HIV TRANSMISSION IN VIETNAM-LAOS BORDER AREAS: CURRENT STATUS AND SOLUTIONS

Joint-Study Report

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Asian Development Bank
Greater Mekong Sub-region
Communicable Diseases Control Project

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HIV transmission in Vietnam-Laos border areas: current status and solutions

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## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretrovirus</td>
</tr>
<tr>
<td>CHAS</td>
<td>Center for HIV/AIDS/STIs</td>
</tr>
<tr>
<td>C&amp;T</td>
<td>Care and treatment</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Deficiency Virus</td>
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<tr>
<td>HSPI</td>
<td>Health Strategy and Policy Institute</td>
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<tr>
<td>IDU</td>
<td>Injection drug use</td>
</tr>
<tr>
<td>IEC</td>
<td>Information education and communication</td>
</tr>
<tr>
<td>LDD</td>
<td>Long distance drivers</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>PC</td>
<td>People’s Committee</td>
</tr>
<tr>
<td>PDR</td>
<td>People’s Democratic Republic</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually transmitted diseases</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint program on HIV/AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
ACKNOWLEDGEMENTS

This study - *HIV transmission in Vietnam-Lao PDR border areas - Current status and solutions* - was conducted by the Vietnam Ministry of Health’s Health Policy and Strategy Institute (HSPI) and the Lao PDR Department for Hygiene and Prevention’s Center for HIV/AIDS/STIs (CHAS). The study was funded by the Pooled Fund from the Regional Coordination Unit of the Asian Development Bank (ADB) - Greater Mekong Subregion Regional Communicable Diseases Control Project (GMS CDC Project). It was carried out from March to October 2009 and conducted at three international entrance gates in six contiguous border provinces located in the Northern, Central and Southern areas of the Vietnam-Lao PDR border.

We would like to gratefully acknowledge the continued support from the study’s technical advisor - Chu Quoc An, MD, MS who is the Deputy Director of the Vietnam Administration for AIDS Prevention and Control, Ministry of Health of Lao PDR and strong collaboration from all authorities, health agencies and organizations in the six provinces that were involved in this study.

We would also like to thank Dr. Le Duc Tho, programme officer, and all staff of the Regional Coordination Unit for their effective support during the study.

**Research team**

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<thead>
<tr>
<th>From HSPI-MoH</th>
<th>From CHAS-MoH Lao PDR</th>
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<tbody>
<tr>
<td>Vu Thi Minh Hanh, team leader, principle investigator</td>
<td>Chansy Phimphachanh, co-principle investigator</td>
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<tr>
<td>Hoang Thi My Hanh, coordinator</td>
<td>Kutmala Banchongphanith</td>
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<td>Phan Hong Van</td>
<td>Sisavath Manivong</td>
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<td>Hoang Ly Na</td>
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The HSPI developed a proposal for a joint-study of “HIV transmission in Vietnam-Lao PDR border areas: Current status and solutions” in collaboration with the Center for HIV/AIDS/STIs of the Department of Hygiene and Prevention, Ministry of Health of Lao PDR. The study aims to provide evidences for the effective implementation of the Socialist Republic of Vietnam Prime Minister’s Decision 38/QĐ-TTg dated January 8, 2008 on “collaboration and cooperation in preventing cross border HIV transmission”. The study, with funding support provided by the Asian Development Bank (ADB), Regional Pooled Fund of the Greater Mekong Sub-Region Communicable Diseases Control Project (GMS CDC Project), was conducted in six provinces located in the three pairs of international border entry points along the Vietnam-Lao PDR border, which include the paired border gates of Bo Y and Phu Cua of Kon Tum province (Vietnam) and Attapeu (Lao PDR) respectively, Cau Treo and Nam Phao of Ha Tinh (Vietnam) and Borikhamxay (Lao), and Tay Trang and Panghok of Dien Bien (Vietnam) and Phongsaly (Lao).

Objectives: The study has three main objectives:

1. Assess the risks for cross border HIV transmission among high risk populations;
2. Based on the findings, make recommendations for behavioral change interventions and improving accessibility to HIV/AIDS prevention, care and treatment in an effort to reduce cross-border transmission of HIV; and
3. Strengthen capacity of and establish long-term collaborative relationships among the participating organizations and individuals in conducting joint research from different countries.

Methods: This is a cross-sectional study. Methods used include secondary data analysis, direct observation of “hot spots” of sex work and injection drug use, and key informant interviews (N=409: 90 with administrative and managerial staff, 237 with high risk individuals, and 82 with other relevant persons).

Conclusions:

- This is the first joint-study to assess the risks for cross border HIV transmission and was conducted through collaboration between the investigation teams of the two countries, using the same methods and on the same target study populations.
- In recent years there have been significant changes in the level of social and economic growth as well as the transactions in the border areas of the two countries.
These changes have attracted lots of mobile population groups, especially women, to these areas.

- Entertainment facilities have quickly mushroomed along the borders between the two countries, which have become hot spots for social crime activities such as FSW and IDU.

- Female sex workers (FSW) that work in the Vietnam-Lao PDR border areas were older, had longer sex work duration and prior experience in selling sex in other regions. This increases the potential risks for transmission of HIV and other STDs.

- Vietnamese FSW in the border areas had the highest risks of HIV, followed by long distance drivers and construction workers.

- Residents along the border areas were also at high risk from infection and transmission of HIV.

- Mobile populations in the border areas had limited access to HIV/AIDS prevention services, which could explain why they also had limited knowledge and attitudes toward HIV prevention approaches.

- While FSW in the border areas, especially Vietnamese and street-based FSWs who worked in Lao PDR, had very high risks of HIV infections, their accessibility to HIV/AIDS and STD prevention, care and treatment services was very limited.

- Mobile populations in the border areas had limited access to HIV care and ARV treatment services due to lack of affordability as well as limited access to information about the existing services, and community stigma.

- Due to constrained resources for HIV/AIDS prevention activities in the border areas, HIV prevention interventions have been implemented at a very small scale in some localities and target specific groups.

- There has not yet been any joint program or collaboration between the two countries in implementing HIV/AIDS prevention, care and treatment programs.

**Recommendations:**

- Establish a partnership to conduct future operational studies

- Allocate more time and resources for better preparatory work such as exchange of information and data, intensive training for investigators.

- Involve all investigators from the initial process during the study protocol development, identification of study locations and appropriate timelines.
Disseminate the study results widely to all provinces to provide timely updates on the situation of HIV to local leaders and authorities, concerned parties and the wider communities.

Replicate and expand the study to other Vietnam-Laos border areas. For better epidemic monitoring and updates, it is also suggested that the study be repeated every 2-3 years.

*Strengthen HIV/AIDS prevention and control across the border*

- Allocate more resources to improve information, education and communication (IEC) activities and harm reduction interventions for preventing HIV among mobile and vulnerable populations in the border areas.
- Allocate more resources for IEC activities and harm reduction interventions that also target residents in the border areas.
- Strengthen capacity in HIV/AIDS prevention, care and treatment for health care workers in the border areas, especially for district healthcare workers in Lao PDR.
- Provide equipment and infrastructure support for the healthcare system in the border area to enable capacity for STD diagnoses and treatment.
- Expand voluntary counseling and testing (VCT) to make the service accessible for high risk individuals.
- Strengthen HIV testing capacity for southern provinces so that they can provide referral support to neighboring localities in Laos when necessary.
- Strengthen collaboration between the two countries in implementing HIV interventions that aim at reducing cross-border transmission of HIV.
Chapter 1

Introduction
HIV transmission in Vietnam-Laos border areas: current status and solutions

Mr. Le Quang Cuong - Director of HSPI (on the left) and Mr. Stéphane P. Rousseau - Regional Coordinator of Regional Coordination Unit- GMS CDC project (on the right) at the signing meeting for the joint-regional research on 12 March 2009, Hanoi, Vietnam

Signing ceremony between HSPI and CHAS on the joint-study on 28 April 2009,
Chapter 1

Introduction

The HIV/AIDS epidemic has continued to expand globally and influence community health; reduce life span; and negatively affect economic development and social security in many countries in the world.

In Vietnam, the HIV/AIDS epidemic started in December 1990, when the first HIV infection was detected in Ho Chi Minh City. As of June 2009, the countrywide cumulative reported number of HIV infections had reached 149,653, including 32,400 AIDS cases and 43,265 AIDS deaths. The HIV prevalence is 176/100,000 PY (VAAC, 2009). The HIV prevalence among the adult population is 0.54% (MOH, 2005). There are changes in the epidemic trend. In the early period, HIV was more prevalent in southern provinces, with higher numbers of high risk individuals such as IDUs and FSWs. In the early 1990s, the epidemic quickly expanded to northern provinces and to other risk groups such as mobility groups and to provinces that border China – Quang Ninh, Lang Son, Lao Cai, etc. and more recently to provinces that border Lao PDR (Dien Bien, for example).

In Lao PDR, the first HIV case was identified in 1990, and the first AIDS case was identified in 1992. The case report from 17 provinces, the cumulative number of reported HIV infections from 1990 to June 2009, is 3,395, including 2,180 AIDS cases and 960 AIDS deaths (CHAS 2009b).

Changes in the pattern of social evils, such as drug abuse and commercial sex work, has become one of the main reasons for the increasing epidemic. However, to date, there has been no research that presents the overall picture of cross-border HIV transmission between Vietnam and Lao PDR. The gaps in existing research on this topic include:

- No records or documentation of the high risk activities along the border of the two countries.
- Prior studies only capture some individuals of the specific groups such as FSW, IDU, long distance drivers (LDD) in some small areas.
- No evidence or documentation of the interventions carried out by the local authorities in the border areas between the two countries.
- Lack of information exchange or dissemination of study findings that support the development of joint action programs that aimed to reduce risk for cross-border HIV transmission.
To fill these gaps and to provide evidence and the basis for effective implementation of the Decision 38/QĐ - TTG dated January 8, 2008 by the Prime Minister of the Socialist Republic of Vietnam on “collaboration and cooperation in preventing cross border HIV/AIDS transmission”, the HSPI developed a proposal for the study HIV transmission in Vietnam-Lao PDR border areas: Current status and solutions”. The study was conducted with the participation of the Center for HIV/AIDS/STIs of the Department for Hygiene and Prevention, Ministry of Health of Lao PDR and the relevant local health organizations and Centers/Committees for the control of AIDS of the provinces along the border areas.
Trucks parked near Bo Y entry point.
Chapter 2

Background

2.1. Situation of HIV infection in the border areas of Southeast Asian countries and the Mekong Delta.

Some information is available on the vulnerability and risks of HIV infection among mobile groups in the Southeast Asia region and the Mekong Delta. The information is mainly based on national reports, project data and some field studies. Two significant studies, one conducted by Supang Chantavanich and colleagues - “Mobility and HIV/AIDS in the Mekong Delta” (2000) - (this region includes Vietnam, Cambodia, Lao PDR, Myanmar, Thailand, and Hu Nan province in China) and “HIV/AIDS and Mobility” (2007) an assessment conducted by 10 ASEAN member countries. According to these research documents, some studies have been done to identify vulnerability and risks for cross-border HIV infection and transmission in mobile groups in some countries of the region (Chantavanich S, 2000, UNRTF, 2008). Results from these studies have identified some key issues as follows:

- Countries in the region have very limited data on the HIV/AIDS situation among mobile groups in the border areas, including Thailand, the country in the region best known for its epidemic information and data.
- Epidemic patterns varied among different areas, however the HIV prevalence is higher in many provinces/localities in the border areas. Some of these areas are:
  - Kawthaung and Tachilek, Myanmar which border Thailand;
  - Muse and Keng Tung, Myanmar that border China;
  - Poipet and Koh Kong, Cambodia that border Thailand;
  - An Giang province, Vietnam that borders Cambodia or Dien Bien province, Vietnam that border Lao PDR and China;
  - or 8 border provinces in Lao PDR (Bokeo, Xayabuly, Vientiane, Borikhamxay, Khamuan, Savanhnakhet, Champasack and Saravanh) that border Thailand (CHAS 2009b).
- Cross-border mobility has led to increasing vulnerability and risks of HIV transmission among individuals of the mobile groups and local residents.
- In border areas with high HIV prevalence, HIV prevalence is high among FSWs. In Thailand, for example, HIV prevalence among FSWs who work in the border areas is always higher than FSWs in other areas. HIV prevalence is especially high among women who are trafficked and sold to become FSWs in other countries in...
the region. Among those are Thai women who returned from Myanmar or Yunnan, China or Vietnamese women who returned from Cambodia.

- Besides FSWs and IDUs other vulnerable and high risk groups are formed among mobile populations and local residents in the border areas. These include LDD, construction workers, Hydroelectricity plant workers, miners and traders. Some areas reported HIV cases among military and government staff (Chamberlain, 2000).

- High risk hot spots have been established along the border areas that increase the vulnerability and risk of HIV transmission among and from mobile groups to the general community. These are hidden sex work venues in the form of entertainment facilities (massage parlors, karaoke bars, beer houses, hair salons, etc); mini hotels, guest houses and rest stops where LDD stop for loading or unloading commodities. In addition, drug use venues are formed along the way. Venues appear, exist, or change regularly, depending on the interventions of the local authorities, but never totally disappear.

- Although knowledge about safe sex among FSWs and mobile group individuals has been improved due to IEC interventions, the rate of condom use has not been high.

