The HIV/AIDS Vulnerability of Labor Out-Migrants and its Consequences on the Left-behind at the Household Level

Dang Nguyen Anh, PhD
Institute of Sociology, Hanoi, Viet Nam
Phone: (844) 972 5053
Fax: (844) 856 1912
e-mail: danganh@netnam.vn

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Abstract

Most previous studies on migration and health have focused on the migrants themselves. Little is known about the health and well-being of those remained in the source communities. Although more secure incomes remitted by migrants can improve the quality of life, including health, for family members who left behind, the out-migration of young adults and their exposure to STDs, including HIV/AIDS, can put the families at risk.

The justification of this paper is to see how migration and its health risk effects can be assessed at a local context. Given the data collected in a rapid assessment on mobile population and HIV vulnerability in Vu Tay commune, Thai Binh province (one of the top out-migration sources in Viet Nam), the analysis limits itself to internal labor migration. The lack of basic knowledge and effective means has put migrants at high risk of contracting HIV/AIDS. The ‘illegal’ status and vulnerable living conditions at destination places leave migrants on their own when dealing with high-risk behaviors and HIV infections.

Severely concerned are about HIV/STD transmissions which the migrants bear on their left-behind spouses, especially wives, at home villages. Women and wives are in a passive and vulnerable position to contract HIV+ from migrant husbands. It is the ‘tensions’ between the HIV/AIDS risk, love, affection and secured livelihoods brought about by out-migration. It is highly recommended that appropriate messages, effective measures on harm reduction, behavioral change be included for migrants and particularly vulnerable groups, in the formulation and implementation of health care and AIDS control programs.
I. Introduction

Viet Nam’s population is now about 82 million. As of August 2004, 84,484 cases of HIV infection had been officially reported. The Ministry of Health (MOH) estimates that the actual number is about three times that (approximately 240,000 cases) representing 0.44% of the population. HIV infections have been recorded in all of Viet Nam's 64 provinces. While IDUs make up the majority of HIV infected people, the epidemic is associated with prostitution and, increasingly, contaminated blood. Vietnam’s sex trade flourishes in both rural and urban areas. Sex workers lack health protection since their work is illegal and their vulnerability to HIV/STD infection has become a major gap in prevention efforts.

Ever-increasing rates of STDs are creating conditions that allow HIV to spread more easily beyond known high-risk groups, particularly among women. The HIV infection is spreading beyond the high-risk groups to the general population. Recognized conduits for this spread include IDUs with contaminated injecting equipment, the clients (mostly men) of CSWs who also have wives and girlfriends, men who have sex with other men who also have wives, girlfriends and other sexual partners, IDUs who engage in sex work to support drug addictions, and CSWs that have IDU partners and support their drug use. In addition, population mobility facilitates the spread of STDs and HIV. Most migrants visit home periodically to reunite with their families. This seasonal "back floating" places those left behind in the rural home areas at high risk.

Of all the HIV risk factors, that of mobile population has been least investigated (UNAIDS and WHO, 2004). Little is known either about the incidence of HIV in migrant populations or their role in spreading the disease in Vietnam and the Asian region. Indeed, surveillance studies in Asia rarely are carried out among migrant communities (UNAIDS, 2004). As population mobility has increased massively in the region over the last decade, it becomes clear that various types of migration can often be associated with the spread of the epidemic. Migrants move into contexts where they are often at increased risk of contracting HIV. They move away from social networks that traditionally limit their exposure, and take on behaviors such as having sexual relationship with CSWs or injecting drug use, which heightened risk. Migrants often have resources that allow them to engage in unsafe behavior, but their lack of knowledge of existing sexual transmitted diseases
(STD) and health services, or lack of access to these services because of their illegal status, can also act to increase their vulnerability to HIV.

The objective of this paper is to make a contribution to understanding the relationship between the spread of HIV/AIDS and migration as well as its emerging consequences for the left-behind in Vietnam. Based on the field research data collected in Thai Binh province (2001), findings obtained from the study question the extent to which rural Vietnam is a low-risk and low-prevalence setting, and suggest, that notwithstanding national policy efforts in AIDS prevention and controls, HIV risks and vulnerabilities do exist and challenge families and people left-behind by migrants.

