THE PRICE OF SUCCESS: RENEWED CHALLENGES REGARDING HIV/AIDS IN VIET NAM

The situation of contemporary Viet Nam raises a paradox. On one hand this country with strong economic growth has enjoyed noticeable improvements in its social and economic conditions, which allowed it to become a middle income country in 2010. On the other hand, because of this success, it is gradually deprived of the powerful international support it has enjoyed during the last decades. This compels the government to undertake measures necessary to ensure the sustainability of its social model. This constraint is especially true in the health sector. The fight against HIV/AIDS will reach a milestone at the end of this year when the main international programs will have come to an end. At this date, the main supports from the Global Fund, the Asian Development Bank and the United States Emergency Plan of Aid for AIDS (PEPFAR) will have withdrawn. Consequently, the Ministry of health has recently appealed to all national resources that could be mobilized. It fears that there would be a resurgence of the epidemic (Bộ Y tế [Ministry of health], 2017). How can social science address these issues? To illustrate the approach adopted in the field of population studies, I will present research works that I have coordinated and before that, provide a quick overview of their socio-demographic and cultural context.

1- From a moral conviction to a more participatory approach

The fight against HIV/AIDS in Viet Nam has experienced rapid changes in a context of low prevalence. Care and support gradually developed for people living with HIV/AIDS.

The first case of the epidemic occurred in 1990. HIV prevalence subsequently increased until the early 2000s. After a period of deceleration, the epidemic is now regarded as stabilized. It is mainly concentrated in specific populations such as injecting drug users, men who have sex with men and commercial sex workers (Bộ Y tế [Department of]) Health], 2017). In 2016, an estimated 250,000 people were living with HIV, which represents 0.4% of the population aged 15-49 years (UNAIDS 2015).

The commitment of the Government in the fight against HIV/AIDS has long been considered to be low (Independent Commission on AIDS in Asia 2008). In the early 2000s, people living with HIV were still highly dependent on their families for their treatment. Most of them were suffering from rapid deterioration of their health and disabling condition. These difficulties added to the hardship of their confrontation to discriminatory behavior (McNally 2002). Until 2003, the 'Social evils' policy has addressed HIV positive diagnosis together with prostitution, drug abuse and gambling addiction, which were banned and repressed (Vijeyarasa 2010). It has bound all these issues in a moralizing discourse, as evidenced by billboards in the public areas (Parker 2007) (Figure 1).

At the end of 2002, the first therapeutic and free antiretroviral program has been set up in several hospitals. This pilot initiative was led by the French Alliance for Global Health Partnership (ESTHER). It helped organize the selection of the candidates for treatment. One aim was to ensure medication compliance, i.e. strict taking of drugs and regular medical tests. One key issue was the positive attitude of HIV patients with respect to their treatment. This compliance and this adherence to treatment were essential to prevent the development of resistant strains of the virus.

Figure 1 - Poster showing discourse on HIV/AIDS within the social evils policy campaign

« Decided to eliminate the harmful culture and social evils » (Sam Son, 2005)

From the middle of the 2000s, new know-how and standards have been adopted (Hirsch et al. 2015) (Montoya 2010). The 2006 law on HIV/AIDS allowed people living with HIV to access health insurance (National Assembly 2006). Medical consultations have evolved towards more individualized care. Medical training designed in collaboration with international assistance has encouraged greater interaction and direct contacts between patients and caregivers. Advisers have been dedicated in health infrastructure to helping people living with HIV and their families. The availability of free anonymous HIV testing has increased (Loenzien 2016). Associations of people living with HIV/AIDS have developed and their participation has gradually been admitted in hospital services. This new approach has been marked by an attitude of empathy for people living with HIV (Pham et al. 2010) (Figure 2).

Figure 2 - Poster showing participative approach of HIV/AIDS prevention and control programs after the abandonment of the social evils policy

“HIV torments you ? To whom could you confide ? Come to the community healthcare counselling center. Do not worry, there’s only you and me. When we give advice we are specialists. when we talk, we are confidants » (Haiphong 2005)

Furthermore, harms reduction programs regarding injected drug use have been implemented including substitution therapy services in 2008 in Haiphong province, and subsequently in several provinces in 2009, including Hanoi (Socialist Republic of Viet Nam 2010) (Des Jarlais et al 2016). In 2017, an estimated 124 000 people living with HIV received antiretroviral treatment (Bộ Y tế [Ministry of health], 2017). However, the gradual decline of funding from multilateral and bilateral aid led to increasing concern regarding the sustainability of HIV/AIDS care and support (Linh, Huong, and Thuy 2015) (Pallas et al. 2015).

