Factors affecting utilization of facilities caring for HIV/AIDS in Ho Chi Minh City, Vietnam

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Abstract

Objective: Vietnam has its share of the HIV pandemic. Furthermore, there are barriers of access to the facilities available for the provision of medical and psychological services such as stigma, financial resources, and distance to the facilities. This study is an exploration of the factors affecting the accessibility and the utilization of facilities available for HIV care and prevention services in Vietnam.

Methods: The data was collected from people living with HIV/AIDS (PLWHA) using a questionnaire at a local NGO in Ho Chi Minh City.

Results: The group which visits the most frequently has the highest levels of personal stigma; a correlation was found between visits per month and personal stigma of （r=0.384, p=0.0157）. People receiving ARV treatment, have education beyond high school level, and are Christian visit more frequently than others.

Conclusion: The results of this study might be useful for developing countries that are facing the threat of HIV/AIDS, especially in modifying the established HIV/AIDS prevention policy and developing new strategies towards prevention.

Introduction

Vietnam also has its share of the global HIV pandemic. The predominant risk factor for HIV infection in Vietnam is injecting drug users (IDU) followed by female sex workers (FSW) in Ho Chi Minh City [1, 2]. The prevalence of IDU and FSW is 20% and 4%, respectively [3]. It has been found that in most instances the husband transmits HIV to his wife after becoming infected through injecting drugs. The consequence of this may be mother to child

transmission (MTCT). Many women only find out about their HIV status when they visit antenatal clinics. Recently, sex-related causes of infection may be increasing.

Some countries have successful programs for reducing the incidence of HIV [4, 5]. The facilities for HIV/AIDS play an important role in caring for and supporting people living with HIV/AIDS (PLWHA), as well as in providing testing and prevention education. However, there are still barriers of access to these facilities such as a lack of medical and psychological services, stigma, financial resource(s) and distance to the facilities.

This study is an exploration of the factors affecting the accessibility and the utilization of facilities providing HIV/AIDS care and prevention services. In addition, it also scrutinizes the relationship between stigma and accessibility.

Objectives

This study has two objects: 1) to measure stigma for PLWHA; and 2) to explore the factors affecting the utilization of the facilities including the NGO, which provides social support, and the hospital/health center which provides ARV treatment.

Material and Method

The subjects are persons living with HIV/AIDS who receive care/support services from the NGO and/or receive free ARV treatment from the hospital/ health center. The subjects were invited to join the study voluntarily, conditional upon their willingness to do so.

The Case-Control study was applied. The subjects were divided into 2 groups according to frequency of utilization: 1) case, i.e., those visiting the NGO more than once a week; and 2) controls, i.e., those visiting the NGO once a week or less. The study site is a local NGO which provides care and support for PLWHA in Ho Chi Minh City. The data collection method is a questionnaire. The questionnaire consists of four parts: A. utilization of facilities; B. HIV infection; C. health status and stigma; and D. demographic characteristics. The 4 subscales of stigma are defined as: 1) personalized stigma: the consequences of other people knowing their HIV status; 2) disclosure concern: controlling information, keeping one's HIV status secret; 3) negative self image: feeling unclean, not as good as others or like a bad person; and 4) public attitudes: what people feel about HIV in general. Questions of stigma were rated on a five-linkert scale from 'strongly disagree' to 'strongly agree' [6].

Results

The questionnaire was administered to 51 subjects. The characteristics of the subjects are shown in Table 1.

