Family health consequences of modernisation programmes in Black Thai communities

Pauline Oosterhoff a b, Joanna White c d & Nguyen Thi Huong a

a Medical Committee Netherlands Vietnam, Hanoi, Vietnam
b Royal Tropical Institute, Amsterdam, The Netherlands
c Independent Researcher, Vietnam
d Centre for Research in Anthropology (CRIA), Lisbon, Portugal

Available online: 12 Apr 2011

To cite this article: Pauline Oosterhoff, Joanna White & Nguyen Thi Huong (2011): Family health consequences of modernisation programmes in Black Thai communities, Culture, Health & Sexuality, DOI:10.1080/13691058.2011.562306

To link to this article: http://dx.doi.org/10.1080/13691058.2011.562306

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan, sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Family health consequences of modernisation programmes in Black Thai communities

Pauline Oosterhoff\textsuperscript{a,b,*}, Joanna White\textsuperscript{c,d} and Nguyen Thi Huong\textsuperscript{a}

\textsuperscript{a}Medical Committee Netherlands Vietnam, Hanoi, Vietnam; \textsuperscript{b}Royal Tropical Institute, Amsterdam, The Netherlands; \textsuperscript{c}Independent Researcher, Vietnam; \textsuperscript{d}Centre for Research in Anthropology (CRIA), Lisbon, Portugal

(Received 16 August 2010; final version received 8 February 2011)

Southeast Asian governments implement ambitious programmes to reduce population growth and maternal mortality in areas with large minority ethnic populations. Although some of these programmes introduce new social and health practices that meet their broader aims, they may pay inadequate attention to the protective and medically beneficial aspects of traditional practices. This study examined the decline of temporary matrilocality (\textit{zu kuay}) among the Black Thai in Dien Bien, Vietnam, as a response to policies adopted under the government programme of \textit{Doi Moi} (‘modernisation’). The patrilocal, patrilinear cultural norms of the majority ethnic Kinh people were promoted and \textit{zu kuay} discouraged at a time when heroin availability increased dramatically but harm reduction programmes were not yet in place. This historical coincidence appears to have heightedn certain Thai women’s vulnerability to marriages with HIV-positive injecting drug users. Policies and guidelines on marriage and reproductive health should take into account the role of minority ethnic traditions, as well as local health-seeking practices, in order not only to improve reproductive programmes but also to reduce HIV vulnerability.

Keywords: Black Thai; drug use; reproductive health; HIV; cultural change; Vietnam

Introduction

The Kinh (Viet) are the largest of Vietnam’s 54 ethnic groups, constituting 86.2\% of the population. Most minority groups (over 10 million people in total) live in rural border areas in the Northern Mountains and the Central Highlands. While there are important differences between and amongst minority ethnic groups, overall they lag behind in key economic and social indicators even though access to credit, health services, schools, roads and markets has expanded (Baulch et al. 2007; World Bank 2009).

Vietnam’s constitution and ethnic policies strive to retain and promote ethnic diversity and traditional cultures, and yet, at the same time, encourage national unity (Keyes 1995; Mukdawijitra 2007). There is a fundamental tension between a nationalist approach to unity, defined by the dominant ethnic group, and the acceptance of difference amongst ethnic groups (Brown 1996; Fischer 2008). Although manifestations of ethnicity differ across locations, the problematic conceptualisation of citizenhood as both a political and cultural entity is characteristic of a number of Southeast Asian countries (Brown 1996; Duncan 2008) and has particular implications for modernisation projects. In Vietnam, this
policy dilemma may contribute to a lack of ability of the state to engage with minority ethnic groups. Article 30 of the Constitution notes, for example: ‘the State undertakes the overall administration of cultural activities. The propagation of all reactionary and depraved thought and culture is forbidden; superstitions and harmful customs are to be eliminated.’ This vague clause enables local governments to brand certain cultural practices as expressions of ‘depraved culture’.

Sexual and reproductive health practices, as well as gender roles, have changed dramatically over past decades among both dominant and minority groups in South-East Asia and South-West China (Amin and Teerawichitchainan 2009; Brown 1996; Fischer 2008). As part of its modernisation drive, the Vietnamese government, like other governments in the region, undertook considerable efforts to improve health services and the utilisation of available services, including initiatives to modernise motherhood, childbirth and postpartum practices (Luong 2007). Ambitious family planning, health and poverty eradication programmes were implemented in areas populated by minority ethnic people, but the results of reproductive health (RH) and other programmes have been mixed. Safe motherhood initiatives have reduced maternal mortality and improved overall knowledge of and access to contraception, for example, but there are significant differences among ethnic groups (United Nations Population Fund [UNFPA] 2007). Low utilisation of antenatal care (ANC) services continues and maternal mortality and home delivery rates in mountainous areas remain high (UNESCAP 2008). In some minority ethnic areas, equipped RH facilities are under-utilised and trained providers are under-employed (UNFPA 2007).

