HIV AND AIDS DATA HUB FOR ASIA-PACIFIC
EVIDENCE TO ACTION

Vietnam

Country Review December 2011

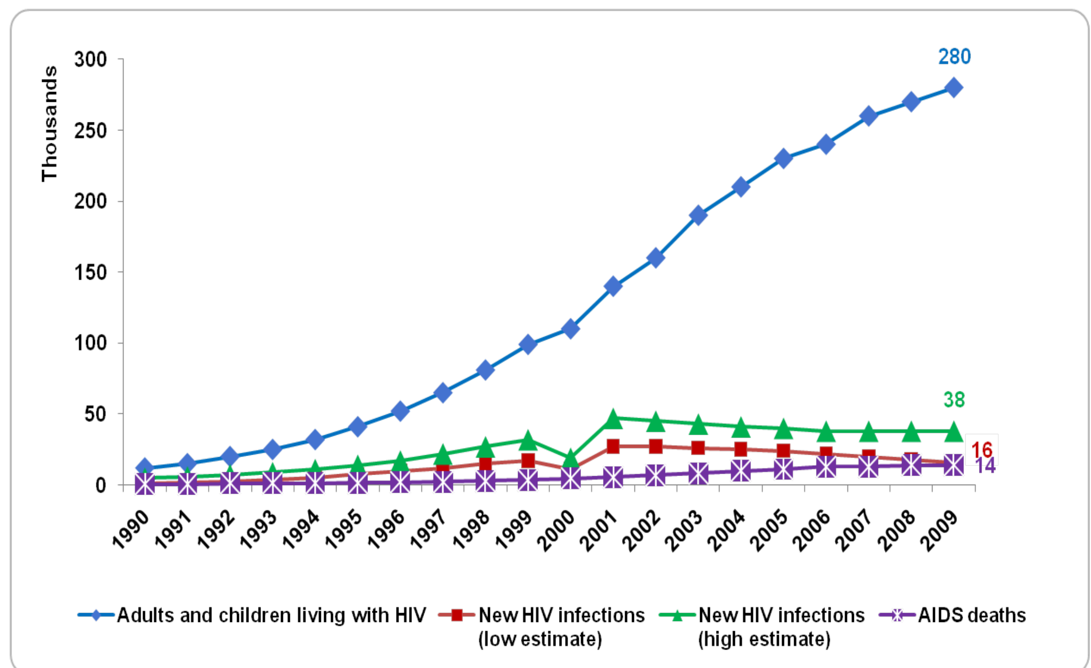
VIETNAM AT A GLANCE

Total population (in thousands)	89,029 (2010)[1]
Annual population growth rate	1.0% (2010-2015)[1]
Population aged 15-49 (thousands)	51,569 (2010)[2]
Percentage of population in urban areas	30% (2010)[3]
Crude birth rate (births per 1,000 population)	17.2 (2008)[4]
Under-5 mortality rate (per 1,000 live births)	14 (2008)[5]
Human development index (HDI) – Rank/Value	113/0.572 (2010)[6]
Life expectancy at birth (years)	74.9 (2010)[6]
Adult literacy rate	92.5% (2005-2008)[6]
Ratio of girls to boys in primary and secondary education (%)	93 (2001)[4]
GDP per capita (PPP, $US)	2,953 (2009)[1]
Per capita total health expenditure (Int.$)	183 (2007)[5]

HIV EPIDEMIOLOGY AND TRENDS

The first case of HIV infection was reported in 1990 in Ho Chi Minh City (HCMC)[7]. By 1992, only 11 cases had been reported. However, by the end of the 1990s, the HIV epidemic in Vietnam had reached the concentrated stage with prevalence above the 5% threshold among key affected populations – mainly people who inject drugs (IDUs). MOH estimates adult HIV prevalence (aged 15-49) at 0.44% in 2010.[7; 8] There were an estimated 280,000 [220,000-350,000] people living with HIV (PLHIV) in 2009, which is double the 140,000 PLHIV estimated for 2001 (Fig. 1).[9] The number of women living with HIV more than doubled from 39,000 in 2001 to 81,000 in 2009.[9]

Figure 1: Estimated number of adults and children living with HIV, new infections and AIDS deaths, 1990-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

In 2009, there were 15,713 newly reported HIV cases and 2,010 AIDS-related deaths.[8] And, as of the end of December 2009, there were a cumulative of 160,019 reported HIV cases and 44,050 deaths due to AIDS-related illnesses.[8]

