Author's response to reviews

Title: Persisting stigma reduces access to the use of HIV-related care and support services in Viet Nam

Authors:

Duong Cong Thanh (congthanhnhihe@yahoo.com)
Knut Fylkesnes (fylkesnes@yahoo.com)
Karen Marie Moland (Molandmaria@yahoo.com)

Version: 2 Date: 1 May 2012

Author's response to reviews: see over
Dear Editorial Board,

BMC Health Service Research

Re: MS # 082251939562881 ‘Experiences of care and support among people living with HIV in Viet Nam’

Thank you for the review of the revised manuscript and the helpful suggestions from the reviewers.

Referring to questions raised by the reviewers, below are our responses:

**Reviewer 1:**

1. The quantitative survey was conducted in 2004, 7 years ago. The findings are likely to be seriously out-of-date as there have been many changes in Vietnam since then, not the least of which has been implementation of the PEPFAR program, several large Global Fund projects, a number of other large donor-funded projects, and increased support for HIV/AIDS programs from the Vietnamese national budget. For this reason, I suggest dropping the material from the quantitative survey except insofar as it can be used to demonstrate changes (or continuities) during the period since it was conducted. In any case, the authors have already reported the findings from this survey in an earlier paper.

   *Comment: We have removed the material from the quantitative survey as suggested.*

2. The qualitative interviews have some rich findings, particularly on stigma and discrimination and the key roles of families, but it is difficult in the results section to
disentangle what findings come from the 2004 quantitative survey and which are from the 2007 qualitative interviews.

*Comment: Not applicable since the quantitative part has now been dropped.*

3. The sampling procedures are not clearly presented for the qualitative interviews, nor are the participants categorized by key variables such as MARP status. Since many were recruited through peer educators, presumably there are numerous IDUs and others in MARPs but the breakdown is not provided.

*Comment: We employed “snowball” referrals to recruit the participants. This statement has been now included in the sampling methods. There were 27 IDUs out of 45 participants. We were unable to collect sex work and other MARP statuses although some were easily guessed as sex workers.*

4. The qualitative analysis is not adequately described. For example, was any software used for this analysis?

*Comment: We did not use any computer programmes to assist analysis. This statement has been now included in ‘data management and analysis’. This part has now been rewritten to give clearer description.*

5. A limitation that should be addressed is that the qualitative interviews were done in only one province, Hai Phong.

*Comment: We have now developed a limitation paragraph and mentioned about transferability of the findings in discussion.*

**Reviewer 2:**

1. I have two concerns with the paper. The first concern relates to its current relevance. The area of HIV related stigma and discrimination can move fairly quickly
within countries depending on the kinds of policies that have been adopted, and the variations in those policies that occur over time. Because the data are now old -- with respect to HIV issues -- it is not clear if the findings remain relevant, and this is the key to whether they warrant publication. Is this a manuscript of historical interest, or does this manuscript have a bearing on HIV in Vietnam today.

Comment: We have now dropped the quantitative part in which data may not relevant to current situation. As we have now mentioned in the limitation paragraph, this study was conducted in a well-established HIV epidemic city and in which the responses to the HIV epidemic is rather comprehensive including HIV/AIDS education. In addition, Hai Phong is a very urban city and many of the remaining 62 cities/provinces in the country are non-urban, mountainous, and isolated and limited investment in term of HIV/AIDS response. The findings from this study might not be transferable to all areas of the country, but given the continuation of national anti-drug and anti-prostitution policy, we argue that the findings are relevant in areas with high prevalence of HIV and injecting drug use. In addition, In the 2012 Global AIDS Response Progress Report, the government of Viet Nam states that the anti-drug and anti-prostitution policy, stigma and discrimination are major barriers to early HIV diagnosis, access, and adherence to care and treatment services

2. My second concern relates to the focus on self-report data. I accept that PLWHA have described the lack of adequate services and difficulties accessing services. A sense by patients that they are not receiving appropriate care is not necessarily evidence that they are not receiving appropriate care. It would be useful if there was a stronger -- evidence based -- indication that health services were deliberately providing inadequate care. I write "deliberately", because eve if it can be demonstrated that a health services' care was less than ideal, it has to be established
that it is less than adequate because of the patients' HIV status. Health services necessarily have to make choices about where to allocate resources. If there is an issue of equity exposed by that choice then something important is revealed. If it is simply the case that health services in general are inadequate for all, that is far less interesting.

Comment: We have developed a paragraph to discuss the findings regarding lack of access to health care services due to the issue of discrimination.

Major Compulsory Revisions

1. First, the authors need to make very clear how findings from 2004 and 2007 are relevant to treatment and care of PLWHA in Vietnam in 2011/2012.

Comment: Please refer to comment corresponding to item (1.) above.

2. Second the authors need to demonstrate that the "experience of care and support" is not simply an empirical investigation of the perceptions of PLWHA but that those reflections reflect a genuine disadvantage and not just a subjective sense of disadvantage. This moves the paper from one that reports a well known and well established phenomenon to one that demonstrates an important, current issue with the treatment and care of PLWHA.

Comment: We do not understand the reviewer’s comment.

