



# Millennium Development Goals Closing the Millennium Gaps

## MDG 6 – Combat HIV/AIDS, Malaria and Other Diseases

### I. Progress towards the achievement of the goal

#### HIV/AIDS

The official estimate of HIV prevalence among adult men and women aged 15-49 years old in Viet Nam was 0.28% by the end of 2002. As of 30<sup>th</sup> September 2003, a cumulative total of 72,240 people had been reported as HIV positive, 11,020 people were diagnosed with full-blown AIDS, and 6,195 AIDS patients had died. The Ministry of Health has estimated that by the end of 2002 there were 160,000 HIV infections cumulatively and projected that by the end of 2005, 197,000 people would be living with HIV in the country.

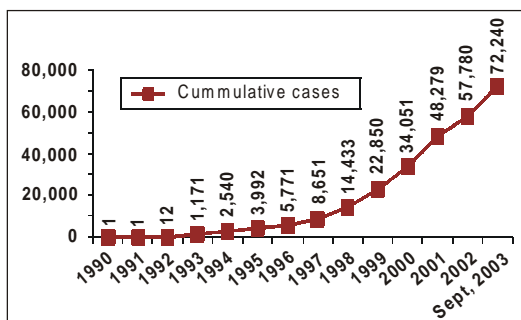
As illustrated in Chart 12 the cumulative total of reported cases of HIV is continuing to increase, and to follow a classic epidemic curve. HIV cases have been reported from all 61 provinces in Viet Nam. Under-reporting of HIV, however, is a continuing problem, as most of those infected do not refer to health services until well into the disease. The vast majority of reported cases are from urban areas, and there seem to be indications of large underreporting, and mis-diagnosis from rural areas.

It is clear that in Viet Nam HIV infection is rapidly being transmitted among Injecting Drug Users (IDUs), through sharing needles and syringe. Chart 13 shows that among of 72,240 HIV reported cases by 30<sup>th</sup> September, 2003, nearly 60% of them were IDUs. Currently, the proportion of reported HIV cases due to sexual transmission is low. However, as in other Asian countries, the number of these cases is increasing, and it is expected that sexual transmission will become the dominant mode of HIV transmission in Viet Nam in the coming years.

HIV surveillance is undertaken yearly among female Sex Workers and IDUs in "05" and "06" rehabilitation centers. Based on this surveillance system, Chart 15 shows that the HIV prevalence rate among IDUs increased from

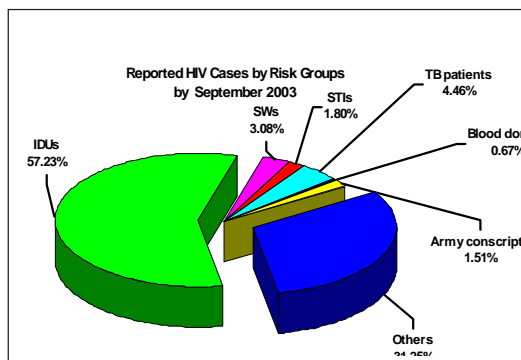
18% in 1996 to 31.31% in 2002. The trend among SWs rose from 0.6% in 1994 to 5.2% in 2002. Substantial provincial differences in prevalence rates for SWs and IDUs are observed.

Chart 12. Cumulative Reported HIV Infections



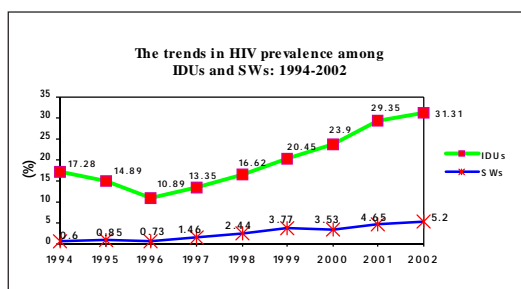
Source: Ministry of Health, October 2003

