

CHAPTER II

ESSAY

ALTERNATIVE HIV PREVENTION PARTNER COUNSELING AND TESTING

2.1 INTRODUCTION

The main issue addressed here is to reduce HIV transmission among the female sex partners of HIV men through the change of their risk behaviors. The national bi-annual surveys evaluating Knowledge, Attitude, Beliefs and Practices (KABP) among people aged from 15 – 49 years in 10 provinces/cities (sample size 8,400) conducted in 1993, 1995 and in 12 provinces/cities (sample size 10,008) in 1997 by the National AIDS Bureau “NAB” (presently the National AIDS Standing Bureau “NASB”) and other concerned organizations shows that most of HIV/AIDS information still came from television (over 90%), nearly all people know the “3 modes of HIV/AIDS transmission” (over 80%) and how to protect against possible infection. A large proportion of the general community (80%) have a non-discriminatory attitude towards People Living With HIV/AIDS (PLWH/A). However, changes in high-risk behaviors are very difficult (1).

The National Research on HIV Epidemiology and Intervention Model in Vietnam conducted by the National AIDS Committee (NAC) and its members showed that with the strong commitment and co-ordination from local authorities, intervention activities, including counseling, can be effective in raising knowledge and changing to safer behaviors among these groups.

The analysis of epidemiological evolution of HIV/AIDS in Vietnam shows that after the first case was found in Ho Chi Minh City, Vietnam in December 1990, the epidemic has developed and spread nation-wide and at the end of year 2000, a total of 27,619 people have been identified as HIV infected in Vietnam, including 4,548 AIDS patients of whom 2,401 have died (2). Based on current data of HIV infections among IDUs, CSWs, STD patients, tuberculosis patients, married men and women in the age groups 15-49 years and on the current prevention measures, the National Institute of Hygiene and Epidemiology (Ministry of Health of Vietnam) projection showed that by the end of 2000, there had been approximately 130,000-160,000 PLWH/A and by the year 2005 there will be approximately 250,000-300,000 HIV positive cases. The previous study showed that 80% of HIV infected persons are male and 87% of them have had sex with their female sex partners, and only 43% use condom properly (3). This put the female sex partners of HIV infected men before the great potential of HIV infection.

Since 1990, facing the menace of HIV spread, the Government of Vietnam established the National AIDS Committee (NAC) within the Ministry of Health. Its

network extends from national to grassroots level, and authorizes funding and activities for HIV prevention. Throughout the past ten years, NAC and its system at all levels has regularly directed Information, Education and Communication (IEC) activities including counseling in order that every individual and family can prevent HIV. Each year, the IEC theme is readjusted and supplemented by the NAC in accordance with the HIV/AIDS situation in the country and the world, and in harmony with national and international strategies on HIV/AIDS prevention. The Ordinance on HIV/AIDS was refined and adopted by the Standing Committee of the National Assembly on May 31th 1995. This Ordinance decreed that the HIV/AIDS activities should be carried out by every individual, family and community, every sector and mass organization, every economic and social organization in the whole country. This is a protective Ordinance that requires to notify the HIV status to spouses of HIV-infected persons. Health workers must offer partner notification and counseling to the partners of HIV infected persons. This Ordinance also stipulated the rights of individuals to know their risk of HIV infection and to learn their HIV status.

A number of intervention strategies have been implemented to increase HIV knowledge and behavior modification. In developing countries such as Vietnam, HIV prevention partner counseling and testing is an especially important component of a comprehensive program for HIV prevention (4). HIV prevention partner counseling and testing has been well documented as an effective means for increasing HIV-related knowledge and supporting changes to safer behaviors among persons at high risk (5).

This is a specific intervention which is targeted to the female sex partners of HIV infected men who are at the highest risk of HIV infection. HIV prevention partner counseling and testing is a public health activity that evolved from “contact tracing” activities developed earlier the 20th century for control of sexually transmitted diseases (STDs) (6). It is a pro-active prevention effort, which starts from HIV infected men (index cases). Then, public health workers will make confidential efforts to locate, and conduct analyses to determine which sex partners were most likely to be infected or at risk of developing HIV infection to provide counseling, diagnosing (testing) and treatment and referral services (7). HIV prevention partner counseling and testing can be instrumental in identifying sexual and drug-injecting networks at high risk for transmission of HIV or other STDs (6). These networks are made up of individuals who share social relationships involving sex or drug use. Such networks can identify and describe at least partly through information obtained by HIV prevention partner counseling and testing activities (6). Future prevention interventions can then be more effectively directed, and the HIV risks within the network(s) potentially reduced. Network research, combined with new methods of virus typing and identification of recently infected persons (8), will contribute to a greater understanding of HIV transmission (9). Although HIV prevention partner counseling and testing is not routinely implemented in Vietnam. The National AIDS Standing Bureau (NASB), which has responsibility for coordinating HIV prevention efforts in Vietnam, intends to select “HIV prevention partner counseling and testing” as a key intervention program to break the heterosexual HIV transmission.