II. Background and setting

Thai Binh is the most densely populated province in Viet Nam after Hanoi and Ho Chi Minh City with a land area of only 1,537 km² and a total population of 1,785,600 according to the 1999 Population Census (CCSC, 2000). With a total of 285 communes, the province is administratively divided into seven districts and one provincial town. Its main income comes from agriculture. Since rice farming is seasonal with about 3-4 months of intensive work, there is often not enough work opportunities in the province for local farmers and young people for several months each year. Therefore, Thai Binh farmers often leave the province for months at a time each year (or even long term) to find work and income opportunities elsewhere (e.g., in major cities such as Hanoi, Hai Phong, and HCMC, or for seasonal work in other rural mountainous areas and manufacturing jobs in industrial zones throughout the country).

Like many other Northern rural provinces located in the Red-River delta, increasing numbers of migrants, both single and married, leave their homes every year in Thai Binh. The province is one of the highest source areas for internal labor migration and inhabited largely by migrants’ left-behind families. With high rates of unemployment and underemployment it is common for local farmers and young people to leave the province seeking work. At any given time it is reported that 100,000 people move outside the province. It was estimated that in most communes of Thai Binh, between 200-500 people go out of the province for at least several months a year. The census data show that
between the year 1994 and 1999, more than 56,000 persons over 5 years of age migrated out from Thai Binh (CCSC, 2001). This figure, however, mainly refers to more permanent or long-term migration and thereby may not capture most of the seasonal and short-term movements. The above statistics do not include overseas labor export workers who are away from home for several years. The province also has fisherman from the coastal communes who sometimes go out for a few months at a time to various fishing spots. Wherever they go, migrants maintain close contact with their home families where they still have farms that are taken care of by spouses, parents, children or other relatives. Such migrants do have responsibilities for sending regular remittances and when possible returning home for planting and harvesting, and at holiday times, as well as other occasions.1

The first reported HIV+ case in Thai Binh province was identified in 1996. By the time this study was conducted, the cumulative number of HIV+ is 357. Among these numbers, 35 had AIDS and 14 had died (PPMC, 2001). The vast majority of reported HIV+ persons in the province are male (92%). However, the proportion of female with HIV+ is increasing. Over two-thirds of the reported HIV+ persons are between the ages of 17-29 years old. A large number of the HIV+ in the province have a history of being migrants or mobile workers as well as IDUs or CSWs. It is reported that rural women suffered HIV/STD infection by their husbands returned from migration trips.

Findings reported in this paper come from a rapid assessment conducted in a rural commune – Vu Tay (Kien Xuong district, Thai Binh province).2 The assessment was intended to explore risk behavior and the HIV vulnerability among mobile population and non-migrants. Vu Tay commune is only 8 kilometers from Thai Binh town, with a population of 9,165 living in 2,394 households in nine villages (by the year 2001). The commune has a long history of labor out-migration. A migrant network was developed over a decade ago in Vu Tay, often through local contractors who moved from the

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1 Agricultural cycle in the Thai Binh’s rural communes is mostly in May-June and September-October. The mobile workers also tend to come back home during the January-February Tet holiday period.

2 The Family Health International (FHI) provided financial support to the assessment, which is highly appreciated.
commune to establish businesses and then called on villagers to work for them. Compared to women, a significant proportion of men have out-migrated in Vu Tay. During the 1990s, young males migrated from the commune to Son La, Lai Chau and Quang Ninh provinces to work as wage labor in the informal sector and gold-diggers in remote mountains. They reportedly bring back HIV/AIDS. Other destinations for internal and seasonal migrants include Hanoi, Hai Phong, Lao Cai, Yen Bai, Lang Son, Ho Chi Minh City, Dong Nai, Binh Phuoc, Gia Lai, Dak Lak and road construction projects throughout the country. Some other men go to work as cyclo drivers, porters, daily laborers, in urban centers and some women go to major cities to work on trading and service jobs.

With a highly mobile population, Vu Tay is also one of the rural communes where several persons live with HIV/AIDS (PLWHA). The authorities are aware of Vu Tay because it had one of the highest recorded cases of HIV in Thai Binh. By the time this study was conducted, eight of the nine villages had PLWHA living there. There were 98 reported drug addicts in the commune, with 43 having very serious daily intravenous drug use problems. By the time of the study, there were 25 PLWHAs in Vu Tay (with eight HIV+ living in one small village alone – Dai Hai village). The commune leaders reported that 77% of HIV+ persons were IDUs and about 23% of the HIV+ persons were considered to have had the virus transmitted through sexual relations. There were three reported HIV cases of mother to child transmission, and eight wives reportedly contracted the HIV virus from their husbands; all these husbands have a history of being migrants as well as experience of injecting drug use outside the commune.

