NATIONAL COMMITTEE FOR AIDS, DRUGS,
AND PROSTITUTION PREVENTION AND CONTROL

VIET NAM AIDS RESPONSE PROGRESS REPORT 2012

FOLLOWING UP THE 2011 POLITICAL DECLARATION ON HIV/AIDS

Reporting period:
January 2010- December 2011

Hanoi, March 2012

PREAMBLE

In June 2011, Viet Nam participated in the UN General Assembly High-Level Meeting on AIDS in New York. At this meeting, Viet Nam renewed its commitment to the HIV response and adopted new targets by signing the *2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*. We take this commitment seriously, and have therefore ensured that the required reporting on our progress against these commitments is comprehensive and accurately reflects the nature of the response to HIV in Viet Nam. This report also reflects a national consensus on key achievements and challenges in the HIV response in Viet Nam in the years 2010 and 2011.

Viet Nam has continued the excellent progress seen in the previous reporting period. We have witnessed a greater expansion of treatment coverage and demonstrated strong commitment to universal access to treatment for all those who need it, particularly with the pilot of Treatment 2.0. Harm-reduction services for people who inject drugs were further scaled up, while methadone maintenance therapy (MMT) continued to be expanded as we work towards the goal of 80,000 people who inject drugs on MMT by 2015. Multisectoral coordination, the strengthening of the HIV-related policy environment and moves towards a more robust response for sex workers and men who have sex with men are also important achievements.

Viet Nam has also finalized its new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*, developed with broad consultation. The targets of the new National Strategy echo those of the 2011 Political Declaration, and illustrate Viet Nam's commitment to the vision of zero new infections, zero discrimination and zero AIDS-related deaths.

Threats to the sustainability of the HIV response are recognized, as international donors begin reducing their resources in Viet Nam, and we understand the importance of increasing our country ownership. To this end, in 2011 the Viet Nam National Assembly approved HIV as a standalone National Targeted Programme for the first time, and increased resource commitment for the period 2011-2015. However, continuing technical and financial support from international partners is crucial for a responsible transition towards a more sustainable national AIDS response.

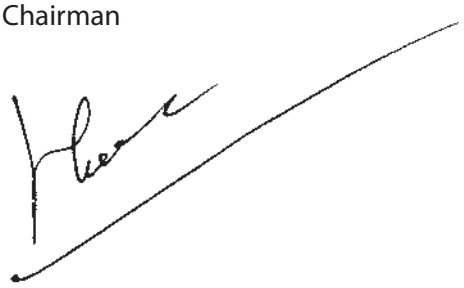
These are just a few highlights of the HIV response in Viet Nam during 2010 and 2011. The country's leadership is dedicated to ensuring that Viet Nam maintains the excellent progress that has been achieved so far, and looks forward to effective coordination between government ministries, as well as continued collaboration with international partners and civil society in order to further our success.

I would like to end by thanking all the many people and organizations involved in the development of this report, and express my sincere appreciation for their important ongoing work for the national response. These include our ministries, UN agencies, international organizations, donors and civil society. Through our collective efforts, we are moving closer towards our shared goal of universal access to HIV prevention, treatment and care.

Viet Nam, 31 March 2012

NATIONAL COMMITTEE FOR AIDS, DRUG AND PROSTITUTION PREVENTION AND CONTROL

Chairman



Nguyen Xuan Phuc
Deputy Prime Minister
Socialist Republic of Viet Nam

TABLE OF CONTENTS

I. LIST OF ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
AusAID	Australian Agency for International Development
BCC	Behaviour change communication
CBO	Community-based organization
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control, USA
CSO	Civil society organizations
CUP	Condom use programme
DFID	Department for International Development, UK
FBO	Faith-based organization
FHI	Family Health International
FSW	Female sex worker
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCMC	Ho Chi Minh City
HIV	Human immunodeficiency virus
HPI	Health Policy Initiative
HSS+	National HIV Sentinel Surveillance Survey with behavioural component
IBBS	Integrated Biological and Behavioural Surveillance
IEC	Information, education and communication
ILO	International Labour Organization
INGO	International non-governmental organization
IOM	International Organization for Migration
IPT	Intimate partner transmission
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MDM	Médecins du Monde
MICS4	Multiple Indicator Cluster Survey
MMT	Methadone maintenance therapy
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOLISA	Ministry of Labour, War Invalids and Social Affairs
MOPS	Ministry of Public Security
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
MWID	Man who injects drugs

NCPI	National Commitments and Policy Instrument
NGO	Non-governmental organization
NIHE	National Institute of Hygiene and Epidemiology
NORAD	Norwegian Agency for Development
NSP	Needle and syringe programme
OI	Opportunistic infection
OPC	Outpatient clinic
OVC	Orphans and other vulnerable children
PAC	Provincial AIDS Centre
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
POA	Programme of Action
PSI	Population Services International
PWID	Person/people who inject(s) drugs
SAVY	National Survey on Adolescents and Youth in Viet Nam from 15-24 years old
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Organization for Drugs and Crime
UNV	United Nations Volunteers
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VAAC	Viet Nam Administration of AIDS Control
VCSPA	Viet Nam Civil Society Partnership Platform on AIDS
VCT	Voluntary counselling and testing
VNP+	National Network of People Living with HIV in Viet Nam
VUSTA	Viet Nam Union of Science and Technology Associations
WB	The World Bank
WHO	World Health Organization

II. STATUS AT A GLANCE

The HIV epidemic in Viet Nam remains in a concentrated stage. There are signs that it may have begun to stabilize over the last two years, with a decrease in HIV prevalence among key populations at higher risk, people who inject drugs (PWID) and female sex workers (FSW) in some provinces, while prevalence trends remain stable or have increased in other provinces. According to 2011 sentinel surveillance, HIV prevalence among PWID and FSW remains high, at 13.4% and 3% respectively; IBBS data indicate that prevalence among men who have sex with men (MSM) also remains high, at 16.7%. The distribution of HIV cases largely follows the distribution of these three populations, which are heavily concentrated in urban centres (though they are not absent in non-urban communities). Overall adult HIV prevalence (ages 15-49) remained at 0.45% in 2011.[1]

The achievements reflecting Viet Nam's efforts and illustrating its commitments during the 2010-2011 reporting period include: (1) increased political commitment and leadership, which have resulted in positive developments in the response; (2) an increased focus on prevention, leading to progress towards increasing access to HIV services, notably harm-reduction services, and especially methadone maintenance therapy (MMT) for people who inject drugs (PWID); (3) the rapid expansion of antiretroviral therapy (ART) provision; and (4) greater participation of civil society in the national response, with strong community engagement.

The Country Progress Report for Viet Nam was written following the UN General Assembly High-Level Meeting on AIDS in New York in June 2011. The report recognizes the significant achievements and efforts made by Viet Nam in 2010 and 2011 in increasing access to and improving the quality of HIV prevention, treatment, care and support services.

The report has been prepared with the broad participation of Government and development partners and civil society. In December 2011, the National Commitments and Policy Instrument (NCPI) questionnaire Part A was sent to members of the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control (Viet Nam's national AIDS coordinating authority) and related ministries/organizations. In addition, more than 100 civil society organizations (self-help groups, faith-based organizations national non-governmental organizations and international non-governmental organizations), business enterprises, bilateral, multilateral and United Nations (UN) agencies gave input to NCPI questionnaire Part B. Between December 2011 and January 2012, five consultation workshops (one with Government partners, two with civil society representatives, one with international non-governmental organizations and one with UN agencies) and one consensus meeting were conducted to complete NCPI sections A and B.

[1] Preliminary Viet Nam HIV/AIDS Estimates and Projections 2011. Ministry of Health, National Technical Working Group on HIV Estimates and Projections, 2011.

The National Consensus Meeting for the overall Country Progress Report for Viet Nam was organized on 14 March 2012 with 57 participants from 32 organizations representing government and development partners, as well as civil society delegates, to present the draft report and to give an opportunity for participants to review and validate the report's findings and recommendations.

Part III of this report provides an overview of the epidemic in Viet Nam, while the national response, including laws, policies and programmes relating to prevention, treatment, care and support are analysed in part IV and part V highlights four examples of national best practice.

Part VI covers the major challenges faced by Viet Nam and the remedial actions that are being taken to address them, part VII summarizes key support from development partners and part VIII provides an assessment of the Monitoring and Evaluation system in Viet Nam.

The Annexes contain additional information on the report preparation process (Annex 1), responses to the National Commitments and Policy Instrument questionnaires (Annex 2), the National AIDS Spending Assessment (Annex 3), and detailed explanations of the key reported indicators (Annex 4).

Data for the indicators came from different sources, including the National HIV Sentinel Surveillance Survey with behavioural component (HSS+) conducted in 2011, the 2010 Multiple Indicator Cluster Survey (MICS4), HIV/AIDS estimates and projections conducted by the National Technical Working Group on HIV Estimates and Projections in 2011, and programme reports from 2010 and 2011. In many cases, data disaggregated by gender was not available.

Furthermore, the data for the indicators on sex workers (SWs) represent findings among female SWs only and the data on the indicators PWID are for men who inject drugs (MWID) only. In additional, due to the sampling methodology of surveys, in which only selected provinces were included in the studies, the results do not always reflect the overall national situation.

Data were not available for indicator 1.5 and 7.2. Indicator 1.6 (on HIV prevalence among youth) applies to a generalized epidemic and is therefore not appropriate in Viet Nam, which has a concentrated epidemic. Viet Nam does not report on indicators 7.3 and 7.4 because they are not included in the National Monitoring and Evaluation Framework.

The key reported indicators are summarized in the tables below.

Target 1. Reduce sexual transmission of HIV by 50% by 2015		
General population		
Indicator	**Data source**	**Status**
1.1. Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	SAVY 2009 MICS4 2010-2011	2009: Male 15-24: 44.1% Female 15-24: 40.8% Total 15-24: 42.5% 2011: Female: 49.9%[2]
1.2. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	SAVY 2009 MICS4 2010-2011	2009: Male 15-24: 0.16% Female 15-24: 0.07% Total 15-24: 0.11% 2011: Female: 0.32%[3]
1.3. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	SAVY 2009 MICS4 2010-2011	2009: Male 15-24: 2.44% Female 15-24: 0.11% Total 15-24: 1.28% 2011: Female: 0.09% [4]
1.4. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	SAVY 2009	2009 : Males aged 15-24: 92.9% Females aged 15-24: no risk reported Total 15-24: 92.9%
1.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	*Not relevant*	
1.6. Percentage of young people aged 15-24 who are living with HIV	*Not relevant*	
Sex workers		
Indicator	**Data source**	**Status**
1.7. Percentage of sex workers reached with HIV prevention programmes	IBBS 2009	2009: FSW: 47.3%
1.8. Percentage of sex workers reporting the use of a condom with their most recent client	HSS+ 2011	2011: FSW: 86.9%
1.9. Percentage of sex workers who have received an HIV test in the past 12 months and know their results	HSS+ 2011	2011: FSW: 43.8%
1.10. Percentage of sex workers who are living with HIV	Sentinel surveillance 2011	2011: FSW: 3.0%

[2] No survey was conducted among young men.
[3] See above.
[4] See above.

Target 1. Reduce sexual transmission of HIV by 50% by 2015		
Men who have sex with men		
Indicator	**Data source**	**Status**
1.11. Percentage of men who have sex with men reached with HIV prevention Programmes	IBBS 2009	2009: 24%
1.12. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	HSS+ 2011	2011: 75.6%
1.13. Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	HSS+ 2011	2011: 30.2%
1.14. Percentage of men who have sex with men who are living with HIV	IBBS 2009	2009: 16.7%

Target 2. Reduce transmission of HIV among people who inject drugs (PWID) by 50% by 2015		
Indicator	**Data Source**	**Status**
2.1. Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	VAAC D28 Routine report 2011	2011: MWID: 140
2.2. Percentage of people who inject drugs reporting the use of a condom at last sexual intercourse	IBBS 2009	2011: MWID: 51.9%
2.3. Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	HSS+ 2011	2011: MWID: 95.3%
2.4. Percentage of people who inject drugs who have received an HIV test in the past 12 months and know their results	HSS+ 2011	2011: MWID: 29.1%
2.5. Percentage of people who inject drugs who are living with HIV	Sentinel surveillance 2011	2011: MWID: 13.4%

Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		
Indicator	**Data Source**	**Status**
3.1. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	VAAC D28 Routine report 2011	2010: 49.1% 2011: 44.0 %
3.2. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	VAAC D28 Routine report 2011	2011: 25.8%
3.3. Mother-to-child transmission of HIV	*No data available*	

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015		
Indicator	**Data Source**	**Status**
4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy	VAAC D28 Routine report 2010 and 2011	Adults: 2010: 46.6% 2011: 53.0% Children: 2010: 83.2% 2011: 82.9% All: 2010: 47.7% 2011: 54.0%
4.2. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Annual data collection on ART cohorts and early warning indicators for HIV drug resistance YEAR	2011: 82,1%

Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
Indicator	**Data Source**	**Status**
5.1. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	VAAC D28 Routine report 2011	2011: 30.1%

Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries		
Indicator	**Data Source**	**Status**
6.1. Domestic and international AIDS spending by categories and financing sources	NASA	2009: US$127.4 million 2010: US$139.3 million

Target 7. Critical Enablers and Synergies with Development Sectors		
Indicator	**Data Source**	**Status**
7.1. National Commitments and Policy Instruments	NCPI results	See Annex 2
7.2. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	*No data available*	
7.3. Current school attendance among orphans and non-orphans aged 10–14	*No data available*	
7.4. Proportion of the poorest households who received external economic support in the last 3 months	*No data available*	

III. OVERVIEW OF THE EPIDEMIC IN VIET NAM

Surveillance system

The Human Immunodeficiency Virus (HIV) was first recognized in Viet Nam in Ho Chi Minh City (HCMC) in 1990, and spread rapidly across the country. HIV case reporting began shortly after the first case was recognized. The HIV sentinel surveillance system began in 1994, with 10 provinces reporting HIV prevalence among 6 sentinel populations perceived to be at increased risk of HIV infection. In 1996, the system expanded to 20 provinces, in 2001 to 30 provinces and in 2003 to 40 provinces. In 2009, Ha Tay province merged with Ha Noi, leaving 39 provinces with sentinel sites. Surveyed populations included men who inject drugs, female sex workers, patients of sexually transmitted infection (STI) and tuberculosis (TB) clinics, pregnant women attending antenatal care clinics and military recruits. Other populations are added at the discretion of local authorities.

In 2011, men who have sex with men were formally added as a sentinel population, where previously only a few provinces periodically surveyed MSM. 2011 also saw the end of surveys in administrative detention centres for people who inject drugs and female sex workers.

Between 2000 and 2001, two rounds of behavioural surveillance were conducted in five provinces – Ha Noi, Hai Phong, Quang Ninh, HCMC and Can Tho. As part of efforts to improve epidemic tracking and programme planning, the first Integrated Biological and Behavioural Surveillance (IBBS) was conducted between 2005 and 2006 in these five provinces, as well as in Da Nang and An Giang. This community-based systematic survey was designed to assess risk behaviours and HIV and other STI prevalence among key populations at higher risk, specifically men who inject drugs (MWID), men who have sex with men (MSM) and female sex workers (FSW). In 2009, the Ministry of Health, the Viet Nam Authority of HIV/AIDS Control (VAAC) and the National Institute of Hygiene and Epidemiology (NIHE) jointly collaborated on data collection for IBBS Round II, with financial and technical support from the President's Emergency Plan for AIDS Relief (PEPFAR) and the United Nations Office on Drugs and Crime (UNODC).

As in Round I, IBBS Round II focused on key populations at higher risk – MWID, MSM and FSW. Round II data were collected in the original seven provinces and in five additional provinces: Nghe An, Yen Bai, Dong Nai and – for MWID – Dien Bien and Lao Cai.[5]

More recently, routine, brief behavioural surveys were added to the annual HIV sentinel surveillance. After a pilot phase in 2009, 7 provinces (An Giang, Da Nang, Ha Noi, Hai Duong, Thanh Hoa, HCMC and Hue) collected these surveys in 2010 and 12 provinces (An Giang, Binh Duong, Ca Mau, Dien Bien, Da Nang, HCMC, Hai Duong, Ha Noi, Hue, Nghe An, Quang Tri, and Thanh Hoa) collected surveys in 2011.

[5] Results from the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam – Round II 2009, Ministry of Health, 2011.

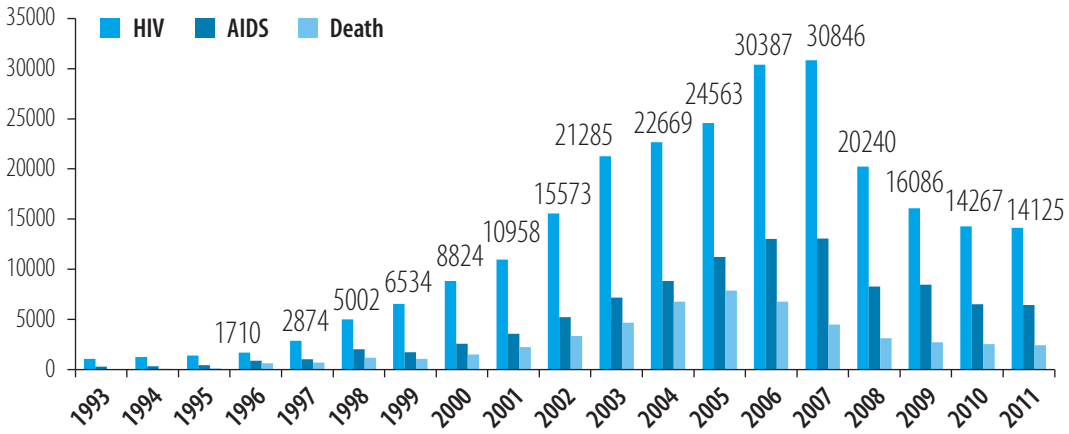
Status at a glance

The epidemic in Viet Nam comprises many sub-epidemics across the country and remains concentrated primarily among three populations defined by high levels of HIV-transmission risk behaviours: men who inject drugs (MWID), men who have sex with men (MSM) and female sex workers (FSW). According to 2011 sentinel surveillance, HIV prevalence among MWID and FSW reached 13.4% and 3% respectively; IBBS 2009 data indicates that prevalence among MSM was 16.7%. The distribution of HIV cases largely follows the distribution of these three populations, which are heavily concentrated in urban centres but do also exist in non-urban communities.

As of 31 December 2011, HIV cases had been reported in all 63 provinces, 98% of districts and 77% of communes. The cumulative total since records began was 249,660 reported HIV cases, with 197,335 PLHIV still living and 52,325 AIDS-related deaths.

The number of HIV cases reported to the Ministry of Health decreased rapidly between 2007 and 2009 and held steady at about 14,000 reports per year in 2010 and 2011. AIDS case reports and related mortality have also remained fairly steady since 2009. These case report numbers are consistent with declining HIV prevalence among key populations at highest risk of transmission. People aged 20-39 years account for more than 80% of all reported cases.[6]

Figure 1:
HIV, AIDS and HIV-related deaths reported 1993 - 2011



According to the preliminary results of the 2011 Viet Nam HIV/AIDS Estimates and Projections, adult HIV prevalence (ages 15-49) was 0.45% in 2011. It is estimated there will be up to 263,317 PLHIV by 2015.[7]

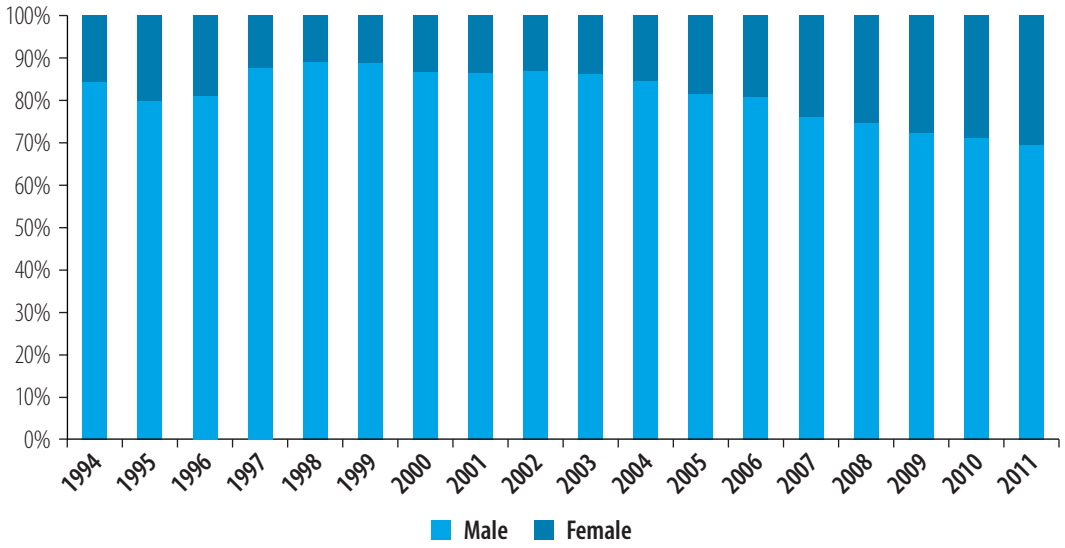
---

6 HIV/AIDS Case Report and Implementation of HIV/AIDS Prevention and Control Program in 2011. Planning for 2012. Ministry of Health, February 2012.

7 Preliminary Viet Nam HIV/AIDS Estimates and Projections, 2011. Ministry of Health, National Technical Working Group on HIV Estimates and Projections, 2011.

A rise in reported cases of HIV-positive women, who now represent 31% of newly reported cases, reflects a probably slow but steady transmission of HIV to women by men engaging in highly risky behaviours.[8] However, the scale-up of prevention of mother-to child-transmission services and a high HIV-testing coverage of pregnant women mean that it is likely that some proportion of these newly reported cases comes from increased testing rather than increased transmission. At the same time, it should be noted that at two sentinel sites, in Dien Bien and Ha Noi provinces, prevalence among pregnant women exceeded 1%, while the overall prevalence among pregnant women attending antenatal care is estimated at 0.2% (n=30,771.)

Figure 2
Distribution of Male: Female cases in HIV case reports 1994-2011



In 2011, UNAIDS and UN Women undertook a data triangulation study to estimate the magnitude of intimate partner transmission (IPT) of HIV.[9] Preliminary analyses of data triangulation efforts (VCT and biological and behavioural survey data) suggest that a large proportion of women living with HIV in Viet Nam were infected by their husband or long-term partner. Indeed, IPT – from men engaging in high-risk behaviours to their intimate female partners – is believed to be one of the factors in the steady decline in the male-to-female ratio of new HIV infections seen in recent years.

