Influences of Gender Norms and Gender Roles on HIV Service Engagement in Vietnam

Mai Do,[1] Ha H. Le,[2] Hien T. Ho,[2] Ha T. Dinh,[2] Tien Q. Truong,[2] Trung V. Dang,[3] Duong D. Nguyen,[3] Katherine Andrinopoulos[1]

[1]MEASURE Evaluation, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA; [2]Hanoi University of Public Health, Hanoi, Vietnam; [3]USAID/Hanoi, Hanoi, Vietnam

Background

- HIV-positive people who inject drugs (PWID) face significant challenges accessing HIV testing and treatment, particularly because of normative expectations of gender and drug use behavior.
- In contexts where heterosexual transmission of HIV is a main driver of the epidemic, such as Vietnam, the female sexual partners (FSPs) of PWID face an increased risk for HIV infection and are also in need for HIV testing and treatment services.
- However, little research has tracked the engagement of HIV-positive PWID and their FSPs in HIV services or how gender-related factors (e.g., gender norms and expected roles) may influence such engagement. Filling this knowledge gap will contribute to the design of nuanced programs that seek to improve access and adherence to HIV services among these groups.

Specific Research Questions

1. How do male PWID and their FSPs differ in their engagement in HIV testing and treatment services?
2. How do expected gender roles within family and intimate relationships influence access to and use of HIV testing and treatment among FSPs of male PWID?

Data and Methods

- The USAID- and PEPFAR-funded MEASURE Evaluation project, led by the University of North Carolina, collected data through in-depth interviews with 30 male PWID and 21 FSPs in September 2017.
- All participants were HIV-positive and in long-term relationships.
- IRB approval was obtained from Tulane University and Hanoi University of Public Health.
- Fieldwork was conducted in Que Phong and Dien Chau Districts of Nghe An Province.
- Interviews were conducted in Vietnamese, translated into English, and analyzed using NVivo 11 software.

Results

Characteristics of study sample

Type	Characteristics of participants: Male	FSPs	PWID	Treatment and care status: Yes	No	Currently in treatment	Reengaged in the past 12 months	Que Phong Dist.	Dien Chau Dist.	Total
	HIV-positive, in a long-term heterosexual relationship									
1	√		√			√		12	9	21
2	√		√				√	5	4	9
Male PWID								17	13	30
3		√		√		√		6	12	18
4		√		√			√	1	0	1
5		√		√		√		1	0	1
6		√		√			√	0	1	1
FSPs								8	13	21

Other characteristics: Age range: 22–52, unstable jobs with low income, had at least one child

Access to ARV treatment

Late presentation to ARV treatment

*"I took HIV testing **[early 2016]** at a private hospital in the south. They told me that I was infected, but **I didn't believe** in that until I came here and took the test again. But at that time **[10/10/2016]**, my illness was **so serious**. I had many ulcers."*

(Male PWID, IDI40, Dien Chau)

Treatment for better health to look after children

"Only when I am healthy, I can take good care of my 3 children and pay their school fees. So, I have to be healthy, I take medicines every month, every day."

(Female SPs, IDI31, Dien Chau)

Gender roles and access to HIV testing and treatment: three scenarios of gender dynamics

Shifting roles of PWID and their sexual partners	Access to HIV testing and treatment
Wives of HIV-positive men take the responsibility of earning money (distant jobs). • Male PWID stay at home and do chores (look after children, prepare meals, etc.) Both are HIV-positive • Male PWID are the ones who earn money (distant jobs). • FSPs stay at home and do chores, help their partners take medicines, and remind husbands to take medicine. • Both are HIV-positive and the husbands are weak. • FSPs take on multiple roles in earning money, looking after children, and taking care of their husbands.	Male PWID have advantages in access and adherence to ARV treatment. Male PWID face difficulties in retention and adherence. FSPs help their partners take medicines and remind their husbands to take medicine. They go to the outpatient center and take medicines together. Some FSPs may present late to HIV testing and treatment, owing to their multiple roles.

Screening and confirmatory testing

Male PWID	FSPs
Late presentation to HIV testing	
Delay screening and confirmatory testing • Did not know their risks (who engaged in drug injection since 1990s–2000s) • Are aware of their risks but feel afraid and avoid confirming their HIV status • Still inject drugs	Unaware of their risk (passive) • Do not know their husband's injection and HIV-positive status
Discover their HIV status by chance when accessing healthcare services	
• Notification of HIV status of someone with whom they share needles • Have to access healthcare service because of other severe illness (e.g., TB or opportunistic infections)	• Give birth • Be in critical health condition • Their husband is severely ill • Their children are ill
	After noticing "HIV symptoms" in the husband, many women persuade their husbands to get tested for HIV and get tested themselves if this persuasion fails.