Chart 13. Reported HIV Cases



Source: Ministry of Health, October 2003

Chart 14. Trends in HIV Prevalence

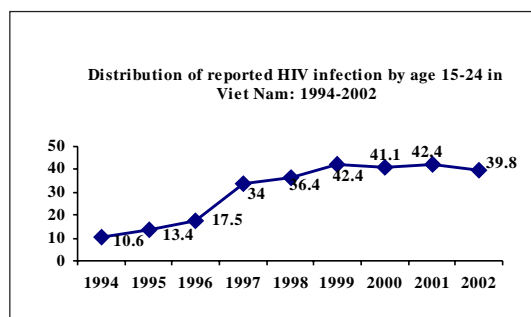


Source: Ministry of Health, October 2003

Among reported HIV cases, there is a noticeable trend towards a younger average age. Just over 10% of reported cases were among young people aged 15-24 years in 1994. Five years later, just over 40% of all newly reported HIV cases were found among this age group. Since 1999, around 40% of all reported HIV cases are among young people, highlighting the continuing vulnerability of youth to HIV.

Young people aged 15-24 makes up some 20% of total population and more than 70% of them are living in rural or suburban areas (GSO 2001). A recent survey of HIV risk behaviour was undertaken among unmarried youth aged 15-24 in five mountainous and border provinces (Lai Chau, Quang Tri, An Giang, Dong Thap and Kien Giang). This study showed that only 26.3% (24.2% of male and 32.2% of female) of them were able to answer correctly two questions related to prevention methods of sexual transmission of HIV (faithfulness, condom use) and to reject major misconceptions on HIV transmission

**Chart 15. HIV Infection among age group 15-24**



Source: Ministry of Health, October 2003

(mosquito bites, having meals with HIV infected people). Only half of young men and a third of young women (52.7% male and 33.3% female) used a condom in their last sexual intercourse with non-regular sexual partners.

Among the most worrisome trends in HIV infection is the evidence that the epidemic is also beginning to spread to the general population. Nationally, HIV prevalence among pregnant women attending antenatal clinics increased more than 10 fold in the past seven years, from 0.03% in 1995 to 0.39% in 2002. However, HIV sentinel surveillance data from five urban areas shows that the HIV prevalence rate reaches up to 1% among pregnant women attending antenatal services in An Giang and Hai Phong.

### **Tuberculosis**

WHO estimates that there are 140,000 new cases of TB in Viet Nam each year. In 1995 the Government of Viet Nam declared TB control a national priority, and since 1996 the National Tuberculosis Programme (NTP) has detected approximately 80% of the cases occurring each year. Full DOTS (Directly Observed Treatment Short Course) coverage was reached in 1998.

Between 1993 and 2000, the NTP treated 294,712 new infectious cases of TB with the WHO recommended short-course treatment regimen. The NTP achieved the second WHO target of curing 85% of new cases from the start of the program. In total 92% of cases were successfully treated.

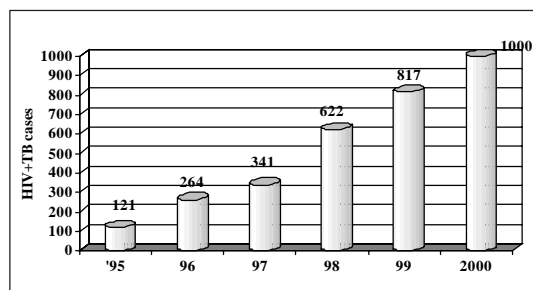
### **Box 9. Risk Behaviour Patterns**

Careful analysis of risk behaviour is critical to understand the potential risk for HIV transmission in Viet Nam. This includes understanding the behavioural links between IDUs and SWs; for example, what percentage of female sex workers also inject drugs, and what percentage of IDUs also go to sex workers. A recent HIV risk assessment survey in 7 provinces (Thanh Hoa, Nghe An, Binh Phuoc, Ha Tinh, Binh Duong, Long An and Soc Trang) found that among 2,000 sex workers including street based (SSWs) and karaoke based sex workers (KSWs), the percentage of condom use with regular clients in the last 12 months was low, 43-61% and 16-70% in KSWs and in SSWs, respectively. A high percentage of SSWs also used and injected drugs (23.8% in Nghe An). Among SSWs injecting drugs, about half to three fourths of SSWs shared needles and syringes in the last month. The percentage of IDUs who had sex with SWs in the last 12 months ranged from 18.2% in Thanh Hoa to 59.4% in Ha Tinh; while only 28.6% and 60.5% (respectively) reported consistent condom use with SWs. More than half of IDUs correctly identified three ways of preventing HIV transmission (regular use of condoms, do not share needles and syringes, and faithfulness).

