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Exploring Household Food Insecurity and Inter-generational Self-help Club Involvement Among Grandparents Raising Grandchildren Due to HIV/AIDS in Vietnam

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Cover Page Footnote

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*Research Article***Exploring Household Food Insecurity and Intergenerational Self-help Club Involvement Among Grandparents Raising Grandchildren Due to HIV/AIDS in Vietnam**

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Abstract

Intergenerational Self-help Clubs (ISHCs), also known as “Empathy Clubs” in Vietnam may aid in improving quality of life and well-being for grandparent-headed households impacted by HIV/AIDS. However, less is known about how club membership impacts household food security. This cross-sectional, mixed methods study examines the differences in household food security and coping responses to food insecurity among 30 grandparents who are raising grandchildren due to HIV/AIDS, 15 who were involved in ISHC groups and 15 who were not involved in ISHC groups, in Hai Phong, Vietnam. In addition to qualitative interviews, all grandparents completed the Household Food Security Insecurity Access Scale (HFIAS) to assess the prevalence of food insecurity. Chi-square and *t*-tests were employed to detect differences between ISHC members and nonmembers. The food security domain of anxiety and uncertainty related to having enough food was statistically significant ($t [28] = 2.27, p < 0.03$), with ISHC participants reporting less anxiety and uncertainty. Close to half (46%) of ISHC members reported mild food insecurity. By comparison, about the same percentage (47%) of nonmembers reported moderate food insecurity. Qualitative interviews revealed that food insecurity arose from barriers to accessing food, which led to three primary coping responses: 1) reconfiguring understandings of age-related nutritional needs, 2) erosive coping, and 3) engaging networks for nutritional support. Differences between members of the ISHCs and those without club involvement suggest that a strong community connection, perhaps bonding social capital, may play a role in reducing anxiety related to having enough food. Findings suggest that ISHCs may build social capital, provide psychosocial support, and increase food security among grandparent-headed households who face vulnerability.

Keywords: food insecurity; grandparent-headed households; self-help clubs, Vietnam, HIV/AIDS, social capital

Grandparent-headed households impacted by HIV/AIDS have greater financial struggles and food insecurity (Tsai et al., 2011), which can have detrimental effects on children. Food insecurity may result when the primary income earners, such as parents, are unavailable and grandparents are no longer working. In Vietnam, expressions of filial piety such as offering financial support for aging parents are disrupted when an adult child dies due to AIDS-related illness. The subsequent decline in support for aging parents and grandparents who are raising grandchildren may result in food insecurity. Financial challenges and food insecurity are complicated by the lack of safety-net policies and programs to support individuals or families who are struggling economically in Vietnam. However, community-based interventions developed during the height of the HIV/AIDS crisis in Vietnam, such as Intergenerational Self-help Clubs (ISHCs), have provided resources and support to grandparents raising grandchildren over the past 15 years.

Vietnam has experienced rapid socioeconomic growth over the past 20 years, which has led to improvements in the health and nutrition of the country's citizens and the establishment of Vietnam as a lower-middle income country with a "Rising Dragon" economy (Hayton, 2010). However, chronic malnutrition is a persistent issue, particularly among women, children and grandparent-headed households, particularly in the rural areas of the country (Rocha et al., 2018). Among families affected by HIV/AIDS, children are vulnerable, due to low breastfeeding rates for fear of mother-to-child transmission, poverty, and lack of access to a diversity of healthy foods (Rocha et al., 2018).

HIV/AIDS Crisis in Vietnam

In Vietnam, the HIV epidemic is concentrated, meaning that transmission of this virus occurs largely within groups that experience disproportionate risk. HIV infection rates remain highest among high-risk populations, including persons who inject drugs (12.7%), men who have sex with men (10.8%), and sex workers (3.6%) (UNAIDS, 2018). Therefore, individuals and families affected by HIV/AIDS continue to be stigmatized, including grandparents who are raising grandchildren. The northern port city of Hai Phong is situated within one of the provinces with the highest rates of HIV in Vietnam (Ahmed et al., 2015; Nguyen et al., 2004). Both the geographic proximity of the province to the "Golden Triangle" (an opium production zone) and significant cultural and economic growth promoted conditions that increased an HIV epidemic driven by substance use in Hai Phong (Nguyen et al., 2004).

Although the number of grandparents raising grandchildren due to HIV/AIDS is unknown, grandparent caregiving is very common, due to high levels of intergenerational connectedness and reliance on support. Approximately half of persons over the age of 60 in Vietnam co-reside with a grandchild (Knodel & Nguyen, 2015). Between the years 2003 and 2013, death rates were high for those with HIV/AIDS in Vietnam. Because most of the deaths were among people of parenting age (18–35), grandparents needed to step into the caregiving role for grandchildren, especially in areas of concentrated rates of HIV/AIDS, such as the city of Hai Phong. The HIV/AIDS crisis reached a peak in 2007, with 11,000 deaths due to AIDS-related illness that year (UNAIDS, 2018). Many children who lost their parent or parents to HIV/AIDS in the early stages of the crisis have now reached adolescence, and have grown up with limited resources for food, education, and healthcare (Harris et al., 2017).

Based on the most recent sentinel surveillance from UNAIDS (2019), an estimated 230,000 people in Vietnam are living with HIV (prevalence ratio of 2.25), and 92,000 children (aged 0-17) are currently orphaned due to AIDS. This public health challenge

persists, with 5,200 new infections and 5,000 AIDS-related deaths in 2019. However, in the fourth decade of medical research into healthcare for persons with HIV, those afflicted have good life expectancy and can function well. Through use of antiretroviral therapies (ART), 66% of persons living with HIV/AIDS (PLWHA) in Vietnam have suppressed viral loads, but only 70% of the population living with HIV/AIDS are receiving ART (UNAIDS, 2019).

Although new infections have decreased by 68% from the height of the epidemic in 2010, grandparents who care for orphaned children still carry an immense burden. In addition to stigma and discrimination, such as policies that disenfranchise families for being impacted by HIV/AIDS, skipped-generation families in rural or mountainous locations suffer from low access to services, and can struggle with food accessibility and availability (Harris, Boggiano & Thang, 2016; Harris & Kim, 2014; Harris et al., 2017; UNAIDS, 2017).

Grandparent-headed Households in Vietnam

For nearly 40 years, grandparents have taken on the primary caregiving role for grandchildren orphaned by HIV/AIDS (Burnette, 1997; HelpAge International, 2008; Joslin, 2002; Kalomo & Taukeni, 2020; Matovu & Wallhagen, 2020; Orbach & HelpAge International, 2007). This phenomenon is often referred to as “skipped-generation” caregiving: grandparents raising grandchildren in the absence of either biological parent (Dolbin-MacNab & Yancura, 2018). Researchers have long established that the skipped-generation caregiving role has many adverse effects, including but not limited to poorer mental and physical health outcomes, poverty, lack of access to social support, isolation due to HIV-related stigma, and caregiver strain (Hayslip & Shore, 2000; Linsk & Mason, 2004; Mall, 2005; Poindexter, 2002). However, how grandparent-headed households have been impacted by HIV and household food insecurity remains understudied in Vietnam.

Food insecurity has been linked to HIV disease progression regardless of the resources available within the country (Gillespie & Kadiyala, 2005). In Vietnam and other countries, the loss of the middle generation diminishes economic stability for both the younger and older generations (de Waal & Whiteside, 2003; Rotheram-Borus et al., 2005). For those of older age, decreasing economic opportunity increases poverty and food insecurity, and decreasing vitality increases the burden of caregiving (Bukusuba et al., 2007; de Waal & Whiteside, 2003).

Household Food Insecurity and HIV/AIDS

Researchers have found that there are common experiences and expressions of food security across different cultures. These involve anxiety related to budget or supply, perceptions of inadequate food quality or supply, reduced food intake by adults, reduced food intake by children, and coping actions to adjust food budget or supply (Coates, 2004; Hamilton & Cook, 1997). The link between household food insecurity and HIV/AIDS has been established globally, yet few studies have examined this link within the Vietnamese cultural context.

According to a report published by the World Bank (2018), while economic opportunities in Vietnam have improved, significant inequities persist between various demographic groups. For example, 45% of ethnic minorities experience poverty, and residents of certain rural or remote locations lack access to secondary education and sanitation. The results indicated that “reduced intergenerational mobility” renders many families unable to keep up with the socioeconomic growth seen in the rest of the country. For example, children who have been orphaned due to HIV/AIDS and raised by their grandparents in Vietnam often must drop out of school to support their families. Therefore, they may not be able to attend university and gain the same economic opportunities as others in their age cohort (Harris & Kim, 2014). Nevertheless, in Hai Phong and other regions that

have been disproportionately impacted by the HIV/AIDS crisis, community-based efforts have engaged grandparents in interventions to bolster family health and support.

