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Social science research of HIV in Vietnam: A critical review and future directions

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Abstract

Social science research, with theoretical and methodological tools that are well suited to capture the complexities of Vietnam's rapidly changing social and political context, could contribute important insights that would enhance the response to Vietnam's growing HIV epidemic. The present paper reviews the published, peer-reviewed English-language social science literature on HIV in Vietnam in order to identify critical theoretical and substantive gaps and lay the groundwork for future research. We found four broad foci for work on the social context of HIV and AIDS in Vietnam: the cultural meanings and social relationships that shape Vietnam's HIV epidemic; stigma and discrimination; social inequality and structural violence as contributors to HIV risk; and, finally, how broader global and social systems shape Vietnam's HIV epidemic. We signal the particular need for additional research on the effects of the media on attitudes toward HIV and AIDS, on social movements, and on health systems, as well as on a number of other key areas. Work along these lines, in addition to more effective communication of policy-relevant findings to those responsible for the development and implementation of policies and programmes, will strengthen Vietnam's response to HIV and AIDS.

Keywords

social science research; HIV; AIDS; Vietnam; public health

Introduction

Since the first case of HIV in Vietnam was reported in 1990, the epidemic has not—as many had feared—developed into a generalised epidemic. It has, however, developed into many concentrated epidemics in various locations where different key populations are affected. By 2012, an estimated 280,000 people were living with HIV/AIDS in Vietnam (Ministry of Health 2009). Early research on HIV in Vietnam was primarily biomedical and epidemiological, with the first social science research findings emerging in the early 2000s. This was a moment when major global health initiatives (GHIs) —most notably the US President's Emergency Fund for AIDS Relief (PEPFAR) program and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) —and other donors such as United Nations Development Programme (UNDP), the Swedish International Development Cooperation Agency (SIDA), and the Ford Foundation began to increase attention to and support for Vietnam's response to HIV and AIDS. These international funders called for

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social and behavioural science research that would inform the scale-up of programmes, monitor their implementation and impact, and assess Vietnam's future needs in responding to the epidemic. The present paper reviews the literature that has emerged in response. We begin by describing the epidemic and situating it in relation to the backdrop of rapid political, social, and economic changes in Vietnam. Next, we review and critique the existing social science scholarship on HIV prevention and AIDS treatment and care in Vietnam. We found four primary foci of research on the social context of HIV and AIDS: (1) cultural meanings and social relationships; (2) stigma and discrimination (although virtually all of the research on HIV and AIDS in Vietnam addresses that in some way); (3) social inequality and structural violence, and (4) the broader global and social system context of HIV and AIDS. The bulk of this research has focused on HIV prevention, rather than on other dimensions of the epidemic, and we note these gaps and opportunities for investigation where relevant. We conclude by indicating areas in which additional social science research would be particularly critical for enhancing the Vietnamese response to HIV and AIDS.

Background: HIV/AIDS in a changing Vietnam

An overall HIV prevalence among the adult population (ages 15 to 49) at 0.45% masks significant concentrated epidemics among injecting drug users (IDUs), female sex workers (FSWs), and men who have sex with men (MSM). According to 2011 sentinel surveillance data, HIV prevalence among IDUs and FSW remains high nationally, at 13.4% and 3% respectively (Socialist Republic of Vietnam 2012). However, prevalence varies significantly between provinces, ranging from 2% to 46% in the case of IDUs and from 1% to 22% in the case of FSW. Sentinel surveillance among MSM, introduced in the past few years, shows prevalence ranging from 0% to 14% (National Institute of Hygiene and Epidemiology 2011). The epidemic has been concentrated among men, in large part because it has been driven by injection drug use, although recent decreases in the sex ratio raise serious concerns about intimate partner transmission from infected men to their wives or female partners (Lim *et al.* 2011). These epidemiological features have marked Vietnam as a country with widespread concentrated epidemics, posing different challenges for an effective response than those faced by countries with generalised epidemics.

Prior to the emergence of HIV, the country had just embarked on a new set of policies in 1986 known as *Doi Moi* (Renovation), which opened what had been a relatively isolated socialist country to global flows of capital, ideas, and people. *Doi Moi* rapidly transformed Vietnam's social, economic, and political landscape: within the next two decades, the gross domestic product increased tenfold, and the gap between the rich and the poor grew even more quickly (Taylor 2004, United Nations Country Team Vietnam 2004). Vietnam found new allies-cum-competitors in the Association of Southeast Asian Nations (ASEAN), opened a bilateral trade agreement with the US in 2000, and joined the World Trade Organization (WTO) in 2006. The epidemic exploded in the decade after *Doi Moi*, when widespread heroin use among young men and the growing visibility of prostitution became part of the experience of these social and economic transformations. As in other countries with similar transitions from a socialist to a market-based economy (Rhodes *et al.* 1999, 2005, Rhodes, Lilly *et al.* 2003, Rhodes, Mikhailova *et al.* 2003, He and Detels 2005, Yang *et al.* 2005, Aceijas *et al.* 2006, Liu *et al.* 2006, Qian *et al.* 2006), the epidemic first took hold among young men using drugs and female sex workers through sex work and drug use, the two most vulnerable and yet the most neglected groups in the years after *Doi Moi* (Khuat, Anh *et al.* 2005).

