

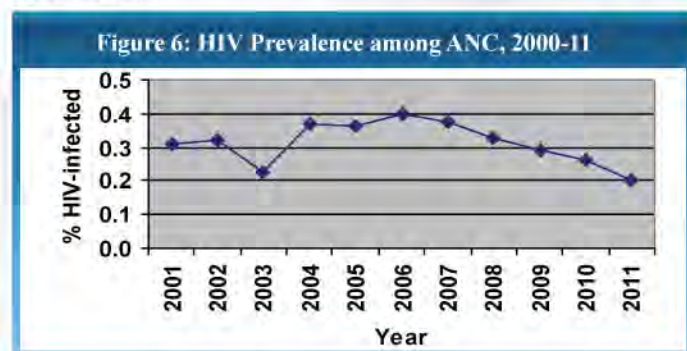
Gender ratio and epidemic state

HIV prevalence from pregnant women attending antenatal care clinics captured within the HSS suggests a steady decline of HIV in this population. The national mean prevalence is consistently below 0.4% and falling over the past decade. HSS 2011 mean prevalence was 0.2% (median=0.13%). There is no indication that a national generalized epidemic is imminent.

A rise in reported cases of HIV-positive women, who represented 31% of newly reported cases in 2011, reflects a probably slow but steady transmission of HIV to women by men engaging in highly risky behaviours.¹⁰ However, the scale-up of prevention of mother-to child-transmission (PMTCT) services and a high HIV-testing coverage of pregnant women mean that it is likely that some proportion of these newly reported cases comes from increased testing rather than increased transmission. At the same time, it should be noted that in only one sentinel site, Dien Bien, prevalence among pregnant women exceeded 1%, while the overall prevalence among pregnant women attending antenatal care is estimated at 0.2% (median=0.13%; n=30,771.)¹¹ Analyses using national HIV testing data indicate that 54% of HIV+ women reported that their only possible exposure to HIV was through a husband/long-term partner with high-risk behaviour.¹² A small on-going study in Thai Nguyen province found that nearly 70% of HIV-infected pregnant women reported that their spouse was HIV+.¹³

There are two concepts that support the idea that the increased proportion of female new infections is attributable to increases in PMTCT coverage. PMTCT began scale up in Viet Nam in 2008 when women reached 30% of the HIV cases reported. In subsequent years, the sex ratio remained steady at 2.3:1 males to female. HIV positive pregnant women make up a steady 10% of the total number of HIV case reports over the last 2-3 years. EPP/Spectrum projections, based on surveillance data not case reports, suggest that the male:female ratio will stabilize around 3:1.

The most critical strategy required to address the HIV epidemic among women is to use couples counseling to find, test and offer relevant services to those who are exposed to men at high risk for HIV infection.



Data limitations

HSS data are collected annually from 39 provinces, making these the best available for developing a national picture of the HIV epidemic.

10. HIV/AIDS Case Report and Implementation of HIV/AIDS Prevention and Control Program in 2011. Planning for 2012. Ministry of Health, February 2012.

11. HSS 2011

12. UNAIDS/UNWomen Report on Intimate Partner Transmission 2012

13. Unpublished data. WHO/Thai Nguyen PAC

However, these surveys may not capture a representative sample of the PWID, MSM and FSW populations of the country. They rely on convenience samples, and there has been uneven implementation over the years and across the country. HSS+ data have the same limits plus reporting bias in the questionnaires. IBBS data are collected with more rigorous sampling methods with their own biases but exist for 10 provinces and only for 2006 and 2009, therefore are not timely.

Case reporting is a poor measure of the state and direction of an epidemic. It relies on persons accessing HIV testing services and the services submitting an accurate case report. There is no denominator to calculate prevalence for meaningful comparisons. Case report data inform programmes of their success in identifying HIV+ persons and allow for projections of future care and treatment needs. The weaknesses of the different data sources can be overcome by considering all data together to create a more complete picture.

Recommendation

Available surveillance data strongly suggest that injecting drug use is the single biggest source of new infections in Vietnam. There is an epidemic that may grow rapidly among MSM and another slow moving epidemic among female sex workers. Regular sex partners of all the above groups are also important people to target for HIV testing, prevention, care and treatment services.