There is ample evidence of the failure of development programmes due to poor understanding of the local context and a failure to take into account existing cultural practices, especially those related to gender, marriage, pregnancy and childbirth (UNFPA 2008). Programmes that succeed in one setting can rarely be ‘replicated’ or ‘scaled up’ in another without adjustments related to differing cultural or socio-economic context. Moreover, analysts have already observed how responsive services are critical in a minority ethnic context, where utilisation of services is notoriously low (UNFPA 2007; World Bank 2009). Yet rather than questioning how services meet the needs of minority populations as users, a common response of policy makers and development experts has been to attribute poor utilisation of facilities by such communities to the users themselves. Moreover, stereotypes of minority ethnic groups include romanticised, dramatic portrayals of certain practices and represent these populations as backward, passive recipients of development, rather than agents of change (Nguyen Van Chinh 2010; World Bank 2009). Such stereotyping has negative consequences, including on the ability of minorities to vocalise their right to policies and services appropriate to their needs.

There is growing knowledge of the role of cultural institutions and practices in reproductive choices and the associated development of the HIV epidemic among the patrilocal, patrilinear Kinh (Bui Thu Huong 2010; Gammeltoft 1999; Pashigian 2002). In contrast, little is known about practices associated with HIV vulnerability amongst Vietnam’s minorities, which limits opportunities to both improve sexual and reproductive health and reduce HIV transmission amongst those most at risk within minority populations. Certain studies suggest that minorities are at low risk of HIV compared to more mobile Kinh populations (Health Strategy and Policy Institute 2009). While focusing on ‘high risk’ mobile groups in HIV interventions is appropriate for some provinces, this approach neglects the situation of traditional opium-using and opium-growing communities in border areas such as Dien Bien, Lai Chau and Nghe An, where certain ethnic groups reside in large
number (Griffiths 2006). Indeed, the vulnerability of women to HIV in these communities may have been underestimated.

Vietnam’s borders were closed during the cold war and following the 1979 war with China. The country’s general isolation protected Northwestern areas, including Lai Chau, from cross-border heroin trade and the HIV sub-epidemics that unfolded among injecting drug users (IDUs) in nearby China, Myanmar and Thailand (Reid and Costigan 2002). But the cold war ended and, in 1986, Vietnam began the transition (Doi Moi) to a market economy. Relations with the USA were normalised in 1995, Vietnam joined The Association of Southeast Asian Nations and cross-border transport routes were restored. Changes associated with Doi Moi over past decades have included decollectivisation of land, an influx of consumer goods, migration and, specifically in terms of the health sector, a rise in private services, self-prescription and growing inequality in access to healthcare across socio-economic groups (Griffiths 2006; Sikor and Dao Minh Truong 2002; Witter 1996). These changes had a dramatic impact on the whole country, including the Northwest.

During the 1990s, as a result of the UN global programme against drugs, local opium production fell but new demands for opiates and other drugs emerged among both Vietnamese and Chinese youth (Drug Enforcement Administration 2003; Griffiths 2006). The simultaneous re-opening of borders led to increased smuggling of various goods, including heroin, as well as greater legal trade. Minority groups in the region were not immune to such changes and in some cases actively embraced them (Brown 1996; Rapin et al. 2005). Nowadays Vietnam is an increasingly important transit country for heroin from Myanmar, Laos and Thailand (Drug Enforcement Administration 2003). Myanmar is a major drug producer of high quality opium, which transits in Laos for processing then moves across the border into Dien Bien en route to markets in Vietnam and China. This trade has exposed minority populations living along transport routes on the Vietnam-Laos border area to increased volumes of heroin (Griffiths 2006; Lyttleton and Cohen 2003; Rapin et al. 2005; United Nations Office on Drugs and Crime 2004), thereby increasing HIV vulnerability amongst both men and women due to the injection of heroin amongst male (often married) drug users.

In many provinces, HIV-positive people are increasingly accessing antiretroviral therapy (ART) and other support. Expenditure on HIV and AIDS doubled from around US$ 50 million in 2006 to US$ 108.7 million in 2008, although 90% of funding came from international sources (National Committee for AIDS, Drugs, and Prostitution Prevention and Control 2010). However, as data on treatment are rarely disaggregated by ethnicity, it is unclear to what extent minority populations most affected by HIV and AIDS are accessing testing and treatment. The research presented in this paper was undertaken under the auspices of a prevention of mother-to-child-transmission (PMTCT) programme working in remote areas, including amongst communities of the Black Thai ethnic group, in Northern Vietnam.