Intergenerational Self-help Clubs

In recent years, more attention has been given to developing ISHCs aimed at improving the lives of grandparents who are raising their grandchildren because of HIV/AIDS-related deaths (HelpAge International, 2008, 2021; Littlewood, 2014; McCallion et al., 2004; McLaughlin et al., 2017; Strozier, 2012; Sumo et al., 2018). ISHCs were originally created in response to the HIV/AIDS epidemic in Southeast Asia but have now expanded to a community-based model that promotes economically productive, healthy, social, and active aging. The goals of ISHCs, also known as “Empathy Clubs,” vary depending on location and the caregiving context. ISHCs often create social support for grandparents and access to resources to assist in caring for their grandchildren. They work to reduce stigma and improve HIV-related knowledge within this population. By joining the ISHCs, grandparents also gain access to services such as health check-ups, volunteer assistance, and financial education and empowerment in the form of a microloan (United Nations, 2019).

Working with local communities impacted by HIV/AIDS, HelpAge International spearheaded efforts to develop ISHCs, with a focus on increasing microcredit, health promotion, income generation, and access to entitlements for grandparents raising grandchildren in Vietnam. Currently, there are 830 ISHCs in 12 provinces across Vietnam (HelpAge Global Network, 2022). Some ISHCs have partnered with local authorities and services providers to develop income-generating activities, which has led to the clubs being financially independent (United Nations, 2019).

In recent years, the ISHC model has received international attention for its success, winning the grand prize for the Healthy Aging Prize for Asian Innovation (Japan Center for International Exchange, 2020) for providing solutions to address challenges faced by older, caregiving adults throughout Asia. Given the positive outcomes linked to ISHCs, grandparent involvement should be expected to have a positive impact on household food security. However, little attention has been given to understanding the how club membership may affect the day-to-day experiences of food insecurity, health-seeking, and building social capital.

Comprehensive Health Seeking and Coping Paradigm & Social Capital Theory

Although the clubs are a local and culturally specific solution to challenges faced by grandparents in Vietnam, the theoretical grounding for understanding ISHCs within the context of this study is derived from the Comprehensive Health Seeking and Coping Paradigm (Nyamathi, 1989) and Social Capital Theory (Coleman, 1988). The Comprehensive Health Seeking and Coping Paradigm offers that a combination of personal factors, sociodemographic factors, and social resources (such as social support) combine to develop a cognitive appraisal of one’s health situation. For grandparents who are raising grandchildren due to HIV/AIDS within the Vietnamese cultural context, this combination can include perceived stigma, knowledge of HIV, and knowledge of personal health information. This cognitive appraisal then leads to health-seeking and coping behaviors, such as a willingness to engage healthcare, seek outside support and engage in problem-focused coping strategies. Secondly, the authors were sensitized to ISHCs through Social Capital Theory and its application to microfinance programs throughout the globe (Coleman, 1988; Putnam, 2000; Yunus, 2007). Within the Vietnamese cultural context and ISHCs, the authors rely specifically on “bonding” social capital, which refers to the ability for people to survive on a daily basis due to a closed network of family and friends. Bonding social capital is especially useful when applied to relationships within homogenous groups or ethnic enclaves who have

all experienced similar circumstances (Putnam, 2000; Turner & Nguyen, 2005) such as losing a loved one due to HIV/AIDS within a specific geographic region such as Hai Phong, Vietnam.

Given gaps in knowledge of the impact of ISHCs on the food security conditions of grandparents raising grandchildren due to HIV/AIDS in Vietnam, this study sought to explore a) the differences in household food security and b) coping responses to food insecurity among 30 grandparents who are raising grandchildren due to HIV/AIDS, 15 who were involved in ISHC groups, and 15 who were not.

Methods

Using a cross-sectional, concurrent triangulation design (Creswell et al., 2003), the research team collected quantitative and qualitative data in one phase. Quantitative data was obtained through families' scores on the Household Food Security Insecurity Access Scale (HFIAS). Scores of groups participating in the ISHCs were compared with scores of those not participating. The interviewers were trained to elicit further information about food insecurity using the HFIAS. The research team combined this information with in-depth qualitative interviews for the analysis. All study procedures were approved by the Institutional Review Board (IRB) at the University of Louisville and by the Women's Union and the Security Force in Hai Phong City, Vietnam.

Sample

Working with the community organization, the HIV and Health Care and Support Centre (HHSC), the researchers utilized a two-stage cluster sampling design and began by dividing all the grandparent-headed households into smaller groups based on geography and into groups by communes (administrative subdivisions in urban and rural areas), known as clusters. Participants ($n = 30$) were then randomly selected from each population, and two to three grandparents were selected from each commune. The research team ensured that there was equal representation in the final sample from both a) grandparents who were involved in ISHCs and b) grandparents who were not involved in ISHCs. From there, participants were recruited by employees of HHSC, who coordinated recruitment efforts with other local NGOs, the Women's Union, and ward health clinics. Cluster sampling was helpful in recruiting from different locations across Hai Phong to include grandparents who were geographically dispersed.

To be selected, grandparents had to be 55 years of age or older, have been a caregiver for more than six months to grandchildren who lost their biological parents to HIV/AIDS, be of Vietnamese origin, and have lived in Vietnam for at least one year prior to the interview.

Setting

The research team partnered with HHSC in Hai Phong, Vietnam. This organization has been working with grandparent caregivers of children orphaned by HIV/AIDS since 2009. The organization developed ISHCs for grandparent caregivers in 2013. Table 1 gives a timeline of the activities facilitated by HHSC, which included not only ISHCs, but also home-based visits by social care workers, and programs for orphaned and vulnerable children (OVC) in three districts until 2015. Grandparents did not have to be enrolled in the ISHCs to be eligible for other services from the organization, such as receiving rations of rice and cooking oil.

Table 1*Timeline of Activities Offered to Grandparent Caregivers*

Year	District	Number of Communes Where Home-Based Care Took Place	Number of Communes Where ISHCs Were Implemented	Number of Clubs per Commune that Supported Programs for OVC
2013	Le Chan	15	4 clubs: Du Hang Kenh, Dong Hai, Tran Nguyen Han, Lam Son	1
2014	Hong Bang	11	4 clubs: Ha Ly, Thuong Ly, Trai Chuoi, So Dau	1
2015	Ngo Quyen	13	4 clubs: Dong Khe, Dang Giang, May Chai, Cau Tre	1

Home-based care consisted of in-home visits by project staff who consulted with grandparents on caregiving and health. Most grandparents were visited one or two times per month; however, when urgent support was needed, project staff visited three to four times per month.

Participation in the ISHCs was voluntary. Each ISHC has 20–25 members, all of whom received the same nutritional support that nonmembers received plus one free health check-up one time per year. The ISHC meets monthly. Half of the meeting time is spent in a support group format, and the other half is dedicated to a psycho-educational presentation on a topic selected by HHCSC staff. In 2015, the year in which this study took place, the 12 topics were nutrition and food safety, government policies concerning older adults, an overview of new policies for PLWHA and caregivers, sight and hearing issues in older adulthood, high blood pressure and heart care, teenagers and development, spiritual and psychological support for grandparents, nutrition for children by age group, hygiene and handwashing, and communication with teenagers about HIV prevention.

Procedures

During the initial contact with potential participants, HHCSC staff would briefly describe the study and agree on a time for participants to meet with the principal investigator (PI) at the HHCSC headquarters, where informed consent was obtained prior to beginning the interview. HHCSC staff agreed to recruit participants for the study and transport them to and from the HHCSC headquarters at their scheduled interview time. Participants were compensated for their time with a small gift. Each participant was interviewed once for a duration of one to two hours. Both quantitative and qualitative data were gathered during the interview.

Interpretation and Translation Process

None of the grandparent caregivers spoke English; therefore, an interpreter worked with the PI for all the interviews. The interpreter functioned as a co-researcher (Harris et al., 2013) and thus was actively engaged in all aspects of the research process, including recruitment, co-interviewing, data analysis, and dissemination of results. An American researcher started each interview by asking the grandparent five basic demographic questions in Vietnamese (Harris et al., 2013). A Vietnamese researcher from Hai Phong advised her that these methods would build rapport with participants, which is indicated by prior research findings (Birks et al., 2007; Rubin & Rubin, 2005).

