CHAPTER II
BACKGROUND OF HIV SITUATION AND COUNSELLING AND TESTING SERVICE IN VIETNAM

2.1 HIV/AIDS epidemic in Vietnam

2.1.1 HIV/AIDS development

The first case of HIV infection was found in Vietnam in 1990. During 1991-1992 and in the first half of 1993 only 11 additional cases were reported. But only in the second half of 1993 more than 1100 new HIV cases were reported in provinces in the South and the South of Center Vietnam. In the four following years (1993-1997), the number of HIV cases increased slowly from 1161 cases in 1993 to 8325 cases in 1997. At the same time, there were 1488 people living with AIDS. This epidemic has developed rapidly in the period from the second half of 1997 up to now *(NASB, 8/2003).* As of December 2004, all 64 provinces in Vietnam reported 86,817 HIV positive cases, of which 13,732cases were diagnosed with AIDS including 7,915people died of AIDS. In 2004, there were 9427 new infected cases, 1279 new cases of AIDS and 715 people died of AIDS *(Ministry of Health, 2003).* According to Government estimation and projection, current HIV prevalence among adults is estimated at 0.22% and will rise to 0.27% by 2005.

2.1.2 HIV/AIDS profile by gender

So far, HIV infection has occurred mainly among male, who accounts for 85.95% of total reported infections. The rate of male living with AIDS (79%) is much higher than that rate of female (12%) *(NASB, 8/2003; UNAIDS, 2003).* Though men are still accounted for major part among the infected population, the percentage of women is increasing.

Among women, addition to commercial sex workers (CSWs), wives of mobile workers at rural areas are also identified in the risk group. It is very common that men in rural areas migrate to the cities, the new economic zones or mountainous areas to increase the income. Within this isolated male community, these men are likely to be attached with drug or/and sex workers. According to research, about 10%-20% mobile

workers often have sex with sex workers. 7%-27% of men who have sex with sex workers do not using condom frequently *(Ministry of Health, 2003)*.

After hard working time, they return the village with their saving and expect for the first child without knowing that they are infected. Many young couples are not aware about their HIV status till the wife is pregnant and is tested HIV positive *(Vietnam news - Vu Tay commune story. 2001)*. The surveillance system also shows that the HIV positive rate among pregnant women is also increased. From 1994 to 2000, the number of HIV positive pregnant women increased ten times *(Ministry of Health, 2003)*.

2.1.3 HIV/AIDS profile by age

People less than 40 years old account for about 90% of the HIV cases. Comparing to the on set time, the epidemic is becoming younger. In 1995, the group 30 - 39 years old took 45.2% of the infected cases. Since 1999, the group 20 - 29 years old is predominant. In addition, infected cases in the group of less than 20 years old is also increasing. The increase of HIV cases among the group under 20 years old is due to the increase in HIV prevalence in children under 5 years old and youth 15 - 20 years old.

In current report of Ministry of Health, the HIV cases are divided by age group of ten. This age group division may be convenient for population statistic. However, it does not reflect the situation of specific target groups such as adolescent and young adult. Thus, it is difficult for researchers and program planners to assess, plan and monitor HIV/AIDS interventions with these groups.

In 1997, there were only 7 cases, in 1998: 68 cases, in 1999: 46 cases, in 2000: 51 cases and in 2001: 40 cases. Up to now, 210 children under 5 years old got the infection from mother. Most of them were abandoned or refereed to charity-school *(MoH - HIV prevention evaluation report in 2003)*.

Table 2.1 **HIV cases classified by age group**

Year	<20 y.o	20 - 29	30 – 39	40 - 49	Over 49	Age unknown
1995	2.8	19.1	45.2	25.6	2.3	5.0
1996	3.4	22.2	41.4	26.4	2.2	4.4
1997	10.9	48.4	21.0	15.4	1.6	2.7
1998	7.0	37.8	30.3	19.7	1.7	3.5
1999	10.1	61.1	18.6	6.9	1.2	2.1
2000	9.74	50.43	24.02	12.05	1.35	2.41
2001	10.13	49.37	23.32	12.61	1.94	2.62

Source: Ministry of Health, 2003.

2.1.4 Transmission modes

65% of the HIV and AIDS reported cases are related to injecting drug use. Study with injecting drug users finds that 68% of them share equipment *(Nguyen Tran Hien, March 2001)*. However, transmission through heterosexuality is also increasing. It is indicated by the steadily increase of cases in women, pregnant women and female sex workers *(UNAIDS, 6/2001)*. Especially, there is a mix between injecting drug and heterosexual transmission. A lot of female sex workers are also drug users. Many of the drug users have sex with sex workers *(Le Truong Giang, 2002)*.