- The good news is that many countries in the region are committed to efforts to reduce vulnerability and the risks of cross-border transmission of their target HIV mobile groups. This is reflected in the form of bilateral and regional memorandums and action plans including in the ASEAN Work Plan III or in the form of regional strategy and declaration, including UNRTF regional strategy for mobility and HIV vulnerability reduction, ASEAN commitment on HIV and AIDS and the ASEAN Declaration on the rights of immigrants. However, to realize these plans requires continuous cooperation and clear funding plans for implementation at the national level in addition to re-enforcing local policies on mobility and reducing HIV stigma as well as mobilizing active multi-sectoral participation, including relevant ministries of health, labor, transport, foreign affairs, and the private sector which is using most of the migrant labor forces (UNRTF, 2008).

The Government of Thailand has been the pioneer in the region in initiating such policies or strategies by implementing the Border Health program, which enables Thai people, local residents, immigrants, individuals of mobile groups, stateless people and ethnic minorities access to health care and HIV/AIDS prevention services. Nevertheless, access to HIV/AIDS prevention services should be improved for both documented and undocumented immigrants and the mobile (UNRTF, 2008).
2.2. HIV situation and policy for preventing cross border HIV transmission in Vietnam and Lao PDR

In Vietnam

The Vietnam Administration for AIDS Control (VAAC) reported that as of June 2009, the countrywide cumulative reported number of HIV infections had reached 149,653, including 32,400 AIDS cases and 43,265 AIDS deaths. The HIV prevalence is 176/100,000 PY (VAAC, 2009). In terms of gender, the proportion of HIV infections is four times higher among males than females (79% vs. 20.98%). However, the number of female cases has been increasing due to the risk of contracting HIV from their husbands or boyfriends. For the first six months of 2009, male HIV cases has decreased to 74.4% while female cases has increased to 25.7% (VAAC, 2009).

HIV transmitted through the blood transmission route predominates accounting for 50-60% of the total cases reported since 2000. HIV transmitted through the sexual route has been increasing, from 15% in 2005 to 28% by the end of June 2009. Case distribution also indicated that sexually transmitted HIV infections are more likely to be reported by southern and central provinces while IDU transmitted HIV cases are more concentrated in northern provinces (VAAC, 2009).

The HIV epidemic in Vietnam is still in the concentration stage. Injection drug use and sex work have continued to be the key drivers of the epidemic. National HIV sentinel surveillance data in 2008 indicated 20% HIV prevalence among IDUs, 3% among FSWs, 9.4% among men having sex with men (MSM) in Hanoi and 5.3% among MSM in Ho Chi Minh City (HCMC) (WHO 2009). The number of FSWs with records (so-called registered FSWs) is much lower, about 3-4 times lower than the actual estimate number (MOH, Department for Preventive Medicine and HIV/AIDS Prevention, 2005), with IDUs accounting for about half of the total cases reported.

The Vietnam Government has a National Strategy for HIV/AIDS prevention and control til 2010 and a vision to 2020 which states the need to strengthen bilateral and multilateral cooperation and expand international cooperation with neighboring countries and other countries in the region in the field of HIV/AIDS prevention and control.

The Vietnam National Law on HIV/AIDS prevention (that took effect from January 2007) is the first national high level working document relating to HIV/AIDS in Southeast Asia. Articles 11 and 16 of the law on HIV/AIDS prevention state the regulations and guidance for preventing HIV/AIDS transmission among mobile groups as follows:

- Article 11: Individuals of mobile population groups is one of the seven target groups that are given priorities in getting access to HIV/AIDS prevention IEC intervention services.
Article 16 on preventing HIV/AIDS transmission among mobile groups states the responsibilities in organizing and implementing education and communication on HIV/AIDS that target individuals of these mobile groups as follows:

Article 16 - HIV/AIDS prevention and control among mobile population groups

1. People's Committees of communes, wards or townships shall be responsible for organizing propaganda about HIV/AIDS prevention and control among new residents coming from other areas.

2. Owners and managers of accommodation service business establishments, parking lots, bus and coach stations, ports and other tourist and cultural, social service establishments shall be responsible for collaborating with local agencies in charge of HIV/AIDS prevention and control to conduct propaganda about HIV/AIDS prevention and control and to implement appropriate harm reduction intervention measures to prevent HIV/AIDS transmission for their service users.

3. Heads of medical quarantine offices at border gates shall be responsible for organizing propaganda about HIV/AIDS prevention and control for people on entry, exit or in transit.

4. Agencies and organizations engaged in sending Vietnamese people to work or study abroad shall be responsible for regularly organizing propaganda and education on HIV/AIDS prevention and control for every laborer and trainee.

The Government Decree No. 108/2007/ND-CP (June, 2007), detailing the implementation of a number of articles of the Law on HIV/AIDS prevention and control, provides clear guidance on implementing effective science-based HIV intervention, especially implementation of harm reduction intervention measures in the prevention of HIV transmission among mobile population groups, as one of the target groups.

In January, 2008, the Prime Minister of the Socialist Republic of Vietnam signed his approval of the Decision 38/QĐ-TTg on "regulations on collaboration in preventing cross-border HIV transmission". The issuance of the Decision has created favorable conditions for collaborative efforts in preventing cross border HIV/AIDS transmission. The Decision outlines four relevant areas for collaboration as follows:

1) Exchange information and experience in HIV/AIDS prevention and control work with the neighboring countries.

2) Collaborate in implementing cross-border HIV/AIDS prevention activities which include:
   a) conduct study and survey to update on the situation of HIV/AIDS in the border area;
   b) implement behavioral change education and communication through different channels using the local language and dialects;
   c) provide free or affordable condoms, syringes and needles programs;
d) establish STD diagnosis and treatment clinics or sites in the border areas;  
e) provide counseling, care and treatment for persons living with HIV.

3) Integrate HIV/AIDS prevention activities into other related programs such as programs that aim at preventing drug use, prostitution, women and children trafficking, and other social crimes.

4) Identify areas for collaborations based on the specific situation in each of the border areas or localities.

Some provinces with border areas with other countries such as China and Cambodia have already started joint efforts in some HIV/AIDS prevention and control activities. However, as yet there has been no policy or direction to guide the collaboration in implementing such activities in Vietnam-Lao PDR border areas.

**In Lao**

According to the report released by the Lao PDR MOH’s Center for HIV/AIDS/STIs, in 2008, HIV prevalence among the adult population is estimated at 0.2%. As of June 2009, the cumulative number of reported HIV infections is 3,395, including 2,180 AIDS cases and 960 AIDS deaths (CHAS 2009b).

The HIV/AIDS situation in Lao PDR has some characteristics that differ from the epidemic in Vietnam:

- Heterosexual transmission is the main HIV transmission route in Lao PDR (87%), homosexual or blood transmission routes make up a very small proportion of the HIV infections.
- There is not a significant difference in terms of gender distribution, with males accounting for 56% and females 44% of total cases. The majority of males with HIV infections are in the 20-34 age group (CHAS 2009b).
- According to UNAIDS, WHO and CHAS, HIV might have first spread to Lao PDR from immigrants, individuals who crossed the border for employment, got HIV and then transmitted into other family members. As Lao PDR borders countries with more serious HIV epidemics in the region, such as Thailand, Cambodia and Myanmar, it is facing more potential risks of increased HIV prevalence among mobile populations, both local and international groups.
- HIV case reporting indicates that HIV prevalence is highest among mobile population groups, farmers and laborers. HIV prevalence among FSW sex partners and clients and FSW clients’ sex partners is similarly high.

Results from HIV and STI survey round 1 (2001), round 2 (2004) and round 3 (2008) indicated HIV prevalence among FSWs of 0.9%, 2.0% and 0.4% respectively. HIV prevalence among MSM in Vientiane in 2008 was 5.6%. In 2008, groups for HIV sentinel surveillance
included FSWs, clients of FSWs, government staff of state-owned water and power companies, and LDD. The prevalence of STD infection among FSWs tended to decrease by 6%-10%, from 32% in 2004 to 21% in 2008 (CHAS 2009a).

Among mobile population groups, until 2004, no HIV infection was reported among LDD after two rounds of surveillance. Therefore, for round 3 in 2008 this group was no longer included as a sentinel group. While there has not been any data about HIV prevalence among mobile workers in the Vietnam – Lao PDR border areas the prevalence among this group in 8 provinces, including Borikhamxay province, in the Lao PDR - Thailand border area was 0.37% (CHAS 2009a).

At national level, Lao PDR has not yet issued any policy for cross-border HIV/AIDS prevention but has worked with other countries in the region (6 GMS member countries) to commit to implementing HIV/AIDS prevention programs for mobile population groups. Article 59 of the Lao PDR Law on Drugs states that the Government should strengthen bilateral and multilateral cooperation at regional and international levels in the prevention and control of drugs in different forms, including through exchange of information and data (CHAS 2009a).

At provincial level, although there is no specific policy for documents for collaborating with provinces of Vietnam in the border area in HIV/AIDS prevention activities, provinces in both countries have already worked together in the control of infectious diseases.

2.3. Prior studies on risks of HIV transmission and infection among mobile population groups in Vietnam - Laos border area.

Dang Nguyen Anh and colleagues carried out an assessment -“Mobility and HIV Vulnerability in Vietnam: a review of published and unpublished data and implications for HIV/AIDS prevention programs” to review relevant studies and data up to 2007. The assessment provides a good overview of the studies and data on HIV vulnerability among mobile population groups in three border areas, including Vietnam - Laos, Vietnam - China, and Vietnam - Cambodia. The study found that there were fewer studies on this topic among the population in Vietnam - Laos border areas than those in border areas with China and Cambodia.

Among provinces in the Vietnam - Laos border areas, Quang Tri was often identified as a critical location for study of the HIV situation. To date, no publication on studies on risks for HIV transmission among mobile population groups in border areas, including Dien Bien, Kontum and Ha Tinh provinces (in Vietnam) and Phongsaly, Borikhamxay and Attapue (in Laos) have been made.

According to Dang Nguyen Anh et al, the proportion of Vietnamese female migrant workers in Vietnam - Laos border areas is lower than in other border areas but the trend of feminization of migrant flows to Lao PDR has been seen. However, the proportion is increasing. This has significant implications for cross-border HIV control among the migrants and mobile population.
The mobile population in Vietnam - Laos border areas can be divided into different groups: short term or seasonal migrant workers (construction workers, coffee harvest collectors, etc.); long-term migrant workers (construction workers, electricity engineers, handicraft men, wood salesmen, etc.); industrial zone workers (soft drink, garment, or auto parts factory workers); businessmen; FSWs; LDDs; and local minorities (those who move to border areas to seek such employment as goods transporters, porters, assistants at construction sites, etc.). Each of these groups has different characteristics and different levels of mobility and therefore their vulnerability to HIV infection also differs.

FSWs and LDDs are the two groups with greater mobility and vulnerability to HIV. Construction workers are frequent clients of FSWs in the hot spots in the border areas.

Below is information on the size and level of vulnerability to HIV among mobile population groups in the Vietnam - Laos border areas, as taken from the Dang Nguyen Anh et al paper:

**Table 1: Level of mobility and vulnerability to HIV among mobile population groups in Vietnam - Laos border areas**

<table>
<thead>
<tr>
<th>Mobile population groups</th>
<th>Population size</th>
<th>Location</th>
<th>Level of vulnerability to HIV</th>
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<tbody>
<tr>
<td>Construction workers</td>
<td>*</td>
<td>Quang Binh, Quang Tri</td>
<td>**</td>
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<tr>
<td>Free laborers</td>
<td>***</td>
<td>Border area provinces</td>
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<tr>
<td>FSW and staff in entertainment facilities</td>
<td>**</td>
<td>Border area provinces</td>
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<tr>
<td>Businessmen</td>
<td>***</td>
<td>Border area provinces</td>
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<tr>
<td>Road construction workers</td>
<td>***</td>
<td>Quang Tri and provinces along this national highway</td>
<td>***</td>
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<td>Government staff (duty travelers)</td>
<td>*****</td>
<td>Border area provinces</td>
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<td>Military staff</td>
<td>*****</td>
<td>Border area provinces</td>
<td>**</td>
</tr>
<tr>
<td>Small businessmen</td>
<td>****</td>
<td>Border area provinces</td>
<td>**</td>
</tr>
<tr>
<td>Minorities</td>
<td>**</td>
<td>Border area provinces</td>
<td>*</td>
</tr>
</tbody>
</table>

\(^*\): Lowest, ****: highest

*Source: Overview of the study results by Nguyen Duy Tung, Nguyen Truong Son and Nguyen The Trung...*
Although mobile population groups have good knowledge about HIV, their safe sex behavior and practice is low. The study on long distance drivers (LDD) in the paired provinces in Vietnam—Laos border area, including Quang Tri (Vietnam) and Savannakhet (Laos) in 1997 found that only 36% of the LDDs who participated in the study reported always using condoms; 39% had extra-marital sex partners and 25% had sex with FSWs in the border areas. In addition, some Vietnamese men held concepts such as that having extra-marital sex with Laotian women was safe; or that the custom of having sex freely among ethnic minority groups would put them at higher risk of HIV infection. Another concerning fact was that both Vietnamese and Laotian workers would take advantage of the traditional culture of “having sex free of charge” with women of the ethnic minority groups where they went to work, while promising the women that they would later marry them and take them away with them. Condom use in such situations was very low (Dang Nguyen Anh et al. 2008).

In 2002, a study conducted in five border area provinces (including Quang Tri province in the Vietnam-Laos border areas) found that among FSWs the rate of condom use “the last time they had sex” with regular or casual clients in the past 12 months was higher among FSWs in Quang Tri than in other border areas (more than 90% if both kinds of clients combined; or 84.6% with casual clients and 66% with regular clients). However, only 10% of the women reported using condoms with their husbands/boyfriends. Meanwhile, this study also reported that only 20% of the LDDs in Quang Tri reported always using condoms with casual sex partners or with FSWs, and only 10% used condoms when having sex with their wives/girlfriends. Nine percent (9%) of the LDDs even reported having had an STD at some time.