Source: National Committee for Population, Family and Children (2002)

Sentinel surveillance data shows that HIV prevalence in tuberculosis (TB) patients has increased from 0.57% in 1995 to 3.03% in 2002 for the whole of Viet Nam (Chart 16). However in selected provinces the prevalence is between 5 and 15%. Though the data is biased by overrepresentation of hospitalised TB patients, there is still a clear increase in all provinces. A great challenge to TB control will be to find and treat new TB cases among HIV positive persons as early as possible. A second challenge is to provide preventive therapy with Isoniazid to HIV positive people who are infected with TB, but have not yet developed the disease. The National Tuberculosis Program (NTP) is actively seeking collaboration with the AIDS program to achieve this.

**Chart 16. HIV + TB Cases**



Source: Ministry of Health, April 2003

The increasing numbers of HIV infections, and their subsequent infection with TB, poses a major threat to the efforts of the NTP to decrease transmission of TB in the community. HIV-positive people infected with TB have a 60% lifetime risk of developing TB disease. This compares with 10% in HIV-negative individuals. Chart 16 shows that the number of reported HIV-positive TB cases has increased ten-fold since 1995.

## **Malaria**

Early efforts in the area of malaria included the Government of Viet Nam's implementation of the "malaria eradication strategy" from 1958 to 1975 in the North and the expansion of its activities to the whole country after reunification in 1975. However, during the period of 1980 to early 1990, malaria control was given low priority and hundreds of malaria outbreaks occurred. Millions of malaria cases and thousands of deaths due to malaria were recorded yearly. To reverse this situation, in 1991 the MOH included malaria control as one of the target objectives of the National Health Program.

Between 1991 and 2000, the malaria control program also developed and implemented a strategy with interventions at the district level to sustain the achievements. For example, impregnated bed nets were supplied free of cost to all target households, target areas received regular indoor spraying and anti-malaria drugs were provided free of charge. These steps helped the program reach and surpass the WHO/WPRO objectives for effective malaria control.

However, significant challenges remain for successful malaria control. A significant proportion of the country is in the malaria endemic area. This includes 75.6% of all districts, 64.7% of all communes; and 72.6% of all villages. Nearly 40% of all communes are in high and moderate malaria risk areas, with a population of about 15 million people.

People in the central highlands area are at especially high risk for malaria, which includes significant numbers of ethnic minority populations. In 2000, the malaria morbidity in the central highland region was 5 times higher than the average morbidity of the whole country. The malaria mortality was 10 times higher than the average of the whole country.

## **II. Provincial Disparities**

Bordering provinces, large urban and industrial centers and tourist areas continue to report larger rates of HIV prevalence. Whereas the 12 least affected provinces reported an average of 10 HIV cases per 100,000 people, the worse affected provinces reported an average of 200 cases per 100,000 people. Quang Ninh, with some 572 cases, Hai Phong, HCMC, and Ba ria Vung Tau ranked bottom, with the central

provinces of Quang Binh, Quang Tri, and Quang Ngai ranking as those with the lowest prevalence rates.