Adherence to ARV treatment

Perception of adherence to ARV treatment

Take medicines at the fixed time, daily, do not miss any dose, regularly do examinations

Male PWID: cases do not adhere because of	FSPs: better adherence compared to male partners
• Drugs • Alcohol • Distant jobs • Do not feel important to take ARV treatment	• Because of their responsibilities to husband and children • But in some cases in Que Phong, it is very difficult for FSPs to access outpatient care, owing to the lack of transportation—do not have a motorbike, cannot afford a petrol bill, and have to ask someone for a ride.

Gender norms and social supports

Both men and women tend to get support from their families

Gender norms	Social supports
• Male PWID are expected to follow the ancestor worship. They need to have a family and children. • Females are expected to be devoted their in-law family.	• Male PWID get more support from family, but face more pressure from family expectations about their marital status and having children. • FSPs are hesitate to ask for support from their maternal family.

"I do not intend to share [HIV status] with my parents-in-law because I do not think it's important; they may not care about that. I also do not tell my parents because I am afraid that I will make them sad. HIV is a stigmatized disease."

(Female, IDI14, Que Phong)

Gender norms and negotiation: HIV testing and treatment and condom use

Negotiation	Gender norms
Mainly in negotiation of HIV testing and condom use among males and females	
• Male PWID determine condom use. • Female sexual partners are not empowered to advocate condom use, if their husband refuses. • FSPs become more active than males in HIV testing once their husband refuses.	• Men are the ones who take the lead in the family. • FSPs perceive more responsibility for taking care of their children and maintaining their family.

Adherence to ARV treatment

Not taking medicines after a heavy drink

*"Sometimes I forget to take medicines, or I **work too hard** to remember, or when I was too **drunk** I decided not to take medicines because [I thought] medicines would not effectively work at that time."*

(Male PWID, IDI10)

Taking medicine because of children

*"My **children** are my **motivation** to determine to ARV treatment."*

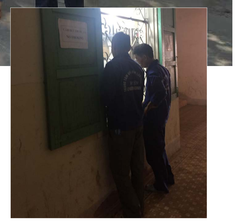
(FSP, IDI14)

Setting an alarm to take medicines

"I almost never forget to take medicine because I set alarm in my phone to remind me about the time to take medicines every day."

(FSP, IDI28)

The Vietnam research team



Male PWID picking up ARV

Conclusions

Evidence of disparities in rates of accessing HIV testing and treatment between male PWID and FSPs

- Gender-related factors, rooted in cultural and social gender norms and expected gender roles within family context, along with other factors (e.g., demographic and structural factors), have a strong influence on health-seeking behaviors among male PWID and long-term FSPs.
- FSPs are particularly vulnerable because of their multiple roles in the family. They are often responsible for ensuring that all family members engage in health services as well as for taking care of their spouse, children, and in-laws, but FSPs often lack social support for these roles or for the maintenance of their own health and HIV service engagement.

Recommendations

<u>For intervention programs</u>

- Help providers at outpatient clinics and community health workers recognize disparities between male PWID and FSPs and appreciate the significant roles of FSPs in the families.
- Design programs that help male PWID to be more active in HIV screening, confirmatory testing, and HIV treatment.
- Encourage family members to support FSPs to help them stay in treatment, while informing them of services available.

<u>For policy makers</u>

- Address social and contextual factors to ease the burden of women and allow them seek care consistently.
- Consider different models that allow patients to pick up medicines that accommodate their social and work conditions.

Limitations

- Results are not generalizable: small sample, poor people, in rural areas, few male PWID and FSPs were primary partners (although all were in long-term relationships), all had children (added vulnerability).
- Health systems factors, including financing, were not a focus of this study.

Acknowledgments

The authors of this research appreciate the support from the MEASURE Evaluation, USAID/Washington, USAID/Hanoi, and Hanoi University of Public Health. The fieldwork could not have been completed without the support and collaboration of Nghe An Province's Department of Health, and the outpatient clinics at Que Phong and Dien Chau Districts.

This poster was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. GR-18-44

www.measureevaluation.org