2.2 HIV/AIDS EPIDEMIOLOGY

2.2.1 Human Immunodeficiency Virus (HIV)

The Acquired Immune Deficiency Syndrome (AIDS) was first recognized in 1981 (10), (11). The virus causing AIDS was isolated in 1983 and is called Human Immuno Deficiency Virus (HIV-1). In 1985 second sero-type, HIV-2, was identified, HIV-1 is the predominant sero-type worldwide, but HIV-2 has spread extensively in west African countries. It has since been identified in most countries, but is much less common than HIV-1. HIV has been found in all body fluids of infected persons. However, only blood, semen, vaginal secretions and to a much lesser extent, breast milk have been implicated in the transmission of the disease (12).

The World Health Organization has classified the epidemiology of AIDS pandemic into three main patterns (13).

Pattern 1: The epidemic began among homosexual/bisexual and injecting drug user population in the late 1970s and early 1980s. Average in the whole population was lower than 1% while prevalence among people engaged in high-risk behavior could be higher than 50%. This pattern can be found in North America, Western Europe, Austria and New Zealand (13).

Pattern 2: The epidemic began in the late 1970s and early 1980s. Transmission was mostly among heterosexual populations, increasingly in children. The average AIDS prevalence in some cities was between 1% and 25% in the population aged 15-49 years old. This pattern could be in Africa and some parts of Caribbean. The epidemic affected heterosexual population (13).

Pattern 3: The epidemic began in the middle to late 1980s and people with AIDS are still small in number. HIV is still transmitted through blood transfusion. The pattern can be found in Asia (13).

HIV is a challenging global social phenomenon, especially as the HIV virus has no biomedical cure and human risk behavior is the most important factor for the transmission. Social interaction, discrimination and stigmatization have an impact on the prevention and care of people with HIV/AIDS in the family and community.

2.2.2 HIV/AIDS Situation in Vietnam

The present HIV situation in Vietnam is serious. The epidemic has been recognized in all provinces and cities in Vietnam and the situation is getting more and more complicated. Particular in some Northern Provinces such as Quang ninh bordering with China, Hai phong and Hai duong, the number detected is rather high (14). From the time when the first case of HIV was detected in Ho Chi Minh City in 1990, HIV/AIDS pandemic has begun to develop rapidly since 1993. Since 1996, a larger national HIV epidemic has emerged, up to 22 November 1997, the reported HIV cases have amounted to 7,350 cases: 1,071 AIDS cases and 581 deaths (15). More than 75% of all cases to date have been reported since 1996 and large increases in HIV infection have now also been reported. At the end of 2000, a total of 27,619 people have been identified as HIV infected in Vietnam, including 4,548 AIDS patients of whom 2,401 have died (14). The analysis of epidemiological evolution of HIV/AIDS in Vietnam shows that the HIV epidemic is still largely confined to persons at very high risk such as intravenous drug users (IDUs) and commercial sex workers (CSWs) and their sex partners (14). Injection drug use is the dominant form of HIV transmission in the country; however, heterosexual transmission is growing up (16). Currently, the National Institute of Hygiene and Epidemiology "NIHE" (Ministry of Health of Vietnam) projection shows that by the end of 2000, there were approximately 130,000-160,000 people living with HIV and by the year 2005 there will be approximately 250,000-300,000 HIV positive cases. Reported

cases only represent a fraction of the actual number of persons living with HIV/AIDS (PLWH/A) in Vietnam.

The development of HIV/AIDS in Vietnam is similar to that in Thailand, China, and Malaysia. The first stage of the epidemic concentrates in the high risk groups such as IDUs, CSWs and then it widely spread to their sex partners and the general population.