Summary about HIV/AIDS epidemic in Vietnam

- HIV/AIDS epidemic in Vietnam is still in the early stage and increases quickly. Reported number is very much lower than actual number. Current HIV/AIDS data's classification is not convenient for policy makers and program planners to develop and evaluate intervention programs for specific target groups such as youth, mobile workers and rural people, etc.

- Male still predominantly accounted for 85.95% of total reported infections but the HIV in female is increasing especially in commercial sex workers (CSW). Wives of mobile workers at rural areas are also identified in the risk group.

- Adolescents and young adults account for a major part among the HIV positive group. People less than 40 years old account for about 90% of the HIV cases.

- Main transmission routes are injecting drug and heterosexual activities. Intermixture transmission makes the epidemic more complicated. There is a mix between injecting drug and heterosexual transmission. A lot of female sex workers are also drug users. Many of the drug users have sex with sex workers *(Le Truong Giang, 2002).*

- Mother to child transmission is increasing. Up to now, 210 children under 5 years old got the infection from mother. Most of them were abandoned or refereed to charity-school *(MoH - HIV prevention evaluation report in 2003).*

- Prevention initiatives should not focus only in urban areas but also rural area where the problem is very much hidden and increasing.

- Surveillance system with specific data for adolescent and young adult age group should be agreed at all levels and between planners, implementers and researchers.

- Further study should be conducted to find out the in-depth meaning of HIV to the community in order to design effective programs.

2.2 National policies

2.2.1 General national policies on HIV/AIDS

Recognizing the danger of HIV/AIDS, the Vietnamese Government issued several ordinances, decrees and guidance to be the legal framework for HIV/AIDS activities in Vietnam (*NASB, 2001*). They are included:

- Ordinance on the prevention and control of HIV/AIDS - Social Republic of Vietnam, National Assembly, Standing Committee. Hanoi, May 31, 1995.

- Instruction on guidance of the prevention and control of AIDS: The Communist Party of Vietnam. The Central Executive Committee Ref: 52-CT/TW. Hanoi March 11, 1995.

- Government Decree: Guidance to Execute Ordinance on the Prevention and Control of HIV/AIDS - Socialist Republic of Vietnam. The Government of Vietnam Ref: 34/CP. Hanoi June 1, 1996.

- Government Decisions: Decision of the Prime Minister of the Government on the tasks, Authority and Organizational structure of the National AIDS Committee and other AIDS Committees at different Governmental levels and in different sectors *(Ref: 1122/1997/QD-TTg. Hanoi December 24, 1997)*. The Decision of the Prime Minister of the Government on the establishment of the National Committee for the AIDS prevention and for drug and prostitution control *(Ref: 61/2000/QD-TTg. Hanoi June 05, 2000)*

- Decision on Sterilization work. Ministry of Health. Ref: 657/BYT-QD. Hanoi, August 8, 1988.

- Decision on Blood transfusion. Ministry of Health. Ref: 937/BYT-QD. Hanoi September 4, 1992.

- Professional Stipulations on Dealing with HIV/AIDS. Ministry of Health. Ref: 265/BYT-QD. Hanoi, March 5, 1993.

• Ministry of Finance Circular: Guidance to Execute the Management and Budget Use for National HIV/AIDS Program. NOF Ref: 21 TC/HCSN. Hanoi April 9,1996.

Though current decrees, ordinances and guidance address different aspects of HIV/AIDS, they seem very much focus on preventive measures. There is still no specific and detail guidelines on treatment (including antiretroviral treatment and opportunistic infection treatment) and care for HIV/AIDS infected people. There is also no specific guidance to prevent transmission from mother to child in the time of pregnancy and in the time of breastfeeding. So far, there is no evaluation on the implementation and effectiveness of the current HIV/AIDS policies at central and community level.

In addition, the social evils approach makes the HIV/AIDS prevention in Vietnam more difficult. First it increases stigma and discrimination with positive people. Community seems not scared of the deadly virus but more of the social evil it associated with. Secondly, it makes HIV/AIDS workers' activities more challenging and prevents an open and flexible strategy for prostitutes and drug users. It is said in the UNAIDS document that:

> " The social evils approach presents HIV/AIDS workers with several dilemmas. Because prostitutes and drug users are unlawful citizens, efforts to reach them with education and information about HIV/AIDS is extremely difficult. Many have "gone underground" to avoid being-placed in re-education or treatment centers. Needle exchange and condom distribution have been particularly sensitive topics. It can be argued that distributing clean needles to drug users and condoms to prostitutes encourages the very type of behaviour that the Government is trying to eradicate."

