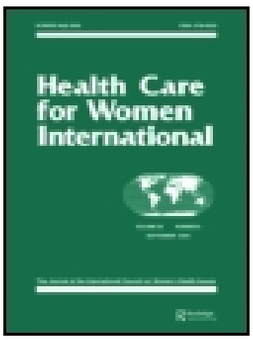

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RUNNING HEAD: THE ROLE OF THE FAMILY IN HIV STATUS DISCLOSURE

The Role of the Family in HIV Status Disclosure Amongst Women in Vietnam: Familial Dependence and Independence

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Abstract

Insights into disclosure by PLWHA can inform strategies for treatment and support, yet Vietnamese women's self-disclosure patterns are poorly understood. We conducted interviews with 12 HIV-positive women, identifying three principal factors influencing disclosure to family members: patrilocal residence, desire to protect own family, and the need for financial support. Women's decision-making about disclosure was significantly affected by dependence on or

independence of parents-in-law and their own parents. We believe that our findings reveal the complex interplay of stigma and disclosure within Vietnamese families, highlighting the need for specific social measures which promote self-disclosure combined with family support for female PLWHA.

Key words:

Disclosure, Women, Independence, Dependence, HIV/AIDS

Introduction

For people living with HIV and AIDS (PLWHA) the decision to disclose one's HIV-positive status to immediate family members, relatives or friends is always a dilemma (Peretti-Watel, Spire, Pierret, Lert, Obadia & The VESPA group, 2006). Yet disclosure is crucial to the HIV-positive individual's health in order to ensure access and proper adherence to treatment, better therapeutic efficacy, and also gain crucial social and emotional support (WHO, 2004; Alema, Misgina, & Weldu, 2017). Insights into disclosure practices can help health care practitioners in counselling PLWHA effectively both before and after diagnosis, and linking them to support (Greeff, Phetlhu, Makoae, Dlamini, Holzemer, Naidoo, Kohi, Uys &Chirwa, 2008). Little is known of the disclosure practices of HIV-positive women in Vietnam. Our study aimed to bridge this gap in knowledge, with a wider objective of enhancing understanding of the cultural and gendered dimensions of HIV disclosure, and ways in which greater support can be provided to vulnerable women.

Numerous scholars have explored the phenomena of disclosure and non-disclosure (WHO, 2004; Lili & Sun, 2007; Greeff et al., 2008; Préau, Bouhnik, Roussiau, Lert & Spire, 2008; Anglewicz & Chintsanva, 2011). The World Health Organization (WHO) revealed how cultural factors influence self-disclosure of PLWHA to significant others (WHO, 2004). Further, Greeff et al. (2008) posited that the decision to disclose HIV status is considered quite differently in Western, Asian and African countries. Overall, rates of disclosure amongst PLWHA in the developed world are understood to be remarkably higher than those from the developing world, where HIV status disclosure amongst women in developing countries is understood to be a

particularly difficult process (WHO, 2004). Barriers to disclosure to partners amongst women in several African countries, for example, were found to be fear of abandonment, discrimination and violence (Maman, Mbwambo, Hogan, Weiss, Kilonzo & Sweat, 2003; Visser, Neufeld, Villiers, Makin & Forsyth, 2008), while a specific reason for non-disclosure to family was a desire to protect parents from the burden of the HIV diagnosis (Visser et al., 2008). At the same time, researchers have identified key disclosure triggers such as the desire for relief from the stress of living with HIV undisclosed, and social and health care support needs (Sethosa & Peltzer, 2005; Olley, Seedat, Nei & Stein, 2004). Previous studies have also found that those with greater social support exhibit a greater intention to disclose their HIV status (Landau & York, 2004). Regardless of causal order, therefore, researchers have identified a positive relationship between disclosure and social support, while stigma has been associated with both fewer disclosures and less social support (Smith, Rossetto and Peterson, 2008).