2.3 FEMALE SEX PARTNERS OF HIV INFECTED MEN

2.3.1 High risk of HIV infection

The female sex partners of HIV infected men are at high risk of HIV infection. Traditionally, women are not supposed to talk about sex or make decisions about sex. They do not have the right to suggest safe sexual practice including condom use. In many areas of Vietnam, condom use is not accepted when a wife has sex with her husband. In reality, many of them lack the knowledge, skills in using condom properly in HIV prevention. The survey of more than 700 CSWs in Khanh hoa province of Vietnam showed that only 52% of them reported always using condom with their client and forty-eight percent of CSWs reported that they had had at least 2 sex partners including regular sex partners and irregular sex partners per day during the last six months (17). Many female sex partners including wives did not know about the HIV status of their male sex partners. Perhaps the men did not inform their female sex partners or the men really did not know themselves, their HIV status.

Women are more vulnerable to HIV infection than men because a larger surface of sex organ is exposed, and semen contains higher concentration of HIV than vaginal or cervical fluids. The chance of infection is twice in female compared to male. HIV/AIDS is transmitted by any form of penetrative sex : anal or vaginal sex without condom used properly. In any form of sex, women are always the receptive partners. Oral sex is also risky, where partner has sores in the sex organs or bleeding or sores in the mouth. Anal sex has a higher risk than vaginal sex because it is more likely to injure the tissue of the receptive partner.

Women infected with HIV is a larger burden to the family, society...etc than other because they possibly transmit HIV to their child during the time of pregnancy, delivery or breast-feeding and children will become orphans when their mothers die. In Vietnamese families, the women normally take care the family so they lack of time to get information and access to medical, and social services as well.

2.3.2 Lack of service accessibility

The primary reasons for HIV transmission among female sex partners of HIV infected men are the lack of proper condom use. In Vietnam as well as Asian countries, women normally have responsibility for managing children and family so they lack the opportunity to access the medical or social services such as medical health care and health counseling services. Women also have less opportunity to get information in general and HIV information in particular. STDs in women present fewer symptoms and therefore they often go un-noticed and un-treated in the health service. Hence HIV and STDs transmission becomes easier. In many areas of the country, the community still stigmatizes and discriminates HIV infected persons, particularly HIV infected women and talking about sex is a sensitive issue with women. These reasons have lead to the lack of services accessibility.

2.4 HIV/AIDS PREVENTION STRATEGIES

2.4.1 HIV prevention strategies

The major goals of HIV prevention strategies are to prevent HIV infection, reduce behaviors likely to transmit the virus, and assist individuals at risk or already infected in gaining access to prevention services, medical care, and other needed services. To obtain these goals, HIV prevention activities should work at multiple levels simultaneously – at individual, social network and community levels, as well as at the structural level – addressing the sometimes hidden societal barriers to effective prevention. Successful prevention provides support for healthy decision-making for people at risk for HIV infection and for those who are already infected, to help them avoid spreading the virus to others. The objectives and strategies that follow are designed to optimize the benefits of a continuum of HIV prevention and treatment. In this continuum:

Individuals use the full array of existing prevention interventions and services to adopt and maintain HIV risk reduction behaviors.



Individuals determine their HIV status through voluntary counseling and testing as early as possible after their exposure to HIV.



If they test negative for HIV, they use the full array of existing prevention interventions and services to adopt and maintain HIV risk reduction

If they test positive for HIV, they use quality prevention services and work to adopt and sustain lifelong protective behaviors to avoid transmitting the virus to others.



If they are HIV-infected, they enter the care system as soon as possible to reap the benefits of ongoing care and treatment.



Once in the care system, they benefit from comprehensive, high quality services, including mental health and substance abuse treatment services; treatment for HIV infection; prevention, prophylaxis and treatment of opportunistic infections and other infections, such as STDs and TB.



In conjunction with their providers and support networks, they work to develop strategies to optimize adherence to their prescribed therapies.

To succeed, HIV prevention efforts must be comprehensive and science – based.

The following elements are required for HIV prevention to work:

- An effective community planning process
- Epidemiologic and behavioral surveillance; compilation of other health and demographic data relevant to HIV risks, incidence or prevalence

- HIV counseling, testing and referral and partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services.
- Health education and risk reduction activities, including individual-, group- and community-level interventions
- Accessible diagnosis and treatment of other STDs
- Public information and education programs
- Comprehensive school health programs
- Training and quality assurance
- HIV prevention capacity-building activities
- An HIV prevention technical assistance assessment and plan
- Evaluation of major program activities, interventions and services

As mentioned above, HIV prevention counseling and testing is a key component of the comprehensive program. As the effective intervention documented in the developing countries, it should be conducted to hamper the transmission of HIV.