Reviewer 3:

This article deals with an important issue: experiences with care and support among people living with HIV in Vietnam, a country where HIV is very stigmatized. The paper concentrates on qualitative data collected in three urban and three suburban districts in Hai Phong, in the North of Vietnam in 2007, relating these findings to results from a

This 'mix' of methods is problematic because of (1) the time-frame involved: the survey was done three years earlier than the qualitative study; and (2) the geographic coverage of the studies: the survey was done in 20 provinces, the qualitative study in and around one town. Moreover the analysis of the qualitative data needs to be refined. I propose that the authors concentrate in this paper on a more elaborate analysis of the results of the 2007 qualitative study, and contextualize the data by giving the reader more information on HIV testing and treatment programs in Hai Phong, including problems in linkage to care and stigma and discrimination for key populations in this town.

Comment: We have now dropped the quantitative part. We have now included two paragraphs about the context and settings in Hai Phong in the ‘Introduction’. In addition, we have now rewritten the analysis of the qualitative data to give clearer description.

Major revisions needed.

1. The methods used for the qualitative study have to be explained better. The methods section states that the first author conducted 15 interviews. Were these done in the six districts? Under results the paper suggests that there were 45 study participants? The methods sample also needs to clarify the sampling procedure, specifically the recruitment from the 6 districts.

Comment: We have now explained more in the methods. We have included the following sentence in the sampling method ‘We used a local health worker and a peer educator in each district as ‘seeds’ then employed “snowball” referrals to recruit the
The first author conducted fifteen in-depth interviews and three focus group discussions which consist of ten participants each group.

2. In analysing the data the authors should be pay attention to differences in background of the participants by gender, marital status and also by being involved in intravenous drug use and sex work or not. Also, the HIV testing trajectory is relevant. It makes a lot of difference if the PLHIV found out about his/her status when ill or in PMTCT.

Comment: The quantitative part has now been dropped. In qualitative data, we only collected drug injection status but not other MARP statuses even though some were easily guessed as sex workers. We can only see the differences by their own statuses about the differences in term of stigma and discrimination as well as PLHIV statuses of drug use and sex work in general as illustrated in the findings and discussion.

3. The researchers sampled from 3 suburban and 3 urban districts. How many PLHIV did they recruit from urban and suburban? And did they find any differences in linkage to care between the urban and suburban or by district? Why did they sample so many more men than women (33 versus 12)? Vietnam has a strong PMTCT program -- could they not have sampled equal numbers of men and women?

Comment: We recruited 25 informants from urban and 20 from suburban districts. We did not see the difference in the linkage to care between urban and suburban, however, we observed typical illustrations in suburban such as ‘neglect’, ‘fear of contagion.’, and ‘isolation’. Due to high numbers of PLHIV who are males in the area and mostly IDUs, therefore, we easily ended up with enough sample size with more males.
3. The family/spousal support needs to be analyzed further. Spousal support seems low, but this could also be related to many of the interviewees not being married? How also is the family/spousal support different when the HIV positive person is also IDU? Or when the HIV positive person is also pregnant?

Comment: Not applicable since the quantitative part has now been dropped.

4. The authors use the word many often in presenting the qualitative findings: they should be more clear about the numbers involved, and also about the minorities who had different experiences: why were these different? For example only few people were member of support groups. Who were member? How did they get involved? how are they different from the ones that rely on family support? Higher educated? Or geographically distributed, an an area with an active program? Or related to wher they were tested. Lack of access to care also needs to be better explained. Where in the linkage to care do problems occur. The data presented are anecdotal.

Comment: We do not come up with statistics in the qualitative findings since study participants were few but we mentioned some number indicative wordings such as many and some ect... Regarding different experience by minorities, it is now no longer applicable since we dropped quantitative part. We explained more about the access to care services.

5. The high level of enacted stigma in Hai Phong needs to be further discussed. Why is this the case? It is related to the social evils policy of the Vietnam government, but we need to know more about what is going on in Haiphong, the context in which the study was done? Are sex workers and IDUs stigmatized? How? Are there billboards in this city with stigmatizing messages? The results also suggest that contagion fears are prominent? To what extent does HIV/AIDS education confront these contagion fears?
Comment: We have now included two paragraphs about context and setting in Hai Phong in introduction. We have discussed further in the discussion regarding stigma and discrimination regarding the causes of stigma and discrimination as well as proper HIV/AIDS education information provision through public health education programmes.

6. The authors point to unmet need in access to ART, using the 2004 survey data. To what extent did the 45 respondents in HaiPhong have access to ART? and why not? The reason for lack of access could also be clinical, CD4 counts still high?

Comment: We have now dropped the survey data. Among 45 respondents in qualitative data, there are 8 (18%) on ARV as mentioned in characteristics of the study sample. We now do not focus to discuss on ARV issue since we dropped quantitative data. In addition, ARV was not widely available at that time and there are many changes since then. The ARV part is not relevance to discuss today.

We have revised manuscript conforming to the journal style.

We hope that these revisions and improvements now render the manuscript suitable for publication. Please let us know if you should require further information.

Sincerely,

Thanh Cong Duong

National Institute of Hygiene and Epidemiology, Hanoi, Vietnam

Centre for International Health, University of Bergen, Norway