The first part of the interview involved gathering demographic data, the second part was the completion of the HFIAS, and the final part was a semi-structured interview. The

interview guide for the semi-structured interview was organized around the Comprehensive Health Seeking and Coping Paradigm (Nyamathi, 1989) and covered the following topics: personal factors, sociodemographic factors, social resources, and cognitive appraisal of family's health situation (Appendix A). The research team utilized the interview guide to understand how individual and environmental factors can influence household food insecurity that takes into consideration both short- and long-term health outcomes of coping strategies.

After the participant completed the demographic questions, the dyad began asking questions and resumed interpreting using a staggered—also known as consecutive or sequential—method (Baker, 1981; Westermeyer, 1980). This process involves the researcher asking a question in English, the interpreter translating the question into Vietnamese, the participant answering in Vietnamese, and the interpreter translating the response into English. Grandparents were interviewed between May and June of 2015, and all the interviews were recorded.

After the interview was complete, the team transcribed the English parts of the audio recording. Then, the English transcript was sent back to the interpreter, who cross-checked the translation with the audiotape of the interview to ensure the accuracy of the text. This interpretation and translation process ensured that there was a clear understanding of what was said and an accurate rendering of meaning in a culturally bound way (Goodenough, 1980; Westermeyer, 1980).

Quantitative Variables and Analysis

An interview guide for nutrition and access to healthcare was utilized to garner information from participants. The first part of the guide asked a series of demographic questions and then items on nutrition and access to healthcare with either a 'yes or no' response or a Likert scale response.

Dependent Variable. The dependent variable was a dichotomous group membership variable (0 = no ISHC membership, 1 = ISHC membership).

Independent Variables. Demographic variables included continuous sample characteristic variables of age, number of children, number of grandchildren, number of grandchildren currently in the care of the grandparent, and number of years in a caregiving role. Categorical sample characteristic variables included gender (0 = Male, 1 = Female), religion (0 = No religion, 1 = Buddhist, 2 = Christian), and marital status (0 = Married, 1 = Separated/Divorced, 2 = Widowed). A continuous variable assessing access to support groups and other community-based activities was included. Participants were asked to quantify the number of support groups and other community-based activities per month in which they were involved.

Financial Health. Financial health was assessed using three categorical variables of monthly income (0 = 0–1,900,000 VND, 1 = 2,000,000–5,600,000 VND), financial stress (0 = No, 1 = Yes), and financial support (0 = No, 1 = Yes).

HIV-related Health. HIV-related health status was determined using four categorical variables of: 1) child with HIV (0 = None/unknown, 1 = Yes, living, 2 = Yes, deceased, 3 = Yes, living and deceased/multiple children); 2) grandchild with HIV (0 = Unknown, 1 = Negative test result, 2 = Positive test result); 3) number of years since grandchild had an HIV test, (0 = Never, unknown, 1 = 0-1 years ago, 2 = 2-3 years ago, 3 = more than 4 years ago);

and 4) years since grandchild had a medical evaluation (0 = Never, Unknown, 1 = Less than one year, 2 = 1 year or more).

Food-related Health. Food-related health was assessed using the Household Food Insecurity Access Scale (HFIAS), a nine-item instrument developed and tested by the Food and Nutrition Technical Assistance (FANTA) project that has been used in several countries and has been translated into Vietnamese (Ali et al., 2013; Coates et al., 2007; Nguyen et al., 2015; Nguyen & Murimi, 2021). The nine questions cover three domains: 1) anxiety and uncertainty about food supply; 2) insufficient quality and variety of food; and 3) insufficient food intake and consequences. Possible responses for each question were never, rarely, sometimes, and often and coded as 0, 1, 2, and 3, respectively. The scores range from 0 to 27, with higher scores reflecting greater food insecurity. Based on those scores, participants are categorized as one of four levels: food secure; mildly insecure; moderately insecure; or severely food insecure. The HFIAS had sufficient reliability for this sample, with a Cronbach's α of 0.76. Previous HFIAS studies with an international sample report similar Cronbach's α scores (Gebreyesus et al., 2015; Knueppel et al., 2009). Household Food Insecurity Access Scale was scored according to the instructions provided by Coates and colleagues (2007).

Statistical Analysis

Based on the size of the sample ($n = 30$), chi-square and t -tests were employed to detect statistically significant differences between ISHC members and nonmembers. Data were analyzed using SPSS (v. 25).

Qualitative Analysis and Positionality

Using a generic qualitative approach (Merriam & Tisdell, 2015), along with constructivist grounded theory coding strategies (Charmaz, 2014), three coders engaged in open and focused coding with interview transcripts to identify frequent and significant themes connected to reoccurring details, explanations, and descriptions.

Once the themes were identified, the researchers used peer debriefing and consensus building around themes (Erlandson et al., 1993) to develop a codebook comprised of thematic codes with definitions. The finalized codebook was based on iterative discussions of interview transcripts (Hsieh & Shannon, 2005; Joffe & Yardley, 2004). The researchers then uploaded the codebook onto Dedoose software (Version 8.0.35, 2018), an organizational tool for qualitative data analysis.

Dedoose, a web-based qualitative data analysis platform, was used to facilitate data organization and coding (Sociocultural Research Consultants, 2021) The codebook was uploaded into Dedoose, and its coding functions were used to code the first ten interview transcripts. Next, Cohen's kappa interrater reliability tests were performed using other researchers' coded transcripts to ensure that agreement was reached among all coders. Cohen's kappa statistic is a widely used measure to measure intercoder agreement against the rate of agreement expected by chance (Cohen, 1960; De Vries et al., 2008). After obtaining a pooled statistic of 80% ("very good agreement" [Landis & Koch, 1977]), the research team met to discuss and adjudicate each excerpt on which agreement was not obtained. After the adjudication process was complete, the remaining 20 interviews were coded. At the conclusion of the study, the coders met again to measure intercoder agreement, and 100% agreement was attained. The authors maintained memos related to analytic decisions, consulted with other team members, and discussed the relationships among codes that emerged from the data (Charmaz, 2014; Corbin & Strauss, 2014).

Positionality

Three coders trained in qualitative data analysis engaged in the coding process. One coder was American-born and speaks a conversational level of Vietnamese, worked for an International Non-Governmental Organization (INGO) in Vietnam for three years and has been engaged in research in Vietnam for over a decade. The second coder was born in Vietnam, has worked with INGOs for over 15 years, and works professionally as a foreign language interpreter. The third coder was born in Germany and has worked with various refugee serving organizations including the Vietnamese population.

Trustworthiness and Credibility

Additional steps were taken to ensure credibility and confirmability of our research findings (Lincoln & Guba, 1985). For triangulation of data, we used three data sources: demographic questionnaires, HFIAS, and interviews with grandparents to understand the phenomenon of household food insecurity at a deeper level. Secondly, we engaged in peer debriefing with the two authors who were not involved in the data analysis to engage analytical probing. This process also led to conversations on taken-for-granted assumptions and perceptions on behalf of the analytic team. This support helped refine the analysis in terms of clarifying emerging findings.

Results

Quantitative Results

Sample Characteristics

Table 2 provides sample characteristics. Within the sample, 15 grandparent caregivers were members of ISHCs, and 15 grandparent caregivers were not. Participants in both groups reported on average the same number of grandchildren who were in their care (ISHC membership $M = 1.60$ $SD = 0.51$; non-ISHC membership $M = 1.93$ $SD = 1.10$) with no statistically significant differences between groups ($t = 1.07$; $df = 28$; $p < 0.30$). Participants with ISHC membership ($M = 9.33$; $SD = 1.99$) had on average less years in a caregiving role, compared with those without ISHC membership ($M = 12.80$; $SD = 3.82$) with a statistically significant difference found between groups ($t = 3.12$; $df = 28$; $p < 0.01$). This held for the number of support groups and other community-based activities per month in which they were involved, with those who had ISHC membership reporting on average 5.20 ($SD = 1.01$) monthly groups and activities, while those without ISHC membership reported a much lower number on average of 2.20 (1.86) monthly groups and activities with a statistically significant difference between groups ($t = -5.49$; $df = 28$; $p < 0.001$).