Another concern with the social evils approach is that it will increase the ignorance about HIV/AIDS among the population especially among the youth. Representatives of UN organizations in Vietnam including UNAIDS, World Health Organization and UNICEF have indicated very clearly in their statement about the disadvantages of the approach and put forward the message for Vietnamese government

to move away from the social evils approach and increase the awareness of wider population about the disease *(Agence France Press, 2002).*

2.2.2 Strategies and objectives of HIV/AIDS activities

2.2.2.1 General objectives of National HIV/AIDS program:

To control the HIV prevalence rate among population to below 0.3% by 2010 with no further increase after 2010; reduce the adverse impacts of HIV/AIDS on socioeconomic development.

2.2.2.2 Specific objectives till 2010:

• 100% of units and localities across the country shall incorporate HIV/AIDS prevention and control activities as one of priority objectives in to their socioeconomic development program;

• To improve people's knowledge about HIV/AIDS transmission prevention; 100% of people living in urban area and 80% of people living in rural area shall be able to correctly understand and identify ways of preventing HIV/AIDS transmission.

• To control HIV/AIDS transmission from high risk groups to the population through implementing comprehensive harm reduction intervention measures: all people with behaviors at HIV/AIDS infection risk shall be covered by intervention measures; 100% of safe injection and condom use when having risky sexual relations.

• To ensure the provision of care and appropriate treatment for HIV/AIDS-infected people: 90% of HIV/AIDS infected adults, 100% of HIV/AIDS infected pregnant mothers, 100% of HIV/AIDS infected or affected children shall be managed and provided with appropriate treatment, care and counselling, and 70% of AIDS patients shall be treated with specific drugs.

• To perfect management, monitoring, surveillance and evaluation systems for the HIV/AIDS prevention and control program: 100% of provinces and cities shall be able to self-evaluate and self project the situation of development of HIV/AIDS infection in their

localities; 100% of HIV/AIDS tests shell be compliant with the regulations of voluntary, testing and counselling;

• To prevent HIV/AIDS transmission through medical services: ensuring 100% of blood units and blood products shall be screened for HIV before transfusion at all levels; 100% of medical establishment shall strictly follow the regulations on sterilization, disinfection for HIV/AIDS transmission prevention.

2.2.2.3 Strategies

• Ensure financial funds for HIV/AIDS activities through the mobilization from national, local and international sources. It is estimated that 60% of the budget will be from national funds, 15% from local funds and 25% from international funds.

• Increase the involvement of all organizations and bodies in the countries in the HIV/AIDS work.

• Accelerate IEC work: IEC should reach every family in Vietnam. IEC message should be design specifically for each target group taking into account their difference in characteristics and locality.

• Enhance AIDS activities among health sector

• Strengthen work of scientific research on HIV/AIDS. The focuses in HIV/AIDS research are both in basic research on HIV groups, HIV development, applying of medical treatment and vaccine in Vietnamese context and operational research.

• Expand international cooperation in HIV/AIDS prevention and control

2.3 Voluntary counselling and testing service (VCT):

2.3.1 Concept and benefits of service:

VCT is the process by which an individual undergoes counselling to enable him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.

Benefits of VCT:

Better health through earlier access to treatment/prevention of HIV-related illness.

Emotional support and better ability to cope with HIV-related anxiety

Awareness of options for prevention of mother to child transmission

Motivation to initiate or maintain safer sexual and drug-related behaviour

Reduction of stigma and discrimination against people infected HIV/AIDS

Safer blood donation

2.3.2 Models of VCT:

- *Individual pre-and post-test counselling and testing ("classic" model, most free-standing VCT sites).* Allows all people offered an HIV test to have in-depth individual discussion of personal risks of infection and explore the implications of HIV testing. Shown to be cost-effective but time-consuming when dealing with large numbers of people.

- *Group information, opt-in individual pre-test counselling, individual post-test counselling.* Widely used in high-prevalence settings, workplaces and outreach counselling. After group pre-test information/education, people can "opt in "for short pre-test counselling, followed by post-test counselling for everyone who accepts testing.

- *Group information, opt-out individual testing, individual post-test counselling for seropositives, seronegatives are informed of their negative status.* Used in low-prevalence countries during routine medical screening, e.g. antenatal clinics. Attendees can opt out. Seronegatives are informed of test result, with little/no post-test or preventive counselling. Seropositives receive post-test and ongoing counselling. This depends on availability of treatment and support for seropositive people. If inadequate services are available, seropositives may be disadvantaged following testing.