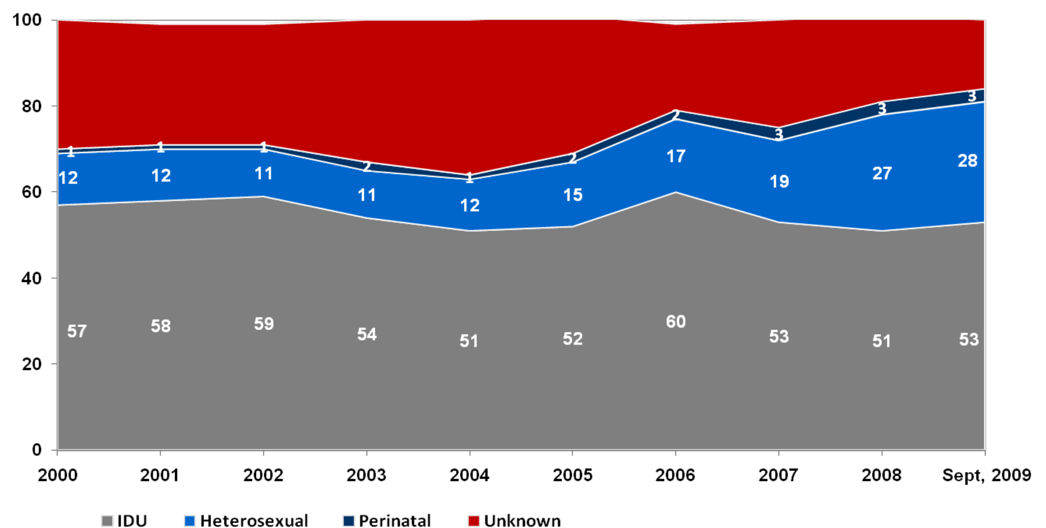
Surveillance systems[10]
Viet Nam has taken steps to improve surveillance and build national capacity in routine reporting, including revision of the National Protocol for HIV Sentinel Surveillance,

- Starting in 2001, the HIV Sentinel Surveillance system has monitored the spread of HIV among members of six groups of special interest in 40 provinces and cities[11]
- STI sentinel surveillance (annually)
- Second round of the Integrated Biological and Behavioral Surveys (IBBS) was conducted in 2009
- Survey Assessment of Vietnamese Youth (SAVY) Rounds I and II carried out in 2004 and 2009
- Population-based surveys
- National AIDS Spending Assessment
- Special progress assessments on the implementation of the National Strategy by the Ministry of Health
- Internationally supported studies and surveys

WHO IS AT RISK OF HIV IN VIETNAM?

The HIV epidemic is predominantly drug-related, with IDUs accounting for most (53%) of the recorded infections as of September 2009 – followed by 28% of cases attributed to heterosexual transmission, 3% to perinatal transmission and 16% to unknown modes of transmission (note: this data from surveillance does not include data on homosexual transmission) (Fig. 2).[8] The epidemic affects mainly those under the age of 40, with 80% of all reported cases of HIV being among those aged 20-39.[8] Seventy-three percent of cases reported in 2009 were among men.[8]

Figure 2: Percent distribution of reported HIV cases by mode of transmission, 2000 – September 2009