The culturally-specific role of the family in the decision to disclose HIV status in both Asia and South-east Asia has been highlighted (Lili et al., 2007). Some scholars have argued that the relatively high rates of HIV status disclosure to family members observed in Asian countries are due to reliance upon family members for primary support (Chandra, Deepthivarma & Marnjula, 2003; Hays, Mukusick, Pollack, Hillard, Hoff & Coates, 1993; Bharat, Sanghnetra & Aggleton, 1998). Yet others have revealed a more complex picture. In China, for example, where family elders hold significant authority, disclosure to family has been found to sometimes occur involuntarily with health providers disclosing patient's HIV status to family members first, despite the individual patients in question disagreeing with this approach (Lili et al., 2007). Contrastingly, in Thailand, women were found to mostly disclose their HIV status to their

husbands rather than their own parents, as they were desirous of protecting their parents from worry (Bennetts, Shaffer, Manopaiboon, Pattrawan, Siriwasin, Mock, 1998; Ross, Sawatphanit, Draucker & Tatirat, 2007). Klunklin & Greenwood (2005) made an association between such behaviour and gender roles within Buddhist culture, whereby women are expected to offer respect and support to their parents for raising them. While little is known, to date, of disclosure patterns in Vietnam, Rudolph, Davis, Quan, Ha, Minh, Gregowaki, Salter, Celentana & Go (2012) found that the decision to disclose to family amongst (male) HIV-positive injecting drug users in Vietnam was fuelled by a strong desire for support and sympathy from their loved ones. There may, therefore, be possible gendered aspects to familial disclosure in certain settings in the region which merit further exploration.

Vietnamese Family Structure – Culture and Confucianism

Confucianism has been a fundamental element of Chinese culture since the second century B.C. (Slote & De Vos, 1998), historically also exerting significant influence on Vietnamese social structure and norms, an influence which continued throughout the modernizing process of the 1980s onwards (Luong, 2009). Family ties are paramount within the patriarchal Confucianist (and subsequent neo-Confucianist) system, which provides women minimal rights, emphasizing their obedience to men and their need of male protection, making it obligatory for a woman to first obey her father, then serve her husband on marriage, and on becoming widowed follow her son (Slote et al., 1998)[1]. According to Confucian ideals of

[1] An expected subservience captured in the Vietnamese proverb: *"Thuyen theo lai, gai theo chong"* ("As a boat follows its tiller, a woman follows her husband").

patriarchal authority and patrilocal family structure, newly married Vietamese couples traditionally co-habited with the groom's parents for an extended period, or even permanently, whereby the bride was subordinated to and dependent upon her family-in-law, both economically and residentially, until her death (Bich, 1999). This practice persists in contemporary Vietnamese society; within the past ten years researchers continued to report that the majority of new couples pursued patrilocal living arrangements immediately following matrimony (Hirschman & Minh, 2002; Luong, 2009). The situation of women who become widowed while living patrilocally is unclear. Some have argued that bearing sons responsible for the in-law family lineage can provide widows with more status and security, while other widows are more vulnerable (Oosterhoff, Anh, Yen, Wright & Hardon, 2009).

The HIV epidemic in Vietnam

The HIV epidemic in Vietnam is developing at a rapid rate. The current infection rate of the total population stands at 0.29%, while the total cumulative number of people living with HIV in the country is 227, 225 with 85,753 of these individuals living with AIDS (MoH, 2016). The epidemic is concentrated amongst certain groups; presently just over 30% of PLWHA in Vietnam are female and 69.8% male, while 45% are injecting drug users (MoH, 2016). Infection routes are predominantly sexual (56%) and through blood transmission (34%; MOH, 2016). Rates of HIV infection amongst women have been increasing over the past two decades (Anh, Oosterhoff, Hardon, Hien, Coutinho & Wright, 2008). The economic transformation of the country since the 1980s has resulted in more men engaging in sexual relationships with sex workers, placing wives and female partners at risk of both sexually transmitted diseases (STDs)

and HIV infection (Go, Quan, Voytek, Celentano & Nam, 2005; Phinney, 2008; Lam, 2008). Indeed, researchers have identified a "hidden" HIV epidemic, with large numbers of Vietnamese women infected with HIV by their husbands, who engage in injecting drug use, unprotected extramarital sex, or both. These women have particular vulnerabilities (Anh et al. 2008; Oosterhoff et al. 2009; Oosterhoff, White and Nguyen, 2011).