2.4.2 HIV counseling

“HIV prevention counseling” is a process that is aimed at personal risk reduction – that is a type of counseling with the explicit goal of helping the client identify and commit to a specific behavior change step that will help prevent acquisition or transmission of HIV. HIV prevention counseling engages the client in the session. It is usually, but not always, done in the context of HIV testing.

HIV counseling is the specific counseling, some counseling components have been repeatedly used in HIV counseling and recognized as the effective intervention program because in each counseling session, it focus on:

- *HIV risk reduction.*

Each counseling session should be tailored to address the personal HIV risk of the client rather than providing a predetermined set of information unrelated to the client’s situation or allowing the session to be distracted by the client’s additional problems unrelated to HIV. Counseling techniques such as use of open-ended question and role-play scenarios, attentive listening, and maintaining a nonjudgmental and supportive approach can encourage the client to remain focused on personal HIV risk reduction.

- *An in-depth personalized risk assessment.*

This assessment allows the counselor and client to identify, acknowledge, and understand the specific details of the client’s own HIV risks and the context in which risks occur (18, 19, 20). Keeping the risk assessment personal, as opposed to global will

help the client identify concrete and acceptable protective measures to reduce personal HIV risk.

- *Important misconceptions about HIV transmission risks.*

The counselor should address any misconceptions about HIV transmission that arise in the client's discussion of personal risk.

- *One concrete, achievable behavior change step that will reduce HIV risk.*

Although the optimal goal may be to entirely eliminate HIV risk behaviors, even small behavior changes can reduce the probability of acquiring or transmitting HIV. Behavioral risk reduction steps should be acceptable to the client and appropriate to the client's situation. For clients with several high-risk behaviors, the counselor should help the client focus on reducing the most important risk that he or she is willing to commit to changing.

- *Support for positive steps that have already been made.*

Exploring previous risk-reduction efforts is essential for understanding the strengths and challenges faced by the client in reducing risk. Support for positive steps already taken increases the client's beliefs that he or she can successfully perform further HIV risk-reduction steps. For some clients, agreeing to have an HIV test is an important step in reducing (21, 22)

- *Seeking flexibility in the prevention approach and counseling process.*

Counselors should avoid a "one size fits all" prevention message. Specific behaviors that are safe for one person may be risky for another (23).

- *Skills-building exercises.*

Depending on client needs, the counselor can model or ask the client to demonstrate proper use of male latex condoms, by using different brands on a penis model; proper use of female condoms, by using female anatomy picture; cleaning injection equipment if clean syringes are unavailable; communicating safer sex commitments to new sex partners; or other problem-solving strategies (24, 25, 26, 27).

- *Being clear when providing test results.*

Test results should be provided at the beginning of the posttest session. Counselors should never ask clients to “guess” their test results. Technical information about the test can be provided in a brochure or other means so that the session can focus on personal HIV risk reduction. Counselors should be clear that negative test results do not mean no HIV risk and should work with the client to reconsider ongoing HIV risk behaviors and the importance of taking steps to reduce those risks.

2.4.3 HIV testing

HIV testing is to seek, ensure early knowledge of HIV infection status among HIV-infected persons and persons at increased risk for HIV infection. During the past decade, the demonstrated medical benefits of anti-retroviral therapy have underscored the importance of expanding voluntary HIV testing services to facilitate early diagnosis and treatment of HIV-infected persons. Early knowledge of HIV infection can also result in public health benefits by decreasing risk behaviors that could transmit HIV to uninfected

persons (28). Uninfected persons may benefit from HIV testing if knowing their HIV status assists them in modifying or reducing risk behavior. In particular, knowledge of both one's own HIV status and one's partner's HIV status may be the most critically important factor for preventing acquisition of HIV (29). The past decade has seen a marked expansion in the array of HIV test technologies. In addition to venipuncture, specimens can be collected for HIV testing by oral fluid, urine, and finger-stick methods (30). These methods can help simplify testing procedures and may increase the proportion of clients at increased risk who accept HIV testing. The availability of rapid HIV testing permits test results to be provided to clients at the time of testing and is particularly useful in settings where clients do not routinely return for their HIV test results and follow-up is difficult (31).