In 2005, a HIV surveillance study of some border area provinces, Dien Bien was included as the one in Vietnam-Laos border, was undertaken. The results showed that in this province, besides IDUs and FSWs, military conscripts and STD patients also had high HIV risks with the prevalence of HIV among military conscripts being 4% and among STD patients 4.14%. These prevalences were highest among all the provinces participating in the surveillance study. This indicates that HIV in some Vietnam-Laos border areas is not only concentrated in traditional high risk groups but is expanding to other groups previously considered “low risk” and into the general community.

In terms of interventions for reducing risks of HIV/AIDS transmission; the recent studies consistently reported that sufficient attention was not being paid to mobile population groups and that there must be a policy that supports interventions aimed at reducing vulnerability to HIV infection among mobile cross-border groups of Vietnam, Laos, Cambodia and China (Dang Nguyên Anh et al, 2008).

In 1997, some provinces in Vietnam-Laos border area started some HIV prevention approaches, such as providing free condoms and using educational videos to disseminate HIV prevention messages, with support from small scale projects. For example, CARE interna-
tional supported such an intervention in Quang Tri province but no evaluation report on the outcomes of the intervention was published (Jamie et al, 2000).

In 2003, HIV/AIDS Prevention Project - the first and largest harm reduction project in Vietnam at that time was started with primary focuses on: IEC, condom program for FSWs and their clients, free needles, and STI management and treatment. Among the 21 provinces that this project covered, three were in the Vietnam – Laos border area, namely Thanh Hoa, Ha Tinh and Hue.

In Ha Tinh, the project provided supports for placing “self-help” clean needle boxes at 33 commune health centers to enable IDUs to have 24/7 access to clean needles. One of the significant public health outcomes from this project was to reduce healthcare providers’ stigma toward IDUs and also to encourage IDUs to talk to healthcare workers.
Objectives
Chapter 3

Objectives

3.1. Overall objective

To provide evidence on the risk of HIV transmission in border areas and to recommend solutions for the establishment and enhancement of the collaborative partnerships among provinces in border areas between the two countries for the introduction and implementation of risk reduction interventions.

3.2. Specific objectives

2.1. To study the risks of HIV transmission among high-risk groups at border areas;

2.2. To identify intervention solutions to change knowledge, attitudes and behavior of the high-risk groups and improve their access to preventive and treatment services in order to move towards a reduction in HIV transmission in Vietnam - Laos border areas;

2.3. To improve the capacity of research institutions conducting this study;

2.4. To establish long-term collaborative relationships among the participating organizations and individuals in conducting joint research across different countries.
Study locations population and methods
Chapter 4

Study locations, population and methods

4.1. Locations

The study was implemented in six provinces located where the three pairs of international entry points are situated along the Vietnam-Lao PDR border, which include:

- In the south: Bo Y - Phu Cua of Kon Tum province (Vietnam) and Attapue (Lao PDR),

- In the centre: Cau Treo - Nam Phao of Ha Tinh (Vietnam) and Borikhamxay (Lao),

- In the north: Tay Trang - Panghok of Dien Bien (Vietnam) and Phongsaly (Lao).
4.2. Study population

The study collected data on different groups directly or indirectly related to high risk groups that steer HIV transmission across the border. These groups included:

- Local leaders and management staff in the provinces along the border areas between the two countries, specifically:
  - At provincial level: Management staff of provincial HIV/AIDS program both of Vietnam and Laos.
  - At the border entry points: Local leaders and management staff, including police (immigration), Patrol soldiers, Quarantine, Customs officers and other local leaders, district HIV/AIDS program staff, commune healthcare workers.
- High risk individuals, including FSWs, IDUs, LDDs, freelance workers, traders, etc.
Chapter 4: Study locations, population and methods

- Others such as guest house owners, entertainment facility owners, private health clinicians, local residents and migrant workers.

4.3. Methods

4.3.1. Study design

This is a cross sectional study. As the study topic was sensitive and on hidden and mobile populations, qualitative methods were chosen as the most appropriate. The “trans-theoretical” model was used to develop the data collection tools. The following behavioral indicators were identified for assessing the risks of cross border HIV transmission among the study populations:

- Frequency of having sex on daily, weekly, and monthly time periods
- Frequency of having unprotected sex on a daily, weekly, and monthly basis
- Clients/sex partner social network
- Times and venues that risk behaviors occur
- Frequency of unsafe injection drug use
- Combined risk behaviors
- Interaction between and among different groups.
Theoretical Frame

Environmental, social and economic characteristics of each study location

Demographic characteristics of study populations:
- Gender
- Age
- Occupation
- Income
- Education

Behaviors (IDU, sexual activities):
- Venues
- Frequency
- Safe behavior
- Combined behaviors
- Interaction between and among groups
- Perceptions about risk of HIV infection prevention

Measures for risk reduction
- Prevention
- Care and treatment (C&T)

Risk of cross border HIV transmission

4.3.2. Data collection

4.3.2.1. Collecting and conducting secondary data analysis

- Legal documents on implementing harm reduction in Vietnam and Laos
- Legal documents on prevention of cross border HIV transmission between the two countries
- Data and information about programs that support regional strategy for reducing HIV vulnerability and mobility in Southeast Asia and South China between 2006-2008
- Data on the situation of the epidemic and prevention activities in the provinces that participate in the study.
4.3.2.2 Direct Observations

Investigators of both countries conducted direct observations of hot spots for sex work and IDU activities in the border areas and identified and analyzed these to assess related risk behaviors.

4.3.2.3 Key informant interviews

Key information interviewing is the key data collection method used for this study. A total of 409 in-depth individual interviews were conducted, using the same data collection tool. All interviewers were trained prior to the start of the data collection process. Key informants were:

- (at national level) management staff of VAAC (Vietnam) and MOH’s Department for Prevention and Environment (Laos).
- (at the local level):
  - 90 interviews with (15/province) HIV/AIDS program management staff of the provincial, district, commune level, commune PC officials, police, border area patrol; (FSWs: 40 in Vietnam and Laos; IDUs 24 in Vietnam and 17 in and 13 in Laos); migrant workers (27 in Vietnam and 30 in Laos);
  - 237 interviews with high risk individuals 29 in Laos; IDUs (24 in Vietnam and 17 in and 13 in Laos); migrant workers (27 in Vietnam of FSWs (12 in Vietnam and 30 in Laos);
  - And 80 interviews with significant others: 20 in Vietnam and 15 in Laos; private living health care providers: 6 in

4.3.2.4 Sampling

Snowball sampling was used, as this was suitable for this sensitive study topic and for reaching hidden and mobile population groups.

4.3.3 Data analysis

Qualitative data (from direct observations and key infor-
mant interviews) were coded (Opening code) to identify emerging themes that corresponded to the study questions.

- Conducted mapping: identify venues (hot spots) for sex work activities in the areas where the study was conducted.
- Identify and study sexual network and social relationships of groups that engaged in sex work to assess the risks of HIV transmission into the general community.
- Mapped out activities that study groups engaged in in order to assess the risks of local and cross-border HIV transmission.
- Venn-diagram to define the interactive relationships and combined risk behaviors among the different study groups.
- Table of hierarchy of risk behaviors.

4.3.4. Study ethics

All participants were fully informed about the goal and objectives of the study and how the information was collected and managed. Participants were also told that they would not receive any immediate benefits. All interviewers completely respected the principles of volunteering and confidentiality. No names or personal identifiers were collected and information shared by the participants was anonymously coded. All interviews were conducted by trained staff. Participants were given a thank-you gift to compensate them for their time to take the interview.

4.3.5. Study limitations

The study was conducted by two investigation teams from the two countries. Investigators conducted interviews on both sides of the border areas therefore language was a major barrier, especially when asking sensitive questions about personal risk behaviors.

Due to limited time and resources, training for the Laotian interviewers was not as thorough as it should have been.

The data collection process in one study location in the north of Laos (Phongsaly province) started in the rainy season, which caused some difficulties for accessing the participants and as a result the desired sample size was not reached. If the two teams had more time during the implementation process to review and coordinate the data collection timelines, this limitations of bad weather could have been avoided.

Another limitation encountered by the study teams was that when interviews were conducted in the border areas, participants usually could not spend a sufficient amount of time, as expected by the interviewers, to explore issues in depth, as the study required
Chapter 5

Results and discussion
Ms. Vu Thi Minh Hanh- research team leader (standing on the right) presented the findings of the joint-research at the dissemination workshop, Hanoi, 18 November 2009
Chapter 5

Results and discussion

5.1. Social and economic characteristics and situation of HIV/AIDS, drug use and prostitution in the study locations

5.1.1. Border areas in the northern region

*Dien Bien* located in north of Vietnam is about 502 kilometers from Hanoi, the capital city of Vietnam. The province borders Lai Chau province in the north, Son La province in the east and northeast, and Lao PDR in the west and southwest and Han Nan, China. With a population of 475,600 (2008), Dien Bien has a land area of 9,554.11 square kilometers which is divided into 9 administrative units, including a city, a town and 7 districts, 4 of these districts being categorized as poor areas. The central city is Dien Bien Phu. There are 21 ethnic minority groups, with the Kinh accounting for 19%. As a poor province with approximately one third of the households (30.6%) living in poverty, the economy of Dien Bien is heavily dependent on the Government budget. The province shares a 360 kilometer long border with Laos and a 38.5 kilometer long one with China. There are currently three entry points on the border with Laos. Three more entry points will be opened soon. The Tay Trang entry point is the most important one for the northwest region and the two governments have agreed to upgrade it to an international entry point and an economic zone is being built. This will become a great opportunity for Dien Bien to begin international commerce and pave the way for a main transportation route to connect Northwest Vietnam to Northern Laos, Southwest China and Northeast Myanmar.

- HIV/AIDS situation: Dien Bien became a sentinel province for the Vietnam national surveillance system. The province is ranked sixth in terms of the number of HIV infections but ranked third in terms of HIV prevalence (501/100,000 PY as of June 2009, nearly three times higher than the national prevalence). During the first six months of 2009, Dien Bien was ranked fourth for the number of new HIV infections (304 cases). As reported by the Dien Bien Provincial Center for HIV/AIDS prevention, as of August 2009, the cumulative number of HIV/AIDS cases in Dien Bien is 3,452; including 1,043 AIDS deaths. HIV in Dien Bien is concentrated among the 20 - 39 age group, which accounts for 85.08% of cases. Most of the total cases are male (87.43%) and similarly 87.4% of cases were through the blood transmission route; 11.5% of cases were through heterosexual transmission; 0.78% from mother to child transmission; and 0.32% were unknown. The current epidemic shows that HIV prevalence is higher in sentinel sites. For example, HIV prevalence is 1.35% in Muong Lay village, 0.91% in Dien Bien Phu and 0.66% in the Dien Bien border district. HIV prevalence among
IDUs is especially high at 42.89% as twice higher than the national prevalence. HIV prevalence among FSWs, according to a survey in April 2009, was 20%, the highest in the whole country (9-15% for Ha Noi, Hai Phong, and HCM). HIV prevalence in antenatal-care (ANC) women in rural area has an increasing trend, currently 2.25%, almost 10 times higher than the national prevalence (Dien Bien Provincial PC, 2009).

In addition, HIV prevalence among FSWs in Dien Bien has continuously increased (Dien Bien Provincial PC, 2009).

- High risk hot spots in the border area: Tay Trang entry point is located in Na U village, Dien Bien district, about 39 kilometers from the central city of Dien Bien Phu. As estimated by the local authority, every month there are about >1,000 visits of which 400 are tourists and businessmen and >600 are local residents from along the border areas. This number does not include individuals who frequently move back and forth along paths to transport goods and other small commercial products across the border.

  - Na U village has a land area of 11,300 hectares but only 400 hectares can be used for farming and the remaining are mountains. There are 216 households with a total of 1,292 persons in the village. 100% of the population are H'Mông. Na U is a poor village with 40% of the households living under the poverty level, a low educational level and with the population existing mainly on rice farming (90%) and animal breeding (10%). The local people cross the border frequently to work as transporters of goods and commodities for businessmen, including addictive substances. Some villagers have become rich and have even bought cars (15) and drive to Ha Khau, another entry point between Vietnam and China in Lao Cai province, for fun and other entertainment activities. Na U has lost two people to AIDS, one person is living with HIV and seven have suspected symptoms but have not been tested for determination. There is no sex work venue in the village but there are two-three drug dealing venues. These venues change regularly to avoid being identified by local authorities. This is a sophisticated route for the transportation of illicit drugs from Myanmar through Laos into Vietnam and from there to other countries. Local people also engage in transporting drugs from Laos via creeks, paths or other hidden ways. Na U has 54 recorded drug users and four of them are female. There are no bars or entertainment facilities in the village but the H'Mong people's traditional local custom of “finding a girl in the dark” (che lọ in H'Mong language) may be one of the factors influencing the spread of HIV in the village and across the border. Young men at the age of 12 or 13 can start “finding a girl in the dark” and are not just limited to their neighborhood but also explore other areas such as PangHok, Muong Mai district of Laos, to look for a wife. Apart from that, the local people’s perception of sex is very “open”, daughters in law can have sex with their fathers in law,
and if a husband is in a drug treatment program, in prison or dies, his wife can have sex with other men, even with men in PangHok across the border.