**Context and setting**

The Black Thai are a subgroup of the Thai (or Tai) people who are found in mainland Southeast Asia, southern China and Northwest India. The Thai are the third largest ethnic group in Vietnam, composing 1.7% of the population. In the Northwest, the Thai constitute the largest population in the area. They appear well assimilated with the Kinh mainstream in certain aspects and have played an important role in Vietnam’s independence wars, especially against the French and the Americans (Xiaobing Li 2010). The Thai are generally understood to be economically integrated but retain their cultural distinctiveness: intermarriage between the Thai and the Kinh is rare, for example (Baulch et al. 2002).
Many Thai communities have retained obvious ‘markers’ of their cultural identity such as traditional female dress, the custom of married women’s hair being tied up in a high round bun decorated with silver (tang cau) and other aspects of material culture such as stilt houses.

Dien Bien, a mountainous rural province in the Northwest, bordering Laos and China, created in 2004 by dividing former Lai Chau Province, is experiencing the fastest growing HIV problem in Vietnam (Cao Kim Thoa 2010; Health Strategy and Policy Institute 2009). HIV prevalence among IDUs in the province is just over 40%, compared to the national average of 20.3%, while prevalence among pregnant women is just over 2.2%, far higher than the national average of 0.3% (Cao Kim Thoa 2010). Ethnic Thai people constitute around 40% of the province population, with Hmong and Kinh people each accounting for around 20% (Central Census Steering Committee Vietnam 1991). All women in Dien Bien are faced with tremendous social changes and an influx of drugs into their neighbourhoods, but women from the various ethnic groups present may engage with local services differently. In order for women to have access to (early) testing during pregnancy and benefit from PMTCT services they need to access appropriate ANC services, for example. Hence, while medical innovations such as HIV testing and ART save lives, access to these may not yet be equitable, a problem that has already been reported in relation to North Vietnam (Nguyen T. Nam et al. 2010).

Given the paucity of research on cultural institutions and reproductive practices of minority ethnic people in Vietnam, the aim of the present study was to enhance understanding of the distinct cultural contexts affecting the programme. The largely qualitative study explored factors influencing HIV vulnerability and barriers to accessing HIV testing and PMTCT through government services amongst rural Thai and Kinh women of reproductive age living in an area with high reported levels of heroin use.

Early in 2009, prior to the study, a Black Thai member of a support group for HIV-positive women in Muong Ang District, Dien Bien, reported to PMTCT programme staff that the short period of zu kuay that occurred before her marriage meant she had been unaware that her future husband was an IDU. Zu kuay (literally ‘in-law staying’) is a longstanding custom amongst the Black Thai whereby following engagement (pay vay) there is a ‘small marriage’ (xu noi) after which the groom moves to live with his wife and parents-in-law to ‘provide service’ to them and prove his suitability as a husband/son-in-law, prior to the ‘big marriage’ (xu o). This matrilocality is normally temporary and the married couple subsequently moves to live with the groom’s parents. Traditionally zu kuay took place over several years during which the couple could have children. During later discussions amongst programme staff, government officials and support group members, the prevailing view was that zu kuay had declined and that this custom had enabled couples to avoid risks associated with hasty marriages. The study therefore also examined the reported decline in zu kuay.

**Respondents and methods**

Qualitative and quantitative data were collected in October 2009 in three villages in the same commune of a district in Dien Bien, which has a known HIV problem related to injecting drug use. The study commune is on a throughway for cross-border trade. Reported HIV prevalence among IDUs in this district was 57.5% (Tran Vu Hoang, Tran Thi Thanh Ha, and Le Thi Cam Thuy 2010). The provincial hospital in Dien Bien has offered PMTCT and ART since 2006. HIV testing has been available routinely at ANC services at both the district and provincial hospitals and has been mandatory for operations, including delivery, since 2003. HIV testing is also available at the Provincial
AIDS Committee (PAC) in Dien Bien city and through some private health providers. In addition, a testing campaign targeting all pregnant women was run by PAC and its partners in the commune in 2008, through the commune health centre (CHC).

The three village study sites have different ethnic compositions: villages Ban Lau and Mau Lau are Black Thai communities, Hoa Dan is a Kinh community. The locations were strategically chosen so that geographical access was unlikely to be the principal issue influencing utilisation of ANC and other RH services. The locations are roughly comparable in terms of geographical access to key local PMTCT health services. A village-based study was conducted over two weeks by a team of five Vietnamese researchers and one international specialist. Focus group discussions (FGDs) were held separately with men and women of mixed ages at all locations. One-to-one interviews were held with a total of 84 women across the three villages.

To select respondents for interview we used a purposive, stratified sample of women of reproductive age (15–49 years) who had already delivered at least one child. The sample was generated across four age ranges (Table 1) to provide historical perspective on certain cultural changes and maternal health-seeking behaviour. The sample included a number of respondents considered by local facilitators to be vulnerable to HIV (i.e., married to an IDU or widow of suspected person living with HIV and AIDS) in order for data to be collected on this specific population. Participants gave their informed consent prior to the commencement of the study. Ethical approval was obtained from the Provincial Commission of Scientific Research, Department of Health, Dien Bien Province.