Epidemic characteristics and trends among men who inject drugs (MWID), men who have sex with men (MSM) and female sex workers (FSW)

Men who inject drugs (MWID)

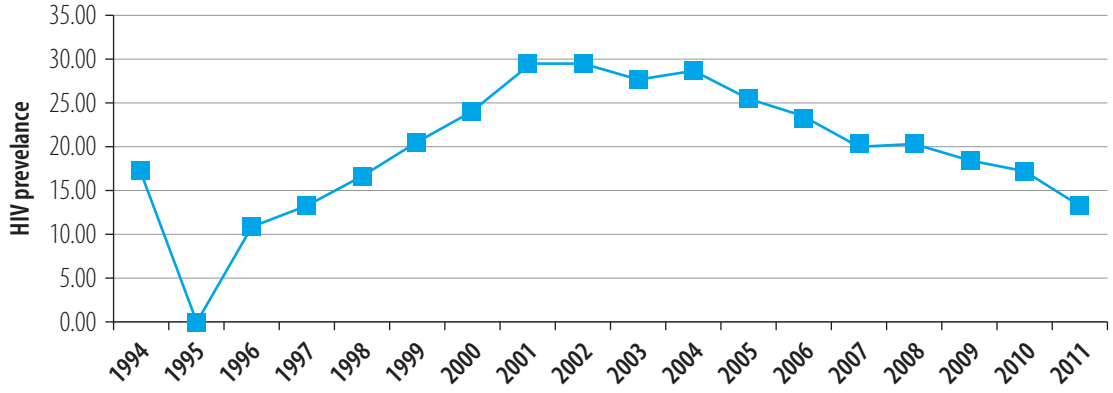
Men who inject drugs are the predominant group of HIV-positive people in Viet Nam. According to the sentinel surveillance data, HIV prevalence among MWID decreased steadily from 2004 through 2011, falling below 15% in 2011 for the first time since 1997. [10]

---

[8] HIV/AIDS Case Report and Implementation of HIV/AIDS Prevention and Control Program in 2011. Planning for 2012. Ministry of Health, February 2012.
[9] Triangulation Exercise on Intimate Partner Transmission of HIV in Viet Nam. UN Women and UNAIDS, 2012 (forthcoming).
[10] Sentinel Surveillance Survey 2011. VAAC, 2011.

The heterogeneity of the epidemic among MWID is highlighted by the range of prevalence among the provinces: the highest prevalence was registered in Dien Bien (45.7%) in the north west and the lowest in Hoa Binh (1.1%) in the north central region.

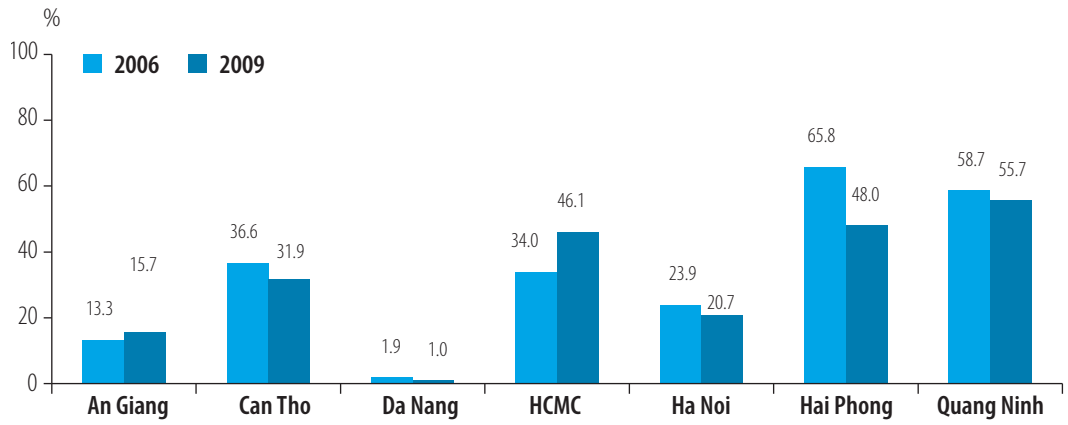
Figure 3
HIV prevalence among men who inject drugs 1994 - 2011



HIV Sentinel Surveillance System, NIHE

In the seven provinces (Ha Noi, Hai Phong, Quang Ninh, Ho Chi Minh City, Can Tho, Da Nang and An Giang) where IBBS was conducted in both 2006 and 2009, HIV prevalence among MWID increased in HCMC only, while prevalence decreased or stabilized in the other six provinces. [11] In HCMC, prevalence among MWID increased from 34% to 46%, although prevalence among recent injectors declined from 28% in 2006 to 5% in 2009, providing preliminary evidence for a decline in incidence.

Figure 4
Comparison of HIV prevalence among MWID - IBBS 2006 and 2009

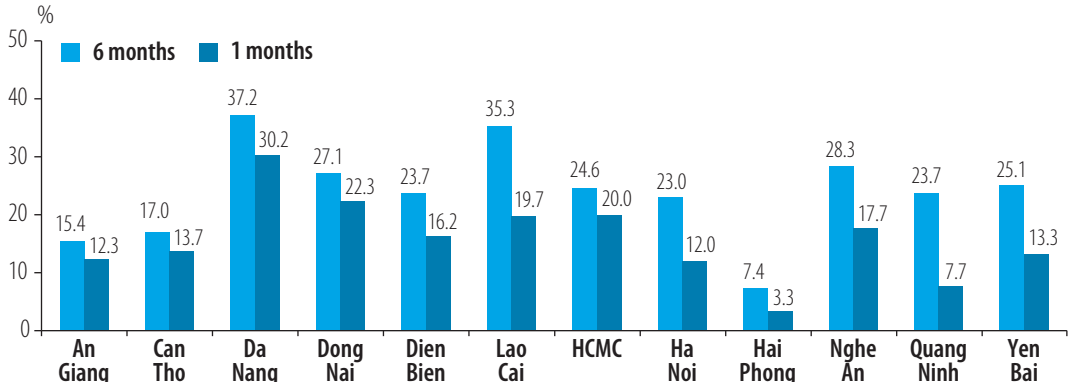


[11] Results from the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam – Round II 2009. Ministry of Health, 2011.

Although there has been an overall decrease in HIV prevalence among MWID, it remained high in many surveyed provinces, including Dien Bien (56%), Quang Ninh (56%), Hai Phong (48%), and HCMC (46%). It was also relatively high in Ha Noi (21%), Lao Cai (22%), Dong Nai and Nghe An (both 24%). Da Nang had the lowest prevalence, at only 1%.

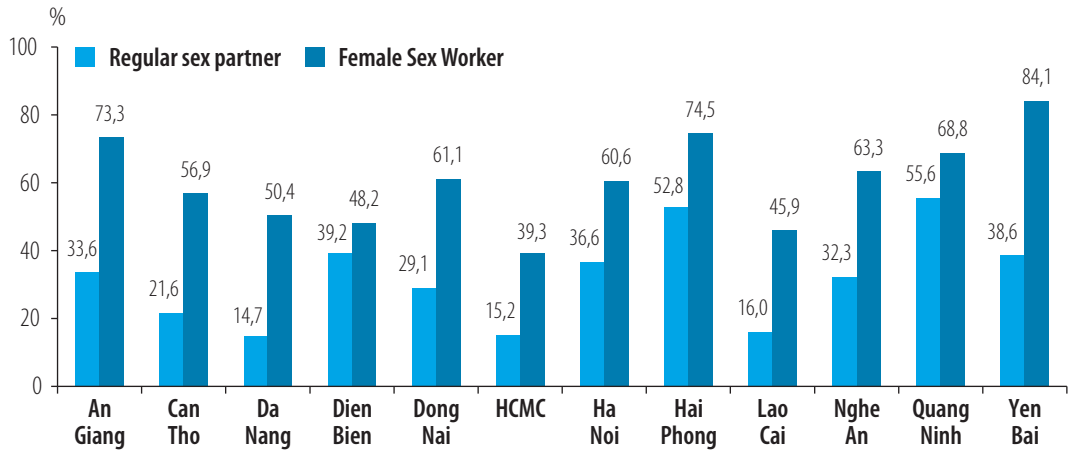
According to the IBBS Round II data, needle and syringe sharing in the last 6 months was relatively high (15% to 37%) in all provinces surveyed except Hai Phong (7%). Reported sharing in the last 6 months was highest in Da Nang (37.2%) and Lao Cai (35.3%).

Figure 5
Proportion of MWID reporting needle and syringe sharing – IBBS 2009



According to IBBS 2009, consistent condom use in the past 12 months among MWID with regular partners (wives and girlfriends) varied, from 15% in Da Nang to 56% in Quang Ninh. While consistent condom use with sex workers was higher than with regular partners, from 38% in HCMC to 74% in Hai Phong, it was still low in the provinces surveyed. Compared to the 2006 results, a greater proportion of MWID reported consistent condom use with their regular sex partners in most provinces (specifically Ha Noi, Hai Phong, Quang Ninh, and An Giang). The reverse is true for Da Nang and HCMC, where the percentages dropped from 25% and 36%, respectively, to 15%.

Figure 6
Proportion of MWID who reported consistent condom use by type of partner in the past 12 months - IBBS 2009



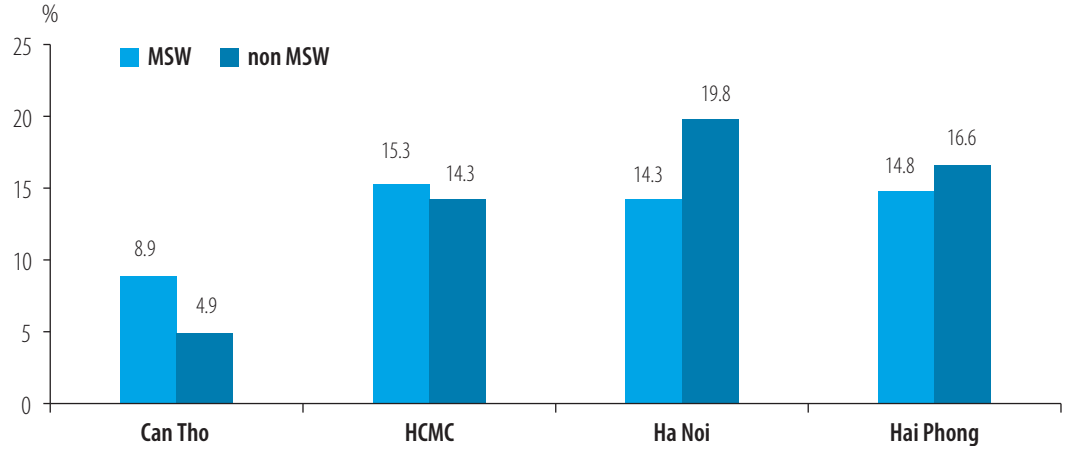
In 2011, the HSS+ found that 55.1% of MWID (n=1628) reported receiving free needles in the month prior to interview. MWID living with HIV reported receiving a mean of 9 needles per month, while seronegative MWID received 20 per month. A total of 28.8% of MWID (n= 1647) reported receiving free condoms in the month prior to interview, with means of 3 and 6 per month for HIV-positive and negative MWID, respectively.

Men who have sex with men (MSM)

Eight provinces (Ha Noi, Hai Duong, Da Nang, Khanh Hoa, HCMC, An Giang, Can Tho and Kien Giang) collected HIV sentinel survey data on MSM in 2011, finding a mean HIV prevalence among them of 4.0% (range: 0.0% in Da Nang to 14% in HCMC).[12] In 2010, 3 provinces (An Giang, Ha Noi and HCMC) conducting brief behavioural surveys with sentinel surveillance found HIV prevalence among MSM to be 8.5%. With two additional provinces (Hai Duong and Da Nang) adding brief behavioural surveys, this estimate decreased to 5.2% in 2011. The data are strongly influenced by a single province, HCMC, where prevalence was estimated at 16.1% in 2010 and 16.3% in 2011.

According to the IBBS Round II results, HIV prevalence among MSM was greater than 10% in 3 (HCMC, Ha Noi and Hai Phong) of the 4 provinces surveyed and as high as 20% (among MSM who had not sold sex) in Ha Noi.

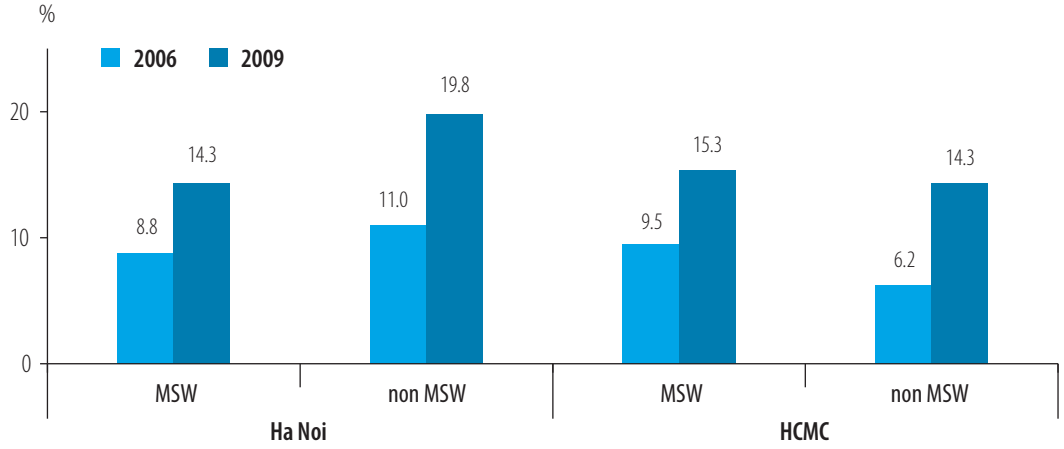
Figure 7
HIV prevalence among MSM who had sold sex (MSW) and MSM who had not sold sex (non-MSW) – IBBS 2009



In Ha Noi and HCMC, HIV prevalence among both groups of MSM in 2009 was significantly higher than in 2006. For MSM who had sold sex (MSW) in Ha Noi, prevalence rose to 14% in 2009 from 9% in 2006. For those who had not sold sex (non-MSW), prevalence was 20% in 2009, versus 11% in 2006. The data for HCMC were similar.[13]

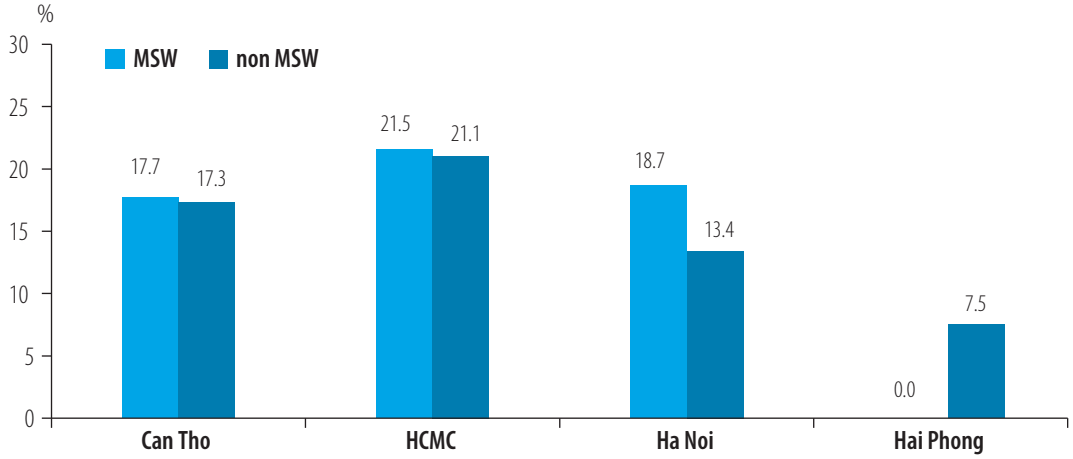
[12] Sentinel Surveillance Survey 2011. VAAC, 2011.
[13] Results from the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam – Round II 2009. Ministry of Health, 2011.

Figure 8
HIV prevalence among MSM who had sold sex (MSW) and MSM who had not sold sex (non-MSW) – IBBS 2006 and 2009



IBBS Round II results also confirm that prevalence of STIs (other than HIV) among MSM was high. One in five MSM in HCMC had at least one of the following STIs: syphilis, genital gonorrhea, rectal gonorrhea, genital chlamydia or rectal chlamydia.

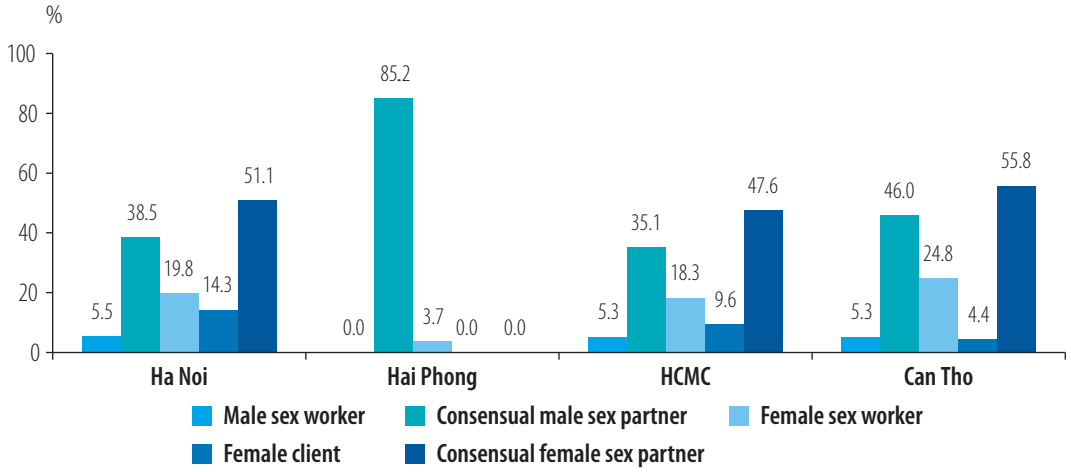
Figure 9
STI prevalence among MSM who had sold sex (MSW) and MSM who had not sold sex (non-MSW) – IBBS 2009



A large proportion of MSM who sold sex in 3 of the 4 survey provinces said that they had had sex with women as consensual sex partners in the past 12 months. Other than in Hai Phong, where MSM who sold sex overwhelmingly had sex with male sexual partners, 47-56% of MSM who sold sex reported consensual sexual partnerships with women at least once in the past 12 months, versus 39-46% with men at least once in the past month. MSM who sold sex were also more likely to report sex with FSW (up to 25% in Can Tho) in the past 12 months.[14]

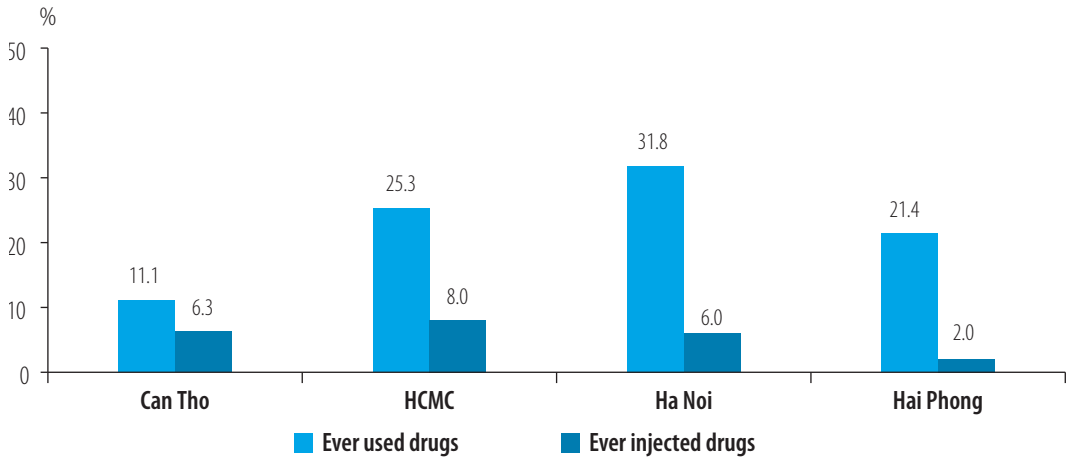
[14] Results from the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam – Round II 2009. Ministry of Health, 2011.

Figure 10
Proportion of MSM who sold sex reporting sex with a male partner in the last month and a female partner in the last 12 months, by partner type – IBBS 2009



Like MWID and FSW, MSM face drug- and sex-related risks, both of which increase their chances of acquiring HIV. Figure 11 shows the percentage of MSM who reported drug use in 2009. Drug use among MSM ranged from 1 in 10 in Can Tho to 1 in 3 in Ha Noi.

Figure 11
Proportion of MSM who ever used drugs and ever injected drugs – IBBS 2009



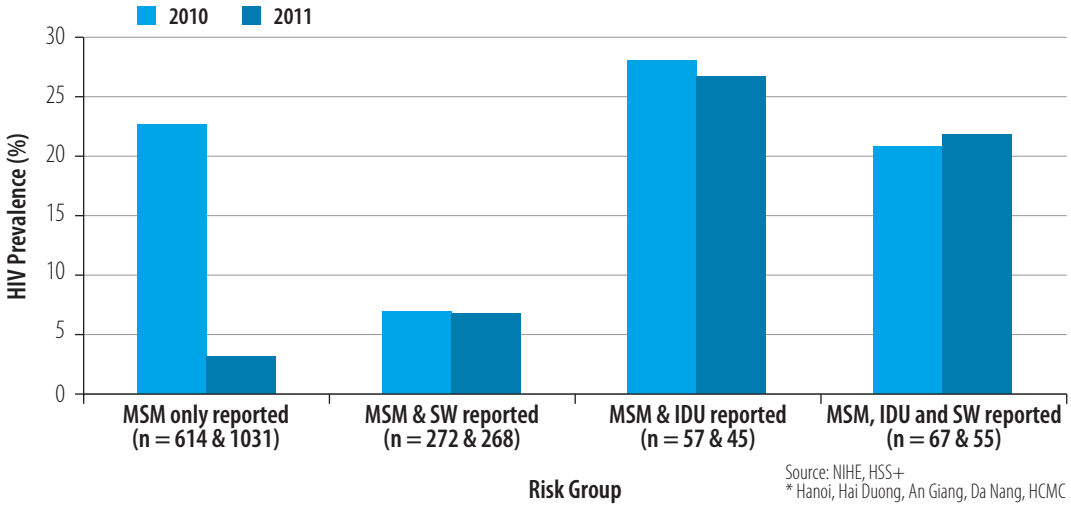
According to the HSS+, in HCMC, 48% of MSM respondents were engaged in sex work and 15.7% reported injecting drug use. This was not dissimilar from An Giang and Ha Noi, where 42% and 20.5%, and 28.1% and 9.1% sex work and injecting drug use were reported respectively.[15]

Figure 12 below makes it clear that injecting drug use and unprotected anal sex are synergistic risks for HIV infection among MSM: on average, MSM who inject drugs have a higher prevalence than people who only inject drugs or only engage in anal sex.

[15] HSS+ 2010 and 2011. VAAC, 2010 and 2011.

More than half of MSM respondents in the 2011 HSS+ reported receiving free condoms in the month before the survey (56.9%, n=1349.) Of 69 MSM reporting injecting drug use in the past month, 44.9% received at least one free syringe. The mean number of syringes given per person during the month prior to interview was 5 and 6 for HIV-positive and -negative injecting MSM, respectively.