Southern Provinces on the Mekong, Southeast, and South Central Coast regions reported the highest rates on TB case detection. An average of 177 TB cases detected was reported by the 12 most affected provinces, with An Giang

**Table 12. Provincial Disparities in HIV/AIDS prevalence, TB, and Malaria**

Top 12 Provinces	Number of HIV case/ 100,000 people (July 03)	Bottom 12 Provinces	Number of HIV case/ 100,000 people (July 03)
Quang Binh	4.27	Thai Nguyen	91.27
Quang Tri	4.56	Dong Nai	92.24
Quang Ngai	5.21	Binh Duong	94.75
Ha Giang	9.64	Khanh Hoa	101.51
Vinh Phuc	11.00	Cao Bang	127.79
Phu Yen	11.07	Lang Son	150.62
Ha Tinh	12.67	Ha Noi	175.40
Quang Nam	12.73	An Giang	184.27
Ca Mau	12.73	Ba Ria Vung Tau	229.10
Thua Thien Hue	14.64	Ho Chi Minh City	248.05
Tuyen Quang	15.78	Hai Phong	331.96
Phu Tho	16.35	Quang Ninh	572.56

Source: UNAIDS (2003)

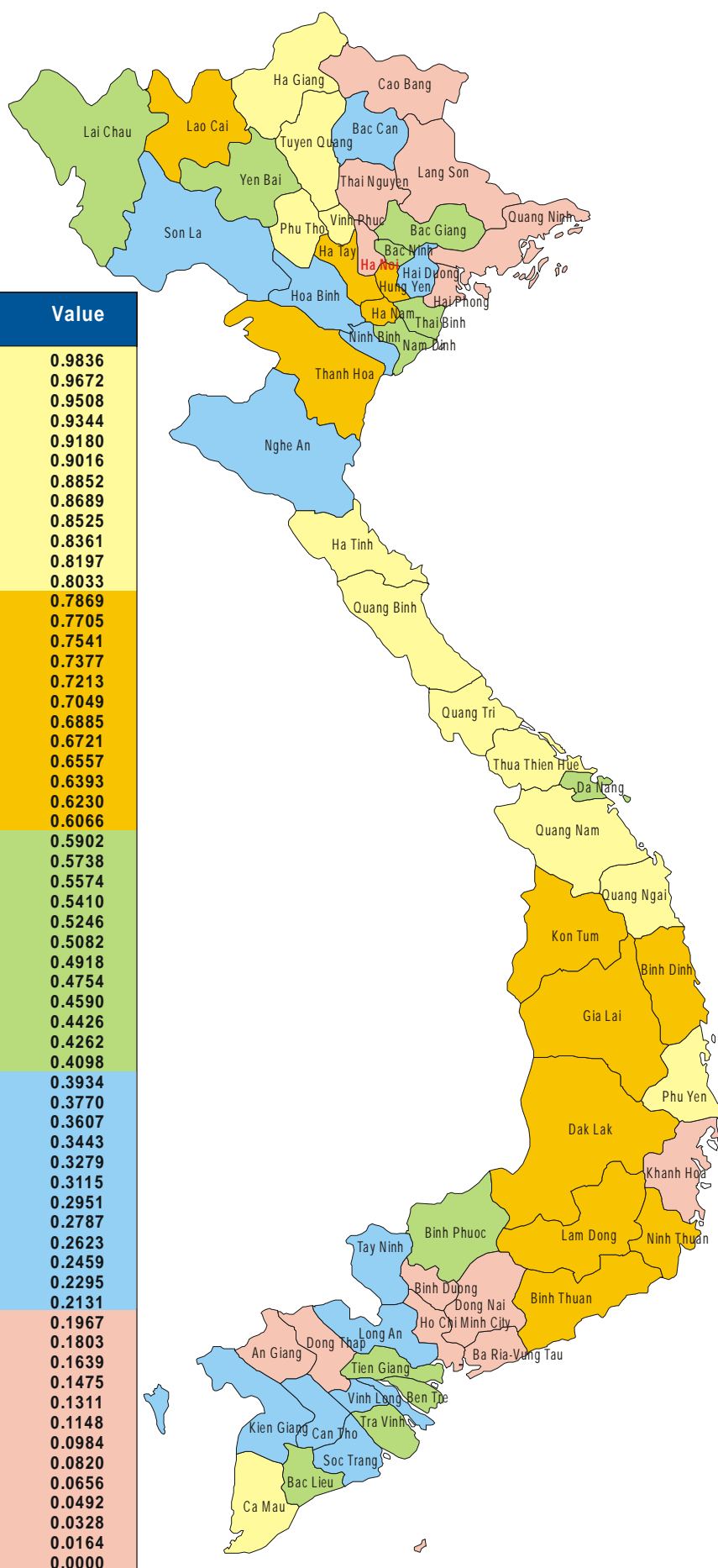
Top 12 Provinces	TB cases detected per 100,000 people (2002)	Bottom 12 Provinces	TB cases detected per 100,000 people (2002)
Bac Can	31.09	Tra Vinh	139.89
Lao Cai	32.13	Soc Trang	149.13
Son La	36.33	Binh Dinh	150.88
Ha Giang	39.20	Long An	154.08
Lam Dong	39.27	Ninh Thuan	157.94
Tuyen Quang	44.24	Can Tho	161.73
Dac Lac	45.49	Kien Giang	166.87
Lai Chau	48.17	Dong Thap	186.46
Gia Lai	51.48	Da Nang	189.92
Hoa Binh	61.33	Tay Ninh	195.69
Vinh Phuc	62.79	Ho Chi Minh City	196.70
Ha Tay	69.03	An Giang	279.83