- About 8 kilometers from the border area, there is a field site for coal mining managed by Hoang Anh Company Limited where FSWs also congregate. The price for a sexual encounter is around VND 50,000. FSWs are women from other villages, they have sex with their clients right on the field site in the open area on a plastic cover and without using a condom. There are also a small number of IDUs.

- Also 10 kilometers away from the border is Na Hai village, Na Man commune, which borders Na U. In this village, a majority of the men are IDUs and women are FSWs not only in Dien Bien but also in many other provinces. Many women in the village also use drugs. The main reason for the increasing number of drug users in Na Hai is Laotian peer pressure during their business trips across the border. There are a total of 60 households in the village while the number of drug users is >40. Some households even include 2-3 drug users.

- *U Va* is a natural spa, located in Ban Lot township, which is about 17 kilometers away from the border. This area also has restaurants, bars and massage parlors. Women who work in these facilities are local people.

- *Dien Bien Phu City* is about 39 kilometers from the border. There are 7 massage parlors, some cafés with FSWs and one venue for street-based FSWs. Charges for sexual encounters vary between venues. FSWs in entertainment facilities charge higher. FSWs in these facilities can be local women or those who come from other places, usually from southwest provinces. The typical charge for each sexual encounter is VND250,000, or VND500,000 if the client has the option to select the FSW. FSWs who work in the cafés are recruited and fed by the owner. In return, they have to give the owner the entire amount that they earn from their clients for sex, usually VND150,000 per encounter. They will receive a monthly salary, ranging from VND1-1.5 million. Street-based FSWs usually solicit their clients in the Do Cat tunnel area; they are older, less attractive and many are also drug users. For each sexual encounter, they are paid about VND50,000 – 100,000.

- *Phongsaly* is a province in the North of Lao PDR and shares a border with Vietnam and China. The province has a land area of 16,270 square kilometres and a population of 167,181. Population density is low, about 10/ square kilometer. Phongsaly is one of the poor province in Laos. The Tay Trang border entry point of Vietnam borders Muong Mai district of Phongsaly province.
Muong Mai is a mountainous district with a land area of 3,106 square kilometers, of which 80% are rocky mountains. Muong Mai borders Vietnam in the east, and Luangprabang and Oudomxay to the south and west. The district has a total of 23,566 residents. There are 13 ethnic minority groups in Muong Mai, namely Kmu (30.23%), Kho (25.88%), Tay den (17.97%), Tay do (6.21%), Tay Trang (6.12%), Mong (4.07%), Laos seng (3.28%), Laos biet (2.88%), Laos Loum (2.36%), Phu Noi (0.66%), Lu (0.11%), Dao (0.10%), and Ho (0.02%). Muong Mai is a remote mountainous area with slow economic growth, and poor infrastructure. Transportation is difficult but this is now being upgraded. Located in Muong Mai are also two Chinese farming companies, an international border entry point (PangHok) which borders Dien Bien province in Vietnam. At PangHok entry point, there are 20 patrol police, two agricultural specialists, three customs officers, two traffic wardens, two foreign affairs staff and one healthcare worker. PangHok is 24 kilometers away from Muong Mai town and two kilometers from Tay Trang border entry point. Muong Mai district has no entertainment facilities, karaoke bars, or draft beer bars (bia ôm). However, there are two guest houses, four small restaurants and a new hotel was opened in August 2008. Muong Mai has no entertainment facilities because the district is in a remote area and is not a stopover for tourists or businessmen; there are also no FSWs because the local people have a very “open” perception towards sex, as extra-marital sexual relationships are widely accepted. Neighboring Muong Mai is Muong Khu, with favorable infrastructure conditions. As a result, the district has become a popular stopover for tourists and cross-border traders. Some FSW venues have been established. In the future, when the Muong Khu industrial zone project has started and begun operating, Muong Mai will have opportunities to develop its social and economic activities. It is noticeable that some villages in Muong Mai district have started producing drugs. The substance is imported from Myanmar with 80% purity, then processed and turned into bars of decreased quality, only 40% pure.

HIV/AIDS prevention, care and treatment services, especially ARV, both at provincial and district level are very limited. HIV/AIDS patients are referred to provincial Luangprabang hospital for treatment. Muong Mai district has one pharmacy and two private clinics owned by healthcare workers that are working without registration.
Map 2. FSW and IDU hot spots in Dien Bien and Muong Mai
HIV transmission in Vietnam-Laos border areas: current status and solutions

Table 2. Level of cross border mobility and vulnerability to HIV among mobile population groups in Tay Trang entry point

<table>
<thead>
<tr>
<th>Mobile population groups</th>
<th>Mobility</th>
<th>Location</th>
<th>Level of vulnerability to HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local residents</td>
<td>***</td>
<td>Communes along the border area</td>
<td>***</td>
</tr>
<tr>
<td>Construction workers</td>
<td>*</td>
<td>Districts in the province</td>
<td>*</td>
</tr>
<tr>
<td>Freelance workers</td>
<td>*</td>
<td>Communes along the border area</td>
<td>*</td>
</tr>
<tr>
<td>FSWs and female staff in entertainment facilities</td>
<td>***</td>
<td>Border towards</td>
<td>*****</td>
</tr>
<tr>
<td>Drug users</td>
<td>**</td>
<td>Along the border area</td>
<td>****</td>
</tr>
<tr>
<td>Businessmen, traders</td>
<td>**</td>
<td>Border towards</td>
<td>***</td>
</tr>
<tr>
<td>Road construction workers</td>
<td>**</td>
<td>Border towards</td>
<td>***</td>
</tr>
<tr>
<td>Government workers, armed army force</td>
<td>** Border towards, Lao PDR</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>LDDs</td>
<td>**</td>
<td>Along the border area</td>
<td>****</td>
</tr>
</tbody>
</table>

5.1.2. Border areas in the central Region

Ha Tinh is a province in the north central coastal region. The province borders Nghe An province to the north, Quang Binh to the south, the sea to the east and Lao PDR to the west.

Ha Tinh has two towns (Ha Tinh and Hong Linh) and nine districts, including four mountainous districts and one township with a total of 261 smaller administrative unit (241 villages, 8 wards, 12 towns). Ha Tinh has a land area of 6,019 square kilometers and a population of 1,307,300 (2008) which is distributed in a low density. The province has a good transport system, including 127 kilometers of the National Highway 1A, 87 kilometers of the Ho Chi Minh Highway and 70 kilometers of the North-South National Highway 8A, which continues through to Lao PDR and Thailand, past the Cau Treo international border entry point.

- HIV/AIDS situation: HIV prevalence and the number of reported HIV infections is lower in Ha Tinh than the national average. Ha Tinh is ranked 50th in terms of the cu-
Chapter 5: Results and discussion

The cumulative number of reported HIV infections and 31st in terms of HIV prevalence (125/100,000 PY). The first HIV infection in Ha Tinh was detected in May 2007. As of December 2008, the province had reported 1,115 HIV cases, including 214 AIDS deaths. The number of persons living with HIV/AIDS is >900, including 271 AIDS cases. Most (90%) of the total cases are male and 62.2% are in the 20-29 age group. HIV cases who are IDUs accounts for 71.8% and FSWs 6.6%. HIV/AIDS in Ha Tinh has spread into the general community and cases can be found in all 12 of the districts and towns. Cases have also been reported among lower risk groups such as high school or university students and government staff.

Hot spots of IDU and FSW in the border area: Cau Treo entry point is located in Huong Son District with four communes located along the border, including Son Kim I, Son Kim II, Son Hong and Son Linh. There is one international entry point and two domestic entry points. These have become routes for trafficking smuggled commodities, including illicit drugs from Lao PDR to Vinh, and from there to other places in the country. In these four communes the number of IDUs and persons living with HIV/AIDS are the highest in the province.

- Cau Treo entry point lies in the Son Kim I Commune. This commune has a land area of 20,500 hectares and a population of 4,719. The living conditions of the local people is better than in other localities in the district and province. Local people live mainly on forestry products, agriculture, and cross-border trade. There are currently 19 active drug users. Six drug dealers have been imprisoned or sentenced to death. There are 21 reported HIV infections, including 11 AIDS deaths. However, the actual number of persons living with HIV is estimated to be 3-4 times higher. HIV is transmitted among male IDUs and from them to their wives and children.

- Every day, about 600 – 700 visitors cross Cau Treo entry point, as estimated by the local authority. At peak times, the number can reach several thousands, as this is one of the main routes that connects Vietnam with Vientiane, Lao PDR, and on to Thailand. The main mobile population groups are tourists and LDDs. On some days, there are hundreds of buses or lorries transporting tourists or wood and other goods from Lao PDR into Vietnam. Other groups include construction workers, porters, and small businessmen or traders.

In 2008, the border patrol police intercepted 10 illicit drug transactions. During the first seven months of 2009, four additional offences were intercepted. Local agencies also identified and stopped one female cross-border trafficking chain. The chain was identified when its leader, a female resident from Vinh, was on her way to traffic 10 women from Nghe An and Ha Tinh to Lao PDR to work as FSWs. Also in 2007, the police station at the entry point rescued 20 young
women who had been sold to Laos and Thailand to work as FSWs and were returning to Vietnam from these countries. In May 2009, this police team also helped two other young women with similar experiences return from Laos. At the Cau Treo entry point, there are no residents but about 30 families have moved from Tay Son town to open small shops to serve stopover tourists or businessmen. About 11 kilometers away from the border, there are two massage parlors close to Nuoc Sot waterfall (one on the left in the tourist area and one on the right in the bottled soft-drink production site, owned by the military). There are FSWs at these massage parlors. The number of FSWs available depends on the specific time, with about 10 being available at the busiest time. FSWs charge VND200,000 for a sexual encounter, or VND700,000 for an overnight request. FSWs do not have to give money to the owners because they already charge their clients VND70,000 for the massage package.

- 18 kilometers from the border entry point is Tay Son Town — a commercial centre. The town has 17 recorded drug users, usually under 25 years old, though some are 25–35 years old. However, the actual number is estimated to be about 2-3 times higher. During the first six months of 2009, four AIDS deaths were reported. In this town there is a guest house which is also a venue for FSWs. The owner does not have FSWs on site but will call them from Nuoc Sot Waterfall or Pho Chau (Huong Son District) when there are requests from the customers. Client are charged VND400,000, including VND200,000 for the FSW, VND100,000 for the hotel room and VND100,000 for the guest house owner’s referral fee.

- Pho Chau Town is approximately 50 kilometers from the border, in Huong Son District. This town has a number of hotels, massage parlors, karaoke bars where a number of FSWs work.

* Borikhamxay* is a province in the central region of Lao PDR with a land area of 14,863 square kilometers and a population of 225,167 (a density of 15 persons/square kilometer). This is a mountainous province with flat land accounting for just 35.89% of the total land area. The urban population accounts for 26.3% with 57.6% of the population living in rural areas with easily accessible roads, and 16% living in areas without accessible roads. Bo Li Khăm Xay has two international border entry points, one with Vietnam and one with Thailand, and five other small entry points, three with Vietnam and two with Thailand. The province reported 41 HIV infections and is ranked 8th among the total of 17 provinces throughout the Country. Of these cases, 13 persons have died of AIDS.
Khamkeut District borders the Cau Treo entry point and has a population of 64,555, accounting for 29% of the entire population of the Borikhamxay province. People in Khamkeut District live mainly on agriculture and small business.

Nam Phao entry point is one kilometer from the border. Working at this entry point are 20 staff, including police, patrol police, customs officers. There are two healthcare workers and one vet. Every day, about 300 people cross the border. In summer, this number can reach up to 500, when Laotian students return for the holiday. Along the border, there are three small shops but no entertainment facilities or FSW venues. Lorries from Khamkeut that pass the entry points are usually transporting fruit from Thailand to and from Hanoi with some goods traded in Vietnamese markets.

Lak Sao Town is about 30 kilometers from the border. There are 22 restaurants, two entertainment facilities, five guest houses, two hotels and four dancing clubs (two in the hotels and two elsewhere). More than half of these facilities are Vietnamese-owned. More than 70 Laotian FSWs work at these places. They come from different places in Laos, such as Borikhamxay, Xieng Khuang, Vientiane, and are moved between facilities every month. In addition, there are more than 20 Vietnamese FSWs in this area. They often move from place to place. Vietnamese clients usually take Vietnamese FSW with Laotian men choosing Laotian FSWs. In just a few cases, clients choose from the other nationality. The number of Laotian clients is much higher than the Vietnamese ones. FSW clients can also be men from China, Thailand or even other countries. FSWs in Lak Sao charge higher for sexual encounters, ranging from LAK (Laos Kip)250,000–500,000 (equivalent to VND500,000–1,000,000) depending on changes in the supply-demand pattern. FSWs in Lak Sao do not use drugs. Very few FSW clients (Laotian men) use or inject drugs but some take Amphetamines.

Healthcare organizations in Lak Sao provide quarterly health check-ups for Laotian FSWs. Laotian FSW clients with STDs usually seek diagnosis and treatment at private clinics. Some district healthcare workers who own the clinics said that about eight men visit their clinic per month. HIV/AIDS services, including prevention, care and treatment, especially ARV services, are very limited. AIDS patients who need ARV treatment are referred to healthcare facilities in Vientiane.
Table 3. Level of cross border mobility and vulnerability to HIV among mobile population groups at the Cau Treo entry point

<table>
<thead>
<tr>
<th>Mobile group</th>
<th>Mobility</th>
<th>Prior Residence</th>
<th>Vulnerability to HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road construction workers</td>
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<td>Central provinces in Vietnam</td>
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<tr>
<td>Freelance employees/ workers</td>
<td>****</td>
<td>North and central region</td>
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<td>FSWs and female staff at entertainment facilities</td>
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<td>Along two sides of the border</td>
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<td>Drug users, IDUs</td>
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<tr>
<td>Military or armed forces</td>
<td>**</td>
<td>Vietnam – Laos border area</td>
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<tr>
<td>LDDs</td>
<td>***</td>
<td>Along two sides of the border</td>
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5.1.3. Border areas in the southern region

*Kon Tum* is a mountainous province in the north west of Vietnam with a land area of 9,676 square kilometers and a population of 401,500 (2008). The province borders Quang Nam province to the north, Gia Lai to the south, Quang Ngai to the east and Lao PDR and Cambodia to the west with a border of some 280.7 kilometers. The province has eight districts and one city and a total of 97 communes/villages, including 51 communes/villages categorized in poverty.