III. Data and methods

Using the qualitative method for data collection, the assessment study included several ways of investigation and information, including focus group discussions (FGDs) and

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3 However, this does not account for the full range of movements, nor the various types of work that are undertaken, which include: construction workers, porters, small traders, truck drivers, gas sellers, cyclo
Table 1. Socio-demographic profile of the respondents: Vu Tay, Thai Binh, 2001

<table>
<thead>
<tr>
<th>Migrants</th>
<th>Occupation – migrant destination</th>
<th>Age – marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD with 7 male</td>
<td>Motorcycle keeper, coal porter, electric worker, machine repairer, technicians</td>
<td>Married, over 30 years old</td>
</tr>
<tr>
<td>migrants</td>
<td>Various areas</td>
<td></td>
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<tr>
<td>FGD with 8 male</td>
<td>Road construction, small trader, construction worker, cyclo driver, motorcycle drivers, etc</td>
<td>Married with children</td>
</tr>
<tr>
<td>migrants</td>
<td>Various areas</td>
<td>Aged from 28-42</td>
</tr>
<tr>
<td>4 x IDIs male</td>
<td>Electric worker, cyclo driver, gas seller, small trader (selection from FGDs above)</td>
<td>Married, single, young and middle ages from 27-44</td>
</tr>
<tr>
<td></td>
<td><em>Quang Ninh, Hoa Binh, Hanoi, Son La</em></td>
<td></td>
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<tr>
<td>FGD with 6 female</td>
<td>Waiter, street vender, embroidery, basket carrier, cleaner, house maid</td>
<td>Married, aged from 28 - 44</td>
</tr>
<tr>
<td>migrants</td>
<td>Various areas</td>
<td></td>
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<tr>
<td>3 x IDIs female</td>
<td>Embroidery worker, house maid, and banana vender</td>
<td>Married, 26, 32 and 29</td>
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<td></td>
<td><em>HCMC, Hanoi, Son La</em></td>
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<td>Left-behind spouses</td>
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<tr>
<td>FGD with 7 wives</td>
<td>Non-migrants, farmers</td>
<td>Younger married with children, aged from 23-35</td>
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<tr>
<td>FGD with 5 wives</td>
<td>Non-migrants, farmers</td>
<td>Older married with children, aged from 33-40</td>
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<tr>
<td>2 x IDIs and 1 x IDI</td>
<td>Non-migrants, farmers</td>
<td>Married, young &amp; older</td>
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<tr>
<td>husband</td>
<td></td>
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<tr>
<td>IDUs</td>
<td></td>
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<tr>
<td>2 x IDIs male</td>
<td>Returned migrants and post-detoxification IDUs</td>
<td>Single, 23 &amp; Married 42</td>
</tr>
<tr>
<td></td>
<td><em>Various areas</em></td>
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<tr>
<td>1 x IDIs male</td>
<td>A returnee with IDUs &amp; HIV+</td>
<td>Married with one child, 28</td>
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<tr>
<td></td>
<td><em>Various areas</em></td>
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<tr>
<td>KIs</td>
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<tr>
<td>2 Key-informants</td>
<td>1 from commune health clinic</td>
<td>Male, married, 47 &amp; 54</td>
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<td></td>
<td>1 from commune people committee</td>
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Source: Rapid assessment data (2001)

individual in-depth interviews (IDIs). The importance of privacy in all interviews was emphasised, and this was strictly followed throughout. Focus group discussions with both ever migrants and temporary home visitors, and their left-behind spouses were conducted. Participant requirements included having single gender groups, and homogeneity in regards to age and sometimes occupation. Their knowledge, attitude and perception about HIV infections and transmission were explored. Attempts were made to capture among participants the behavioral and social-cultural milieu in the commune. Insights relating to drivers, motorbike driver, embroidery workers, wood cutters, house maids, street and stall vendors. This is
left-behind people’s lives and livelihoods, spousal and familial interactions regarding migration, love, affection, trust and fidelity were obtained from interviews.

The procedure used for selecting individuals for in-depth interviews was primarily through choosing participants from the FGDs who could provide relevant in-depth data in one-to-one interviews. This system worked well. Respondents include both males and females, married and unmarried. Many have a remarkable history of migration, being in different provinces and regions to earn a living. Ages range from 18-54, but a vast majority of them are under 35 years old (see Table 1 below for a profile of the respondents interviewed in the field).