When HIV and AIDS first emerged in Vietnam, most infections were among drug users and sex workers, groups classified by the government as "social evils" (Ogden & Nyblade, 2005), within a discourse which sanctioned moral judgment and stigmatization of PLWHA. When the epidemic began affecting the general population, female PLWHA remained associated with the "social evils" label, experiencing severe stigmatization (Doan, Brickley, Dang, Colby, Sohn, Nguyen, Le & Mandel, 2008; Hong, Anh, & Ogden, 2004). Further, scholars have posited that HIV-positive women in Vietnam not only experience social exclusion, but a simultaneous reinforcement of existing gender inequalities (Oosterhoff et al. 2009). For example, given the role bestowed on her through Confucianist philosophy, as guardian of family respectability and enforcer of moral standards, a woman infected with HIV is considered to have brought shame to the household, for which she may be blamed more than a man (Khuat, Nguyen, & Ogden, 2004).

At present little is known about under what circumstances HIV-positive Vietnamese women disclose their HIV status to those close to them, and the factors influencing this decision. Indeed, research into the barriers to and outcomes of women in the region revealing their HIV status has been recommended (Medley, Moreno, McGill & Maman, 2004). In the current study we analysed factors influencing Vietnamese women's decision-making regarding the divulgence of their HIV status to family members.

Method

Design and Sample

We conducted the research under the auspices of Hanoi Medical University (HMU) which provided ethical approval. We selected a qualitative methodology with the aim of gaining deeper understanding of the social phenomena influencing HIV status disclosure, following a grounded theory approach for both data collection and analysis, which we considered appropriate for eliciting explanations and interpretations of behavior (Glaser & Strauss, 1967). Two female researchers were responsible for conducting the study and formulated initial, open-ended questions, together with follow-up probes and themes (Dahlgren, Emmelin & Winkvist, 2004), which were used to construct an interview guide. The first interview was conducted by both researchers, following which the guide was revised to include further issues of interest which emerged. All subsequent interviews were conducted by the lead researcher (first author). Criteria for inclusion were for participants to be female, over 18 years of age and HIV-positive. A total of twelve women were recruited through a self-selection process from three different sources: a clinic treating PLWHA (six women), a Hanoi community group of PLWHA (five women), and an existing, large-scale quantitative study on attitudes to HIV (one woman). Verbal informed consent was obtained from all participants who were advised that they could withdraw from the study at any time, and that all information would be collected anonymously and kept confidential.

Data Collection and Analysis

One-to-one interviews were conducted in a private room either at the interviewee's house, a clinic which provided antiretroviral medication (ARVs) or at HMU. We asked participants about their status disclosure, how and why they chose to disclose (or not disclose) their HIV status, with whom information was initially shared within the family, and the reasons for disclosure to that particular person/s. Each interview lasted between one and two hours and was digitally recorded. All interviews were transcribed in Vietnamese, and then translated into English. Certain data and some terms were translated back and forth between Vietnamese and English to ensure the trustworthiness of the translation. Coding was conducted jointly by both researchers following close reading of the transcripts, using Open Code version 3.4 (Umea University, Sweden). The open codes were grouped together into categories and subsequently reorganized and re-grouped to represent links and relationships in order to generate core variables (categories). Constant comparison was then made between women living with and not living with their family-in-law to establish any key commonalities or differences.

