HIV/AIDS POLICY IN Vietnam

A Civil Society Perspective

A series of reports on HIV/AIDS policy in Nicaragua, Senegal, Ukraine, the United States, and Vietnam

PUBLIC HEALTH WATCH

OPEN SOCIETY INSTITUTE
Public Health Program

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Khuat Thi Hai Oanh
Institute for Social Development Studies

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ISBN: 978-1-891385-78-0

Published by
Open Society Institute
400 West 59th Street
New York, New York 10019 USA
www.soros.org

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Design by Jeanne Criscola | Criscola Design
Layout by Judit Kovács | Createch Ltd.
Printed in Hungary by Createch Ltd.

Photography
Front cover (clockwise from left) Luke Wolagiewicz, WPN: support group for people living with HIV/AIDS, Ukraine; Associated Press: a center caring for abandoned children living with HIV/AIDS, Vietnam; Donna DeCesare: 16-year-old living with HIV, and his mother, Central America.
Back cover (top to bottom) Associated Press: lab assistant tests blood for HIV, Senegal; Associated Press: coordinator with ACLU National Prison Project talks with people in the HIV/AIDS Housing Unit at Mississippi State Penitentiary.

Contents

Preface

In June 2001, at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), 189 national governments agreed to the Declaration of Commitment on HIV/AIDS (DoC). The document commits governments to improving their responses to their domestic AIDS epidemics and sets targets for AIDS-related financing, policy, and programming.

The DoC also stipulates that governments conduct periodic reviews to assess their progress toward meeting their UNGASS commitments. In recognition of the crucial role that civil society plays in the response to HIV/AIDS, the DoC calls on governments to include members of civil society, particularly people living with HIV/AIDS, in the review process.

Established by the Open Society Institute (OSI) in 2004, Public Health Watch supports the independent monitoring of governmental compliance with the UNGASS DoC and other regional and international commitments on HIV/AIDS. It aims to promote informed civil society engagement in policymaking on HIV/AIDS and tuberculosis (TB)—two closely linked diseases that lead to millions of preventable deaths annually. To this end, Public Health Watch also supports the monitoring of TB and TB/HIV policies by civil society, examining compliance with the Amsterdam Declaration to Stop TB and the World Health Organization's (WHO) Interim Policy on Collaborative TB/HIV Activities.

Public Health Watch's methodology incorporates multiple opportunities for dialogue and exchange among a broad range of policy actors. Researchers convene an advisory group of national HIV/AIDS and TB experts, activists, and policy actors. The researchers draft reports based on input from the advisory group, desktop and field research, interviews, and site visits. They then organize in-country roundtable meetings to invite feedback and critique from policymakers, academics, government officials, representatives of affected communities, and other key stakeholders. Finally, Public Health Watch supports researchers in conducting targeted advocacy at the domestic and international levels in response to report findings and recommendations.

For the HIV/AIDS Monitoring Project, Public Health Watch's civil society partners in Nicaragua, Senegal, Ukraine, the United States, and Vietnam have prepared assessments of national HIV/AIDS policies based on a standardized questionnaire, which facilitates the structured review of governmental compliance with key elements of the UNGASS DoC.

To access the reports of the HIV/AIDS Monitoring Project and to learn more about Public Health Watch, including the TB Monitoring Project and the TB/HIV Monitoring and Advocacy Project, please visit www.publichealthwatch.info.

Acknowledgments

This report on HIV/AIDS policy in Vietnam was researched and drafted by Khuat Thi Hai Oanh, the head of Social Health Department at the Institute for Social Development Studies (ISDS) in Hanoi. The staff of Public Health Watch prepared the overview report and provided editing and administrative assistance. OSI's Communications Office provided additional editing and production assistance.

We would like to acknowledge the significant contributions of those who helped conceptualize the report, provided input during interviews, reviewed earlier drafts, and participated in the roundtable discussions, many of whom wish to remain anonymous and are not listed here. Their comments and suggestions were invaluable in finalizing this report.

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Public Health Program

The Open Society Institute's Public Health Program promotes health policies based on social inclusion, human rights, justice, and scientific evidence. The program works with local, national, and international civil society organizations to foster greater civil society engagement in public health policy and practice, to combat the social marginalization and stigma that lead to poor health, and to facilitate access to health information.

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Open Society Institute

The Open Society Institute works to build vibrant and tolerant democracies whose governments are accountable to their citizens. To achieve its mission, OSI seeks to shape public policies that assure greater fairness in political, legal, and economic systems and safeguard fundamental rights. On a local level, OSI implements a range of initiatives to advance justice, education, public health, and independent media. At the same time, OSI builds alliances across borders and continents on issues such as corruption and freedom of information. OSI places a high priority on protecting and improving the lives of marginalized people and communities.

Investor and philanthropist George Soros in 1993 created OSI as a private operating and grantmaking foundation to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism. OSI has expanded the activities of the Soros foundations network to encompass the United States and more than 60 countries in Europe, Asia, Africa, and Latin America. Each Soros foundation relies on the expertise of boards composed of eminent citizens who determine individual agendas based on local priorities.

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Abbreviations

AIDS:	Acquired Immune Deficiency Syndrome
ARV:	Antiretroviral
BCC:	Behavior Change Communication
CCIC:	Communist Party's Central Commission for Ideology and Culture
CCM:	Country Coordinating Mechanism
CHAI:	Clinton Foundation HIV/AIDS Initiative
CPRGS:	Comprehensive Poverty Reduction and Growth Strategy
DoC:	UNGASS Declaration of Commitment on HIV/AIDS
HIV:	Human Immunodeficiency Virus
IBBS:	HIV/STI Integrated Biological and Behavioral Surveillance
IEC:	Information, Education, and Communication
ISDS:	Institute for Social Development Studies
M&E:	Monitoring and evaluation
MDGs:	Millennium Development Goals
MOLISA:	Ministry of Labour, War Invalids and Social Affairs
MOPS:	Ministry of Public Security
NCADP:	National Committee for the Prevention and Control of AIDS, Drugs and Prostitution
NGO:	Nongovernmental Organization
OIs:	Opportunistic Infections
PEPFAR:	U.S. President's Emergency Plan for AIDS Relief
PMTCT:	Prevention of Mother-to-Child Transmission
QTC:	*Quan ly–Tu van–Cham soc*, or Management, Counseling, and Care
STIs:	Sexually Transmitted Infections
TB:	Tuberculosis
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNGASS:	United Nations General Assembly Special Session
VAAC:	Vietnam Administration on HIV/AIDS Control
VCT:	Voluntary Counseling and Testing
VND:	Viet Nam Dong (monetary unit)
WHO:	World Health Organization
WTO:	World Trade Organization

Executive Summary

Since the first case was registered in 1990, HIV/AIDS has spread rapidly in Vietnam. Today, more than a quarter-million people in the country are living with HIV/AIDS. Although the overall prevalence rate among adults is 0.5 percent, prevalence rates are significantly higher among high-risk groups, such as injecting drug users and sex workers. Estimated HIV-prevalence rates for injecting drug users range from 33 percent to 65 percent. The prevalence rate for female sex workers is approximately 16 percent.

The incidence of drug use and sex work escalated around the same time that HIV emerged in Vietnam. The illegal nature of drug use and sex work has complicated efforts to prevent HIV among these high-risk groups. Harm reduction interventions, such as the provision of condoms to sex workers and of sterile needles and syringes to drug users, are only now scaling up gradually. Substitution therapy is not yet available in Vietnam, although there are plans to start a pilot in 2008. The new Law on the Prevention of and Fight Against HIV/AIDS (HIV/AIDS Law) passed in June 2006 finally provides the necessary legislative support for a full scale-up of harm reduction activities, including substitution therapy, but how quickly and effectively the interventions will be rolled out remains uncertain.

Epidemiological evidence suggests that HIV/AIDS is spreading beyond these high-risk groups through sexual networks of drug users and clients of sex workers. In 2005, more than 70 percent of new HIV infections occurred through sexual transmission.Vietnam's current response does not effectively address this rapid rise in sexual transmission, however. There is no specific provision in the National Strategy on HIV/AIDS Prevention Control in Vietnam until 2010 with a Vision to 2020 (National AIDS Strategy) to prevent sexual transmission in the general population, nor are there education or condom-promotion programs for groups other than sex workers and injecting drug users.

Vietnam has demonstrated a high level of political commitment to control HIV/AIDS among its population, as evidenced by its agreement to the terms of the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS (DoC). Its prominent leaders have frequently spoken about the importance of addressing the HIV/AIDS epidemic. Despite these actions, however, the country has not made the prevention and control of HIV/AIDS a priority on the broader social and development agenda, although it has adopted a relatively sound domestic policy framework.

The National AIDS Strategy was adopted in 2004. Lauded as one of the best and most progressive in the region, the strategy identifies nine key, priority areas for action: information, education, and communication (IEC); harm reduction; care and support; treatment; prevention of mother-to-child-transmission (PMTCT); management of sexually transmitted infections (STIs); blood safety; capacity building; and monitoring and evaluation (M&E).

Some progress has been noted in most of these areas, although the country has only recently developed M&E guidelines, without the involvement of civil society. As a result, there has been little comprehensive assessment of program implementation. In addition, the nine action plans create unnecessary divisions among intervention efforts that are inextricably linked, hindering effective collaboration across programs.

The strategy also fails to address the prevention of sexual transmission of HIV and the vulnerability of women and girls, an alarming omission given the recent increases in the number of female infections. In addition, although fighting stigma and discrimination against people living with HIV/AIDS is prominently featured in the policy framework, there is no mention of efforts to address stigma and discrimination against marginalized groups, such as drug users and sex workers.

The implemented programs have achieved mixed results. For example, the government has produced and disseminated a large volume of IEC materials, but condom use remains insufficient, particularly within pre- and extra-marital relationships. Although the new HIV/AIDS law may bring about broader implementation of harm reduction activities, legal and social barriers and the lack of a system for monitoring treatment have so far proven an impediment to the effective scale-up of pilot projects. The government has not adequately acknowledged the importance of nongovernmental organizations (NGOs), self-help groups, and home- and community-based caregivers. Palliative care is not available outside of hospices managed by a small number of faith-based organizations.

Several factors contribute to the weak implementation. There is a lack of trained health care professionals to adequately care and treat people living with HIV/AIDS. Comprehensive training for health care workers is still in development; most training tends to focus on only a specific aspect of care. In addition, the higher compensation of health care workers who treat HIV-positive patients has reinforced the perception that HIV/AIDS is dangerous. The complicated procedure for claiming higher compensation has also led some hospitals to isolate HIV departments rather than promote integrated care. The provinces, districts, and communes also lack the human and financial resources to implement policy directives from the central government. Administrators at the lower levels of government lack management skills and technical knowledge about policies, and, there are insufficient resources to comply with policy directives. To date, there has been little effort to increase the capacity of the health sector or management.

There has also been little coordination of efforts between donors and government. Donors tend to fund specific projects, which often reflect their own priorities, rather than funding overall development objectives. There is no effective multisectoral coordinating body that oversees the national AIDS program. The National Committee for the Prevention and Control of AIDS, Drugs and Prostitution (NCADP), which was established in 2001 to coordinate HIV/AIDS control with drug and prostitution control, has largely remained

inoperative. The AIDS program is managed by the Ministry of Health, which has no authority over other ministries.

In order to prevent a nationally generalized HIV/AIDS epidemic, the report identifies two key areas for immediate action:

- Redouble efforts to stop the spread of HIV by implementing proven interventions, such as comprehensive harm reduction interventions for injecting drug users and sexuality education and condom promotion for young people.

- Ensure full and meaningful participation of civil society, including people living with HIV/AIDS and marginalized groups, in the national HIV/AIDS response, by creating space and the mechanism to involve civil society organizations in policy development, program design, implementation, and evaluation and also by fighting stigma and discrimination against all people living with HIV/AIDS.

