART consistently used condoms compared to 83 % of those not on ART. Of those who did not know the HIV status of their sexual partner, 72 % of those on ART had consistently used condoms compared to 48 % of those not on ART. The reason for the greater use of condoms by people on ART is not known, however it may be related to increased access to information and counselling through HIV treatment and support services, greater awareness of sexual health, or exposure to biomedical discourses that would make reporting non-use more sensitive.

People with HIV reported being trapped between the pleasure of not using condoms and the fear of transmitting HIV. They also described a tension between the feeling of being protected by condoms and the cumbersome nature of their use.

> If I don't use condom, I am afraid that I may infect my wife. But I hate condoms. So does my wife. Sometimes after putting a condom on, I lose the excitement. Then I tried to avoid [sex] (HIV-positive, male).

Very often, people with HIV in serodiscordant relationships considered condom use an obligation. A positive man, who reported consistently using condom for 10 years with different HIV-negative partners confided:

> It is not really relaxing because using condoms is not very comfortable. I use them only because of a sense of responsibility (HIV-positive, male).

"Responsibility" may be understood as a desire to prevent HIV transmission but also unwanted pregnancy.

> I don't know if they [partners] are infected or not. I should prevent transmission. Also, I don't want [them] to get pregnant (HIV-positive, male).

In general, condoms were perceived by the majority of people with HIV in serodiscordant relationships as a pleasure inhibitor. In many cases, people considered not using condoms as a sign of trust. Others experienced fatigue using condoms and/or their reluctance to use condoms increased over time

> In general, [people] do not use condoms very much with sexual partners [they've] been with for a long time. [Me and my partner] have had sex for a long time so we are not afraid (HIV-positive, female).

One respondent articulated a perceived disconnection between knowledge and practice.

> To tell you the truth, many people who have knowledge from top-to-toe and preach about condom use, if you ask them, they don't use them (HIV-positive, female).

Some people reported not using condoms because of the difficulty of disclosing their status within the context of limited knowledge in the community and, specifically, limited knowledge of their HIV-negative partner.

> I didn't say anything yet. Every time we had sex I considered it normal, using no protection with my wife. Nothing. It is because [her] knowledge and understanding of [HIV and safe sex] was really zero. When I discovered I was infected, I came home and had sex normally. I didn't say that I was infected. I hid it. I didn't want my wife to know. If she knew, she would be shocked (HIV-positive, male).

Couples with children reported more consistent condom use across all categories: sero-concordant couples with children (69.8 %) compared to those without children (53.1 %); serodiscordant couples with children (91.7 %) compared to those without children (80.4 %); and couples with children where one partner was HIV-positive but the other's status was not known (60.6 %) compared to such couples without children (50.3 %).

It is important to recognise that condom use may be related to a desire to prevent HIV transmission or contraception, or a combination of both. Among negative partners in serodiscordant couples, 85 % reported using contraception, with 98 % of those reporting condom use. Yet notably, 17 % of HIV-negative women with an HIV-positive partner who had ever been pregnant reported that the last pregnancy was due to lack of access to contraceptives that suited them.

The differentiated use of condoms by couples with children is not fully understood, but may be partly explained by findings that condom use was associated with a sense of responsibility and desire to be alive and healthy, and to keep partners alive and healthy, for their children.

> We are thinking about the baby. Our wish has come true, so we no longer dare to take risks as before (HIV-positive, female).

The above findings suggest a need to design responsive HIV prevention strategies and programming that go beyond the rhetoric of 100 % condom use, recognizing the real reasons why people don't always use condoms and the interconnectedness of SRH services. These findings also suggest great potential for the use of treatment-as-prevention (TasP), which had yet to become a recognized prevention strategy at the time of this study, particularly if HIV testing and post-diagnosis counselling

facilitates identification of serodiscordant couples. We note Sawada and colleagues' recent study in Northern Vietnam, which found no seroconversion during (a median 24.1 months) follow up of 61 serodiscordant couples in which HIV-infected male partners were taking antiretroviral treatment (Sawada et al. 2015).

Pregnancy and Child Bearing

It is a norm in Vietnamese society for adults to marry and have children. Culturally, a person's life is not considered complete until they have children.

> Many times, his old mother cries that as people die they have children and grandchildren, 'losing the rice but the broken rice remains' [the family line continues], but here everything will be gone, no broken rice, nothing left [there will be no children left to continue the family line] (HIV-negative, female).

In the core PLHIV survey, less than one-third of participants (21 %) stated they still wanted to have children (22.9 % men, 15.5 % women). For most people with HIV, their desire for children was overridden by fear of the child being HIV-infected, fear of economic hardship and fear of leaving the child orphaned. All HIV-positive people who wanted children stated that their dominant concern was having a child uninfected with HIV. Among people with HIV who had no children, the most common reason for wanting children was to continue the family line. Among HIV-positive people with children, the most common reason for wanting another child was wanting a child of a particular sex, usually (but not always) male.