Results

Social Demographic and Health Characteristics

Table 1 presents socio-demographic data on participants' age, marital status, education, occupation and residence at the time of interview. All women lived in or around the greater Hanoi area in Northern Vietnam. Ten participants reported that they contracted HIV from their husbands who used/had used drugs or had sex with a sex worker, one attributed her HIV

infection to “unsafe heterosexual sex”, and one considered herself to have contracted HIV through a needle stick accident when caring for her brother who was living with AIDS. Six interviewees were married at the time of interviewee and four were widows, though a total of five women had been widowed due to HIV/AIDS, and one had subsequently remarried. Six respondents lived with their parents-in-law (two of these were widows); one lived with her husband in a nuclear household (she had been a widow prior to re-marriage); two lived with their new partners in a nuclear household (both had left their first husbands due to domestic violence; their children were still living with their ex-husbands); one lived with her mother and child (a widow), and one lived as a sole adult with her children (also a widow). All but one of the twelve women had immediately moved into the house of the groom’s family following their first marriage, in adherence to Vietnamese custom. Of the five women widowed due to HIV/AIDS, two remained living with their parents-in-law, while two reported having to move out of their in-laws’ home and seek support elsewhere following the death of their husbands, while one had already resided with her husband and child with her own mother, working in her maternal family’s shop, at the time of his death. Eleven of the 12 women were utilising health care services to monitor their HIV status at the time the interviews were held; ten participants were already taking ARVs.

Factors Influencing the Decision To Disclose

We found a number of factors influenced women's decision as to whether to disclose their HIV status. Associated with these factors, the concepts "dependence" and "independence" emerged as core influencing categories in terms of the relationship between women, their family-in-law and their own blood family.

Patrilocal Residence

Most respondents reported their parents-in-law to have been the first family members to know their HIV-positive status, through either voluntary or involuntary disclosure. They described the principal reason for their voluntary disclosure as the combined realization that HIV had been transmitted to them by their husband, and the impossibility of keeping their status secret, particularly from their mother-in-law, due to the situation of co-habitation. Further, despite having being infected by their husbands, many respondents described being fearful their parents-in-law would doubt their personal morality due to their HIV status, which would exacerbate an already difficult relationship, as detailed in the following citation:

> *"... when I am at home, I am so miserable because I have no money so she [my mother-in-law] makes me feel guilty about that. She complains the whole day… I came home to talk with my in-laws [about my status] and I did not dare to tell them that I, independently, went to take an HIV test. If I said that I went of my own free will, they would be suspicious of me. So I made up a story that, by*

chance I had a stomachache and my brother took me to see Mr. X [a village health worker], but he was out at the time. So I went to the hospital and I was unlucky and they took a test that's when they discovered I was like that [HIV positive]."

- 30 year old widow.

Fear of stigmatization and maltreatment following disclosure does not appear to be unfounded; three of the five respondents who were living with their husbands and family-in-laws at the time of interview described being poorly treated due to their (disclosed) HIV-status; in one case they were expected to eat their meals separately, for example.

Disclosure to their husband's family, difficult as it was, was not found to have been a voluntary choice for all women; in some cases women described how health workers directly informed their husband or the family of their husband about their status. As one interviewee described:

"The first time in the preventive health center I came along with my mother-in-law, and she did not let me get the result. The health worker gave the result to her. Everybody told me that there was no problem with me. I asked them where my result was and said that if I could not see the result I would not go home. When I knew [the positive result] I was so shocked and it took time for me to get home" - 26 year old married woman.

Being seen by others to be living patrilocally, hence under the care and responsibility of their family-in-law meant that health staff apparently accepted disclosing to the married woman's husband's family without her permission.

In many cases, women described being advised by their family-in-law to take a test at the hospital following their husband's own positive diagnosis, rendering the process highly visible within the family with which they were resident. Indeed, some interviewees reported how it transpired that the family-in-law already had long-standing knowledge about their husband's infection, yet only suggested their daughter-in-law take an HIV test once she was widowed, underscoring the selectivity and variability of intra-family disclosure. As one woman described:

> *"After finishing everything for my husband [the funeral], relatives from my family-in-law encouraged me to get a test. Indeed, everybody hoped that I was not infected but I knew that I had it"* - 29 year old widow.