Background

The Socialist Republic of Vietnam has a population of approximately 83 million.[1] Since the implementation of economic reforms (Doi Moi) in 1986, Vietnam's economy has grown at a rapid pace. In 2005, the gross domestic product (GDP) reached more than $52 billion with an annual growth rate of 8.4 percent.[2]

HIV was first reported in Vietnam in 1990 and has since spread rapidly. Currently, there are approximately 292,930 people living with HIV/AIDS (up from 96,000 in 1999).[3] By the end of 2005, 56,600 Vietnamese people had lost their lives to AIDS.[4] The Ministry of Health estimates that between 18,000 and 39,000 people contract HIV every year—50 to 100 new infections daily. The national HIV-prevalence rate among adults ages 15 to 49 was estimated to be 0.5 percent at the end of 2005.[5] Prevalence rates have, however, reached generalized levels (greater than 1 percent nationally) in several areas, including Ho Chi Minh City (1.25 percent), Quang Ninh (1.15 percent), and Hai Phong (1.15 percent).[6]

HIV-prevalence rates are also significantly higher among groups at elevated risk. For example, the 2005 estimated national prevalence rate among injecting drug users was 33 percent, while other estimates have put it at as high as 65 percent.[7, 8] The prevalence rate among sex workers is also high, with a national estimate of 16 percent, and rates of 20 to 30 percent in some provinces.[9] Limited surveillance data among men who have sex with men indicate a prevalence-rate range that is between 5 percent (Ho Chi Minh City) and 9 percent (Hanoi.)[10]

The HIV/AIDS epidemic in Vietnam was initially largely driven by injection drug use and, to a lesser extent, by sex work. Recent evidence, however, suggests that HIV is spreading to the general population through the sexual networks of drug users and clients of sex workers. As a result, an increasing number of women are being infected with HIV. Women now account for one-third of all new infections.[11]

HIV/AIDS may also be hindering Vietnam's efforts to control tuberculosis (TB). Since 1995, there has been a tenfold increase in the number of HIV-positive TB patients.[12] In 2004, a TB control program achieved a case-detection rate of 89 percent and a treatment-success rate of 92 percent—far exceeding the targets for DOTS, the internationally recommended TB control strategy. Despite the success of this program, there have been no signs of decline in Vietnam's TB burden.[13] The annual incidence rate was 176 cases per 100,000 in 2004, placing Vietnam 13th among the world's 22 high-burden countries.[14] According to recent estimates, 3 percent of adult TB patients ages 15 to 49 were also infected with HIV.[15] Other sources indicate that the TB/HIV coinfection rate may be higher. however. A sentinel surveillance in 2002 indicated that HIV prevalence among TB patients in the Binh Duong and Hai Phong provinces was higher than 10 percent.[16]

Government Response to "Social Evils"

Vietnam has struggled to understand and address the rise in drug use, which has been increasing concurrently with the spread of HIV/AIDS for more than a decade. Drug use and sex work are not only illegal, they are "social evils," a perception deeply embedded in Vietnam's culture and social mores. Because drug use is not seen as a medical condition requiring treatment, punitive measures against drug users—such as requiring mandatory stays in residential rehabilitation centers—have met with strong support from both policymakers and the general public.

Despite the low price of drugs in Vietnam compared to other places in the world, many drug users inevitably commit crimes in order to finance their habit, which has reinforced the perception that drug users "cause chaos" in society and should be locked up. Approximately 70 percent of criminals use drugs.[17]

Those who test positive for drug use and fail to respond effectively to an initial community-based rehabilitation attempt (which occurs in 90 to 100 percent of cases) are sent to a compulsory drug rehabilitation center, called the 06 center after the legislation that created it.[18, 19] The description of the 06 center directly translates to "labor and social education" center, and the key rehabilitation measures in these centers include mandatory detoxification, social education on the dangers of drug use and risk of HIV transmission, and labor. Similarly, those caught selling sex are sent to re-education centers known as 05 centers.

As of 2006, there were 83 drug rehabilitation centers in Vietnam, with a population of approximately 57,000 undergoing a compulsory rehabilitation of one to two years, as stipulated by the drug control law passed by the legislature in 2000.[20, 21] Recidivism rates are high, however—70 to 80 percent—even after two years in these centers.[22] Efforts to help sex workers "return to an honest living" have also not been effective.[23] In the meantime, the number of registered drug users has increased steadily, from 69,000 in 1996 to 170,000 in 2005.[24]

In order to decrease recidivism rates, several provinces recently implemented a voluntary post-rehabilitation program, which provides residential vocational training and job opportunities to drug users for a term of one to three years.[25] The program is mandatory, however, for individuals deemed to be at high risk of relapse, including those who have been through compulsory rehabilitation two or more times and those without commitments from family members, the workplace, or a school to ensure a drug free life, employment, or education after their return to the community.[26]

Although, on the surface, these vocational programs appear to be designed to benefit drug users, some critics have voiced concern that the programs are actually part of an effort to keep users locked away for longer periods. Former drug users commented that

vocational training doesn't help when users are forced to participate.[27, 28] Drug users whose term in the rehabilitation centers ended before the vocational program went into effect consider themselves lucky to have avoided a "longer sentence."[29]

The 05 and 06 centers and the vocational programs are under the guidance of the Ministry of Labour, War Invalids and Social Affairs (MOLISA). Prisons, on the other hand, are overseen by the Ministry of Public Security (MOPS), which also oversees drug control measures.

The Ministry of Health of Vietnam is supposed to provide technical guidance on health-related matters within detention centers and prisons regarding issues that range from detoxification to treatment of sexually transmitted infections (STIs). In reality, however, health professionals employed by the MOLISA or the MOPS provide health-related services within the 05 and 06 centers.

Government Response to HIV/AIDS

Given the public sentiment against "social evils," harm reduction—the notion of helping and providing services to drug users—has been slow to meet with support in Vietnam. At the administrative level, the division of responsibilities among the ministries has hindered the development of effective interventions to address the incidence of HIV in high-risk groups. The issue of HIV/AIDS falls within the purview of the Ministry of Health, but efforts toward drug control and drug-user rehabilitation are managed by the MOPS and the MOLISA, respectively. The government has attempted to facilitate collaboration among these three ministries by creating the National Committee for the Prevention and Control of AIDS, Drug and Prostitution (NCADP) in 2001. Due to the lack of a dedicated secretariat and clear reporting lines, however, coordination of their efforts has not been effective to date.

In the mid-1990s, with the support of international organizations, Vietnam piloted several harm reduction measures, including needle and syringe exchanges and methadone maintenance treatment. In the early 2000s, it began to distribute condoms to sex workers. There had not been discussions of, or plans for, a full scale-up of these interventions until Vietnam adopted the National AIDS Strategy in 2004. The strategy sets targets to achieve by 2010 100-percent coverage rates for needle exchange and the distribution of condoms to sex workers. Since then, harm reduction interventions have been scaling up. Implementation has been slow, however, due to lack of sufficient political support and management capacity.

Although drug use continues to play a large role in the spread of HIV, the focus on high-risk groups has resulted in the neglect of sexual transmission among the general population, which now accounts for the majority of new HIV infections. There is inadequate sexuality education, particularly among young people, to effectively prevent sexual

transmission of HIV. In addition, despite the fact that women account for an increasingly greater percentage of those newly infected, gender is not a priority in the country's HIV/AIDS response. Reproductive health and HIV/AIDS have been officially accepted as topics in school curricula, but as of late 2006, pilot programs had not launched, and the curriculum content was being revised a second time.

Some experts in Vietnam believe the HIV/AIDS epidemic has outpaced the government's response. Vietnam was slow to implement harm reduction interventions that targeted drug users and missed the opportunity to control HIV/AIDS while it was concentrated among this high-risk group. Harm reduction measures are now available on a limited scale, but the epidemic has started to become generalized, with a prevalence rate of greater than 1 percent in a number of cities that have populations of 1 to 8 million people.

There has been progress on treatment, however. Since antiretroviral (ARV) drugs became available in 2005, the number of people receiving treatment has increased dramatically—from about 50 people in 2003 to 7,000 by the end of 2006 and 10,678 by the end of March 2007.[30, 31] An insufficient number of testing and treatment facilities, the costs associated with diagnostic tests, and the stigma and discrimination associated with HIV/AIDS all continue to pose significant barriers to access to treatment for many. For instance, injecting drug users and sex workers reportedly face particular difficulties in accessing treatment, despite their elevated risk for HIV and higher prevalence rates.

The country's capacity for the treatment of opportunistic infections (OIs) is also seriously lacking. People living with HIV/AIDS have reported that local hospitals cannot provide proper treatment for OIs due to inadequate diagnostic and technical capacity, yet these institutions refuse to refer patients to facilities in the central level because limitations in physical space often lead to overcrowding and long waiting periods. There is also insufficient care and support for people infected with and affected by HIV/AIDS. Pain management medications are not widely available because hospitals and health care professionals fear possible diversion to the black market or other possible legal consequences of stocking opioid drugs. To date, the government has not offered any financial assistance to home- or community-based care givers, nor has it supported NGOs or any other groups in providing psychological and other forms of support to people living with HIV/AIDS.

Primary Health Care System

During the past 15 years, Vietnam has expanded the primary health care system at the communal level, which links to district, provincial, and specialized hospitals. Primary health centers provide preventive, ambulatory, and inpatient services and also implement a range of national health programs, including maternal and child health and family plan-

ning; the expanded program of immunization; communicable disease control; and the HIV/AIDS program. By the end of 2004, nearly all communes had health centers staffed with an average of 4.5 health workers.[32] As a result of these efforts, life expectancy at birth has steadily increased and now exceeds in total an average of 71 years. Infant and child mortality rates have also declined dramatically, dropping to 17 and 23 deaths per 1,000, respectively, in 2004.

Despite the expansion of the primary health care system, public expenditure on health as a percentage of total health spending has declined in recent years. As it built up the health care system, the government concentrated on capital expenditure rather than recurring costs, so although facilities were constructed, they were inadequately supplied, staffed, or maintained.[33] In order to allow resource-strapped public health facilities to generate revenue, the government has allowed them to charge fees for services, which means that patients must pay out-of-pocket for services, even in the public sector.[34] In addition, about 80 percent of public health care staff supplements low incomes by providing services in the private sector, which limits the time they can spend in public facilities and compromises the quality of care provided there.[35]

Private expenditure now accounts for 72 percent of all health spending in Vietnam. The 2006 *World Health Report* places Vietnam among the countries with the highest out-of-pocket spending on health.[36] A 2002 survey revealed that, for the poorest quintile, a single visit to a district hospital will cost more than 20 percent of the average annual nonfood budget per person; admission in a provincial hospital will cost nearly 45 percent of the household nonfood budget.[37] The government has acknowledged that ill health and health care costs are among the primary causes of poverty.[38]

Socioeconomic Impact of HIV/AIDS

> *By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community, and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services....*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 68*

The trend of increasing health care costs raises concerns about the burden these growing costs place on the poor, particularly those living with HIV/AIDS. According to a government assessment of the socioeconomic impact of HIV/AIDS in 2003, most of the families

of people living with HIV/AIDS live below the poverty line. Health expenditures for these families are on average 13 times higher than for families without HIV-positive members.[39] At the same time, household income will likely decrease due to loss of employment or missed days of work, both for the person living with HIV/AIDS and the caregiver. In 2004, 124,000 families became officially impoverished because of the effects of HIV/AIDS (a poor household, by definition, has a monthly per-person income of less than 200,000 VND [Viet Nam Dong, approximately $13]), and the figure could potentially reach a half million by 2015.[40]

Despite the clear connection between HIV/AIDS and poverty, the government's 2003 Comprehensive Poverty Reduction and Growth Strategy (CPRGS)—a key national development policy document endorsed by the World Bank and the International Monetary Fund (IMF)—does not consider HIV/AIDS as a development issue.[41] HIV/AIDS is regarded only as a disease that elicits a medical response; the socioeconomic impact of HIV/AIDS and measures to counter these effects are not addressed in this strategy.

Political Commitment

> *Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, preamble to "Leadership"*

The Vietnamese government has demonstrated strong political commitment to HIV/AIDS prevention and control. High-ranking officials, including the prime minister, president, and vice president, have spoken out publicly about the government's efforts to address the epidemic. For example, in August 2004, President Tran Duc Luong visited HIV patients in Bach Mai Hospital, marking the first public meeting between a top political leader and a person living with HIV/AIDS. In 2005, Vice President Truong My Hoa held a meeting with a large group of people living with HIV/AIDS on World AIDS Day (December 1). However, since then, there have not been any formal meetings between top government officials and people living with HIV/AIDS.

In June 2006, at the UNGASS high-level review meeting, Deputy Prime Minister Pham Gia Khiem issued a public statement reiterating Vietnam's political support for the fight against HIV/AIDS. Proposed actions included the mobilization of organizations and individuals in HIV/AIDS prevention and control activities, the redoubling of efforts to eliminate stigma and discrimination, the provision of equal access to health and social

services for all affected people, and the increase of investment in efforts to prevent and control HIV/AIDS.[42]

At the domestic level, Vietnam's political commitment to control HIV/AIDS has resulted in the adoption of the National AIDS Strategy in 2004. The strategy reaffirms the government's commitment to uphold the UNGASS DoC and the ASEAN Summit Declaration on HIV/AIDS. It has been publicly hailed by the country coordinator of the Joint United Nations Program on HIV/AIDS (UNAIDS) as one of the most comprehensive strategies in Asia. A number of key elements of the DoC, such as the need for a policy response to address the vulnerability of women and girls, are not adequately reflected in this important document, however.

