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***Tabula diptycha*: Differential HIV knowledge, stigma, and intended behavioural outcomes amongst visitors at Vietnam's *Pain and Hope* exhibition**

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Abstract

Stigma reduction efforts in Vietnam have been encumbered by contradictory and dynamic views of People Living With HIV (PLWH) and the epidemic over the past two decades. World AIDS Day 2010 saw the launch of *Pain and Hope*, a museum exhibition showcasing the lives and experiences of Vietnamese People Living with AIDS at the Vietnam Museum of Ethnology (VME). Between December 2010 and May 2011, a random sample of visitors completed exit surveys regarding attitudes towards the exhibition and Vietnamese living with HIV/AIDS. The survey sought to determine what kind of visitors the museum and exhibition attracted, and the stigma-related impacts of this kind of exposure and parasocial contact. Of 2,500 Vietnamese visitors randomly selected, 852 completed the computer surveys (response rate of 34.1%), 92.3% of whom had seen *Pain and Hope*. We found two sub-strata or types of visitors attending the exhibition, with varying demographic characteristics, HIV-related knowledge, some differences in stigma ideation, and clear differences in intended behaviours specifically attributable to the exhibition. Social desirability biases notwithstanding, there has emerged a diptych typology of visitors to the VME, for whom the experience of the exhibition is likely interacting with divergent prior knowledge, experiences, interests and motivations.

Keywords

Vietnam; HIV/AIDS; stigma; museum; visitor survey

Introduction

Among the greatest challenges of the HIV epidemic has been stigma, defined as a social process of marking differences between groups of people either affected with HIV or

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associated with it (Parker and Aggleton 2003). Regardless of the epidemiologic impact of the epidemic worldwide, every single country that has People Living With HIV (PLWH) or populations associated with the epidemic is affected by stigma.

Vietnam is no exception to this: according to its Fourth Update Report on Declaration of the Commitment on HIV (2010), the adult prevalence of HIV in Vietnam was 0.44% in 2010, and is expected to rise to 0.47% in 2012. The burden of infection has been historically skewed towards males, disaggregated in official figures into risk groups of men who have sex with men (16.7% of whom are living with HIV) and male Injection Drug Users (IDUs) (18.4% of whom are living with HIV) (Fourth Country Report on Following Up on the Declaration of Commitment on HIV 2010). Comprehensive knowledge on HIV is relatively low: only 44.1% of men and 40.8% of women can identify ways of preventing sexual transmission of HIV and reject major misconceptions about transmission (Ministry of Health 2009).

These relatively low figures of awareness are a corollary to the first decade or so of the epidemic in Vietnam; HIV was at this time associated with “social evils” as a matter of policy under the purview of the Department of Social Evil Prevention in the Ministry of Labour, Invalids and Social Affairs (MOLISA), in turn raising the level of stigma associated with and vitiating discussion and mobilisation around HIV (Gammeltoft 2008, Hong *et al.* 2004, Maher *et al.* 2007, Oanh 2007, Oanh *et al.* 2008a, Oosterhoff 2008). More recently, there has been an explicit move away from such a policy to an explicit ban on HIV/AIDS-related stigmatisation and discrimination under the 2006 law, and a growing upon stigma-reduction interventions in communities (Institute for Social Development Studies [ISDS] *et al.* 2006, Oanh 2008a, 2008b). Behaviour Change Communication (BCC) interventions directed at the wider community promote awareness and reduction of stigma (Hong *et al.* 2004, Nyblade *et al.* 2008), while groups of PLWH have received support to form networks across the country (USAID 2009).¹

Overall, stigma reduction interventions have tended to focus on the achievable goals of increasing knowledge and awareness (PEPFAR 2009) and offering support to PLWH while admittedly encumbered by the structural conditions in place that shape the processes of stigma (Parker and Aggleton 2003). Often because of these pre-existing conditions, there are limited opportunities for interaction between PLWH groups and the wider public. Such interaction, under Allport's interpersonal contact hypothesis (1954), has been theorised to reduce stigma and prejudice against PLWH (and empirically shown in only a few instances outside Vietnam). A notable exception is the Dance4Life youth education programme, which includes a testimonial segment where PLWH discuss their experiences of being subjected to and overcoming HIV-related stigma (Smoot 2009).