Table 2

Sample Characteristics

Variable	Club Involvement n (%), M (SD)	No Involvement n (%), M (SD)	X^2 , t (df)
Age	69.40 (8.01)	65.93 (5.56)	-1.38 (28)
Gender			1.15 (1)
Female	12 (80%)	14 (93%)	
Male	3 (20%)	1 (7%)	
Marital Status			2.49 (2)
Married	7 (46.5%)	11 (73%)	
Separated/Divorced	1 (7%)	1 (7%)	
Widowed	7 (46.5%)	3 (20%)	

Religious Affiliation			2.47 (2)
Buddhist	10 (67%)	12 (80%)	
Christian	0 (0%)	1 (7%)	
Not identified	5 (33%)	2 (13%)	
Adult children	3.80 (1.57)	3.27 (1.53)	-.94 (28)
Grandchildren	6.40 (4.52)	4.80 (2.98)	-1.15 (28)
Grandchildren cared for	1.60 (.51)	1.93 (1.10)	1.07 (28)
Years in caregiving role	9.33 (1.99)	12.80 (3.82)	3.12 (28)**
Amount of community involvement	5.20 (1.01)	2.20 (1.86)	-5.49 (28)***

* $p < .05$, ** $p < .01$, *** $p < .001$

Note. Percentage reported within group

Bivariate Results

Financial. Grandparents who were members of the ISHC reported to have on average a lower monthly income (\$1,513,666 VND, or approximately \$65.00 USD) than those who were not members (\$2,638,666 VND or \$113.00 USD) with a statistically significant difference between groups ($\chi^2 = 4.82$; $df = 1$; $p < 0.03$). All participants in the sample reported financial stress; however, those with ISHC membership reported less financial support ($n = 3$) compared to those without ISHC membership ($n = 8$) with no statistically significant differences between groups ($\chi^2 = 3.49$; $df = 1$; $p < 0.06$).

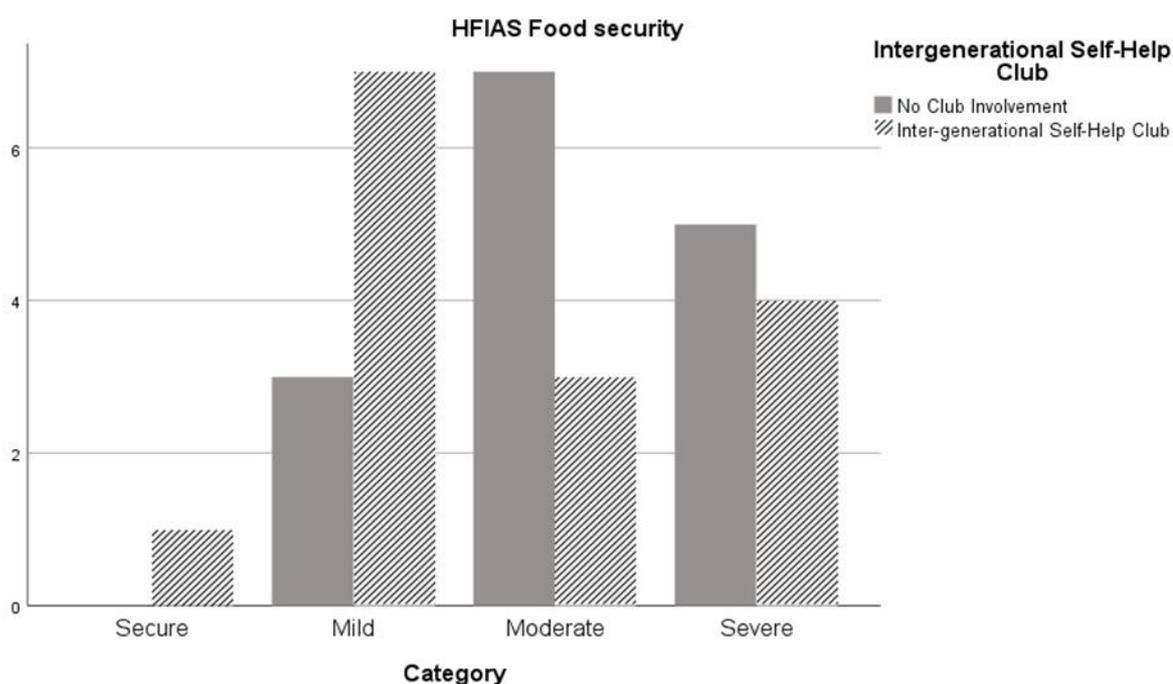
HIV Status. The majority of grandparents in both groups reported having children with HIV who were living (ISHC membership $n = 2$; non-ISHC membership $n = 3$), deceased (ISHC membership $n = 1$; non-ISHC membership $n = 6$), or living and deceased/multiple children (ISHC membership $n = 8$; non-ISHC membership $n = 3$) with no statistically significant differences between groups ($\chi^2 = 6.19$; $df = 3$; $p < 0.10$). The reverse was reported regarding grandchildren with HIV with most grandparents in both groups reporting grandchildren who had a negative HIV test result (ISHC membership $n = 13$; non-ISHC membership $n = 11$) with no statistically significant differences between groups ($\chi^2 = 3.50$; $df = 2$; $p < 0.17$). Both groups reported either not knowing the date of the last HIV test for their grandchild (ISHC membership $n = 5$; non-ISHC membership $n = 8$), or that the test was more than four years ago (ISHC membership $n = 9$; non-ISHC membership $n = 5$) with no statistically significant differences between groups ($\chi^2 = 2.83$; $df = 2$; $p < 0.42$). This was also the case with years since their grandchild had a medical evaluation with both groups either not knowing the date of the last evaluation (ISHC membership $n = 5$; non-ISHC membership $n = 2$) or reporting that the evaluation was over a year ago (ISHC membership $n = 5$; non-ISHC membership $n = 10$) with no statistically significant differences between groups ($\chi^2 = 3.45$; $df = 2$; $p < 0.18$).

Food Security. The HFIAS scale was used to assess food security differences between groups. The food security domain of anxiety and uncertainty related to having enough food was statistically significant ($t = 2.27$; $df = 28$; $p < 0.02$) with ISHC participants ($M = 0.60$; $SD = 0.51$) reporting less anxiety and uncertainty compared with those who did not have ISHC membership ($M = 0.93$; $SD = 0.26$). There were no statistically significant differences between groups in food security categories of insufficient quality of food ($t = 1.17$; $df = 28$; $p < 0.13$), or insufficient intake of food ($t = 1.40$; $df = 28$; $p < 0.09$). Participants with ISHC membership ($M = 10.20$; $SD = 7.08$) reported on average less frequency of food insecurity compared with those who did not have ISHC membership ($M = 13.60$; $SD = 5.28$) with no statistically significant differences between groups ($t = 1.49$; $df = 28$; $p < 0.07$). Regarding food security categories, less than half of participants with ISHC

membership reported moderate ($n = 3$) or severe ($n = 4$) food insecurity, while close to 80% of those without ISHC membership reported either moderate ($n = 7$) or severe ($n = 5$) food insecurity with no statistically significant differences between groups ($\chi^2 = 4.31$; $df = 3$; $p < 0.23$). Participants with ISHC membership ($M = 10.20$; $SD = 7.08$) reported on average less frequency of food insecurity compared with those who did not have ISHC membership ($M = 13.60$; $SD = 5.28$) with no statistically significant differences between groups ($t = 1.49$; $df = 28$; $p < 0.07$). See Figure 1 for categories of food security as defined by the HFIAS scale.

Figure 1

Categories of HFIAS Food Security by Club Involvement



It is notable that statistically significant bivariate chi-square and t -test differences were found between the groups in the anxiety and uncertainty domain of food security and in the amount of monthly community involvement. ISHC members reported more community involvement and less anxiety and uncertainty, even though ISHC members' monthly income was less than that of nonmembers.

Qualitative Results

The qualitative findings of this study are derived mainly from the semi-structured interviews. However, grandparents responded to questions related to the HFIAS domains when taking the survey, allowing for a deeper understanding of how anxiety, food quality, and food intake contributed to household food insecurity.