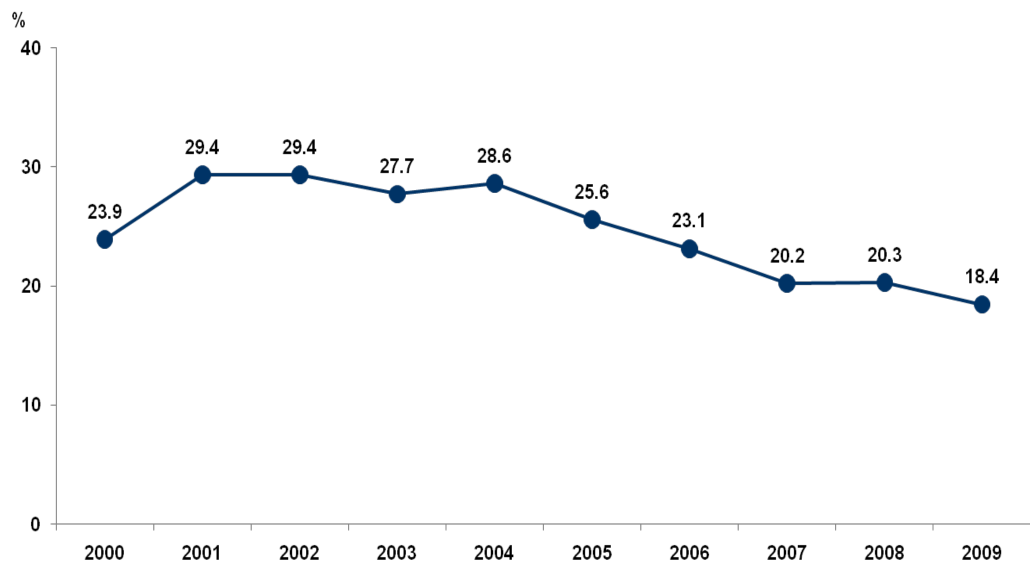


Source: Prepared by www.aidsdatahub.org based on Vietnam Administration of HIV/AIDS Control, 2010

Injecting drug users

Data from sentinel surveillance among IDUs in 40 provinces show that HIV prevalence in 2008 was 20.3% and had decreased to 18.4% in 2009. In 2009 the highest HIV prevalence among IDUs was found in Ho Chi Minh City (55.1%), Can Tho (41%), Dien Bien (43%), Thai Nguyen (34%), Gia Lai (33.3%), Binh Duong (32.4%) and Quang Ninh (29%)[8]. While IBBS conducted in 10 IDU hot-spot provinces in 2009 showed great variation from 1% (Danang) to 56% (Quang Ninh). With the community-based random sampling strategies, IBBS gives higher estimates of prevalence than does the sentinel surveillance in many places.[8] Although the national level, HIV prevalence among IDU followed the slightly declining trend since 2002 (Fig. 3)[8], the current prevalence is still considered high. Prevention efforts need to be strengthened to contain and reduce HIV transmission in this group.

Figure 3: Trend of HIV prevalence among injecting drug users, 2000 -2009



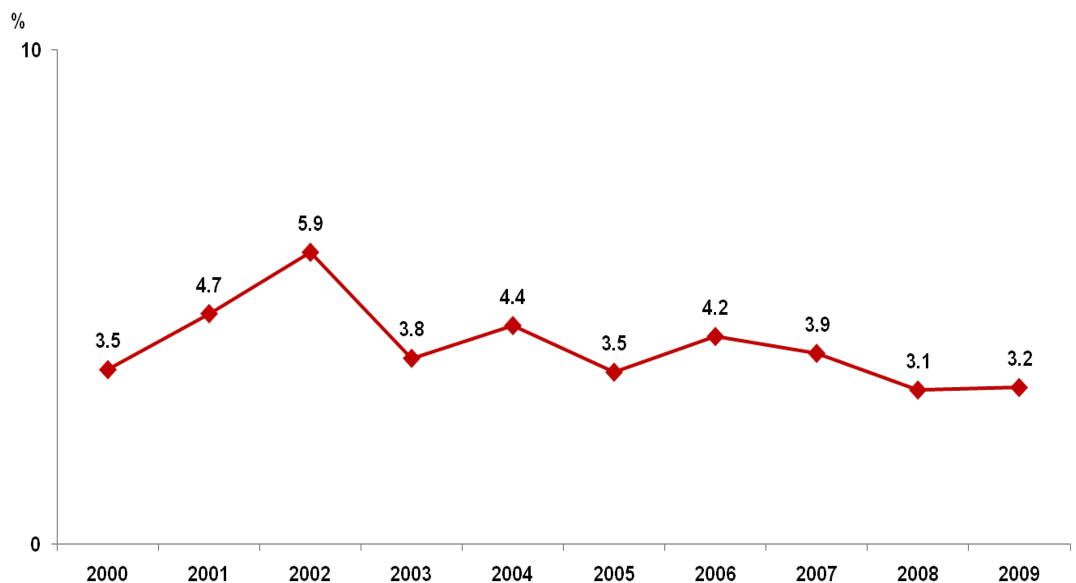
Sources: Prepared by www.aidsdatahub.org based on HIV Sentinel Surveillance, Vietnam Administration of HIV/AIDS Control; HIV Sentinel Surveillance, VAAC, 2009 cited in UNGASS 2010

According to 2007-2012 Estimates and Projections, the IDU size population is 273,579.[7] Even though the size of IDUs is relatively small compared to the total Vietnamese population, the contribution of IDUs to HIV epidemic is considerable. Moreover, the 2005-2006 IBBS found high levels of high-risk practices among IDUs. High proportions of IDUs (ranging from 13% to 37%) are clients of female sex workers (FSWs), and some FSWs also inject drugs.[12] Given that IDUs are not isolated within their injecting networks, they can transmit HIV sexually to their partners. In addition, a survey carried out among the primary sexual partners of IDUs in Hanoi in 2008 found that: 67% live in a sero-discordant or unknown HIV status relationship; only 17% reported always using a condom; HIV prevalence in this population was 14%.[13]