The policy responses to the epidemic have reflected this rapidly changing political environment. When the first cases of HIV/AIDS emerged in the 1990s, the Vietnamese

state, equipped with limited alternatives, resorted to what it knew best—the Leninist mode of governance, exerting state power to address the perceived linkages of HIV to drug abuse and prostitution (Nguyen-Vo 2008). Even in the wake of *Doi Moi* policies about economic openness, the government initiated a campaign to eradicate ‘social evils’ of culture, with devastating effects in terms of the resulting stigmatisation of those infected with HIV. Defined as ‘... behavior that is bad, with regard to the morals of society, and inimical to the edification of the socialist state ...’ (Blanc 2005, p. 662), this discourse associated HIV with practices of drug abuse and prostitution. As the HIV epidemic grew in Vietnam, increasingly touching traditionally ‘lower risk’ populations, such as heterosexual men, married women, and ethnic minorities residing in mountainous areas, intense pressure from the international donor community rendered the language of ‘social evil’ harder for the government to sustain. Despite the government’s official move away from this campaign with the endorsement of the Law on Prevention and Control of HIV and AIDS in 2006, in which stigma against people living with HIV and/or AIDS (PLWHA) is prohibited, the stigma continues to be an obstacle to prevention, care, and treatment today.

In addition to changes in state policy, *Doi Moi* has also resulted in significant transformations in cultural and social aspects of gender and sexuality in Vietnam (Le and Huong 2009, Anh *et al.* 2010). Key changes include new language to speak about sex and gender, new sexual scripts, and a rising acceptance of pre-marital sex, particularly among those living in urban areas (Khuat *et al.* 2009, Gammeltoft 2002, Ghuman *et al.* 2006, Martin 2010). Negative attitudes toward discussing sexual matters with adolescents has limited the growth of programmes for sexual education (Ingham 2005, Lerdboon *et al.* 2008), despite the United Nations Population Fund’s (UNFPA) support for these initiatives (UNFPA 2012). Vietnam’s population structure is characterised by a remarkably high proportion of youth—44.4% under age 25 (GSO 2009)—and these constraints on the development of sexual health education exist in tension with the growing acceptability of pre-marital sexual relations; these contradictions potentially have critical consequences for HIV transmission among at-risk populations. Research now includes heterosexual men and women and, to a lesser extent, Vietnam’s various groups of ethnic minorities (Phong 2008, Gammeltoft 2002, Martin 2010, Van Tuan 2010). Although largely ignored at the beginning stages of the epidemic in Vietnam, research now includes MSM as a previously absent population vulnerable to HIV infection (Sarraf 2009, Van Hiep 2011).

From early on in the epidemic, biomedical and epidemiological research on risk-related behaviours and individual-level interventions dominated the field (Ministry of Health-Vietnam 2012). Epidemiological data described the incidence and prevalence of HIV within ‘high risk’ populations of IDUs and FSWs (Dore *et al.* 1996), and research on patterns of sexual behaviour examined how HIV is spread at the individual level. For IDUs, this included describing risks such as needle sharing, the frequency of condom use, and the geographical areas where drug injecting takes place (Hien *et al.* 2000, Hammett *et al.* 2006). For MSM, these studies used quantitative methods to describe individual-level analysis of risk behaviours such as sexual practices, drug use, local hangouts, and knowledge about HIV transmission (Colby 2003, Colby *et al.* 2004). Research using qualitative methods also found similar risk-related behaviours (Clatts *et al.* 2007, Bao Ngoc *et al.* 2012).

Behavioural science research has described how the capacity of FSW to negotiate condom use depends on their visibility in public space (i.e., those who are more visible are more likely to be able to negotiate condom use) and their socio-economic background (Johnston *et al.* 2006, Le *et al.* 2010, Choi 2011). This genre of research has focused on individual-level factors for HIV transmission, such as condom-use patterns and communication about safer sexual practices (Rosenthal 2006, Hoffman *et al.* 2011). Behavioural studies have also

measured women's self-efficacy and assessed the relation of self-efficacy to women's ability to negotiate sexual activity and condom use (Do and Fu 2011).

This epidemiological and behavioural research, however, has largely overlooked the social factors that both drive the spread of HIV and structure responses to the epidemic. Despite the fact that they are often mentioned in combination or even conceptually elided, social and behavioural science are distinct approaches. They share a focus on determinants of health beyond the strictly biological, but have very different contributions to make in shaping responses to HIV. Behavioural science—characterised by a theoretical grounding in psychology, an emphasis on individual-level interventions, and a set of theories focused on the inter-personal and intra-psychic dimensions of risk and prevention—has served as the foundation for the development of replicable evidence-based prevention interventions (Wingood 2004, Herbst *et al.* 2005, 2007, Remien 2005), some of which have had international dissemination. In contrast, social science draws not only on social psychology but also on anthropology, sociology, political science, and history, and is vitally different in both its social rather than individual level of analysis and in the scope of resultant interventions it is likely to generate.