Experiences of Food Insecurity

All but one grandparent faced a food security issue and often had to improvise when it came to providing food for their families. For example, Lien, (77, female, non-ISHC member) described the process about being worried and anxious about food: "Of course we have to be very careful with the money we spend on food. We have a fixed income every

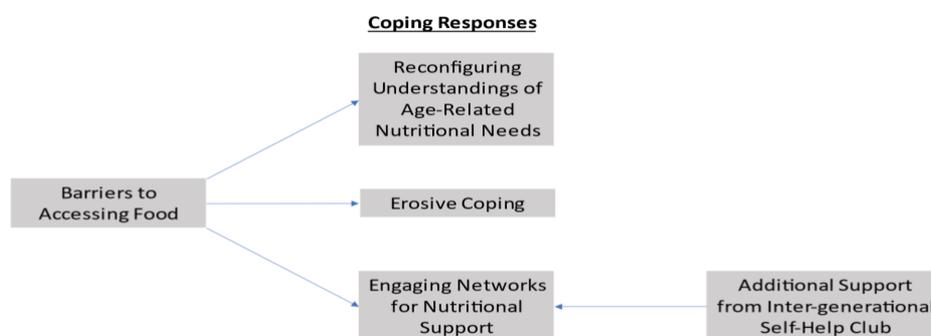
month, so we just, you know try to spend that money carefully, to make sure we have enough food.”

In terms of coping strategies related to increasing quality and diversity of food within the household’s diet, Binh (69, female, ISHC member) said, “Usually in the morning I do morning exercises near an apartment building, and I pick up some plants we can eat as vegetables. It’s very clean. It helps to diversify our meals, but it also helps to reduce the money.” Many grandparents spoke about lowering their own food intake to support their grandchild(ren). Hoa (69, female, ISHC member) explained, “I usually skip breakfast, because I worked through the night, so in the morning, after coming home from the market, I just sleep. And I usually give my granddaughter 10,000 VND for her to go out to eat something for her breakfast.” Grandparents also engaged in tactics to expand existing limited food to extend meals. Tu (57, female, ISHC member) said, “Sometimes we even run out of rice, and we have to cook porridge, to make it bigger fill it with water.”

A process (Figure 2) emerged from the grandparents’ account that contextualized their understanding and experiences with food insecurity. All grandparents indicated that food insecurity arose from barriers to accessing food, which led to three primary coping responses used to buffer food insecurity: reconfiguring understandings of age-related nutritional needs, erosive coping, and engaging networks for nutritional support. Grandparents who were involved in ISHCs reported additional support from their club members when it came to food access.

Figure 2

Vietnamese Grandparents Experiencing Food Insecurity: Barriers, Coping, and Support



Barriers to Accessing Food

Competing priorities and financial stress (i.e., health care costs and school fees) were barriers to accessing food. Huong (female, 62, ISHC member) stated, “What I care more about is the money to support her [granddaughter] studies so I cannot use all the money to buy food.” Van (62, female, ISHC member) described a similar situation: “What worries me most is the money to pay for their [grandchildren] school fees and health insurance. It costs a lot of money, food is second.” Financial stress further exacerbated the grandparents’ food insecurity. Yen (59, female, non-ISHC member) stated, “We have to make sure that everything is manageable in the budget. If we exceed it, we will have an empty stomach for the rest of the month.”

Reconfiguring Understandings of Age-related Nutritional Needs

The barriers to accessing food led grandparents to the cognitive process of reconfiguring understandings of age-related nutritional needs. Both grandparent groups concluded that “being old means needing less.” Xuan (non-ISHC member, 73, female) explained that her age enabled her to go longer periods of time without eating: “I can skip meals—I am old and don’t need much—but the grandchildren cannot.” Duong (male, 80, ISHC member) related older adulthood to having the endurance to cope without food: “I have two granddaughters which I will make sure that they go to bed at night with a full stomach. We are old people so we can stand the feeling of hunger.” Phuong (non-ISHC member, 70, female) justified her grandchildren’s developmental stage as the reason to prioritize their needs over hers: “The children, they need food more than me.”

Erosive Coping

To meet the nutritional needs of their grandchildren, grandparents reported that they engaged in erosive coping strategies, cutting back on their own food intake to meet their grandchildren’s nutritional needs. In contrast to the cognitive processes above, erosive coping involved actions taken by grandparents to resist household food insecurity.

Erosive coping strategies—skipping meals, eating less, or lower consumption of diverse, nutrient-dense foods—relieve temporary household food insecurity but potentially put the grandparents’ health at risk. Linh (61, female, non-ISHC member) said, “I have to skip some meals, but nobody knows. So having no lunch has become our habit. We are familiar with it.” Yen (59, female, non-ISHC member) explained, “We just fry the leftover vegetables for us and give the more nutritious food like the meat and the rice to the grandchildren. I try to be very stingy with myself to make sure that the children have enough to eat.” Bich (ISHC member, 72, female) stated, “I try to leave the good food for my grandchildren, and I eat what they don’t eat.”

Engaging Networks for Nutritional Support

Both grandparent groups identified the necessity to rely on outside support during periods of time when their food sources were low. However, grandparents who were ISHC members were more likely to ask neighbors for nutritional support during times of need. In contrast, only five non-ISHC members reported engaging their networks for nutritional support.

Chi (68, female, ISHC member) engaged in active strategies to secure food for her grandchildren: “Even if we don’t have enough money, we have to go knock on the door of this neighbor or that neighbor to borrow some money to buy food.” Dung (male, 80, ISHC member) stated, “Some of the neighbors we ask for food are rich people, and they are willing to give us some food. They have extra and give it to us.”

Grandparents who were involved in the club elaborated on how ISHC membership contributed to their household food security through emotional and instrumental support. Grandparents reflected on emotional support as being given empathy, comfort and compassion by peers and group leaders. Whereas instrumental support was defined as being given tangible assistance or help in physical ways. An (68, female, ISHC member) said, “This lady from the club maybe comes twice a month to my house and we can talk together, and we also have one monthly meeting. Sometimes we receive some material support like rice or like cooking oil. I like that we can share our activities, be together, and we encourage each other.” Other grandparents who were in the ISHCs explained that loans and in-kind donations they received through the club allowed them to focus their finances on providing food. Binh (69, female, GC member) explained, “We used to also borrow some money, like a loan, from the project. But the project provided us with a lot of things, like a blanket for our

son, or a jacket for the last winter, and school supplies.” All the grandparents enrolled in the club recognized that the ISHC enhanced their ability to access health care and increased their food security through nutritional support and information.

Discussion

The goal of this analysis was to understand the differences in household food security and coping responses to food insecurity among grandparents raising grandchildren due to HIV/AIDS in Vietnam. Notably, our findings contribute to a deeper understanding of the context and experiences of food insecurity among grandparent caregivers affected by HIV/AIDS. Available evidence showed that food insecurity remains a critical issue facing families. Outcomes from the statistical analysis exploring differences between members of the ISHCs and those without club involvement suggest that a strong community connection, perhaps bonding social capital, may play a role in reducing anxiety related to having enough food. This assumption is strengthened by ISHC members reporting a significantly lower income and less financial support from family members than non-club members. It appears there may be a relationship between a lack of financial resources and a reduction in anxiety and uncertainty related to having enough food.

It should also be noted that ISHC members had enhanced knowledge about the biomedical aspects of HIV as well as HIV stigma due to their club involvement. This knowledge may have increased their social confidence, reducing the effects of HIV stigma, decreasing social isolation, which could have impacted their willingness to express their needs to others in the community. When considering the role of social capital, ISHCs members may have broadened their social networks as evidenced by their reaching out to their neighbors for food, thus reducing household food insecurity.

The Vietnamese grandparents’ narratives about hardships in providing food for the entire family are consistent with other studies of grandparents from lower socioeconomic contexts (Tsai et al., 2011). With the little they have each month, grandparents must make conscientious choices around nutrition and food intake that prioritize their grandchildren’s well-being over their own. While the grandparents’ coping mechanisms reflect their pragmatic solutions for survival, these responses have detrimental consequences for the long-term health of the caregivers and their grandchildren.

Vietnamese grandparents did not mention an understanding of the long-term impacts of reducing their personal food consumption to provide for their grandchildren. Globally, studies have shown that although grandparents may experience concern over the difficulties of their role, their priorities consistently focus on grandchild well-being and safety (Taylor et al., 2018). Erosive coping strategies have been studied within the context of poverty experienced by families affected by HIV, particularly in Southern Africa (Drimie & Casale, 2008; Haan et al., 2003). These coping strategies can provide short-term solutions and relief, despite placing the welfare of the family at risk in the long term.