Concomitant to the emergence of HIV in Vietnam has been the emergence of ‘new museology’ in the world; the idea that the museum is a democratic, educational entity in the service of societal change and development (Davis 1999). This idiomatic turn in the study and practice of museums is continuously experimental and “resolutely challenges the museum as an institution, the omnipotence and omniscience of curators...the absolute precedence of objects over life” (Baron 1987, p.1). Following a process of “radical

reassessment of the roles of museums in society” (Davis 1999), the museum has been deemed a “place outside other places” where divergent stories are assembled in an assumed coherence, creating an illusory space that innately questions the order of things (Foucault 1998). In the context of HIV, therefore, the juxtaposition of stories and objects related to the lives of PLWH could become a space to question the order of society that enables the stigma such populations face. It also becomes an illusory space where alternative subaltern narratives can be imagined, created, represented, and experienced.

While the bulk of the literature on new museology is theoretical and/or focuses on countries in the global north, new museology may be seen in practice and as a function of the design of Hanoi’s Vietnamese Museum of Ethnology (VME). Established in 1997 as per Resolution 90 (encouraging the socialisation of cultural production), this institution is described as “not always producing the linear accounts found in other state museums” (MacLean 2008, p. 288). The VME is one of the few state institutions pushing the boundaries of representation and offering a space for discussion and treatment of more controversial topics, like Vietnam’s subsidy period, and the HIV epidemic.

It is therefore not a coincidence that in 2010, supplementing the Ministry of Health’s scientific forum and conferences for review of epidemiological and policy responses to the epidemic was the VME’s launch of an exhibition entitled *Pain and Hope: 20 years of HIV/AIDS in Vietnam*. This effort was a joint collaboration between the VME and the Centre for Community Health Research and Development (CCRD), in consultation with an advisory panel comprising the STAR Partnership (Social Science Training and Research on HIV/AIDS – a collaboration between the Department of Sociomedical Sciences, Columbia University and several local Vietnamese organisations), ISDS, Vietnam Administration for AIDS Control [VAAC], General Department of Population and Family Planning [GOPFC], and Vietnam Network of People Living with HIV [VNP]. Ministry funding for this exhibition was complemented by a grant from the Ford Foundation. International technical support was also offered by on-going collaborators of the VME with relevant expertise from, for example, the Museum of Natural History and the Museum of Sex in New York, USA. The development of the exhibition entailed over two years of consultations, deliberation, grantmaking, planning, fieldwork, and design, detailed elsewhere. The goal of the exhibition, as described in programme documentation, was to “disseminate information about HIV/AIDS, spur public discussion about the epidemic in Vietnam, and ameliorate social stigma that has hampered prevention and treatment efforts.”

Based upon the extended aforementioned curatorial process, the exhibition was designed into six sections entitled “Anybody can...” - introducing the epidemiology of HIV in Vietnam; “The days of panic” – reflecting on the first diagnoses in the early years of the epidemic; “I fear those eyes” – on the stigma faced from society by PLWH; “Pain” – the loss of illness and death faced by families affected by HIV; “Hearts” – talking about the efforts made to support PLWH, encourage testing, etc.; “The desire to live” – talking about the commitment to and obstacles faced in accessing antiretroviral treatment, and “Challenge and Hope” – which describes steps forward with the epidemic. Sections displayed everyday artefacts and memorabilia from People Living With HIV (PLWH), oral and visual testimonials, as well as graphic and written displays, featuring the experiences over the past

two decades, as well as the views of policymakers, community groups, civil society, health providers, and those providing support to PLWH.

The exhibit opens with a mannequin dressed in the clothing of Vietnam's first diagnosed person living with HIV/AIDS – visitors are allowed and encouraged to touch the clothes. The walls depict statistics of Vietnam's current HIV burden and official HIV prevention posters. Further in the exhibit, a bicycle suspended upside down in the air carries a caption describing how it was taken away from its owner and flushed with hot water to “disinfect” it (see Figure 1). Visitors can also walk into a hut recreated to depict the separate living quarters forced upon a PLWH by his family, featuring a televised interview with this person about his experience. Another mannequin poses in traditional Vietnamese attire made out of condoms. Further on in the exhibition are pictures of NGOs conducting outreach and objects used in meetings with PLWH networks, and crafts produced by PLWH networks as part of their income generation activities. Near the end of the exhibition is a large portrait of a wedding celebration of a PLWH couple. As visitors leave the exhibit, they have the opportunity to write notes and letters of support for PLWH and tie them up on a message board.