2 - From the hospital to the family: the various facets of the epidemic

The research studies I participated to dealt with the way HIV/AIDS prevention and control was held in the hospital as well as within households and families.

The first research program aimed at specifying the conditions of psychosocial support for people living with HIV within the hospital. It took place from 2003 to 2006 in Hanoi and Haiphong provinces (Figure 3). An important interest of our topic lied in exploring the continuity of care. This concept concerns the whole care and treatment process from HIV test to the treatment of opportunistic infections, from prevention to palliative care, which access was still restricted at this time. This continuity involved several actors including the health infrastructure, the families of people living with HIV/AIDS and groups providing support to people living with HIV/AIDS and their relatives (Loenzien 2014b).

Figure 3 - Hospital-based study in Haiphong Province

The results show that access to antiretroviral drugs has greatly improved the living conditions of patients and has been accompanied by profound social changes. Health infrastructures that were already undergoing structural changes gradually adapted to HIV/AIDS programs. ESTHER initiative has been relayed by the implementation of huge international programs promoting antiretroviral drugs access, allowing for a full development of the pilot experience. The family appeared very present in care and treatment. We therefore conducted a community based study from 2005 to 2010 (Loenzien 2014). It consisted in a case-control study in order to compare households with people living with HIV and households without people living with HIV (figure 4).

Figure 4- Community-based study in de Quang Ninh province

This study took place in the North of the country. The high prevalence of HIV in Quang Ninh province was partly explained by the cross-border flow of drugs, the many mining activities leading to the concentration of young males migrating alone, the correlated circulation of commercial sex workers and sex tourism from China. The sociodemographic and epidemiological situation was mixed. On the one hand Ha Long city was characterized by a high level of HIV prevalence, availability of modern health infrastructures and active associations of people living with HIV AIDS. On the other hand the rural district of Dong Trieu had a relatively low prevalence and no visible HIV/AIDS support groups. The contrast between the idyllic vision of Ha Long Bay and the living conditions of the population was striking (Figure 5).

Figure 5 - Fishermen and traders off the coast of Ha Long city

Our study has drawn the socio-demographic profile and family situation of people living with HIV/AIDS. Due to late testing, an important part of them were young single men while caregivers were mostly women, especially their mothers, sisters and for some of them their wives. The strong social norm of assistance within the family group was strained as soon as HIV status was suspected. We have been able to show that HIV/AIDS led to a weakening of the marriage bond regarding healthcare support. The family appeared as playing a central role but also as carrying much ambivalence (Loenzien 2009). Members of the family were trying to facilitate links between the patient, health infrastructure and support groups in order to ease care and treatment. But they were also contributing to limit and control these contacts in order to obey the dictates of prevention and preservation of secrecy of HIV status in a context of strong stigma and discrimination behaviors. The preferential treatment for the HIV-positive person in the family contributed to isolate this person and deprive him or her of social contacts. Families were struggling to maintain their cohesion and their integration in a community marked by limited resources and fear of transmission (Loenzien 2014).

Conclusion

HIV/AIDS epidemic is a complex phenomenon. Its study mobilizes knowledge in biomedical but also social sciences. The way we approached it illustrates some aspects of the deep transformations experienced by Viet Nam over the past decades. It highlights the evolving social norm of mutual assistance and solidarity, the relevance of taking into account gender relations and the role family as a regulator. Family has been gradually relayed by HIV/AIDS support groups that have increased rapidly with the implementation of care and treatment programs. The Government's goal is now to reach less than 0.3% HIV prevalence and follow the worldwide program 90-90-90 for 2020: 90% of HIV positive cases detected, 90% of people with positive result receiving antiretroviral treatment, 90% people receiving treatment with an undetectable viral charge (Bộ Y tế [Ministry of health],) 2017. This is an objective to which social and human sciences could contribute.

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