Figure 12
HIV prevalence by reported multiple risk group among MSM, 5 provinces (Ha Noi, Hai Duong, An Giang, Da Nang, HCMC), Viet Nam 2010-2011 (IDU = injecting drug use; SW =sex work)



Female sex workers (FSW)

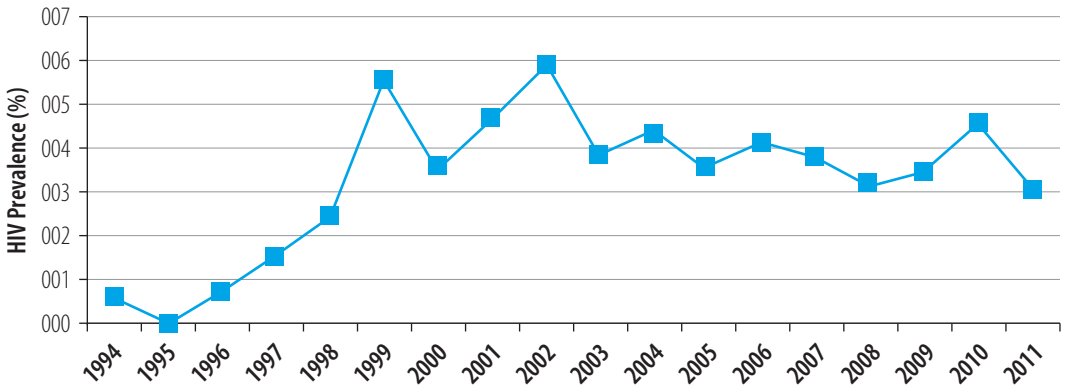
HIV prevalence among female sex workers (FSWs) began declining in 2002. In 2011, at 3.0%, it reached a level not seen since 1998 (range: 0.0% in 6 provinces to 22.5% in Ha Noi).[16]

Brief behavioural surveys integrated into sentinel surveillance indicate that this estimate is somewhat influenced by injecting drug use among sex workers. In 2010, 7.2% of female sex workers (n=992) interviewed reported a history of injecting drug use. HIV prevalence among these women was 25.4%.[17]

In 2011, 2.7% of 2,986 FSW respondents in 12 provinces reported a history of injecting drug use, and HIV prevalence among them was 30%.[18] The national estimate is derived from a sample of 7,983. As the behavioural survey component expands to more provinces, a clearer picture of risk among FSWs should emerge.

[16] Sentinel Surveillance Survey 2011. VAAC, 2011.
[17] HSS+ 2010. VAAC, 2010.
[18] HSS+ 2011. VAAC, 2011.

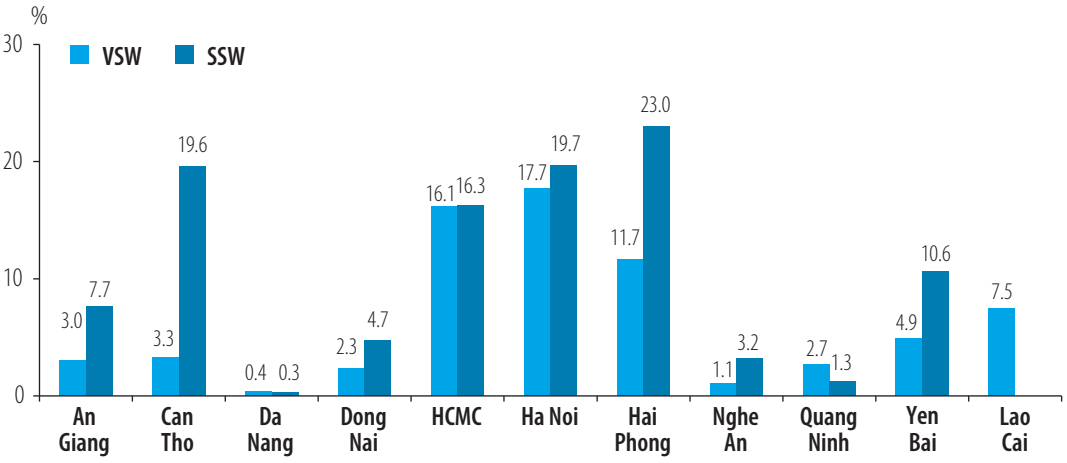
Figure 13
HIV Prevalence among Female Sex Workers, 1994-2011



HIV Sentinel Surveillance System, NIHE
2011: n = 7983

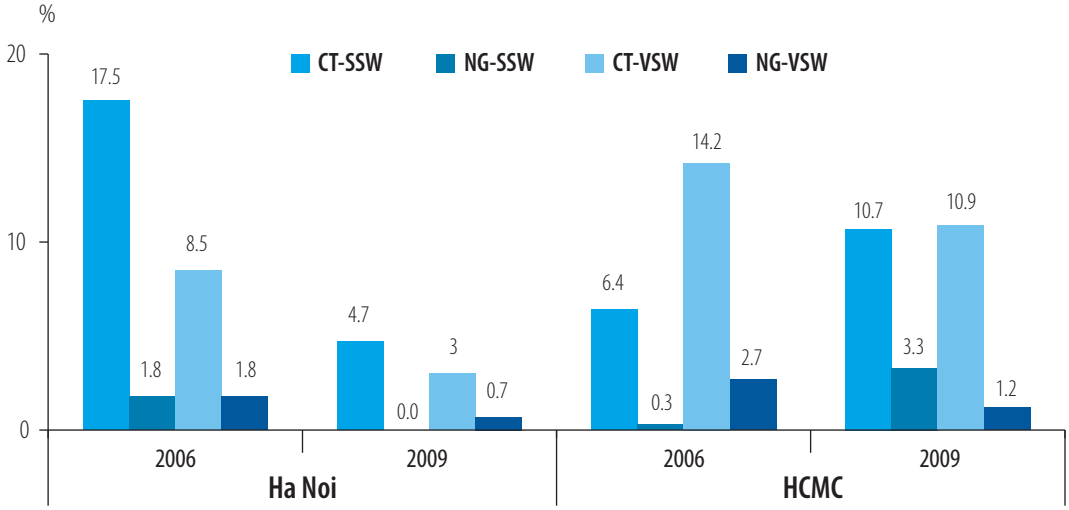
The IBBS Round II results revealed that HIV prevalence among FSW varied considerably by province and classification (street-based versus venue-based). In most provinces, prevalence was higher among street-based sex workers (SSW) than among venue-based sex workers (VSW). Prevalence exceeded 10% in Ha Noi, Hai Phong and HCMC in both sex work subpopulations and in Can Tho and Yen Bai among SSW. Among both SSW and VSW in Quang Ninh, Nghe An, Da Nang and Dong Nai, prevalence was 3% or below. SSW in Hai Phong had the highest prevalence, at 23%.

Figure 14
HIV prevalence among VSW and SSW - IBBS 2009



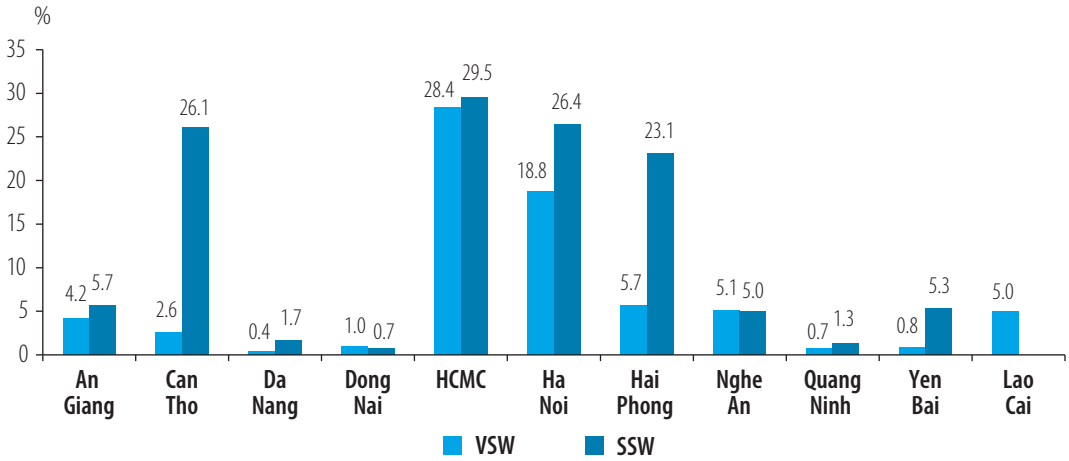
According to IBBS 2009 data, STI prevalence appears to have decreased between 2006 and 2009 for both SSW and VSW in Ha Noi, while chlamydia prevalence appears to have increased for SSW in HCMC (10% in 2009 compared to 6% in 2006). Gonorrhoea prevalence was low and relatively rare in both cities. Syphilis prevalence remains low among FSW, at under 2% in most provinces surveyed (except Can Tho and An Giang).

Figure 15
Chlamydia (CT) and gonorrhea (NG) prevalence among VSW and SSW in Ha Noi and HCMC - IBBS 2006 and 2009



Injecting drug use is an increasingly critical risk factor for HIV transmission among FSW and, according to the IBBS Round II data, rates are considerably elevated in Ha Noi, Hai Phong, HCMC and Can Tho. SSW were much more likely to report injecting drug use than VSW. HIV prevalence among FSW who injected drugs was higher than among those who did not inject in all provinces surveyed, while figures for prevalence among injecting FSW were equal to or higher than those of men who inject drugs in the same provinces.

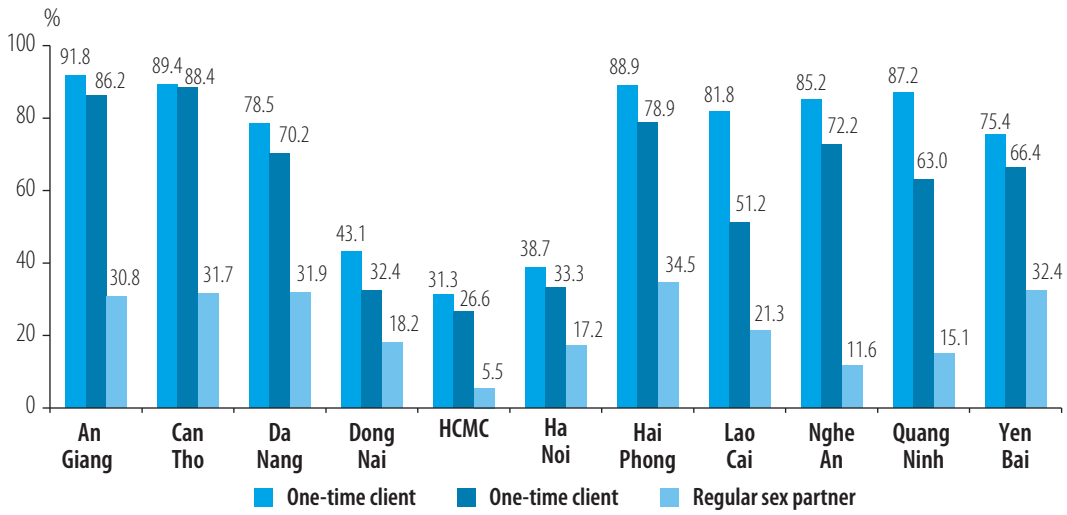
Figure 16
FSW who have ever used drugs – IBBS 2009



While condom use with regular clients at last sex was reportedly high in most provinces, consistent condom use in the last month varied considerably, and was particularly low in Ha Noi, HCMC and Dong Nai. FSW reported using condoms more consistently with one-time clients than with regular clients. Data from Ha Noi and HCMC are cause for concern.

For both SSW and VSW, consistent condom use dropped considerably between 2006 and 2009 for both one-time and regular clients. In HCMC, consistent condom use among SSW more than halved from 69% to 31% for one-time clients, and 64% to 27% for regular clients.[19]

Figure 17
Consistent condom use in the last month among SSW by sex partner type – IBBS 2009



A majority of female sex workers responding to the 2011 HSS+ reported receiving free condoms in the month prior to the survey (65.5%, n = 2832.)

Of the 75 FSW who inject drugs who responded, 49.3% reported receiving free needles in the same period. The mean number of condoms received by FSW living with HIV was 24, while sero-negative FSW received 19; the mean number of needles received by HIV-positive and -negative FSW was 17 and 15, respectively.

[19] Results from the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam – Round II 2009. Ministry of Health, 2011.

IV. NATIONAL RESPONSE

1. Governance and leadership

The year 2011 saw the handover of positions within Viet Nam's political system. In order to implement *Decision No. 50/2007/QĐ-TTg*, dated 12/4/2007, of the Prime Minister on consolidating the National Committee for AIDS, Drugs and Prostitution Prevention and Control, *Decision No. 1867/QĐ-TTg* on appointment of members of the National Committee for AIDS, Drugs and Prostitution Prevention and Control was promulgated on 24/10/2011 by the Prime Minister. Under this Decision, Deputy Prime Minister Nguyen Xuan Phuc became Chairman of the National Committee; additional members were appointed for the first time from the Viet Nam Union of Science and Technology Associations (VUSTA); and new leaders of ministries/sectors replaced those members who had retired or moved to other positions. In parallel with the consolidation of the National Committee's structure, committees for AIDS, Drugs and Prostitution Prevention and Control at the provincial, district and commune levels have also been strengthened. In its new role as a member of the National Committee, VUSTA represents civil society organizations, reflecting the National Committee's coordinating role in Viet Nam's multisectoral HIV response.

The Deputy Prime Minister and new Committee members paid supervisory visits to AIDS, drugs and sex work prevention and control activities; took the lead on launching the national action month on HIV prevention and control; and led a conference on Methadone Maintenance Therapy (MMT). In addition, the National Committee organized training workshops on HIV prevention and control for 600 new leaders in the provinces of Hai Duong, Hung Yen, Nam Dinh, Phu Tho and Bac Giang.

During the 2010-2011 reporting period, the HIV response made important progress under the direction of the Party Executive Committee and authorities throughout the political system, and with close collaboration between the core sectors of public security, health, and labour, war invalids and social affairs and the Viet Nam Fatherland Front, mass organizations, civil society and ordinary people. Previous and new Communist Party and State leaders worked at the national and local levels to continue to improve and broaden service delivery, particularly in the areas of harm reduction and HIV treatment and care. Programme implementation was improved, based on international best practice and adapted to the situation in Viet Nam. At the central level, they worked to ensure that HIV was mainstreamed into key policies and decisions, and that relevant provisions (including those incorporated into Viet Nam's ten-year Socioeconomic Development Strategy 2011-2020 and Socioeconomic Development Plan 2011-2015) were implemented.

The Social Affairs Commission of the National Assembly held workshops with international partners and relevant ministries to develop a sustainable budget for HIV prevention and control activities. The Party Central Propaganda and Education Committee organized a review meeting to mark 5 years of implementing *Directive No. 54-CT/TW*, dated 30/11/2005, on "Enhancing leadership for HIV/AIDS prevention and control in the new period".

Leaders at the highest level of the Party participated in this review meeting, providing direction for HIV prevention and control activities in coming years.

Public awareness of HIV and risk behaviours, as well as of AIDS, drugs and prostitution prevention and control measures, was improved.

The years 2010 and 2011 also saw major changes in funding for the HIV response. Consistent efforts by leaders and collaboration between the Ministry of Health and other ministries resulted in the approval by the National Assembly in 2011 of a National Targeted Programme for HIV 2011-2015 with an associated budget. This meant not only that the response could be better coordinated between relevant ministries and other actors, but that a certain level of national funding was guaranteed – at least to the end of 2015. Viet Nam is also the recipient of a grant under the Global Fund to Fight AIDS, Tuberculosis and Malaria Round 9 and has recently embarked on a process to reform the Country Coordinating Mechanism (CCM), establishing an oversight committee and selecting new CCM members. These reforms will enable the CCM to successfully oversee service delivery and prepare future grant applications.

However, despite such encouraging indications of national commitment to funding and managing HIV-related activities, there are serious concerns regarding sustainability. Viet Nam's response to HIV continues to rely heavily on international assistance, but the country's achievement of middle-income country status, coupled with global financial concerns, has resulted in decreasing international funds for HIV. Donors have planned to end funding for the response or (as in the case of PEPFAR) will dramatically reduce the funds available; the Global Fund has postponed new grant applications due to a funding shortfall. Unless national budget sources for expenditure on HIV prevention and control activities increase to cover the shortfall, there is a risk that the significant gains in HIV prevention, treatment and care will be lost.

In March 2012 the Deputy Prime Minister convened a National Conference to review the implementation of activities in 2011 and plan for 2012. The conference was attended by leaders at the ministerial/sectoral level, People's Committees from 63 provinces/cities and heads of international organizations in Viet Nam. The Conference emphasized the achievements outlined above, but recognized the challenge of sustainability, and the complexities of the concentrated epidemic in Viet Nam – including the intersecting issues of HIV, drug use and sex work; the potential for outbreaks; and stigma and discrimination towards PLHIV, female sex workers and people who use drugs. The following were identified as potential barriers to a successful response and areas for improvement:

- Insufficient awareness of HIV and related issues impedes multisectoral collaboration and wider involvement.
- The legal and policy environment and the implementation of current laws need to be further strengthened.
- HIV communication and education, including on the law, remain insufficient and there is a lack of targeting of such activities to specific groups.
- The mobilization, allocation, management and use of resources are inadequate and inefficient.
- Management and use of data need to be strengthened.
- Human resources, capacity and management for the response remain inadequate and there is insufficient coordination.

Deputy Prime Minister Nguyen Xuan Phuc's closing remarks at the National Conference confirmed that the Government has identified both the achievements and the shortcomings of current HIV prevention and control activities. He also clarified tasks for 2012, emphasizing the directorial roles of leaders at different levels, intersectoral collaboration, community mobilization, the promotion of resource mobilization and technical activities. The themes for 2012 are: systems strengthening; awareness-raising; resource mobilization; and intensifying prevention efforts. [20]

2. Policy and legislative environment

The Government of Viet Nam acknowledges that HIV is an important development and multisectoral issue. HIV prevention and control should therefore be treated as an important and long-term task requiring a multisectoral response, and the Government is committed to creating favourable conditions for the implementation of HIV prevention and control activities. There is also increasing awareness of the importance of engaging civil society to provide input to the drafting of policies and laws. The *Law on HIV/AIDS Prevention and Control No. 64/2006/QH11* (hereafter, the Law on HIV) passed in 2006 provides provides the legal foundation for a strong, multisectoral response to HIV, and for the protection of the rights of PLHIV. In recent years, the Government and National Assembly have enacted, supplemented or amended numerous policies and legal documents, creating a stronger and more consistent legal framework for prevention and control activities.

Notably, the Viet Nam Authority for HIV/AIDS Prevention and Control (VAAC) coordinated the development of a new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*. The new Strategy was written in consultation with government ministries, civil society, the United Nations and international partners, and contains ambitious targets that resonate with the *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, which was agreed at a special session of the UN General Assembly in June 2011. The National Assembly also passed a *National Targeted Programme on HIV 2011-2015*, which secured more state budget for HIV activities, while the Communist Party reviewed *Directive 54 on HIV*, leading to *Party Notice 27-TB/TW* renewing the Party's commitment to continued leadership on HIV prevention and control at both the central and local levels.

Another major development in 2011 was the passing of *Decree No. 69/2011/ND-CP* dated 08/08/2011 on handling administrative violations in health prevention, the medical environment and HIV/AIDS prevention and control, which provides crucial support to the enforcement of the Law on HIV. While administrative violations and their sanctions are contained in various pieces of legislation, Decree 69 describes the overall framework, provides more details about administrative violations affecting PLHIV and increases the number and types of sanctions for such administrative violations. This Decree sets specific sanctions for providing incorrect information about HIV, for preventing people from accessing treatment and care, and for various forms of discrimination against PLHIV (including restricting access to health services, employment and education). It also provides for specific sanctions where the rights to testing, counselling or privacy have been violated.

[20] Letter number 84/TBVPCP dated 9/3/2012 of the Office of Government containing the conclusions of the Deputy Prime Minister at the National Conference.

Over the past two years there have also been further positive changes in the legislative environment relating to the implementation of harm-reduction activities. For example, *Joint Circular 03/2010/TTLT-BYT-BCA*, dated 20/01/2011, of the Ministries of Public Security and Health regulates the issue, management and use of Outreach Worker Cards for those who directly participate in harm-reduction activities for HIV prevention.

Following the success of the pilot project to deliver methadone maintenance therapy (MMT) to people addicted to heroin, Viet Nam's leaders increasingly recognize the value of the approach. The programme has already been expanded and is due to be extended to additional provinces. As a result, new legislation has been enacted/drafted, including:

- The *Protocol on Manufacturing and Using Methadone in Viet Nam (Period 2010-2015)*, which will support the expanding MMT programme with nationally produced methadone products, up to 80% of need by 2015.
- *Decision 5146/QD-BYT*, dated 27/12/2010, of the Ministry of Health to approve the above Protocol.
- A draft *Decree on Substitution Treatment for Opioid Addiction* which elaborates the conditions for the recipients and delivery of MMT.
- *Decision 3140/QD-BYT*, dated 30/08/2010, of the Ministry of Health to issue Guidelines on Substitution Treatment by Methadone and Implementation Instructions.
- *Decree 94/2010/ND-CP*, dated 09/09/2010, of the Government on home-based and community-based detoxification.

In addition, there have been efforts to expand harm-reduction approaches to sex work. On 10 May 2010, the Prime Minister issued Decision 679/QD-TTg to approve the *Programme of Action on Sex Work 2010-2015*, while focused on the enforcement of anti-prostitution ordinance, includes a range of harm-reduction approaches targeting female sex workers (FSWs), including the provision of condoms, access to HIV and STI treatment and other health services, and social-protection measures for sex workers. Voluntary and community-based efforts to help FSWs build alternative livelihoods are also key parts of the Programme of Action.

A new *National Comprehensive Condom Programme for 2011-2020* specifically targets people at high risk of HIV infection, such as the sexual partners of PLHIV, people who inject drugs, sex workers and men who have sex with men. As overall demand for condoms in Viet Nam increases, the Condom Programme also establishes a framework for more effective coordination, stronger linkages with HIV and sexual and reproductive health programmes, and the expansion of market-based approaches, which are all critical as donor resources for condoms in Viet Nam decline. In addition, in 2010 the Ministry of Culture, Sports and Tourism released Decision 2859/QD-BVHTTDL approved the implementation plan for the condom programme for HIV and STI prevention and control at tourism establishments for the period 2010-2015, with a target of making condoms available in 80% of all hotels and guest houses across the country by 2015.

Moreover, improvements have been made in the policy and legislative framework for treatment and care. Viet Nam has adopted 2010 WHO guidelines on the initiation of antiretroviral therapy (ART) for all PLHIV, including pregnant women living with HIV, with a CD4 count of ≤350 cells/mm3 and for those with WHO clinical stage 3 or 4 if CD4 testing is not available. The new national HIV treatment and care guidelines should improve survival rates of ART patients and better leverage the preventative benefits of treatment. The roll-out of the guidelines is being supplemented by a pilot of "Treatment 2.0" – Viet Nam was one of the first countries to commit to such a pilot. Treatment 2.0 is a WHO/UNAIDS initiative that encourages innovation, efficiency and sustainability in the HIV response, focusing on scale-up and universal access to ART treatment.