- HIV/AIDS situation: as compared to other provinces, Kon Tum is not a “hot” area for HIV. The province is ranked 55th in terms of the number of HIV infections and 41st in terms of HIV prevalence (88/100,000 PY) (VAAC, 2009). The first HIV infection was detected in 2004. To date, the province has reported a cumulative 273 HIV infections, including 102 AIDS cases. Eight out of nine districts reported HIV/AIDS cases. The predominant route of transmission is injection drug use. The HIV epidemic tends to spread into other places. Between 1994-2008, an average of 10 infections were detected in a year, but this increased to 18 cases in the first quarter of 2009 alone.

- FSW and IDU hot spots in the Vietnam-Laos border area: The Bo Y entry point is located in Ngoc Hoi District in Kon Tum. The District is divided into six communes and one town with a population of less than 40,000 people. There are a variety of ethnic minority groups living in the district, including Xe Dang, Gie Trieng and other groups who have moved from the north of Vietnam (Muong from Da Bac or Hoa Binh; Tay; Nung; Kinh, etc.). Local people live mainly on agriculture, forestry and small business.

In the past few years, Ngoc Hoi has seen a higher rate of economic growth because the District lies along the Ho Chi Minh National Highway, and has received Government investment to develop into a border economic zone. Therefore, more and more people (8,000 – 9,000 people) have moved to Ngoc Hoi for different employment such as doing small business, freelance workers, porters, and others. Ngoc Hoi also receives thousands of forestry workers, wood product, hydroelectricity and construction site workers from, and working in, Laos. The number of visitors from Laos to Ngoc Hoi is increasing (70 – 80/day) mainly for buying food. Some visit Ngoc Hoi as tourists or at the invitation of their business partners in Vietnam.

The recent social and economic development has led to an increase in social crime activities in the District. Ngoc Hoi has more than 35 recorded IDUs, mainly in Plei Kan, Bo Y and Dak Su communes. Many of them are long term IDUs who moved from the north and introduced drug use to young local men in Plei Kan town and some other places in the border area. There are four drug dealing venues (three in town and one in the border area). IDUs are unemployed and usually wander around but do not cross the border because they do not speak the language. Venues and times to inject vary to avoid detection by the police.
Plei Kan Town is 20 kilometers from the border. An estimated 150 FSWs are working in the area, at the five hotels, nine guest houses, three massage parlors and six secret café venues. There are no street-based FSWs in Plei Kan. They usually come from other provinces, especially from the north. For those working in cafés, a typical charge for a sexual encounter is VND150,000; FSWs getting VND70,000 and the owner getting VND80,000. In hotels, guest houses and massage parlors, FSWs are more carefully recruited from a chain in the north and as a result sexual encounters are charged at a higher rate, VND400,000, more than twice as much. The share between the FSWs and the owner is 50:50.

Dak Su commune is about ten kilometers from the town and is the loading area for lorries carrying wood from Laos. This is the rest stop for the lorry drivers and also the venue for sex work and IDU. FSW clients are LDDs and FSWs come from other places and live in Plei Kan Town. When requested by the clients, FSWs take taxis to meet and provide sex. IDUs are mainly local people, some are LDDs.

- Bo Y Commune has an international border entry point with Laos. The commune has a population of 5,632, from a variety of ethnic minority groups. The local people live mainly on agriculture and forestry. A lot of people move to new industrial zones in northern provinces to seek employment and return home with risky behaviors, including IDU. The commune has three recorded IDUs but they have been imprisoned because of drug dealing. There are five HIV infections and four of them have died due to AIDS.

- Every day hundreds of lorries carrying wood pass through Bo Y border entry point. In addition, about 300 – 400 tourists and businessmen cross the border. There are currently 14 companies in the central and western region registered to send thousands of workers across the border to work in the hydroelectricity industry, road construction, forestation, wood produce, coal and other mineral mining in Laos. No FSW or IDU activities were observed along the border areas.

Attapeu is a province in the south of Laos with a land area of 10,320 square kilometers. The population is 112,171 with a density of 11 persons per square kilometer. The urban area of Attapeu is about 111 kilometers from the border with Vietnam. The road from Vietnam to Attapeu urban area was opened in 2003.

Phuvong district borders Vietnam’s Bo Y international border entry point. The district has a population of 10,668, accounting for 10% of Attapeu province. The local people live mainly on agriculture and small business. In comparison to other provinces, the economy of Attapeu province in general and of Phuvong district in particular has grown faster thanks to a favorable transport system that connects with Vietnam and
Cambodia and three hydroelectricity projects are being built in SeKaMan Lake. This has led to an increase in the number of FSWs (including Vietnamese FSWs). There has also been an increase in amphetamine use among in and out of school youths. Furthermore, the number of mobile freelance workers moving into Phuvong district and Attapeu province has increased quickly and they usually stay for 3-6 months, some having stayed several years.

The first HIV infection in Attapeu was detected in 2003 and there is now a total of 12 reported cases, including four AIDS deaths and four in ARV treatment. Attapeu is ranked 14th out of the 17 provinces in Laos in terms of the number of cumulative HIV infections.

- There are no restaurant or entertainment spots in Phuvong district. Around the border area, there are a couple of small restaurants. There are four small restaurants about 1 kilometer away from the border area and the female staff there are also FSWs. The FSWs can negotiate with their clients to have sex in a small room right next to the restaurant. Some of the FSWs participating in this study said that when they had an STD, they went to the district or provincial hospital for examination and treatment. About 12 kilometers from the border area, there is a group of 6-7 restaurants along both sides of the border and at these restaurants there are more than 10 FSWs available. There is a lorry loading area, which is about 72 kilometers from the border area and also nearby the SeKaMan Hydroelectricity plant. There are more than 40 restaurants in this area. More than 50 Vietnamese and 10 Laotian FSWs work in this area. They charge LAK200,000 for each sexual encounter (equivalent to VND400,000, twice that charged by FSWs in Ngoc Hoi). Vietnamese FSWs in this area are older, less attractive and have moved here from other regions. Their living condition are poor, without electricity or clean water. When they are sick, they have to return to Vietnam for treatment. Vietnamese FSWs in this area are very mobile. They frequently move to Vientiane and Thailand and come back or continue to move to Ngoc Hoi District or to other provinces in Vietnam.

- The urban area of Attapeu province is 124 kilometers from the border area. There are five hotels, guest houses and eight karaoke bars operating as secret FSW venues with more than 40 Vietnamese and at least 150 Laotian FSWs. Charges for sexual encounters range from LAK200,000 to LAK500,000, depending on the time.
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Map 4. FSW and IDU hot spots in Ngoc Hoi and Attapeu
Table 4. Level of cross border mobility and HIV vulnerability at Bo Y border entry point

<table>
<thead>
<tr>
<th>Mobile group</th>
<th>Mobility</th>
<th>Prior residence</th>
<th>HIV vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local residents/people</td>
<td>*</td>
<td>Communes along two sides of border</td>
<td>*</td>
</tr>
<tr>
<td>Construction, road and hydroelectricity plant workers</td>
<td>*****</td>
<td>Provinces in the central or western region</td>
<td>***</td>
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<tr>
<td>Forestation workers</td>
<td>***</td>
<td>Provinces in the central or western region</td>
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<tr>
<td>Freelance workers/employees</td>
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<td>Provinces in the central or western region</td>
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<tr>
<td>FSWs and female staff at entertainment facilities</td>
<td>****</td>
<td>Along the border areas</td>
<td>*****</td>
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<tr>
<td>DU, IDUs</td>
<td>**</td>
<td>Vietnam border area</td>
<td>***</td>
</tr>
<tr>
<td>Businessmen, traders</td>
<td>**</td>
<td>Vietnam border area</td>
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<tr>
<td>Government workers, armed forces</td>
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<td>Vietnam-Laos border area</td>
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<td>LDDs</td>
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<td>Along the border area</td>
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5.2. Risks for cross-border HIV transmission among mobile groups in the border areas

5.2.1. Demographic characteristics of the mobile

5.2.1.1. FSWs

- Gender: Most of the sex workers in the six provinces in the three paired border entry points between the two countries were female. Only in Lak Sao town in Borikhamxay province, Laos, were the team able to access and interview two male sex workers. In Vietnam, although the interviewers worked hard to explore the issue of male sex work in the study’s participating provinces they couldn’t obtain any information or make observations.

- Age: FSWs were typically in the 25-30 age group, although in Laos some were under 20 while some others were older than 30-35 years. FSWs in entertainment facilities (e.g. restaurants, hotels, massage parlors or dancing clubs) were younger...
and more attractive than street-based FSWs. Street-based FSWs had longer sex work experience, were older and were now “past their prime” and had to move around to solicit clients on the street and in public places, such as bus stations and squares, and as a result usually charged 2-5 times less per sexual encounter.

* "We typically charge VND400,000 for a sexual encounter. The younger the FSW, the higher charge they can make. Therefore, some FSWs who also work here charge only VND300,000. I would not accept a client at that price, I would get at least VND400,000 - VND600,000. If clients want a cheaper girl (FSW), they can find them at a café, where they would have to pay only VND150,000, or on the street, where they would be charged only VND100,000."

(A 23 years old FSW working in a hotel)

** “I started this job (sex work) when I was 30 and when my husband was in prison and our children were small. I did not have any income to feed them. At the beginning, I worked in a bar for a year then had to move to the street to solicit clients. Now I get only half of the charge that I would get before.”

(A 35 year old street based FSW)

Laotian FSWs were typically younger (16-20) than Vietnamese FSWs (20-35). Compared to prior studies, FSWs in this study were much older. For example, among the 13 FSWs in Ha Khau participating in the study, one was 17 years old, three were 19 years old, and nine were above 20. Being older, with longer sex work experience and having usually moved from other places, FSWs in the Vietnam-Laos border area had higher risks of HIV infection. The main reason for taking up sex work may be that most of the provinces that participated in this study are remote, mountainous areas with limited economic development and are therefore less attractive to more ambitious, productive young women.

- **Education**: FSWs in the Vietnam-Laos border area had usually completed mid school or high school education. Few FSWs had just completed elementary school or less, and most of these were Laotian or from ethnic minority groups in Dien Bien. This finding was consistent with a prior study on FSWs in the Vietnam-China border area in Lao Cai, but were very different to findings from studies conducted on FSWs in northern provinces (Khuat Thu Hong, 1997) or on FSWs in Quang Ninh (Vu Thi Minh Hanh and Nguyen Thanh Tam, 1998). In our study, only one of the 40 FSWs near the Vietnamese border entry points participating in the study were ethnic Thai and seven others had not completed elementary school education.

- **Marital status**: Most FSWs were single, separated or divorced. Many of them were not married but had children to support because their sex partner had left them. A
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majority of both Vietnamese and Laotian FSWs were not local (except FSWs in Dien Bien). They were from a wide range of locations (some Vietnamese FSWs had come to Laos to do sex work there). They were completely independent from their families, and rented a house or an apartment near the place where they sold sex.

Family background: Most FSWs were born into poor or disadvantaged families, such as those with a lot of children, low income, orphans, and/or separated or divorced parents. Therefore, they did not receive sufficient care or may even have been deserted by their parents. Once slightly older, they often had bad experiences such as having been deceived, cheated, sexually coerced, etc. by their boyfriends or others.

5.2.1.2. Injection drug users

Gender: Most of the drug users (DUs) and IDUs in the border areas were male. However, in recent years the number of female users has increased. Noticeably, there is an increasing trend of both sex work and drug use in the border areas of both countries. Among 40 FSWs interviewed in the Vietnamese border areas, only one FSW, in Plei Kan Town, reported using drugs. However, the information obtained from participants indicates that drug use among FSWs is emerging, not only among Vietnamese ones but also among Laotian FSWs.
In addition, in some communes along the border areas, it appears that the number of women using drugs is increasing.

** "... Drug use among us is not common but exists. They use drugs for more pleasure and/or to relieve tiredness so that they can better satisfy their clients and thus get paid more money...."

(A 28 year old FSW in Nuoc Sot Fall, Ha Tinh)

** “...Laotian FSWs believe that using drugs will prolong the pleasure, their youth and make them more attractive to clients. Therefore, many Laotian FSWs use drugs to support their sex work ...”

(A 38 year old FSW client in Lak Sao Town, Borikhamxay)

- **Age**: Laotian IDUs participating in this study were younger (16 – 37) than Vietnamese IDUs (19 – 62). Most of the IDUs (18/24) interviewed in Vietnam border areas were older than 30, a few (5) were younger while one was 51 and another 62. In comparison with IDUs in Quang Ninh and Lang Son in previous 1990s studies (when 85% were in 18-30 age group), IDUs participating in this study were much older. The reason for this difference was that the number of young users seems to have decreased in recent years. The majority of the currently active IDUs are long-term users, with more than 10 years of drug use, and many of them started using due to the local custom of using opium from a very young age.