Although the government's commitment to controlling HIV/AIDS is evident in official speeches and some policy documents, it is not prominently featured in the government's social or economic agenda. For example, as noted previously, in the CPRGS, HIV/AIDS is considered a disease rather than a socioeconomic issue. The resolution of the most recent Communist Party congress—one of the most important policy documents in Vietnam—also classifies HIV/AIDS as a disease and proposes that the capacity of the health sector should be increased to "discover and control epidemics, especially HIV/AIDS and newly emerged epidemics."[43] Moreover, financial allocations reinforce the message that the control of HIV/AIDS ranks lower in priority than other initiatives. For example, in Hanoi, drug control received 50 billion VND in 2006; HIV/AIDS received 1.2 billion VND.[44]

There has been insufficient effort to publicize the government's political commitments to and policy framework for the control of HIV/AIDS. As a result, most of the general population has little knowledge about international commitments, such as the UNGASS DoC or the Millennium Development Goals (MDGs), and about the country's progress in upholding these commitments. When asked about the UNGASS DoC, one representative of a self-help group admitted that it was the first time he had heard about it.[45] Another member explained, "People living with HIV/AIDS do not know much about the UNGASS Declaration. I don't even know much about this and I'm an insider. It's not that ordinary people don't pay attention to this issue. It just hasn't been communicated enough."[46]

Even many government officials are not aware of international commitments or national efforts to control HIV/AIDS. A recent survey revealed that only 29 percent of officials in charge of HIV/AIDS communication knew about the UNGASS DoC and MDGs, and only 42 percent had read or attended a presentation about the National AIDS Strategy.[47] One official from the Vietnam Administration on HIV/AIDS Control (VAAC) said of UNGASS, "I have heard about it but I don't really know what it is about."[48]

Policy Framework

The National AIDS Strategy is the most recent and comprehensive policy document on HIV/AIDS and provides the foundation for national efforts. The document states that the "prevention and control [of HIV/AIDS] must be considered a pivotal, urgent and long-term task that requires multisectoral coordination and intensified mobilization of the participation of the whole society."[49] The strategy identifies nine priority areas for action, to be implemented through an action plan: information, education, and communication (IEC) and behavior change communication (BCC); harm reduction; the care and support for people living with HIV/AIDS; monitoring and evaluation (M&E); increased access to treatment; prevention of mother-to-child-transmission (PMTCT); control and treatment of sexually transmitted infections (STIs); blood safety; and capacity strengthening and increased coordination with international donors. As of mid-2007, however, only six of the nine action plans had been approved. Action plans for harm reduction, blood safety, and capacity strengthening and coordination with international donors are still in drafting stages.

Vietnam's National AIDS Strategy has received international praise for being progressive and comprehensive, but there are gaps between the government's stated aspirations and actual policy. For example, although harm reduction interventions are considered a priority in the strategy, substitution therapy, a key component of harm reduction interventions, is not addressed. Also, the strategy encourages people living with HIV/AIDS to play a greater role in HIV/AIDS prevention and control but does not provide sufficient support for them to form independent associations. In order for a group to register as an official organization, which enables it to attract financial support from donors, it must be sponsored by a government-endorsed entity.

Legal Framework

From 1995 to mid-2006, the National Assembly Ordinance on HIV/AIDS was the highest legislative document to support the national AIDS program.[50] The ordinance reflected the government's response to HIV/AIDS during the mid-1990s. It did not include provisions for the treatment of people living with HIV/AIDS. For the most part, its prevention efforts were limited to the dissemination of information, with no mention of needle-exchange programs, substitution therapy, or condom distribution. It also did not sufficiently address the legal protection of the rights of people living with HIV/AIDS or legally ensure the confidentiality of HIV tests.[51]

When the National AIDS Strategy was adopted in 2004, the ordinance could not provide adequate support for the strategy's implementation. Ordinances rank lower

than laws in term of legislative power, so, for example, the ordinance could not provide sufficient backing for certain of the strategy's harm reduction interventions that conflicted with provisions in the Drug Control Law.

To support the National AIDS Strategy more effectively, Vietnam passed a new HIV/AIDS law in June 2006. The Law on the Prevention of and Fight against HIV/AIDS is a significant improvement over the ordinance. It provides stronger protection of the rights of people living with HIV/AIDS, including provisions to ensure confidential HIV testing and to prohibit discrimination against people living with HIV/AIDS in education, employment, and social services. It also explicitly supports needle-exchange programs and substitution therapy for injecting drug users and condom provision for sex workers. The law also provides for the reimbursement of medical costs to those people living with HIV/AIDS who have medical insurance and for free, publicly funded ARV treatment for pregnant women, for children under age six, and for health care workers who acquire HIV through professional exposure.[52]

Some observers have already expressed concerns about the prospects for full implementation of the HIV/AIDS Law, however. A special decree is required to provide implementation guidelines, and, after much delay, one was finally released in late June 2007, three days before the anniversary of the law's passage. The decree includes implementation instructions addressing five critical issues in the HIV/AIDS Law, including harm reduction, ARV treatment, and the care and support of people living with HIV/AIDS. Future guidelines will address additional issues, and, as a result, it may be years before the HIV/AIDS Law is fully in effect. It also remains to be seen how quickly and effectively the instructions issued in the 2007 decree will be implemented. Activists and NGO representatives have emphasized the importance of educating the public—particularly those people living with HIV/AIDS—about the HIV/AIDS Law and its provisions—so that people know their rights and can hold the government accountable.[53]

There is also particular concern about the implementation of harm reduction interventions. With the passage of the HIV/AIDS Law, there is now equal legislative power between HIV/AIDS control and drug control, but any conflicts between the HIV/AIDS Law and the Drug Control Law still must be negotiated. Moreover, there needs to be a large-scale effort to educate police and other law enforcement officers that needle possession and harm reduction interventions are no longer against the law.[53] The full-scale rollout of harm reduction measures would represent a significant shift away from the forced rehabilitation of drug users in 06 centers, which will likely continue to exist as long as the government is committed to drug control. There is hope that the harm reduction interventions stipulated in the HIV/AIDS Law will be an integral component in the eventual phase-out of these rehabilitation centers and provide an opportunity for patients to safely and effectively reenter society.

Civil Society and Policy Development

Mass organizations—such as the Vietnam Women's Union (VWU) and the Vietnam Youth Union (VYU)—are referred to as civil society in the national HIV/AIDS program. They receive funding ($15,000 in 2001) from the national program for HIV/AIDS prevention and care and support activities and are also included as representatives in the NCADP.[55] Some civil society activists argue that these organizations are more governmental than civil, however, because the government fully funds and staffs them. Civil society is a relatively new phenomenon in Vietnam, but is growing rapidly in number, capacity, and scope. The involvement of civil society in social and political processes is still new, but the government appears to be increasingly more receptive, particularly toward HIV/AIDS prevention and control. Civil society—local NGOS and groups of people living with HIV/AIDS—has also demonstrated that, given the opportunity, it can contribute meaningfully to HIV control efforts, not only in implementing programs but in helping to guide and shape policies.

The drafting process for the HIV/AIDS Law provides examples of civil society's participation in both types of activity. The National Assembly of Vietnam held a series of consultations with local and international NGOs and people living with HIV/AIDS, inviting comments on the draft HIV/AIDS Law. For instance, during one session, approximately 40 people living with HIV/AIDS, from regions throughout the country, discussed issues ranging from protection against stigma and discrimination to the right to participate in policy formulation, implementation, and evaluation. To ensure that these consultations would be fruitful and would reflect the needs of a broader group, people living with HIV/AIDS organized consultations among themselves, prepared letters, and sent representatives to attend meetings and discussions.

The participation of nongovernmental actors in the drafting process had several positive effects. Their efforts contributed to the creation of strong language regarding stigma and discrimination and the rights of people living with HIV/AIDS—particularly, the right to confidential HIV testing, to education, to employment, to marriage, and to reproduction. One significant change was the inclusion of substitution therapy in the HIV/AIDS Law, a direct result of joint efforts by policymakers, international organizations, and local activists to advocate for comprehensive harm reduction interventions. For example, a local NGO worked closely with the WHO and the Communist Party's Central Commission for Ideology and Culture (CCIC) to organize seminars on the topic with journalists and to convene meetings with high-ranking officials. Before the final discussion of the HIV/AIDS Law, the CCIC and the Office of the National Assembly distributed a briefing paper focusing on substitution treatment to all National Assembly members. A former drug user living with HIV/AIDS courageously provided personal testimony before the Cultural and Social

Commission of the National Assembly on the urgent need for the treatment. The entire advocacy process took more than two years, but ultimately resulted in the passage of a progressive law.

The POLICY Project, an international NGO, was instrumental in pushing for a transparent process in drafting the HIV/AIDS Law. It helped to convince policymakers of the importance of civil society participation, particularly the participation of people living with HIV/AIDS. Ideally, there will be a formal mechanism to ensure the regular participation of civil society organizations in future processes.

The national delegation to the 2006 UNGASS high-level review meeting included two local NGO representatives and two people living with HIV/AIDS, setting a precedent for the inclusion of civil society in high-level delegations. Prior to the meeting, the civil society representatives consulted with a broader group of civil society members to receive their input for discussion at the meeting. During the consultation, participants (the majority of whom were HIV-positive) expressed concern about a wide range of issues, including the stigma and discrimination faced by children infected with and affected by HIV, the availability and affordability of treatment for members of marginalized populations, the reproductive rights of people living with HIV/AIDS, PMTCT of HIV as an integral part of reproductive health, and the right of people living with HIV/AIDS to form associations.[56]

The civil society representatives in the national UNGASS delegation reported that the opportunity to observe and participate in HIV/AIDS policy dialogue at the global level was a positive experience."I am very proud to be a part of the national delegation," said Pham Thi Hue, a young woman living with HIV. "To me, it means the government recognizes and appreciates the participation of people living with HIV/AIDS. I am very impressed by people living with HIV/AIDS in countries like Brazil and other African countries. They are very strong. I learned a lot from them. This opportunity made me more confident that people living with HIV/AIDS can contribute a lot."[57]

Despite the fact that people living with HIV/AIDS have been included in policy dialogue, there is still no official organization of people living with HIV/AIDS due to a lack of support from government-endorsed entities. Without this support—a legal requirement—an organization cannot have a bank account. It also cannot have a registration stamp, which is required for official communications with other organizations and agencies, to receive funding, for example, or to apply for a license to publish documents. Even without legal status, however, people living with HIV/AIDS have organized self-help groups with assistance from international and local organizations. For instance, the Bright Future Network currently has more than 1,800 members in 17 provinces. It supports people living with HIV/AIDS by facilitating access to treatment and by providing education, counseling, and home-based care, and child support. As of mid-2007, there were more than 50 groups

of people living with HIV/AIDS throughout the country, which are increasingly becoming unofficially recognized as representatives of people living with HIV/AIDS.

HIV/AIDS in the Media

There is a dire shortage of journalists and other media specialists covering HIV/AIDS in Vietnam. Of the nearly 600 media organizations, approximately 20 have journalists assigned to report on HIV/AIDS, none on a full-time basis. Journalists have a limited knowledge of HIV/AIDS, despite numerous training courses organized by the Ministry of Health, the Ministry of Culture and Information, and the CCIC, with support from international organizations. The training courses have reached only a small group of participants, and the course content has been too general to relate to the situation in Vietnam.

The media is an important source of information on HIV/AIDS for the general population. In 2004, more than 96 percent of youth reported that they received information about HIV infection through mass media.[58] The Ministry of Culture and Information reported that during the first half of 2007, there were nearly 200 newspaper articles and 15 radio programs concerning HIV/AIDS.[59] The quality of information is not guaranteed to be high, however. Media reports about HIV/AIDS tend to be superficial, mainly containing statistics rather than in-depth discussion of HIV-related issues. When people living with HIV/AIDS are featured, the stories are often sensational in nature. For example, one newspaper recently reported that a police officer and his wife were both infected by an HIV-positive drug user who stuck them with a needle. The innocent victims were contrasted with the drug users, who "deserve to get infected."[60] Another newspaper article reported another incident in which an HIV-positive drug user attacked a security guard with a needle during a drug bust, claiming that "attacks with syringes by drug users are common."[61]

In order to reduce the incidence of these sensational and highly stigmatizing stories, the CCIC has recently issued guidelines for reporting on HIV in more positive ways. Although this is a positive step, there needs to be a longer-term strategy to build the capacity of journalists and to increase mass communication about the government's efforts to and progress in controlling HIV/AIDS. As the Vietnamese public is largely unaware of the government's domestic and international commitments regarding the control and prevention of HIV/AIDS, enhanced media coverage could be a valuable tool in increasing the country's awareness of the National AIDS Strategy, the new HIV/AIDS Law, and other government efforts.

Stigma and Discrimination

> *By 2003, enact, strengthen or enforce, as appropriate, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups....*
>
> *— UNGASS Declaration of Commitment on HIV/AIDS, Article 58*

> *The question [in people's minds] is always why they got HIV in the first place. Normal people don't get it. They must have done something to get it.*
>
> *—Medical doctor, Quang Ninh*

The legal protection of people living with HIV/AIDS has strengthened in recent years. A decree passed in April 2005 improved upon the National Assembly Ordinance on HIV/AIDS by stipulating punitive sanctions against stigma and discrimination.[62] For example, an institution could be fined if it was found to have breached the confidentiality of HIV test results, refused provision of medical care to people living with HIV/AIDS, or fired employees due to their HIV status. The decree lacked a sufficient enforcement mechanism, however, as there was no ombudsperson or other channel through which to lodge complaints.