Globally, social science work on HIV has played a critical role in highlighting the role of social inequalities in shaping the epidemic, and in highlighting the ways in which structural and environmental intervention can play a key role in responding to the epidemic (Pigg 1997, Bayer and Oppenheimer 2000, Berkman *et al.* 2005, Biehl 2006, Kalofonos 2006a, Nguyen 2006, Oppenheimer 2007). Much of the early social science work on HIV underlined the importance of understanding how the meanings people give to relationships, identities, and practices shape and constrain behaviour and contribute to patterns of HIV risk (Socialist Republic of Vietnam 2006, Tran, Nguyen, *et al.* 2012). Social scientists have built on the early emphasis on the disjuncture between sexual identity and sexual practice (Socialist Republic of Vietnam 2006, Le and Nguyen 2007, Hammett *et al.* 2008) to explore the political economy of risk (Nguyen *et al.* 2008, Montoya 2012), and they have underlined the conditions under which social conditions facilitate or even determine the practice of individual-risk behaviours, and have shown how broad social factors such as racial inequality, economic development, and gender stratification intertwine to create risk differentials (Vu *et al.* 2009, Kincaid *et al.* 2012). They have contributed pioneering research on structural interventions for sexual and injection-related risk (Carrier and Magana 1991, Parker *et al.* 2000) and critical insights to undergird HIV care and treatment programmes. This includes exploring stigma as a barrier to testing and treatment (Parker 1987, 1991), looking at how antiretroviral therapy (ART) transforms the local meanings of HIV/AIDS (Parker 2002), documenting social movements' role in social mobilisation and in creating the conditions necessary for universal access to ART (Farmer 2001), highlighting the limits of individual-level research (Parker and Easton 1998, Parker *et al.* 2000), and underlining the relevance of therapeutic itineraries and communities of care (Hardon *et al.* 2007, Smith and Mbakwem 2007) for understanding adherence. Social scientists have also explored the institutions and policies that play such key roles in shaping the daily lives of those living with, or at risk for, HIV (Parker *et al.* 2000, Parker and Aggleton 2003, Castro 2004, Blankenship *et al.* 2006, Link and Phelan 2006). Many of these questions, which have made vital contributions to the global understanding of the epidemic, have been only partially explored in Vietnam.

Methods

We searched for English-language peer-reviewed articles about HIV in Vietnam using Web of Knowledge, Web of Science, Scopus, JSTOR, PubMed, Medline, EBSCO, ProQuest, and Google Scholar. In addition, scholars in the field were contacted for references. Keywords

used in searches were ‘Vietnam’, ‘HIV’, and ‘AIDS’, ‘social science’, and ‘research’. We did not limit our search to a particular time period. Inclusion was limited to social science research on the prevention, treatment, or care of HIV in Vietnam. The literature that did not specifically use social scientific research methods or theories (such as work focused on epidemiologic, genetic, and clinical aspects of HIV) was excluded. Also excluded from this review paper is the majority of grey literature, some of which does describe social contextual factors related to HIV and AIDS. Most of that work, written as descriptive and atheoretical formative research or programme evaluation, is only superficially grounded in social science theory if at all.

After assessing the searches using the inclusion criteria, 64 articles remained. Fifty-nine were research articles, with 5 non-research commentary articles. Of the research articles, the majority employed qualitative methods (50), such as in-depth interviewing, focus group discussions, ethnography, and life histories. There were 9 studies employing a mixed-method approach using both quantitative and qualitative data.

Cultural meanings and social relationships that shape the HIV epidemic

Social science theory and methods have frequently been used to study how the meanings people give to relationships, identities, and practices shape and constrain behaviour and contribute to patterns of HIV risk (Parker and Easton 1998). Research with heterosexual men in Vietnam has described how changing gender expectations and ideas about pre-marital sex have made sexuality a contested site for identity formation (Martin 2010). Other studies have examined how men respond to new images of masculinity that foster chauvinism toward both women and men through strengthening male identity and male social networks (Van Tuan 2010, Horton and Rydstrom 2011). Men, influenced by new meanings and beliefs about their own sexuality, seek out paid sex but resist using condoms with FSWs, putting themselves and their partners at risk of HIV infection (Horton and Rydstrom 2011). Research focused on MSM has identified particular—and particularly stigmatised—conceptualisations of the identity and sexuality of Vietnamese MSM (Ngo *et al.* 2009, Bao Ngoc *et al.* 2012). The potential applications of this work go beyond identifying the determinants of practices that put people at risk of infection; researchers have argued that this work on gender, sexuality, and sexual practices in Vietnam can contribute to HIV-prevention strategies focused on advocacy for the rights of sexual minorities and reduction of sexual discrimination (Blanc 2005).