As these examples of exhibition artifacts suggest, *Pain and Hope* utilises the illusory space of the exhibition and the physical space of the museum to privilege the subaltern voices of PLWH and subaltern modes of artistic expression that are not part of the mainstream behaviour change communication. Thus, the combination of these voices can both question the (structural) order of things and at the same time, imagine a different order. Seven months post launch of the exhibition, this study attempts to determine whether the museum succeeded in its goal of using an altogether new approach to tackle stigma associated with the HIV epidemic in Vietnam.

The objective of this study is to characterise the contact between the HIV/AIDS exhibition and its relationship to feelings and attitudes towards PLWH from the perspective of visitors to the exhibition. It takes the view, moreover, expressed by museum visitor researcher Falk (in Dawson and Jensen 2011, p.132), that far from being a *tabula rasa* – or blank slate – visitors arrive at museums with “prior knowledge, experience, interest, and motivations for their visit.” It tries to characterise and theorise how this *tabula* shapes the interface between visitors and the HIV/AIDS exhibition and more broadly, how this reflects larger cultural responses to HIV in Vietnam.

Methods

This study draws upon cross-sectional survey methodology administered to Vietnamese visitors at the Vietnam Museum of Ethnology through the first seven months of the exhibition.

Data collection

A random selection of visitors was recruited at ticket purchase during entry to the museum. Eligible participants were Vietnamese visitors at the Vietnam Museum of Ethnology during the first seven months of the exhibition (December 2010 – June 2011, N=2500),

representing roughly 2% of the total adult Vietnamese museum visiting population in this period (over 128,000 people). Inclusion criteria were: 1) Over the age of consent (i.e. 18 years) and otherwise possessed the ability to read consent form and give consent' 2) Received a ticket to enter Vietnam Museum of Ethnology premises between 1 December 1 2010 and 30 June 30 2010, and; 3) Received a golden sticker for participation in the study. Exclusion criteria were: 1) Under age of consent (18 years) or otherwise incapable of giving consent, and; 2) did not receive ticket or did not enter during designated time period. Based on an external, computer-generated random selection process, visitors with chosen ticket serial numbers were given an additional serialised sticker and informed in general terms that once they complete their visit, their feedback on their museum experience was desired, that this was voluntary and anonymous, and that a small souvenir (a local craft item costing researchers US\$0.25 each) would be given to them for their participation.

Computer survey stations were positioned near the exit of the exhibition venue in the museum. At each station, a 15-minute anonymous computer-administered survey was available in Vietnamese and English. Participants also had the option of filling out the same anonymous survey in paper format. Data collection was facilitated by research staff from the education department at the Vietnam Museum of Ethnology with masters-level training in ethnographic research methods, extensive experience with museum evaluation and additional training in public health research methodology. Data was uploaded on a weekly basis to a password-protected database. Data checking was undertaken on 1% of the data to ensure consistency across ticket sellers' tallies of recruitment and survey completion. Final data cleaning was undertaken on Stata Version 11.2 (StataCorp 2009).

Data analysis and measures

Surveys for visitors comprised questions on socio-demographic characteristics, museum engagement, experience, and emotional reactions, knowledge of HIV/AIDS in Vietnam, HIV/AIDS-related attitudes and intentions related to HIV testing, care and support. These items were typically used indicators in the HIV/AIDS domain in Vietnam and internationally, vetted, piloted, and adapted by authors in close consultation with VME and CCRD research staff. The goal of the survey was, on the one hand, to determine what kind of visitors the museum and exhibition attracted, and on the other, to ascertain the impacts of this kind of exposure and parasocial contact with PLWH.