Quantitative data were analysed using SPSS and thematic analysis was undertaken for the qualitative data. Data missing for one Thai respondent. Preliminary findings were presented to health staff, other authorities who had collaborated in the study and representatives of a local support group for HIV-positive women (including Thai members) for their feedback.

The study faced certain limitations. Firstly, the good working relationship between the PMTCT programme and health staff facilitated access to communities but may have created biases in how the research team was perceived. Secondly, although numbers were small, as the purposive sample included some women perceived to be at risk of exposure to HIV, this may have led to an over-representation of ‘vulnerable women’. Thirdly, the small sample size means that no statistical analysis or inferences can be drawn. Lastly, the Thai are a diverse ethnic group (Keyes 1995; Mukdawijitra 2007), hence the study cannot claim to represent the situation amongst wider Thai communities.

Findings

**Widespread injecting drug use**

The reported historical trajectory of drug use amongst the local Black Thai population, described by FGD participants, confirmed observations made by other researchers: from

<table>
<thead>
<tr>
<th>Age range</th>
<th>Ban Lau</th>
<th>Mau Lau</th>
<th>Hoa Dan</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20–30</td>
<td>15</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>31–40</td>
<td>8</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>&gt;40</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27</td>
<td>28</td>
<td>29</td>
</tr>
</tbody>
</table>
the late-1990s onwards a shift occurred from traditional opium use, largely by older men, to more widespread use, including injection, of heroin amongst younger men (Griffiths 2006).

Both Thai and Kinh representatives stated that female use of illicit drugs could occur (the use of opium to relieve menstrual pains apparently took place among some elder women in the past, for example) but no cases were reported amongst households included in the study. Male drug use was widespread, however, with only a minority of respondents reporting no male family member² addicted to drugs (32.7% amongst Thai and 44.8% amongst Kinh). Moreover, the proportion of women who reported being married to an IDU ranged from around 17 to 25% across the three study locations (Table 2), reflecting the widespread nature of male drug use.

A number of respondents reported only discovering their husband’s drug use after marriage. Drug dependency clearly has a significant impact on women on their families and some interviewees were candid about the problems caused by their husband’s drug use:

In 1995 he started using drugs. From then on our family’s economic situation went downwards together with my happiness. He only worked to pay for his addiction. I raised our two children by myself. Sometimes he used physical violence. When he asked me for money, and I did not give it to him, he took our rice or furniture to sell. I felt embarrassed in front of my neighbours. I could not suffer any more and we separated. However, living without a husband is also not happy. We were husband and wife for 20 years. He is a kind and hard working person. It’s only the drugs that caused our problems. Whenever I have dinner, and I am holding my rice bowl, my tears flow when I think of him and my children. (Tu Anh, Kinh woman, 42 years old, Hoa Dan)

Dependency within the family, as well as pre-existing experimentation with drugs, is known to be a high risk factor for drug abuse in many parts of the world (Meyer 1996; Nguyen and Scannapieco 2008). This was confirmed by the study: a common scenario was clusters of men within the same family using drugs (Figure 1). Almost 42% of Thai women (23 out of 55) reported that a male member of their family had already died due to drug use and of the eight Thai widows in the sample, five had been married to a drug user. (No Kinh respondent reported any drug-related deaths in their family.) Moreover, Thai respondents described drug-related deaths as a well known public problem in their communities. They also reported a transition from traditional smoking of black opium to modern injecting patterns of heroin use found in other studies:

We had black opium since the 1990s, but this stopped. Today people take heroin instead. There are a lot of heroin users since 2004. Almost all are young. ... This month three users died. (Nguyet, Thai woman, 44 years old, Ban Lau)

Focus group discussion participants from Ban Lau (Thai) reported that as many as 20 male villagers had died due to drug use during 2009. In such communities (with a total

| Table 2. Reported injection drug use (IDU) amongst respondents’ male family members. |
|----------------------------------|---------|---------|---------|
|                                   | Ban Lau | Mau Lau | Hoa Dan |
| n = 27                           | n = 28  | n = 29  |
| Husband was/is IDU               | 6 (22.2)| 7 (25.0)| 5 (17.2)|
| Brother/brother-in-law was/is IDU| 12 (44.4)| 14 (50.0)| 11 (37.9)|
| Other male family member was/is IDU| 3 (11.1)| 3 (10.7)| 2 (6.9)|
male population of around 180), injecting drug use may be reaching epidemic proportions, in terms of the loss of male householders. It was unclear what proportion of the reported deaths was due to overdosing or to HIV and AIDS. It is notable, however, that medical treatment of heroin overdose is not in the curriculum of the medical school in Dien Bien city, where local village health workers and CHC staff are trained.