The following will also contribute to improving treatment and care for people vulnerable to and living with HIV:

- The Women's Union's five-year national strategic plan on HIV and reproductive health.
- Decision No. 4620/QD-BYT includes HIV testing and counselling as a component of the *National Standards and Guidelines for Reproductive Health Care Services*.
- *Decision 4139/QD-BYT* amends the National Guidelines on HIV Diagnosis and Treatment (Decision 3003/QD-BYT) and fully incorporates the WHO's 2010 recommendations on ART.
- *Circular 04/2011/TT-BLDTBXH* on national minimum standards for care in social protection centres.
- *Decision 1781/QD-BYT*, dated 27/05/2010, of the Ministry of Health providing guidelines on home-based and community-based care for PLHIV and Decision 1782/QD-BYT, dated 27/05/2010, of the Ministry of Health regulating home-based and community-based care for PLHIV.
- *Circular 33/2011/TT-BYT*, dated 28/08/2011, of the Ministry of Health on compulsory HIV testing, which makes exceptions for direct-transfusion blood donors and dialysis patients.
- Decree 96/2011/ND-CP on administrative fines for violations related to health care examinations, including refusal to provide health services to PLHIV.
- *Circular 01/2010/TT-BYT* guiding the notification of positive HIV test results
- *Decree 61/2011/ND-CP* amending and supplementing certain Articles of Decree 135/2004/ND-CP, which prescribes the application of the measure of consignment to medical treatment establishments, the organization and operation of medical treatment establishments under the Ordinance on Handling of Administrative Detention
- *Circular 09/2011/TT-BYT* stipulating the conditions and scope of medical establishments which provide ART.
- *Joint Circular 06/2010/TTLT-BYT-BNV-TC* provides for the implementation of *Decree 64/2009/NĐ-CP* on incentive policies for health staff working in disadvantaged regions, while Decree 56/2011/ND-CP regulates allowances for officials in public medical establishments. These pieces of legislation will help to retain staff working on HIV.

Government policy and strategy have shifted from HIV-specific and vertical support for children living with and affected by HIV to strengthening integrated social protection to include these children. The Government continued to prioritize prevention, treatment, care and support for these children:

- Impact mitigation for children is reinforced in the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*.
- MOLISA drafted the multisectoral National Plan of Action for Children affected by HIV and AIDS, 2011-15, which lays out specific objectives and directions for the HIV response as it relates to children.
- MOLISA also developed the *National Programme on Social Work Development and National Programme on Child Protection*, both of which will provide crucial infrastructure for the sustained support of children affected by HIV, in addition to the existing social allowance scheme under *Decree 67/2007/ND-CP AIDS*, which was amended and supplemented by *Decree 13/2010/ND-CP*; *Circular 24/2010/TTLT-BL DTBXH-BTC* provides guidance for the implementation of a number of its articles.
- HIV programming was strengthened within the education sector through the development of a Ministry of Education and *Training Strategic action plan for the education sector on HIV/AIDS prevention 2011-2020 with a vision to 2030* which includes an Information Management System, and the inclusion of HIV in the new *Education Strategic Development Plan 2011-2020*.
- Children living with or affected by HIV are protected under *Decree 69/2011/ND-CP*. Under this Decree, schools that base admission on HIV status, expel students because of their HIV status or that of a family member, or discipline students because of their HIV status can be fined or obliged to readmit the student.
- *Decree 91/ND-CP* also includes sanctions for stigma and discrimination against children living with or affected by HIV, such as preventing access to education.
- *Decision 1053/QD-BYT* provides guidance on HIV testing for children under 18 months.
- *Circular 02/2010/TT-BYT* lists additional medicines for children under 6 which are paid by the social security fund, including treatment for opportunistic infections (but not ART).
- The new national minimum standards of care for institutions will also help to protect children affected by HIV.

At the UN General Assembly High-Level Meeting on AIDS in June 2011, Viet Nam's Deputy Prime Minister at the time, Truong Vinh Trong, was among global leaders who committed to eliminating mother-to-child transmission (MTCT) by 2015. In order to achieve this ambitious target, the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* includes the target of eliminating MTCT by 2020; the *National Targeted Programme on HIV 2011-2015* also includes prevention of MTCT (PMTCT). The Ministry of Health strengthened the policy framework by approving a number of new relevant guidelines[21] and by revising the PMTCT guidelines (QD4139/2011) in line with 2010 WHO guidelines.

[21] National Guidelines on Comprehensive PMTCT (Ref. 2816/QD-BYT, 2010), National Guidelines on PMTCT Supervision and Monitoring (Ref. 2880/QD-BYT, 2010), National Training Curriculum on VCT for PMTCT at Medical Teaching Facilities (Ref. 8282/BYT-K2DT, 2010), National Training Manual on HIV Paediatric Care and Treatment (Ref. 4746/QD-BYT, 2010).

Meanwhile, under *Decree 12/2003/ND-CP*, PLHIV are currently barred from accessing fertility treatment, including "sperm washing" and IVF. This puts HIV-negative partners in sero-discordant relationships, as well as the children of sero-discordant and HIV-positive, sero-concordant couples, at higher risk of HIV infection. The Ministry of Health has begun a process of consultation to provide input into a revision of the Decree.

Additional workplace-related protection has been established to complement that under Article 14 of the Law on HIV, according to which employers are responsible for HIV prevention and control in the workplace:

- Under *Decree No. 69/2011/ND-CP*, employers who violate the right to work of PLHIV can be fined or obliged to rehire PLHIV and arrange appropriate jobs for them.
- *Notice 316/TB-VPCP* aims to reduce HIV-related stigma and discrimination in the work place, including through legal recourse for employees fired based on their HIV status.
- Under *Decree 122/2011/ND-CP*, expenditure on workplace-based HIV prevention and control (including relevant training for staff, communication activities on HIV prevention and control for employees, counselling fees, HIV tests and financial support for HIV-positive employees) is excluded when calculating income for corporate income tax. Businesses of 20 employees or more (and not working in the areas of finance and real estate) with at least 30% HIV-positive and/or disabled staff, and/or staff recovering from drug addiction, can apply for corporate income tax exemptions, while income earned from vocational training for PLHIV or recovering drug users is exempt.
- Circular No 42/2011/TT-BYT adds HIV infection to the list of occupational hazards covered by insurance schemes under the provisions of the Labour Law and its guiding documents
- Viet Nam was among the States of the International Labour Organization (ILO) to adopt the Recommendation Concerning HIV and AIDS and the World of Work (R200)38, which calls for the delivery of workplace safety and health and HIV prevention, treatment and care to all workers and their families/dependents, and in all labour forms or arrangements including formal and informal sector workers, sex workers, migrant workers and people in the uniformed services.

However, despite these ongoing developments in the legal and policy environment, there are still inconsistencies between policy and regulatory documents. In particular, public security measures to control drug use and sex work conflict with public health messages trying to reach the populations engaged in these activities. For example:

- Inconsistencies regarding support for harm-reduction interventions still exist between the Law on HIV and *Decree 108/2007/ND-CP* and the 2003 *Ordinance on Prostitution Prevention and Control*. Under the Ordinance, anyone selling sex is subject to administrative detention in 05 Centres.[22] This presents a barrier to the provision of effective HIV services

[22] Under the Ordinance on Administrative Violations 04/2008/PL-UBTVQH12, drug use and sex work are administrative violations and result in detention for up to two years in centres managed by the Ministry of Labour, War Invalids and Social Affairs (MOLISA). These centres are referred to as 05 Centres for female sex workers and 06 Centres for drug users.

- Although the Law on Drugs was amended to decriminalize drug use under the *Ordinance on Administrative Violations*, which improved its overall consistency with the Law on HIV, drug use still remains an administrative violation, with users subject to administrative detention for up to two years. This presents a barrier to the provision of effective HIV services.
- In addition, a number of new legal obstacles may affect the ability of HIV programmes to reach key populations at higher risk of HIV infection. *Decree 94/2009/ND-CP*, which guides the implementation of the Law on Drugs following the 2009/21 Directive, threatens to create a more punitive legal environment for PWID. Under this new legislation, repeat drug offenders are subject to an additional period of 'post-detoxification management' for between one and two years. As detainees have limited access to HIV services, this measure may further impede HIV prevention efforts with people who inject drugs as well as the provision of HIV treatment and care to PLHIV within these facilities.

This situation may improve in the near future as the Government has proposed to the National Assembly a draft law on administrative sanctions that – if passed in its current form (end 2011) – would improve due process for individuals accused of an administrative violation and remove administrative detention as a sanction for selling sex. The removal of the threat of detention will create an environment in which sex workers feel more comfortable seeking health care and harm-reduction measures, including condoms.

In 2010-2011, a measure of progress for women living with, at risk of or affected by HIV has been achieved as a result of efforts to mainstream HIV into gender equality programmes. HIV-related targets have been included in both the new National Strategy on Gender Equality 2011-2020 and the Plan of Action on Gender Equality in Health 2011-2015. However, additional policy initiatives are still required to address women's specific access to HIV prevention, treatment, care and support interventions – particularly sex workers (who often inject drugs) and the sexual partners of men who engage in risky behaviour. Already marginalized, sex workers living with HIV face double stigma[23] and have difficulties in accessing alternative employment, education and social support services. Preliminary analyses of data also suggest that a large proportion of women living with HIV in Viet Nam were infected by their husband or long-term partner. Existing HIV-prevention programmes do not adequately address individuals' responsibility to protect their intimate partners or to confront sensitive issues of gender power imbalance in sexual relationships, and HIV and reproductive health laws and policies do not yet adequately challenge power relations between men and women, particularly in sexual relationships.

A series of documents has been issued to create a legal framework for the provision of HIV-related services for prisoners in prisons. Decision 96/2007/QD-TTg, dated 28/06/2007 of the Prime Minister covers the provision of HIV prevention, treatment and care and counselling services in correctional settings, including prisons and Centres for Treatment, Education and Social Labour (05/06 Centres). Decree 117/2011/ ND-CP, dated 15/12/2011, of the Government regulates the management of prisoners and regulations on food, accommodation and medical care for prisoners, including those living with HIV.

[23] According to the VNP+ Stigma Index, sex workers living with HIV are more than four times more likely to face stigma and discrimination than PLHIV who do not sell sex. People Living with HIV Stigma Index in Viet Nam, preliminary results, 2012. VNP+, 2012.

Other activities, including education, prevention and treatment, have been implemented in 15 provinces but are very limited. Currently, ART is not available in any prisons, although by 2011 ART had been provided in 05/06 Centres in 35 provinces through Global Fund project activities implemented by MOLISA. Voluntary counselling and testing (VCT) and information, education and communication (IEC) services are provided in 05/06 Centres in 31 provinces through Global Fund and the AusAID-funded HIV/AIDS Asia Regional Programme (HAARP) projects.

Efforts to enforce the 2006 Law on HIV are still limited by a lack of awareness and understanding on the part of both rights holders and duty bearers. Programmes have been developed to raise PLHIV's awareness about their rights. To date, five legal aid clinics and one hotline have been established for PLHIV. In addition, a training manual on HIV and the Law has been developed to enable PLHIV, those who work with them and those who make decisions affecting them, to learn about the rights of PLHIV, people affected by HIV and key populations at risk. Efforts have also been made to make legal support services available, including legal aid systems for HIV casework and private-sector law firms providing free or reduced-cost legal services to PLHIV. However, the clinics require further capacity strengthening, especially as stigma and discrimination remain a significant barrier to accessing HIV prevention, treatment, care and support services. Meanwhile, major gaps in insurance coverage for PLHIV persist under the Health Insurance Law.

3. Multisectoral collaboration for HIV prevention and control

Multisectoral collaboration in the implementation of HIV prevention and control activities has been strengthened over the past two years. Ministries and sectors worked with each other and with mass organizations, civil society and international organizations to ensure the provision of prevention, treatment and care services and public awareness of HIV.

For example, the Ministry of Health (VAAC) routinely held biannual meetings with the standing HIV prevention and control agencies of ministries/sectors, as well as periodic meetings with the press to disseminate information on HIV prevention and control via the mass media. Under the direction of the National Committee for AIDS, Drugs and Prostitution Prevention and Control, leaders of different ministries/sectors organized annual supervisory visits to AIDS, drugs and prostitution prevention activities in provinces and cities. Visiting teams were headed by a ministry/sector leader and consisted of department-level leaders of relevant ministries/sectors. In addition, ministries/sectors collaborate closely when developing legal documents and technical guidelines and organizing fora on HIV prevention.

The Ministries of Planning and Investment and Finance worked together to promulgate guiding documents and guidelines for HIV prevention and control in both ministries. They also collaborated on evaluating the National Targeted Programme for HIV and submitting it to the Prime Minister and the National Assembly. A circular guiding the application of cost norms for the National Targeted Programme and other related documents were developed by line ministries. The Ministry of Justice also promulgated guiding documents and guidelines for the implementation of HIV prevention within the ministry, organized thematic talks and published HIV-related information in legislative newspapers and journals. In addition, it conducted studies and assessments of the uniformity, synchronicity and legitimacy of regulations and related documents on AIDS, drugs and prostitution prevention and control, and contributed to HIV-related aspects of the Decree on handling administrative violations.

In 2011, through a Global Fund to Fight AIDS, Tuberculosis and Malaria-supported HIV-prevention, care and treatment project, the Ministries of Health, Public Security and Labour, War Invalids and Social Affairs collaborated to implement HIV services for people living with HIV in prisons and 05/06 Centres. The Ministry of Public Security continued to facilitate training courses on HIV prevention for its staff and staff working in prisons, and began introducing counselling, care and ART in prisons. However, activities were still limited, mainly focusing on capacity building for health staff in prisons (relating to counselling, HIV testing and ART), and the pace of implementation of patient treatment is slow. At the same time, the Ministry of Labour, War Invalids and Social Affairs ran capacity-building training workshops for staff in 05/06 Centres, and implemented activities to improve HIV-related knowledge about counselling, HIV testing, care and ART.

With PEPFAR support, counselling, testing and ART have been provided at military health service facilities, while ART was also provided to people living near these facilities. In addition, the Ministries of National Defence and Health conducted a joint programme to combine military and civil health care services. The strength of this programme is that it is based on the military health personnel system deployed in such locations as border areas, shorelines, islands and areas without easy transport access, etc., with local inhabitants provided with health care support by military health personnel. The Ministry of Health also plans to integrate HIV prevention, care and counselling activities for local inhabitants.

Different ministries/sectors also worked together or side-by-side on HIV-related information, education and communication (IEC) campaigns. The Ministry of Information and Communication took the lead on collaborating with agencies to intensify propaganda on HIV prevention via the mass media. This included the development by Viet Nam Television (VTV) of a special programme on HIV prevention, broadcasts twice a week on VTV1, an information channel which currently draws the most viewers.

At the same time, the Ministry of Transport also worked with the mass media, including through printed messages about HIV prevention in the "Giao Thông – Vận Tải » (Traffic and Transport) newspaper. Training on communication about HIV was conducted for communicators, managerial staff, trade union staff, health staff, youth union members, students, drivers, workers in remote areas; and health care and HIV-prevention projects were carried out at project and construction sites. Meanwhile, the Ministry of Education and Training strengthened HIV-prevention activities in education facilities; organized workshops on HIV-related stigma and discrimination reduction in the education sector; supplied CDs and lectures on HIV prevention to education and training facilities; and organized visits to monitor and evaluate the results of HIV-prevention activities in education facilities.

The Ministry of National Defence enhanced IEC activities on HIV prevention for soldiers, especially new recruits. The Committee for Ethnic Minorities collaborated with the Border Army to undertake HIV-related communication activities for ethnic minorities in border areas, and conducted capacity-building training workshops for local staff working on ethnic minority issues and HIV.

Communication materials, including the "AIDS and the Community" magazine, were provided in provinces with ethnic minority populations in remote and mountainous areas. The Committee also collaborated with the Ministry of Health to develop a model for HIV-

prevention communication for ethnic minorities. Finally, the Ministry of Culture, Sports and Tourism worked with the Central Committee of the Fatherland Front to carry out the Joint Action Plan "Everyone participates in HIV prevention and control in the community". It also organized dramatic performances about HIV prevention.

These efforts were supported by those of mass organizations and other bodies. The Central Committee of the Viet Nam Fatherland Front and member organizations jointly implemented HIV-prevention activities in the community, and conducted HIV-prevention communication campaigns through the Front's information system, which includes the "Đại đoàn kết » (Great Solidarity) newspaper, a website, bulletins and a magazine on the Front's activities, which are provided to communes, wards and residential areas across the country. Advocacy was undertaken to link activities with the movement for economic development, hunger and poverty elimination, as well as patriotic movements in residential areas.

The Viet Nam Women's Union and the Ho Chi Minh Communist Youth Union continued to promote behaviour change communication activities. These included direct communication sessions to improve knowledge about HIV and the prevention of HIV-related stigma and discrimination through club activities, such as those of the "Sympathy" clubs in 5 provinces (Dien Bien, Ha Nam, Tuyen Quang, An Giang and Long An). Community-based communication on HIV prevention was also provided annually to around 700 adolescents and youths in industrial, export and processing zones. Training workshops on HIV prevention and control were also organized for nearly 200 local Youth Union staff. The Viet Nam General Confederation of Labour improved the HIV knowledge of trade union staff in provinces; directed the implementation of HIV-prevention communication activities for workers; produced leaflets and manuals for enterprises; supplied HIV-related communication materials such as CDs, handbooks, leaflets and brochures at the local level; and ran training workshops for private-sector workers on HIV prevention and control activities.

Finally, MOLISA has made progress in the implementation of *Decree No. 67/2007/NĐ-CP*, dated 13/4/2007, of the Government on support for groups of people eligible for subsidies, including orphans, abandoned children, children living with HIV from poor families and people living with HIV who are unable to work from poor families. People belonging to these groups register with MOLISA at their place of residence to receive subsidies in line with the Decree.

4. Prevention

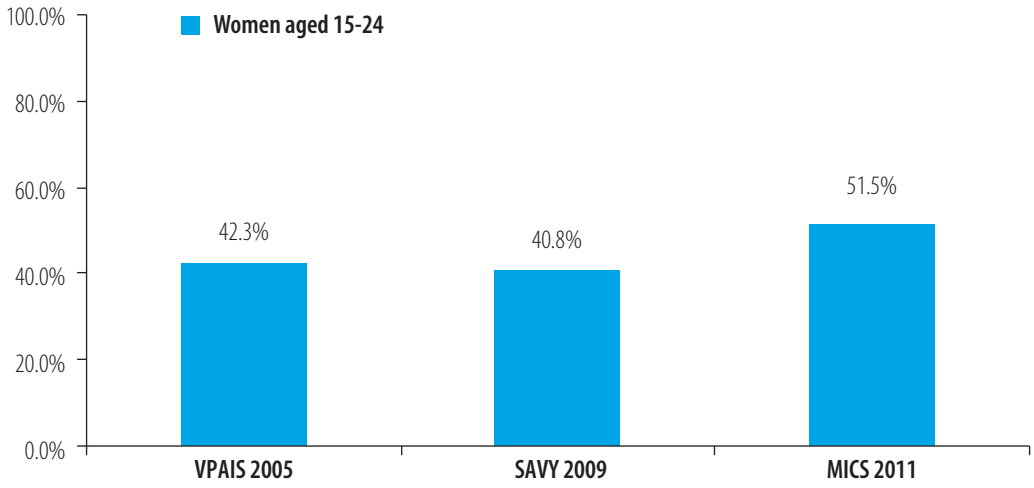
Information, Education and Communication (IEC) and Behaviour Change Communication (BCC)

Information, Education and Communication (IEC) and Behaviour Change Communication (BCC) activities have been implemented in collaboration with multisectoral organizations and in various forms at all levels throughout the country. Magazines, television programmes, newspapers, bulletins, posters, banners leaflets and campaigns featuring HIV campaign messages have been delivered to key populations at higher risk as well as the general population. IEC/BCC activities included training, peer education among key populations at higher risk, counselling, establishing hotlines, running competitions, 'edutainment' shows, stories and photo exhibitions. The Ministry of Health, the Ministry of Culture, Sport and

Tourism and the Central Committee of the Fatherland Front jointly carried out the Joint Action Plan entitled "Everyone participates in HIV prevention and control in the community", reaching approximately 17 million people. Other ministries have also conducted IEC/BCC activities to reach mobile populations, migrants, youths and teenagers with HIV prevention messages and services.

Youth are one of the priority target groups of the IEC/BCC programme. Results of the 2010-2011 MICS4 show that 51.5% women aged 15-24 correctly identified ways of HIV transmission and were able to correctly reject misconceptions about HIV transmission (see Figure 18).[24] This proportion is slightly higher than that found in the 2009 SAVY survey (44.1% male and 40.8% female at the same age group).[25] Among women aged 15-24 years old, 0.32% reported having sex before the age of 15 and 0.8% reported having had sex with a non-marital, non-cohabiting partner in the last 12 months.

Figure 18
Proportion of women aged 15-24 who correctly identified ways of HIV transmission and were able to correctly reject misconceptions about HIV transmission



The Ministry of Education and Training (MOET) continued to target teachers, school managers, students and their families with school-based IEC/BCC activities and through mass media channels, workshops and training on the reduction of stigma and discrimination towards children living with and affected by HIV. In 2010, an interdepartmental mechanism for coordinating the planning, implementation and monitoring of HIV interventions in the education sector was established. HIV education for students has been integrated into existing school-based training curricula. MOET has also collaborated with other ministries and organizations to pilot internationally funded projects, including life skills-based HIV education for students in grades 5, 8 and 10 in selected schools, the development of training curricula on HIV for students in grades 7 and 8 and the use of IT in HIV education for students in the Mekong delta.

[24] Multi-Indicator Clusters Survey (MICS4). General Statistics Office, 2010 and 2011. There is no recent survey providing similar figures for men in the same age group.
[25] National Survey on Adolescents and Youth in Viet Nam from 14-25 years old (SAVY). GSO, 2009.

Harm-reduction programmes

Viet Nam's new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*, the 2006 Law on HIV and *Decree 108/2007/ND-CP*, dated 26/6/2007, of the Government 108 detail the implementation of the Law on HIV and specifically support the scaling-up of comprehensive harm-reduction interventions to reduce the transmission of HIV among people with high-risk behaviours. These include the Needle and Syringe Programme (NSP), the 100% Condom Use Programme (100% CUP) and opioid substitution with methadone maintenance therapy (MMT).

These embedded national HIV policies and the new Strategy identify HIV transmission among people who inject drugs (PWID), sexual transmission among female sex workers (FSW) and their clients, men who have sex with men (MSM) and young people and vertical transmission as priority areas for intervention.

According to the Ministry of Labour, War Invalids and Social Affairs (MoLISA), by the end of 2011 there were 158,414 people nationwide using drugs (around 85% of whom inject opiates) and 30,000 women engaging in sex work.[26] However, these figures probably do not reflect the actual size of populations of PWID and FSW. According to 2011-2015 HIV Estimates and Projections, key populations at higher risk may include up to 335,990 PWID, 101,272 SWs, 3,163,580 clients of SW and 393,467 MSM.[27] These upper estimates (known as the 'high scenario') are based on several assumptions for each of the key populations at higher risk. [28]

In a concentrated epidemic, knowing the size of these sub-populations facilitates advocacy for appropriate interventions and the allocation of resources. Research is ongoing, with PEPFAR support, into the best methodologies for conducting accurate size estimations of PWID, FSW and MSM populations.