Due to the high sensitivity and social stigmatization regarding HIV/AIDS prevailing in the commune at the time this study was conducted, the research team did not hold focus group discussion, but in-depth individual interviews with IDUs with the assistance of local health staff. The sensitive nature of the topic also inhibited interviews with their wives and free discussion of HIV testing results. Very special attention was paid to maintaining privacy and confidentiality about the respondents. Future research should conduct further discussions with PLWHAs in order to assess the families’ coping strategies and responses to HIV impacts.

**IV. Study findings**

In this section, major findings from the study will be presented with a focus on the HIV/AIDS vulnerability among migrants and the families left-behind. Both are indispensable elements of the migration system. Two themes emerge quite clearly from the interviews. One is the low perception on HIV vulnerability and high-risk behaviors adopted by migrants. The second is the susceptible position of left-behind spouses. The generally low status of women in marriage clouded with social norms seems to place them at risk of being infected.
The Migrants

Living conditions at destination places
Living arrangement may lead to diversified vulnerability. Except for those who migrate to work as housemaids, most migrant workers stay nearby or right at their workplaces. The types of lodging vary, but guesthouses and temporary huts are popular where between 10-15 male migrants share an area of 20m². They sleep altogether on the floor. Due to high housing costs and the requirement of work, some female embroidery workers in HCMC live in narrow and stuffy workshops on the work-site, sometimes sleeping on the floors of the workshops. There is often no toilet facility available in such dwellings. Water can be taken from a drilling well where they wash and bathe.

Even for female workers who are living in guesthouses, the facilities are unhygienic and cannot meet the needs of tenants. It is often a kind of collective bathroom where people have to shower together and "there would be no place if someone comes late." In some kinds of jobs, such as banana sellers or cyclo drivers, migrants leave for work at 3:00AM in the morning. This is to meet the demand of traders in the markets. The living conditions for many can be very hard, but they have to accept inadequate conditions in order to keep their jobs, and to have sufficient savings.

Many migrants go out for breakfast, to places with reasonable prices (e.g. 1,000VND per person for a cup of sticky rice). Lunch costs 2,500VND per person and dinner about 3,000 VND. If cooking together, migrants may be able to save more and have better food. Most of migrants live in and connected to an embedded social network in places of destination. The networks can support migrants when they face difficulties. Migrants could assist each other in problems of money, kinship obligations, sickness care, and protection from violence, etc.

Migrants interviewed said that the worst difficulties were limited incomes and finding jobs. Many respondents, especially female migrants, cited homesickness:

“...When I hear of my children or husband being sick, I just miss them so much and wish to visit home” (Female, banana vender, 29 years, 2 children)
When asked, migrants generally said that their health became worse after migrating. Hard working and living conditions weakened their health. They reported that some friends contracted malaria or high fevers. The problem is that most migrants self-treat when sick, rarely visiting formal health providers. The main reason is money constraints and old habits from their home village. Some seriously sick migrants were hospitalized but only when it was too late. Many tried to return home to have treatment in commune health stations (often for free/low costs). There was a case of at least one who died on the way home.

However, other migrants remarked that they feel stronger, due to the fact that they have fewer worries, especially in being employed and making money for the family:

"I feel useful for my family, and can learn about life outside. I could have been less healthy if I got to stay home, being unemployed and seeing my wife and children in hardship" (Male, electric worker, 30 years, 2 children).

The perception of those left-behind appears to be positive with regard to migrants’ health outcomes. Wives of migrants in a FGD confirm having an improved health status of their husbands who migrated to work elsewhere:

"Oh, they are healthier as they are able to work and eat better. We notice that they are stronger when they visit home...[laugh]" (Non-migrant wife, 32 years, 2 children).

Migrants' experience of risk behaviors

Migration led not only to undergo new experience but change in behaviors of the migrants. This behavioral change is important to recognize as it contributes to the potential risk of being infected. In general, results from several FGDs reveal that migrants do change behaviors with migration. People alone and partly homesick in new surroundings often have increased sexual needs. Being away from home, people, especially men, tend to drink more, inhale heroin, use drugs, play cards/gambling. Among male migrant workers there is also increased visiting of sex workers, engaged in casual sex.
“On the heavy raining days when we got to stay indoor, the group played cards with a small amount of money. Young people, without family burdens, went out for fun. They do not have to save much money like we do, and are able to afford drink, karaoke, heroin, and visit sex workers” (Male, construction worker, 39 years, 2 children).