Source: National Hospital of TB (2003)

Top 12 Provinces	Malaria morbidity per 100,000 people	Bottom 12 Provinces	Malaria morbidity per 100,000 people
An Giang	1.22	Quang Binh	670.41
Ha Noi	1.71	Lao Cai	695.28
Can Tho	2.98	Ha Giang	701.11
Ho Chi Minh City	4.71	Ca Mau	733.76
Dong Thap	7.22	Cao Bang	758.98
Long An	9.11	Quang Tri	897.01
Tien Giang	10.16	Dac Lac	955.20
Ben Tre	17.57	Binh Phuoc	1194.77
Ha Tay	18.20	Bac Can	1227.51
Thai Binh	24.30	Gia Lai	1317.58
Vinh Long	25.07	Kon Tum	1400.00
Da Nang	26.18	Lai Chau	1724.30

Source: MoH (2003)

# HIV/AIDS



Province	Value
Quang Binh	0.9836
Quang Tri	0.9672
Quang Ngai	0.9508
Ha Giang	0.9344
Vinh Phuc	0.9180
Phu Yen	0.9016
Ha Tinh	0.8852
Quang Nam	0.8689
Ca Mau	0.8525
Thua Thien Hue	0.8361
Tuyen Quang	0.8197
Phu Tho	0.8033
Lao Cai	0.7869
Binh Dinh	0.7705
Ha Tay	0.7541
Kon Tum	0.7377
Ninh Thuan	0.7213
Thanh Hoa	0.7049
Gia Lai	0.6885
Lam Dong	0.6721
Dac Lac	0.6557
Ha Nam	0.6393
Hung Yen	0.6230
Binh Thuan	0.6066
Bac Lieu	0.5902
Tien Giang	0.5738
Bac Giang	0.5574
Ben Tre	0.5410
Binh Phuoc	0.5246
Bac Ninh	0.5082
Thai Binh	0.4918
Tra Vinh	0.4754
Da Nang	0.4590
Yen Bai	0.4426
Lai Chau	0.4262
Nam Dinh	0.4098
Hoa Binh	0.3934
Vinh Long	0.3770
Ninh Binh	0.3607
Long An	0.3443
Bac Can	0.3279
Nghe An	0.3115
Kien Giang	0.2951
Soc Trang	0.2787
Tay Ninh	0.2623
Hai Duong	0.2459
Son La	0.2295
Can Tho	0.2131
Dong Thap	0.1967
Thai Nguyen	0.1803
Dong Nai	0.1639
Binh Duong	0.1475
Khanh Hoa	0.1311
Cao Bang	0.1148
Lang Son	0.0984
Ha Noi	0.0820
An Giang	0.0656
Ba Ria Vung Tau	0.0492
Ho Chi Minh City	0.0328
Hai Phong	0.0164
Quang Ninh	0.0000