A further geographic expansion of the NSP, 100% CUP and HIV prevention for MSM programmes took place during the reporting period. In 2011, 49 of 63 provinces carried out community outreach activities for PWID and FSW, 60 implemented some level of NSP and 57 distributed condoms free of charge.[29] The Ministry of Health and departments of health at the provincial and district levels have worked with peer educators, PLHIV support groups, local officials and police to provide harm-reduction services to PWID, FSW and MSM.

According to the VAAC, by the end of 2011, there were 3,875 PWID peer educators (former and current drug users), 2,278 FSW peer educators (former and current sex workers and entertainment establishment owners), 145 MSM peer educators (men who currently have sex with men) and 11,782 district collaborators (mostly health-service staff) participating in the HIV prevention programme.[30]

---

[26] Report on detoxification, rehabilitation and anti-prostitution in 2009 and key missions for 2010. Ministry of Labour, War Invalids and Social Affairs 2010. This figure was still in use in 2011, for example at the conference on MMT in June 2011.

[27] Preliminary Viet Nam HIV/AIDS Estimates and Projections 2011. National Technical Working Group on HIV Estimates and Projections, Ministry of Health, 2011.

[28] For the high scenarios, a multiplier that varied by province was applied to MOLISA estimates to determine the number of PWID; MOLISA estimates of FSW were tripled; clients of sex workers was set at 10% of adult males in the 15-49 age group; the number of MSM was set at 3% of adult males in Ha Noi and HCMC, and 1.5% in other provinces.

[29] Report on HIV/AIDS Prevention and Control Programmes in 2010. VAAC, 2011.

[30] D28 Routine Report of HIV/AIDS Programme. VAAC 2012.

These peer educators have now been issued with peer education cards by local authorities to formalize and support their activities and facilitate the delivery of commodities to clients of harm-reduction interventions.

In addition, the national Methadone Maintenance Therapy (MMT) programme, piloted in HCMC and Hai Phong in 2008, has been expanded to a total of 11 provinces (Hai Phong, HCMC, Ha Noi, Thai Nguyen, Dien Bien, Da Nang, Nam Dinh, Hai Duong, Quang Ninh, Thanh Hoa and Can Tho) and treats more than 6,900 people in 41 clinics, with an adherence rate of 96%.[31] Drug use in HCMC and Hai Phong declined from 100% to 15.9% after 2 years, while the quality of life of clients also improved. [32] It is planned to continue to expand this service to 245 clinics in 30 provinces and 80,000 patients by 2015. [33] There are also plans to offer MMT in prisons.

Viet Nam is at the advanced pilot stage of developing a package of tools to improve document outreach and service delivery to key populations at higher risk, including a 10-character unique identifier code (UIC), a pocket field data-collection book and a simplified computer-based data entry and reporting system. This will allow service providers at the district and provincial levels to better identify individuals contacted and reduce double counting, while providing more accurate service coverage reports to the National Monitoring and Evaluation System. There are plans to scale up the use of the UIC and data-collection system across HIV prevention programmes in Viet Nam with World Bank/DFID and Global Fund support.

Harm-reduction interventions for MSM used to be limited to seven provinces, funded by PEPFAR, but there has been a substantial increase in the number of provinces undertaking risk and needs assessments for local MSM networks, as well as initiating HIV-prevention programmes involving condom/lubricant distribution, support for local MSM peer networks and involvement in national MSM networks. During the reporting period, partners successfully advocated for targeted interventions for MSM, the scale-up of current initiatives and increased geographic coverage of MSM assessments and interventions under the Ministry of Health with World Bank/DFID and Global Fund support.

However, many challenges remain. Programme coverage is still low. Access by MSM to free and socially marketed condoms and water-based lubricants is restricted to a small number of provinces, and uptake of VCT and STI services is also low. Many MSM do not see themselves as being at risk of HIV infection, or are unsure of whether they are at risk. In addition, the diversity of sub-populations of MSM in Viet Nam presents a challenge for programme designers and implementers. Draft National MSM Guidelines require urgent approval and dissemination so they can serve as a foundation for the Government, the MSM community and partners to create a more enabling environment and to scale up a comprehensive package of prevention, treatment, care and support services.

An evaluation of the previous National HIV Strategy and the development of peer-educator and MMT training materials and the NSP and MSM programme guidelines are all in the final stages.

---

[31] Weekly report 26-30 December 2011. VAAC, Department of Harm Reduction, 2011.
[32] Promising results and impacts from a 2-year pilot methadone program in Vietnam. FHI, 2011.
[33] Summary Report on HIV/AIDS in 2009 and key missions for 2010. Ministry of Health, 2010

The response to HIV prevention, diagnosis and treatment service needs in prisons, pre-trial detention and 05/06 Centres remain a serious challenge. Most of these closed settings still lack basic HIV services, even though HIV prevalence within them is estimated to be as high as 50% in the Centres and 30% in prisons.[34] Through initiatives of HAARP in 3 provinces and Global Fund Rounds 8 and 9, basic HIV education, diagnosis and treatment services are being established in prisons and other closed settings in more than 31 provinces, with additional piloting of some prevention initiatives, including condom provision, in 06 Centres.

Condom-promotion programmes

During the reporting period, promotion of condom use and free condom distribution were carried out in 57 provinces/cities. As of 2011, 28.7 million condoms had been distributed.[35]

At the national and provincial levels, structural support has been provided to increasing the availability of condoms. For example, the Ministry of Culture, Sports and Tourism plans to make condoms available in 80% of all hotels and guest houses across the country by 2015. In parallel, authorities in a number of provinces have issued instructions requiring condoms to be available at hotels and guest houses. In many provinces, with support from PEPFAR and World Bank/DFID programmes, condoms are available free (through retail purchase, social marketing and free distribution) in more than 80% of hotel and guest house rooms.

Peer-educator networks, including entertainment establishment owners and current or former sex workers, continue to distribute 65% of all condoms distributed through the 100% CUP. HSS+ 2011 data from 12 provinces indicates that 61% of SWs reported having received free condoms in the last month. The HSS+ data also showed that HIV testing for the SW surveyed remained low (64% ever tested for HIV; 50.4% tested in the last 12 months)[36]. According to the HSS+ 2011 data, and IBBS 2009 data from the 10 provinces, in the majority of provinces more than 80% of sex workers used a condom with their most recent client.

However, condom use among MSM and PWID remained relatively low. According to the 2011 enhanced sentinel surveillance with PWID and MSM in 12 and 5 provinces respectively, in the majority of provinces around a fourth and a fifth, respectively, of those interviewed did not use a condom during their most recent vaginal or anal sexual encounter.

Needle and Syringe Programme

With support at a variety of administrative levels and using mainstream health service structures and the employment of peer educators, the Needle and Syringe Programme (NSP) was further expanded during the reporting period. The distribution of free needles and syringes was sustained at around 30 million in 2011,[37] and expanded access was provided through community pharmacies and self-service boxes at commune health stations and community hotspots.

---

34 Global Fund Round 9 HIV proposal, 2009
35 D28 Routine Report of HIV/AIDS Programme. VAAC, 2012.
36 HSS+ 2011. VAAC, 2011.
37 D28 Routine Report 2011. VAAC, 2012.

In 35 provinces, with funding from the World Bank/DFID and AusAID, Provincial AIDS Committees and People's Committees have established working groups at the district level which bring together health care workers, police officers, representatives of Departments of Labour, War Invalids and Social Affairs and members of the Women's/Youth Unions to support the implementation of the NSP. However, the fear of being identified and registered, and of possible arrest and detention, continues to deter many PWID and SW from accessing HIV-prevention, diagnosis and care services.

Methadone Maintenance Therapy

Under the legal framework of the Law on HIV, *Decree 108/2007/ND-CP* and *Decision 5073/2007 QDBYT* by MoH, a national pilot methadone maintenance therapy (MMT) programme began in Hai Phong and HCMC in May 2008. The roadmap for expanding the MMT programme in the period 2010-2012 aims for the implementation of the programme in 13 provinces, benefiting 15,600 PWID. In the period 2013-2015, 17 additional provinces will receive MMT services, targeting 80,000 PWID.

By December 2011, a total of 11 provinces had implemented MMT (85.7% of the roadmap target), with 6,931 people (44.4% of the roadmap target) receiving services in 41 clinics. Evaluation of the 4-year MMT programme showed evidence of effectiveness: drug use declined significantly to 14% after 24 months of treatment. The percentage of patients suffering from depression declined from 80% to 15% after 12 months of treatment.

There were community benefits, too, with improvements in security in areas with large numbers of resident PWID: the percentage of reported drug users involved in crime reduced by 40% to less than 3% after 9 months of treatment. Family conflicts among MMT clients also declined over time (from 20% to 3.5% after 9 months of treatment). In terms of economic impact, a significant reduction of household expenditure among families with a member who injects drugs was observed. The percentage of MMT clients who are employed is increasing, as they do not have to pay for drugs, search for drugs, or suffer from cravings. The programme's effectiveness has led additional provinces to conduct research into applying the model. To date, a further 11 provinces (Son La, Bac Giang, Cao Bang, Hoa Binh, Thai Binh, Ninh Binh, Bac Kan, Phu Tho, Ba Ria Vung Tau, Lao Cai and Binh Thuan) have received Government approval to implement the MMT program. There will therefore be 24 provinces implementing MMT during phase 1, and an additional 6 provinces will do so in phase 2, which will begin in 2013.

Blood transfusion safety

Blood safety in Viet Nam has always been one of the cornerstones of health sector interventions for HIV prevention. Continuous efforts are being made to screen each donated blood unit for HIV and hepatitis B and C.

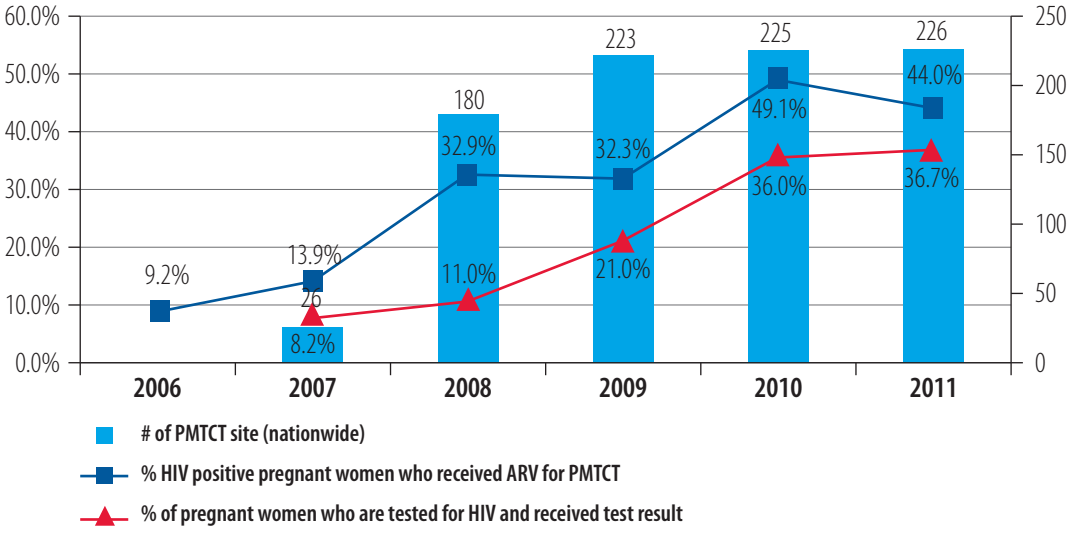
According to 2011 Blood Transfusion Committee reports on the activities of 82 blood centres/ blood screening laboratories, there were 313,453 blood units collected nationwide, with 248,610 units coming from volunteer blood donors. One hundred per cent of blood units were screened for HIV, hepatitis B, hepatitis C, syphilis and malaria. Of these, 369 blood units tested positive using an HIV rapid test.

Prevention of mother-to-child transmission of HIV (PMTCT)

At the end of 2011, PMTCT services were available at 226 sites, of which 133 provide comprehensive services, including ART for women and children. This is only a slight increase on the 223 sites providing such services in 2009. However, according to the Ministry of Health, the coverage of both "pregnant women tested for HIV and who know their results", and "HIV-positive pregnant women who received ARV prophylaxis for PMTCT" increased from 480,814 (21% of all pregnant women) and 1,372 (32.3% of estimated HIV-positive pregnant women) in 2009 to 690,108 (36.0%) and 1,838 (49.1%) in 2010, respectively, and 846,521 (36.7%) and 1,707 (44.0%) in 2011, respectively.[38]

This indicates that after the rapid scale up between 2007 and 2008, the programme is now improving the quality of services (Figure 19). Out of the 1,909 pregnant women who were identified as HIV-positive during pregnancy, 1,707 mothers and 1,733 babies received ARV prophylaxis in 2011. A General Statistics Office population-based survey confirms that 28.6% of women who gave birth in 2010 and 2011 were tested for HIV and received the results.[39]

Figure 19
Progress of PMTCT coverage 2006-2011



However, significant challenges remain. Despite the high coverage of antenatal care, many pregnant women are tested during labour rather than earlier: in 2011, 42% of women were reported to have been tested at delivery, not during antenatal care visits.[40] This late testing prevents HIV-positive women from receiving the optimal treatment regimen.

[38] Viet Nam Universal Access Reports 2008, 2009, 2010 and 2011.
[39] Multiple Indicator Cluster Survey 2010-2011. General Statistics Office, 2011.
[40] 20 Years Responding to HIV/AIDS in Viet Nam. Ministry of Health, 2010

It is also estimated that a significant proportion of new HIV infections among women result from the high-risk behaviour of their husbands. Unintended pregnancies have been observed among women living with HIV. Prevention activities for women at risk, and activities to reduce unintended pregnancy among women living with HIV, therefore need to be improved. In 2010, the Ministry of Health released *Comprehensive PMTCT Guidelines* to reinforce the 'four-pronged' approach to PMTCT.[41]

In June 2011 the Ministry of Health invited the Inter-Agency Task Team (IATT) on Children affected by AIDS[42] to conduct a Joint Technical Review of the PMTCT programme, with international and regional participants from CDC, UNICEF, WHO and UNAIDS. The Joint Review recognized that the programme had produced impressive results in a short period, supported by strong leadership and commitment, a robust legal framework and policies, good knowledge of the epidemic, strong partnerships, and technical capacity at all levels. However, it also noted that coverage is still limited, largely because of the fragmented approach of donor-funded projects and the complexity of the management structure.

Universal coverage of antenatal testing is a prerequisite for eliminating MTCT. Achieving this requires a paradigm shift, with PMTCT becoming part of routine antenatal care carried out under reproductive health/maternal-and-child health programmes rather than a vertical HIV intervention. This shift is also essential for the transition from donor-funded projects to an institutionalized health service. The Ministry of Health has already taken important steps in this direction:

- The department of maternal and child health has included HIV testing and counselling (alongside hemoglobin testing and testing for syphilis and hepatitis B) as a component of the *National Standards and Guidelines for Reproductive Health Care Services* (Decision No. 4620/QD-BYT), although a lack of funding has hampered the implementation of the standards.
- Provincial initiatives to improve operational links and referrals in Tien Giang, Ho Chi Minh City, Quang Ninh and Ninh Thuan, jointly supported by VAAC and MCH departments, have resulted in the significant integration of PMTCT into reproductive health and maternal and child health services.

Links with other HIV programmes have also been improved. HIV-positive pregnant women and those who have delivered babies are referred to HIV clinics for follow-up and treatment. Early infant diagnosis using virological testing was introduced in 2009 and is being expanded. In 2011, 1,804 infants received a virological test and were referred to pediatric care services. In 2011, 3,261 out of an estimated 3,934 children living with HIV were receiving ART, compared to 1,087 in 2009.[43]

---

41 The UNICEF/WHO-recommended "four-pronged" approach to PMTCT consists of 1) primary prevention of HIV among women of reproductive age; 2) prevention of unintended pregnancies among women living with HIV; 3) prevention of vertical transmission from HIV-positive pregnant women; and 4) provision of care and treatment for HIV-positive women and their children.

42 The IATT on Children affected by AIDS, led by UNICEF, provides a forum for supporting a coordinated, accelerated and expanded evidence-based response to protect and promote the rights of children affected by HIV and AIDS.

43 Viet Nam Universal Access Report 2011.

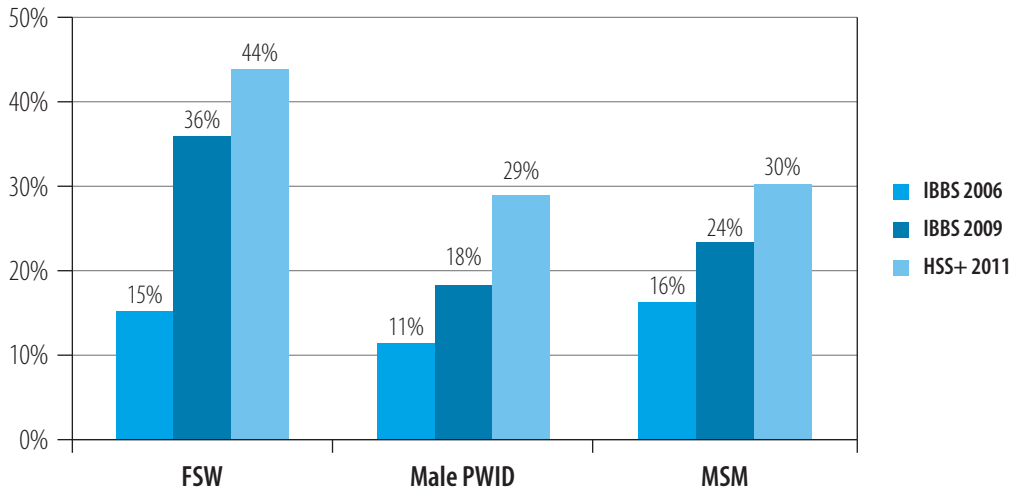
Viet Nam's strong basic health infrastructure and capacity, demonstrated by the provision of at least one antenatal care visit to 95% of pregnant women, and its remarkable success in reducing infant and maternal mortality, provide a solid basis for eliminating MTCT. However, more efficient, integrated and sustainable PMTCT services need to be established to ensure that declining donor funds do not threaten the sustainability of achievements so far.

Voluntary HIV counselling and testing (VCT)

Viet Nam's VCT programme has been scaled up in recent years, with the number of VCT sites and VCT clients increasing from 157 sites in 2005 to 244 sites in 2008, 256 sites in 2009 and 317 sites in 2011.[44] More than twice as many people received VCT services during 2011 (851,470 people), including 812,540 people tested for HIV, than in 2009 (345,947 people). However, there is regional variation in VCT uptake: VCT sites located in Ho Chi Minh City and Ba Ria Vung Tau attracted large numbers of clients, while those in Binh Dinh, Phuc Yen, Bac Lieu and Gia Lai only tested a few hundred clients each.[45]

Mobile VCT has been piloted in Thanh Hoa, Hai Phong and Dien Bien. Furthermore, provider-initiated HIV testing and counselling have been conducted in venereology and dermatology hospitals and TB clinics at 117 sites in 21 provinces. According to the 2011 HSS+ survey conducted in 12 provinces,[46] the percentage of key populations at higher risk who received a HIV test in the last 12 months and knew the results was 43.8% among FSW, 29.1% among male PWID and 30.2% among MSM. Although the HSS+ study used different study methods, these results still show an increase compared to those of IBBS 2009 (see Figure 20).

Figure 20
Proportion of people who received a HIV test in the last 12 months and know their test results



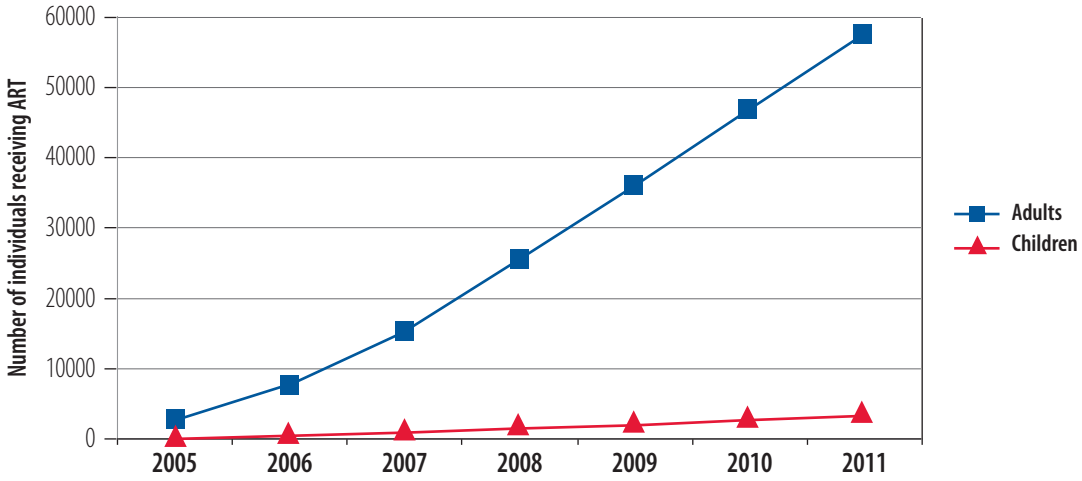
However, HIV counselling and testing services are not available in some areas, particularly rural areas, and in closed setting. The quality of such services remains limited.

[44] Bá Report on HIV/AIDS programmes in Viet Nam. MOH, 2011.
[45] D28 routine reports. VAAC, 2011.
[46] An Giang, Binh Duong, Ca Mau, Da Nang, Dien Bien, Ha Noi, Hai Duong, Hue, Nghe An, Quang Tri, Thanh Hoa, HCMC.

5. Treatment, care and support

The reporting period saw continued scale-up of antiretroviral therapy (ART) services, and a remarkable expansion in provision. At the end of 2011, 57,663 adults and 3,261 children were receiving ART in Viet Nam (Figure 21). This is an increase of 22 times the total number of individuals under treatment in 2005, and 1.5 times that in December 2009. In 2011, ART coverage also increased to 53% in adults and 83% in children.[47]

Figure 21
Number of individuals receiving ART in Viet Nam



There is also growing evidence that the ART programme in Viet Nam has had significant positive impacts. The average annual retention rate for ART at 12 months has been 80% among both adults and children since 2007 – 82.1% among adults and 82.8% among children who initiated ART in 2009.[48] It is also estimated that, cumulatively, the ART programme prevented 18,110 AIDS-related deaths between 2000 and 2009.[49]

To facilitate this scale-up, and to ensure the quality of services, Viet Nam has developed or updated a number of policy and guidance documents and training materials. In particular, the National Guidelines on HIV Diagnosis and Treatment now fully incorporate the WHO's 2010 recommendations on ART, including earlier ART initiation (at CD4 350 cells/mm3 in adults) and the phase-out of toxic ART regimens.