- **Education**: Nearly one third (30%) of Laotian DUs participating in this study had completed high school education, with 47% having completed mid school education. Vietnamese DUs in this study seemed to have lower educational level with most of them having just completed mid school education. Among the 40 IDUs interviewed at the three international border entry points, four (in Dien Bien) were illiterate and
six had just completed elementary school. One explanation for this difference is that Laotian IDUs were younger and had only been exposed to and started using amphetamines since the end of the 1990s and early 2000s.

- **Employment**: the majority of Vietnamese DUs were farmers (13), small businessmen or freelance employees doing work such as motor scooter transportation and porters. Very few had other jobs - one was a hair salon owner, two were heads of small enterprises. In comparison, 53% of Laotian DUs were farmers, 41% were freelance employees and 6% were students.

- **Marital status**: A majority of Vietnamese DUs were married and living with their wives and children. Of 24 DUs who supplied information, 18 were married and only six were single. Nearly half (47%) of Laotian DUs were married and the rest (53%) were single.

- **Family background**: DUs in this study had very different family backgrounds. Some were born into business families with good living conditions while some were born into farming families or families doing freelance work to survive. Of the latter group, the DU had to start work from a very early age to earn their living. Most of them were local people living with their families. Few IDUs were from other provinces. There was just one IDU venue in the Laos border area where Vietnamese IDUs (workers from the hydroelectricity plant or road construction sites) would meet.

### 5.2.1.3. LDDs

- **Gender**: All of the LDDs in this study were male. Direct observations showed that there were very few female LDDs. All 22 LDDs participating in this study (15 in Vietnam and 7 in Laos) were male and 17/22 were Vietnamese.

- **Age**: Most of the LDDs were in the 30 – 50 age group. Very few LDDs were under 30 or over 50.

- **Education**: LDDs usually had high school or elementary school education. Very few of them had higher education.

- **Working conditions and income**: Most LDDs drive lorries transporting wood from Laos to Vietnam; some transport fruits or electronics from Thailand to Laos, and after that to Vietnam. From Vietnam, some transport basic commodities to Laos while others drive buses transporting passengers across the border. On average, LDDs who transport wood cross the border four times in a week, every month. They receive their monthly schedule and itinerary from their employers, who are usually located in the central or western provinces. On some occasions, they have to stay in Laos for 6-10 days to wait for a sufficient load of woods. LDDs transporting other
commodities or passengers usually cross the border twice a week and make stops along the way. The income of a cross-border LDD depends on the volume of work they undertake but is usually not very high, ranging from VND5-8 million per month.

- **Marital status:** Most LDDs participating in the study were married, only a few were single. As a LDD, they usually live away from home and visit their home once a month. Some LDDs who transport fruit also bring their wives along on their trips.

- **“Special” interest of LDDs:** The majority of LDDs share the same interests: having sex with multiple sex partners or using entertainment services such as karaoke bars, hair salons, playing cards, etc.

* “... You know it! Any men who usually work away from home like us need to do something for pleasure. However, we are superstitious of the bad luck associated with having sex with FSWs in the van or with FSW while on the way. Only when we reach the loading site, and after taking a bath, will we get together, call a taxi and visit FSWs in the entertainment facilities. I have had sex with many FSWs, both Vietnamese and Laotian. Only when I do not have any money, I don’t ...”.

(A 48 year old LDD transporting wood, Bo Y entry point, Kon Tum)

** “… I followed the planned itinerary. At about 8 PM we reach Lak Sao, stay over night, wake up, have breakfast then start off again the next morning to arrive in Cau Treo entry point to complete the paper work. So Lak Sao is our stop for food, sleep and to do something fun. I would do it (have sex) with FSWs. FSWs can be of all types, Vietnamese or Laotian.”

(A 52 year old LDD transporting passengers, Cau Treo entry point)

5.2.1.4. Other mobile population groups

- **Gender:** According to data provided by the local authorities in the Vietnam-Laos border areas, there are other mobile population groups besides LDDs. These groups include tourists, construction workers, rubber forestation or production workers, construction site owners, small businessmen, and freelance employees. The majority of them are male. Females are those who trade scrap metal, small goods or provide labor services on request. However, in the past few years, the number of women crossing the border, especially Cau Treo entry point, has significantly increased. Most of them are Vietnamese women who go to Laos to open small businesses, work as freelance employees or engage in some other social service activities.

- **Age:** These other mobile groups are of different age groups, ranging from 20-50. There are very few under 20 or over 50.
- **Education**: They tend to have low education (high school education or less). Very few had completed high school education.

- **Marital status**: About 30% are single (more construction workers and road laborers are single). The majority are married and usually work away from home. Very few of them bring their wives or children along, except tourists or groups operating small businesses.

- **Working conditions and income**: Construction workers, road laborers or forestry workers usually work and sleep in remote areas which are often inaccessible in terms of transport. They only travel to centres at weekends. They usually stay in these areas for several months, a year or even several years, until their contract or project ends. Their income is stable and usually ranges from VND 4-5 million per month. Such living conditions also put them in situations with high risk behaviors. The level of cross-border mobility among people who work as freelance employees doing work such as porters or trading is much higher because it is usually difficult for them to find long term work to do and thus to stay in one place for long. The income of this group is also unstable and difficult to determine.

### 5.2.2. High risk behaviors and access to HIV/AIDS

This study revealed that mobile population groups in the border areas are directly involved in high risk behaviors that cause the cross-border transmission of HIV. These behaviors include injection drug use and having unprotected sex. Risks of cross-border HIV transmission resulting from mobile population groups’ risky behaviors are measured by age at which they first engaged in such behavior; the reason why they engaged in this behavior; and where, when and how often they engage in such risky behavior.

#### 5.2.2.1. FSWs

**a) Sexual behavior**

- **Age at which first had sex**: FSWs who participated in this study reported first having sex at a very young age. For Vietnamese FSWs (n=40), the average age was 18 and the range was 16 – 25 years old. (The age at which the participants of a study on Vietnamese youth first reported having sex was 19 (SAVY). The age was much lower among Laotian FSWs (n=17), the range being 13-25 years old. This result indicates a trend of having sex for the first time at “a young age”. The younger the FSW, the earlier the age at which they first had sex.
**First sex partner:** Most of the FSWs reported having sex for the first time with their boyfriend, some said they had sex the first time with a rich man. Among the 40 FSWs that were interviewed in both border areas, only one FSW (working in a massage parlor in a hotel in Dien Bien) said she had sex for the first time with a client, as her “virginity was sold”, while another (a FSW working in a massage parlor in Plei Kan town, Kon Tum) said she had been deceived and raped.

**Current sex partner(s):**

- **Clients:** The main sex partners of FSWs in the border areas are their clients. FSWs’ clients include men from Vietnam, Laos, Cambodia, Thailand and China, and tourists from some foreign countries. FSWs prefered clients from Laos or western countries because they offered more money, and were more polite and tender than clients who came from Vietnam or China.

* “...My first boyfriend was my classmate when we were in 10th grade. After several months dating, we had sex. At that time we did not know why we did it. At grade 11, I dropped out of school because I could not catch up with the program. Two years later, I got married, but not to that classmate. At the age of 20, we had our first child. When our child was two years old, my husband left for another woman. I was depressed and moved to the city to find a job then some people asked me to go with them to Hai Phong to work in a massage parlor... and now I am here....”.

(A 26 year old FSW, working in a massage parlor in a hotel in Dien Bien)

** “... Clients who are from Laos come to see us with their Vietnamese business partners at first. After that they come by themselves and learn some Vietnamese word to communicate. I prefer Laotians because they usually have us overnight, pay more and never bargain. Sometimes we charge two times higher than Vietnamese clients but they are still ok. They are also more tender, when we finish, they just fall asleep and stop annoying us...”

(24 year old FSW in Pleikan town, Kon Tum)

** “... Sometimes we also see foreign clients (from western countries). Other than that, they are mainly from Laos and China. When we receive a foreign client we feel very lucky because foreign clients are polite, tender and pay more money. Laotians are also soft and calm not like Chinese men who always bargain...”

(23 year old FSW working in a massage parlor in a hotel in Dien Bien)

FSWs’ clients who are Vietnamese include local men, freelance workers, small businessmen, government workers or uniformed men. Most of them are from other places. FSWs in Laos said that their local clients were fewer...
than government workers on traveling duty or members of mobile groups that had come from other places.

- **Steady or regular partners:** Each FSW reported having 1-3 regular partners who are their boyfriends, regular clients or facility owners or pimps. Thirty percent of FSWs in Laos said they usually had sex with their steady partner once a week because he also worked far away. More than two thirds (70%) of Vietnamese FSWs reported having sex with steady or regular partners. Their regular partners were regular clients with whom they had established relationships for many years.

- **Husbands:** Only one FSW who worked in a massage parlor in Dien Bien reported still having sex with her husband.

- **Duration of sex work:** A majority of FSWs had been offering sex for 1-5 years. Few of them reported starting sex work recently. A significant proportion of FSWs reported more than five years experience, a couple even had nearly 10 years experience of sex work. FSWs in this study had longer sex work duration in comparison to a study among FSWs in the Vietnam-China border area in Lao (FSWs in Ha Khau, where the study had been conducted, reported a duration of sex work ranging from 3 months to 3 years). The reason for this difference was that the economic situation in the Vietnam-China border area is better and men in that area can spend more for sex but at the same time they are more choosy about selecting FSWs. In contrast, most localities in the Vietnam - Laos border areas are poor and men in these area do not pay much for sex and thus take FSWs who have usually relocated from other provinces or cities and are less expensive. However, this situation may put them at more potential risks of HIV infection because these FSWs also have higher risks of HIV infection and transmission.

- **Sex work venues:** There were a variety of sex work venues in the Vietnam - Laos border areas. In Laos, 70% of FSWs reported having sex with their clients in small guest houses, 20% right at the entertainment facilities and 10% in other less private areas such as in rice fields, at the edge of woods or in the road/street. In Vietnamese border areas, venues for having sex depends on the “social class” of the FSWs. Venues can be hotels, restaurants, guest houses, massage parlors, cafe or on the hills, gardens, etc. For example, high social class FSWs solicited or met their clients in karaoke bars, hair salons, cafes and then go to a hotel or a guest house for sex. For normal or lower social class FSWs, venues can be right at the place where they met the client, such as a cafe or guest house. For older and less attractive FSWs, venues could be in quiet public places. In some cases, FSWs were asked to come to clients’ offices or private houses for sex.
Sexual risk patterns: vaginal sex was most common, followed by hand jobs, which more commonly occurred among FSWs at massage parlors. Charges for these sexual forms was about half that of other forms, such as oral sex, which was favored by a lot of clients but which only some FSWs accepted (because they were not used to doing that) when a higher rate was offered.

**"... If a massage client wants a hand job, we do it right at the massage parlor and he has to pay VND150,000 or VND250,000 more. If he wants a blow job (oral sex), some FSWs will do it but the charge would be VND300,000. I never do it because I find it disgusting..."**

(A FSW in a massage parlor in Nuoc Sot Fall, Huong Son, Ha Tinh)

**"... Some clients have strange behavior. They just touch our bodies or vaginas (with their hands or mouth) ("vet mang" in Vietnamese). We like that because we do not get tired and still get paid, but it still feels weird however..."**

(A 22 year old FSW in Pleikan town, Kon Tum)

Number of clients: The frequency of taking clients was dependent on the social class of the FSWs and venues. Laotian FSWs had 2-4 clients per week, while some did not have any for an entire week. Vietnamese FSWs reported having 2-3 clients per day, some even had 7-8 clients per day. The number of clients was similar to the findings from a study on FSWs in the Vietnam-China border area in Lao Cai. This suggests that the demand for sex work in the Vietnam-Laos border has been increasing and is getting as high as the demand in the Vietnam-China border area in the late 1990s.

Condom use: The FSWs had low rates of condom use, especially when they had sex with their boyfriends or regular sex partners.

- **Condom use with clients:** The FSWs reported high rates of condom use. Most (97%) Laotian FSWs and 80% of Vietnamese FSWs said they used condoms when having sex with their clients. However, a majority of them did not know how to use a condom correctly. They did not check the quality of the condom before use, and did not use a condom from the beginning. In some cases, condoms broke and slipped into the FSW’s vagina and they had to seek help from healthcare workers.

More than half of the Laotian FSWs said they used condoms to prevent pregnancy, only 30% used condoms to prevent STDs. The type of condoms they preferred to use were **Number one** condoms, manufactured in Thailand, which cost LAK5,000 – 10,000/pack of three. Vietnamese FSWs also reported often using condoms imported from Thailand at the cost of VND12,000/pack. Condoms were available for purchase at the pharmacies, guest houses, or hotels where FSWs offered sex.
In some situations, condoms were not used. For example, when FSWs’ clients were government officers, they were afraid to ask them to use a condom or they simply trusted them so that a condom was not used. Or for older FSWs who had fewer clients, and who needed money and did not want to lose any clients, they allowed the client to decide on condom use. In situations like these, there are potential risks of HIV infection and transmission.

- **Condom use with boyfriends/lovers or regular clients:** Most FSWs reported having boyfriends/lovers or regular clients. They did not use a condom when having sex with these partners, even if they knew their partner was having STD symptoms.

 More than 50% of the Laotian FSWs reported not using condoms when having sex with their boyfriends. The rate of condom use with boyfriends among Vietnamese FSWs was even lower. Only five out of the total of 40
Vietnamese FSWs participating in the study reported using a condom when having sex with their boyfriend or lover.