Female sex workers

It has been estimated that there are 87,177 FSWs in Vietnam, and 2,878,601 clients of sex workers.[7] IBBS 2009 showed HIV prevalence among FSWs in 10 provinces was 8.5% ranging from 0.33% (Danang) to 23% (among street-based sex workers in Hai Phong).[8] As mentioned earlier, the community-based random sampling strategies used in the IBBS often generate higher prevalence estimates than the sentinel surveillance. Sentinel surveillance found that HIV prevalence among FSWs in the 40 surveyed provinces was 3.2% in 2009, down from 5.9% in 2002 (Fig. 4).[8] Notably, HIV prevalence remained as high as 19% in Can Tho, 8.5% in Hai Phong, 7.7% in Thai Nguyen and 6% in Ha Noi.[8]

Figure 4: Trend of HIV prevalence among female sex workers, 2000 -2009



Sources: Prepared by www.aidsdatahub.org based on HIV Sentinel Surveillance, Vietnam Administration of HIV/AIDS Control; HIV Sentinel Surveillance, VAAC, 2009

The 2005-2006 IBBS revealed that FSWs are frequently engaged in drug use and/or injecting. For instance, Ha Noi and Can Tho are reported to have a high proportion of street-based FSWs who also are injectors – 17% in both cities, as well as 4.2% and 1% of karaoke-based FSWs in Ha Noi and Can Tho, respectively.[12]

Men who have sex with men

It has been estimated that there are 481,631 men who have sex with men (MSM) in Vietnam.[7] According to the IBBS 2009 conducted among MSM in four provinces (Ha Noi, Hai Phong, HCMC and Can Tho), HIV prevalence was 16.7% overall among this group.[8] This is an increase from the 9% reported in 2006.[12] MSM are not included in the HIV sentinel surveillance.

KNOWLEDGE, VULNERABILITY, & RISK BEHAVIOURS

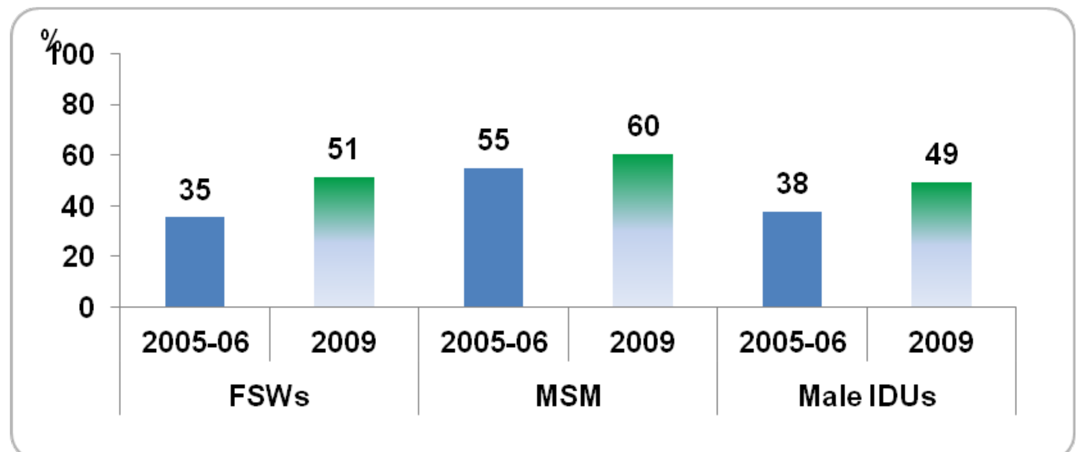
Vulnerability factors

- Commercial sex is on the rise[14]
- Key affected, notably drug users, are severely marginalized and discriminated against. These issues hinder access to interventions when individuals become fearful of being identified, arrested, or mistreated[15]
- Over 70% of all workers in the industrial parks and export processing zones in Vietnam are migrant workers[11]
- Continued low rates of condom use among young, sexually active people[11]
- HIV is spreading increasingly among the younger and economically active population[11]
- Since 2005, there has been an increase in overlap between injecting drug use and sex work[11]
- A range of sexual networking occurs among current key affected populations and the population at large.