**Declining zu kuay**

The consensus amongst Thai FGD participants was that, generally, the practice of *zu kuay* has shortened over recent decades. The apparent historical transformation of the traditional length of ‘service’ was confirmed by interview data (Table 3). Between 1999 and 2009, for example, the most common reported *zu kuay* period fell from 12 months to one month or less. It was found that the average length of *zu kuay* initially fell during the 1980s and then shortened substantially from the late-1990s onwards. Some variability in the length of *zu kuay* was also identified within historical periods, which appeared to depend on the particular circumstances of the families involved in the prospective marriage, including poverty and land and labour availability.

Certain FGD participants considered the decrease in *zu kuay* to be a direct response to patriarchal Kinh perceptions about the value of men and women’s labour, the structure of family and residential permanence. Indeed, some government representatives noted how *zu kuay* was considered a ‘backward’ practice and an obstacle to modernisation and so attempts were made to persuade against this tradition:

Men had to work for the wife’s family for several years before they could start their own household. Some households were very large and different generations were economically too
dependent on each other. Zu kuay was discouraged to promote independency of households.

(Hien Kinh health sector official, 51 years old, Dien Bien city)

The formal discouragement of zu kuay appears to have occurred largely in the form of government officials visiting households to inform them of advised practices. This promotion of independency of households was in line with contemporaneous land policies. Resolution 10 on land decollectivisation, passed by the Communist Party in April 1988, shifted control over production and exchange back to independent households in the 1980s and into the 1990s, for example (Sikor and Dao Minh Truong 2002).

Population increase and associated competition for land appears to have been one reason why some Thai men and women were, in fact, glad to see the decline of zu kuay:

Nowadays men only have to practice zu kuay for 10 days. The reason is that we do not have more land but we have more people so we should let them live separately then they can work for themselves. It is better now because everything is quicker. The husbands used to have to work hard for zu kuay. Women want their husbands to work for them, not for their parents!

(Huong, Thai Woman, 25 years old, Ban Lau)

The growing influence of Kinh patrilocal and patrilinear cultural norms signified by the decline in zu kuay may also have been consolidated by a greater influx of Kinh people into what were previously predominantly Thai areas during this period. Moreover, in informal discussions a number of Thai women reported that in some cases wealthier families, such as those which made financial gains as a result of the new economy, were apparently able to ‘fast track’ to a big wedding for their sons, hence monetarising the service represented by zu kuay, transforming payment-in-kind (labour) into cash.

However, some study participants considered that shorter zu kuay means that men care for and respect the woman they marry less. Moreover, these individuals felt that a briefer period of zu kuay means that couples get married quickly and have ‘less knowledge’ of each other:

I liked zu kuay. In the past we had to work hard. I practiced zu kuay to get my wife. I got up very early and pounded rice for three years. Therefore we respected our wives. (Luu, Thai Man, 48 years old, Mau Lau)

**Arranged marriages**

Arranged marriages also exist amongst the Thai and in some cases marriage partners have scarcely met before commencement of zu kuay. This appears to be a minority practice, observed in only 11/55 cases (20%) and is likely to be linked to family poverty. The duration of the courtship before the ‘small marriage’ varies considerably and is significant in this context. Thus, a short courtship (as is common with arranged marriages, for example) and/or brief zu kuay may make it particularly easy for men to hide their heroin addiction.

### Table 3. Reported changes in duration of zu kuay.

<table>
<thead>
<tr>
<th>Period during which marriage occurred</th>
<th>Length of zu kuay (mode/s*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978–1984</td>
<td>36 months (range: 6–72 months)</td>
</tr>
<tr>
<td>1985–1989</td>
<td>12 months (range: 0–288 months)</td>
</tr>
<tr>
<td>1990–1994</td>
<td>12 months (range: 0.3–12 months)</td>
</tr>
<tr>
<td>1995–1999</td>
<td>12 months (range: 0–36 months)</td>
</tr>
<tr>
<td>2000–2004</td>
<td>6 months (range: 0–14 months)</td>
</tr>
<tr>
<td>2005–2009</td>
<td>0, 0.3, 1 months (range: 0–24 months)</td>
</tr>
</tbody>
</table>

Note: *Mode/s selected as value due to extreme ranges.
In several cases women whose parents arranged their marriages found themselves married to IDUs:

My parents asked me to marry him. I obeyed my father because my family is poor. I did not know he injected drugs. I did not love him. We did not meet each other until the marriage happened: the first time I saw him was when I tied my hair up [tang cau]. We did not talk to each other. We did not have sex during the two months following the marriage. He is still using drugs and we always quarrel. I work for our family and our house. He takes everything out from our home for his drugs including the rice I grow. I hate him. Just because of poverty, my family depends on his family. (Thai woman, 37 years old, Mau Lau)

The woman in this case has two children with her husband, which highlights the importance of recognising women’s vulnerability to HIV being associated not only with local IDU problems but also women’s reproductive role, or burdens, as found in other studies in Vietnam (Oosterhoff et al. 2008).