- *Group information, opt-in couple/family pre-test counselling, individual/couple/family post-test counselling.* Shown to be highly effective in promoting

sexual behaviour change to prevent HIV transmission. Overcomes problem of sharing test results, enables couples to be counselled together to avoid blame and make risk reduction plans together before testing.

- *No pre-test information, testing with an option to opt-out, individual post-test counselling for those found HIV positive.* Used for screening in some antenatal, sexually transmitted infection (STI) and drug clinics in some low-prevalence countries. In practice, very few people opt out and testing cannot be considered truly voluntary due to lack of informed consent. Of little benefit for seronegative people who are at risk from HIV infection.

2.3.3 VCT activities in Thaibinh City:

VCT service have been implementing in Thaibinh City since September, 2002 with the aims are to provide counselling and testing service to risk group like drug user, sex workers and general community who have demand for this service.

This is a cooperated project between Vietnamese Government and CDC (Centre for Disease Control and Prevention of America), so that every cost of this service was covered by CDC, customers who come to this service do not have to pay anything. At the end of the year 2005, CDC will quit to support for this service, so that, Vietnamese government has to maintain this service itself. Vietnamese Government intends to subsidize 70% of VCT cost, the other of 30% customer has to pay out of pocket.

On average, the number of customer come to service is 250 persons per month, most of them are in the age group of active sexual relation.

Table 2.2 **Distribution of customer classified by gender and age group**

Age group	Male		Female		Total	
	Number	%	Number	%	Number	%
<=13	43	4,1	34	7,0	77	5,0
14-19	35	3,3	8	1,6	43	2,8
20-29	465	44,0	213	43,8	678	43,9
30-39	354	33,5	169	34,8	523	33,9
40-49	114	10,8	43	8,8	157	10,2
>=50	47	4,4	19	3,9	67	4,3
Total	1058	68,5	486	31,5	1545	100

Source: Centre for preventive Health of Thaibinh province from July 2004 to Dec. 2004

Table 2.3 **Prevalence of HIV in customer**

		Number	Percent
Number of customer counseled		1545	
Number of customer tested		1459	(94,4)
Testing result	HIV(+)	267	18,3
	HIV(-)	1192	81,7

Source: Centre for preventive Health of Thaibinh province from July 2004 to Dec. 2004

Table 2.4 **HIV cases classified by gender in customers**

Age group	Number	Number of HIV(+)		Sig.
		Number	%	
<=13 yrs	74	6	8,1	p <0,001
14-19	41	2	4,9	
20-29	640	140	21,9	
30-39	495	104	21,0	
40-49	147	13	8,8	
>=50	62	2	3,2	
Total	1459	267	18,3	

Source: Centre for preventive Health of Thaibinh province from July 2004 to Dec. 2004

Table 2.5 **Cost per customer tested and counseled.**

Cost items	Unit	Number	Cost (VND)	Subtotal	Number of customer
Bio-products and medical equipments					
FSD	Test	196	10,250	2,009,000	
ELISA	Test	98	11,689	1,145,522	
Determine	Test	15	13,240	198,600	
Syringes	Piece	60	420	25,200	
Gloves	Pair	60	1,470	88,200	
Pipet	Piece	1	584,267	584,267	
Other			100	0	
Supervisor, counselor, administrative and guard					
Counselor	Hour/month	395	12,320	4,866,400	
Medical technician	Hour/month	395	10,780	4,258,100	
Administrative	Month	1	1,694,000	1,694,000	
Supervisor	Month	1	1,078,000	1,078,000	
House guard	Month	1	770,000	770,000	
			Total	16,717,289	250
			Unit cost		66,869.156

Source: Centre for preventive Health of Thaibinh province from July 2004 to Dec. 2004

2.4 Poverty line in Vietnam and in Thaibinh City

Basing on the experiences of the WB and research in regional countries, the Vietnamese GSO calculated the National poverty line for the 1992-1993 Vietnam Survey on Wealth and Poverty by expenditure for food and non-food basic need. Expenditure for food basic need is money to purchase a basket of food items that conforms to Vietnamese food consumption patterns and provides 2100 calories per day. Assuming that household balance their food and non-food need, household that are just at the point of meeting their food basic need are also at the point of meeting their non-food basic need. So non-food basic needs are defined as non-food expenditures of households whose food expenditure is equal to the food poverty line.

The non-food cost calculated for 2002 is simply defined by multiply the non-food cost of poverty line in 1993 with the non-food price deflator from January 1993 to January 2003. The general poverty line for 2003 is 2,915,000 VND per person per year (242.9167 VND per person per month). Thaibinh City has some difference in term of economic condition, human resource, individual income, so poverty line applied for Thaibinh City is 400,000 VND per person per month in the year 2004.