Despite fears of infecting the HIV-negative partner or having an HIV-infected child, most serodiscordant couples wanted children, especially those who had not had a child. The main reasons given were to satisfy their desire to be parents, to strengthen the bond with their partner or to fulfill their responsibility with family.

> His family condition is like that – no grandchild. His father was desperate. I know [my partner] wants a child very much but he didn't dare ask me [because it would mean HIV infection risk through unprotected sex]. I was also afraid that he would go with a girl who is also infected to have children. So I decided to take the risk (HIV-negative, female).
>
> At the beginning we used condoms, then I heard his mum say, 'This family is so unfortunate. Every other family has grandchildren except this one.' So I stopped using condoms. I decided that on my own. I stopped for three months. Then I got pregnant (HIV-negative, female).

Serodiscordant couples wanting to conceive relied most frequently on condomless sex, as alternative conception options were unavailable or unknown.

> It's almost like we gamble. At the time my husband and I affirmed the saying 'Gamble with God'. If God cares, then there is no problem but if he doesn't, then we have to accept whatever happens. We were fearful. My husband was very worried for me as well (HIV-negative, female).

Serodiscordant couples came up with their own strategies, including "home remedies", to reduce infection risk while trying to conceive, such as cutting the tip off

condoms, calculating days and not using condoms when ovulating, calculating days combined with the male partner masturbating and inserting his penis only when about to ejaculate, having sex without condoms and then the HIV-negative partner taking ART as post-exposure prophylaxis, and “having sex gently”.

> I think if we were unlucky and the baby was born positive, we would be miserable. My wish is to have a child but I don’t know where to go for counseling to know how to have a child without infection (HIV-positive, male).

Information and counseling services addressing the special needs of serodiscordant couples were not available when this study was conducted and remain largely unavailable in 2015.

Conclusion

The serodiscordant couples interviewed generally remained committed to each other, but many partners continued to experience fear that HIV would be transmitted. Many also described difficulty maintaining a satisfying sexual relationship and concern that the pressures of the relationship would cause one (HIV-positive or HIV-negative) partner to leave.

Limited knowledge of HIV risk reduction methods and contraception prompted use of a range of HIV prevention and family planning strategies, including unreliable “home remedies”. Couples’ strong desire for children, intensified by weighty cultural drivers to continue “the family line”, remains unaddressed in Vietnam. The data suggested an urgent need for more comprehensive SRH services and their linkage to HIV services (including prevention of mother-to-child transmission services). It remains urgent 6 years later. That finding is supported by the 2011 *Vietnam: Rapid Assessment of Sexual and Reproductive Health and HIV Linkages* (World Health Organization et al. unpublished), which also argued for further exploration of the factors behind the high rates of abortion among women with HIV, including pressure from family, community or health services, fear of HIV transmission during pregnancy or delivery, and concern about supporting children in case of a parent’s ill health. Prior poor experiences of health care may also play a role, given APN+’s (the Asian Pacific Network of People Living with HIV/AIDS) findings that during delivery and postpartum care, many HIV-positive women report extreme discrimination, including neglect during labour and healthcare professionals refusing to attend to them, touch them or bathe their newborn infant (APN+ 2012).

Social contexts, psychological drivers and gender dynamics of intimate partner relationships have tangible ramifications for service provision, particularly couple testing and counseling, prevention of mother-to-child transmission services, and TasP. Early evidence from pilot studies indicates that couples HIV testing and counseling, followed by immediate ART are feasible approaches to prevent transmission within serodiscordant couples in Vietnam (e.g. Kato et al. 2014). Similarly, Sawada and colleagues found that at-risk wives of HIV-positive men can be protected from

HIV transmission by proper use of ART (2015). Option B+ for prevention of mother-to-child transmission (i.e. provision of lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count) has also been piloted in several provinces (Loc 2014).

Findings from this 2009 study have contributed to significant programmatic and policy reform within a brief period. It informed the ground-breaking 2011 workshop, Forgotten Voices: Issues of HIV Negative Spouses and Sero-Discordant Couples,[2] which raised awareness of HIV risk, care and support needs among serodiscordant couples, particularly the importance of spaces for HIV-negative partners to access support, network and advocate. Recent funding and capacity building for peer-support groups for negative spouses of people with HIV has enabled their representation on the Vietnam Civil Society Partnership Platform on AIDS, and the inclusion of serodiscordant couples and HIV-negative partners of people with HIV and other high risk populations as priority populations in formal national HIV response mechanisms such as the National Strategic Plan on HIV/AIDS. The 2009 study provides a resource for ongoing development of prevention policy as the Government of Vietnam and development partners seek to reorient prevention in the context of TasP (Kato et al. 2014). Importantly, care should be exercised in the development of increasingly biomedical prevention approaches to ensure people with HIV are not considered only in terms of "transmission risk" but are instead considered as whole human beings for whom sexuality, the quality of their intimate relationships, and their aspirations for their family lives are central issues.