The HIV/AIDS Law includes stronger language regarding the protection of the rights of people living with HIV/AIDS and strictly prohibits stigma and discrimination against HIV-positive people. The law also spells out specific rights for people living with HIV/AIDS, including the right to live within the community and within society; to treatment and care; to education, vocational training, and employment; and to privacy and confidentiality. The degree to which these provisions can be enforced remains uncertain, however.

Despite the improvements in legislation protecting people living with HIV/AIDS, there are still many reported incidents of stigma and discrimination in communities, schools, workplaces, the media, and, most common, health care settings.[63, 64] These cases are often the result of misinformation about the casual transmission of HIV and the public's perception of HIV/AIDS being inextricably linked to the "social evils" of injecting drug use and sex work. Further, women tend to be stigmatized more severely than men due to the assumption that HIV is acquired through "immoral" behavior, which challenges the social expectation that women uphold the moral integrity of family and society.[65]

Widespread IEC efforts have raised the public's awareness of HIV/AIDS, but misconceptions persist, which lead to fears about casual HIV transmission through everyday contact.[66] For example, in a survey of more than 1,200 government officials, 17 percent responded that they believed that HIV can be transmitted by mosquitoes, and 13 percent

indicated that they believed that HIV could be spread by sharing towels, clothes, linen, or combs with an HIV-positive person.[67] During debates in the National Assembly, some assembly members insisted on creating separate schools for HIV-positive children because children may "fight and bite each other" during play, which could result in the transmission of HIV.[68] Others argued that people living with HIV/AIDS should be prohibited from marrying and discouraged from having children because children of HIV-positive parents would be infected. In a survey conducted in two hospitals, fewer than 30 percent of hospital workers agreed that HIV-positive women should be allowed to have children.[69]

The activities of mass organizations and the media are effective in reducing stigma and discrimination against people living with HIV/AIDS. IEC and media outreach efforts have improved the general population's understanding of HIV transmission, while, at the same time, encouraging compassion for people living with HIV/AIDS. There are numerous billboards calling for "sympathy and support for people living with HIV/AIDS" throughout the country. Presidential visits to AIDS patients also highlight the importance of supporting people living with HIV/AIDS and advance the view that HIV/AIDS is a public-health issue rather than a social ill.[70]

As a result, there is anecdotal evidence that stigma and discrimination against people living with HIV/AIDS has started to decline. Pham Thi Hue, a person living with HIV/AIDS who was named one of Asia's Heroes by *Time* magazine in 2004, shared her experience. "When I got on a bus before, people didn't want to sit next to me," she said. "But now people are very nice to me."[71] A man living with HIV in Quang Ninh province said, "Before, an HIV-positive person was like a monster. People would keep away from me. But now it is okay. They even offer me a drink and let me hold their kids."[72]

Some people living with HIV/AIDS attribute these changes in public behavior to people's fear of violating the law, not to a genuine shift in attitude. An HIV-positive woman whose daughter started school this year said, "I know the school doesn't want to accept my daughter but because they are afraid of violating the law they have to take her. But I know they are not happy."[73] In addition, although people may discriminate less overtly, many continue to pass moral judgment. One doctor explained, "The question [in people's minds] is always why they got HIV in the first place. Normal people don't get it. They must have done something to get it."[74]

Interviews with health care providers, government officials, and those in self-help groups also suggest that not everyone has benefited from the antistigma campaigns. Drug users and sex workers, in particular, continue to experience severe stigma and discrimination. For example, one official from VAAC said, "I agree that we shouldn't discriminate against HIV-positive patients. But I cannot agree that we shouldn't discriminate against drug users and sex workers. They are illegal. Even by law, they are criminals. And you see drug users

create chaos in society. How can you not be angry? They must be discriminated against."[75] A member of a self-help group said that drug users should be locked up in forced rehabilitation centers because they commit crimes.[76]

The increased acceptance of some people living with HIV/AIDS coupled with the ongoing negative attitudes toward drug users and sex workers has led to divisive categories of "innocent" and "guilty" people living with HIV/AIDS. Media stories that tell of HIV-positive drug users attacking police or security officers reinforce the distinction. Recent public appearances by women infected by their husbands have drawn attention to the rise in female infections and have increased sympathy for "innocent" victims of HIV/AIDS, but their victimization invariably is contrasted with the "guilt" of those who put themselves and others at risk with their behavior.

To ensure that efforts to counter widespread stigma and discrimination are effective, existing measures must be strengthened and reinforced. Dissemination of accurate information about HIV/AIDS could help eliminate fears of casual transmission. In addition, the government must make a concerted effort to disassociate HIV/AIDS from "social evils." Many AIDS experts believe that HIV/AIDS-related stigma and discrimination can only be substantially reduced when the rights of drug users and sex workers are protected and when people understand and develop empathy for them. Finally, working with the media to present more positive portrayals of people living with HIV/AIDS could help to reinforce antistigma campaign messages.

HIV/AIDS Policy

The National AIDS Strategy identifies nine priority areas of action: information, education, and communication (IEC) and behavior change communication (BCC); harm reduction; care and support for people living with HIV/AIDS; monitoring and evaluation (M&E); increased access to treatment; prevention of mother-to-child-transmission (PMTCT); control and treatment of sexually transmitted infections (STIs); blood safety; and increased coordination with international donors. The translation of policy into programs requires instructions for implementing action plans to address these priorities, but not all of the priorities have clear programmatic guidelines and plans for implementation. As of mid-2007, almost four years after the National AIDS Strategy was approved, only six of the nine priorities have implementation guidelines.

Some AIDS experts have criticized the lack of integration among the nine action plans. They believe that, rather than emphasizing separate programs, the action plans should instead focus on broader categories, such as prevention, care and treatment, and the mitigation of the socioeconomic impact of HIV/AIDS. For example, in the view of these experts, IEC should not be its own action plan, but rather integrated into all programs.[77] In addition, they believe that issues not covered by the nine priority areas—such as the integration of TB and HIV/AIDS programming, the prevention of sexual transmission, and impact mitigation—do not receive adequate attention.

Policy Administration and Financing

> *By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS....*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 37*

> *Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required, and ensure that adequate allocations are made by all ministries and other relevant stakeholders.*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 82*

Responding to pressure for administrative reform from the international community, in 2001 Vietnam created a multisectoral body called the National Committee for the Prevention and Control of AIDS, Drugs and Prostitution (NCADP). This action was an attempt to reduce the number of government ministries and eventually improve coordination among

the three ministries that are responsible for the control of HIV/AIDS, drug use, and sex work: the Ministry of Health, the Ministry of Labour, War Invalids and Social Affairs (MOLISA), and the Ministry of Public Security (MOPS).[78] The NCADP is tasked with setting national priorities, coordinating all program activities, and overseeing implementation of the relevant strategy for each of the three programs.

In reality, however, the NCADP exists largely on paper only and has not been effective in its role as coordinator. The NCADP never received sufficient human or financial resources and does not exercise meaningful authority over the three programs. According to a former manager of the national AIDS program, NCADP meetings are held only every six months or once a year and are simply reporting sessions on the progress of the three programs.[79] By definition, the NCADP makes an explicit link between HIV/AIDS, drug use, and sex work, which reinforces the perception that HIV/AIDS and "social evils" go hand in hand. A truly multisectoral approach to HIV/AIDS control would coordinate closely with other ministries and programs—for example, those responsible for education, transportation, and labor—not only those controlling drug use and sex work.

In practice, the national AIDS program is managed by the Ministry of Health, MOLISA oversees drug user and sex worker rehabilitation programs, and MOPS is responsible for drug control efforts. Within the Ministry of Health, the VAAC serves as the executive body of the national AIDS program. Although the VAAC's primary responsibility is to coordinate all activities of the AIDS program, it has never been accorded sufficient administrative or financial negotiating power to exercise meaningful authority over other ministries and institutions outside the Ministry of Health. These restrictions limit its functionality and relegate it to an advisory rather than an enforcement role. As a result, there is little coordination across sectors, so the response to HIV/AIDS is primarily a single-sector approach.

In 2005, Vietnam began setting up a system of provincial AIDS centers to help decentralize HIV/AIDS activities more effectively. By mid-2006, more than 20 provinces had their own AIDS centers. The organization, capacity, and authority of these centers remain weak, however. Many are staffed with personnel who lack prior experience with HIV/AIDS-related issues, yet there has been little effort to provide them with training or other forms of support. One-time training sessions are offered, but they are sporadic and limited in scope, addressing the needs of only specific projects.

Staff at national and provincial AIDS agencies need comprehensive training on program content and management. According to a member of a self-help group for people living with HIV/AIDS, "the technical staff at local levels doesn't know much about policies."[80] The task of training staff has also been complicated by high turnover rates. One director of a provincial AIDS center explained that "the staff are not committed or motivated. They are paid low salaries and have heavy work loads."[81] In order to ensure implementation of the HIV/AIDS Law, it is critical to build the capacity of provincial AIDS centers.

HIV/AIDS policies are determined at the central level and, as a result, sometimes do not correspond to the needs of each province or community. The Ministry of Health is insulated from the impact of HIV/AIDS on the local level, and provincial administrators, who are often more in touch with the issues, do not have sufficient authority to influence policies.[82] In addition, central-level policy directives also not paired with adequate resources or sufficient instructions. Resources often get "stuck" at the various levels of bureaucracy. There have been some reports of provincial health authorities diverting AIDS funding from donors or from the government to other health programs so that the AIDS center only gets a fraction of the intended amount.[83] In 2005, the Ministry of Health reported that nine provinces diverted state funding for AIDS programs for other uses.[84]

International Donor Assistance

Vietnam has significantly increased its domestic budget allocation for HIV/AIDS in recent years, reaching $5 million in 2005 and more than $9 million in 2007.[85] At the same time, the government has actively sought international donor assistance to help finance HIV/AIDS activities. The resulting influx of donor funding has been staggering, with more than $200 million committed for the five-year period from 2004 to 2008.[86] In 2004, the total expenditure for HIV/AIDS was approximately $29 million, which exceeded the estimated amount of $20 million required to finance the National AIDS Strategy.[87] Although the government has since revised the estimate upward (to more than $518 million for the 2007–2010 period), lack of funds is no longer a critical challenge for implementing comprehensive interventions to control HIV/AIDS.[88] The real challenges ahead lie elsewhere, for example, in ensuring efficient use of available financial, human, and institutional resources; building local capacity in managing and absorbing funds; and increasing coordination between government and donors.

A large proportion of donor funding supports international organizations or governmental agencies rather than local organizations. The National Health Accounts (NHA) subanalysis for HIV/AIDS in 2004 revealed that nearly 66 percent of external funding was disbursed to international organizations, 24 percent to the Ministry of Health, and less than 10 percent to local organizations.[89] In 2005, for example, of the 17 partners in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), only three were Vietnamese: the Ministry of Health, the Hanoi School of Public Health, and the Ho Chi Minh City AIDS Committee. Only $3 million of the $27.6 million the U.S. government committed for 2005 was disbursed to these Vietnamese partners and approximately $13 million to international partners, primarily American NGOs.[90] PEPFAR's commitment also includes its own management expenditures, which account for nearly one-third of its total budget.

Overhead costs and consultancies account for as much as 71 percent of the funding to international organizations.[91] Some international organizations report overhead costs of 25 to 40 percent. As a result, the actual amount of money spent on HIV/AIDS prevention and control in Vietnam may be far less than the total amounts that donors have committed. Some local organizations have questioned whether the government should acknowledge receipt of total committed funds if, in reality, only a small portion of those funds has actually been spent on the ground. Their concern is that the dramatic increases in donor funding may discourage other potential donors from providing additional support. By indicating the actual amount spent on HIV/AIDS activities, the government may better make the case for continued or increased international support.

On the other hand, many representatives of local and international NGOs do not view international donor support for consultancies as an extravagance. External technical experts are often critical to the success of locally implemented projects.[92] NGO representatives emphasize that the funding allocated to international organizations does eventually flow back into Vietnam, as many of the organizations partner with or subcontract to local organizations. For example, Family Health International (FHI), an American NGO, subcontracts with over 30 provincial and district health services and local NGOs. International organizations may manage 66 percent of external AIDS funding, even though they are not the intended beneficiaries.

One of the primary reasons that a large proportion of international funding is managed by international organizations is because local organizations do not have the capacity to manage the funds themselves. Although the number of local NGOs that are working on the issue of HIV/AIDS has increased significantly in recent years, their capacity and strategy remain weak, and there has been little effort to strengthen them. Many local organizations are understaffed and underfunded, operating primarily as consulting groups to implement projects designed by international organizations, but without clear direction or purpose. Increased donor support for building local capacity could help ensure that the Vietnamese could provide their own management and technical expertise in the future, without having to rely on outside assistance.