Following disclosure, some women reported receiving support from their family-in-law, others did not. In two of the five cases of women being widoes by HIV/AIDS and being diagnosed as HIV-positive, the situation eventually led to an end to their patrilocal residence and their being forced to seek a home and livelihood elsewhere.

Desire to Protect Own Family

Respondents detailed how the decision not to disclose to different family members was a prolonged process associated with many factors. All of the women interviewed expressed concern about the potential impacts of disclosure on their own family, their desire to protect their

blood family serving as a barrier to disclosure. Respondents frequently voiced a particular unwillingness to disclose to their own mother, highlighting concern about the potential shock of hearing such bad news, particularly if the relative in question was deemed to be in frail health:

> *"I was afraid for my mother, that she might get a shock as she was ill at that time…My father passed away more than 10 years ago. My mother is ill so I do not dare tell her. She has cardiovascular problems.*" – 26 year old married woman

Patrilocal residence was also explicitly connected women's non-disclosure to their own parents and family: numerous women described how co-habitation with their in-laws and the associated relationships defined their lives and decision-making.

> *"I told my mother-in-law that when I am married then I follow the family-in-law. Even when I die I become a ghost of the family-in-law - people believe that a person after death becomes a ghost and will bring luck to people alive in that family. I had better not let my maternal family know [my HIV-positive status]. Even if they know they cannot solve anything. It will just make them anxious and people may talk [gossip]"*- 31 year old married woman

The distance imposed by patrilocality, coupled with an expressed desire not to cause worry to parents (and potential shame), was, similarly delineated other cases:

> *"…I did not dare to talk to anyone… if my own parents knew about it they would be shocked… They were living far away from me in the South. I have not seen them for long*

time… I was shocked myself. My parents brought me into this world and did not give me that disease [HIV]"- 26 year old married woman.

"My parents' brothers and sisters [uncles and aunts] did not know [about my HIV status], only my own brothers-in-law and sisters-in-law knew about it… I did not dare to tell them [my family] in case they wouldn't understand and might start feeling disdainful towards me. I just told my family-in-law" – 29 year old widow.

Selective Disclosure and Non-Disclosure to Family Members

Certain interviewees described "selective disclosure" within their own family, however. One woman hid her HIV status from her mother yet disclosed to her father, for example, attributing this partial disclosure to the financial and spiritual support provided to her by her father. She therefore decided to disclose to him and rely upon him to inform her mother in the first instance:

"My father still supports me financially…he reassures me … My father is an educated person. I found it difficult to hide something from him…I did not let my own mother know [my HIV status]; only my father knows. I used to be so worried because my mother is the kind of person who dwells on things a lot. I asked my father to share it with her gradually. Then when I tell her she will not be so shocked" – 26 year old married woman.

While most respondents depended very little on their own family financially following marriage and patrilocal residence, in the case of this particular respondent, a level of existing economic support, as well as an emotional connection, contributed to the decision to disclose. As detailed

further below, the nature of the economic relationship with the blood family (dependence/ independence) was a particular element we identified as influencing women's decision-making.

Women described being independent of family (be these blood relatives or in-laws) only when they were not living close to them; distance therefore facilitated non-disclosure. Many respondents associated disclosure negatively with its potential impact on the honor and status of family in the community:

> *"We kept it [ourHIV positive status] secret from my husband's homeland people living in rural areas. If my husband had not caught an opportunistic infection [OI] we would have kept it confidential longer. That would have kept the nice honor [danh du] of my parents-in-law"*- 26 year old married woman.