Research on gender, sexuality, and HIV has also articulated how the meanings of social relationships can create vulnerabilities for HIV infection. For IDUs, relationships with sexual partners and needle-sharing friends are based on feelings of mutual trust as well as necessity, because IDUs share financial responsibilities for obtaining drugs (Dao 2002). In addition, for heterosexual drug-using couples, needle sharing and gender inequality shape decision-making regarding condoms (Go, Quan *et al.* 2006, Nguyen *et al.* 2008, Hammett 2010). The practices that from a health point of view would be labeled ‘risk behaviours’ are seen by IDUs as strategic actions that balance the individual risk of HIV infection against the necessity of preserving the trust that is critical for these valued social relationships (Nguyen 2008). Researchers have also looked at the contexts and meanings of sexual relationships among MSM (Ngo *et al.* 2009), describing how sexual encounters involve trade-offs between pleasure and risk, with condom use depending on the physical attractiveness and perceptions of ‘cleanliness’ of their partner (Vu, B.N. 2008).

As with social science research on HIV globally, one dominant theme has been how the normative dimension of gender and sexuality contribute to vulnerabilities for less powerful groups. Research on social relationships and HIV among heterosexual women has

highlighted how gendered expectations for women, included the paramount importance given to their primary roles as obedient and faithful wife and mother, have constrained women's agency (Khuat *et al.* 2009, Werner 2009, Do and Fu 2011). Furthermore, fears about the social and physical consequences loom large for women who test positive for sexually transmitted infections (Go *et al.* 2002). In addition to feeling sexually obligated to their partners, the role of the family also shapes women's knowledge and attitudes about sex and sexual practice. Vu Song Ha, for example, found that women's ability to communicate openly about sex or refuse sex was tied to the need to maintain harmony and stability in the family (Vu, S.H. 2008). Initially hindered by difficulties in access to rural and mountainous areas, recently a small body of research on HIV prevention among ethnic minorities in Vietnam has emerged (Nguyen *et al.* 2012), providing further examples of how the cultural construction of sexuality can limit access to information and thus create vulnerabilities. Nguyen Huy V. and colleagues found that parents thought that education about sexual and reproductive health and sexually transmitted infections was important for young children, but they felt it was the responsibility of youth groups and educators to teach these topics to children.

Complementing the substantial body of social science research on gender, sexuality, relationships, and HIV risk has been social science research on reproductive health that is more focused on treatment and care. HIV positive women who are pregnant or wish to become pregnant face stigma and discrimination from the wider community due to HIV's association as a 'social evil' (Brickley *et al.* 2009), but because they do not fall under the 'high risk' groups of commercial sex workers or drug users, HIV-positive women have been overlooked by the state in terms of reproductive health initiatives (Nguyen *et al.* 2010). Testing has continued to be an important step in preventing perinatal transmission and an important source of social support (Oosterhoff, Hardon *et al.* 2008a, Nguyen, Rasch *et al.* 2009, Nguyen *et al.* 2011); however, lack of antenatal HIV testing is often associated with poor socio-economic characteristics such as poverty, living in remote areas, and not being informed during the antenatal visit of the potential for mother-to-child transmission (Nguyen *et al.* 2011).

Some of this research on social relationships and collectivity has also touched on themes related to the sexual and reproductive rights of people living with HIV and AIDS. For heterosexual women who are HIV-positive, interventions that encourage social relationships have helped women gain access to important resources. Sunflowers, the first support group in Hanoi for women with HIV, helped its members access social, medical, and economic support and services for themselves and their partners and children through personal development plans and access to state services, loans, job counseling, and legal advice (Oosterhoff, Anh *et al.* 2008, 2008a, 2008b). In addition, women felt empowered by their social status and identity as mothers to organise and develop strategies to access these essential services. Despite the successful results of Sunflowers in Hanoi, women in cities such as Ho Chi Minh and Hai Phong, without access to support groups, lack information about their sexual and reproductive rights, access to medical counseling, and face HIV-related discrimination from their families and health care providers (Messersmith, Semrau, Anh *et al.* 2012).

Stigma and the experiences of people living with HIV and AIDS

In Vietnam, the intense stigmatisation that individuals living with HIV are subject to continues to have devastating social, institutional, and emotional consequences, both on those individuals and on the course of the epidemic. In terms of prevention, social scientists have argued that the intersection of pervasive stigma and discrimination against HIV and individuals living with HIV with Vietnam's rapidly shifting social context has proven to

have individual-, social-, and structural-level influences on HIV vulnerability (Khuat 1998, Khuat, Anh *et al.* 2005, Khuat, Duong *et al.* 2005). Discrimination has shaped the landscape of treatment and care as well; despite strict legislation intended to protect people living with HIV or AIDS, stigma continues to be a barrier to accessing care.