The attitude and exposure to risk behaviors are different for migrants, the younger and the older. Young people tend to start new experience of risk behaviors; they try drugs and visit sex workers. Young married males did so as they are separated from their wives. For them, being out of social control (e.g. parents, wives, neighbors) at destination places when cash is available is favorable conditions. Generally older men are less likely to be involved in risk behaviors than most young men are:

“During the free-time, they play gambling and drink together, some smoke opium. They go to entertainment establishments and try everything (karaoke-bars, sex workers). Even for a couple of time, I was asked to come to karaoke to sing with friends but I just sang and not go beyond the services” (Male, coal porter, 41 years, 2 children).

As for female migrants, the risks for getting involved in drugs and becoming sex workers may be lower but some migrants in such work as street venders, basket carriers, and housemaids may fall into difficult situations. The most commonly reported problem is sexual harassment and abuse by employers or bad people. Men also take advantages in having sexual relations with women who are away from home. Some young female migrants got trapped and became café-shop girls without knowing that they are exploited and at risk that may arise from the temptation of higher earnings:

“My aunt in Ho Chi Minh City asked me to come and work for her at her coffee shop. I stayed with the family, but I served and received guests in the evening when the coffee shop is opened. She paid me well and I decided to leave my embroidery job at the factory” (Female, 26 years, single, current migrant).

Migrants’ drug use experience

Many migrants decided to try drug with a group of friends due to curiosity, peer pressure or depression when working away from home. They tried to smoke opium fist then
switched to injecting drug use. A respondent reported his changing behavior as follows: Smoked opium 3 times a day → injected heroin 1-2 times a day at 30,000 VND per day → then injected opium 5-6 times a day at 20,000 VND per day. For IDUs, the first time they injected cocaine/heroin is often a few years after they smoke opium. The reason they provided varies but all agreed that smoking would require longer time, but has slower effect than injections (normally after two hours). As smoking also requires a place that is easily exposed to the police, they are inclined to injecting drug use.

The interviewed IDUs call opium "black drug" and heroin "white drug". The latter is easy to buy (available) but it is expensive whereas the former is difficult to find but cheaper. Those who inject heroin find it difficult to go back to opium. They must inject opium many times a day to get the same effect. In some case, the switch took place under the pressing situation of police's strict control over drug suppliers:

"It was 1996 when drug use was seriously criticized in the society, smoking was so inconvenient because there was no place available to supply smoking cocaine, we switched to injections" (Male IDU/ HIV+, 28 years, 1 child)

It is frequent for IDUs that they got to share needles the first time they injected. Friends also helped each other to find vein. This is a problem because these IDUS got to inject together and often shared syringes or cup right in the first time. A respondent fell into a different situation:

“I may have contacted with HIV when I worked in Mong Cai. It was the time when I went out to work daily, and did not find time to buy drug, so I asked my friends to buy for me. When I came back from work, drug was ready in syringe for injection and I did not know if the syringe was new or reused" (Male IDU, 23 years).

A former IDU respondent said he injected anywhere he found a vein, and mentioned that it was important to find a “ma” which is a place with a good vein (“a favorite vein”). A good “ma” can last three or four months or even a year, in his words “It depends on the quality of the 'ma'. ” A "ma" is not necessarily a vein, but a larger artery as well. This has implications for HIV risk. For new IDUs, they do not need to find the "ma" but can try any
veins in their arms/thighs. "Because of my eyes problem, I could not inject myself and got to ask my friends to help. I did not know the syringes they used were new or not. They were probably sharing syringes" (Male IDUs, 23 years, single)

Other respondent recalled: "There were five of us waiting for injections but we had only three syringes, so my friends cleaned the syringes by water before injects. We then shared a syringe for two persons" (Male, IDU, 42 years, married, no children).