**Table 13. The success of the Viet Nam Malaria Control Programme, 1991 to 2002**

Indicators	1991	2002	Reduction (%)1991 - 2002
<b>Malaria cases</b>	1,091,251	185,500	83
<b>Morbidity/1.000 people</b>	16.5	2.8	83
<b>Malaria deaths</b>	4,646	50	98
<b>Mortality/100.000 people</b>	7.3	0.078	98
<b>Outbreaks</b>	144	0	100
<b>Malaria endemic communes in 31 provinces</b>	2.167	709	67

Source: National Program on Malaria Control, National Institute of Malariology, Parasitology, and Entomology Annual Reviews

(280), HCMC, and Tay Ninh ranking last. This compares with an average of 46 cases of TB detected among the 12 better-off provinces, where the Northern Uplands provinces ranked among the least affected.

### III. Policy Framework and Challenges at the Local Level

#### **HIV/AIDS**

The HIV/AIDS epidemic in Viet Nam is spreading rapidly. Forty to 120 Vietnamese are getting infected every day. The epidemic is evolving into dual and overlapping epidemics, with transmission through both injecting drug use and unprotected sex. This complex epidemic requires a comprehensive policy and programme response.

The government is increasingly recognizing the need to address HIV/AIDS. A directive issued by the Prime Minister in February 2003 emphasized the need for a comprehensive and multisectoral approach to HIV/AIDS. A HIV/AIDS National Strategy for 2004-2010, with a vision to 2020 is being finalized. And the Community of Concerned Partners was formed in 2002 as a coalition of stakeholders in Viet Nam concerned with the growing threat HIV/AIDS poses to the people of Viet Nam and to the nation's development, and the achievement of the Millennium Development Goals.

This expanding epidemic needs an extraordinary response from the leadership and people of Viet Nam. To be effective, this response must involve all sectors of the county, and be undertaken at all levels. The first priority is to engage the Party, National Assembly and the Government in leading and promoting the national response to the epidemic.

Interventions with drug users, sex workers and their male clients must be undertaken on a large scale, if the number of HIV infections is to be reduced. HIV/AIDS is largely an epidemic among young people, and they need to be provided with the information, skills and to

services to protect themselves from infection. There is also a need to strengthen the involvement of communities in HIV prevention, care and support, including care for orphaned and vulnerable children. Urgent action is needed to prevent stigma and discrimination against people living with HIV/AIDS, and to promote their involvement in HIV/AIDS activities.

#### **Tuberculosis**

The NTP has made considerable achievements over the past decade, but efforts must be taken to maintain and institutionalize TB control in Viet Nam. In particular, The Ministry of Health, with the support of the National Tuberculosis Programme should develop the next medium term development plan for the period 2006-2010, including a strategy for resource mobilization. There is a need to ensure long term and adequate financing of the NTP activities. Expected costs over the next five years amount to US \$ 35 million, including US\$ 9 million for drugs.

In the technical area, there is a need to discuss and agree on the introduction of new national treatment guidelines which should include FDC regimens for community DOT. Importantly, the existing good drug management practices of the NTP should be continued, including batch testing of drugs from international and domestic suppliers. There is also a need for improved training and monitoring of treatment provided by the private sector. Regulations should be established prohibiting the sale of 1st and 2nd line drugs in the private sector, to limit the development of resistance to these crucial drugs.

At the district and provincial level, TB control activities should be integrated into a larger programme for the control of communicable diseases, developed under the leadership of the Ministry of Health. A coordination mechanism should be established to bring together all stakeholders, and to ensure linkages between programmes (e.g. TB and HIV).

### **Malaria**

Important challenges remain in malaria control in Viet Nam, including the risk of malaria resurgence. Due to internal migration, larger numbers of people are moving into malaria endemic areas, potentially exposing more people to malaria. Migrants may take the disease back to their communities as imported cases, causing transmission and outbreaks. Annually, thousands of people migrate to the central highlands and southern provinces for employment. Reports indicate that migration to the highly malaria endemic areas included 880,000 people in 2000 and 2.2 million migrant people in 2001.