The state of the epidemic suggests that most trends are in a good direction. An effective epidemic response for Viet Nam will include evidence-supported best practices. With the expected reduction of overseas development assistance to Viet Nam, a cost-effective, sustainable response becomes more crucial. Such a response would include: expanded access to high quality needle and syringe programs, methadone, condom promotion, care and antiretroviral treatment. Expanded early testing, including point of care diagnostics, and early treatment targeting highest risk persons, like PWID, can prevent further transmission while improving the health of the treated individuals. Proven, quality-assured programs that target PWID, MSM and FSW and their regular sex partners will undoubtedly yield the highest cost-effectiveness in preventing new infections. Rigorously collected surveillance and monitoring data should be routinely used to validate current mixes of prevention, care and treatment strategies.

Key Recommendations

- Expanded access to high quality needle and syringe programs
- Methadone
- Condom promotion
- Care and antiretroviral treatment
- Expanded early testing
- Point of care diagnostics
- Early treatment targeting highest risk persons and serodiscordant couples

Note: For more information please contact Mr. Alankar Malviya, Senior Advisor Policy Strategy UNAIDS Vietnam on MalviyaA@unaids.org



THE HIV EPIDEMIC IN VIET NAM, 2012

***A SUMMARY BY AND FOR
THE UNITED NATIONS JOINT HIV TEAM***

KEY FINDINGS

1



Injecting drug users sharing needles remains the most common mode of HIV transmission in Viet Nam, and people who inject drugs are the highest priority population for HIV prevention.

2



Sexual transmission of HIV in Viet Nam is primarily among people who inject drugs and their regular sex partners, men who have sex with men, sex workers and their clients, and sex work clients and their regular sex partners.

3



HIV prevalence among pregnant women and other signals from the general population are low and show no sign of increasing.

4



Most women living with HIV report that they were infected by stable sexual partners who either inject drugs or visit sex workers.

Purpose of this document

This review of surveillance data serves as the foundation for evidence-based decision-making by the UN Joint HIV Team. The data are drawn mostly from, but not limited to, reports by or for the Viet Nam Ministry of Health.¹

Epidemic status at a glance

There were about 250,000 people living with HIV in Viet Nam at the end of 2011. Roughly 14,000 new infections have been reported annually from 2009-11. The epidemic in Viet Nam comprises many sub-epidemics across the country and remains concentrated primarily among three populations defined by high levels of HIV-transmission risk behaviours: people who inject drugs (PWID)², men who have sex with men (MSM) and female sex workers (FSW). The risk behaviours in these populations are not mutually exclusive; MSM and FSW who inject drugs have much higher HIV prevalence than those who do not inject. According to 2011 HIV sentinel surveillance (HSS) in 39 provinces, prevalence among PWID, FSW and MSM (8 provinces) averaged 13.4%, 3% and 3.5% respectively; IBBS II (2009) data among the same populations in 11 provinces ranged from 1.0% (Da Nang) to 56% (Quang Ninh) among PWID, and from 0.3% among venue-based sex workers to 23% among street sex workers. IBBS II data measured HIV prevalence among MSM in 4 cities. Prevalence ranged from 4.9% among non-male sex workers to 19.8% among male sex workers.

Epidemic characteristics and trends among people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW).

People who inject drugs

Summary: Sharing of needles and other injecting equipment is the single most important mode of transmission in Viet Nam. Even among populations with high-risk sexual behaviour, such as MSM and FSW, those who inject drugs are much more likely to be HIV-infected and skew the prevalence figures for those populations.

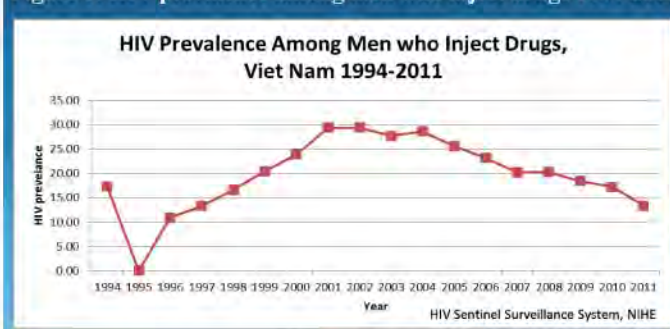
1. Recent statements express concern that the HIV epidemic in Viet Nam is becoming generalized and/or feminizing. The UNAIDS/WHO Surveillance Technical Working Group defines a generalized epidemic as ones in which HIV prevalence among pregnant women attending antenatal care (ANC) for the first time in a pregnancy is consistently greater than 1%. A concentrated epidemic has prevalence below 1% among ANC-attending women but over 5% for any one key population such as PWID. A feminizing epidemic is indicated by a male:female ratio approaching 1:1. The implication of a generalized or a feminizing epidemic is that a majority or plurality of HIV transmission is likely taking place within heterosexual couples engaging in non-transactional sex. The epidemic response for generalized epidemics differs from those in an epidemic concentrated among key populations.