**The Left-behind Wives**

*Perception of their migrant husbands:*

Women who stay behind reported that they know some of their husbands are likely to go out drinking and eating with friends, including karaoke bars. From one FGD, many wives believed that is likely that husbands visit sex workers, with one expressing the sentiment of the group:

"The sexual desire of them [their husbands] is heightened while they are away from home, so they are seek out entertainment" (Female, farmer, 31 years, 2 children)

However, the women seem to accept this as their husbands do work hard to support the families. Some participants are concerned about how to prevent their men from ‘social evils’ but their efforts are in vain:

"My husbands work takes him away from home, I can only remind him, when he visits home, to be aware of the risks. If there were paid work to do around here I would not let him go away. Nobody wants to live away from wives and children" (Female, farmer, 32 years, 2 children).

As for the left-behind wives, the problem is the absence of husbands. In their minds, they do not want to see their men migrate and being away from home, but due to the need for the family survival and economic livelihoods, one spouse got to migrate and work far away from children. What makes the left-behind wives most worry is therefore their husband's
health situation. They are afraid that their men get accidents or being sick without family members around to care for:

“They[men] are likely to have an accident on the way, like falling off the bike because they are too drunk” (Farmer, 26 years, 1 child).

The tension between livelihoods, affection and love has been locally interpreted as, expressed in words "direct sentiment" and "indirect sentiment" (tinh cam truc tiep and tinh cam gian tiep). The former is understood as being close with the family while the latter means financial support men can provide to the family. Both types are well respected and appreciated by the left-behind.

While men are away, the left-behind women got to work harder. They have to take good care of the family economy, parent-in-law while earn money and educate children, etc. It is quite strange that wives would not see it a burden. They all want to give up their own interests for the well-being of their families, parents in-laws and children without complaints.

Condom use and HIV/STD awareness
For a long period, condoms had been used primarily for contraception, not for disease prevention in Vietnam, and condom use rates are generally low and erratic among the population (currently at 5.8% according to the 2002 DHS). Research evidence from a number of previous studies found that sex worker’s clients rarely used condoms and men
were willing to pay more for sex without a condom (NCPFP, 1997; Khuat et al., 1998; Dang and Le, 2003).

Our study showed that condom use is not popular among migrants, although they know condoms can help to prevent HIV and some social diseases (STDs or "benh xa hoi"). They strongly object the idea of using condoms to prevent STDs/HIV as "it is inappropriate for such faithful persons like us."

The results from FGDs with male migrants however indicated that many of them have visited sex workers. Very few respondents reported using condoms with CSWs. None reported using condoms continuously. A respondent disclosed that he never used condoms even though he had visited sex workers during his marriage:

“The prostitutes dare not ask clients to use condoms because they are paid money. When we got drunk, we did not use condoms. In many times, it’s already inside so it would be useless to withdraw and to wear a condom” (Male, small trader, 28, one child).

The problem is that all migrant men admitted that they did not use condoms with their wives. None of the male respondents use condoms when they visit home. The husbands are both the dominant partner and the decision maker on safe sex practices. While living away from home, condom use is also less consistent among men if they are with their usual sex workers. All think that condoms should be used for family planning purposes only. However most migrant respondents say that they do not want to transmit HIV to their wives and children.

For the left-behind women, they know that 90-100% men have not faithful when migrating and living away from home, but they see it impossible to try and control the husbands who are so far away. None of the wives we interviewed believe that their husbands use condom when having sex with CSWs:

"I bet they never use condoms, they never use condom with their wives, then with new women, they are even less likely to use" (Farmer, 36, 2 children).
As for drug use, the women believe that their men rarely addict to drug. They trust their men in this matter. What may happen to men is to visit sex workers, which is okay.

"...I just let him go, the most important thing is to bring money home. Being away from home, wife and children, I could not prohibit him from having entertainment and such things [having sex with CSWs]" (Farmer, 32 years, 2 children).

There is a common belief among the left-behind wives that if one were faithful to husband, she would be safe from HIV infection. Some respondents understand that there could be a chance for them to get STDs from their migrant husbands but nobody could think about HIV and the use of condoms or seeking for voluntary testing. Some reported the high social and programming costs to access/use of condoms:

"I have IUD inserted, so I am not eligible to receive condoms distributed by commune programs. Besides, I dare not to buy condoms while my husband away, my parent-in-laws will immediately interrogate me why I buy condoms, even my husband will suspect my faithfulness" (Farmer, 26 years, 2 children).

The use of condom can be uneasy in certain situation in rural settings. As respondents reported: "My husband often visited home late at night, so there is no way for me to prepare a condom beforehand. He also argued that why we have to use condom if he is faithful with me" (Farmer, 25 years, 1 child).