In accordance with the National AIDS Strategy, increased donor support allows for full funding of proposed HIV/AIDS activities, but some officials have voiced concern that donors are pushing their own agendas without regard to Vietnam's priorities and objectives. For example, PEPFAR prohibits the use of its funds to purchase clean needles for drug users, It also promotes the AB approach (abstinence until marriage/be faithful) and does not endorse condom use. These preventive methods, however, have been identified as a need in Vietnamese policy and are permitted by law. On the other hand, the United States does allow the use of its funds for substitution therapy for HIV-positive injecting drug users, which was not permitted in Vietnam until the HIV/AIDS Law was passed in June 2006.

To provide substitution therapy to HIV-negative injecting drug users, PEPFAR implementers have had to secure other sources of funding. However, a one-year exception was granted in 2007, allowing funding for substitution therapy for people who are not HIV-positive. In addition, despite the fact that stigma reduction is a priority in Vietnam policy, PEPFAR no longer provides meaningful funding for this intervention. For example, in 2007, of the more than $60 million committed to control HIV/AIDS in Vietnam, only $100,000 was allocated to stigma reduction. There was an intention to mainstream stigma and discrimination reduction efforts into other HIV interventions, but experts indicate this has yet to happen.

Health Sector Capacity

> *Some doctors are very good, but some are really incompetent. Sometimes when I visit a clinic for an OI [opportunistic infection], I have to read the prescription for the doctor to write out.*
>
> *—Person living with HIV/AIDS, Hanoi*

Vietnam's centralized, top-down health system has been successful in addressing many health issues, including TB, leprosy, and immunization. In the area of HIV/AIDS, however, the government has acknowledged that there are not enough trained health care workers to adequately support the objectives outlined in the National AIDS Strategy. According to the Ministry of Health, health care personnel, particularly at the district and community levels, "are thinly staffed, assigned too many tasks, and lack experience in counseling, diagnosing, caring [for], and treating people living with HIV/AIDS," even as the number of HIV infections continues to rise.[93]

Vietnam needs a comprehensive training program for health care workers in order to strengthen the health care system and to ensure effective prevention of HIV and high-quality care and treatment. In the past, training has focused on specific aspects of care and treatment, either to meet the specific needs of a project or to offer a quick, low-cost course. For example, not all programs included training in both ARV treatment and the management of opportunistic infections (OIs), although, in practice, the two are inextricably linked. As of mid-2007, a comprehensive training curriculum was still being developed by the Ministry of Health, with the close support of international organizations.

Lack of motivation among health care workers is another key issue that must be addressed. A staff member of an international NGO said, "[Health workers] don't know much about treatment for opportunistic infections, nor are they interested in learning."[94] One of the reasons for the lack of motivation may be the widespread perception that the working conditions are hazardous. As one doctor explained, "The working environment is dangerous. You can imagine, if we are stuck by a needle, our lives may be finished.

And patients here are not like those in other departments. They come from the complicated elements of society."[95]

In addition, many health care workers in HIV/AIDS departments consider their posts as only temporary because the high risks should be equally shared by all hospital staff. Such attitudes do not foster the development of expertise, and training must be ongoing as new staff continually enter the department. One hospital director said, "We can only post to the HIV/AIDS department those who are already married and have children because otherwise nobody will want to marry them. People are afraid."[96]

The government has reinforced the perception that working with HIV-positive patients is risky by offering higher monetary compensation to staff members who work with HIV-positive patients—which, in turn, exacerbates the stigma against people living with HIV/AIDS. A social worker indicated that HIV-positive patients are less likely to offer "under the table" payments as other patients do, which means that staff who work exclusively with HIV-positive patients may actually earn less than the staff in other departments. As a result, monetary compensation is not a sufficient incentive for health care workers to provide services to people living with HIV/AIDS.

In addition, the procedure for claiming compensation is complicated, which has led some hospitals to create separate HIV/AIDS departments. Having separate departments may discourage some people from accessing services for fear of having their status disclosed if they are seen by someone they know. Donor support that is targeted for specific programs has also reinforced this division.[97] Some AIDS experts have emphasized the importance of using donor funds to strengthen the health system for the long term, by integrating HIV/AIDS services with other services, rather than creating stand-alone services, and by investing in capacity building to ensure sustainability.[98]

Prevention

Prevention must be the mainstay of our response.

—UNGASS Declaration of Commitment on HIV/AIDS, preamble to "Prevention"

By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection....

—UNGASS Declaration of Commitment on HIV/AIDS, Article 48

By 2005, ensure: that a wide range of prevention programmes...is available...including information, education and communication, ...aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour,...; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections.

—UNGASS Declaration of Commitment on HIV/AIDS, Article 52

Five of the nine priority action areas in the National AIDS Strategy relate to prevention: information, education, and communication (IEC); harm reduction; prevention of mother-to-child-transmission (PMTCT); management of sexually transmitted infections (STIs); and blood safety. Of these, harm reduction activities have received the most attention, due to the disproportionate impact of HIV/AIDS on injecting drug users and sex workers. As previously noted, however, this focus on high-risk groups has had the unintended consequence of contributing to stigma against these groups in particular and against people living with HIV/AIDS in general.

In addition, despite the government's declared objective to make harm reduction interventions widely available, efforts have not yet been scaled up to the degree necessary, and coverage levels remain low.[99] A recent study revealed that approximately 60 percent of sex workers surveyed reported receiving a condom during the previous six months, and none of the injecting drug users in Hanoi reported receiving a clean needle more than six times during the previous six months. In Hai Phong, which showed the highest level of coverage of injecting drug users (30 percent), between 56 and 97 percent of injecting drug users reported that they had not received any clean needles and syringes during the previous six-month period.[100] With the passage of the new HIV/AIDS Law, which bolsters legal support for harm reduction and legalizes substitution therapy for the first time, there is now greater potential for an increase in the availability and accessibility of harm reduction measures.

Prevention of sexual transmission among the general population has not received sufficient attention, even though approximately two-thirds of all new infections now occur among individuals who are neither injecting drug users nor sex workers. There is, therefore, an urgent need to design and implement effective interventions to prevent sexual transmission, particularly among young people, as pre- and extramarital sexual relations are common and condom use rates remain low.[101, 102]

Despite the prominence of prevention activities in the overall national strategy, donors' budget allocations for prevention pales in comparison to their allocations for other

types of interventions. For example, in 2004, approximately 9 percent of total donor funding was allocated to prevention services.[103] IEC received the largest share of the prevention funding—almost 7 percent of total donor funding. Harm reduction efforts (the provision of condoms and sterile needles and syringes) and voluntary counseling and testing (VCT) services each received little more than 1 percent of donor funding.[104]

These statistics indicate that prevention is not the priority of many donors. Indeed, many representatives of local and international NGOs claim that donors tend to prioritize treatment activities over other interventions.[105] The landscape is slowly changing however. The Asian Development Bank is funding prevention programs that target young people, and the World Bank is supporting more prevention initiatives that meet local needs. Information regarding the allocation of domestic expenditure on HIV/AIDS is not publicly available, so it is difficult to assess what proportion of funds is spent on prevention activities.

Information, Education, and Communication (IEC)

IEC efforts have been a central component of the HIV-prevention strategy since the beginning of the epidemic and continue to be a priority for the government. During the five-year period from 2001 to 2005, the government produced and disseminated as many as 32 million brochures and leaflets, nearly 2.5 million posters, more than 37,000 billboards, nearly half a million books, and more than five million other IEC materials.[106] In 2004 alone, the national radio station, Voice of Vietnam, broadcasted more than 250 HIV/AIDS-related interviews and 150 news pieces.

The dissemination of a large quantity of IEC materials has successfully raised awareness about HIV/AIDS among the general population. More than 90 percent of those surveyed had heard of AIDS, and approximately 80 percent knew how HIV is transmitted[107, 108] Awareness levels are also high among young adults. A recent study revealed that more than 96 percent of people ages 15 to 24 have heard about HIV/AIDS.[109]

There is a lack of evidence that awareness has led to behavioral change, however, and incorrect knowledge about HIV/AIDS is relatively common.[110] A survey conducted in five provinces found that 28 percent of youth ages 15 to 28 had incorrect knowledge about HIV transmission. Condom use during first-time sexual intercourse is only 30 percent among young adults, and only 9 percent among young women.[111] Some AIDS experts contend that IEC messages are too general and do not focus on particular behavior. Although the messages are not incorrect, these experts say, they fail to "awaken" people to change their behavior.[112]

IEC messages tend to focus on high-risk groups rather than on risky behaviors. The public understands that injecting drug users and sex workers are at high risk for

HIV infection, but it does not know which specific behaviors expose them to HIV. In some cases, this ignorance of the facts has led to a false sense of security, even among those who practice risky behavior. For example, a man who engages in sexual activity with a sex worker may believe that he is not at risk of HIV infection because he himself is not a sex worker or an injecting drug user. In a survey among 493 men in Hanoi, 76 percent of whom had had sex with sex workers, 72 percent said they do not worry about getting HIV, and 65 percent believed they would never contract HIV. Only 36 percent of the respondents reported consistent condom use when engaging in sexual activity with a sex worker.[113] An analysis of the HIV/AIDS epidemic in Ho Chi Minh City in 2006 indicated that among the 9,100 new infections, 4,000 were male clients of sex workers, who subsequently infected 2,000 women, many of whom were their own wives.[114]

It is unclear whether IEC messages that target high-risk groups have led to behavioral changes among these groups. After two years of issuing messages, one project's findings indicated that 16 percent of injecting drug users reportedly share needles and 60 percent of sex workers use condoms with regular sex partners—but without a baseline against which to compare these figures, it is difficult to assess the project's impact.[115]

As HIV/AIDS begins to spread into the general population and sexual transmission becomes an increasingly more common mode of HIV transmission, the need grows more urgent for effective IEC and BCC aimed at promoting safe sex. The national action plan on IEC makes an effort to move beyond the traditional high-risk groups by including other groups, such as young people, among the priority targets. This effort has yet to translate into effective action, however, and IEC messages continue to focus almost exclusively on high-risk groups. Among the 54 national M&E indicators, there is not a single indicator for behavior change among the general population.[116]

Voluntary Counseling and Testing

> *Of course we need to test all patients to know who has HIV so that we can protect our staff.*
>
> *—Medical doctor, Hai Phong*

Although HIV testing is not one of nine priority action areas identified in the National AIDS Strategy, it has been a regular activity of the national AIDS program since the beginning of the epidemic. HIV testing has become mandatory and routine in some health care settings for the primary purpose of identifying HIV-positive people in order to protect health care workers. In an environment in which patients are not the intended beneficiaries of HIV

tests, abuses, such as testing without patient consent and failure to inform patients of test results, are common.

During the early years of the HIV/AIDS epidemic, Vietnam promoted a program called QTC (*Quan ly–Tu van–Cham soc*, or Management, Counseling, and Care), whose target was to provide post-test counseling and care services to 70 percent of those people who had tested as HIV-positive. The QTC program often did not include pre-test counseling or consultation. Information about HIV-positive people would be disseminated through the vertical health care system, from the provincial level to the district and then to the commune health center. A health care worker in charge of the HIV program at commune health centers would then visit each person at home to provide counseling. Even though test results were supposed to be kept confidential and shared only with participating health care professionals and the HIV-positive person, confidentiality breaches were frequent.

Hospital staff admitted to not informing patients who had tested positive for HIV infection.[117] In some cases, test results were shared with family members but not with the person tested. In others, results were already widely known within the community before the tested person returned from the hospital or the drug rehabilitation center. These violations of the right to privacy made people reluctant to test for HIV, for fear of facing stigma and discrimination if they were to test positive.

The national AIDS program adopted VCT services in the early 2000s. The number of VCT sites that provide anonymous testing has increased in recent years with assistance from international donors. As of early 2006, there were 53 testing centers in 40 provinces, serving 40,000 clients annually.

As ARV treatment becomes more widely available, VCT centers are serving more frequently as entry points for treatment. VCT centers are commonly located within or close to clinics that provide ARV drugs. They are also often linked with targeted outreach activities that encourage testing among high-risk populations, such as injecting drug users and sex workers, and introduce these clients to other prevention services. There is lack of evidence that VCT efforts are effective in reaching the intended target audience, however. A large proportion of high-risk groups still are unaware of their HIV status. For example, in Ho Chi Minh City, less than one-third of the HIV-positive people in high-risk groups targeted by VCT knew their status. More striking, 90 percent of HIV-positive men who have sex with men in Hanoi, 84 percent of HIV-positive injecting drug users in Can Tho, and 75 to 85 percent of HIV-positive female sex workers in An Giang were unaware of their status.[118] Similarly, the 2005 UNGASS national progress report indicated that, at the national level, only 10.6 percent of injecting drug users and 12.1 percent of sex workers who received an HIV test knew their test results.[119]

There are also efforts to increase VCT services in some health care settings, for example, in obstetrics and gynecology hospitals and TB centers. In early 2006, the

LIFE-GAP Project of the U.S. Centers for Disease Control and Prevention (CDC) began to pilot free HIV- testing and counseling services in three Vietnamese TB hospitals as an initial step toward integrating TB and HIV/AIDS programs. There has not yet been an assessment of the success or replicability of this pilot program.