Demographic questions pertaining to gender, age, ethnicity, educational attainment, religion were drawn from the SAVY questionnaire (Ministry of Health 2009). Latest SAVY (2009) data suggest that age at first sex has reduced from 19.6 years (in 2004) to 18.1 years (in 2009) in Vietnam, with nearly 10% of married youth under the age of 24 reporting premarital sex. Students represent about 42% of the adult Vietnamese visitorship of the VME, as per programme records. Based on discussions with collaborators and public health researchers, the question on relationship status was therefore designed to capture these nuances of premarital sex among young people, inasmuch as being sexually active may have bearing on knowledge and stigma associated with sex and HIV.

In addition, based on consultations with VME staff, it was considered more appropriate to use self-rated measures for economic and professional attainment, drawing from the

MacArthur scale of subjective social status (Operario *et al.* 2004). A standard 10 point Likert scale of risk perception was used, and a free listing of sources of HIV information. Indicators comprising Comprehensive HIV Knowledge and HIV-related were drawn from the UNAIDS HIV Indicator registry (www.indicatorregistry.org), as well as the large literature in this domain (Mahajan *et al.* 2008; Nyblade *et al.* 2008). Finally, based on policy documentary review and consultation with researchers working in Vietnam, questions pertaining to knowledge of HIV in Vietnam (eg. true/false: Vietnam has a 100% condom use policy) were included. Finally, a scale of intended behaviour in the next six months was drawn up (eg. I would write a letter to a PLWH), based on the information disseminated in the exhibition and prior evaluation research in the HIV/AIDS domain (Nambiar *et al.* 2011). In order to be able to specifically attribute behaviour change to the intervention, we gave participants the option of answering “no,” or “yes, I would do this because of the exhibition,” and “yes, I would do this anyway.”

Descriptive statistics were applied to cleaned data, including two-tailed Fisher's exact t-tests to compare linear outcomes and chi-squared tests to compare categorical outcomes, using Stata Version 11.2 (StataCorp 2009).

Results

Of 2,500 Vietnamese visitors randomly selected to participate, 852 completed the computer surveys (response rate of 34.1%), 92.3% of whom had seen *Pain and Hope*.

Participants were relatively homogenous demographically (see Table 1): predominantly female (62.6%), of Kinh ethnicity (96%), aged 21.5 years on average (Standard Deviation (SD)=4.0 years), with high levels of college attainment (76.1%). Almost half reported not being currently in a romantic relationship (47.7%), and a majority of the remaining respondents reported being in a romantic relationship without physical involvement with their partner (40%). The sample was predominantly atheist (85.8%) and modal self perceived educational, economic and professional status was “average” (80.2%, 81%, and 85.2% respectively).

Over half the participants reported seeking sources of information on HIV (51.6%). The most cited source of HIV information was television (for 8.6% of participants), followed by newspapers (8%), and the HIV exhibition itself (7.8%). Out of a range of 19 possible sources of information (ranging from family members and union officials to television, radio, and the HIV exhibition), the mean number of sources reported was 5 (SD=6).

The large standard deviation and overall pattern of responses to this indicator drew our attention to it: citing the exhibition as a source of HIV information seemed to reflect a bifurcation of the typology of visitor at the museum (see Table 1). Those reporting the HIV exhibition as a source of HIV information had a significantly higher number of sources of information in general (11 sources, SD=4) as compared to those not (1 source, SD=2 sources, $t(850)=-48.32$; two-tailed $p<0.001$). Emerging literature on visitor studies suggests that visitors have prior sets of information-seeking patterns that shape their motivations and experiences in museum (Dawson and Jensen 2011). Drawing upon this literature and our

data, we postulated that this group, with “High Engagement” (HE) sought a wider range of sources of HIV information, were receptive and, importantly, were conducive to the exhibition insofar as they considered it a source of HIV information. In contrast “Low Engagement” (LE) participants relied on a narrow range of sources of HIV information, importantly NOT including the HIV exhibition. Based on their information seeking behaviour, we felt these groups had different receptivity to the HIV exhibition, which we hypothesised, would be associated with variation in HIV-related knowledge, stigma, and behavioural intent.