Likewise, another respondent reported the difficulties to use condoms when having sex upon her husband’s visit:

"My husband visits home late at night without notice. It is not easy to get a condom when he wants to have sex, so we do not use it at all" (Farmer, 31 years, 2 children).

*Perception of problems of HIV/AIDS:*
In general, the left-behind are aware of HIV/AIDS and can state the basic means for prevention. They also know AIDS is incurable. However, males are more likely to have
knowledge on HIV/AIDS than their female counterparts. This is probably due to their higher education and access to more information.

Not all left-behind people have correct understanding about the epidemic. By and large, many believed that people could contract HIV by eating together, having haircut, shaking hands with the infected persons, etc. They admit that they do not know clearly and/or understand well about HIV/AIDS. In general, their perception about HIV/AIDS is not deep and accurate enough. They would like to know more than what is said or drawn in the posters they see. The findings are interesting given the HIV prevalence in Vu Tay.

V. Discussion

Obviously migrants in Thai Binh not only include seasonal movers, but also fishermen, seafarers, truck drivers, tourists, traders, government officials, drug users and sex workers as well. They are characterized by their growing number, rapid turnover and sexual contacts both in destination and their home villages. Female migrants who are not in the sex industry are often vulnerable to pressure or on the job sexual harassment; they are at risk of HIV/STD infection. As such, rural areas have been opened to the outside through either in-coming visitors or out-going migrants. This has gradually increased the mixing of different at-risk populations, and thereby accelerates the spread of HIV/AIDS to rural populations. Spouses or sexual partners of migrants require attention in AIDS prevention programs, since they are usually less aware of health risks but with larger probabilities to be affected. However, existing AIDS program interventions do not capture or target them. Today, HIV/AIDS has penetrated into families and general population in Thai Binh province, not merely within high-risk groups.

This paper makes several observations. Our most concerned problem is the spread of the AIDS epidemic (and other STDs) to the left-behind population. A significantly high proportion of rural out-migrants are sexually active. Some of them lack even basic knowledge of HIV/STDs and limited awareness on effective ways for HIV prevention. They are considered vulnerable to contracting HIV and/or contributing to its spread. As young adults are more likely to expose themselves to risk behaviors, they can bring back HIV/STDs to the left-behind spouses in the villages. Vu Tay commune is just an example, illustrating a critical case of rapid HIV transmission if protective measures are not
effectively taken. As aforementioned, wives and children of HIV+ husbands in the commune were also infected.

Rural out-migrants move into a different setting where they are often at increased vulnerability and risk of contracting HIV. They travel away from their home environment that traditionally limit their exposure, and take on behaviors such as having sexual relationship outside marriage or injecting drug use, which heightened risks. The relation between HIV/AIDS and migration has lots to do with the fact that the living and working conditions of migrants produce risks for themselves and their families. Migrant workers often travel as singles. Due to curiosity, peer pressure, isolation and depression when working away from home, they are more likely to engage in sexual relations and may try drugs. The interactions with sex workers, sexual partners and drug users can help reduce their loneliness, but in turn, place them at highest risk of becoming infected. Consequently, the susceptible to HIV infection that they can bring home to their spouses and home communities would be undeniable.

The vulnerable status of migrants has acted to increase the HIV vulnerability. It is also important to note that most migrants are isolated, socially and culturally, from the mainstream society in the places of destination. The lack of a legally recognized status can also further cut migrants off from the government programs and other formal channels of assistance (e.g. legal protection, housing, information, education, reproductive health care and other social services). HIV/AIDS program, grounding and focusing mainly on regular population, have a very limited effectiveness, as spontaneous migrants are often excluded from the interventions. Once arrived in the place of destination, most labor migrants live with fellow migrants from the same village at their place of work such as construction sites, huts in the forests, temporary guesthouses provided on-site by factories, etc. The potential risk for migrants and their families at home is associated with the nature of their work as well as its conditions.

More general, findings suggest that migrant behaviors can place the left behind families at high risk of being infected. Migrants’ wives cannot negotiate abstinence from sex, nor can they insist their men remain faithful or use condoms. The decision to have sex and to use condom was left to their husbands. Being faithful is a rational choice, but responsible
sexual partners should always protect him or her. Gender stereotypes and the knowledge gap between women and men obstruct awareness about HIV/AIDS prevention. These encourage women to be passive and innocent regarding safe sex while encouraging men to take on high-risk and controlling roles. Poor reproductive health in women increases their susceptibility to sexual transmission of HIV. The widespread of STIs in rural Vietnam making the women at highest risk of being contracted to HIV/AIDS. For years, ironically, AIDS preventive programs for the general population have focused on abstinence and delay sexual initiation; be safer by being faithful or reduce the number of sexual partners. This approach is of limited value for women who lack social and economic power to negotiate safe sex and use of condoms. In addition, trust, love and affection within marriage are an important part of the problem. Gender stereotypes and gaps are evident, and consequently women and wives are more susceptible to HIV infection.