Table 1. Charactersristics of the subjects (n = 51)

Sex	
Male	39
Female	12
Age	
16-20	2
21-25	18
26-30	24
31-35	7
(Mean 26.9)	
Marital Status	
Single	31
Married	16
Divorced	4
Religion	
Buddhism	29
Christianity	17
Others	2
Non	3

Cause of infection

From spouse: infected by IDU	3
From spouse: infection by CSW	3
Through IDU	25
Through CSW	9
Blood transfusion	0
Unknown	9

ARV treatment

Yes	35
No	14

NGO utilization frequency

More than once a week	11
Once a week or less	28

The results were analyzed by a case-control, which divided the subjects into 2 groups according to their frequency of utilization of the NGO. The t-test was performed with the question items concerning each subscale of stigma, total stigma, age, income and expense spent on food. One item carried a significant difference: this was personal stigma which addressed the perceived consequences of other people knowing that the respondent has HIV, specifically with relation to the respondent's personal experiences or fears of rejection (Table 2). The group, which visits the most frequently, carried the highest personal stigma.

Table 2 Score of Personal Stigma and frequency of utilization of the NGO

	Frequency of utilization	Mean	Std Dev	p
Total Stigma	High	33.091	8.3601	0.1679
	Low	29.542	6.1784	
Personal Stigma	High	10.364	2.8731	0.0192*
	Low	8.250	2.2381	
Disclosure Concern	High	5.5385	2.4019	0.9163
	Low	5.4643	1.9338	
Negative Self Image	High	10.231	3.0319	0.8105
	Low	10.000	2.7903	
Public Attitudes	High	6.0769	2.0191	0.2286
	Low	5.3103	1.8147	
Age	High	25.134	4.4879	0.2085
	Low	26.226	3.5469	
Income	High	1203.4	1617.6	0.2711
	Low	646.97	612.91	
Expense for food	High	542.31	332.82	0.1984
	Low	734.48	615.01	

*; $p<0.05$

The correlation was found between visits per month and personal stigma ($r=0.384$, $p=0.0157$).

The chisq-test was performed on the answered categories namely, duration of infection, existence of infection of other family members, cause of infection, self assessment of health status, symptoms of HIV/AIDS, disclosure of HIV status, gender, marital status, religion, education history, job status, full or part time work and ownership of motorcycle. Three items have significant difference, these are: ARV treatment (Table 3); religion (Buddhist or Christian) (Table 4); and education history (Table 5). Patients who are on ARV treatment are educated beyond high school level, are Christian and visit more frequently than others.

Table 3: ARV treatment status and frequency of utilization of NGO p=0.036

Frequency of utilization	Yes	No
High (more than once a week)	7	6
Low (once a week or less)	26	5

Table 4: Religion and frequency of utilization for NGO p=0.043

Frequency of utilization	Buddhist	Christian
High (more than once a week)	5	7
Low (once a week or less)	21	7

Table 5: Education history and frequency of utilization of NGO p=0.0499

Frequency of utilization	High school or less	College or more
High (more than once a week)	6	7
Low (once a week or less)	23	7

Discussion

Higher levels of personalized stigma lead to more frequent usage of the NGO. Often they have lost their friends after disclosing their HIV status, or they stopped socializing altogether and may be compensating for losing these support networks. The friendly and warmhearted atmosphere of the NGO becomes more appealing with their miserable circumstances.

Christians have more familiar social activity than other religions. This may cause the greater numbers of Christians visiting the NGO when compared to their Buddhist counterparts.

Individuals who are educated beyond high school level visit more often than those who are educated up to high school level. Because of their higher education they have more leadership and may visit more in order to help the staff through volunteering.

The results of this study might be a useful for developing countries which are facing rising threat of HIV/AIDS, especially in modifying the established HIV/AIDS prevention policy and developing new strategies towards prevention.

References

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Appendix

Scale of Stigma

A. Personalized Stigma

1. I have been hurt by how people reacted to the knowledge that I have HIV
2. I have stopped socializing with some people because of their reactions to my having HIV
3. I have lost friends after telling them that I have HIV.

B. Disclosure Concern

4. I am very careful about who I tell that I have HIV
5. I worry that people who know I have HIV will tell others

C. Negative Self Image

6. I feel that I am not as good as others because I have HIV
7. Having HIV makes me feel unclean
8. Having HIV makes me fee that I am a bad person

D. Public Attitude

9. Most people think that a person with HIV is disgusting
10. Most people with HIV are rejected when others find out.