Knowledge about HIV

The numbers of IDUs and FSWs who have comprehensive HIV knowledge (both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions) have increased from 2004 to 2005/6 and again to 2009. However, the level of HIV knowledge among MSM – which is only available as of 2005/6 – has remained stagnant, which is notable given the 3-to-4 year time period between surveys. Most recently, in 2009, 51.5% of FSWs, 49.2% of male IDUs and 60.3% of MSM had comprehensive knowledge about HIV (Fig. 5).[9]

Figure 5: Percent of key affected populations with comprehensive HIV knowledge, 2005-06 and 2009



Sources: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010 citing Vietnam, IBBS, 2005-06 and 2009

Similarly, the percentage of young people with comprehensive knowledge about HIV remained very much the same in 2009 as compared to the previous, 2005 survey results. Specifically, 42.5% of young people aged 15-24 had comprehensive knowledge in 2009 versus 46% in 2005.[16]

Stigma and Discrimination

Stigma and discrimination against people living with HIV (PLHIV):[16] Among adults aged 15-49, only 52% of women and 61% of men reported that they would buy fresh vegetables from a shopkeeper with HIV in 2005. However, 93% of women and 96% of men were reportedly willing to take care of a family member with HIV.

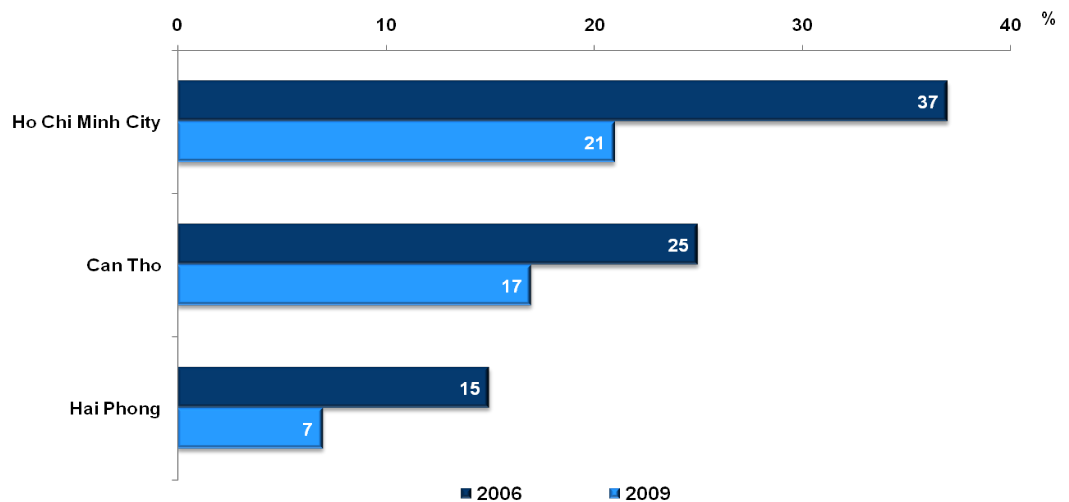
Condom Use

In 2009, 52% of IDUs reported the use of a condom the last time they had sex while (ranging widely from 26% to 94%).[8] At the same time, 67% of MSM reported using a condom the last time they had anal sex with a male partner. Condom use was higher in 2009 among FSWs, with 78% (ranging from 59% to 92%) reporting having used a condom with their most recent client.[8] Another recent (2008) survey conducted among FSWs in seven provinces found even higher levels FSWs reporting condom use at last sex – although reported figures combine responses for sex with a client and regular sexual partners: 97.8% of street-based FSWs and 96% of karaoke-based FSWs reported such usage.[8]

Sharing of injecting equipment

Preliminary results of the second round IBBS 2009 indicate 87% - 98% of male IDU reported the use of sterile injecting needles/syringes the last time they injected[8]. While the 2005-2006 IBBS showed that 89% of IDUs reported using sterile injecting equipment the last time they injected.[12] The 2005-2006 IBBS also found that the rate of sharing needles and syringes among IDUs six months prior the survey was very high, especially in HCMC, An Giang, and Da Nang among 37%, 33%, and 29.3% respectively. While 2009 IBBS data indicates the positive development fewer IDUs reported sharing needles and syringes (Fig. 6). Moreover, a large proportion of male IDUs, 52%, reported using sterile injecting equipment the last time they injected (ranging from 87%-98% across the 10 provinces surveyed).[8] Further, a 2009 survey among IDUs in two additional provinces found that 75% of IDUs in Son La and 87% in Vinh Long reported having consistently used sterile injecting needles/syringes in the last month.[8]

Figure 6: Percentage of IDUs who reported needle sharing during past 6 months, selected cities, 2006 and 2009



Sources: Prepared by www.aidsdatahub.org based on Vietnam, IBBS, 2005-06 and NIHE/ MOH, FHI, drafted IBBS round II, 2009, cited in Power Point Presentation by Le Thi Ban, Overview of Peer education, Outreach and Needle exchange in Vietnam, 2010

HOW MIGHT HIV AFFECT VIETNAM IN THE FUTURE?