HIV testing includes:

Anonymous testing (testing information not documented in client's record) has been used widely and effectively and may offer important benefits for the health of individuals and the public, such as earlier entry into medical care (32). Some persons who would otherwise not have been tested may seek anonymous HIV testing and learn their HIV status.

Confidential testing (testing information documented in client's record) is preferred when the client has no clear preference regarding testing format. Confidential testing may facilitate linkage to follow-up counseling and referral for needed services after test results are received.

2.5 HIV PREVENTION PARTNER COUNSELING & TESTING

HIV prevention partner counseling and testing services combines two elements (HIV partner counseling and HIV testing) into the one model or partner counseling conducted in the context of HIV testing.

HIV partner counseling: is a specific HIV counseling, where clients are sex partners of HIV infected persons, and aims at preventing HIV transmission from HIV infected persons to their sex partners mainly through sexual intercourse. Partner counseling process is similar to the HIV counseling. Difference is made to emphasize in risk reduction of female sex partners of HIV men, moving them to the safe sex behaviors

HIV partner counseling and testing: is the process of partner counseling in the context of HIV testing. It is known as “contact tracing”, pro-active prevention activities for finding, counseling, diagnosing, and treating partners of persons infected with HIV. It originated from the sexually transmitted diseases control program in the United States, in the 1930s. Surgeon General Thomas Parran who established this program asserted that “we can break the chain of infection promptly by treatments; we can find the source and the exposed contacts, get them under treatment, and prevent new chains of infection”.

“Contact tracing” was later expanded to include partners of persons infected with gonorrhea and other STDs, including the human immunodeficiency virus (HIV), and came to be known in the 1980s as “partner notification” (6). In the 1980s, when public

health workers were first being confronted with the rapid spread of HIV, the virus that causes acquired immunodeficiency syndrome (AIDS), informing persons of their possible exposure to HIV and offering counseling, testing services were already recognized as an important disease prevention effort that could help stem the tide of HIV infection. As HIV prevention activities have evolved, so has the terminology for informing the HIV-infected person's sex partners of their possible exposure to the virus. To day, the term HIV prevention partner counseling and testing services more accurately reflect the range of services available to HIV infected persons, their partners, and affected communities through this public health activity.

Why need to combine HIV partner counseling with HIV testing:

We need to combine because if HIV partner counseling without testing:

- Less opportunities to counsel female sex partners of HIV infected men when it is combined, at least there are two counseling sessions for each female sex partner including pretest and post test counseling. Counseling alone, it is very difficult to appoint client for next counseling session and follow-up counseling.
- It is very difficult to convince or expect female sex partner behavior change without supporting evidence. Even though test result is negative, the counselor can say that she is lucky, however a negative result does not mean she is immune from being infected with HIV if she continues the high-risk behaviors.

HIV testing without HIV partner counseling:

- How health workers explain about test results and answers the questions of clients and when the clients need emotional support.
- Sometimes, health workers may encounter violence or complaint from clients when providing test results without counseling.

In conclusion, HIV prevention partner counseling and testing combined, the effectiveness of the program can be multiplied many times, compared with separated program. So it should be integrated into one.

2.6 NEED FOR HIV PREVENTION PARTNER COUNSELING AND TESTING

HIV prevention partner counseling and testing is the model that aims at preventing HIV transmission from HIV positive men to their sex partner mainly through sexual intercourse. HIV prevention partner counseling and testing is one interactive counseling approach in a health setting or any place where confidentiality can be maintained. It is face-to-face counseling and evaluated in controlled studies, and found efficacious in changing behavior or reducing sexually transmitted infections (21, 33). A prevention activity that aims to provide services to HIV-infected persons and their sex partners so they can reduce their risk for infection or, if already infected, can prevent transmission to others; and to help partners gain earlier access to individualized

counseling, HIV testing, medical evaluation, treatment, and other prevention services. Through partner counseling and testing service (PCTS), persons-many are not suspicious of their risk-are informed of their exposure or possible exposure to HIV. Notified partners can choose whether to be tested, and if not tested or if found to be uninfected, can receive counseling about practicing safer behaviors to avoid future exposure to HIV. If, however, they are found to be infected, they can seek early medical treatment and practice behaviors that help prevent transmission of HIV to others and reduce the risk of becoming infected with other STDs. HIV prevention partner counseling and testing can be instrumental in identifying sexual and drug-injecting network at high risk for transmission of HIV or other sexually transmitted diseases. These networks are made up of individuals who share social relationships involving sex or drug use. Such networks can be identified and described at least partly through information obtained by PCTS activities. Future prevention intervention can then be more effectively directed, and the HIV risks within the network(s) potentially reduced.