Knowledge of HIV transmission and prevention

Knowledge of sexual transmission of HIV was high (Figure 2). This is probably linked to the fact that the Vietnamese authorities and international organisations have conducted community-based HIV prevention talks in the study area. Knowledge of transmission through needle sharing was also relatively high in Villages Ban Lau and Hoa Dan (74.1 and 69%, respectively), but low in Mau Lau (46.4%). Knowledge of mother-to-child transmission of HIV was low (50% or less) across all three locations.

Despite the aforementioned knowledge of sexual transmission of HIV, reported condom use was variable. One explanation for this disjunction is the desire and expectation of young married couples to have children. Once this aspiration has been met, both Kinh and Thai women are encouraged by health services to use contraception, mostly, but not exclusively, an inter-uterine device (IUD). (Condoms are available free of cost at family planning departments at all levels, but men are not targeted by these agencies.)

![Figure 2. Knowledge of HIV transmission.](image-url)
Reported condom use was substantially higher amongst couples in which the husband was an IDU: 11 out of 18 women with an IDU husband reported to have ever used condoms, compared to 17 out of 66 women with husbands who were non-IDU, perhaps reflecting the efforts of HIV and AIDS prevention programmes in Dien Bien, which have targeted ‘high-risk’ groups. All women married to IDUs who reported having ever used condoms already had children, indeed, the largest group of respondents who had ever used condoms was found to be women with two children who had already fulfilled the ‘modern’ Kinh norm of a nuclear family with two children.

Access to HIV testing

Around 30% (25/84) of respondents had ever been tested for HIV, some more than once. The majority (23) tested negative, one did not receive her results and one declined to share the results of her test. Overall, just over 32% (27/84) of respondents’ husbands had ever tested for HIV. Rates of testing were considerably higher amongst husbands reported to be IDUs, at 13/18 (72.2%).

The most common form of testing was through routine services for women or at the voluntary counselling and testing (VCT) clinic at PAC. Not all women reported receiving counselling about the tests they received:

They took my blood before I delivered at the provincial hospital but I did not know what they did it for. They did the examination and blood only. They did not explain why when I asked them. (Thai woman, 32 years old, Ban Lau)

Factors affecting access to HIV testing

Clear differences were observed in reported utilisation of RH services by Kinh and Thai respondents. Access to early HIV testing for pregnant Thai women is influenced by the current situation whereby testing is only offered at district level health facilities or higher and not as part of ANC at CHC level, which is the health post most commonly utilised by Thai women who attend such services. This is in stark contrast to Kinh respondents who were more likely to access ANC at the provincial or district hospital and/or private clinics.

Of respondents who were pregnant and visited ANC services after 2003, when HIV testing was made available, only 23% (6/26) of Thai women attended a district level or higher government service compared to 71.4% (5/7) of Kinh women. Of the total number of Thai women pregnant after 2003, several did not attend any ANC services at all (2/28) and so, again, did not access early VCT through the current system, although rates of attendance have increased historically (Figure 3).

Although some women may not attend any ANC services, study data reveal that most Thai and all Kinh women do now appear to be delivering in an institutional health setting where they can receive routine HIV testing right before the delivery (Figures 4 and 5). Yet despite the increases in delivery in health facilities, in the most recent period (2008–2009) at least 41.2% of the Thai women included in the study still could not receive a HIV test at their site of delivery because 29.4% (5/17) delivered at home and 11.8% (2/17) delivered at the CHC.

The study revealed a sharp increase in Thai women’s use of the CHC and other state facilities for delivery after 2004: since the end of 2007 a substantial drop appeared to have occurred in the practice of delivering at home. In 2007 a local government ruling stipulated that a birth certificate – a document necessary for school enrolment – will only
be issued to babies born in health facilities, which has clearly influenced where Thai women choose to deliver. As one respondent commented:

For the last two years the policy has been that women have to deliver at the CHC for birth certificate. Before this most women delivered at home. Only difficult cases would be taken to the CHC. But we need to have the birth certificate. (Thai woman, 26 years old, Ban Lau)

This situation provides a further example of state intervention regarding Thai cultural practices. The linkage of institutional delivery to the issuance of birth certificates may seem a practical way for the state to simultaneously increase both the number of registered children and safe deliveries, especially when registration and delivery in health settings has been low, as appears to have been the case in the geographical area included in the study. However, there are likely to be other impacts associated with such rapid, state-imposed transformation of local behaviour. The conditional issuance of birth certificates possibly aggravates the problem of unregistered children who are not well protected by the state and are thus vulnerable to abuse including trafficking, for example, a particular risk of undocumented unregistered women that is well known globally, especially in areas where many illicit goods are traded (Laczko and Gozdziak 2005).