Climatic change and man-made actions are expanding malaria endemic areas. Climatic and environmental changes such as drought, floods or man-made actions such as expanding the brackish water shrimp cultivation areas, construction of hydro-electronic plants, irrigation projects, road building in the malaria areas and forestation etc. are the main causes of malaria increase and malaria outbreaks where good surveillance and appropriate control measures are lacking.

People's self protection against malaria in the highly endemic and remote areas is limited: A high proportion of population (20-40% of malaria patients in the malaria endemic areas, especially in the southern provinces) buy anti-malarial drugs from the private sector for self treatment. According to a survey in Tra Mi of Quang Nam province (8/2001) only 16% of the population used bed nets regularly, the rate of

born bed nets was 73.9%. In Huong Hoa, Quang Tri province, only 30% of the people used bed nets regularly.

There is a need to strengthen the village and commune health network in malaria control, particularly in mountainous and remote areas. At present, some 62% of Village Health Workers are operative, with only 38.68% trained in malaria control. The mobile team in the mountainous district is lacking of personnel, means of transportation, and budget for surveillance and supervision activities. Some provinces in malaria highly endemic areas still lack provincial malaria control centers, and needed personnel, equipment and working facilities.

There is a lack of stable funding for malaria control. The budget from government and provinces for malaria control has been reduced in the last few years despite the expanding threat of malaria, and on occasion, available monies provided by the national malaria control programme are used for other activities. The serious risk of malaria resurgence is still not yet fully understood or accepted by some local authorities

Policy priorities in this sector would include maintaining sufficient resources for malaria control, for which continued international cooperation would be required. Viet Nam needs to improve malaria epidemiological surveillance, case management, and interventions for migrant populations, in particular by establishing commune microscopic points.

The successful model of civilian-military cooperation to improve the effectiveness of malaria control in remote and border areas needs to be strengthened, while the intensification of Information and Education Communication activities with special attention to high risk groups are required. Improve contents and training methodology at all levels, particularly for VHWs and private sector activities in malaria control.

### **Box 10. HIV prevention among Injecting Drugs Users**

Sharing needles is a very common practice among the Vietnamese injecting drug users, and remains the major cause of HIV transmission in the country. In response to the fast increase in HIV/AIDS cases observed in the northern provinces of the country, the United Nations International Drug Control Programme (UNODC) in Viet Nam launched in 1997 an innovative initiative to improve HIV prevention and reduce drug-related harm among high-risk target groups.

As the first initiative of its kind ever executed in Viet Nam, the project aroused much controversy, as many people consider harm reduction lenient and condoning of social evils, running counter to the conventional suppressive measures.

After intense negotiations, the Government of Viet Nam agreed to implement a series of then daring initiatives in 11 wards of five northern cities and provinces, including Ha Noi, Hai Phong, Lang Son, Thai Nguyen, and Nghe An. Project implementation met with considerable difficulties. Some peer educators were arrested while distributing disposable syringes and condoms in the streets and the paraphernalia that they carried around were used as obvious evidence for their 'social evil' activities.

An outstanding feature of the initiative was the adoption of a 'community-based' approach to applying the harm reduction model and providing a comprehensive package of intervention measures. Peer education was the major intervention activity carried out at the ward level, with the direct supervision and participation of the community leaders. Training was provided to the peer educators with particular focus on life skills in order to achieve behavior change among drug-injecting users. In addition, a network of volunteer drug users was also created through the peer educator groups. The sustainability of the approach is demonstrated by the fact that more than 50 per cent of the peer educators trained in the project are still working actively with the national and international NGOs after the project is finished.

Empirical lessons learned in Viet Nam have shown that harm reduction can hardly succeed in the absence of support from local authorities and law enforcement. Policy advocacy workshops to create awareness among the law enforcement officers who would facilitate prevention activities in the community were indispensable.

Families of drug users and of HIV positive drug users were also encouraged to take care of their children. At least within the project setting, drug users were no longer stigmatized and discriminated against, and opportunities were given to drug users, also those with HIV/AIDS, to play a positive role in the community.

*UNODC (2003) Strengthening National Capacity for Prevention of Drug Abuse and HIV/AIDS Among High-Risk Target Groups in Viet Nam (AD/VIE/97/B07)*