Household food insecurity proved not only to be a threat to the current welfare of the grandparent-headed households but also to the grandchildren’s long-term security. By eroding their own nutritional needs, grandparents may be placing grandchildren at risk for becoming “double orphans” (Finlay et al., 2016; Huy et al., 2016), who may be at greater risk of entering an orphanage or other institutional care. In a study exploring guardianship plans among grandparents raising grandchildren due to HIV/AIDS, the findings indicated that within the Vietnamese cultural context, institutional care is the least desirable option for the care of children (Harris et al., 2017).

Grandparent caregivers are at higher risk of health problems, which could jeopardize the welfare of their grandchildren (Minkler & Fuller-Thompson, 1999; Musil & Ahmad, 2002; Whitley et al., 2001). Nutritious food intake is ever more critical to maintaining health

and preventing the development or further complications of existing health problems among older adults. Yet, findings indicate that the caregivers eat fewer meals, skip meals, or eat the less nutritious food.

In addition, the grandchildren were either in childhood or adolescence, a critical period for biological, psychological, and social development (Nyaradi et al., 2013). Adequate, healthy, and nutritious food consumption can affect cognitive status and children's ability to thrive (Benton, 2010). Yet, findings suggest that these households have limited their consumption of nutritious food in both quantity and quality.

Few studies have evaluated the effectiveness of ISHCs for grandparents raising grandchildren. Strozier (2012) found that grandparent caregivers who participated in support groups experienced more social support than those who did not. These findings are consistent with McCallion and colleagues (2004), who reported that a support group intervention for grandparents raising grandchildren resulted in a significant reduction in symptoms of depression as well as an increased sense of empowerment and caregiving mastery. Littlewood (2014) evaluated and measured the outcomes of support groups for grandparents raising grandchildren in five US states and developed the GrOW Support Group Inventory to help identify a gap in existing support group performance management. The study found that support groups were even more effective when combined with other services, such as case management, mental health counseling, and providing information and referrals to meet caregiver needs. These findings are consistent with our study on ISHCs in Vietnam.

Implications for Practice

The findings highlight several key considerations for programs (such as ISHCs) that aim to reduce the burden of caregiving for Vietnamese grandparents raising their orphaned grandchildren. Programs should engage in active outreach to increase membership in the ISHCs and promote access to social support and resources to address food insecurities. In this study, ISHC-affiliated grandparents highlighted the importance of asking neighbors for help as a means to reduce food insecurity in their households, and they are more likely to do so than grandparents who are not participating in an ISHC. One plausible explanation for this difference in help-seeking may be that non-ISHC grandparents are uncomfortable reaching out to others for support, and hence they have not yet participated in ISHCs. Given the stigma that households affected by HIV/AIDS experience in Vietnam (Gaudine et al., 2010; Nyblade et al., 2008; Salter et al., 2010; Thi et al., 2008), it is not surprising that some grandparents are hesitant to join ISHCs. It might be fruitful for ISHCs to focus on community awareness, outreach, and engagement campaigns across the communes to increase participation from households affected by HIV/AIDS.

Implications for Policy

Our study supports findings from across the globe that food security interventions positively impact persons and families who have been affected by HIV/AIDS (Aberman et al., 2014). Based on these findings, it is recommended that there is a need to strengthen nutrition and HIV programming and policy. Given that grandparents raising grandchildren within this context experience economic hardship due to the loss of the parental generation from HIV/AIDS, the government and nongovernmental organizations must do more to support grandfamilies. For example, food assistance should be required within HIV programs. The Vietnamese government should partner with community organizations to integrate caregivers into programs that address household food insecurity and HIV care (Weiser et al., 2011). These findings support the need for livelihood interventions in Vietnam, directed at the root causes of poverty and food insecurity. Grandparents might have better health outcomes and provide for their grandchildren if multiple domains are addressed,

for example, nutritional, mental health, and behavioral support. Food insecurity is a multifaceted phenomenon, and we suggest that support groups, combined with microfinance or other income generation approaches, can best maximize support and health among grandparents.

Limitations and Future Research

Some limitations of this study should be noted. First, all grandparent-headed households in Hai Phong had access to rations of rice and oil. However, those who attended ISHCs might have had more access to the rations due to frequent contact with and visits to the organization. Second, data obtained from the survey were self-reported; therefore, recall bias and social desirability bias may be a limitation. Resources were not available to engage grandparent caregivers in member-checking for respondent feedback or participant validation of the qualitative findings. The sample size was small for the comparative quantitative analysis; thus, no causal conclusions can be made. This study was only able to establish if a relationship existed between club membership and nutrition and healthcare status. Moreover, pre-study measures were not collected, thus no conclusions can be drawn as to whether the clubs actually contributed to the findings.

Future research should employ more rigorous research designs, with larger sample sizes to provide greater evidence for findings. It should be noted that these data were collected prior to the COVID-19 pandemic, which has increased food insecurity and reduced the positive effects of social connection in Vietnam and worldwide (Nguyen & Vu, 2020). We posit that the pandemic not only increased food shortages among skipped-generation families coping with HIV/AIDS, but also reduced the amount of time ISHCs could spend together, thus reducing social capital. Future research should focus on the impact of the pandemic on ISHCs, and food security among grandparents raising grandchildren.

Researchers are calling for more studies that examine the positive and negative effects of social networks (Kaschula, 2011). More research is needed to understand the long-term effects of borrowing food from community members to determine whether such borrowing can be seen as an issue of “recourse” or “resource.” Tsai and colleagues (2012) recommend continued development and implementation of interventions aimed at reducing HIV stigma and bolstering emotional and informational support to improve food security for persons and families affected by HIV/AIDS. The positive impacts of ISHCs have been noted in terms of creating more opportunities for grandparents to receive social support and other resources that can improve food security (Gharib, 2020). Future studies should explore the relationships formed in the ISHCs with peers to understand trust, reciprocity, information-sharing, and cooperation, which may have a positive impact on grandparents’ securing food on behalf of themselves and their grandchildren.

Conclusion

This study focused on providing a deeper understanding of household food insecurity among grandparent-headed households impacted by HIV/AIDS in Vietnam. This study also provides further evidence of the effectiveness of ISHCs, which may create more community engagement and more opportunities for grandparents to access resources in other areas, such as nutrition and social capital. These results suggest that grandparents who were members of the ISHC had less anxiety about procuring food during times of hardship due to their affiliation with and support from their ISHC group and community. We posit that the reason was because they had developed more social capital with their fellow club members and surrounding community, thus relying on instrumental, social, and emotional support from their peers. We recommend that any intervention addressing food insecurity within the region should include support across various domains including stigma reduction, nutritional

education, social support, social capital, mental health, medical support, and income generation.

References

- Aberman, N. L., Rawat, R., Drimie, S., Claros, J. M., & Kadiyala, S. (2014). Food security and nutrition interventions in response to the AIDS epidemic: assessing global action and evidence. *AIDS and Behavior, 18*(5), 554–565.
- Ahmed, T., Long, T.N., Huong, P.T., & Stewart, D.E. (2015) Drug injecting and HIV risk among injecting drug users in Hai Phong, Vietnam: A qualitative analysis. *BMC Public Health, 15*(32).
- Ali, D., Saha, K. K., Nguyen, P. H., Diressie, M. T., Ruel, M. T., Menon, P., & Rawat, R. (2013). Household food insecurity is associated with higher child undernutrition in Bangladesh, Ethiopia, and Vietnam, but the effect is not mediated by child dietary diversity. *The Journal of Nutrition, 143*(12), 2015–2021.
- Baker, N. (1981). Social work through an interpreter. *Social Work, 26*, 391–397.
- Benton, D. (2010). The influence of dietary status on the cognitive performance of children. *Molecular Nutrition & Food Research, 54*(4), 457–470.
- Birks, M. J., Chapman, Y., & Francis, K. (2007). Breaching the wall: Interviewing people from other cultures. *Journal of Transcultural Nursing, 18*(2), 150–156.
- Bukusuba, J., Kikafunda, J. K., & Whitehead, R. G. (2007). Food security status in households of people living with HIV/AIDS (PLWHA) in a Ugandan urban Setting. *British Journal of Nutrition, 98*(1), 211–217.
- Burnette, D. (1997). Grandparents raising grandchildren in the inner city. *Families in Society, 78*(5), 489–501.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed). Sage.
- Coates, J. (2004). *Experience and expression of food insecurity across cultures: Practical implications for valid measurement*. Food and Nutrition Technical Assistance Project. USAID.
- Coates, J., Swindle, A., & Bilinsky, P. (2007). *Household food insecurity access scale (HFIAS) for measurement of food access*. Food and Nutrition Technical Assistance (FANTA). Academy for Educational Development.
- Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20*(1), 37–46.
- Coleman, J.S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94*, S95–S120
- Corbin, J., & Strauss, A. (2014). *Basics of qualitative research*. Sage.
- Creswell, J. W., Clark, V. L. P., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social & behavioral research* (pp. 223–227). Sage
- De Vries, H., Elliott, M. N., Kanouse, D. E., & Teleki, S. S. (2008). Using pooled kappa to summarize interrater agreement across many items. *Field Methods, 20*(3), 272–282.
- De Waal, A., & Whiteside, A. (2003). New variant famine: AIDS and food crisis in southern Africa. *The Lancet, 362*(9391), 1234–1237.
- Dolbin-MacNab, M. L., & Yancura, L. A. (2018). International perspectives on grandparents raising grandchildren: Contextual considerations for advancing global discourse. *The International Journal of Aging and Human Development, 86*(1), 3–33.
- Drimie, S., & Casale, M. (2008). *Families' efforts to secure the future of their children in the context of multiple stresses, including HIV and AIDS*. Joint learning initiative on children and HIV/AIDS. JLICA Learning Group One: Strengthening Families.