Given the effects of cultural and contextual factors on critical behaviors, such as adherence to ART, condom use and the intersection of SRH and HIV prevention initiatives, a nuanced understanding of the dynamics and social circumstances of serodiscordant relationships in Vietnam is required to inform HIV program interventions.

References

APN+. (2012). *Positive and pregnant: How dare you. A study on access to reproductive and maternal health care for women living with HIV in Asia. Findings from six countries: Bangladesh, Cambodia, India, Indonesia, Nepal, Vietnam*. Asia Pacific Network of People Living with HIV. http://www.aidsdatahub.org/sites/default/files/documents/positive_and_pregnant_2012.pdf. Accessed 3 Apr 2016.

Eyakuze, C., Jones, D. A., Starrs, A. M., & Sorkin, N. (2008). From PMTCT to a more comprehensive AIDS responses for women: A much-needed shift. *Developing World Bioethics, 8*(1), 33–42.

[2] This workshop was organised by the Community Advocacy Initiative (CAI), in collaboration with project partners, the Center for Supporting Community Development Initiatives (SCDI), Asia Pacific Council of AIDS Service Organisations and the Australian Federation of AIDS Organisations with funding from the Australian Government.

General Statistics Office. (2005). Population and labor force. *Vietnam statistical yearbook 2005.* http://www.gso.gov.vn/default.aspx?tabid=512&idmid=5&ItemID=5690. Accessed 3 Apr 2016.

Hong, K. T., Le Bach, D., & Nguyen, N. H. (2009). *Sexuality in contemporary Vietnam: Easy to joke about but difficult to talk about*. Hanoi: Institute for Social Development Studies.

Kato, M., Long, N. H., Duong, B. D., do Nhan, T., Nguyen, T. T., Hai, H. N., et al. (2014). Enhancing the benefits of antiretroviral therapy in Vietnam: Towards ending AIDS. *Current HIV/AIDS Reports, 11*(4), 487–495.

Loc, G. (2014). Treatment programme cuts HIV transmission rate. *Vietnam News*. http://vietnamnews.vn/society/255695/treatment-programme-cuts-hiv-transmission-rate.html. Accessed 3 Apr 2016.

Ministry of Health. (2014). *Optimizing Viet Nam's HIV response: An investment case*. Hanoi: Ministry of Health. http://www.unaids.org/sites/default/files/country/documents/VNM_narrative_report_2015.pdf. Accessed 3 Apr 2016.

Oanh, K. T., Tri, V. M., Tung, O. V., Linh, P. T., & Lan, N. P. (2011). *Sexual and reproductive health needs and rights of PLHIV in Vietnam.* Hanoi: Institute for Social Development Studies & Vietnam Civil Society Partnership Platform on AIDS (unpublished report).

San, P., Dung, P., Hong, K., Oanh, K., & Tuan, T. (2002). *Report: Evaluation of the national AIDS program, January 1996 – June 2001 in Vietnam*. Hanoi: AusAID, UNDP & Ministry of Health, National AIDS Standing Bureau. http://www.hivpolicy.org/Library/HPP000337.pdf. Accessed 3 Apr 2016.

Sawada, I., Tanuma, J., Do, C. D., Doan, T. T., Luu, Q. P., Nguyen, L. A., et al. (2015). High proportion of HIV serodiscordance among HIV-affected married couples in northern Vietnam. *PLoS ONE, 10*(4), e0125299.

Socialist Republic of Vietnam. (2006). *Law on HIV/AIDS prevention and control* (No. 64/2006/QH11). Ha Noi. http://www.hsph.harvard.edu/population/aids/vietnam.aids.06.pdf. Accessed 3 Apr 2016.

Socialist Republic of Vietnam. (2014). *Vietnam AIDS response progress report 2014: Following up the 2011 political declaration on HIV/AIDS. Reporting period: January 2012 – December 2013.* Hanoi. http://www.aidsdatahub.org/sites/default/files/publication/Vietnam_narrative_report_2014.pdf. Accessed 3 Apr 2016.

UNAIDS & UN Women. (2012). *Measuring intimate partner transmission of HIV in Viet Nam: A data triangulation exercise*. Hanoi: UNAIDS & UN Women. http://unaids.org.vn/wp-content/uploads/2015/08/IPT-Triangulation-VietNam-FactSheet-FINAL.pdf. Accessed 3 Apr 2016.

Vietnam Administration of HIV/AIDS Control. (2013). *Vietnam HIV/AIDS estimates and projections 2011–2015.* http://www.vaac.gov.vn/Cms_Data/Contents/Vaac/Media/Documents/Uoc-tinh-va-Du-bao-2011-2015_FINAL.pdf. Accessed 3 Apr 2016.

Vietnam Administration of HIV/AIDS Control. (2014). *An annual update on the HIV epidemic in Viet Nam*. Hanoi: VAAC.

World Health Organization, United Nations Population Fund, & International Planned Parenthood Federation (unpublished report). *Viet Nam: Rapid assessment of sexual and reproductive health and HIV linkages 2011.*