Improvements are needed, however. The "voluntary" and "counseling" aspects of VCT in are not always closely adhered to in health care settings. Many hospital-based VCT staff members do not regard counseling as a primary component of their duties, and therefore, the quality of counseling is highly inconsistent. VCT may have replaced QTC, but mandatory testing without counseling and confidentiality breaches are still common, and medical information on HIV-positive individuals is still shared through the vertical reporting system.

VCT is also implemented in rehabilitation centers for sex workers and injecting drug users. In these facilities, too, the testing is often mandatory and unaccompanied by counseling—in other words, only the testing is provided, without the voluntary or counseling components. Because only those who test positive are called in to receive their test results, maintaining confidentiality is a challenge. Injecting drug users recently released from a rehabilitation center in Hanoi said that compulsory testing of HIV had been abandoned in that particular center. Those who opted for HIV tests at the center had to pay for it out-of-pocket.[120]

Harm Reduction

Data from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) illustrate the need to rapidly scale up harm reduction interventions. Almost one-third of injecting drug users in Da Nang, Ho Chi Minh City, Can Tho, and An Giang admitted to sharing needles during the previous six months. More important, between 25 to 48 percent of those who reportedly shared needles shared with more than one injector. The percentage of female sex workers who shared needles was higher than the percentage of male injecting drug users who did.[121]

The same study found a low rate of consistent condom use among high-risk populations. Many female sex workers reported that they did not use condoms with their clients. In five out of the six provinces studied, 20 to 64 percent of respondents admitted to not using condoms consistently with one-time or regular clients. The rate of condom use with steady partners (non-clients) was even lower, with around 80 percent reporting inconsistent use. The statistics were similar for male sex workers, with 68 percent in Ho Chi Minh City and 76 percent in Hanoi reporting inconsistent condom use. Among injecting drug users, between 64 and 84 percent admitted to inconsistent condom use with their regular partners.

Notably, a considerable percentage of those who were HIV-positive in these groups reported to having unsafe sex. Between 9 and 28 percent of HIV-positive injecting drug users in Ho Chi Minh City, Hanoi, and An Giang had unprotected sex with sex workers in the previous 12 months.[122] During the same period, between 23 and 45 percent had unprotected sex with their wives and girlfriends. Similarly, in the month prior to the survey, more than 60 percent of HIV-positive men who have sex with men did not use condoms consistently with their partners.

Harm reduction has been a priority in the National AIDS Strategy since 2004, but the implementation of harm reduction interventions has been limited due to several legal, social, and other barriers. For example, provisions of the Drug Control Law that prohibit supplying drug-related equipment have posed legal obstacles to needle-exchange programs. In some provinces, possession of condoms or needles can be considered evidence of sex work or drug use, both of which are illegal. Whether condom distribution and needle exchange are tolerated or criminalized depends largely on the local authority. As a consequence, there is considerable geographic disparity in the availability of harm reduction interventions.

The new HIV/AIDS Law, which has equal status to the Drug Control Law, does provide stronger support for the development and implementation of harm reduction interventions, but the fact remains that drug use and sex work are both illegal, which hinders intervention measures. A policeman in charge of drug control in a southern province admitting that he had no knowledge about harm reduction interventions and received no instruction to collaborate with harm reduction efforts. Instead, he admitted to ambushing injecting drug users at pharmacies when they came to exchange vouchers for clean syringes, which were distributed through harm reduction programs.[123]

The HIV/AIDS Law also does not change the perception, firmly held by many, that drug use and sex work are social ills that deserve punishment. A survey conducted in mid-2006 in two TB hospitals indicated that 40 percent of hospital staff believed that infection with HIV/AIDS is a punishment for bad behaviors.[124]

Successful scale-up of harm reduction activities therefore require mass education of police and other law enforcement agents, local AIDS authorities, injecting drug users, sex workers, health care workers, and the general public. Indeed, pilot harm reduction projects have demonstrated the importance of multisectoral collaboration and communication among all participating agencies and the need to educate members of the community prior to and throughout the implementation period.[125] For example, regular meetings between the health department, police, and other agency representatives provide opportunities to address and resolve problems, such as police misconduct. They also provide opportunities to educate the police about the need for and appropriateness of harm reduction interventions for injecting drug users.[126]

Even when harm reduction services are available, injecting drug users and sex workers do not always take advantage of them, due to widespread stigma and discrimination, fear of being arrested, or lack of family and community support. One peer educator reported difficulties in reaching out to drug users: "When I approach them to offer [clean] needles, they sometimes shout at me, saying they are not on drugs anymore. Or whenever I visit them at home, the family will say they are not home. I know it is not true. They are afraid that I will make them use drugs again."[127]

The new HIV/AIDS Law has also legalized substitution therapy, but implementation guidelines are still being developed, so methadone is not yet available. After the HIV/AIDS Law was approved, advocates had hoped that substitution therapy would be rolled out rapidly. Initially, the government intended to start a pilot program in three provinces, planning for 11 sites. As news about the challenges in China's substitution therapy program came to light, however, the Ministry of Health of Vietnam cautiously scaled back the pilot to include six sites in two cities and two provinces. As of mid-2007, these pilots had not yet started.

Easier access to substitution therapy may help improve the quality of treatment that is currently available in the rehabilitation centers. In time, it may also change official attitudes about the need for these forced rehabilitation centers. Detainees in drug rehabilitation centers are severely stigmatized and often have difficulty finding employment after they are released. Recorded recidivism rates are as high as 80 percent. The scale-up of harm reduction interventions, particularly if coupled with counseling and other support services, can help ensure safe and effective reintegration of these former drug users into society and, in the event of relapse, provide an alternative to forced rehabilitation.

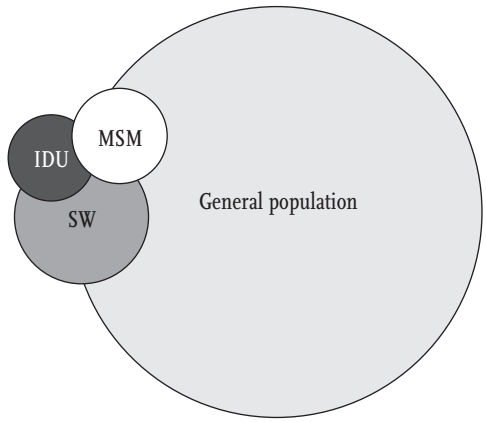
An estimated 15,000 to 18,000 residents were released from drug rehabilitation centers in 2006, 30 percent or more of whom were HIV-positive.[128] In Ho Chi Minh City alone, an estimated 10,000 residents will be released by year-end 2007.[129] Currently, there are PEPFAR-supported initiatives in Ho Chi Minh City that provide work training to those released from 06 centers. There are also plans to start methadone clinics in Ho Chi Minh City and Hai Phong, two of the provinces hardest hit by drug use and HIV infection.

There is evidence that targeted outreach among injecting drug users can reduce the incidence of risky behavior. A recent study indicated that increased knowledge about HIV leads to behavior that reduces risk of infection, for example, obtaining clean needles in safe places and no longer sharing injection equipment.[130] There is little documentation on the impact that harm reduction activities have had because interventions have been intermittent and small in scale. Although harm reduction programs are reportedly implemented in 21 of Vietnam's 64 provinces, only one or two districts within each province actually implement the interventions, which means that only a small number of the 600 districts have programs in place. The situation is similar for interventions that target sex workers. Although

50 percent of the 64 provinces supposedly implement programs for sex workers, the actual coverage, in terms of people reached, is much lower.[131]

To date, harm reduction has primarily focused on substitution therapy and the provision of sterile needles and syringes to injecting drug users and condoms to sex workers and men who have sex with men. There is a need to expand beyond this traditional scope, however, in order to address the dangerous intersection between unsafe drug use and unsafe sex. The combination of high-risk behaviors and the interplay of high-risk populations and the general population may lead to the rapid spread of HIV. Figure 1 demonstrates the complexity of the interaction between the various populations.

Figure 1: Relative interaction of those engaged in high-risk behaviors and general population



IDU: Injecting-drug users
MSM: Men who have sex with men
SW: Sex workers

The majority of drug users in Vietnam are young, sexually active males. More than 70 percent of those young men surveyed reported to having had sex in the previous 12 months, both with sex workers and with their wives or girlfriends.[132] Increasingly more female sex workers report using injection drugs. They have sex with both injecting drug users and clients and partners from the general population. The MOLISA estimates that 20 to 40 percent of sex workers use drugs.[133] Several studies also found increasing rates of drug use among sex workers. The IBBS reported more than 15 percent of female sex workers in Hanoi and Can Tho inject drugs, and a survey of 1,000 sex workers in Ho Chi Minh City found that 38 percent of female sex workers use drugs.[134] Findings from a 2005 cross-sectional survey in Hanoi revealed that as much as 51 percent of arrested street-based sex workers tested positive for opiates.[135]

In addition, many men who have sex with men inject drugs. They also have female sexual partners and buy sex from both male and female sex workers. Of those surveyed in Ho Chi Minh City and Hanoi, 21 and 23 percent of men who have sex with men reported drug use, respectively.[136]

Epidemiological evidence suggests that HIV-prevalence rates among sex workers who inject drugs is high—as high as 49 percent in Ho Chi Minh City compared to an average prevalence rate of 19 percent among sex workers who do not inject drugs.[137] In order to prevent the spread of HIV to the general population, the need is urgent for interventions that reach out to clients of sex workers, the sexual partners of these clients, injecting drug users, and their sexual partners, who must be encouraged to adopt safer sexual practices.

Prevention of Mother-to-Child-Transmission (PMTCT)

PMTCT has been implemented since the late 1990s with a pilot project supported by UNAIDS.[138] PMTCT was the first action plan released following the adoption of the National AIDS Strategy. The strategy established these targets for the 2006–2010 period:

- Maintain the national HIV-prevalence rate of 0.5 percent or lower among pregnant women.
- Provide counseling to 90 percent and VCT to 60 percent of pregnant women.
- Ensure all HIV-positive pregnant women have access to treatment to prevent transmission to their newborns.
- Provide follow-up care for 90 percent of HIV-positive mothers and their newborns.[139]

The goals are ambitious, and a number of challenges must be addresed in order to achieve them. One important challenge is the provision of HIV testing for pregnant women. The Ministry of Health reported that, by the end of 2005, 100 percent of the pregnant women who came to five of the major obstetrics and gynecology hospitals for checkups were offered HIV testing and counseling.[140] Such services are not available outside large hospitals, however.

Data from a larger sample reveal a lower uptake for HIV testing. In the five-year period from 2001 to 2005, less than 10 percent of all pregnant women were tested for HIV.[141] Many people also doubt the "voluntary" nature of these tests as only 10 percent of those tested knew their HIV status. The majority of the Vietnamese population live in rural and mountainous areas, and many women receive prenatal and perinatal care in commune health centers, which have inadequate laboratory capacity. The PMTCT action plan specifies that commune health centers should collaborate with district-level preventive

medical centers to conduct counseling and testing. Pregnant women may be reluctant to travel to the district centers for HIV tests, however.

According to some people living with HIV/AIDS, HIV-positive women do not seek ARV treatment to prevent transmission to their children due to both lack of knowledge and the fear of stigma, resulting from their status being involuntarily disclosed.[142] A pilot project supported by the United Nations Children's Fund (UNICEF) found that, even with counseling and the offer of free testing at commune health centers, only 30 to 50 percent of pregnant women agreed to be tested, largely due to reasons related to stigma.[143] In addition, according to a recent survey, only 20 percent of respondents knew that there is treatment available to reduce HIV transmission from mother to child.[144] A member of the Quang Ninh chapter of the Bright Future Network recounted a story of an HIV-positive woman who killed herself when she was more than seven months pregnant, saying that perhaps the woman would not have resorted to suicide had she been counselled well and had known about the availability of ARVs to prevent HIV transmission to her child.[145]

The lack of coordination between reproductive health care services and the HIV/AIDS program—which have parallel structures from the central level down to the district level—poses another challenge in implementing PMTCT. Preventing such transmission is clearly relevant to both spheres and may serve as a test case for successful intrasectoral collaboration.