**STDs and medical care seeking behavior:** The prevalence of self-reported STDs among FSWs in Vietnam – Laos border areas was high. Many FSWs had long duration of sex work and had had STDs before they moved to the area. Some (24%) Laotian FSWs reported having had genital discharge. Some of them even reported having had and been treated for gonorrhea. About 80% of the Vietnamese FSWs reported itches in the genital areas and a significant number reported having been treated for STDs. Both Laotian and Vietnamese FSWs commonly reported self-medicating their STDs. This means that when they had a STD, they would go to a pharmacy to buy medicine and treat themselves. Some went to private clinics for diagnoses and when they were told they had a STD, they had to travel to hospitals sometimes hundreds of kilometers away for treatment.

* “... When I get sick or feel itchy in the genital area, I go to the pharmacy and buy medicine to treat myself. If it does not go, I go to a private clinic. I do not go to the hospital because there is a lot of paperwork and a long wait. In addition, we do not feel comfortable to identify ourselves as FSWs and do not want to expose ourselves in places with a lot of people. If the symptom won’t go away, we will go to the hospital for treatment...”

(A 28 year old FSW in Nuoc Sot Fall, Huong Son, Ha Tinh)

** “... FSWs in this area usually come to my clinic for examination. They usually come in a group of 2-3 in a taxi and are always in a hurry. Once I finish examining them and give them the prescription, they leave right away and never stay a few more minutes for directions...”

(An owner of a private clinic in Plei Kan Town, Kon Tum.)

Among street-based FSWs in Vietnamese border areas and in the hot spots in Lao- tian border areas the risk of getting STDs is very high because of poor hygiene conditions. There was no clean water or electricity...

* “... every night I have 3-4 clients. We have sex right on the street/road. There was no water so I just used tissue paper or leaves to clean myself after each encounter. I have to wait until I get back to the creek to wash...”

(A street-based FSW in Do Cat Tunnel, Dien Bien Phu City)

** “... We have very poor hygiene conditions here (in Laos), especially in the dry season. It is difficult just to get a bowl of water. That is why many of us often experience genital discharge and itches. We have to go back to Vietnam every several months for examination and treatment of the itchy symptoms...”

(A Vietnamese FSW in Kilometre 52 in Laos border area)
The high self-reported prevalence of STDs and poor access to treatment services means that FSWs in the Vietnam - Laos border area have many potential risks of contracting or transmitting HIV.

**Attitudes towards HIV/AIDS and access to prevention services:** Due to great mobility, FSWs in the Vietnam - Laos border area have very limited access to information and services for HIV/AIDS prevention. At the time this study was being conducted, only FSWs in the provinces of Attapeu and Borikhamxay in Laos, and Dien Bien in Vietnam were receiving peer education intervention supported by some projects. In the remaining provinces, including Ha Tinh and Kon Tum in Vietnam and Phongsaly in Laos, there have been no harm reduction interventions that target this population. Therefore, the FSWs in these provinces had little knowledge of HIV and HIV prevention. Although most of the FSWs knew that using condoms would prevent HIV, many of them did not know how to use a condom correctly to be safe. They had limited knowledge about HIV transmission routes and how HIV could be prevented.

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* "... I heard that HIV is transmitted through blood. There is no blood in semen so HIV cannot be transmitted then..."  
(27 year old FSW in Dien Bien Phu City)

** "... HIV can be transmitted through semen, but if the semen does not go into our body we cannot get HIV. Anytime when I do not use a condom when having sex with a client or when a condom is broken, I just bend my body really hard to push the virus out, if there is any. That is all I need to do to avoid..."

*** "... I think I cannot get HIV from giving a client a blow job but I am wondering if I can get infected if I receive oral sex from a client. Actually, we just hear general things about HIV on television, we never hear more specific things about HIV so we do not really know..."  
(A 22 year old FSW in Plei Kan Town)

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**b) Drug use behavior**

**Drug use behavior among FSWs:** Drug use was not common among the FSWs and seemed to be decreasing. Most FSWs were aware of the dangers related to drug use. Most FSWs said they did not want to become dependent on drugs because they were afraid of the economic loss and its harm to their health. However, some FSWs used drugs because of peer pressure, or wanted to use them because they thought they would help them work better. Some hotel and guest house owners,
both in Vietnam and Laos’ border areas, said some FSWs and their clients used
drugs before having sex (took amphetamine or smoke/inject heroin) because they
thought using drugs would help them to have a more beautiful body, prolong their
sexual intercourse and also that they would be able to have sex multiple times.

- Pattern of drug use: FSWs who used drugs first started by taking amphetamine (with
  Laotian FSWs) or smoking heroin (with Vietnamese FSWs) then shifted into inject-
ing. In the communes in the border area in Dien Bien, FSWs who injected drugs
usually wandered around and had very few clients. When they had clients, they
would accept any price and even had unprotected sex with them. This group had
very high risks of HIV.

5.2.2.2. IDUs

a) Drug use behavior

- Time of first use: Most drug users, both in Vietnam and Laos’ border areas, started
  using drugs after the 1990s when there was the appearance of a new drug – am-
  phetamine - which was trafficked from Myanmar through Laos into Vietnam and
  then to other countries. Among the 41 drug users participating in this study, only one
  reported that he had started using more than 40 years before.

- Age at first use: The range of ages at first use of drugs among Laotian users in this
  study was 16 to 39 years old.

- Reasons for using: Peer pressure or love sickness were main reasons why they
  started using drugs. In addition, some used drugs because they thought they would
  make them feel stronger so that they could carry heavy things across the border
  more easily and some started using without even knowing the related dangers.

- Use pattern: It was true that both Laotian and Vietnamese users started using drugs
  by taking non-injection amphetamines before moving on to injection drug use. The
duration from smoking amphetamine to injection drug use was one to five years.
There were a variety of reasons why they shifted to injection drug use such as lack
of money to afford amphetamines or wanting to get higher. Some Laotian drug users
claimed that one dose for smoking could be divided into five doses for injecting with
the same results in terms of getting high.

- Venues for using: Venues for using drug varied a lot. To avoid being identified by
  local authorities, IDUs in Vietnam usually found deserted places such as a bush, on
  a mountain or a corner of a bus station for injecting. For example, IDUs in Bo Y (Kon
  Tum) and Na U (Dien Bien) even went across the border and found difficult to iden-
tify places such as goods loading areas or a mountain to do their shots. Laotian
IDUs usually injected drugs on the edge of a wood, a rice field or at an IDU partner’s home. Each venue could include 3-5 IDUs, up to as many as 20 Laotian IDUs, including both males and females. Most Laotian female IDUs were also FSWs.

- **Frequency of use**: Frequency of use depends on individuals’ personal drug tolerance, at least from 1-2 times daily up to 10 times daily, costing VND50,000 per dose.

- **Sharing needles**: All IDUs participating in this study reported sharing syringes and needles without proper cleaning. Although needles were available at affordable prices and most IDUs knew that using sterile needles could prevent HIV infection, a significant proportion of them still shared. Therefore, IDUs in the Vietnam-Laos border areas, especially in Dien Bien, had very high risks of HIV infection and or transmission.

* “... We do not gather as much as we used to, sometimes 4-5 of us get together to shoot up. Usually each of us has our own syringe and needle but at times, when there are not enough for everyone, we have to share. In such situations, those who have not been diagnosed with HIV inject first. For me personally, when I do not have a syringe I will pick someone else’s and use it to inject. Some of the IDUs that I know even have to use dirty water (from the rice field) to dissolve the drug...”*

(An IDU in Dien Bien Phu City)

**b) Sexual behavior**

- **Proportion of IDUs who had sex**: Most drug users in this study (both Laotian and Vietnamese) reported having had sex although some of them were single. Only two of the total 41 drug users in this study said they had never had sex. This finding suggests that IDUs risk HIV through both drug use and sexual activity, especially if they did not practice safe behaviors.

- **Age at which first had sex**: Drug users had sex for the first time at a young age (around 20 years old). Some reported having sex for the first time when they were under 18 years old. Drug use was the main reason why drug users had sex the first time so young. Those who started using drugs at a young age also had sex for the first time at a young age.

- **First sex partner**: The first sex partner of drug users were their classmate, girlfriend/boyfriend or FSW. One third (33%) of Laotian drug users reported having sex the first time with their classmate, 33% with FSWs, 27% with their girlfriend/boyfriend and only 7% with their wife.
- **Condom use:** Only a small proportion of the drug users reported having "safe sex". All the married drug users reported not using a condom when having sex with their wife. They rarely used a condom when having sex with FSWs because they were afraid of losing the pleasure. In addition, some said that using a condom would not make sexual intercourse much longer (2-3 hours) because of the effects of the drugs.

- **Attitude and access to HIV/AIDS prevention:** Compared with FSWs, drug users had more access to HIV/AIDS prevention services because most existing HIV/AIDS programs in the study location target this population. Therefore, the drug users had good knowledge about HIV and how to prevent HIV infection. However, their knowledge did not always result in safe practice. The prevalence of using safe practices was low. The HIV positive drug users in the Vietnam-Laos border areas had limited access to HIV/AIDS care and treatment services because of the long distance to travel, the inability to afford treatment or the concerns about self-esteem or stigma.

5.2.2.3. LDDs

a) **Sexual behavior**

- **Age at which first had sex:** LDDs reported having sex the first time when they were young (mostly under 20 years old). A majority of them had sex before marriage, with their girlfriend, lovers or with FSWs.

  * "... I am 28 years old. I am married. Before getting married I had sex with a FSW when I was 20 years old. I now sometimes have sex with FSWs, both in Laos and in Vietnam. But I always look for Vietnamese FSW, even in Laos, because I do not know the language ..."  
  (A LDD who transports fruit through Cau Treo entry point)

- **Current sex partner(s):** LDDs participating in this study reported having sex with different partners, as follows:
  
  - **Wives:** The majority of LDDs were married and they usually had sex with their wives about two times a week on average, because they worked from home.
  
  - **FSWs:** Disregarding their marital status, most LDDs reported having sex with FSWs. The frequency with which they have sex with FSWs depends on whether they can afford it or on their personal appetite for sex, but on average once a week.
Girls friends or lovers: LDDs who were not married had girl friends. Apart from their girlfriend or wife, some had other sex partners. They still main
tained sexual relationships with these partners and had sex with them more
often than with their wife.

* "... Due to my job, I usually work far from home. We, therefore, all seem to need to “have
pleasure” with women. I only have sex with FSWs on average once per month because I
don’t have much money. My younger colleagues visit FSWs more frequently, sometimes
even a few times per week. The venues to have sex with FSWs are not fixed, and depend
on where we stop, both in Laos and Vietnam..."

(A LDD who drives buses through the Tay Trang entry point, Dien Bien province)

Frequency of visiting FSWs: How often the LDDs visited FSWs depends on their
income and the availability of FSWs in the border area. Some LDDs could have sex
two to three times with a FSW during one visit. On average it was once per week
(range: 1-4 times a week).

*) "... When business is good, I cross the border more often and thus earn more money.
Therefore, I can visit FSWs three or four times a week, sometimes in Vietnam, other times
in Laos or Thailand...".

(A LDD in Cau Treo entry point, Ha Tinh)

**) "... At times I get very excited when I could have sex one to three times during a
visit...."

(A LDD transporting passengers in Tay Trang entry point in Dien Bien)

Number of FSWs LDDs reported having sex with: The LDDs reported having sex
with a lot of FSWs (mean: 30, range: 10-100). Therefore, LDDs had the potential
risk of HIV infection and transmission because they had sex with so many different
FSWs.

Condom use:

With wives: Almost all LDDs, even some with STDs, reported not using a
condom when having sex with their wife, except when they wanted to avoid
an unwanted pregnancy. The reason given for not using a condom when
having sex with their wife was simply the perception that in a sexual relationship between a husband and wife, a condom should only be used as a contraception tool otherwise is not necessary.

- **With girlfriends/lovers:** The LDDs reported not using a condom when having sex with their girlfriend or lover because they had already established a respectful and trustworthy relationship with them and thus condom use was not necessary. Some LDDs thought condom use would destroy such a relationship.

- **With FSWs:** Most LDDs reported using a condom when having sex with FSWs either because they were afraid of getting STDs from the FSW or because the FSW had requested that they use a condom. However, the LDDs did not have full knowledge about correct condom use.

*) "...I use a condom every time I have sex with a FSW. FSWs have sex with lots of people, if you do not protect yourself, you would be in trouble. Every time, I just let the FSW put a condom on. I do not think that it is necessary to check the quality of a condom because once it was made by a Ministry it must be safe..."

(A LDD who transports wood, Bo Y entry point, Kon Tum)

**STD symptoms and access to HIV/AIDS services:** Only one of the LDDs (n=22) reported having STD symptoms. When having a STD they had easy access to STD treatment at the private clinics in Vietnam.

*) "... One time I had problems (having STD symptom that present at the penis) because I had sex with a FSW without using a condom because I was too drunk. That time I had to travel to Qui Nhon for treatment. It was expensive and time-consuming, not to mention that I was very worried that I had transmitted it to my wife..."

(A LDD who transports wood, Bo Y entry point, Kon Tum)

The LDDs had limited access to HIV/AIDS information and prevention services because they moved frequently and did not have much time for television, newspapers or radio, or to receive information directly from anyone...

*) "... We live on the road, in our van, no television, no radio because the network coverage was very poor... There was no television at the loading site, either. There is at the entertainment facilities but we do not visit these places often..."

(A LDD who transports wood, Bo Y entry point, Kon Tum)
b) Drug use behavior.

Not many of the LDDs reported using drugs. Only some of the ones who transported passengers, commodities or wood used drugs. Among those, heroin was most commonly used, either smoked or injected.