As increasing numbers of PLHIV received treatment and care, the distribution of HIV care outpatient clinics (OPC) was reviewed and new HIV OPC were established where necessary. At the end of 2011, there were a total of 320 facilities providing ART in Viet Nam (305 providing services for adults and 122 services for children), with 5 sites at the central level, 140 at the provincial level and 175 at the district level.

---

47 Denominator for coverage is the estimated number people in need of antiretroviral therapy with ART eligibility threshold defined at CD4 350 cells/mm3. The number is preliminary results calculated by the National Technical Working Group on HIV Estimates and Projections using EPP and Spectrum.

48 Annual data monitoring of care and treatment programme. VAAC, 2009. N=5,646 for adults, N=308 for children. No more recent figures are available.

49 Final draft report on the evaluation of the National Strategy 2006-2011. VAAC. No more recent figures are available.

Another extremely important accomplishment is increasing access to ART and decent treatment outcomes[50] for people who inject drugs (PWID). A 2010 study in HCMC showed that 73% of patients receiving ART reported having injected drugs,[51] corroborating anecdotal information which suggests that 60-70% of ART patients in Viet Nam are former or current PWID.[52] Reasonable treatment outcomes have been reported among PWID: At two clinics in HCMC, there was no difference in the increase in median CD4 count during the 24 months following ART initiation between PWID and non-PWID.[53]

Community partners and services increasingly play a critical role in delivering HIV diagnoses and treatment, care and support. The national guidelines and standard operating procedures regarding community and home-based care were approved in 2010, facilitating the expansion and standardization of these services. A greater number of PLHIV and key affected populations also work closely with HIV OPC to promote earlier diagnosis, to help navigate the procedures from HIV diagnosis to initiation of care and to support retention and adherence among those who receive care and ART. A growing network of non-governmental organizations, faith-based organizations and community-based organizations in Viet Nam is also working to provide care and support for children affected by HIV.

PLHIV support groups are actively working throughout the country. In 2011, there were there are more than 200 self-help groups fully or partly dedicated to providing support to PLHIV, many of which actively supported access to and retention in care, treatment and support. The National Network of People Living with HIV in Viet Nam (VNP+), established in 2009, continues to play a critical role in coordinating these support groups in the country. In 2011, VNP+ also undertook advocacy to avoid any negative impacts of the Trans-Pacific Partnership (TPP)[54] on access to antiretroviral drugs, and conducted a large-scale survey among 1,640 people (the Stigma Index survey)[55] to estimate the level of stigma and discrimination in five provinces (Ha Noi, HCMC, Hai Phong, Dien Bien and Can Tho).

The Stigma Index survey found that access to ART and treatment for opportunistic infections is high (90% and 87% of respondents, respectively, have access), including among key populations at higher risk, although these results may be influenced by the fact that 1,200 of the respondents were interviewed at OPC.

However, access to PMTCT appears to be lower, with only 45% of women who were living with HIV while pregnant reporting having ever accessed PMTCT and indeed one respondent reporting having been refused PMTCT. Quality of care may also be an issue, as only 53% of respondents reported having a constructive discussion with a healthcare worker on HIV treatment in the past 12 months.

---

50 'Decent treatment outcomes' here defined as treatment outcomes for PWID that are equivalent to treatment outcomes for people who do not inject drugs.

51 FHI. Results of the program evaluation of patients initiating antiretroviral therapy in two health facilities in Ho Chi Minh City, Viet Nam. Ha Noi, Viet Nam: Family Health International, 2010.

52 Aceijas C, Oppenheimer E, Stimson GV, Ashcroft RE, Matic S, Hickman M. Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the "Treating 3 million by 2005. Making it happen. The WHO strategy" ("3 by 5"). Addiction 2006;101(9):1246-53.

53 FHI. Results of the program evaluation of patients initiating antiretroviral therapy in two health facilities in Ho Chi Minh City, Viet Nam. Ha Noi, Viet Nam: Family Health International, 2010.

54 The Trans-Pacific Partnership is a multilateral free trade agreement between Australia, Brunei Darussalam, Chile, Malaysia, New Zealand, Peru, Singapore, Viet Nam and the USA. It has been argued that proposed intellectual property provisions under the agreement could restrict developing countries' access to affordable medication.

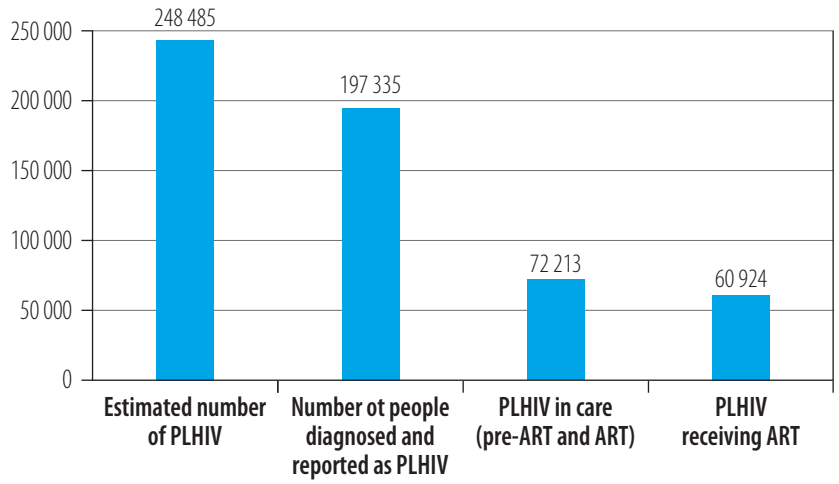
55 People Living with HIV Stigma Index in Viet Nam, preliminary results, 2012. VNP+, 2012.

The laboratory system has been strengthened to support HIV treatment and care, with 41 laboratories capable of performing CD4 counts. National guidelines on early infant diagnosis using the Dried Blood Spot technique were approved in 2010, and 1,804 infants received a virological diagnosis in 2011. Efforts were also made to streamline the procurement and supply management (PSM) of ARV drugs to establish a unified national PSM system.

Despite all of these achievements, considerable challenges remain. Half of all people in need of treatment do not have access to it. People are starting ART late, with a very low CD4 cell count, which is associated with high mortality and severe opportunistic infections. A total of 52.7% of those who started ART in 2010 had a CD4 count of less than 100 cells/mm3 (1,711 out of 3,247 people sampled).

Retention in care is also a challenge, especially during the period between HIV diagnosis and enrolment in care and before initiating ART. By the end of 2011, while 197,335 PLHIV were reported through the case reporting system, only 72,213 PLHIV were enrolled in care, of whom 60,924 were receiving ART - meaning that only 11,289 were receiving pre-ART care (Figure 22).

Figure 22
Cascade of HIV diagnosis, treatment and care in Viet Nam (2011)



Source: Number of people diagnosed and reported as living with HIV (case reporting system); PLHIV in care and PLHIV receiving ART (Programme Monitoring Routine Reporting System); estimated number of PLHIV (EPP 2011 preliminary results). VAAC, Ministry of Health.

Punitive laws against people who inject drugs (PWID) and female sex workers (FSWs), and the associated stigma and discrimination, are a serious obstacle to early diagnosis and to access to and retention in treatment and care.

The Stigma Index survey revealed a high level of stigma and discrimination, while other studies[56] have reported that the fear of arrest means that members of some key populations at higher risk delay attendance at health facilities until they are very sick.

[56] See, for example: Scaling up HIV treatment, care and support for injecting drug users in Vietnam. Lisa Maher, Heidi Coupland, Rachel Musson, *The International Journal of Drug Policy* 18 (2007) 296–305. and Results of the Program Evaluation of Patients Initiating Antiretroviral Therapy in two Health Facilities in Ho Chi Minh City, Viet Nam. FHI360.

Tuberculosis remains the main cause of mortality among PLHIV. While many provinces and districts have made attempts to improve HIV/TB collaborative activities, progress has been limited. As per new international and national guidelines,[57] all PLHIV with active TB are supposed to receive both ART and TB treatment; however, only an estimated 30.1% received such treatment in 2011. Isoniazid preventive therapy was introduced on a small scale, benefiting 1,162 adults and children in 2011.

A VAAC/CDC/WHO study[58] reported that first-line ART provision at adult outpatient services costs USD 365 per patient per year for the first year and USD 312 for subsequent years, and that the treatment of opportunistic infections is especially costly if people start treatment with a CD4 count of under 100 cells/mm^3. It is crucial that Viet Nam explore sustainable funding solutions, including the further mobilization of resources, through health insurance, and a more efficient use of resources, including earlier ART initiation.

In order to address these challenges and to maximize survival and the preventive benefits of ART, the Government of Viet Nam has committed to piloting "Treatment 2.0", a WHO-UNAIDS initiative that encourages innovation, efficiency and sustainability in the HIV response, focusing on scale-up and universal access to ART treatment, in the provinces of Dien Bien and Can Tho. Many of the elements of Treatment 2.0 are new to Viet Nam, and the pilot will require a major shift from the current model, meaning that considerable training and capacity building, as well as human resources reorganization, will need to be carried out. In addition, ART needs to be combined with targeted behaviour-change programmes and policy developments to develop an integrated response to the epidemic that will support change at the individual and community levels, develop community responses, reduce stigma, and ensure access to and uptake of services.

In addition, VAAC and international partners (including CDC, WHO, HAIVN and FHI360), established a national Technical Working Group to introduce quality improvement (QI) activities for HIV care and treatment services.

The Technical Working Group selected 10 indicators to monitor the performance of pre-ART and ART care services at HIV outpatient clinics. It has worked since 2011 to empower local health teams to collect and analyse data and to plan, implement and evaluate pilot QI activities in HCMC, Ha Noi, Can Tho and Thanh Hoa.

6. Civil society involvement

Civil society played an increasingly active role in the national response to HIV during the reporting period, especially in the areas of advocacy, policymaking, capacity building and service delivery. This development reflects the expansion and strengthening of self-help groups and networks of people living with HIV (PLHIV) and key populations at higher risk of HIV infection. Notably, civil society representatives participated in important national fora, while in 2011 the Viet Nam Union of Science and Technology Associations (VUSTA) – which helps to coordinate civil society organizations – became an official member of the National Committee

[57] WHO 2010 guidelines on ART for adults and adolescents; Decision 4139/QĐ-BYT amending the National Guidelines on HIV Diagnosis and Treatment (Decision 3003/QD-BYT).

[58] VAAC Costing Study. VAAC, CDC, WHO, 2012 (forthcoming).

on AIDS, Drugs, and Prostitution Prevention and Control and the Country Coordination Mechanism of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

VUSTA was established in 1983, and currently has 130 members (73 national branches and 57 local associations). In recent years, VUSTA has supported the foundation of and directed more than 30 non-governmental organizations and HIV or HIV-related networks (including those relating to gender equality, health care and community development, sexual health and reproductive health care and poverty reduction). VUSTA has also helped and directed other networks, such as VCSPA, the Viet Nam Alliance of Non-Governmental Organizations and the Gender and Community Development Network (Gencomnet).

Organizations working on HIV under VUSTA (such as the Institute for Social Development Studies (ISDS), the Centre for Community Health and Development (COHED), the Viet Nam Community Mobilization Centre for HIV/AIDS Control (VICOMC), Community Health Promotion (CHP), Life, the Community Health and Development Organization (LIGHT),
Consultation of Investment in Health Promotion (CIHP) and the Centre for Creative Initiatives in Health Promotion (CCIHP)) have made active contributions to the response since 1994.

The Viet Nam Network of PLHIV (VNP+) now includes approximately 150 groups of people living with HIV (PLHIV), more than double the number of groups that founded the network in 2008. VNP+ is widely recognized as a national forum for PLHIV and a platform for advocacy on their rights and needs. VNP+'s focus on policy advocacy, information sharing, network development, capacity building and resource mobilization complement the work of other PLHIV networks that are focused on service delivery, such as Bright Futures, the Southern Network of PLHIV (SPN+), Hope and the Sunflowers. Many PLHIV self-help groups are members of more than one network, so they can benefit from a wider range of support and information sharing.

VNP+ advocacy has focused on ensuring continued access to affordable medicines following Viet Nam's achievement of middle-income country status. The network has been active in regional and country-level debates about the potential impact of the Trans-Pacific Partnership free-trade agreement, as well as challenges to the patenting in Viet Nam of medicines for HIV and opportunistic infections.

The network has also been engaged in the Country Coordinating Mechanism of the Global Fund to Fight AIDS, Tuberculosis and Malaria. At the regional level, VNP+ is a member of the Asia Pacific Network of People Living with HIV/AIDS (APN+), and in 2012 will serve as a sub-recipient of APN+'s Global Fund regional grant project.

VNP+ advocacy is also being informed by two PLHIV-conducted studies on access and barriers to HIV services. In 2010, VNP+ worked with The Global Network of People Living With HIV (GNP+) and the Population Council to conduct a Positive Health, Dignity and Prevention study among 600 PLHIV in 4 provinces. In late 2011, VNP+ conducted a HIV Stigma Index in five provinces (Dien Bien, Ha Noi, Hai Phong, Can Tho and HCMC). About 30 PLHIV were trained to be interviewers. The research compiled information from a total of 1,640 PLHIV, including 140 men who have sex with men (MSM) (in HCMC), 150 sex workers (in Ha Noi) and 150 people who inject drugs (in Dien Bien). A total of 22% of respondents reported rights violations within the last 12 months. Among these, 58% reported that their right to privacy/confidentiality had

been violated. Sex workers and MSM were more than four times more likely to report stigma and discrimination, and drug users were nearly twice as likely.[59] The Stigma Index data support concerns that stigma and discrimination are having a negative impact on the lives of PLHIV and efforts to scale up services. Higher levels of stigma and discrimination reported among people who inject drugs, sex workers and MSM suggests that these high-risk behaviours are also highly stigmatized.

Over the reporting period, the MSM community has taken a greater leadership role in efforts to control the worsening HIV epidemic among this key population. Community ownership of the National MSM Working Group was considerably strengthened during the reporting period, including through the selection of new co-chairs who are representatives from within the MSM community. The working group has proved to be an effective platform for MSM to interact with and make their voices heard by different stakeholders.

Examples of MSM community involvement coordinated by the working group include the development of national 'Guidelines for Comprehensive HIV Interventions for Men who have Sex with Men' and Viet Nam's participation in the Purple Sky regional network and the MSM multi-city regional project. Eight provincial MSM working groups conducted workshops with provincial policy makers, health system managers, health care workers, media, MSM community leaders and other duty bearers to reduce stigma and discrimination against MSM and improve uptake of HIV services among them. These workshops were jointly conducted by Provincial AIDS Centres and local MSM community leaders using the toolkit on 'Understanding and Reducing Stigma and Discrimination related to HIV and MSM'. A total of 754 duty bearers were trained.

Sex workers also organized themselves better in 2011. A National Working Group on Sex Work and HIV was established under the national HIV Technical Working Group, with the aim of strengthening community capacity and community participation in policy advocacy around sex work. The group co-chair and four provincial representatives of the community are former sex workers currently working to expand HIV services for sex workers. Since establishment, the group has facilitated a stronger representation of the sex worker community in national discussion fora on sex work. The group plans to conduct a study on HIV transmission risks in the context of sex work in 2012.

People who inject drugs, who previously worked together largely within the framework of PLHIV groups, have now set up their own networks of interest. The latter half of 2011 marked the establishment of two significant networks: the Southern Network of People Who Use Drugs and the Viet Nam Network of People Who Use Drugs. The Southern Network covers 10 Southern and Central Highland provinces, and is currently hosted by SPN+ with a view to becoming fully independent. The Viet Nam Network of People Who Use Drugs consists of eight member groups, mostly from the North. Many PLHIV, MSM, SW and drug user groups are also members of an umbrella network, the Viet Nam Civil Society Partnership Platform on AIDS (VCSPA), which has supported efforts by VUSTA to increase the participation of civil society in the development of national policies and programmes.

[59] People Living with HIV Stigma Index in Viet Nam, preliminary results. VNP+, 2012.

VCSPA is a voluntary association of civil society organizations in Viet Nam. It has 267 members in 40 provinces nationwide, including non-governmental organizations; community-based organizations; PLHIV self-help groups; key populations at higher risk such as MSM, transgender people, FSWs, PWID, sexual partners of PLHIV or PWID; and charities and religious and volunteer organizations. In 2011, with Global Fund project funding, VCSPA supported its members to collaborate with local authorities and religious organizations to organize a candle-lit prayer ceremony ("Lighting the fire of love") on World AIDS Day to commemorate those who have died from AIDS-related illnesses and show solidarity with those who are still living.

The implementation of Viet Nam's grant under Global Fund round 9, signed in early 2011, represents the first time that Viet Nam civil society has managed and implemented a Global Fund project, reaffirming the strengthened capacities of local NGOs.

The civil society component of the grant is implemented by VUSTA, with the Institute for Social Development Studies (ISDS) and the Centre for Community Health and Development (COHED) among the project implementers. One of the project's components is policy dialogue and training on the legal registration of civil society groups, which has been a major challenge as civil society expands its role.

In the area of HIV policy and strategy development, civil society was engaged in the development of the new National Strategy for HIV/AIDS Prevention and Control to 2020, with a vision to 2030, which resulted in stronger attention to gender issues and the needs of PLHIV and key populations at higher risk. Representatives of VNP+ and groups of key populations at higher risk actively participated in consultations organized by the Viet Nam Authority for HIV/AIDS Control (VAAC). VUSTA organized a final consultation workshop on the draft strategy with more than 100 representatives of PLHIV, people at higher risk of infection, community-based organizations, faith-based organizations and Vietnamese NGOs. PLHIV, people at higher risk of HIV infection and local NGOs also contributed to the development of a variety of legal and policy documents related to HIV, including the draft Law on Administrative Sanctions – which has articles related to the sensitive issues of sex work and drug use – the draft *Decree on Substitution Treatment for Opioid Addiction*, and a draft *Circular* guiding the establishment and operation of health-sector facilities which charge for the use of services.

Civil society groups are playing leading roles in efforts to improve awareness of and respect for HIV-related rights that are protected under Vietnamese and international law.

PLHIV leaders worked with the UN, legal NGOs, and law schools across Viet Nam to develop a "Learn About Your Rights" training manual. About 545 people – including PLHIV, law lecturers, law students, representatives from legal aid offices and local stakeholders – were trained in 2011, resulting in strengthened knowledge among rights holders and duty bearers about the rights of PLHIV and existing mechanisms to protect these rights under the Vietnamese legal framework.

Vietnamese civil society also participated in important regional and international fora in 2010 and 2011, adding their voice to a global effort to accelerate progress towards international targets to achieve universal access to HIV services and achieve the "Three Zeros" – zero new infections, zero stigma and discrimination and zero AIDS-related deaths. Representatives of PLHIV and people at higher risk were included as official members of Viet Nam's delegation

to the UN General Assembly High-Level Meeting on AIDS in June 2011. Other important fora in which Vietnamese civil society actively participated included the Regional Consultation on Universal Access, the World Youth Summit on HIV, the Regional Dialogue on HIV and the Law and the 10th International Congress on AIDS in Asia and the Pacific.

Although there has remarkable progress in civil society participation, challenges still exist and need to be thoroughly addressed if civil society is to become an equal partner in the national response to HIV. Significant challenges include:

- Legal barriers: Viet Nam does not have a coherent legal framework for the registration and regulation of civil society organizations (CSOs), creating barriers for organizations when implementing activities. Groups must navigate a complex and fragmented system, resulting in some registering as technology organizations or household businesses.
- Sustainable funding: Most CSOs depend on international funding. As donor funding decreases in response to Viet Nam's middle-income country status, CSOs must generate additional funding from local sources to maintain their activities.
- Uneven participation: Whilst there has been increasing civil society involvement in planning at the national level and in some provinces, many provinces still do not properly engage civil society in their HIV responses
- Weak capacity: Self-help groups and networks of PLHIV and key populations at higher risk must strengthen their leadership, management and technical capacities if they are to play a greater role in the response.
- Stigma and discrimination: Attitudes are changing, but the Stigma Index and other studies have confirmed that stigma and discrimination are powerful barriers to service delivery and the greater involvement of PLHIV and key populations at higher risk in the response.

V. BEST PRACTICE

1. Methadone Maintenance Therapy (MMT) in Viet Nam

A focus on prevention has resulted in progress towards increasing access to HIV services, notably harm-reduction services. Strong leadership by senior political champions and legislators (also reflected in the 2009 decision to decriminalize drug use) led to the initiation of a national pilot MMT Programme for drug users in May 2008. The success of the pilot, and continuing support from senior leaders, led in 2010-2011 to an increased awareness of the benefits of community treatment for people who inject drugs, and the pilot project was expanded.

The MMT Programme is implemented at the provincial level in partnership between Government agencies, civil society and development partners, with support from the national level. Significant financial and technical assistance for the programme have been provided through the United States Government's PEPFAR programme. Under the MMT programme, substitution therapy is delivered in combination with psychological support services, vocational training and job placement.

The MMT pilot began in May 2008 with six clinics in Hai Phong and HCMC. By the end of 2009 the programme had exceeded its initial target of 1,500 drug users and was providing services for 1,735 people. Ministry of Health figures indicated that after the first 9 months of treatment the adherence rate was 96.5%[60] and clients reported positive behaviour changes. This success led to the Government's decision to expand MMT services and set a goal of 80,000 drug users on MMT by 2015.

During 2010 and 2011, the programme was expanded to a total of 11 provinces (Hai Phong, HCMC, Ha Noi, Thai Nguyen, Dien Bien, Da Nang, Nam Dinh, Hai Duong, Quang Ninh, Thanh Hoa and Can Tho) with improved national MMT guidelines. At the end of 2011, a total of 6,931 people were receiving services in 41 clinics in the 11 provinces, and the programme had an adherence rate of 96%.[61] An evaluation[62] of the pilot in HCMC and Hai Phong at 24 months showed continued progress, with drug use declining from 100% at the baseline to 15.9% after 2 years. The quality of life of clients also improved, with their unemployment rate decreasing from 35.96% to 24.10%, physical health scores increasing from 68 to 75 (out of 100) and mental health scores increasing from 56 to 70 (out of 100).

Social conflicts with friends and family declined over time, with the number of respondents reporting serious problems in getting along with families or friends declining from 20% to 3% and, remarkably, of respondents reporting family conflict from 90% to 2%. There were community benefits, too, with crime data from the Hai Phong Department of Security showing a reduction of approximately 30% in reported drug-related crimes and drug users involved in crime.

---

60 Report on progress of MMT pilot programme 2009. MOH, 2010.
61 Weekly report 26-30 December 2011. VAAC, Department of Harm Reduction, 2011.
62 Promising results and impacts from a 2-year pilot methadone program in Vietnam. FHI, 2011.

The continued effectiveness of the programme has led to a review of the benefits of MMT over an administrative detention-based approach. The Government has reaffirmed its commitment to the 2015 goal and plans to open further clinics, to a total of 245 clinics in 30 provinces by 2015. There are also plans to offer MMT in prisons, and training for relevant staff has been carried out alongside the development of a peer-education training manual and associated information/education communications materials.