Like most Asian countries, the HIV prevalence among the general population in Vietnam is probably not high enough to have a major effect on the death rate and life expectancy. Vietnam's well-established health care system in addition to the increasing economic growth of the country during recent decades have had major impacts on increasing the life expectancy and reducing the crude mortality and infant mortality rates. These improvements have occurred at a faster rate than any decreases caused by AIDS. However, the aggregate national indicators likely mask the more serious impact at the sub-national level. For example, while a change in life expectancy at national level shows a decline of 0.1 year it is twice higher in HCMC with 0.2 year.[17]

In 2004 a simulation model was developed to simulate the impact of AIDS-related expenditure and income effects on the consumption expenditure of households with PLHIV in four countries (Cambodia, India, Thailand and Vietnam).[18] It also aimed to project the aggregate impact of AIDS on poverty between 2003 and 2015. The analysis commenced by dividing the total number of households into quintiles. Using the household size by consumption quintile, the number of individuals per expenditure quintile was calculated.

The total healthcare expenditure for households with a person living with HIV was 13 times higher than the average household spending in Vietnam. HIV also added to funeral costs, non-trivial loss of employment and income by PLHIV, the burden of care falling on women, as well as loss of employment and income by caregivers. The consequence of decreased consumption expenditures put households with a PLHIV at greater risk of poverty. It is estimated that by 2015, 504,000 people will either become newly poor or fall deeper into poverty because of HIV.[18]

The simulation model also revealed that household consumption expenditures dropped between 34% and 37% among households with PLHIV who are not using antiretroviral (ARVs).[17] Households in the poorest two quintiles with PLHIV will fall deeper into poverty whether or not ARVs are used. Households in quintile 3 with PLHIV fall below the poverty line whether or not ARVs are used. Households in quintile 4 with PLHIV using ARVs will fall just below the poverty line.

NATIONAL RESPONSE

Law and policy related issues

Legal issues relating to HIV in Vietnam include the following:

- The government issued *Decree 108/2007 on implementing the HIV/AIDS law* in June 2007. It includes specific directives for implementation of harm reduction interventions at all levels for all affected groups, IDUs, FSWs, MSM, HIV-infected people, migrants and those who have sexual relationships with members of these groups.[19] Also included within the scope of the Decree are the following: the management, distribution and use of HIV drugs; the care for abandoned HIV-infected children, HIV-infected persons who have nobody to rely on or have no working capacity; and the setting up of non-public establishments for caring for HIV-infected persons; the integration of HIV/AIDS prevention and control activities into socio-economic development programs; as well as a list of occupations which require HIV testing prior to recruitment;[20]
- The *Law on HIV/AIDS Prevention and Control* provides for the care, treatment and support for HIV-infected people and conditions for the implementation of HIV/AIDS prevention and control measures;[20]
- Sex work is illegal;
- MSM is not illegal, but is not socially accepted;[21]
- Vietnam retains the death penalty for drug-related offences, and although decriminalization of the possession of injecting equipment has occurred in Vietnam, former prohibitive laws are reportedly still being enforced.[22] There is a discrepancy between the existing drug control law and the *Law on HIV/AIDS*, and police crackdowns on drug users have been widespread, resulting in fear among drug users in possession of injecting equipment.[23]

Governance

Vietnam has made significant advances in the response to HIV since the 2004 launch of the *National Strategy on HIV/AIDS Prevention and Control in Vietnam until 2010 with a vision to 2020* and the establishment of the Vietnam Administration for HIV/AIDS Control (VAAC) under the Ministry of Health (MOH). Under the National HIV Strategy and coordinated by VAAC, nine Programmes of Action were called for to provide detailed guidance for the implementation of HIV programmes. The National Strategy also calls for members of the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control to develop their own programmes of action to support the national AIDS response.[14]

Among the key responses to HIV and AIDS undertaken over the years are as follows:

- Development of policy and legislative frameworks for HIV prevention, control, treatment, care and support;
- Integration of AIDS response into development plans, especially in poverty reduction strategies at all levels;
- Strengthening of health infrastructure and human resources, which includes the establishment of Provincial AIDS Centres in 58 out of 64 provinces;
- National workshops and conferences on HIV and harm reduction to raise HIV awareness and response from various participants: government leaders, health workers, PLHIV and other partners at various levels;
- Multisectoral collaboration in leading mass support and participation in the AIDS response;
- Incorporating civil society, including self-help groups and faith-based involvement in all aspects of the response - from prevention, treatment, care and support, behavioural change communication, counselling and testing, harm reduction and, to a lesser extent, policy development processes.