As indicated in Table 1, High and Low Engagement participants did not vary except in ethnicity, level of schooling, and self rated economic status. High Engagement (HE) groups were more less likely to be students ($\chi^2(1)=5.37, p=0.02$), of minority ethnicity ($\chi^2(2)=8.14, p=0.04$), report less than post-graduate levels of education ($\chi^2(4)=10.53, p=0.03$), and report themselves as being in the poorest income category relative to other Vietnamese ($\chi^2(2)=5.41, p=0.07$). There were no significant differences between the groups in terms of gender, average age, relationship, religion, and a number of other sociodemographics. Importantly, individual risk perception did not vary significantly, although HE participants did on average rate themselves at lower risk than LE participants.

There appears to have been noteworthy differences across groups in comprehensive HIV knowledge (see Table 2). While almost two-thirds of HE participants reported comprehensive HIV knowledge as per the UNAIDS definition (recognizing 3 correct modes of transmission ($\chi^2(1)=557.2, p<0.001$) and rejecting at least two incorrect modes ($\chi^2(1)=275.6, p<0.001$)), only 1 in 10 LE participants could do the same ($\chi^2(1)=278.1, p<0.001$).

Knowledge of past policy was similarly skewed, although knowledge of current policy was not significantly better among one group or the other. For instance, close to three-quarters of participants from both groups seemed to know that Vietnam has an anti-discrimination policy to support PLWH and methadone treatment for drug users, while a larger majority (90-93%) knew about school-based HIV education. However, a significantly larger proportion of LE participants as compared to HE held the opinion that the Vietnamese state considers drug use a ‘social evil’ ($\chi^2(1)=4.04, p=0.04$), and that no civil society organisations exist in Vietnam to support PLWH ($\chi^2(1)=4.04, p=0.04$).

Similarly, while mean levels of stigma did not vary significantly across groups (see Table 3), a significantly higher proportion of LE participants reported that they'd feel ashamed if someone in their family had HIV (15.9% vs 10.9%, ($\chi^2(1)=4.31, p=0.04$)) and mentioned that HIV is a punishment from God (8.8% vs. 4.9%, ($\chi^2(1)=4.66, p=0.03$)), as compared to HE participants. The latter of these is particularly striking, since the proportion of those reporting being atheist was 3% points higher among the former group (LE) as compared to the latter (HE). Moreover, the HE group comprised a greater proportion of Catholics relative to the LE group,. A statistically significant difference was also seen in the proportion of HE participants agreeing that employers should be allowed to dismiss an employee diagnosed with HIV (HE=10.3% vs LE=14.3% ($\chi^2(1)=2.84, p=0.09$)). Both groups seemed to not have

hesitations about interacting with or using materials used by PLWH in daily life (see Table 3).

Participants were also asked about their intentions over the upcoming six months with respect to a number of HIV-related behaviours (see Table 4). They were asked to specifically indicate whether they would do each activity because of having seen the exhibition. We found that overall, compared to LE, HE participants were more likely to perform certain behaviours (including the intention to explain what HIV is, take a friend to get HIV tested, and support a petition or march for PLWH rights) because of the HIV exhibition. In contrast, a greater (but not significantly) proportion of LE participants as compared to HE reported the intention to take an HIV test and disclose their HIV status specifically because of the HIV exhibition. The only statistically significant difference in intended behaviours in the two groups, specifically attributed to the intervention, was willingness to support a petition or march for the rights of PLWH, which was 60% among HE participants and 53% among LE participants ($\chi^2(2)=4.69, p=0.1$).

Discussion

New reflections on earlier findings: situating this study in the museum visitor study literature

The profile of the visitorship of *Pain and Hope* points the continued relevance of Bourdieu and Darbel's analysis (1991) of museums as an example of class (specifically educational attainment and occupation) shaping cultural preference, although not following trends seen in this earlier work. For one, the overall sample did have a high level of educational attainment (over three-quarters had some college education), although out of a kind of social modesty, self rated professional achievement was rated “average” for four out of five participants.

The difference between the LE and HE groups, however, is noteworthy: a greater proportion of LE participants were current students and had postgraduate educational attainment as compared to HE; a greater proportion of HE participants reported being in the lowest socio-economic status as compared to most Vietnamese. This suggests that in the case of Vietnam, quite distinct from the conclusions drawn in mid 20th century art museums in Europe, 21st century museum exhibitions on HIV may have greater resonance among those outside formal educational structures and from possibly lower socioeconomic strata.