Despite recent advances in treatment, we do not yet have a cure for AIDS, so HIV remains a lifelong issue for those infected. Furthermore, because society frequently stigmatizes and sometimes discriminates against HIV infected persons, families, and friends, particularly female sex partners. So confidential “contact tracing” or HIV prevention partner counseling and testing is considered as the most effective program in HIV prevention strategy.

2.7 CONCLUSION

HIV/AIDS is a real threat for Vietnam and this is more so because it is in the South and South East Asia region, which has the potential to be the epicenter of the HIV/AIDS epidemic. The infection rate in certain population is already high and through sexual bridging the epidemic can easily enter the low risk population. In line with many other countries, HIV infected men have the potential of HIV transmission to their female sex partners because of their risky sexual lifestyle, necessitated by mobility risk environment and stress. Educational or other preventive services were unable to reach them. Further limitation of education approach in bringing behavior change, particularly related to sex, indicates that enhanced behavioral intervention is required.

Transtheoretical model developed by the Centers for Disease Prevention and Control (CDC), United States, suggests that behavioral change is not a one time but rather an incremental process and it is influenced by different social, cognitive and emotive factors. Counseling and testing has been found as an appropriate method to these influences. HIV Prevention Counseling and Testing has been effectively applied to promote safer behaviors. Hence, this intervention can be implemented by the National AIDS Standing Bureau, Vietnam (NASB) with the collaboration and support of the CDC. A problem may arise again regarding accessibility. However, well trained counselors can deliver counseling and testing services to the targeted groups. Careful planning, regular monitoring and evaluating activities can ensure its success.

References

1. National AIDS Committee of Vietnam. Reports about HIV/AIDS situation in Vietnam. (1999).
2. National AIDS Committee of Vietnam. Reports about HIV/AIDS situation in Vietnam. (2000).
3. Tien, CV., West, Gary R. Durant, Tonji M and Valdiserri, Ronald O. Unpublished munsript. An Emerging HIV Epidemic in Northern Vietnam, a study on program assistance for HIV Prevention Partner Counseling and Testing in Northen Vietnam. (2000).
4. A Chung., Chu, An Q., Nguyen, Thang V. an Dang, Khoat V. Evaluation of the Real Situation of Peer Education in Vietnam. (2000).
5. Gary R. West., A. Stark. Partner Notification for HIV Prevention: A critical Reexamination International Journal of Group Psychotherapy. (1997).
6. Ronald O. Valdiserri., Gary R. West., et al . HIV Counseling and Testing: Its Evolving Role in HIV Prevention. International Journal of Group Psychotherapy. (1997).
7. Bayer, R., Toomey, K. HIV Prevention and the two faces of Partner Notification. American Journal of Public Health, 85. (1992). 1158-1164.
8. Janssen., et al. HIV Infection among Partners in US. Acute Care Hospital: Strategies for the Counseling and Testing of Hospital Patient. The New England Journal of Medicine ; 327(7). (1992). 445-52.
9. Peterman, T., Toomey., Dicker, L., Zaidi, A., Wroten, J., and Carolina, J. HIV Partner Notification: Cost and Effectiveness Data from A Multicenter Randomized Controlled Trial. (Abstract 4587). Abstracts of the Eleventh International Conference on AIDS. (1996).
10. Daniel, VG., AIDS: The Acquire Immune Deficiency Syndrome, MTP, Press limited. (1987).
11. Schoub, B., AIDS & HIV in perspective: A guide to understanding the Virus and its Consequences. (1994).
12. Panza, A., Migrants: HIV testing and counseling: A manual for IOM counselors , International Organization of Migration, Switzerland. (1995).