HIV Prevention programmes

Data from IBBS in 2009 show the lower coverage of prevention programs among key affected populations comparing to data from previous years – FSWs 47.3% from 65.2% (World Bank and DFID, 2007); MSM 24% from 25.6% (IBBS 2005/6); Male IDUs 15.4% from 43.2% (World Bank and DFID, 2007) [8; 14]. FSWs are most readily reached by HIV prevention programmes. However, it is notable that this most recent data shows that less than 50% of each of the key affected populations is being reached with HIV prevention, despite efforts to scale-up activities. In addition to the lack of resources resulting in the inability to meet the demand of expanding prevention coverage of intervention programs, there may be methodological reasons for the measured decline, for instance, expansion of survey sites for FSW from 7 provinces in 2006 to 10 provinces in 2009. Furthermore, the 2009 IBBS followed the most recent UNGASS guidelines in terms of question format and corresponding calculations (e.g. know where to get HIV tested and received condom/needle in the past 12 months), whereas the 2006 IBBS did not.

HCMC was the first to establish a formal needle and syringe programme in 1995, but expansion of such interventions was limited directly thereafter. More recently, the number of needle and syringe programme sites per 1,000 IDUs in Vietnam was at 1.5, with an average of 124 needles/syringes being distributed per IDU per year.[24] One of only five countries worldwide to report more than 100 syringes per IDU per year (along with Bangladesh, Kazakhstan, Kyrgyzstan and Tajikistan); however, still far below the internationally recommended target that is likely to have an effect on the HIV epidemic – of 200 syringes provided per IDU per year.

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The percentage of those exposed to needle and syringe distribution in 2009 ranged widely from only 2% in Da Nang to 84% in An Giang.[8]

Opioid substitution therapy (Methadone Maintenance Therapy, or MMT) programmes were initiated in 1996, but were soon discontinued.[23] However, MMT was recently reinitiated through a National Pilot Program in HCMC and Hai Phong in 2008 and in Ha Noi in 2009; the corresponding figure for 2009 was 0.04 sites per 1,000 IDUs. The Pilot is considered to be best practice with an adherence rate of 96.5% and clients reporting positive behavior changes: only 12.5% were found to have traces of drugs in their system, only 3% were engaged in criminal activities (compared to 40% before treatment).[8]

Another significant programme coverage issue highlighted by the two rounds of IBBS is that – in 2009 – only 34.8% of FSWs, 19.1% of MSM and 17.9% of IDUs received an HIV test in the past 12 months and knew their results.[8]

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

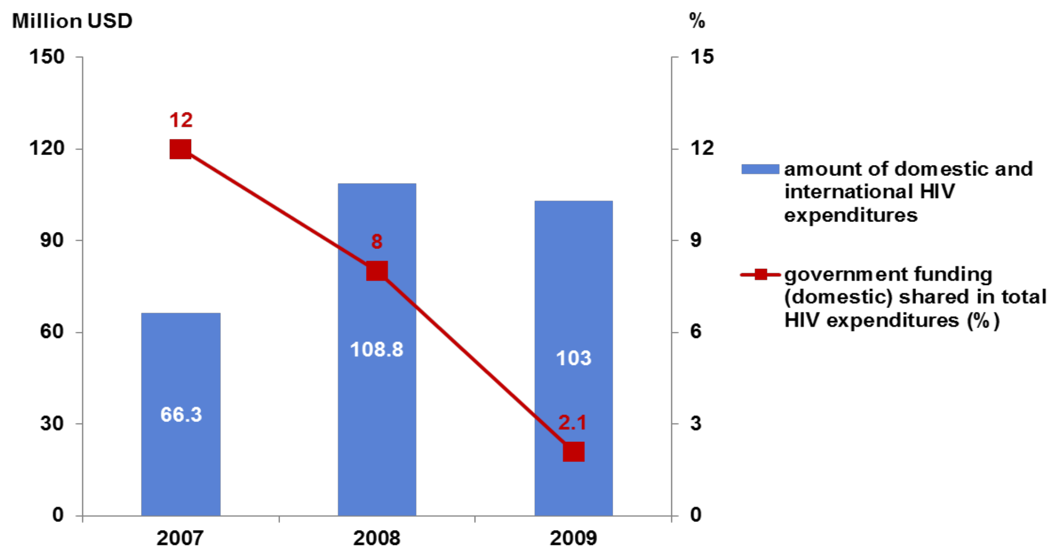
As of the end of 2009, 479 health facilities were offering ART.[24] There have been notable increases in numbers of HIV-positive adults and children who received ART, from 17% in 2006 to 45% in 2009 (based on 2006 guidelines, at 26% based on 2010 guidelines).[24] In 2009, the cumulative number of adults and children on ART were 36,008 and 1,987, respectively.[8]