This embedded difference is echoed in the distribution of ethnicity. The overall population was predominantly Kinh ethnicity, reflecting, likely, the demographics of Hanoi city. In sub-analyses, HE participants had a wider ethnic distribution than LE, suggesting that minorities embedded within majority populations may have a stronger penchant for the exhibition and its messages. This is a contrast to prior conclusions drawn about Vietnamese mainstream populations relating strongly to the “other” (be they minority ethnicities or the marginalised minority of PLWH) (Maclean 2008, Pieterse 1997).

Overall, there are many remarkable differences in context between Bourdieu's study and this one; this was an ethnology museum (not an art museum) carrying an exhibition on HIV (as

opposed to art for its own sake). The Vietnamese Museum of Ethnology, in particular, is a unique space in this regard, not just because of its unusual ability to pool funds and engage in collaborations extending beyond state entities (unlike other Vietnamese museums) (Maclean 2008, Sutherland 2005), but also in its particular appeal for domestic visitors (rather than foreign) (Maclean 2008). Inasmuch as museums are “sites where definitions of culture and identity are articulated and asserted” (Karp 1992 in Butler 2000), these nuances of identity and difference are noteworthy.

The lessons of high and low engagement

There appears to have been a striking difference between HE and LE groups in comprehensive HIV knowledge, suggesting that even majority museum-going populations – largely youth - in Vietnam may lack basic knowledge about transmission and prevention, as found in the Survey Assessment of Vietnamese Youth (SAVY) (Ministry of Health [Vietnam] 2009). The perpetuation of the ‘social evil’ paradigm in the view of both HE and LE participants and the perceived lack of civil society organisation in HIV reflects the recalcitrance of wider popular opinion -or to use Bourdieu's (1979) coinage - *doxa* -, which continues endorse the now outmoded ‘social evils’ paradigm and be oblivious to the positive and encouraging shifts in both these areas observed in recent years (Nyblade *et al.* 2008, Oanh 2007).

The higher shame and punishment related ideation in LE groups may be expected, echoing findings from other studies (see, for example Hong *et al.* 2004, Nguyen 2006). Overall mean levels of stigma do not seem to vary across levels of engagement. This null finding may well be a feature of instrumentation, but could also reflect failure of this exhibition in issuing more radical challenges to the larger structural processes of stigma (Parker and Aggleton 2003). Such change may well be beyond the purview of an exhibition alone; requiring longer periods of continuous, concerted, and multifarious efforts to address the larger inequalities in access to rights of stigmatised Vietnamese populations who are also disproportionately vulnerable to HIV (such as IDUs). Notwithstanding the considerable efforts in the area of HIV stigma reduction in Vietnam, efforts in HIV stigma reduction must also scale up, deepen, and widen. The themes that could be expanded upon are shame, punishment, as well as the rights of PLWH in society at large – moving away from stigma themes related to transmission and fear of contagion.

In this regard, we also note that fewer HE participants intended to take an HIV test as compared to LE participants, and moreover that the mean level of self-perceived risk of HIV infection among HE participants was lower than among LE participants. Even though neither of these findings was statistically significant, we feel there is social significance of these differences, in that they reflect a complex nexus between risk of infection and risk of getting tested that may be differentially perceived across visitors. HE visitors may have felt low risk of infection but that the social costs of getting tested were high. LE visitors, in turn, especially having seen the exhibition, may see the HIV test as a more accessible and approachable process, relatively speaking. These findings ought to be borne out by additional, in depth research.