2. Surveys of injectors in Viet Nam include only men. Historically, women who inject have been difficult to reach; they are few in number and less likely to socialize widely with other PWID.

PWID are found throughout the country, but an estimated 80% of the drug injecting population lives in 22 of Viet Nam's 63 provinces. Similarly, HIV is unevenly spread throughout the drug injecting community. In some provinces, such as Dien Bien in the northwest, nearly half of men who inject drugs are living with HIV. But in other provinces, the epidemic among PWID is much less severe. For example, PWID in Quang Tri in the north central coast region has the lowest measured HIV prevalence in the country at 1.7%.

Recent efforts to provide PWID with sterile injecting equipment, methadone, ART among other HIV services appear to be having an impact. According to HSS data, prevalence among PWID decreased steadily from 2004 through 2011, falling below 15% (median = 11.7%) in 2011 for the first time since 1997³. However, HIV prevalence within this population remains highest of any identifiable group.

Figure 1: HIV prevalence among men who inject drugs 1994-2011



Men who have sex with men (MSM)

Summary: HIV prevalence among MSM appears to be high in major cities. Unprotected anal sex is the main route of transmission among MSM. A small group injecting drug using MSM have very high prevalence and cannot be overlooked. In HSS+ provinces (n=5; 2011) HIV prevalence among MSM who inject drugs was 24%; among MSM who report never having injected drugs, mean prevalence was 3.8%. IBBS II (n=4 provinces) found similarly discrepant results between injecting and non-injecting. MSM-IDU made up 7.2% of the total MSM survey population, most of whom were in HCMC and Hanoi. HIV prevalence among MSM was greater than 10% in 3 of the 4 provinces surveyed (HCMC, Ha Noi and Hai Phong), and as high as 20% among MSM who had not sold sex in Ha Noi. Median prevalence among MSM was 15.7%. MSM injectors and sex workers and their sex partners should be a target population within the both PWID and MSM prevention, care and treatment programs.

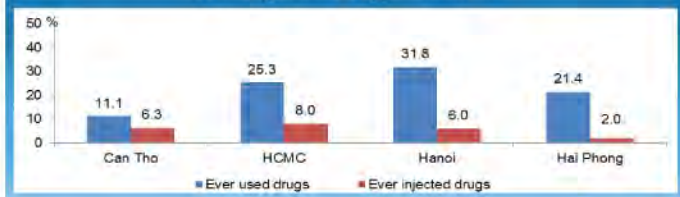
HSS data from MSM in 2011 (n=8), found a median HIV prevalence of 1.5% (range: 0.0% in Da Nang to 14% in HCMC).⁵

3. Sentinel Surveillance Survey 2011. VAAC, 2011.

4. HSS+⁴ = Sentinel survey sites with behavioral surveys added to prevalence

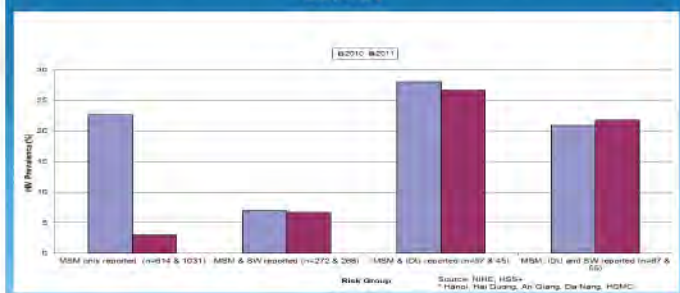
5. Sentinel Surveillance Survey 2011. VAAC, 2011

Figure 2: Proportion of MSM who ever used drugs and ever injected drugs – IBBS II



Like PWID and FSW, many MSM face both drug- and sex-related risks, both of which increase their chances of acquiring HIV. Figure 2 shows the percentage of MSM who reported drug use in 2009.