Financial Resources

We found women´s economic situation and associated family dependency to be significant contributing factors affecting disclosure. As already described, in most cases where respondents lived patrilocally, they were completely financial reliant on their in-laws. In the words of one respondent:

> *"I don't want to affect my own parents. Surviving or dying, I will belong to the family of my husband and they will be responsible for burying me, when I die…Last year, I put a little money aside to build a tomb for my husband (although he's buried already)*[2]*. I*

[2] In Vietnam it is customary that three years following a person´s death and burial family members dig up the grave, remove the bones of the deceased and put them in a small earthenware coffin which is buried in a tomb.

totally depend on my mother-in-law and have to give most of my salary to her.[3] *She has to pay for my food every day".*

- 30 year old widow.

In situations where women required financial assistance from their own family, however, a different – and, for the women in question, extremely difficult - disclosure pattern often emerged. One widow living with her mother and son, described such a situation:

"…my mother was the first person I talked to about it... my own mother…I did not think that what I told her could have made her so upset…I found myself so selfish that I told my mother about it. I myself was so shocked when I got the result and my mother was even more shocked…she supported our living expenses such as food, for me, my husband and my child, and we had to earn money to pay for other expenses ourselves.[4] *In this way I was luckier than others in that I did not have to worry…she took care of the whole family and of my child"*- 30 year old widow

In such instances immediate familial assistance was essential when the woman (or couple) did not earn sufficiently to cover their expenses, particularly when new expenses were incurred associated with living with HIV. In another case, despite living with her two sons at the home of her family-in-law, one widow decided to tell her own family about her HIV status at a time of

[3] Common practice in Vietnamese households.

[4] In this case the respondent, her husband and child, moved in with her mother when her husband was dying of AIDS so that she could work in her mother´s shop.

extreme hardship on the death of her husband. Financial assistance again appeared to have been a critical influencing factor:

> *"I… just told the people in my maternal family [my HIV status] …. Oh my God, everybody was really shocked and upset…They also supported me financially…. I earn just enough from work to buy medicine for myself. It isn't enough for the whole family… My husband died when my second son was 11 months old."* - 29 year old widow.

Discussion

We found a number of inter-connected factors influencing Vietnamese women's decision-making regarding disclosure of their HIV status to family members. The key determinants identified were patrilocal residence, desire to protect the (maternal) family, and financial resources. Decision-making was highly influenced by the Confucianist cultural context whereby married women are subordinated to and dependent on their families-in-law, invariably through patrilocal residence. Families-in-law (particularly parents-in-law) were often those first informed by HIV-positive women about their status, evidencing continuing Vietnamese norms regarding the role of families-in-law in married women's lives. Such a disclosure dynamic can also be attributed to the responsibility families through marriage are perceived to hold towards

their daughters-in-law, particularly, perhaps, in circumstances where women have been infected by their husbands. Moreover, living patrilocally, in the same house, women felt that they were unlikely to be able to conceal their HIV status, reflecting how their lives were interwoven with those of their family in-law. Cases were also uncovered of health staff disclosing women's status to their parents-in-law without their permission, a similar phenomenon to that already been observed in China (Lili et al., 2007), underscoring women's lack of autonomy within the patrilocal setting, and their continuing dependence on their families-in-law in terms of everyday living and residential security.

While some women described how they and their children received support from their families-in-law following disclosure, in certain cases respondents described how their situation became more difficult and they experienced stigmatization. Two of the women interviewed reported having to move out of their in-laws' home and seek support elsewhere on the death of their husbands, a phenomenon which may be particularly, or increasingly, prominent in a context of HIV/AIDS. Our analysis of data confirms previous scholarship regarding the vulnerable and extremely challenging situation in which many Vietnamese women find themselves when living under the authority of their in-laws, which can be exacerbated by the double stigma of being HIV positive, and also a widow (Oosterhoff et al. 2009).