Although discussions about stigma are present in almost all social science research on HIV in Vietnam, research focused directly on the topic provides more substantial insight into the experience and meaning of stigma faced by PLWHA and its ramifications across the community (Khoat *et al.* 2005). These studies examine qualities of stigma such as fear of HIV and its transmission, moral implications, and the association with ‘social evil’ discourses (Khuat *et al.* 2004). By conducting interviews and focus group discussions with PLWHA, their family members, and community leaders, Gaudine and colleagues find four dimensions of HIV-related stigma particular to Vietnam: feelings of shame and scorn, differences in behaviour, stigma due to association, and fear of transmission (2010). While PLWHA experience stigma directly and are obliged to learn stigma-reduction strategies (Gaudine *et al.* 2007, 2009, Thi *et al.* 2008, Small 2009), community leaders expressed negative views of persons infected with or affected by HIV, often viewing stigma as a just punishment for moral impropriety and thereby reinforcing stigmatisation of those living with HIV and AIDS by the community. Families with HIV-infected members also experienced secondary stigma, feeling the need to hide the seropositive status of the member to ward off financial hardships and community moral judgment. In some instances, however, that same stigma engendered social support from families and friends for those living with HIV (Small 2009, Salter *et al.* 2010).

With the majority of research on HIV in Vietnam (both social science and otherwise) focused on determinants of HIV transmission and prevention, social science research on stigma has filled a critical gap by providing a window into the experiences, concerns, and relationships of people living with HIV or AIDS. This includes topics such as the continuity of care inside and outside of the hospital setting, access to social support, mental health, and adherence to drug therapy. PLWHA often report low health-related quality of life, joblessness, and barriers to accessing health services (Tran 2011). PLWHA have been shown to lack both psychological and social support as well as access to mental health services (de Loenzien 2009, Duchesne and Franchi 2011), with stigma creating a barrier to adherence because PLWHA fear that ART medications will disclose their serostatus (Van Tam *et al.* 2011a). Nevertheless, informal care through kinship ties, close friends, and HIV support groups continues to be an important way to improve coping (de Loenzien 2009, Oosterhoff 2010), especially for HIV-positive mothers seeking access to essential services (Oosterhoff, Anh *et al.* 2008, 2008a, 2008b).

Research on social inequalities, structural violence, and HIV vulnerability

Complementing studies on the more micro-level social context of HIV transmission, other research has examined the structural sources of HIV vulnerability. Social science has been especially important in highlighting the role of structural and institutional factors in shaping the epidemic. It is widely acknowledged that structural factors create barriers to accessing health care, especially for stigmatised groups. However, the details and sources of those structural barriers are rarely discussed. Social science research fills this gap by examining the connection between structural changes and disparities in risk and access to care.

One major theme of social science research in Vietnam has been the circumstances under which social conditions facilitate risk behaviours. In an article on structural violence experienced by Vietnamese FSW in Cambodia, Hudgins (2005) criticises NGO policies for ‘rescuing’ women from brothels or ‘empowering’ them with harm-reduction practices. She

argued that instead attention should be paid to the structural violence that leads women to enter sex work (Hudgins 2005). Specific factors to which she points include Cambodia's weak institutional capacity to enforce laws after the devastation of the Pol Pot era; the restructuring of the physical landscape of the city for sex tourism; and the effects of *Doi Moi* decollectivisation, which left uneducated women with few employment opportunities. The privatisation of land, she argues, has also compelled landless families in rural areas to obtain loans, with debt bonding the daughters into prostitution as a means to deal with financial crisis. In addition to structural factors influencing the entrance to sex work, FSW attempting to leave sex work found it difficult due to discrimination at health care settings and job settings, which often led to the return to sex work among rehabilitated FSW (Rushing *et al.* 2005, Ngo *et al.* 2007, Pham *et al.* 2008).

Scholars also have explored how structural institutions and policies shape the daily lives of those living with or at risk for HIV. While much of the research on men's gender and sexuality focuses on men's beliefs, Phinney's work on men's heterosexuality provides a larger picture of how political and economic factors facilitate HIV risk practices (Phinney 2008, 2009). She argues that policies regarding migration, families, economic restructuring, and gendered images of masculinity have shaped men's opportunities for extramarital relations that put their wives at risk for HIV. Her articulation of the political economy of sexuality points to the ways in which behaviours are shaped by policy and larger social processes.

Taking a parallel focus on policies relevant to HIV risk for IDUs, Hammett and others highlight the contradictions between drug control and harm reduction, finding that harm-reduction programmes were impeded by actual and perceived threats from law enforcement (Hammett, Bartlett, Chen, Ngu, Cuong, Phuong, Tho, Van, Liu, Donghua, *et al.* 2005, Hammett 2008, Vuong *et al.* 2011). Despite the new availability of methadone treatment for IDUs, the intense stigmatisation that IDUs are subjected to, along with threats from law enforcement, create barriers to participation in harm reduction (Hammett, Norton, Kling, Liu, Chen, Ngu, Binh, Dong, Jarlais *et al.* 2005, Hammett *et al.* 2007). They argue that in order to successfully implement HIV-prevention programmes with this population, the tensions between drug control and harm-reduction policies must be further examined for consistency and support from multiple sectors of society (Hammett 2008).