Sexually Transmitted Infections

Despite more than a decade of efforts to improve the management of STIs—by integrating it into HIV/AIDS programs, for example—prevention and treatment interventions are still ineffective. Many cases of STI are not even reported. Of an estimated 1 million cases of STIs in Vietnam each year, only between 110,000 and 180,000 cases are reported and treated.[146] The national action plan on STI acknowledges that IEC efforts concerning STIs are weak and that, as a result, knowledge levels among the general and high-risk populations are low. A survey of more than 7,500 youth revealed that, of the eight STIs they were asked about, 22 percent of respondents had only heard of one, hepatitis B. Only about one in seven (13 percent) had heard of more than four of the STIs, and only 2 percent reported having heard of all the eight.[147]

Among the other challenges are inadequate counseling, lack of medicines to effectively treat STIs, and a high degree of stigma and discrimination against STI patients.[148] Also, STI management systems are fragmented and unorganized. For example, at the provincial level, STI services may be managed by the dermatology center, the centers for control of social diseases, the preventive medicine center, or the HIV/AIDS center. There

have not been sufficient resources or dedicated staff to provide quality services or develop expertise. As a result, many people with STIs either self-medicate or visit private health care providers, the quality of whose services are neither monitored nor controlled.[149]

Blood Safety

One of the first interventions carried out by the national AIDS program was the guarantee of blood safety. The government has been successful in achieving its target, screening 100 percent of the blood units intended for transfusion. The screening is done with antibody detection, a technology that requires the blood to be stored in a blood bank for a period of time before it can be used. As of early 2007, however, the blood bank facilities were still being created, which means screened blood is used without being stored for an adequate period. Alternatively, there is a more sophisticated screening technology that permits immediate use of the blood, but this technology is expensive, so it is rarely used.

Although universal precautions are recommended to prevent HIV transmission in medical settings, not all health care workers fully observe them. Hand washing is infrequent, gloves are not changed before providing services to each new patient, and syringes are unsafely recycled.[150] There is no data available on how many HIV infections have resulted from blood transfusion to date.

Treatment

> *Care, support and treatment are fundamental elements of an effective response.*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, preamble to "Care, support and treatment"*

The VAAC estimates that approximately 49,000 people are in need of ARV treatment in Vietnam.[151] The government's commitment to increasing access to treatment is reflected in a substantial increase in the annual domestic budget for ARVs: from 1 billion VND (approximately $65,000) in the late 1990s to 10 billion VND in 2005.[152] Despite this significant increase, donors still constitute a major source of funding for treatment. PEPFAR supports the highest number of people on ARV treatment, followed by the Global Fund. The Ministry of Health reported that, as of March 2007, PEPFAR had provided ARV treatment to 5,874 patients, and the Global Fund to 2,118 patients.[153] (As of July 2007, PEPFAR had provided ARV treatment to more than 7,800 people living with HIV/AIDS.) Other significant

treatment providers are the French government's ESTHER Project and the Clinton Foundation HIV/AIDS Initiative (CHAI). In comparison, domestic funding can only purchase ARVs for 1,200 to 1,500 patients.

Various organizations are collaborating closely with the VAAC to ensure that treatment programs are implemented efficiently, for example, by agreeing to pool resources to increase cost-effectiveness. Global Fund resources are allocated for the purchase of generic drugs for OIs, and PEPFAR funding for the purchase of generic ARV drugs. The ESTHER Project provides testing equipment for patients in Hai Phong, whose treatment is also funded by PEPFAR.

Due to the increased resources for treatment, in recent years there has also been a dramatic increase in the number of people on ARVs, but there are still significant barriers to treatment access, particularly for marginalized populations. The government accepts responsibility for and prioritizes the provision of free treatment and care to pregnant women, children, workers infected through occupational exposure, and people who contribute to the HIV/AIDS program (for example, volunteer peer educators). In addition, the shortage of trained health care workers and the lack of an adequate treatment-monitoring system have posed challenges to the scale-up of existing treatment programs.

The National AIDS Strategy presents two ways to increase the availability and accessibility of ARVs: by negotiating lower prices for drugs and by strengthening the capacity of the local pharmaceutical industry to produce ARVs. Further analysis is needed, however, to determine whether Vietnam will be able to exercise these options as a member of the World Trade Organization (WTO).

Access to Treatment

> *By 2003, ensure that national strategies,...are developed in close collaboration with the international community, including Governments and relevant intergovernmental organizations, as well as with civil society and the business sector, to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs,...[and] make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS....*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 55*

In addition to the priority groups to whom the government commits to provide free ARV treatment, anyone who meets certain clinical criteria can become eligible for free treatment as ARVs become more widely available. In provinces with major donor-funded projects, such

as those of PEPFAR or the Global Fund, access to ARV is on a relatively straightforward, first-come-first-served basis. To access free ARV treatment, people must be tested for HIV and register at a designated ARV provision center near their home (or be referred from a VCT site). The patients then undergo an immune monitoring test (CD4 count) and other tests to determine their clinical eligibility for treatment. A series of counseling and treatment education sessions follow—group sessions first and then private ones. If ARV drugs are readily available, the patients can start treatment right away. If not, they have to wait for a period of time that can vary from days, as for the Global Fund–supported treatment program in Hanoi, to months, as in most cases.

According to some people living with HIV/AIDS in Ho Chi Minh City, the process of starting treatment can still be complicated and lengthy, even when ARVs are available. An average patient has to spend one month and make nearly a dozen trips to a treatment site before finally receiving ARV drugs. For those who have jobs or are very sick, these obstacles can present a real challenge.[154]

The difficulties faced by people living with HIV/AIDS in Ho Chi Minh City or in other PEPFAR and Global Fund treatment implementation sites pale in comparison to those faced by their counterparts in more than 40 nonproject provinces. Each of these provinces receive enough ARVs to treat approximately 30 people, regardless of the local HIV-prevalence rates. Provinces such as Vung Tau, Dong Nai, and Son La have some of the highest prevalence rates in the country. Each has thousands of people in need of ARVs, so 30 doses of ARV is "a spoon of salt in the ocean," as one person living with HIV/AIDS said.[155] To put this number in perspective, as of July 2007, PEPFAR had treated more than 7,800 patients in six provinces.

In these nonproject provinces, not only is access to ARVs limited to a lucky 30 or so patients (the majority of whom belong to government-defined priority groups), but access to other services, such as diagnostic tests, is also limited. People often have to pay for tests out-of-pocket or travel long distances to seek services unavailable in their provinces. The set of tests required for enrollment in the free ARV treatment program—such as hemoglobin, CD4 count, and liver enzymes tests—can easily cost some people a month's income. When people must wait long periods before they can start treatment, the test results become outdated, so tests must be taken again. Some tests also need to be repeated on a regular basis for monitoring purposes.

For those who live far from ARV clinics (usually located in urban centers) or in a province without a CD4 count machine, the costs of transportation, food, and lodging increase the financial burden associated with treatment. For example, a person from a district in Quang Ninh would have to take several buses and rely on other means of local transportation to get to a hospital in Hanoi that has a CD4 count machine—and then might have to wait a day or two for the test. The trip, combined with the cost of the test itself, could

cost 700,000 to 800,000 VND (approximately $50 to $60), an amount equal to almost 10 percent of an average individual's annual income.[156] As of mid-2007, within the country's 64 provinces, there was a total of only 24 CD4 count machines.[157]

Certain marginalized groups also face difficulty in accessing treatment. Because registering for ARV treatment requires proof of residency, the poorest segment of the population—for example, homeless people and migrant workers—cannot easily gain access. Although there is no policy that explicitly denies injecting drug users access to ARVs, interviews with people living with HIV/AIDS reveal that this group's access to ARV treatment is limited and that they are frequently discriminated against in health care settings. Many health care workers, and even some people living with HIV/AIDS, consider drug users to be "guilty" and unreliable, so, therefore, unable to adhere to treatment. One provincial AIDS official said, "Drug users don't care about anything, so they don't need ARVs."[158] As a result, there are few injecting drug users on ARV treatment, although there are no disaggregated data available to provide an exact number.

There have been many efforts to link HIV/AIDS treatment with treatment for OIs, such as TB. In 2006, the government formally established mechanisms for TB/HIV collaboration: the national technical advisory group for TB/HIV collaboration at the central level, TB/HIV coordinating committees at the provincial level, and expert panels for TB/HIV diagnosis and treatment at the district level. In 2007, the national AIDS program and the national TB program jointly produced guidelines for TB/HIV control collaboration. The overall principle is collaboration "between all health facilities at all levels in TB/HIV prevention, case detection, treatment and management." The guidelines have not yet been implemented, however. The CDC-funded LIFE-GAP Project recently piloted a TB/HIV collaboration project in three provinces, which may help to establish best practices in implementing joint TB/HIV activities.

Availability and Delivery of ARVs

As a result of increased financial support from the government and donors, by the end of 2005 approximately 4,000 people were receiving ARV treatment. A year later, approximately 7,000 were receiving treatment.[159] By early 2008, an estimated 14,000 people will be on ARV treatment in Vietnam.[160] Despite this impressive rate of treatment scale-up, several challenges remain that must be addressed before ARV treatment is widely available in an effective, sustainable manner.

Although the government's efforts to negotiate lower drug prices and to increase capacity for local ARV production have contributed to increased access to treatment, the first-line ARV drugs produced locally are still more expensive than the generic drugs procured

through international initiatives: $300 per person per year for local drugs compared to $140 per person for generic drugs available through the CHAI.[161] The average price of ARVs procured through Stada, a German pharmaceutical company, is about $220 per person. In the private sector, the prices of ARVs are even higher, ranging between $600 and $800 per person.[162] The country has set a target to produce 50 percent of the ARV drugs it needs by 2010.[163] Vietnam's recent membership in the WTO, however, may make it difficult for the government to continue to negotiate lower prices or produce generic ARVs locally.

The shortage of trained and motivated health care workers and the limited capacity of the health sector also hinder the pace of the scale-up of ARV treatment. For example, in 2005, provinces that did not have sufficient capacity to dispense ARV drugs returned them to the Ministry of Health, even though each province received only about 30 doses.[164] Rather than returning unused ARV drugs, in some provinces, as one person living with HIV/AIDS said, "[the HIV/AIDS center] just called people living with HIV/AIDS to come and gave them the drugs, without a CD4 count test or counseling."[165] Some treatment programs, including those supported by PEPFAR, invest time and resources in the training of health care providers at ARV sites, but government-sponsored ARV programs and other small-scale programs have not been able to do so.

The Ministry of Health has made an effort to standardize treatment protocols by issuing guidelines for treatment, developed through consultations with local and international partners, but ensuring adherence to these protocols has been a challenge. The government collaborated with the WHO and PEPFAR to develop a computerized monitoring system to keep track of patients' progress on ARV treatment. Each registered person is given a magnetic card, which stores the person's data and which can be read by a computer, helping health care workers follow up with patients and refer them from one site to another as needed. This system, which has been operating in Ho Chi Minh City since late 2006, is only available there, however, and much more work is needed to expand it nationally.

Although the government has made efforts to improve the quality of treatment in the public sector, the quality of services in the private sector continues to raise concerns. Several members of the Bright Future Network claim that health care providers in the private sector often prescribe ARVs without providing any counseling, instruction, or warnings as to the possible side effects. Sometimes, they have even dispensed expired drugs.[166] People living with HIV/AIDS also report that doctors sometimes choose to send patients to specific pharmacists (with specially coded prescriptions that can only be deciphered by those pharmacists), who then might charge a very high price or prescribe an incorrect ARV regimen.[167] Although a government decree requires that only those who have been trained in the Ministry of Health treatment protocols are eligible to prescribe

ARVs, there is no mechanism for enforcement. In addition, there is no information available on how many people are being treated with ARVs by the private sector.

Support for ARV treatment from major donors, including PEPFAR and the Global Fund, is likely to be extended for some years beyond 2010, but continued financial support after that point is not guaranteed, particularly given Vietnam's rapid economic development. Therefore, it is critical that Vietnam develop a strategy to sustain treatment without donor support, including by securing low prices for ARVs, building the capacity of the health sector, and implementing a national system to monitor treatment.

Care and Support

> *By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care.*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 56*

There has been some political commitment to the care and support of people living with HIV/AIDS and of those communities affected by HIV/AIDS. The national budget allocates approximately 3 million VND (less than $200) annually to help support communes that have HIV-positive members (referred to as focal communes), which range in population from 4,000 to 20,000.[168] This funding includes monetary incentives for health care staff in charge of HIV/AIDS programs, and the remaining funds are only sufficient to fund an event or a meeting.

The National AIDS Strategy addresses the provision of care and support in general terms, but it fails to cover many important aspects of these services. For example, it does not—nor do other policy documents—consider palliative care, although program guidelines on the provision of palliative are now being developed. The strategy also does not include specific measures that facilitate or support community-based caregivers, even though the government is open to having faith-based organizations, community groups, and NGOs provide care and support to people living with HIV/AIDS. In fact, self-help groups and NGOs have already been providing services to people living with HIV/AIDS, but their efforts could be better unified and sustained if they had government assistance and direction. As noted previously, the restrictions on the official registration of associations make it difficult for self-help groups to organize themselves and also limit their ability to attract financial support and mobilize a wider constituency. As a result, their capacity to provide more comprehensive support to people living with HIV/AIDS is also limited.

Palliative Care

The health system in Vietnam is only concerned about keeping people alive, not how they feel.