VI. Conclusion and recommendations

As the HIV epidemic in Vietnam increasingly enters the general population, more attention is being placed on promoting behavioral change among populations considered most vulnerable to HIV. Rural migrants and residents are among those considered vulnerable to contracting HIV and contributing to the epidemic spread. Examining population mobility in relation to HIV/AIDS does not imply blaming migrants for the AIDS epidemic. Rather, it requires appropriate directions in the AIDS control programs. The paper has identified implications for HIV prevention policies and programs. It includes a number of following recommendations addressing risks and harm reduction and reducing constraints to behavior change; addressing the migration system; and addressing the underlying development forces:

- Current social marketing of condoms at non-traditional outlets such as restaurants, karaoke bars, cafes, guest houses, road-side stalls, general stores, work places, etc. is important. However, in order to reduce vulnerabilities to HIV, it requires more than just condom promotion. Behavioral change has to take place. The AIDS prevention program should focus on effecting changes in behavior through targeted BCC strategies, creating an environment supportive of behavior change. At the same time, mobile outreach can be an innovative means of reaching migrants and
raising awareness on HIV/AIDS. They can compliment other approaches and refer migrants to health clinics and other sites with IEC materials.

• In such a rural setting infected by HIV/AIDS as Vu Tay, it is important to establish family and community-based care and support for IDUs and for persons living with HIV/AIDS. Appropriate measures should be taken to counter social stigmatization toward IDUs and PLWHA. It is a stigmatization of being IDUs doubled with the HIV infection. Local authorities and community-based organizations should stimulate HIV-oriented dialogue within the community, which raise AIDS awareness, engenders compassion, promotes traditional solidarity, enhances care and support while reduces victimization and stigmatization. Without this effort, AIDS remains being regarded as a social evil.

• The left-behind people’s HIV/AIDS knowledge is fairly low; their prevention measures are ambiguous and migrant adults remain dominant decision makers. HIV awareness must be created among the left-behind people by providing access to voluntary counseling and testing. Community-based home care initiatives should be fostered to support families to deal with HIV impacts. The study in fact has strengthened the argument for a gender consideration so that the intervention strategies should ensure women's involvement and build their capacity to make decisions vis-à-vis men within marital relationships.

• It is necessary to recognize the current gaps in AIDS control programs in Vietnam. HIV/AIDS is largely understood as a health-related problem and thus managed from health perspectives. There is a difference between communicable diseases such as malaria, tuberculosis or bird flu and HIV/AIDS. In HIV/AIDS the primary mode of transmission is through personal or intimate contact. Thus it goes beyond the classic exposure analysis to involve behavior factors. Health managers hardly recognize the strategies to lower HIV/AIDS/STDs risks by BCC and reducing development-induced vulnerabilities and increasing community resilience. Each of the ministries does not look beyond its narrow interests and areas of responsibility. They hardly work with each other in a coordinated manner under the health sector approach. A new development-based approach is required to complement existing
health sector approach. Policies should be multi-sectorial, involving not only health but also labor, agricultural, justice sectors and civil society, etc. The current health care system need to cover migrants and the program responses need to promote and apply people-centered, multi-sectoral and development-linked approaches to build HIV resilient communities.

• Economic growth does not automatically translate into improvements in human well-being. The processes of industrialization and modernization create an environment whereby people are mobile and increase vulnerability to HIV. To have effective responses, one needs to address relevant factors underlying population movements and development that increase HIV vulnerability, rather than react to symptoms. It is necessary to reduce poverty, regional disparities and improve livelihood security to provide alternatives for taking survival migration, reducing HIV vulnerability and minimizing the negative impact of HIV/AIDS. Addressing the conditions under which migration take place can reduce vulnerabilities and build resilience to HIV for the communities. It must be ensured that this effort is not lost as Vietnam continues down the road of reforms, regional reintegration and globalization.
References