Moreover, birthing at state health facilities is a highly medicalised procedure in which women deliver lying on their back attended by medical staff while family members wait outside. In contrast, a Thai homebirth is a more communal occasion. Various people, normally but not exclusively close family members, are present to provide emotional and physical assistance. When a woman enters the final stages of labour she holds a strong

Figure 3. Reported attendance at ANC services.
Figure 4. Place of last delivery disaggregated by period gave birth – Kinh respondents.

Figure 5. Place of last delivery disaggregated by period gave birth – Thai.
woven scarf suspended from a beam in the corner of the house. Her husband and others
hold her to support her. Although Thai women mentioned that they considered a facility
delivery safer if something goes wrong and delivery at a district or provincial level facility
provides the possibility for vulnerable Thai women to be tested for HIV (particulary
important given current poor ANC attendance at district-level or above), the resilience of
homebirth prior to the 2007 ruling suggests the importance of this traditional practice to
the local Thai populations included in the study.

There may be as yet unforeseen cultural, social and health costs to Thai women and their
communities related to what appears to be a largely state-imposed shift from a practice that
provided specific forms of support to women in childbirth and a more advantageous
delivery position for women in non-emergency situations (White, Oosterhoff, and Nguyen
2011), to a more medicalised delivery in a facility setting.

**Conclusion**

An historical increase in injecting drug use, limited harm reduction efforts and low levels
of condom use, partly linked to fertility pressures, were all found to contribute to the
overall present vulnerability of rural women in Dien Bien contracting HIV from their
partners. Further, the study found that the vulnerability of both Kinh and Thai women to
HIV infection in the three locations studied need to be placed in a broader historical socio-
economic context of increasing heroin supply and demand in the region and various
elements of ‘modernisation’ of Vietnam during *Doi Moi*. In addition, conventional harm
reduction programme emphasis on classic ‘high-risk’ mobile groups may have neglected
the rural Thai population.

National policies on the market economy, decollectivisation, the nuclear family,
modern (medicalised) pregnancy and childbirth, have shaped Black Thai marital,
reproductive and birthing practices in different ways. Policies on cultural practices
formulated during the *Doi Moi* period were defined rather unclearly leaving policy-makers
with the freedom to interpret and implement them locally. This flexibility provided the
scope for policy-makers in Dien Bien to transform ethnic minority practices concerning
marriage (zu kuay) and childbirth as part of a modernisation project, without necessarily
grasping the repercussions of policies directed against such phenomena. Study findings
suggest both a lack of understanding of national and local level officials on the protective
role of cultural institutions such as temporary matrilocality on women and the unanticipated
impacts – both positive and negative – of economic change and ‘modernisation’ on
practices related to marriage, family and reproductive health.

Both the transformation of the economy and geo-political changes enabled an influx of
drugs, especially heroin, to the Northwest, resulting in a growing number of male IDUs
from the 1990s onwards. At the same time Thai families living in the region became
increasingly transformed into patrilocal, patrilinear units with stable residence, with
shortened zu kuay. These simultaneous developments had implications for the particular
vulnerability of Thai women to HIV, as in some cases women were more likely to have
limited knowledge of their new husband and therefore unknowingly married a man they
did not know to be an IDU. Although the decline of zu kuay was apparently desired by
certain sectors of the Thai population, the impact of the declining practice on increased
vulnerability to HIV may never have been anticipated. While this may not be the biggest
factor affecting vulnerability today, our findings nonetheless highlight the importance of
policy-makers attempting to understand cultural institutions and their social functions in
their specific context and the potential negative implications of their decline or loss.
Similarly, while the apparent increased uptake among Black Thai of health services for childbirth may reflect both ‘modern development’ and pressurised utilisation related to state for the issuing of birth certificates, this change does not necessarily signify that the current medicalised service (which is most accessible to the poorest rural families at CHC level) is most suitable for, or meets the most pressing reproductive health needs of, Thai women.

Although many Thai women appear to be vulnerable to HIV due to their husband’s drug dependency, current low level of HIV testing amongst pregnant Thai is impeding HIV treatment, including PMTCT. Although attendance at ANC and delivery at formal health services has increased, Thai women are more likely to attend ANC at commune level where early HIV testing and counselling is not offered, which suggests the need for an outreach strategy which renders HIV testing and care more accessible. The fact that both Kinh and Thai women increasingly deliver in health facilities but the Thai are more dependent on their local CHC, while Kinh women are more likely to access ‘higher level’ state services or private clinics, reflect financial and political inequities between the two groups, which have repercussions for their respective health, including early testing and treatment for HIV.