- Erlanson D. A. (1993). *Doing naturalistic inquiry: A guide to methods*. Sage.
- Finlay, J. E., Fink, G., McCoy, D. C., Tavárez, L. C., Chai, J., Danaei, G. & Fawzi, M. C. S. (2016). Stunting risk of orphans by caregiver and living arrangement in low-income and middle-income countries. *Journal of Epidemiology & Community Health*, 70(8), 784–790.
- Gaudine, A., Gien, L., Thuan, T. T., & Dung, D. V. (2010). Perspectives of HIV-related stigma in a community in Vietnam: A qualitative study. *International Journal of Nursing Studies*, 47(1), 38–48.
- Gebreyesus, S. H., Lunde, T., Mariam, D. H., Woldehanna, T., and Lindtjorn, B. (2015). Is the adapted household food insecurity access scale (HFIAS) developed internationally to measure food insecurity valid in urban and rural households of Ethiopia? *BMC Nutrition*, 1(2).
- Gharib, M. (2020). *Older People, Got A Pandemic Problem? A Club To Help You Figure It Out — Yourself*. National Public Radio. Retrieved from <https://www.npr.org/sections/goatsandsoda/2020/09/23/904604257/older-people-got-a-pandemic-problem-a-club-to-help-you-figure-it-out-yourself>
- Gillespie, S. & Kadiyala, S. (2005). *HIV/AIDS and food and nutrition security: From evidence to action*. International Food Policy Research Institute.
- Goodenough, W. H. (1980). *Ethnographic field techniques*. In H. C. Triandis & J. W. Berry (Eds.), *Handbook of cross cultural psychology* (pp. 29–55). Allyn Bacon.
- Haan, N., Marsland, N., & Oliveira, L. (2003). *Towards identifying impacts of HIV/AIDS on food security in Southern Africa and implications for response: Findings from Malawi, Zambia and Zimbabwe*. Southern African Development Community [SADC], Food, Agriculture and Natural Resources Vulnerability Assessment Committee.
- Hamilton, W. L., & Cook, J. T. (1997). Household food security in the United States in 1995: Technical report of the food security measurement project. US Department of Agriculture.
- Harris, L.M., Boggiano, V., Thang, N.D. & Linh, P.L.H. (2013). Working in Partnership With Interpreters: Studies on Individuals Affected by HIV/AIDS in Vietnam. *Qualitative Health Research*, 23(10), 1408-1418.
- Harris, L.M., Boggiano, V. & Thang, N.D. (2016). “Social Crimes”: Understandings of HIV/AIDS as a Disease among Grandparents Raising Grandchildren in Vietnam. *Social Work in Public Health*, 31(6), 520-529.
- Harris, L.M. & Kim, B.J. (2014). Problem-Focused Coping: Skipped-Generation Caregivers Affected by HIV/AIDS in Vietnam. *Qualitative Health Research*, 24(8), 1048-1056.
- Harris, L. M., Wilfong, J., Thang, N. D., Kim, B. (2017). Guardianship Planning Among Grandparents Raising Grandchildren Orphaned by HIV/AIDS in Northern Vietnam. *GrandFamilies: The Contemporary Journal of Research, Practice and Policy*, 4(1).
- Hayslip, B., Jr., & Shore, R. J. (2000). Custodial grandparenting and mental health services. *Journal of Mental Health and Aging*, 6(4), 367–383.
- Hayton, B. (2010). *Vietnam: Rising dragon*. Yale University Press.
- HelpAge Global Network (2022). *Ageing population in Vietnam*. Retrieved from <https://ageingasia.org/ageing-population-vietnam/#:~:text=The%20number%20of%20older%20people%3A%20Vietnam%20is%20one%20of%20the,third%20of%20the%20total%20population.&text=The%20majority%20of%20older%20people,in%20rural%20and%20mountainous%20areas>
- HelpAge International (2008). The impact of AIDS on older people. *Ageways: Practical issues in ageing and development*, 71, 4–5.

- HelpAge International (2021). *Why we work in Vietnam*. Retrieved from <https://www.helpage.org/where-we-work/east-asia/32vietnam/>
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288.
- Huy, B. V., Teeraananchai, S., Oanh, L. N., Tucker, J., Kurniati, N., Hansudewechakul, R., Truong, K. H., Khol, V., Nguyen, L. V., Do, V. C., Lumbiganon, P., Kongstan, N., Bunupuradah, T., Sudjaritruk, T., Kumarasamy, N., Yusoff, N. K. N., Razali, K. A. M., Wati, D. K., Fong, M. S., ... Sohn, A. H. (2016). Impact of orphan status on HIV treatment outcomes and retention in care of children and adolescents in Asia. *Journal of Virus Eradication, 2*(4), 227.
- Japan Center for International Exchange (2020). *2020 Healthy Aging Prize for Asian Innovation*. Retrieved from: <https://www.ahwin.org/winners-of-1st-healthy-aging-prize-for-asian-innovation/>
- Joffe, H., & Yardley, L. (2004). Content and thematic analysis. *Research Methods for Clinical and Health Psychology, 56*, 68.
- Joslin, D. (2002). *Older adults raising children in the wake of HIV/AIDS*. Columbia University Press.
- Kalomo, E. N., & Taukeni, S. G. (2020). Elderly grandparents as caregivers of children affected or infected by HIV and AIDS in Namibia. In Taukeni, S. G. (Ed.), *Biopsychosocial perspectives and practices for addressing communicable and non-communicable diseases* (pp. 68–83). IGI Global
- Kaschula, S. (2011). Using people to cope with the hunger: Social networks and food transfers amongst HIV/AIDS afflicted households in KwaZulu-Natal, South Africa. *AIDS and Behavior, 15*(7), 1490.
- Knodel, J., & Nguyen, M. D. (2015). Grandparents and grandchildren: Care and support in Myanmar, Thailand and Vietnam. *Ageing & Society, 35*(9), 1960–1988.
- Knueppel, D., Demment, M., & Kaiser, L. (2009). Validation of the household food insecurity access scale in rural Tanzania. *Public Health Nutrition, 13*(3), 360–367.
- Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*(1), 159–174.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Sage.
- Linsk, N. L., & Mason, S. (2004). Stresses on grandparents and other relatives caring for children affected by HIV/AIDS. *Health and Social Work, 29*(2), 127–136.
- Littlewood, K. A. (2014). Grandfamilies Outcome Workgroup's (GrOW) review of grandfamilies support groups: An examination of concepts, goals, outcomes, and measures. *GrandFamilies: The Contemporary Journal of Research, Practice and Policy, 1*(1), 3.
- Mall, F. (2005). The impact of HIV/AIDS on older people. *Humanitarian Exchange Magazine, 31*. Retrieved from <https://odihpn.org/wp-content/uploads/2005/09/humanitarianexchange031.pdf>
- Matovu, S. N., & Wallhagen, M. I. (2020). Perceived Caregiver Stress, Coping, and Quality of Life of Older Ugandan Grandparent-Caregivers. *Journal of Cross-Cultural Gerontology, 35*(3), 311–328.
- McCallion, P., Janicki, M. P., & Kolomer, S. R. (2004). Controlled evaluation of support groups for grandparent caregivers of children with developmental disabilities and delays. *American Journal on Mental Retardation, 109*(5), 352–361.
- McLaughlin, B., Ryder, D., & Taylor, M. F. (2017). Effectiveness of interventions for grandparent caregivers: A systematic review. *Marriage & Family Review, 53*(6), 509–531.

