THE POLITICAL ECONOMY OF MEN’S HIV RISK IN VIETNAM AND INTERVENTION CHOICES

In her qualitative research on married men in Vietnam, Phinney has convincingly articulated how men’s extramarital sexual behavior can be partially attributed to the country’s dramatic metamorphosis, under Doi Moi policies, from a planned socialist economy to a free-wheeling capitalist state.1 The question is, what to do with this revelation?

Phinney proposes a set of structural interventions that range from the laudable and immediate (condom marketing in establishments where sex is sold) to the more long-term and quixotic (having married couples socialize more with each other). However, if our goal is to ultimately reduce HIV infection among wives of men who engage in sexual intercourse with commercial sex workers—and to do so urgently—then it is imperative to note Vietnam’s complex HIV epidemic dynamics and the evidence-based interventions needed to address them.2–4

Unlike the HIV epidemics of its neighbors, Thailand and Cambodia, Vietnam’s epidemic is highly driven by an interaction of commercial sex and drug use. Recent surveillance indicates that injection drug use is fueling the HIV epidemic among sex workers.2 Thus, in order to break the infection chain that ultimately leads to wives of men who frequent sex workers, interventions that reduce drug-related HIV infection among sex workers (e.g., harm reduction and drug treatment programs) are just as important as condom promotion.5

Phinney recommends selling condoms, but the mention is far too modest and cursory in relation to the intervention’s proven substantial impact in reducing HIV epidemics. Witness neighboring Thailand and Cambodia, which have reduced their HIV epidemics through aggressive national condom social marketing programs in various forms and venues.6 Recent integrated biobehavioral surveillance data in Vietnam has shown that condom use is increasing in commercial sex throughout the country, and this trend will ultimately lead to a downstream effect of HIV cases averted among wives of men who frequent sex workers.2

Thailand and Cambodia also provide some clues as to what else may happen in Vietnam to lower HIV infection. Partially because of the correct association that men made between HIV and commercial sex in both countries, sexual norms changed and a lower proportion of men now frequent sex workers than was the case prior to the HIV epidemic.7 Although there is not yet empirical evidence for this same trend in Vietnam, it is possible that the same change will occur there. Partner reduction at the population level, especially in commercial sex encounters, significantly reduces HIV transmission and should be encouraged.8

Finally, it is critical to note that individuals need access to user-friendly HIV counseling and testing, and serodiscordant couple counseling, so that individuals can know their status, avoid infecting others through unprotected sex or the sharing of needles, and, if needed, gain early access to HIV care and treatment.9

In regards to the President’s Emergency Program for AIDS Relief mandatory antiprostitution pledge, many detractors of this ill-advised policy have mistakenly blamed it for more sins than they should have. While the policy mandates that organizations obtaining US government funding must pledge that they do not support the legalization of prostitution, it fully supports condom promotion, HIV counseling and testing, and treatment for sexually transmitted infections for sex workers and their clients. Admittedly, the pledge can make this work far less efficient, because organizations cannot, according to the policy, advocate for the changing of laws that criminalize sex workers.10

Whatever the debate and laudable contributions of research such as Phinney’s, we must continue to advocate for the funding and implementation of the most effective HIV incidence–reducing interventions.5

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References
CONSUMPTION OF SOFT DRINKS AND OTHER SWEET DRINKS BY WIC INFANTS

The Journal has published numerous articles on consumption of soft drinks and other sweet drinks by children,1–4 but none of these articles has reported on infants. Papers published elsewhere on complementary feeding of infants have seldom considered these beverages.

The Women, Infants, and Children (WIC) Infant Feeding Practices Study,5,6 a nationally representative 1-year longitudinal study carried out in the mid-1990s, found high levels of consumption of these beverages by infants. In the first month of life, 14% of infants received sweet drinks (i.e., sugar water, fruit-flavored drinks, sodas, tea, and coffee), and by the age of 4 months, nearly one third of infants received these drinks.

This practice was most common among Hispanic infants—one fourth of whom were given sweet drinks in the first month and almost one half of whom were given sweet drinks in the first 4 months. Many Hispanic mothers reported giving their infants “manzanailla” tea in hopes of preventing or treating colic.

Many infants also received fruit juice earlier than the recommended age of 6 months7–5% in the first month and almost half by the age of 4 months. There was little variation among White, African American, and Hispanic mothers. At the time the study was conducted, the WIC program recommended giving fruit juice only when the infant could drink from a cup, after about 4 months of age8; fruit juice has recently been removed from the WIC food package for infants younger than 4 months.

The 2002 Feeding Infants and Toddlers Study9 documented that infants of all ages who were enrolled in WIC were much more likely than were nonparticipants to receive fruit juice. Consumption of sodas and other sweet drinks was not reported.

A recent meta-analysis10 reported that soft drink intake among children and adults was associated with higher energy intake and body weight, lower intake of milk and calcium, and increased risks of several medical problems, particularly diabetes. Thus, the dramatic increase in soft drink consumption in children10 (which is likely to be mirrored in infants) is of great concern.

Although health care workers are likely to talk with mothers about inappropriate feeding of juice to young infants, our study indicates that they should also advise against soft drinks and other sweet drinks for infants of any age.

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This study was approved by the institutional review board of the Battelle Memorial Institute. All participating mothers gave written informed consent.

References

COMMENT ON NAME-BASED REPORTING

Tesoriero et al.1 report data from multiple databases that address the impact of name-based reporting and partner notification on HIV testing in New York State. The authors note several limitations to the data bases underlying their study, but a common and significant limitation is not mentioned. Specifically, none of the databases provides unbiased population-based estimates of changes over time in the size of the at-risk population. The observed pattern of no change in HIV testing over time may, in fact, represent either a decline in testing (at-risk population has increased over time), or an increase in testing over time (at-risk population has declined over time). For instance, population-based data from studies conducted between 1996 and 2003, albeit outside of New York State, illustrate that the size of the population of men who have sex with men exhibiting risky sexual behavior has increased over time.2–4

Among men who have sex with men, it would be reasonable to expect that the size of the population obtaining HIV testing should have increased over time, but according to the data gathered by Tesoriero et al., that has not occurred. Furthermore, the data may in part be based on problematic research conditions that are not easily rectified. That is, the study appears to be confronted with the problem of examining the behavioral impact of an HIV testing policy change in settings wherein anonymous testing already exists and