Related themes have emerged in research on HIV risk among ethnic minority populations (Ha and Fisher 2011). Work conducted among the Black Thai has argued that *Doi Moi*-related modernisation and economic liberalisation programmes coupled with the eradication of opium production (which has led to increased heroin injection to replace opiates) has increased HIV risk among the Black Thai community by shifting opiate use to injection drug use (Oosterhoff *et al.* 2011). In addition to the material changes wrought by *Doi Moi*, these studies describe resultant cultural changes with implications for HIV risk; the matrilineal tradition of *zu kuay* among the Black Thai, which allowed for potential marriage partners to become more familiar with each other before marriage, is gradually being replaced by patrilineal cultural norms of the ethnic Kinh people, which has disempowered women in the community. These studies provide insight into the social factors shaping HIV vulnerability among these ethnically marginalised groups in a resource-constrained setting.

The political economy of HIV and AIDS

Other scholarship has focused on the historical and structural contexts that shape HIV and AIDS-related experiences, research, and policy implementation. These studies examine the consequences of *Doi Moi* as a large-scale shift in the social system of Vietnam. As mentioned before, these policies of economic restructuring brought about economic changes

as well as cultural ones; social scientists have productively analysed these changes using concepts of neoliberalism, socialisation, and globalisation. These terms refer to transformations in the role of the state, both in terms of a shift toward providing social welfare through household self-management, as well as in terms of the state's role in bringing Vietnam into the capitalist world order through trade liberalisation and flexible labour. Although Vietnam's 'market socialism' presents a critique of neoliberalism's conceptual tendency toward global uniformity of state practices and philosophies (Schwenkel and Leshkovich 2012), scholars working in Vietnam have continued to use it as an analytic for understanding the ways in which intersections of global capitalism and state socialism have shaped knowledge, governance, and cultural logics of practice in this transitioning country (Werner 2002, Montoya 2012, Schwenkel and Leshkovich 2012).

In relation to HIV, researchers have used varied approaches and substantive foci to look at the ways in which *Doi Moi* and economic restructuring have been the source of new political and cultural arrangements that have important implications for the course of the epidemic. In her historical analysis of HIV prevention, Nguyen-Vo examines how political philosophy has shifted in regard to how the Vietnamese state manages HIV spread through FSW (Nguyen-Vo 2002, 2008). Political discourse defined prostitution initially as a vestige of Western colonialism and 'social evil'; however, economic liberalisation and the conspicuous instances of the re-emerging sex industry transformed policies of governance over morality into governance guided by medical experts. This reflected the country's shift from a Leninist mode of governance to state acknowledgment of HIV as an important socio-economic and public health issue. Just as the level of intervention changed from disciplining the individual prostitute to disciplining the sexual practices of the population, the responsibility for health maintenance and HIV prevention changed from a state matter to an individual concern.

Montoya similarly tracks a shift in government policy toward individualising health management through biomedical expertise, but draws attention to how global institutions have shaped Vietnamese efforts to control the epidemic (Montoya 2011, 2012). With global humanitarian aid (mostly from the PEPFAR) as a main source for HIV relief in Vietnam, Montoya describes how neoliberal logics and technologies influence both the ways in which NGOs in Vietnam receive financial funding as well as how the government intervenes in the lives of the population to prevent HIV and treat those living with AIDS. For NGOs, the neoliberal logics of measurement and audit prioritise indicators of performance that contribute to what Montoya calls a competitive 'economy of virtue' among humanitarian organisations (2012, p. 563). This is characterised by a moral economy of images of suffering and illness narratives that circulate and eventually accrue real capital. By focusing on HIV and AIDS through the lens of a transitioning social system within a global arena, its prevention and control is investigated as an assemblage of state socialist governance, humanitarian organisations, as well as biomedical and international standards of 'best practices'.

Future directions for social science research of HIV and AIDS in Vietnam

Social science research in Vietnam has focused primarily on the population groups thought to be at highest risk, applying conceptual frameworks ranging from the individual level to the macro-structural level to ask questions about HIV risk and (to a lesser extent) the experience of living with AIDS as a social phenomenon. In this section, we point to topics and frameworks that have been underemphasised in this research and that offer important potential for future research on HIV and AIDS in Vietnam.

One issue, looking ahead, is the balance researchers must strike between attending the sub-populations who continue to experience the greatest burden of disease, and about whom many questions remain unanswered, and addressing the potential for a more generalised epidemic. While we reject the notion of bridge populations as implying that specific vulnerable groups are of primary concern as vectors, somehow culpable for their socially organised sexual networks that have the potential to disseminate HIV between stigmatised social groups and the broader national body, the shift in sex ratios demands attention. There has recently been increasing attention to what epidemiologists call Intimate Partner Transmission (IPT) (as if MSM were not also having sex with intimate partners), with a male/female ratio among HIV-reported cases that has decreased substantially, from 5.3 men to 1 woman in 1994 to 2:1 in 2005 (Commission on AIDS in Asia 2008). Indeed, one researcher has referred to the 'latent feminisation of HIV epidemics in Vietnam' (Tran, Ohinmaa, *et al.* 2012). However, not much has been done to address the risk of marital transmission, with the exceptions of two intervention studies (i.e., small scale) by Theodore Hammett and colleagues (Hammett, Bartlett, Chen, Ngu, Cuong, Phuong, Tho, Van, Liu, Donghua, *et al.* 2005, Hammett *et al.* 2007). Also, little work has been done on violence against women and HIV risk, which elsewhere has been the focus of substantial scholarship.