- Minkler, M. & Fuller-Thomson E. (1999). The health of grandparents raising grandchildren: Results of a national study. *American Journal of Public Health* 89, 1384–1389.
- Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.
- Musil, C. M., & Ahmad, M. (2002). Health of grandmothers: A comparison by caregiver status. *Journal of Aging and Health*, 14(1), 96–121.
- Nguyen, P. H., Gonzalez-Casanova, I., Nguyen, H., Pham, H., Truong, T. V., Nguyen, S. & Ramakrishnan, U. (2015). Multicausal etiology of anemia among women of reproductive age in Vietnam. *European Journal of Clinical Nutrition*, 69(1), 107-113.
- Nguyen, B., & Murimi, M. W. (2021). Lack of calcium rich foods in the diet, low knowledge on calcium level recommendations and severe food insecurity predicts low calcium intake among Vietnamese women. *Appetite*, 163, 105242.
- Nguyen, T. H., Nguyen, T. L., & Trinh, Q. H. (2004). HIV/AIDS epidemics in Vietnam: Evolution and responses. *AIDS Education and Prevention* 16, 137–154.
- Nguyen, T. H., & Vu, D. C. (2020). Impacts of the COVID-19 pandemic upon mental health: Perspectives from Vietnam. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(5), 480.
- Nyamathi, A. (1989). Comprehensive health seeking and coping paradigm. *Journal of Advanced Nursing*, 14(4), 281–290.
- Nyaradi, A., Li, J., Hickling, S., Foster, J., & Oddy, W. H. (2013). The role of nutrition in children’s neurocognitive development, from pregnancy through childhood. *Frontiers in Human Neuroscience*, 7, 97.
- Nyblade, L., Hong, K. T., Anh, N. V., Ogden, J., Jain, A., Stangl, A., & Ashburn, K. (2008). *Communities Confront HIV Stigma in Viet Nam: Participatory Interventions Reduce HIV Stigma in Two Provinces*. International Center for Research on Women.
- Orbach, D., HelpAge International (2007). *Committed to caring: Older Women and HIV & AIDS in Cambodia, Thailand and Vietnam*. Nopburee Press. Retrieved from <https://www.helpage.org/silo/files/committed-to-caring-older-women-and-hiv-aids-in-cambodia-thailand-and-vietnam.pdf>
- Poindexter, C. C. (2002). Stigma, isolation, and support for HIV-affected elder parental surrogates. In Joslin, D. (Ed.), *Invisible caregivers: Older adults raising children in the wake of HIV/AIDS*, 42–63. Columbia University Press.
- Putnam, R. D. (2000). *Bowling alone: America’s declining social capital*. Palgrave Macmillan.
- Rocha, C., Nguyen, D. H., Mendonca, M., Huynh, N. P., Do, T. B. H., Brown, M., & Yuan, Y. (2018). *Scaling up Small-Scale Food Processing for Therapeutic and Complementary Food for Children in Vietnam: Final Technical Report*. Retrieved from <https://idl-bnc-idrc.dspacedirect.org/bitstream/handle/10625/57224/57215.pdf>
- Rotheram-Borus, M. J., Flannery, D., Rice, E., & Lester, P. (2005). Families living with HIV. *AIDS Care*, 17(8), 978–987.
- Rubin, H. J., & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). Sage.
- Salter, M. L., Go, V. F., Minh, N. L., Gregowski, A., Ha, T. V., Rudolph, A. & Quan, V. M. (2010). Influence of perceived secondary stigma and family on the response to HIV infection among injection drug users in Vietnam. *AIDS Education and Prevention*, 22(6), 558–570.
- SocioCultural Research Consultants, LLC (2021). *Dedoose Version 9.0.17* [Software]. Available from www.dedoose.com
- Strozier, A. L. (2012). The effectiveness of support groups in increasing social support for kinship caregivers. *Children and Youth Services Review*, 34(5), 876–881.

- Sumo, J. N., Wilbur, J., Julion, W., Buchholz, S., & Schoeny, M. (2018). Interventions to improve grandparent caregivers' mental and physical health: An integrative review. *Western Journal of Nursing Research*, 40(8), 1236–1264.
- Taylor, M. F., Marquis, R., Coall, D. A., & Werner, J. (2018). The enjoyment rewards of fulfilling a custodial grandparenting role in the lives of grandchildren removed from their parents' care. *Child Care in Practice*, 24(1), 92–110.
- Thi, M. D. A., Brickley, D. B., Vinh, D. T. N., Colby, D. J., Sohn, A. H., Trung, N. Q., & Mandel, J. S. (2008). A qualitative study of stigma and discrimination against people living with HIV in Ho Chi Minh City, Vietnam. *AIDS and Behavior*, 12(1), 63–70.
- Tsai, A. C., Bangsberg, D. R., Emenyonu, N., Senkungu, J. K., Martin, J. N., & Weiser, S. D. (2011). The social context of food insecurity among persons living with HIV/AIDS in rural Uganda. *Social Science & Medicine*, 73(12), 1717–1724.
- Turner, S., & Nguyen, P. (2005). Young entrepreneurs, social capital and Doi Moi in Hanoi, Vietnam. *Urban Studies*, 42(10), 1693–1710.
- Weiser, S. D., Young, S. L., Cohen, C. R., Kushel, M. B., Tsai, A. C., Tien, P. C., Hatcher, A.M., Frongillo, E.A. & Bangsberg, D. R. (2011). Conceptual framework for understanding the bidirectional links between food insecurity and HIV/AIDS. *The American Journal of Clinical Nutrition*, 94(6), 1729S–1739S.
- Westermeyer, J. (1990). Working with an interpreter in psychiatric assessment and treatment. *Journal of Nervous and Mental Disease*, 178(12), 745–749.
- Whitley, D. M., Kelley, S. J., & Sipe, T. A. (2001). Grandmothers raising grandchildren: Are they at increased risk of health problems? *Health & Social Work*, 26(2), 105–114.
- World Bank (2018). *Climbing the ladder: Poverty reduction and shared prosperity in Vietnam*. Retrieved from <https://openknowledge.worldbank.org/handle/10986/29684>
- UNAIDS (2017). *UNAIDS Data 2017*. Retrieved from https://www.unaids.org/en/resources/documents/2017/2017_data_book
- UNAIDS (2018). *UNAIDS Data 2018*. Retrieved from <https://www.unaids.org/en/resources/documents/2018/unaids-data-2018>
- UNAIDS (2019). *AIDS Fact Sheet: Vietnam*. HIV/AIDS and Estimates. Retrieved from <https://www.unaids.org/en/regionscountries/countries/vietnam>
- United Nations (2019). Viet Nam's Self-help Clubs. Retrieved from: <https://www.un.org/development/desa/en/news/sustainable/sdg-good-practice-vietnam.html>
- Yunus, M. (2007). *Banker to the poor: Micro-lending and the battle against world poverty*. Public Affairs.

Appendix A Interview Guide

General Health of Grandchild:

- 1) Does your grandchild have any health issues that concern you?
- 2) When was the date of your grandchild's last health check-up?
- 3) Do you know your grandchild(ren)'s HIV status?

Circle sero-status: HIV+ HIV-unknown

- 4) What year did you get your grandchild tested for HIV?

If grandchild is HIV+, then ask the following questions:

Did you register your grandchild as an HIV case?

Is your grandchild currently taking anti-retroviral therapy medication for HIV?

Are you having any difficulty accessing HIV medication for your grandchild?

Grandparent Self-Care: Food

- 1) Can you tell me about what you eat during the course of the day? Take me through a typical day for you—breakfast, lunch, dinner, and snacks.
- 2) Tell me about a time when you faced a challenge securing food for your family.
- 3) What strategies do you use to secure food for your family?
- 4) If you could change one thing about the kind of food that you serve to your family, what would it be?

Grandchild Care: Food

- 1) Tell me about what your grandchild typically eats during the course of the day. Take me through a typical day for you—breakfast, lunch, dinner and snacks?
- 2) How does your living environment and community help you in securing food for your grandchild?
- 3) How does your environment and community create barriers to securing food for your grandchild?
- 4) What concerns do you have about your grandchild's current diet?

Closing: Is there anything else that I should know about nutrition and access to healthcare that I have not asked you about today?