—HIV/AIDS care and treatment specialist, Hanoi

Palliative care is a new concept in Vietnam—in fact, the term *palliative care* was only recently correctly translated into Vietnamese. A few faith-based organizations have been providing palliative care on a small scale, but their capacity is limited, and the need is great. For example, the Mai Hoa Center in Ho Chi Minh City, a Roman Catholic charity hospice with 30 beds, provides housing and end-of-life care to those people living with HIV/AIDS who are homeless or have been abandoned. Since 2001, the hospice has cared for more than 300 patients, 180 of whom have died there.[169]

Although the government has recently developed guidelines on palliative care, it must address several challenges in order for the guidelines to be implemented effectively. Specifically, there must be an increased supply of medication for pain management and specialized training for health care staff to improve the quality of care currently available to people living with HIV/AIDS.

People living with HIV/AIDS have limited access to pain management medication to alleviate severe, chronic pain.[170] As a result, many people living with HIV/AIDS suffer for a long time and die in severe pain, or they turn to heroin or other black-market drugs.[171] Morphine is the only opioid analgesic that is legally available in Vietnam. Oral morphine, which is very effective and inexpensive, is not available in most hospitals, and parenteral morphine is available only in small quantities.

Most hospitals are reluctant to stock other types of opioid-based medications, and doctors are unwilling to prescribe them for fear of possible legal consequences. (The diversion of opioid drugs from a cancer hospital to the black market several years ago resulted in a scandal and the punishment of a number of hospital staff members.[172]) Data from the International Narcotics Control Board (INCB) indicate that the quantity of controlled opioids consumed in Vietnam is very low compared to the quantity consumed in other countries. For example, in 2004, an estimated 8 kilograms of morphine was consumed in Vietnam, compared to 41 kilograms in Cuba, 55 kilograms in Thailand, and 3,500 kilograms in France.[173]

Not enough health care workers are trained to provide palliative care. One HIV/AIDS treatment specialist said that "doctors [in Vietnam] focus only on the cure and don't care about symptoms unless it is life-threatening. If a patient feels nauseous, the doctor will not give him anything. They will wait until the patient vomits. Even if the patient vomits, they will wait until he vomits a lot."[174] Further, there are not enough medical facilities

available to provide care and treatment to the number of people living with HIV/AIDS in Vietnam. For example, in Hanoi, there are only 40 beds available for more than 10,000 HIV-positive people.[175] According to the members of one group of patients, people living with HIV/AIDS can access care and treatment only in designated departments within hospitals, and hospitals are reluctant to provide in-patient treatment or perform surgery on HIV-positive patients.[176]

Community and Family Caregivers

Many self-help groups for people living with HIV/AIDS have emerged in recent years. For example, the Empathy Club, which convenes people living with HIV/AIDS, their families, friends, and concerned community members to share their experiences and to support each other, has more than 5,000 members in 150 communities. Since its establishment in 2003, the Bright Future Network has grown to include more than 1,800 members in 17 northern and central provinces. Injecting drug users and sex workers are not readily welcomed into these groups, however. The Bright Future Network accepts drug users as members, but does not entrust them to perform administrative duties in the office.[177] The Empathy Club tries to persuade HIV-positive drug users who come to their meetings to quit drugs before it offers them support.

To date, the government has not offered any training programs or financial support to family or community caregivers. It does not provide caregivers with information on how to avoid infections or properly care for people living with HIV/AIDS or with ready access to food and necessary supplies, such as clothing, gloves, and bleach. Communities and families are often left to cope with the burden of caring for their ill members themselves, and fear of contagion at times leads to stigma and discrimination against people living with HIV/AIDS. Many people living with HIV/AIDS claim that in fact they find their immediate families and communities to be the most stigmatizing of any group.[178]

Some international organizations have offered financial and technical support to implement care and support activities. For example, the WHO and PEPFAR have supported care and support centers at the district level, such as the community counseling and support centers in Ho Chi Minh City. These centers provide comprehensive services, including medical, psychological, social, and financial support for people living with HIV/AIDS. This model has been replicated in almost all of the districts in Ho Chi Minh City. There are also plans to introduce methadone maintenance therapy in a number of these centers.

Monitoring and Evaluation

Conduct national periodic reviews with the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments, identify problems and obstacles to achieving progress, and ensure wide dissemination of the results of these reviews.

—UNGASS Declaration of Commitment on HIV/AIDS, Article 94

Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, and develop appropriate monitoring and evaluation instruments, with adequate epidemiological data.

—UNGASS Declaration of Commitment on HIV/AIDS, Article 95

Commitments are only beautiful words if they are not implemented.

—Tran Tien Duc, country director, Health Policy Initiatives, Hanoi

On a weekly basis, the Vietnamese government collects various types of information about HIV/AIDS, including the number of new and cumulative cases of HIV infection, the number of full-blown AIDS cases, and the number of AIDS-related deaths. The collection of this information relies on the HIV reporting system and data from HIV testing sites. When a person tests positive for HIV, the testing site records the patient's information (including name and address) and submits it to the provincial preventive medicine centers. From there, the information is disseminated through the system until it reaches the commune health center. Staff in charge of the communal HIV/AIDS program verifies the person's name and address and then reports to the district on a regular basis as to whether the person has developed AIDS or died. The district then reports to the province, which then reports to the central level.

Despite the extensive system and the frequency of reporting and recording, the compiled official data available to the public is often outdated. For example, as of September 1, 2007, the latest official data accessible on the VAAC website were from October 2006 in the Vietnamese version and from May 2006 in the English version.[179, 180] In addition, there is consensus among stakeholders that the official data do not accurately reflect the reality of the epidemic in Vietnam. For example, government reports indicate that, as of August 2007, there were 130,000 cumulative cases of HIV infection, 26,000 full-blown AIDS cases, and 14,000 AIDS-related deaths.[181] These totals are significantly lower than other estimates,

which place the number of people living with HIV/AIDS at about 292,930, of whom 49,000 are in need of ARV treatment.[182, 183]

The government also presents HIV information about populations at high risk for HIV, which may contribute to a distorted picture of the epidemic. In previous years, the majority of HIV tests were mandatory (for example, the testing of injecting drug users or sex workers at the time of arrest or while in prison) or were conducted without consent (for example, the testing of patients in health care settings who were suspected of being HIV-positive). Although the government is trying to move toward voluntary testing with counseling, it continues to rely on the existing data, which, because of the prevalence of high-risk groups in the samples, reinforces the widespread perception that only injecting drug users and sex workers get HIV. In fact, the majority of new infections occur through sexual transmission. According to estimates, in 2005, injecting drug users and sex workers accounted for only one-third of the new cases of HIV.

National Monitoring and Evaluation System

The 2004 National AIDS Strategy was the first policy document that called for the establishment of a single, comprehensive M&E system. In January 2007, the M&E indicators for the national AIDS program were finally released, along with the action plan on HIV/AIDS surveillance and program monitoring and evaluation.[184] There are 54 indicators that address issues that include capacity building, prevention, and treatment and care. The implementation of the national M&E system includes four steps:

1. Establish M&E units at all levels of government
2. Develop guidelines and provide equipment for testing and data collection
3. Build human resource and management capacity for M&E at all levels
4. Mobilize resources

Although the M&E system is an important milestone, it has shortcomings, largely as a result of the process through which it was developed, which has limited its scope. The government developed the indicators and action plan without input from civil society, which was also not informed about the progress of development. As a result, the two documents give the impression that the national AIDS program is centralized, medicalized, and exclusively managed by the government. There is virtually no allowance for the engagement of civil society. There is also no mention in the documents of efforts to build the capacity of civil society so it can participate in program implementation and in the monitoring of the progress of the national HIV/AIDS response.

The Role of Civil Society

Civil society has played only a minor role in M&E efforts. NGOs are occasionally involved at the project level, but not at the national level. They are also not involved in the monitoring of international commitments. In 2001, however, Market and Development Research Center, a local research organization, collaborated with Research Triangle Institute, an international research organization, to evaluate the national AIDS program.[185] The Ministry of Health's scientific committee approved the report. However, this positive precedent for civil society involvement in the national M&E process has not been repeated.

The process of preparing Vietnam's second progress report on its implementation of the UNGASS DoC also reveals the lack of meaningful civil society involvement in national M&E efforts. Representatives from international NGOs and key national organizations were invited to a consultation in December 2005, after the draft of the UNGASS progress report had already been completed.[186] Local NGOs and representatives from marginalized groups and groups of people living with HIV/AIDS were not invited to attend. Participants had little time to prepare for the meeting and only three days to review the 67-page draft. Although the meeting resulted in some changes to the final report (the government lowered its self-assessment rating on civil society participation and acknowledged that substitution therapy was being piloted, not "available"), the majority of the civil society representatives expressed disappointment about their lack of participation.[187, 188] Although the government has since indicated that it would be open to a more inclusive process when preparing future progress reports, the lack of time, guidance on ways to involve civil society, and technical support from international agencies posed significant challenges to the meaningful involvement of civil society in the creation of the 2006 progress report.

Similarly, members of civil society were not engaged in the universal access target-setting process at the national level. As of September 2007, the government had not consulted civil society groups, including local NGOs and people living with HIV/AIDS, about the universal access process and had not shared any background or resulting documents.

Under pressure from the Global Fund to include more civil society representatives, particularly people living with HIV/AIDS, the Vietnamese government recently appointed two people living with HIV/AIDS to serve on the Country Coordinating Mechanism (CCM). One of the representatives, however, believed that their role was more symbolic than substantive. "It is only in name that people living with HIV/AIDS are on the CCM," he said.[189] Also, because the representative didn't have the capacity or support needed to participate in a meaningful way, he lacked motivation to stay involved. "All other CCM members—they have a job," he said, "they have a salary. I have no job and no income, but they keep asking me to participate in meetings, and so many meetings! What do I live on?

Do they care about that? Before each meeting, they send us a lot of documents. Who can read all of them? And even when I try to read them, I don't understand."[190]

A member of the Bright Future Network expressed dissatisfaction with the way the CCM had selected the representatives of people living with HIV/AIDS. "Those in the CCM are well-known, but they do not know much about care and treatment."[191] He also expressed disappointment that the civil society representatives on the CCM have not reached out to the larger constituency they are representing. "If they don't know [about certain issues], they should ask people who know. They should discuss with us. Otherwise, how can they represent us in the CCM?"[192]

In order to encourage more meaningful participation by civil society, many stakeholders believe the Global Fund should provide guidance and support to civil society representatives on the CCM, including by selecting representatives through an open and transparent process and by offering technical assistance to representatives to help them prepare for and engage in meetings and liaise more effectively with the civil society community. In addition, they believe that multilateral agencies, such as UNAIDS and international NGOs, should facilitate and advocate for greater and more meaningful involvement of civil society groups in order for them to be key stakeholders in the national response to HIV/AIDS.

Recommendations

Vietnam has demonstrated political commitment to control HIV/AIDS; its National AIDS Strategy and the newly passed HIV/AIDS Law are considered as among the most progressive policies in the region. However, implementation of HIV/AIDS programs has had mixed results due to inadequate health sector capacity, lack of effective coordination with donors, and continued perception that HIV/AIDS is related to "social evils" of drug use and sex work, which contribute to intense stigma and discrimination against people living with HIV/AIDS. There is increasing evidence that HIV is spreading beyond high risk groups through sexual networks—in 2005 over two-thirds of all new infections occurred through sexual transmission. The research for this report has identified two key areas in which the Vietnamese government should take immediate action in order to prevent a nationally generalized HIV/AIDS epidemic and to ensure a sustainable response.

- Redouble efforts to stop the spread of HIV by implementing proven interventions, including
  - condom promotion, needle-exchange programs, and substitution therapy for marginalized groups, including injecting drug users, sex workers, and men who have sex with men; and
  - sexuality education and condom promotion for the general population, particularly young people, to prevent sexual transmission of HIV.

- Ensure full and meaningful participation of civil society, involving marginalized groups and people living with HIV/AIDS in the national HIV/AIDS response, including by
  - allowing and creating mechanisms for the involvement of civil society groups in policy development and program design, implementation, and evaluation, including by dedicating budget funds to programs initiated by civil society and by building capacity;
  - fighting stigma and discrimination against all people living with HIV/AIDS, particularly those in marginalized groups, to encourage their participation in HIV/AIDS prevention, treatment, care, and support activities; and
  - supporting organizations of people living with HIV/AIDS to form legally recognized associations.

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[We] acknowledg[e] the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects, and recogniz[e] that their full involvement and participation in the design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic.

—UNGASS Declaration of Commitment on HIV/AIDS, Article 33

Public Health Watch promotes informed civil society engagement in policymaking on tuberculosis and HIV/AIDS. The project's monitoring reports offer a civil society perspective on the extent to which government policies comply with international commitments such as the Amsterdam Declaration to Stop Tuberculosis and the Declaration of Commitment on HIV/AIDS—and on the extent to which those policies have been implemented. HIV/AIDS monitoring reports include assessments of policies in Nicaragua, Senegal, Ukraine, the United States, and Vietnam.

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