There has been little work at the intersection of social science and public health that looks at the role of the media, either in shaping the meanings of HIV and AIDS or as a broader influence on the cultural landscape. As shown by the work discussed above (Khuat *et al.* 2009, Phinney 2009), the proliferating images that shape ideals of masculinity and femininity have influenced ways of knowing about matters of sex and sexuality that are of great consequence for the landscape of HIV risk. Thus, it would be useful to see more work that explores representations of HIV, and to understand the actors and agendas that have shaped these media representations to support or stigmatise those suffering from the illness. As the media in Vietnam remains mostly controlled by the state, it would also be useful to explore the political processes through which particular ideas and images are challenged or reproduced in a way that influences public perception.

Globally, HIV and AIDS illuminated the social fault lines that became the basis for politically charged activism against sexism and racism (Almeida *et al.* 1998, Epstein 1998, Kalofonos 2006, Smith and Siplon 2006, Brier 2009). In Vietnam, social movements such as the country's first gay pride parade in 2012 have generated little scholarship, let alone scholarship that explores their engagement with questions of HIV and AIDS. In addition, no literature has been published about the rights of PLWHA or sex workers despite projects and activities occurring in this area. It would be useful to know the spaces and possibilities that exist for civil society engagement in HIV and AIDS policy-making, how rights and claims are constructed in Vietnam, and whether these nascent social movements have had an effect on HIV and AIDS stigma and discrimination. Given the important contributions of social movements to enhancing access to AIDS care globally, it seems vital to know more about the role of social movements and civil society in Vietnam in shaping HIV prevention and AIDS care.

Looking ahead, there is a pressing need to ensure that a greater proportion of the HIV intervention research carried out in Vietnam is shared with the international scholarly community. With funding from PEPFAR, the Global Fund, the World Bank, and Department for International Development (DFID), as well as many others, many interventions—ranging from behavioural change for HIV prevention to treatment and care and to advocacy for policy change—have been carried out and evaluated. However, with some exceptions (Hammett, Bartlett, Chen, Ngu, Cuong, Phuong, Tho, Van, Liu, Meng *et al.* 2005, Hammett, Johnston, Kling, Liu, Ngu, Tung, Binh, Dong, Hoang *et al.* 2005, Hammett, Norton *et al.* 2005, Oosterhoff *et al.* 2008, Broadhead *et al.* 2009, Nguyen, Oosterhoff *et al.*

2009, Messersmith, Semrau, Anh *et al.* 2012, Messersmith, Semrau, Hammett *et al.* 2012), including some recent intervention studies on injecting drug users and their partners (Go, Frangakis, *et al.* 2006, Go, Quan, *et al.* 2006, Go 2011), very little of that work has made its way into the peer-reviewed literature, despite having systematically documented the intervention and its effects. The many reports produced by NGOs (both international and domestic) that end up solely as grey literature reflect the Vietnamese political economy of knowledge, which favors short-term, less theoretically driven programme evaluation. Furthermore, the institutional reward structures through which consultants navigate provide little incentive for the additional work necessary to turn a programme evaluation into a peer-reviewed publication. Much that could have been learned during the past two decades of international engagement with HIV prevention, and more recently with AIDS care, in Vietnam, has been lost because of a national and institutional context in which research is under-incentivised.

HIV is embedded in many larger social processes and institutions shaped by policy, discourse, and structural transformation. However, one critical institutional factor that has been largely overlooked in social science research is Vietnam's health system, where important questions remain to be asked both in terms of the experiences and determinants of health systems engagement and in relation to the ways that the country's growing social and economic inequality will affect access. For example, some work has examined the ongoing policy contradictions in drug treatment and how poverty, stigma, and discrimination prevent drug users and/or persons with HIV/AIDS from accessing drug treatment and health care services (Van Tam *et al.* 2011, Vuong *et al.* 2011, Do *et al.* 2012). However, there is almost no research on how these recent policy and treatment changes are perceived and experienced by HIV-infected IDUs and how that might influence their utilisation of drug and HIV treatment services. More generally, substantial opportunities exist for social science research to shed light on barriers to optimising the cascade of care. Vietnam is currently scaling up its health-financing system with the hope of reaching universal coverage through its social health insurance programme, but the benefits do not cover illnesses already addressed by vertical programmes, including HIV and AIDS (Ekman *et al.* 2008, Dao 2012). Despite the fact that most health care costs are currently paid out of pocket (Wagstaff and Lieberman 2008), it may be useful to explore how new financing arrangements will impact different groups affected by HIV and AIDS, such as health care providers, government aid workers, and patients themselves. Research should also examine how responses and policies change both politically and culturally as responsibility for health shifts away from external funding mechanisms and global apparatuses.