As Viet Nam's methadone supply is currently imported, the Ministry of Health has developed a protocol aiming to produce 80% of the required methadone by the end of 2015.[63] The Government also aims by 2015 to use exclusively national resources (including user contributions) to fund the programme.

2. Adaptation of the Investment Framework in Viet Nam

In order to maximize efficiency and results, responses to HIV worldwide need a more targeted and strategic approach to investment. UNAIDS has therefore suggested that countries adopt an investment framework for their HIV responses.[64] The proposed investment framework aims to support the management of HIV responses, to encourage transparency in programme objectives and results, and to enable decision makers and financiers to galvanize support for effective action. It is intended to close the conceptual gap between global resource estimation and large-scale programming to help shape investment strategies to achieve the best outcomes for the fewest resources.

The use of such a framework is particularly important in Viet Nam, given the need to sustain strengthened country ownership of the HIV response in an environment of increasing demand for prevention, treatment, care and support services, and decreasing supply of external financing as donors withdraw or reduce support in light of the global economic downturn and Viet Nam's new middle-income country status. Even under the most conservative of scenarios, the HIV resource needs gap will grow substantially in Viet Nam from 2011 to 2015.

Closing this gap will require both a reduction in needs – by achieving greater economies of scale and cost-effectiveness in service delivery, expanding task shifting and promoting decentralization – and an increase in available resources from the Government (such as greater commitments by a range of ministries), private providers and insurance schemes, and from new and existing development partners.

Progress is underway in Viet Nam to develop solutions to meet these challenges—through approaches that maximize the impact of existing resources, do more with less and tap underutilised technical and human capacities to expand HIV service access in a tighter fiscal environment.

---

63 *Protocol on Manufacturing and Using Methadone in Viet Nam (Period 2010-2015).*

64 Towards an improved investment approach for an effective response to HIV/AIDS. Bernhard Schwartländer, John Stover, Timothy Hallett, Rifat Atun, Carlos Avila, Eleanor Gouws, Michael Bartos, Peter D Ghys, Marjorie Opuni, David Barr, Ramzi Alsallaq, Lori Bollinger, Marcelo de Freitas, Geoff rey Garnett, Charles Holmes, Ken Legins, Yogan Pillay, Anderson Eduardo Stanciole, Craig McClure, Gottfried Hirnschall, Marie Laga, Nancy Padian, on behalf of the Investment Framework Study Group, Lancet 2011; 377: 2031–41.

This includes the following, which draw on the new proposed investment framework:

- Development of criteria for resource allocation: In response to the major shifts in funding sources for the HIV response, and the need for investment in evidence-based interventions targeting key populations at higher risk of HIV, UNAIDS in Viet Nam has supported the Viet Nam Administration for HIV/AIDS Control (VAAC), and involved key national and international stakeholders at the country level (including major donors PEPFAR, and the World Bank/DFID), in joint planning and discussion about resource allocation. Initial triangulations of various sources of epidemiologic data available at the sub-national level have been conducted, with the purpose of developing systematic criteria to classify different geographic areas according to the type or severity of HIV epidemic, in order to prioritize areas for intervention. This was followed by the development of a draft *Resource Allocation Scenario Viet Nam* workbook which will be further refined in the coming months.
- Expanding long-term financing options for HIV in Viet Nam: In partnership with VAAC and Oxford Policy Management, UNAIDS in Viet Nam set out to explore how the Government could approach long-term financing for HIV. Scenarios were developed based on the National AIDS Spending Assessment and resource needs estimations. In addition, an analysis was conducted of the efficiency of Viet Nam's HIV response and of whether and where savings could be made; this was followed by a sensitivity analysis and an overview of potential funding sources. Finally, a 'road map' was developed to manage the transition from the current to the future HIV financing strategy.

3. A strengthened response to HIV for men who have sex with men

Stigma regarding male-to-male sex in Viet Nam is high, which has created barriers to the establishment of adequate policies and programmes, as well as a slow uptake of available services. HIV has thrived in this context, and epidemiological data suggest that HIV prevalence among men who have sex with men (MSM) in Viet Nam is rising rapidly.[65]

In 2010-2011, national and provincial authorities responded to this challenge with stronger leadership and greater collaboration with the rapidly strengthening MSM community. Greater action has resulted in a more substantial evidence base, a more enabling policy environment, greater resource mobilization, and stronger community engagement.

Increased understanding of the scale and dynamics of the HIV epidemic among MSM in Viet Nam has been achieved through improved surveillance and research. Bi-annual HIV/STI Integrated Behavioural and Biological Surveillance (IBBS) now collects data on MSM in four provinces. The collection of HIV sentinel surveillance (HSS) data on MSM began in three provinces in 2010 and was scaled up to five provinces in 2011. Two central provinces that were not included in either the IBBS or HSS – Nghe An and Thua Thien-Hue – conducted rapid assessments of the local HIV epidemic among MSM to inform their responses in 2011.

[65] IBBS data show that HIV prevalence rose sharply between 2006 and 2009 among both MSM who reported transactional sex and those who did not in Ha Noi and HCMC.

Smaller-scale research studies are also increasing understanding of how recreational drug use may be increasing HIV risk among MSM; male-to-male sex in closed settings; and the stigma, discrimination and gender-based violence faced by MSM.

Many of these data informed the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*. National Guidelines for Comprehensive IV Interventions for Men who have Sex with Men have also been developed, and once approved, they will assist HIV programme managers to develop a comprehensive package of HIV prevention, treatment, care and support services that are easily accessible to MSM.

The Government has worked with international partners to increase fund allocation and technical support for the response to HIV among MSM. Viet Nam's Round 9 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria included funds for HIV interventions on MSM, and the World Bank/DFID project on HIV prevention expanded its target groups to include MSM in 2010. MSM also continue to be a priority for PEPFAR in Viet Nam.

The MSM community itself is playing an increasingly active role in both policy advocacy and programme implementation. In 2010, MSM community leaders were elected as the chair and co-chair of the National MSM and HIV Working Group—positions that had previously been held by government officials or NGO leaders. The National Working Group and its nine provincial working groups are unique fora for dialogue and coordination between the Government of Viet Nam and the MSM community. The working groups initially concentrated on information-sharing, but in recent years they have increasingly focused on policy issues and the capacity building of the MSM community to play a larger role in the HIV response. For example, the National Working Group was closely involved in the development of the National MSM Guidelines, and it also provided inputs to the new National HIV Strategy. The provincial groups have conducted stigma- and discrimination-reduction workshops that reached 754 duty bearers in eight provinces – including provincial policymakers, health-system managers, health care workers, the media and MSM community leaders. In addition, MSM groups in nine provinces are working with Provincial AIDS Committees to manage peer-education programmes that promote condom use, HIV testing and other HIV services.

Several provincial governments are leading strong initiatives on HIV and MSM, setting good examples for others to follow. HCMC, the province with the highest HIV prevalence among MSM in Viet Nam, is participating in the regional MSM and Transgender Multi-City HIV Initiative. This initiative aims to promote better links between public health prevention programmes and care, support and treatment services, and increase coordination between community programmes and private-sector health services in six Asian cities where HIV infection among MSM and transgender persons is particularly concentrated. HCMC has leveraged this experience sharing to conduct a detailed situation analysis and develop a five-year plan of action for the HIV response among MSM.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. Efforts and achievements in resolving the challenges and difficulties mentioned in the 4th UNGASS Report (January 2010 reporting for the period of 2008 and 2009)

Over the past two years, the Communist Party, elected bodies and local authorities have further strengthened their commitment to HIV and enhanced the implementation of the National Strategy on HIV/AIDS Prevention and Control to 2020 with a vision to 2030 through: (1) improved collaboration between ministries, which has ensured a stronger multisectoral response; the issue of new policies and the revision of overlapping policies and regulations; and a subsequent improvement in service delivery, most notably a rapid increase in the number of people accessing HIV prevention, care and support services; (2) an ongoing focus on prevention, resulting in the expansion of harm-reduction programmes, particularly the Needle and Syringe Programme (NSP) and the Methadone Maintenance Therapy (MMT) Programme for drug users and interventions for men who have sex with men; (3) the rapid expansion of the Antiretroviral Therapy (ART) Programme; (4) a strengthened HIV prevention and control system at all levels, alongside increased government budget allocations to infrastructural investment in the HIV prevention and control system; (5) the greater and more meaningful participation of civil society in the national HIV response.

2. Main challenges encountered during the period 2010-2011 in implementing the National Strategy and UNGASS commitments

Despite the great efforts the Government of Viet Nam made to address HIV over this reporting period, a number of weaknesses hindered the implementation of HIV interventions.

Policy and legal framework: Rapid developments in the legal and policy environment provided a powerful framework but also created a number of overlapping policy and regulatory documents and sets of measures. Despite provisions in the Law on HIV enabling greater access to prevention services for key populations at higher risk, Viet Nam still faces considerable policy barriers in establishing and scaling-up effective interventions such as the NSP and the Condom Use Programme (CUP) at the local level. While the Law on Drug Prevention and Control No.16/2008/QH12 (Law on Drugs) has been amended to decriminalise drug use, under the Ordinance on Administrative Violations, drug use still remains an administrative violation and results in detention for up to two years in 06 centres.

Decision 96 mandates the provision of HIV prevention, treatment and care in correctional facilities and 05/06 centres; however, under Decree 108 the provision of opiate substitution therapy is prohibited in these facilities. There are provisions regarding HIV prevention for mobile people, particularly for mobile people who are employed; however, there are no provisions for non-discrimination and the protection of mobile populations who are not employed.

Furthermore, transgender is a term that has not been included in any regulations, and there are therefore no laws or policies specifying the protection of this group. There are also difficulties in implementing Decree 13/2010/ND-CP due to administrative procedures and changes in the definition of poverty.

Challenges in programme coverage increase: The coverage of HIV prevention, treatment and care programmes remains limited. Access to HIV services in 05/06 Centres and prisons is still a challenge. There is still an insufficient coverage of MMT, coupled with complex procedures. The PMTCT programme is not relevant to every region in the country, creating barriers to meeting the target of 100% pregnant women tested for HIV. Patients with HIV-related illnesses frequently seek hospital treatment only when they are already very ill, resulting in increasing treatment costs, high mortality rates in the early phase of ART, and consequent reductions in the effectiveness of treatment. Access to ART is restricted in 05/06 Centres, prisons and remote mountainous provinces. There is limited integration of HIV treatment and care into other health programmes, such as TB control, public health and antenatal care.

Stigma and discrimination: More than twenty years after the first HIV case in Viet Nam was reported, PLHIV continue to face stigma and discrimination. While people who use drugs and sex workers are among those most vulnerable to HIV infection, drug use and sex work are both illegal, creating barriers to accessing vital services and serving to link HIV with 'social evils', increasing stigma and discrimination against PLHIV. The 2010-2011 reporting period continued to see incidents of children being denied entry to school; workers living with HIV removed from their positions; the stigmatization of MSM; and drug users and sex workers in closed settings without access to proper treatment and care services. A lack of understanding of HIV and AIDS, prejudice relating to behaviours that are still widely socially unacceptable and a lack of knowledge of the rights of PLHIV are the main reasons behind these discriminatory practices.

Health-system constraints: These include a lack of personnel, health facilities, equipment and laboratories. The limited programmatic and management capacity of local institutions can be linked to a lack of staff at all levels within the HIV prevention and control system, and particularly constrains the expansion of treatment and harm-reduction programmes.
It is not only difficult to recruit experienced staff, but existing staff ask to be moved to other areas due to the stresses of the job and unattractive incentives. In addition, some Provincial AIDS Centres (PACs) have still not been allocated land and funding to build offices, particularly in mountainous area and the Mekong delta, meaning staff have to work without adequate infrastructure, equipment and labs. Capacity with regard to logistics/supply chain management at the commune/health-station level is still limited.

Limited resources for sustainable programmes: The national and local budgets allocated to HIV prevention and control programmes remain low. While collaborators and peer educators contribute effectively to the harm-reduction programme, they are not motivated due to low salaries. In addition, the majority of current funding for HIV prevention and control programmes has come from international donors, while HIV services are delivered mainly through donor projects.

Viet Nam's recently acquired middle-income country status has meant existing and planned decreases in these funds and projects, and the country has not yet been able to allocate adequate state budget to fill the gap. A particularly important example in the context of prevention is the planned termination of World Bank/DFID funding for needle and syringe and condom provision, which is due at the end of 2012. It is not yet clear how the costs of sustaining these programmes will be met.

3. Concrete remedial actions

Achieving the Millennium Development Goals (MDGs), particularly MDG 6 relating to HIV, meeting Universal Access targets and committing to the new 2011 Political Declaration on HIV/AIDS will require: (1) a significant scale-up of access to HIV services; (2) far greater investment in cost-effective HIV prevention, treatment, care and support services, particularly for key populations at higher risk; and 3) the termination of ineffective and low-impact interventions.

The reporting period saw further increasing awareness of the key challenges that were hindering the national response to HIV. As a result, the Government developed a new National Strategy on HIV/AIDS Prevention and Control to 2020 with a vision to 2030 that includes strategic, cost-effective and sustainable planning for the years to come. Some of the immediate remedial actions Viet Nam will undertake include:

- Continue to strengthen political commitment on HIV, to improve the legal framework and regulations, and to strengthen multisectoral collaboration in order to encourage behaviour change, to disseminate information about HIV and to improve the implementation of the current legal framework to tackle HIV-related stigma and discrimination
- Scale up efforts to ensure universal access to HIV prevention, treatment, care and support services for all in need
- Expand the MMT Programme and provide HIV-prevention services in prisons and 05/06 Centres
- Enhance the participation of civil society organizations, PLHIV and the private sector in programme and policy development and in the implementation and monitoring and evaluation of HIV programmes
- Develop a human-resource strategy to retain qualified staff and provide capacity-building opportunities for staff at all levels, but especially in the provision, management and coordination of provincial-level HIV efforts
- Strengthen institutional and human-resource capacity to gather and use strategic information; promote data use and analysis for the effective monitoring and planning of the national AIDS response
- Ensure that HIV prevention and control are mainstreamed into the current system of health service provision, as well as into other sectors (including education; labour; etc.) and national social-economic development programmes

- Seek alternative funding mechanisms for selected HIV prevention and control programmes, including counselling and MMT, for example through innovative public-private partnerships or involving users in paying for services ("socialization" of programmes)
- Increase domestic HIV funding and promote the targeted allocation of funds at both the national and provincial levels to address the drivers of the epidemic: unsafe drug injection and unsafe sex work (as opposed to using funds for public health campaigns for the general population, among whom risky behaviours – and therefore prevalence – are extremely low).

VII. SUPPORT FROM COUNTRY DEVELOPMENT PARTNERS

The 2010-2011 period saw a halt to the significant increases in bilateral and multilateral support for the national HIV response seen in previous years. Due to Viet Nam's economic progress, the country has achieved middle-income country status. As a result, donors have begun to withdraw their funding and are increasingly focusing on ensuring country ownership and the transition of programmes to national management.

Development partners providing technical assistance and funding for the national HIV response in Viet Nam include:

- Bilateral: Australia (AusAID), Denmark (DANIDA), France, Ireland, Luxembourg, the Netherlands, Sweden (SIDA), the United Kingdom (DFID) and the United States of America (PEPFAR)
- United Nations Organizations: ILO, IOM, UNAIDS, UNDP, UNESCO, UNFPA, UNICEF, UNIFEM, UNODC, UNV and WHO
- Multilateral Organizations: the Asian Development Bank (ADB), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and The World Bank (WB)
- International non-governmental organizations, projects and foundations: Abt Associates/Health Policy Initiative (HPI), AIDS Health Care Foundation (AHF), CARE, Chemonics, Clinton Health Access Initiative (CHAI, Clinton Foundation), Esther, Family Health International (FHI360), Harvard Medical School AIDS Initiative in Viet Nam (HAIVN), Management Science for Health (MSH), Médecins du Monde (MdM), Medical Committee of the Netherlands in Viet Nam (MCNV), Pact, Program for Appropriate Technology in Health (PATH), Pathfinder, Population Services International (PSI), Save the Children, World Vision, Worldwide Orphans and others.

These partners continue to stress the importance of harmonization and the alignment of Government strategies and donor funding in line with the Accra Agenda for Action and the Ha Noi Core Statement.

The Joint United Nations Team on HIV (hereafter the Joint Team) leads a coordinated UN approach to support the national HIV response, ensuring that each agency provides targeted and effective support on behalf of the Joint Team. The Joint Team organizes joint programme and annual review meetings with national implementing partners and civil society to ensure that participation and collaboration are aligned with country needs.

The Ambassadors/Heads of Agency Informal HIV Coordination Group is a high-level forum comprised of Ambassadors and the Heads of Agency of multilateral, bilateral and UN agencies. The group meets quarterly and promotes coordination and advocacy on policy issues related to the national HIV response.

During the reporting period, the group has continued to be extremely active, engaging in dialogue with the Government on key policy issues and advocating around a number of issues, including: drug use and HIV; the functioning of the Global Fund CCM; and support for the National Plan of Action for Children Affected by HIV (NPA). Alongside Government participants, the Group has also participated in study tours to a number of provinces in Viet Nam that highlight important HIV issues and provide opportunities to learn more about effective HIV responses.

In addition, UNAIDS led the establishment of a Donor Group in 2011 to bring together the major HIV donors in Viet Nam and coordinate donor support for the national HIV response. The group meets monthly, and is an important platform for discussing the harmonization of donor programmes and sustainability in the current climate of decreasing international resources. Initiatives such as this are welcomed by the government, as the maintenance of technical and financial support from the international community is crucial to continued success in the response.

External funding still accounts for the majority of HIV resources supporting the HIV response in Viet Nam. A number of major HIV donors are reducing their funding and/or withdrawing from the country: the WB/DFID programme will cease at the end of 2012, PEPFAR has announced a significant reduction in funds for 2012 and warned that funds will continue to decrease in coming years, and the Global Fund has recently cancelled funding Round 11.

With this significant decrease in available international resources, an increase in domestic funding is urgently needed to ensure that recent progress made in the response is not reversed. A sustainable HIV response also requires a focus on transition planning and support for improved multisectoral coordination.

VIII. MONITORING AND EVALUATION

The principles of national ownership and priorities, and of partnering for results, are central to the development and implementation of an effective national HIV response in Viet Nam. Also key is an understanding of the epidemic and its features. Over the last two years, a number of activities were undertaken to maintain commitment and continue efforts to strengthen the national monitoring and evaluation (M&E) system.

Substantial contributions were made by partners to ensure that HIV strategic information guides prevention, treatment and support efforts where they can deliver the greatest returns to investment. Activities focused on: the enhancement of the HIV surveillance system and the HIV routine monitoring/reporting system; the development of prioritization criteria; costing, financial gap analysis and the development of sustainable financing scenarios; and capacity development for data use at national and provincial levels.

Organizational HIV monitoring and evaluation structures, coordination and partnerships

The Viet Nam Administration for AIDS Control (VAAC) and its Department for HIV/STI Surveillance and Monitoring and Evaluation (M&E) is the lead national HIV M&E institution. Through its 4 regional institutes, it offers national guidance and M&E technical assistance to all 63 Provincial AIDS Centres.

The National Strategic Information and Monitoring and Evaluation Technical Working Group (SI/M&E TWG), chaired by VAAC, brings together practitioners from central and provincial level national institutions, international partners and the UN to share resources and experiences. In 2010 and 2011, the SI/M&E TWG, together with its subgroups, continued to lead national efforts to further strengthen the national M&E system and ensure the provision of good quality data to inform planning and the implementation of the national HIV response. To inform the development of the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*, the SI/M&E TWG focused on the development of HIV estimations and projections for the period 2011-2015. In addition, the surveillance subgroup reviewed the surveillance system, identified data gaps and made recommendations to guide the revision of the national surveillance protocol.

VAAC coordinated the development of the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*. In 2011, VAAC, with support from the Joint UN Team on HIV, facilitated a number of consultations with ministries, civil society organizations, the UN and donors. The consultations aimed to solicit partners' inputs and ensure that in the next 10 years the national response focuses on a core set of programmes that are known to work, prioritizing models of service delivery for HIV services that are sustainable, while maintaining a geographic focus on provinces with the highest burden of disease or the highest epidemic potential.

Human resource capacity for HIV M&E

In 2010 and 2011, refresher training for provincial staff on the implementation of Decision 28 (which promulgates reporting regulations and forms for HIV prevention and control activities), data management and use was conducted by VAAC and the Regional Institutes. In addition, development partners continued efforts to build capacity in this area. A project initiated by PEPFAR and their implementing partners (Abt/HPI and FHI 360) provided training courses on data analysis and data use for decision making (the "DDM" project). This training was provided for provincial staff in seven PEPFAR targeted provinces and was supplemented by technical assistance and study tours. In many provinces supported by donors, project-oriented workplans are usually developed for the donor-funded component.

Comprehensive, provincial HIV plans that encompass all (i.e. both nationally and internationally funded) prevention, treatment and care activities are not common at the provincial level. In order to strengthen M&E coordination and partnerships and to improve provincial capacity for data analysis and use, UNAIDS supported VAAC in the finalization and roll-out of the *Development of Strategic Provincial HIV Plan Training Modules* and piloted training materials in two different settings: 1. provinces with available data, and 2. provinces with limited data and/or limited donor support. Two training sessions were organized in 2011, with 46 participants from 14 provinces. The momentum achieved through training in the strategic planning process will be maintained by follow-up activities to address data gaps, as well as trainings in data use to ensure that data synthesis and analysis are established as part of routine input into HIV programme decisions at the provincial level.

Surveys, surveillance, dissemination and use of data

In 2010 and 2011, Viet Nam has made significant progress in improving surveillance and built national capacity to analyse, disseminate and use data effectively. The HIV sentinel surveillance system in Viet Nam began in 1994, with 10 provinces reporting HIV prevalence among 6 sentinel populations perceived to be at increased risk of HIV infection. In 1996, the system expanded to 20 provinces, in 2001 to 30 provinces and in 2003 to 40 provinces. In 2009, Ha Tay province merged with Ha Noi, leaving 39 provinces with sentinel sites. Surveyed populations included men who inject drugs, female sex workers, patients of sexually transmitted infection (STI) and tuberculosis (TB) clinics, pregnant women attending antenatal care clinics and military recruits. Other populations are added at the discretion of local authorities. In 2011, men who have sex with men were formally added as a sentinel population, where previously only a few provinces periodically surveyed MSM. 2011 also saw the end of surveys in administrative detention centres for people who inject drugs and female sex workers.

More recently, routine, brief behavioural surveys were added to the annual HIV sentinel surveillance (HSS+). After a pilot phase in 2009, 7 provinces (An Giang, Da Nang, Ha Noi, Hai Duong, Thanh Hoa, HCMC, and Hue) collected these surveys in 2010 and 12 provinces (An Giang, Binh Duong, Ca Mau, Dien Bien, Da Nang, HCMC, Hai Duong, Ha Noi, Hue, Nghe An, Quang Tri, and Thanh Hoa) collected surveys in 2011.