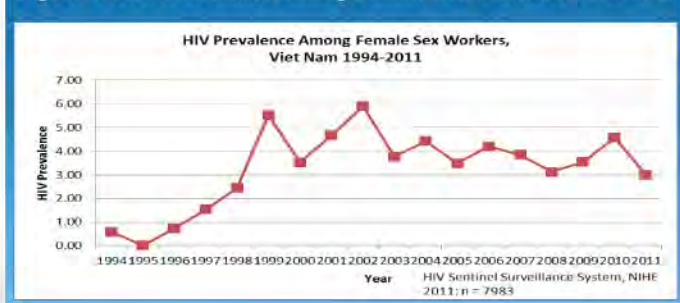
Figure 3: Multiple risk behaviours among MSM in five provinces, 2010-11



According to the HSS+, in HCMC, 48% of MSM respondents were engaged in sex work and 15.7% reported injecting drug use. This was not dissimilar from An Giang and Ha Noi, where 42% and 20.5%, and 28.1% and 9.1% sex work and injecting drug use were reported respectively.⁶ Figure 3 makes it clear that injecting drug use and unprotected anal sex are synergistic risks for HIV infection among MSM: on average, MSM who inject drugs have a higher prevalence than people who only inject drugs or only engage in anal sex.

Data remain sparse for MSM in Viet Nam. The true magnitude of the epidemic will only become clear with 1-2 more survey rounds over a greater geographic area.

Figure 4: HIV Prevalence among Female Sex Workers, 1994-2011

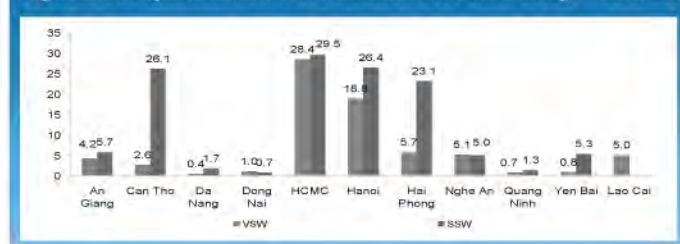


Female sex workers

Summary: HIV prevalence among female sex workers (FSWs) began declining nationally in 2002. In HSS 2011, at 3.0%, (median = 1.5%) it reached a level not seen since 1998, however some provinces remain disproportionately affected (range: 0.0% in 6 provinces to 22.5% in Ha Noi)⁷. HSS+ data indicate that this average is influenced by injecting drug use among sex workers in a few provinces. In 2010, 7.2% of FSW (n=992) interviewed reported a history of injecting drug use. HIV prevalence among these women was 25.4%⁸. In 2011, 2.7% of 2,986 FSW in 12 provinces reported a history of injecting drug use, and HIV prevalence among them was 30%.⁹

According to IBBS II, prevalence among this population is highest in Ha Noi, Hai Phong, HCMC and Can Tho. HIV prevalence among FSW who injected drugs was higher than among those who did not inject in all provinces surveyed, while figures for prevalence among injecting FSW were equal to or higher than those of men who inject drugs in the same provinces. Injecting drug use is an important risk factor for HIV transmission among FSW and should be considered in prevention mixes for FSW.

Figure 5: Proportion of FSW who have ever used drugs – IBBS II



HIV case reporting data and national estimates and projections

The number of HIV cases newly reported to the Ministry of Health decreased rapidly between 2007 and 2009 and held steady at about 14,000 reports per year in 2010 and 2011. AIDS case reports and related mortality have also remained fairly steady since 2009. These case report numbers are consistent with declining HIV prevalence among key populations at highest risk of transmission. However, HIV case reporting is a poor marker of the epidemic state for several reasons: 1) HIV testing is voluntary and requires access; only people who have access and think themselves at risk seek a test; 2) the number of individuals who test is unknown; 3) risk ascertainment is weak.

New cases, as with prevalence, are unevenly distributed throughout the country. This can be attributed to the uneven distribution of key populations in the country. It may also be the result of uneven access to HIV testing and counselling and subsequent reporting.

6. HSS+ 2010 and 2011. VAAC, 2010 and 2011.

7. Sentinel Surveillance Survey 2011. VAAC, 2011.

8. HSS+ 2010. VAAC, 2010.

9. HSS+ 2011. VAAC, 2011.