The other set of health systems questions that are vital to ask relate to looming changes in the structure of HIV and AIDS funding and the turn toward horizontal health systems strengthening (Taye *et al.* 2012, Wagstaff and Lieberman 2008). In the past 10 years, HIV/AIDS policy in Vietnam has shifted rapidly, moving from a focus on punishing those who have HIV risk behaviours by labeling them as 'social evils' to a focus on limiting public harms brought about by these behaviours (Nguyen Ha *et al.* 2010, Vuong *et al.* 2012). However, these impressive developments have been primarily bankrolled by international donors; PEPFAR, for example, has invested more than US\$800 millions dollars since 2004, when Vietnam was selected as the only Asian country counted among the fifteen countries that received PEPFAR Round I support. While investment from the Vietnamese government has increased almost threefold during this period, government spending per capita still accounts for less than one-third of the total expenditure on AIDS (Vietnam Authority of AIDS Control and UNAIDS 2011). In such a context, the planned phasing out of PEPFAR, with plans for a complete withdrawal by 2016, is expected to have significant impacts on the Vietnamese responses to HIV/AIDS, at both policy and implementation levels. Although Vietnam is certainly not the only country to have experienced significant levels of

internationally financed scale-up followed by an exodus of international donors, in few other cases have both processes happened as rapidly and abruptly as in Vietnam. New policies need to be formulated to address both the need for scale-up and the need for sustainability of services; new strategies need to be developed to streamline the costs and yet maintain certain levels of quality; and new ways need to be determined to adapt policies under trying circumstances and ultimately make them work for those who are affected by the epidemics. The pending withdrawal of PEPFAR and the consequential shifting responses of Vietnamese individuals and collectives offer unique opportunities to further understand the processes through which HIV policy is both formulated and implemented. Furthermore, although the confluence of factors related to the local context as well as the global HIV policies might be unique for the case of Vietnam, lessons drawn from Vietnamese policies and responses will shed light on broader questions related to the sustainability and country ownership of HIV and AIDS policies.

Conclusion

Globally, the capacity of social scientists to contribute to policy formation is highly variable (Turner *et al.* 1989, Blankenship *et al.* 2006). Although social science research on HIV has made many contributions to policy formation globally (Peabody and Hesketh 1996, Trostle *et al.* 1999, Philpott *et al.* 2002, Nathanson 2007), its potential to inform national policies for the prevention of HIV and for the treatment and care of AIDS has not always been fully realised, even in developed countries. In resource-poor countries such as Vietnam (Ministry of Health-Vietnam 2012), longstanding neglect of research infrastructure, as well as political sensitivities reflecting the often critical nature of social science research findings, have resulted in the underdevelopment of social science research on health, both in general and in relation to HIV and AIDS. In Vietnam, biomedical and epidemiological research has dominated the field since the beginning of the HIV epidemic (Ministry of Health-Vietnam 2012), and the rapid process of HIV/AIDS scale-up that began in the 2000s made even more evident the limited Vietnamese capacity to conduct the social and behavioural science research that would provide a solid foundation for the scale-up of programmes, monitor their implementation and impact, and assess Vietnam's future needs in responding to the epidemic.

Moreover, there is a growing awareness that social scientists could be more effectively trained to communicate the relevance and significance of their findings, and that there is an urgency to doing so; even if behavioural prevention interventions were effective and sustainable, they would not be scalable, and so it is only by identifying social population-level influences on the HIV risk and engagement with care that it will be possible to develop higher impact, truly public health approaches to the challenges presented by HIV and AIDS. While Vietnam's experience is perhaps illustrative of the broader challenges regarding ensuring that policy-relevant social science research contributes to policy formation, the challenges faced there are hardly unique. Around the globe, social scientists have been adept at articulating how structural forces shape HIV risk, but much less successful at communicating the significance of their findings to non-specialists, much less at translating research into policies. Indeed, most social science training programmes in the United States, even those in schools of public health, provide little training in dissemination or translation. Those investigators who become successful advocates for the policy importance of their work do so largely as independent intellectual entrepreneurs, rather than as the result of any structured guidance on what social science dissemination or translation means or how to accomplish those goals. This lacuna exists despite the fact that there is a large body of knowledge from health policy, political science, history, and sociology concerning the circumstances under which scientific knowledge is more or less able to contribute effectively to policy (Davis and Howden-Chapman 1996, Peabody and Hesketh 1996,

Trostle *et al.* 1999, Philpott *et al.* 2002, Nathanson 2007). It is therefore not a surprise that the translation of research findings has received even less attention in resource-constrained settings such as Vietnam.

The social science of HIV and AIDS in Vietnam has already made critical contributions, depicting the previously undocumented life experiences of injection drug users, the development and diversity of multiple MSM identities, the struggles faced by sex workers, and the challenges faced by women living with HIV who are seeking to have children. It has also pointed to institutions—the family, the workplace, the health care system—buffeted by the rapidly changing political, economic, and financial climate of Vietnam. Some of the gaps in the research to which we have pointed are addressed in the other articles presented in this supplement. Others questions, however, remain unanswered. Moving forward with this agenda and with the broadest possible range of methodological and theoretical tools will be critical for communicating policy-relevant findings to key stakeholders and strengthening the Vietnamese response to HIV and AIDS.

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