Tabula Diptycha: what can we learn from this segmentation exercise

Studies have historically segmented museum visitors on the basis of demographics (like gender, class, etc.) or psychographics (like lifestyle choices, attitudes, etc.), drawing roughly on the pioneering work of Bourdieu and Darbel. This logic has recently been questioned, as has the larger assumption of Falk (2009) and others that a shared cultural framework shapes museum visitation. Dawson and Jensen (2011) submit that motive for visitation emerges as an important domain of inquiry, echoing in our finding of a split in engagement. It could be, for instance, that the motive for visitation of HE participants was distinct from that of LE participants; it may have been out of a peculiar interest in and pre-existing knowledge of HIV that these participants came to and engaged with *Pain and Hope*. There wasn't a significant difference in the proportion of HE (17.9%) and LE (15.3%) participants who had heard of the exhibition before visiting VME, most commonly through word-of-mouth (9.7% overall) or the media (7.1% overall). Perhaps the most striking of segmentation findings is a black box: HE participants reported finding out about the exhibition through sources other than invitations, being on a guided tour, social networking sites, phone/SMS, word of mouth/people talking or the media (HE: 28.6% vs LE: 3.7% ($\chi^2(1)=11.16, p=0.001$)). We do not have more data on what this source or impetus to come to the HIV exhibition was, but it may reflect a broader range of factors – demographic, psychographic and otherwise, that have shaped this separate group of participants.

Earlier in this paper, we raised the inappropriateness of the notion of *tabula rasa* in describing museum visitors. Our study seems to suggest a *tabula diptycha* – or rather two distinct writing tables marked distinctly by varying levels of knowledge, types of experience, ranges of interest, and motivational arcs with respect to this key national issue. In some cases, we propose, the palimpsest of these other factors has shaped intentions and reactions to the museum exhibition in ways we have only partially been able to capture in our modest study. And yet, we seem to have found something rather significant in this division of audience of the exhibition and possibly of the museum more generally, according to which future museum exhibits as well as HIV education efforts may be shaped.

The conclusions of this exploratory study are encumbered by many of the typical limitations of studies of a single cross-sectional observational study design. For one, all data are self reported and may under or overestimate levels of stigma. One could also hypothesise that HE groups, by virtue of their greater awareness of HIV issues, also were more aware of what responses should be like on more subjective domains like stigma and intended behaviours – in the interest of being politically correct. This mutes, to a certain extent, the strength of conclusions that can be drawn. Moreover, although participants were randomly selected, the proportion who actually responded may reflect a sub-sample of participants more comfortable with the style of instrumentation (on a computer), with more time and inclination to share their views on HIV. Notwithstanding these limitations, the comparison in this analysis has been among sub-groups of visitors and infers a bifurcation of types of visitors that is likely typical of all museums. This, we postulate, is a major area of further study.

Conclusion

This study began with the aim of characterising the relationship between a unique exhibition on a highly stigmatised topic and the knowledge, attitudes, and behavioural intent of those experiencing it. We have concluded that there is a diptych visitorship at *Pain and Hope*, with relatively high and low engagement with HIV, whose characteristics we have begun to characterise. As Vietnam moves into the second score years of its response to HIV, these variations in engagement with HIV shall have to be taken into account, and catered to, especially in innovative, culturally sensitive, and emotionally provocative efforts as this HIV exhibition has been.

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Figure 1.
Images from *Pain and Hope*.
Photo credits: Hannah Olsen, Leon Morenas

Table 1

Participant Demographics (N=852).

Proportion female	64.6%	59.8%	62.6%
Average age in years (SD)	21.8 (4.2)	21.2 (3.6)	21.5 (4.0)
Proportion student **	19.7%	13.2%	16.8%
Ethnicity **			
Kinh	97%	94.5%	96.0%
Tay	2.3%	2.9%	2.6%
Other	0.6%	2.6%	1.46%
Relationship status			
Not in a relationship	46.8%	49%	47.7%
Romantic relationship (non-physical)	38.7%	43.7%	40.0%
Romantic and physical relationship	14.3%	9.3%	12.2%
Level of schooling **			
Post-graduate	7.9%	5.5%	6.7%
College and/or vocational training	72%	81.3%	76.1%
Schooling only	19.8%	12.9%	17.0%
None	-	0.3%	0.14%
Religion			
Atheist	87%	84%	85.8%
Buddhist	9.6%	9%	9.4%
Catholic	3.1%	6.7%	4.6%
Other	0.2%	0.3%	0.24%
Self-rated educational attainment (schooling) relative to other Vietnamese			
Highest	19.1%	17.5%	18.4%
Average	79.4%	81%	80.2%
Least	1.5%	1.5%	1.5%
Self-rated economic attainment (income) relative to other Vietnamese *			
Highest	7.6%	4.1%	6.1%
Average	80.7%	81.4%	81.0%
Least	11.7%	14.5%	12.9%
Self-rated professional attainment (job type) relative to other Vietnamese			
Highest	14.7%	10.3%	12.9%
Average	82.7%	88.8%	85.2%