Conversely, through patrilocality women had become residentially and economically independent of their birth family, which enabled them to hide their HIV status from these relatives more easily following marriage. As women's birth parents and blood siblings played a more limited role in their lives, respondents expressed the view that non-disclosure would not

only protect their own family from distress, but in any case their problems while living with their in-laws were their own, hence even if their birth family was aware of their HIV status, they would be able to exert little influence. These various factors again underscore married HIV-positive women's continuing dependence on their families-in-law in the traditional Vietnamese familial context.

Women inevitably weighed up the possibilities offered by disclosure, as a stratified decision. If disclosure could reduce some kind of dilemma then they were more likely to disclose, if not, they would rather bear the burden of their status themselves, in order to protect their blood family. Extreme economic need inevitably prompted certain women to disclose to their parent/s, resulting in new financial support. However, in such instances, women described this disclosure as not only enabling them to obtain essential material assistance, but simultaneously reducing the overall personal burden of their situation.

Conclusions

Our study explored Vietnamese women´s decisions about and experiences of disclosure of their HIV-positive status. Independence and dependence in relation to both family-in-law and birth

family influenced women significantly in terms of their decision to disclose, and with which family members to share their HIV status. Parents-in-law were found to be those most likely to be aware of women's HIV status, whether through women's own disclosure or involuntary disclosure by others. Inter-generational, patrilocal residence, a feature of Confucianist patriarchal tradition, played a significant role in women's disclosure decisions and outcomes, and it was apparent that within some families daughters-in-law are still treated as subordinates in a form of gender-based, intra-familial discrimination, a situation which may be exacerbated by women's HIV status, regardless of how they contracted the disease. We believe our study reveals the "double edged sword" of patrilocal residence, which, while ostensibly protective, can, in practice, severely restrict autonomy and in the worst scenarios, contribute to gender-based discrimination.

The normalizing of HIV testing and disclosure is an essential process (Medley et al. 2004), with community based-programmes providing an important model for creating an enabling environment for PLWHA to live openly as productive members of society, (Rudolph, et al., 2012; Hammett, Norton, Kling, Liu, Chen, Ngu, Binh, Dong & Des Jarlais, 2005). Previous research has demonstrated the positive relationship between disclosure and social support (WHO, 2004; Smith, Rossetto and Peterson, 2008). It is only following disclosure that positive benefits can be given to PLWHA so they can better access services and support to enhance their quality of life (Alema, Misgina, & Weldu, 2017).

We believe that our findings reveal the complexity of stigma, disclosure and support within the cultural specificities of Vietnamese family settings, which may be relevant to other cultural

settings where the practice of patrilocality persists. We consider that our study reveals important insights into the "double edged sword" of patrilocal residence and dependency for women, which, while ostensibly protective, can severely restrict autonomy and in the worst scenarios, can be characterized as a form of gender-based discrimination. Substantial social transformation may be necessary for women to openly disclose their HIV status, rather than be disclosed involuntarily or disclose selectively to particular individuals or family groups due to their situation of patri-local residence or due to severe economic pressure. Widows living with HIV/AIDS who have children to support can be considered a particularly vulnerable group requiring strategic social and financial assistance, yet can be in the most precarious position in the current Vietnamese social and familial context. New interventions are needed which not only reduce the stigma of being an HIV-positive woman, but promote the disclosure of HIV status within a trustworthy and supportive familial and broader community environment, empowering women to live more positively with their condition. Married men and their parents (as parents-in-law of HIV-positive women or widows), in particular, appear to be logical targets of interventions aimed at improving the quality of life for married Vietnamese women living with HIV.

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Table 1: Characteristics of study participants (n=12)

	Number of participants
Age	
(mean=31)	
25- 30	9
>30 – 40	3
Marital status	
Married	8
Widow	4
Education	
College	1
High school	8
Secondary	3
Occupation	
Tailor	3
Seller	4
Worker at factory	2
Other (e.g. house maid, teacher)	3
Residence	
Living with in-laws	6
Living with own family	1
Living with husband/ partner	4
Living alone/with children	1