*) "... I have been working as a LDD for 5 years, transporting goods from Laos. Two years ago, some of my friends asked me to try heroin saying that it would help me stay awake, which was good for driving at night. I did and now I am addicted. I have to do my shot twice at our frequent stop...."

(A LDD who transports goods, Cau Treo entry point, Ha Tinh)

**) "... We load wood at Kilometer 52 in Laos. It was very boring to wait many days doing nothing. There is an IDU venue there. A few of us were wise enough not to try. But some of us tried and become addicted...."

(A LDD who transports wood, Bo Y entry point, Kon Tum)

In summary, the LDDs in the Vietnam-Laos border areas did not only have multiple sex partners and frequently visited FSWs but some of them also used drugs. These findings suggest that LDDs in the border areas are a potential risk and could contribute to the spread of HIV.

5.2.2.4. Other mobile population groups

Sexual behavior: Other mobile population groups have sexual behavior similar to the LDDs but with lower frequency due to their work and the level of their mobility.

Drug use behavior: The construction workers or road laborers were more likely to use drugs than the LDDs. This may be because they had to stay away from home at the construction site for much longer so they were more likely to visit nearby IDU venues and local FSWs. The combined risks and some other potential factors for HIV infection among these groups are also worrying.

5.2.3. Trajectory of mobility among mobile population

FSWs: The trajectory of mobility among FSWs, especially among Vietnamese FSW was broad. This study revealed that the Vietnamese FSWs had long sex work experience and had moved from place to place throughout the country before moving to the Vietnam-Laos border areas. They also often move from one border area to another to selling sex, not only in Vietnam, but also in Thailand and China, before returning. This trajectory among Laotian FSWs was narrower, they were more likely to move around locally.
- **IDUs**: The IDUs had a narrower trajectory of mobility in comparison to FSWs and their clients. They mainly moved within one area or from their area to neighboring provinces and across the border entry point.

- **LDDs and other mobile population groups**: These groups had the broadest trajectory of mobility. They moved from all provinces and cities of Vietnam, to Laos, Thailand and some also went to Cambodia and China.

**Map 5. Trajectory of mobility among FSWs, IDUs and other mobile population groups**
5.2.4. Social and sexual networks

5.2.4.1. Social networks

- **FSWs**: Due to low self esteem and stigma about doing sex work, FSWs did not live with their families and also hid the fact that they were doing sex work. Their social network was limited to other FSWs or other related groups such as facility owners, bar owners, pimps, clients and boyfriends... Some FSWs often had sex with their regular clients who were both Vietnamese and Laotian.

- **IDUs**: Drug use is illegal and strongly criticized by society. Therefore, IDUs usually lack confidence in their relationships with the surrounding people. A majority of them just had relationships with their family members or with their IDU partners. Some of them also had IDU partners who were Laotian.

- **LDDs and other mobile population groups**: These are more hidden groups. Their visits to FSWs and drug use are not made known and usually performed in different venues. They had diverse and complicated social networks. Apart from normal relationships, they also networked with specific groups such as groups of individuals with the same interests, employers, business partners, owners of hotels, bars and restaurants and other entertainment facilities, pimps, FSWs, etc...
HIV transmission in Vietnam-Laos border areas: current status and solutions

FSWs

Clients (Vietnamese)
Other FSWs
Regular clients, boyfriends
Family members
Neighbors
Gate keepers
FSW
Pimps
Facility owners
Clients (foreigners)

LDDs and other mobile population groups

Pimps
Relatives
Family members
Gate keeper
FSWs (Vietnamese)
FSWs (Laotian)
Facility owners
Neighbors
LDD and other mobile groups
Individuals with same interests
5.2.4.2. Sexual networks

Mobile population groups in the Vietnam-Laos border areas have extended sexual networks. Their sex partners were diverse. FSWs, LDDs and other mobile population groups have more complicated sexual networks than IDUs.

- **IDUs**: Their sex partners include FSWs, wives or girlfriends/lovers.
- **FSWs**: FSWs had multiple sex partners, including clients (including regular clients), boyfriends, pimps, gate keepers, and facility owners...
- **LDDs and other mobile population groups**: Like FSWs, these groups also have complicated sexual networks. They have sexual relationships with their wives, different FSWs (Vietnamese, Laotian or FSW from other countries), girlfriends and lovers...

### Maps of sexual networks of mobile population groups

<table>
<thead>
<tr>
<th>Key</th>
<th>Regular relationship</th>
<th>Interrupted relationship</th>
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<tbody>
<tr>
<td>IDU</td>
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**IDUs**
HIV transmission in Vietnam-Laos border areas: current status and solutions

FSWs

- Clients Vietnamese
- Clients foreigners
- Gate keeper
- Pimps
- Facility owner
- Husband
- Lover/Regular Clients

LDDs and other mobile population groups

- Girlfriend
- Wife
- FSW (Vietnamese)
- FSW (foreigner)
- Lovers
- LDD and other mobile groups
5.2.5. Interaction between different mobile population groups

There are interactive relationships between FSWs with LDDs and construction workers due to the fact that LDDs and construction workers usually follow fixed itineraries and schedules and the rest stops or construction sites are attached to FSW venues. Therefore, LDDs usually had sex with FSWs they already knew. For other mobile population groups, the relationship with FSWs was not established as long as LDDs with FSWs, because these groups or FSWs moved from place to place more often. FSWs did not often establish relationships with their clients in other provinces in Vietnam because they moved from these provinces after years of sex work experience and were losing clients. In contrast, FSWs established relationships with drug users in the Laotian border area because drug users were young and non-injection drug use fuelled their sexual appetite and thus they often visited FSWs.

In conclusion, FSWs and LDDs had more interactive relationships and more potential risks of HIV infection and transmission.

5.3. Situation of cross-border HIV/AIDS control and prevention

In Vietnamese border areas, in recent years the local authorities have made lots of efforts in the control and prevention of social evils such as drug use, prostitution and female trafficking. Therefore, these social evil activities seem to have decreased. Individuals who engaged in these activities change their venues to avoid being identified. However the recent rapid economic growth, with more and more investment in cross-border commercial transactions and tourism, have made the Vietnam – Laos border areas become more attractive to many mobile population groups. Hot spots of FSWs and IDUs have also been established and are beyond the local authorities ability to control them. There is more risk of the spread of HIV/AIDS across the border while the structure of the HIV/AIDS prevention system in these provinces is still constrained.

The HIV/AIDS prevention programs in the three provinces in the Vietnam border areas (Dien Bien, Ha Tinh and Kon Tum) are dependent on Government budget. HIV/AIDS IEC activities have been implemented but primarily focus on urban areas. Very few activities have been carried out in rural, mountainous or border areas. These provinces have not been able to introduce comprehensive harm reduction interventions and are currently limited to education and syringe and needle exchanges targeting IDUs. Except for Dien Bien, the provinces have not implemented any harm reduction interventions for FSWs.

HIV VCT, STD diagnoses and treatment services are very limited in these provinces. By the time this study was conducted, Kon Tum province did not even have HIV testing confirmation capacity.
There has not been any collaboration between local government and authorities in the border areas between the two countries in implementing surveillance, prevention, care and/or treatment of HIV/AIDS.

**In the provinces of the Laos border areas**, HIV/AIDS prevention educational activities have been implemented. However, due to constrained resources, HIV/AIDS programs in these provinces are very limited. The healthcare workers, especially at district level have limited awareness and attitudes towards HIV/AIDS. Not all provinces involved in this study have the capacity to provide STD diagnoses and treatment services or HIV screening and testing. Instead, patients are referred to other provinces which are hundreds of kilometers away, even further than provinces that border Vietnam. When this study was conducted, some harm reduction interventions had already been introduced that targeted FSWs in the border areas. IDUs in Laotian border areas do not have access to harm reduction programs. There is a gap in the collaboration between the local government and authorities between the two countries in implementing HIV/AIDS prevention programs.
Chapter 6

Conclusions
And
recommendations
Chapter 6

Conclusions and recommendations

6.1. Conclusions

- This is the first study on the risks of cross-border HIV/AIDS transmission between the two countries. The study was conducted with the participation of investigators from the two countries. The study locations include areas along the border. Both investigation teams used the same study protocol, that includes study groups and procedures for collecting data and approaching the study subjects. The investigators had opportunities to develop their skills in implementing a community-based assessment, especially in poor communities, how to approach a study subject and how to use qualitative methods to explore the breadth of information. In particular, investigators were updated about the actual epidemic situation and based on that are able to make recommendations for more appropriate and feasible interventions.

- Laos has seen significant changes in its economic development in the border areas as well as in social interactions across the border. These changes have attracted mobile population groups, including an increase of females.

- More and more entertainment facilities have been established along the border areas, both in Vietnam and Laos. These facilities have become hot spots of social crime activities and high risk behavior patterns.

- FSWs in Vietnam-Laos border areas are older with longer sex work duration and prior experience selling sex in other regions. This increases the potential risk for HIV and STDs infection and transmission.

- FSWs (especially Vietnamese FSWs) had the highest risks of cross border HIV transmission, followed by LDD and construction workers, because these are groups with greater mobility and a broader trajectory of social activities, as well as more complicated social and sexual networks. In addition, many individuals from these groups also inject drugs, putting themselves at higher risk of HIV infection.

- Residents along the border areas are also at risk of cross-border HIV transmission due to their custom of having sex freely and exposure to HIV when crossing the border for trafficking commodities and illicit drugs. Freelance workers along the border areas also risk HIV infection and transmission because of their frequent visits to FSWs in entertainment facilities.
Mobile population groups, especially LDD in Vietnam - Laos border areas, followed by construction workers and workers on hydroelectricity plants, and forestation sites, as well as Vietnamese FSWs working in Laotian border areas, have limited access to information and HIV/AIDS prevention services. Therefore, they do not have sufficient knowledge about HIV and HIV prevention. Access to HIV VCT and care and treatment, including ARV services is very limited.

FSWs, especially Vietnamese FSWs and or street-based FSWs in Laotian border areas, had high risks of STIs. However, they do not have access to STI diagnoses and treatment due to lack of these services along the border areas.

Mobile population groups in the border areas have limited access to HIV VCT and care and treatment, including ARV services, due to a lack of affordability and transport as well as limited access to information about the existing services and stigma from the community.

HIV prevention services have been introduced but on a very small scale, at a few sites and targeting only a few groups. All provinces have limited resources to implement more comprehensive HIV/AIDS programs.

To date, there has not yet been any collaboration between the two countries in implementing programs for surveillance, control and prevention, care and treatment of HIV/AIDS.

This study yields significant findings about risks of HIV transmission in the Vietnam - Laos cross-border areas. However, during the implementation process, the activities of the two investigation teams was not adequately coordinated. In addition, this study is primary and it is suggested that it is replicated in the future and expanded to other areas in order to gain broader and more comprehensive information to support the development of intervention programs.

6.2. Recommendations

6.2.1. Establish a partnership to conduct future operational studies

- Allocate more time and resources for better preparatory work such as exchange of information and data, intensive training for investigators.
- Involve all investigators from the initial process during the study protocol development, identification of study locations and appropriate timelines.
- Disseminate the study results widely to all provinces to provide timely updates on the situation of HIV to local leaders and authorities, concerned parties and the wider communities.
- Replicate and expand to other Vietnam - Laos border areas. For better epidemic monitoring and updates, it is also suggested that the study be repeated every 2-3 years.

### 6.2.2. Strengthen cross-border HIV/AIDS control and prevention

- Allocate more resources to scale up IEC and harm reduction programs that target mobile population groups in the border areas by:
  - Establishing peer educators groups to do outreach to provide educational materials in both Vietnamese and Laotian languages, condoms, syringes and needles, and genital washes (for the FSWs). Condoms should be provided directly to the target populations, not through facility owners because they would sell them to FSWs.
  - Organizing mobile services to distribute educational materials and condoms, and locate boxes of clean needles at places accessible to the target populations, including LDDs and other mobile population groups, while they are waiting to complete the customs control paperwork at the entry points.
  - Developing and distributing edu-tainment video tapes that contain messages about HIV/AIDS prevention for LDDs so that they can use these while they are on the road.
- Allocate resources to strengthen harm reduction interventions in the border areas so that local residents have better knowledge about HIV and practice safer behaviors to reduce their risks of HIV infection and transmission.
- Strengthen the capacity of local healthcare workers, especially healthcare workers at the district level in Laos, in HIV/AIDS prevention activities. TOT training is recommended.
- Invest more in improving equipment to enable the provinces in the border area to provide STD diagnoses and treatment. It is also recommended that mobile STD teams be established to provide outreach services at the hot spots for FSWs and IDUs.
- Invest more for establishing HIV VCT sites to make the services accessible to the mobile population groups.
- Provide more resources to strengthen HIV testing capacity for provinces in the Vietnamese border areas so that they can provide referral training and support for Laotian colleagues.
Establish and strengthen the collaboration and coordination between the two countries in implementing comprehensive HIV/AIDS programs in order to reduce cross-border HIV transmission by implementing joint program in:

- Providing IEC activities whereby Vietnamese IEC teams can go to Laos every month to provide educational services to Vietnamese FSWs, LDDs and construction workers and others who are staying and or working in Laos.

- Collaborating in providing STDs diagnoses and treatment. STDs mobile teams can go to Laos to provide on-site services to Vietnamese individuals at risks who are staying and or working in Laos.

- Collaborating in providing HIV VCT and ARV services. Improve the healthcare system in the provinces in Vietnam that border Laos so that these provinces can provide support to their Laotian colleagues or partners.

- Exchanging and updating information on the HIV situation for the purpose of epidemic surveillance and monitoring.
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