Least	2.7%	0.9%	2.0%
Mean level of HIV risk perception (Range: 1-10 scale – higher is greater risk (SD))	2.6 (2.7)	2.4 (2.5)	2.5 (2.6)
Spontaneous report of seeing HIV exhibition	91.4%	93.5%	92.3%
Mean number of sources of HIV information ^{##}	0.88 (2.4)	11.4 (4.0)	5.3 (6.1)

[#] $p < 0.01$

^{*} $p < 0.10$

^{**} $p < 0.05$

^{##} $p < 0.001$

Table 2

HIV-related knowledge

Comprehensive HIV Knowledge (a and b, below) ^{##}	10.9%	65.6%	33.7%
a. Can recognise 3 correct modes of transmission ^{##} (non-use of condoms; sharing syringes; giving or receiving unchecked transfusion)	16.3%	98.3%	50.5%
b. Can reject at least 2 incorrect modes of transmission ^{##} (living with someone with HIV, mosquito, sharing food)	7.03%	33%	17.3%
Knowledge of HIV in Vietnam (proportion saying "yes")			
Correct			
Vietnam has an anti-discrimination policy to support PLWH	70.5%	72.8%	72.3%
Vietnam has methadone treatment for drug users	74.4%	74.1%	74.1%
Vietnam has HIV education in schools	90.8%	93.1%	93.0%
Incorrect			
Vietnam has a 100% condom use policy	82.8%	79.9%	80.7%
Vietnam considers drug use a 'social evil' ^{**}	98.8%	93.1%	94.1%
There are no NGOs for people with HIV in Vietnam ^{**}	52.3%	40.4%	42.5%

* $p < 0.10$

$p < 0.01$

** $p < 0.05$

$p < 0.001$

Table 3

HIV/AIDS-related stigma.

Average HIV stigma score (alpha 0.67, range 0-2.6) Proportion indicating "agree" or "strongly agree"	1.03 (0.02)	0.99 (0.02)	1.01(0.40)
1. I would ride a cycle/bike previously used by a person with HIV	88.2%	84.7%	86.7%
2. A school teacher with HIV should be allowed to continue teaching	88.3%	84.9%	86.9%
3. I would buy fresh vegetables from a vendor with HIV	78.8%	77.6%	78.3%
4. I would be ashamed if someone in my family had HIV ^{**} ($p=0.04$)	15.9%	10.9%	13.8%
5. HIV is a punishment from God ^{**} ($p=0.03$)	8.8%	4.9%	7.2%
6. HIV is a result of social evils	62%	63.7%	62.7%
7. People with HIV should be allowed to decide whether or not to tell others their HIV status	66.4%	70.5%	68.1%
8. Employers should be allowed to dismiss a worker for having HIV($p=0.1$)	14.3%	10.3%	12.6%
9. People with HIV should be allowed to marry	74.4%	74.5%	74.4%

$p<0.10$

$p<0.01$

$p<0.001$

** $p<0.05$

Table 4

Intended behaviours.

1. Explain to someone what HIV is	56.4%	61.7%	58.6%
2. Tell a friend or family member personal story of someone with HIV	58.1%	56.7%	57.6%
3. Take an HIV test	37.9%	37.2%	37.6%
4. Tell someone about your HIV status	36.6%	32.2%	34.7%
5. Take a friend to get tested for HIV	38.5%	41.7%	39.9%
6. Help out a friend if I find out s/he has HIV	53.1%	53.9%	53.5%
7. Donate money to an organization to support people with HIV	52.5%	56.9%	54.4%
8. Volunteer for an organization to support people with HIV	51.3%	57.2%	53.8%
9. Support a petition or march to protect the rights of people with HIV* ($p=0.1$)	53.3%	60.3%	56.3%
10. Write a letter to a person with HIV	52.6%	54.5%	53.5%
11. Continue a romantic relationship with someone even if I know or suspect s/he has HIV	26.7%	42.2%	27.7%