13. AIDS Division of Vietnamese MOH, HIV/AIDS situation and Preventive and Control AIDS program in Vietnam, AIDS workshop in Asia. (1997).
14. National AIDS Standing Bureau: Report on HIV situation in Vietnam. (2000)
15. Ministry of Health of Vietnam, Country Reports. (1997).
16. Quan, Vu M., Chung, A., Hoang, Long T., and Dondero, Timothy J. HIV in Vietnam: The evolving Epidemic and Prevention Response, 1996 Through 1999. Journal of Acquired Immune Deficiency Syndromes 25. (2000). 360-369.
17. Minh, Truong T., West, Gary R., Do, Nhan T., Jenkins, Richard A., Vadiserri, Ronald O., Durant, Tonji M. and Pham, Huong T. Unpublished manuscript of "XaDI, SIDA" (Go Away, AIDS), a study of commercial sex workers in Nha Trang City, Khanh Hoa Province, Vietnam. (2000).
18. Jemmott JB3, Jemmott LS, Fong GT. Reductions in HIV Risk-Associated Sexual Behaviors among Black Male Adolescents: Effects of an AIDS Prevention Intervention. American Journal of Public Health ;3(1). (1992). 21-6.
19. Kelly JA, Murphy DA, Sikkema KJ, and Kalichman SC. Psychological Interventions to Prevent HIV Infection Are Urgently Needed: News Priorities for Behavioral Research in the Second Decade of AIDS. American Psychologist ; 48(10). (1993). 1023-34.
20. McCusker J, Stoddard A, Zapka J, Zorn M, and Mayer K. Predictors of AIDS-Preventive behavior among homosexually active men: a longitudinal study. AIDS ; 3(7). (1989). 443-8.
21. Sikkema KJ and Bissett R. Concepts, Goals, and Techniques of Counseling: Review and Implication for HIV Counseling and Testing. AIDS Education and Prevention; 9(Supplement B). (1997). 14-26.
22. Wiktor S, Biggar R, Melbye M, Ebbesen P, Colclough G, Digioia R, Sanchez W, Grossman R, and Goedert J. Effect of Knowledge of Human Immunodeficiency Virus Infection Status on Sexual Activity Among Homosexual Men. Journal of Acquired Immunodeficiency Syndromes; 3(1). (1990). 62-8.
23. Kelly JA, St.Lawrence J, Betts R, Brasfield T, and Hood H. A Skill-Training Group Intervention Model to Assist Persons In Reducing Risk Behaviors for HIV Infection. AIDS Education and Prevention; 2(1). (1990). 24-35.

24. Kamb ML, Fishbein M, Douglas J, Rhodes F, Rogers J, Bolan G, Zenilman J, Hoxworth T, Malott K, Iatesta M, et al. Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial. Journal of the American Medical Association; 280(13). (1998). 1161-7.
25. Sikkema KJ, Winett RA, and Lombard DJ. Development and Evaluation of an HIV-Risk Reduction Program for Female College Students. AIDS Education and Prevention;7(2). (1995). 145-59.
26. Kelly JA and Kalichman SC. Increased Attention to Human Sexuality Can Improve HIV-AIDS Prevention Efforts: Key Research Issues and Directions. Journal of Consulting and Clinical Psychology;63(6). (1995). 907-18.
27. Centers for Disease Control and Prevention. Adoption of protective behaviors among persons with recent HIV infection and diagnosis – Alabama, New Jersey, and Tennessee, 1997 – 1998. Morbidity and Mortality Weekly Report; 49(23). (2000). 512-5.
28. Varhese B, Maher JE, Peterman TA, et al. Quantifying the reduction in risk for HIV infection by choice of partner, sex act, and condom use. (Abstract) XII International World AIDS Conference, Durban, South Africa, July 9-14. (2000).
29. Kassler W. Advances in HIV Testing Technology and Their Potential Impact on Prevention. AIDS Education and Prevention;9(SupplementB).(1997).27-40.
30. Centers for Disease Control and Prevention. Update: HIV Counseling and Testing Using Rapid Test – United States, 1995. Morbidity and Mortality Weekly, 47(11) report. (1998). 211-5.
31. Webger N, Linn L, Epstein M, Shapiro M. Reduction of High-Risk Sexual Behavior among Heterosexuals Undergoing HIV Antibody Testing: A Randomized Clinical Trial. American Journal of Public Health; 81(12). (1991).1580-5.
32. Bindman AB, Osmond D, Hecht FM, Lehman JS, Vranizan K, Keane D, and Reingold A. Multistate Evaluation of Anonymous HIV Testing and Access to Medical Care. Journal of the American Medical Association;280(16). (1998).1416-20.
33. Centers for Disease Control and Prevention. Revised HIV Counseling and Testing Guidelines for Pregnant Women. In preparation. (2000).