The transformation of Thai practices outlined in this paper reflect a deeper problem facing the Vietnamese state in addressing and incorporating ethnic difference: the definition of the nation in both cultural and political terms prioritises certain cultural attributes and practices, namely Kinh patrilocal and patrilinear cultural norms, while devaluing and in certain circumstances forcibly excluding others. Whereas ‘non-political’ practices of minority ethnic groups – such as dress, decoration and housing – continue unrestrained, practices that could be perceived as conflicting with national identity formation, including temporary matrilocality, appear more likely to be subjected to local government control. It can be argued that the manner in which the Thai have, to date, been assimilated within ‘modern’ Vietnamese society, including methods of service provision, have disempowered Black Thai communities, particularly women, by providing them with less choices. Current approaches may, moreover, signify a missed opportunity to make both policy-making and services more responsive to Thai communities’ needs. Our study findings confirm the need for service that can engage with and accommodate local practices where possible. Such responsiveness is particularly critical in a context where utilisation of services is notoriously low.

At the same time, acknowledging and taking account of traditional cultural institutions and practices and accommodating cultural diversity in policy-making can be considered as posing no threat to a nationalist political agenda and, moreover, can be considered the sign of an open and modern nation.

Acknowledgements

The authors are indebted to the Provincial AIDS Committee in Dien Bien, the villagers and Sunflower group members who participated in the study and to the generous funding of the Royal Netherlands Embassy, Hanoi.

Notes

2. Defined as extended family, including husbands, fathers or uncles.
References
Oosterhoff, P., Nguyen Thu Anh, Ngo Thuy Hanh, Pham Ngoc Yen, P. Wright, and A. Hardon. 2008. Holding the line: Vietnamese family responses to pregnancy and child desire when a family member has HIV. *Culture, Health and Sexuality* 10, no. 4: 403–16.


Résumé

Les gouvernements sud-asiatiques mettent en œuvre des programmes ambitieux visant à freiner la croissance démographique et à diminuer la mortalité maternelle dans des régions habitées par d’importantes populations appartenant à des groupes ethniques minoritaires. Bien que certains de ces programmes introduisent de nouvelles pratiques sociales et sanitaires qui répondent à leurs objectifs au sens large, il se peut qu’ils ne s’intéressent pas suffisamment aux aspects bénéfiques – en matière de prévention et de santé – des pratiques traditionnelles. Cette étude a examiné le déclin de la matrilocalité temporaire (zu kuay) chez les Thaïs noirs de Dien Bien au Vietnam, en tant que conséquence des politiques menées dans le cadre du programme gouvernemental Doi Moi («modernisation»). Les normes culturelles patrilocales et patrilineaires des Kihn, groupe ethnique majoritaire, étaient promues, et le zu kuay déconseillé, à un moment où la disponibilité de l’héroïne s’est considérablement accrue, mais où les programmes de réduction des risques n’étaient pas encore en place. Cette coincidance historique semble avoir accrus, pour certaines femmes thaïes, les risques du mariage avec des usagers de drogues injectables, séropositifs au VIH. Les politiques et les directives sur le mariage et la santé reproductive doivent prendre en compte le rôle des traditions au sein des minorités ethniques, ainsi que les pratiques locales de recherche de soins, non seulement en vue d’améliorer les programmes de santé reproductive, mais aussi pour diminuer la vulnérabilité au VIH.

Resumen

Los gobiernos de Asia Sudoriental ponen en marcha programas ambiciosos para reducir el crecimiento de población y la mortalidad maternal en zonas con grandes poblaciones de minorías
éticas. Aunque algunos de estos programas introducen nuevas prácticas sociales y sanitarias que satisfacen sus objetivos más generales, a veces prestan poca atención a la protección y los beneficios médicos de las prácticas tradicionales. En este estudio analizamos la matrilocalidad temporal (zu kuay) entre los tailandeses negros de Dien Bien, Vietnam, como una respuesta a las políticas adoptadas bajo el programa gubernamental de Doi Moi (‘modernización’). En un periodo en que aumentó de manera drástica la disponibilidad de heroína sin que se pusieran en marcha programas para reducir los daños, se promovieron las normas culturales patrilocales y patrilineales de la mayoría étnica de la población Kinh, y a la vez se descartó el zu kuay. Esta coincidencia histórica parece haber reforzado la vulnerabilidad de ciertas mujeres tailandesas a los matrimonios con seropositivos que consumen estupefacientes por vía intravenosa. En las políticas y directrices sobre el matrimonio y la salud reproductora se deberían tener en cuenta el papel de las tradiciones de las minorías étnicas, así como las prácticas locales sanitarias a fin de mejorar los programas sobre reproducción y reducir la vulnerabilidad al VIH.