HIV prevalence among pregnant women has begun decreasing and continues to be observed at low levels (0.15% in 2009).[8] As of December 2009, 32% of pregnant women were tested for HIV in the last 12 months and received their results.[24] In addition, 32.3% of HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission – which, according to UNGASS reporting, is more than twice the number reported in 2007 (13.9).[8] Also in 2009, 48% of infants born to HIV-infected mothers received ARVs for prevention of mother-to-child transmission.[24]

ECONOMICS OF AIDS

In 2009, domestic and international AIDS spending reached US$ 103 million, down slightly from US$ 108.8 million in 2008 (Fig. 7).[9] The majority of AIDS spending was financed by international sources, with total expenditures from public sources (central and local Government) at US$ 8 million in 2009.[8] The major donors are the President's Emergency Plan for AIDS Response (PEPFAR), the Global Fund to fight AIDS, TB and Malaria (GFATM); the UK Department for International Development (DFID), the Asian Development Bank (ADB) and the World Bank.

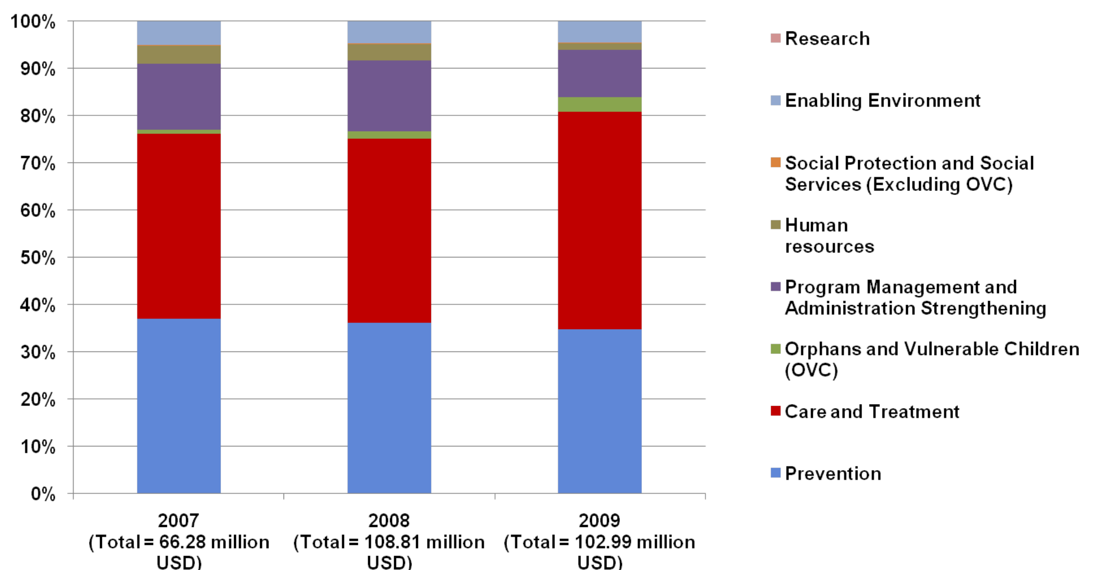
Figure 7: Amount of domestic and international HIV expenditures and % shared by government, 2007 - 2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

Similar to 2007 and 2008, most of the resources in 2009 went towards treatment and care (47%) and prevention (35%) (Fig. 8).[9] With regards to key affected populations, only 0.02% of AIDS spending was reported as being specifically targeted to each of harm reduction programs among IDUs and prevention programmes for sex workers and their clients, while none was allocated towards prevention among MSM.[8]

Figure 8: Percent distribution of total HIV expenditures by major spending category, 2007-2009



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