The initial success of the 2009 pilot inclusion of short behavioural questionnaires into routine HIV sentinel surveillance among people who inject drugs (PWID) and female sex workers (FSW), and the inclusion of MSM in eight provinces in 2011, showed that HSS+ is both feasible and potentially cost-effective in Viet Nam.

A draft of the revised National Protocol for HIV Sentinel Surveillance, due to be finalized in early 2012, also includes HSS+ as a recommended approach. In addition, efforts have been made to integrate HIV and sexually transmitted infection (STI) surveillance in some provinces to improve the technical efficiency of HIV/STI surveillance and the use of STI surveillance data.

From a prevention perspective, the lack of reliable size-estimation data for key populations at higher risk makes it difficult to prioritize provinces or appropriately allocate prevention resources for these groups. In a concentrated epidemic, shifts in and relative concentrations of these groups in different areas constitute an important early warning system for emerging pockets of the epidemic. The lack of denominators on the number of members of key populations at higher risk to be reached also makes coverage measurement and the evaluation of potential impacts nearly impossible.

Obtaining information on the size of key populations at higher risk remains a challenge. Over the last two years, technical and development partners (including the USA Centers for Disease Control, the National Institute of Hygiene and Epidemiology and FHI-360) have attempted to gather more direct size-estimation data and gauge the feasibility of several size-estimation approaches. In three geographically and epidemically diverse provinces (Can Tho, Dien Bien, and HCMC), different size estimation methods were applied for PWID, FSW and MSM (the latter in Can Tho only): a 3-way capture-recapture; a police count of numbers of PWID and FSW; and a multiplier using survey proportions against available programme data. The results were compared to official numbers provided by ministries, which are generally thought to be two to three times lower than the real totals. Preliminary results indicate that the physical landscape played an important role in methods relying on surveys. In addition, there is some evidence that the police counts may be closer to reality than conventional wisdom suggests.

In order to promote HIV research activities and use evidence provided by research findings effectively, VAAC, in collaboration with other units, international organizations and national and international researchers, developed in 2011 a National Research Agenda on HIV for the period 2011-2015. The National Research Agenda aims to: identify research gaps; select research priorities based on important and urgent issues in HIV prevention and control; and minimize duplication and repetition in HIV research to ensure the efficient use of resources.

The HIV information-management system

In 2010 and 2011, VAAC put great effort into developing a single reporting form and database for routine monitoring (as per Decision 28) and encouraging donors to mainstream their data collection activities. Improvements to the routine monitoring system included the operationalization of a single monitoring database and a national web-based reporting system.

The reporting template was computerized and provinces were trained to enter and submit data online. Efforts were also made during the reporting period to address the issue of the quality of data obtained through the routine reporting system. In 2011, several joint field trips were organized by VAAC with members of the National SI/M&E TWG to review the implementation of Decision 28. The findings of the review will inform the revision of the Decision.

Costing, financial gap analysis and the development of sustainable financing scenarios

The first National AIDS Spending Assessment (NASA) was conducted in 2010 by VAAC with support from UNAIDS. It captures AIDS expenditures over the two-year period of 2008 and 2009. NASA tracks the resources available to health services, social mitigation measures, education, labour, justice and other sectors to fully represent the multisectoral response in Viet Nam. The NASA findings, together with a VAAC/CDC/WHO treatment costing study and financial and human resource gap projections developed with the HIV/AIDS Program Sustainability Analysis Tool (HAPSAT) and supported by Abt Associates, will inform the costing of the new National Strategy on HIV/AIDS Prevention and Control for the period 2011-2020, with a vision to 2030.

As Viet Nam has achieved middle-income country status, the country needs to transition away from reliance on international donors for public health funding. Vietnamese government officials and international partners addressed this issue in May 2011 at a national meeting, with participation from all key stakeholders, chaired by Truong Thi Mai, head of the National Assembly's Committee on Social Affairs, and Vice-Minister of Health Trinh Quan Huan.

In addition, and in partnership with Oxford Policy Management, UNAIDS supported VAAC to further explore how the Government of Viet Nam can approach long-term financing for AIDS. Based on the NASA and resource needs estimations, scenarios were developed. An analysis of the efficiency of Viet Nam's AIDS response and whether and where savings could be made was undertaken, followed by a sensitivity analysis and an overview of potential funding sources. Finally, a draft 'road map' to manage the transition from the current to the future financing strategy for HIV was formulated and will be discussed with partners.

Development of a prioritization framework

In light of major shifts in funding sources for the HIV response, and the need for investment in evidence-based interventions targeting key populations at higher risk of HIV, UNAIDS supported VAAC to involve key national and international stakeholders at the country level in joint planning and discussion about resource allocation. Through the triangulation of various sources of epidemiologic data available at the sub-national level, systematic criteria to classify different geographic areas according to the type or severity of the HIV epidemic were developed in order to prioritize the areas for interventions.

The way forward

The National SI/M&E TWG, together with its subgroups, will continue to be the forum that will lead national and international partners' efforts to further strengthen Viet Nam's M&E System to ensure the provision of good quality data that will guide the planning, coordination and implementation of the national response, assess the effectiveness of ongoing interventions and identify areas where programmes can improve.

The upcoming review of the National M&E Framework and its alignment with the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*, will provide an opportunity to further address the current weakness of the national system.

In addition, quality assurance (QA) and quality improvement (QI) approaches have been introduced to monitor the quality of service delivery. The QA/QI initiative incorporates the use of strategies, frameworks, minimum standards and standard operating procedures, checklists, proxy indicators and monitoring processes covering the major programme areas, including all technical activities as well as programme management and administrative functions. The scale-up and expansion of these approaches should be considered to ensure the quality and accuracy of data.

IX. ANNEXES

ANNEX 1

CONSULTATION/PREPARATION PROCESS FOR THE COUNTRY PROGRESS REPORT (CPR) ON FOLLOWING UP ON THE DECLARATION OF COMMITMENT ON HIV/AIDS

1. Which institutions/entities were responsible for filling out the indicator forms?

a. NAC or equivalent	Yes
b. NAP	No
c. Others	No

2. With input from:

Ministries:

Ministry of Education and Training	Yes
Ministry of Health	Yes
Ministry of Labour, War Invalids and Social Affairs	Yes
Ministry of Public Security	Yes
Ministry of National Defence	Yes
Ministry of Transportation	Yes

Other institutions:

Labour Union	Yes
National Assembly – Social Affairs	Yes
Border Guard High Command	Yes
Customs General Office	Yes
National Committee of Ethnic Minorities	Yes
Office of Government	Yes
Civil Society Organizations	Yes
People Living with HIV	Yes
Private Sector	Yes
UN Agencies	Yes
Bilateral and multilateral donors	Yes
International NGOs	Yes

3. Was the report discussed in large fora? Yes, on 14 March 2012

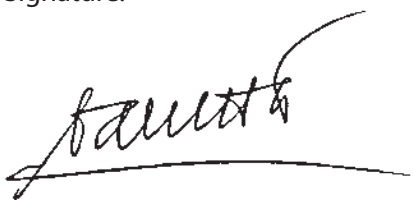
4. Are the surveys stored centrally? Yes

5. Is the data available for public consultation? Yes

6. Name of National AIDS Committee Officer in charge of submitting report and reflecting questions relating to the report:

Name: **Dr Phan Thi Thu Huong**
Title: Vice Director, Viet Nam Administration of AIDS Control, Ministry of Health

Signature:



Address: 135/3 Nui Truc,Ba Dinh, Ha Noi, Viet Nam
Email: huongphanmoh@gmail.com
Tel: +84 - 4 - 38465731

Date of submission: 31.03.2012

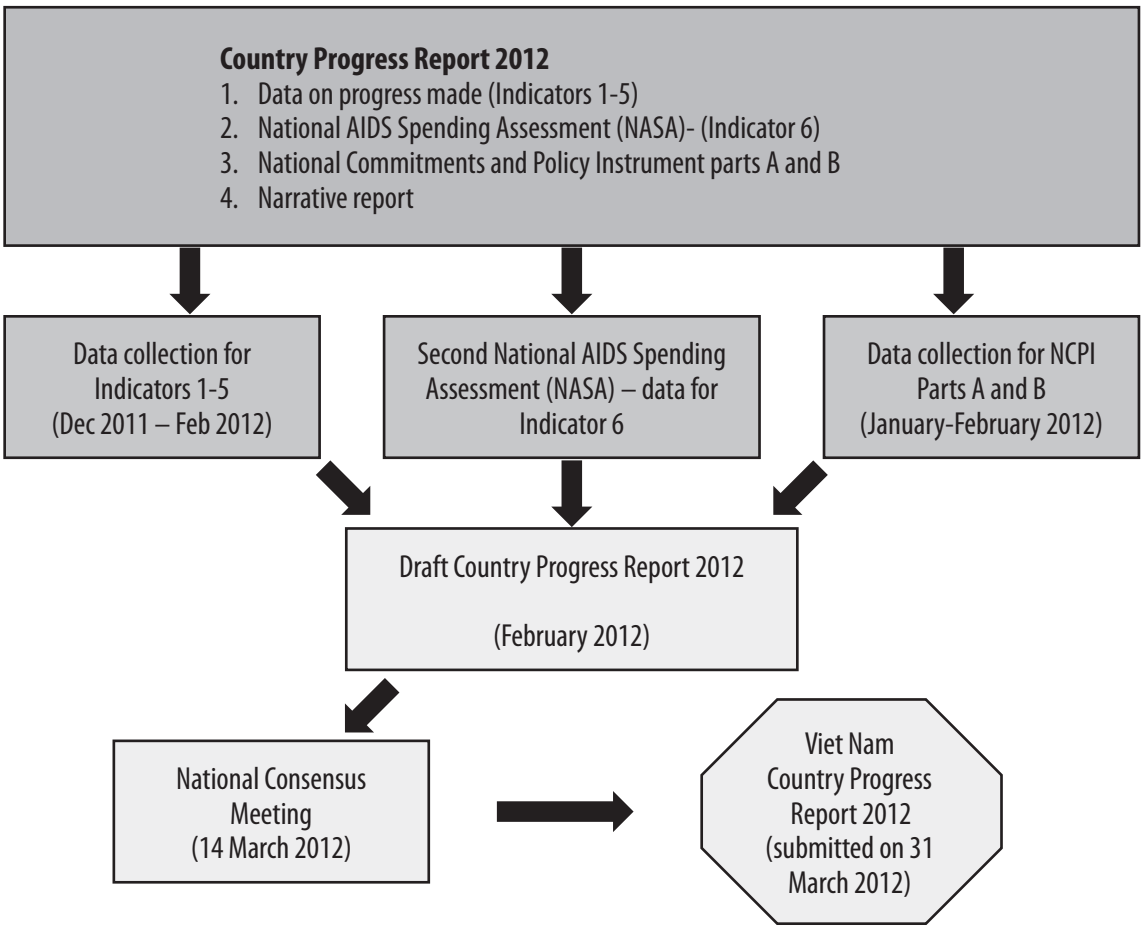
VIET NAM COUNTRY PROGRESS REPORT 2012

PREPARATION PROCESS

This report was prepared with broad participation from Government, development partners and civil society. Planning for the report began in November 2011 with the development of a road map for an extensive consultation process.

A total of 17 Government agencies, 84 civil society organizations (self-help groups, faith-based organizations, non-governmental organizations and international non-governmental organizations), business enterprises, bilateral, multilateral and United Nations (UN) agencies were involved in the preparation of this report. Figure 1 describes the main components of the overall report preparation process.

Figure 1
Viet Nam UNGASS 2012 reporting process outline



A number of consultants were engaged to support the writing team, which was led by the Viet Nam Administration of AIDS Control (VAAC), with technical support from UNAIDS Viet Nam.

Local consultants facilitated the collection of data for Indicators 1.1-7.2 and the National Commitments and Policy Instrument (NCPI). With regard to Indicator 6 (6.1. Domestic and international AIDS spending by categories and financing sources), a national consultant was recruited to collect and process data according to NASA methodology. The results include a database of national HIV and AIDS expenditure detailed by NASA dimensions (financing sources (FS), financing agents (FA), providers of services (PS), beneficiary population (BP) and AIDS spending category (ASC)). The data collection began in November 2011 and was completed by mid-January 2012. Although incomplete, the data collected and presented in this report is the most comprehensive available to date.

In December 2011 the NCPI Part A questionnaire was sent to members of the National Committee for AIDS, Drugs and Prostitution Prevention and Control. Fourteen Government agencies responded. Government agencies were asked to only complete the sections relevant to their work.

Of particular note is the consultation and data-collection process for the NCPI Part B questionnaire. VUSTA was selected to coordinate and organize the participation of civil society organizations (CSOs) in the overall process.

VUSTA held two consultation meetings, one in Ha Noi and one in Ho Chi Minh City, in January 2012 to gather CSO inputs and to discuss and unify the NCPI Part B questionnaire. In total, 86 people representing 80 CSOs from 21 provinces throughout the country participated in the two meetings. These organizations included self-help groups, faith-based organizations, local NGOs and businesses. Participants at each consultation meeting selected a three-member civil-society task force, made up of people living with HIV, people who inject drugs, men who have sex with men, sex workers and representatives of faith-based organizations to represent them at the NCPI Part B consensus meeting. This extensive involvement of CSOs is testament to the ongoing strengthening of the role of civil society in the national response.

Local NGOs, international NGOs and the Joint UN Team on HIV attended separate NCPI Part B consultation meetings, while the NCPI B questionnaire was sent to bilateral agencies to collect their inputs. At each meeting, participants reached consensus and completed the NCPI Part B questionnaire. In the end there were six completed questionnaires representing the different constituencies (two questionnaires from two consultation meetings organized with CSOs in the north and in the south; one from a consultation with international NGOs; one from consultations with the Joint UN Team on HIV; and two based on donor inputs).

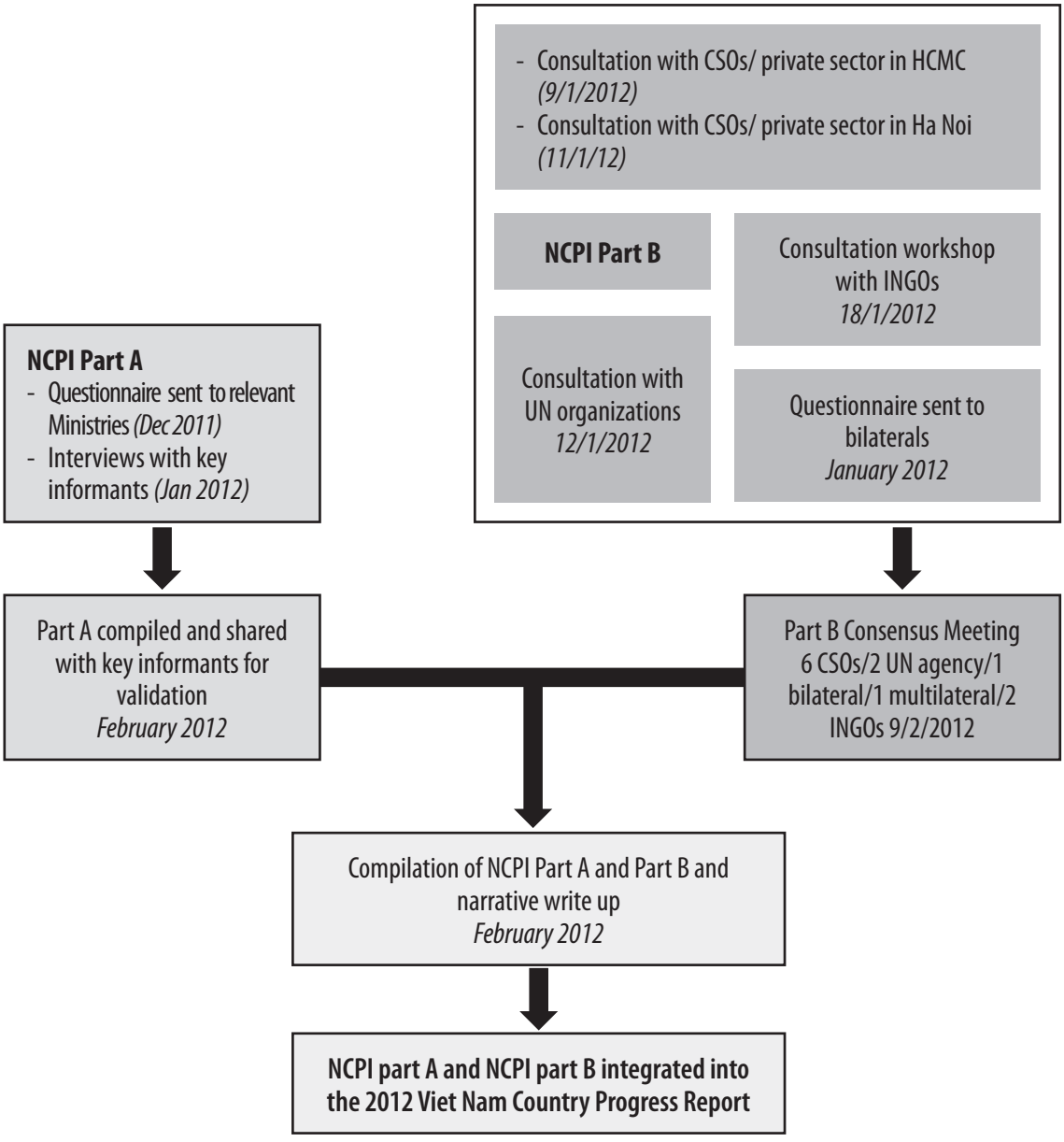
The NCPI Part B consensus meeting was held on 09 February 2012. At this meeting, representatives from civil society organizations, bilateral and multilateral agencies and the Joint UN Team on HIV engaged in a frank discussion, with representatives of key populations at higher risk debating confidently with development partners.

Together the 16 meeting participants, representing different constituencies, combined the experiences of people living with HIV and working at the local level with the perspectives of partners working at the policy level and financing the response to reach a consensus on the NCPI Part B questionnaire.

The last step in the development of the progress report was the National Consensus Meeting for the Country Progress Report, hosted by VAAC in Ha Noi on 14 March 2012. The goal of this meeting was to present the findings and give participants an opportunity to review and validate the draft report. A total of 57 participants from 32 organizations representing the Government, development partners and civil society were present.
Civil society participants were drawn from the task forces, which selected five individuals to represent them. Participants provided inputs to the narrative and reviewed the overall report. The amended report, based on the comments received, was then submitted through the Ministry of Health to the National Committee on AIDS, Drugs and Prostitution Prevention and Control for approval.

A full list of participants is below. The process behind the data collection for the National Commitments and Policy Instrument is described in Figure 2.

Figure 2
NCPI Part A and B data collection outline



LIST OF PARTICIPANTS AT THE NATIONAL CONSENSUS WORKSHOP FOR THE COUNTRY PROGRESS REPORT 14 MARCH 2012

	NAME	ORGANIZATION
I	**Viet Nam Administration for AIDS Control**	
1	Nguyễn Mạnh Yên	Department of Monitoring and Evaluation
2	Võ Hải Sơn	Department of Monitoring and Evaluation
3	Hà Thị Minh Nguyệt	Department of Monitoring and Evaluation
4	Bùi Hoàng Đức	Department of Monitoring and Evaluation
5	Nguyễn Thanh Huyền	Department of Monitoring and Evaluation
6	Nguyễn Khắc Hải	Department of Monitoring and Evaluation
7	Đỗ Thị Nhàn	Department of Care and Treatment
8	Mai Xuân Phương	Department of Communication and Community Mobilization
9	Trần Văn Sơn	Department of Scientific Research and International Cooperation
II	**Other health sector representatives**	
10	Trần Xuân Hằng	Ministry of Health - Department of Legislation
11	Dương Công Thành	National Institute of Hygiene and Epidemiology (NIHE)
12	Nguyễn Trần Hiển	National Institute of Hygiene and Epidemiology (NIHE)
13	Nguyễn Trường Khanh	National Health Education & Communication Centre
14	Nguyễn Văn Phẩm	National Lung Hospital
15	Phan Thị Thu Nga	National Obstetrics Hospital
16	Phạm Nhật An	National Paediatrics Hospital
17	Giang Thanh Thủy	National Paediatrics Hospital
18	Phạm Minh Phương	National Institute of Dermatology
III	**Other sectors**	
19	Phạm Long Biên	Border Guard High Command
20	1 representative	Customs General Office
21	Hà Thị Dung	Ministry of Education and Training - Student Affairs Department
22	Phạm Thị Thơm	Ministry of Education and Training - Student Affairs Department
23	Lê Văn Khánh	Ministry of Labour, War Invalids and Social Affairs - Department of Social Evils Prevention and Control
24	Lê Văn Chứ	Ministry of National Defense - Health Department
25	Nguyễn Thị Thu Ba	Ministry of Public Security - Health Department
26	Phạm Thành Lâm	Ministry of Transportation - Health Department
27	Phạm Đức Thụ	Ministry of Transportation - Health Department
28	Xa Trung Hưng	National Committee of Ethnic Minorities - Propaganda Department
29	1 representative	National Committee of Ethnic Minorities - Propaganda Department
30	Vũ Công Thảo	Office of Government
31	1 representative	Viet Nam Labour Federation

	NAME	ORGANIZATION
IV	**Civil Society**	
32	Monk Thích Đồng Nguyện	AIDS Association - Viet Nam Buddhism Institute - HCMC
33	Phạm Thị Huệ	Flamboyant Flowers (PLHIV self-help group)
34	Nguyễn Thanh Hảo	Northern Youth Centre
35	Huỳnh Như Thanh Huyền	SPN+ (VNP+)
	Nguyễn Sơn Minh	We are students/MSM network in the North
37	Nguyễn Thành Tuấn	You, I, and We (PWID self-help group)
V	**International non-governmental organizations**	
38	Ted Hammett	Abt Associates/Health Policy Initiative
39	Nguyễn Tuấn Phong	Abt Associates/Health Policy Initiative
40	Steve Mills	FHI360
41	Nguyễn Cường Quốc	FHI360
42	Lê Thu Hiền	FHI360
43	Nguyễn Thị Hiệp Hiệp	Pact
VI	**Bilateral agencies**	
44	Viviane Chao	President's Emergency Plan for AIDS Relief, USA (PEPFAR)
45	Amy Gottlieb	President's Emergency Plan for AIDS Relief, USA (PEPFAR)
46	Nguyễn Hồng Nhung	President's Emergency Plan for AIDS Relief, USA (PEPFAR)
47	Jonathan Ross	United States Agency for International Development (USAID)
48	Patrick Nadol	Centers for Disease Control, USA (CDC)
49	John Leigh	Department for International Development, United Kingdom (DFID)
VII	**Multilateral and United Nations agencies**	
50	Eamonn Murphy	UNAIDS
51	Vladanka Andreeva	UNAIDS
52	Nguyễn Thị Cẩm Anh	UNAIDS
53	Nguyễn Thị Phương Mai	UNAIDS
54	Phạm Nguyên Bằng	UNFPA
55	Nguyễn Thị Mai	The World Bank
56	David Jacka	World Health Organization
VIII	**Consultants**	
57	Nina Allen	

ANNEX 2

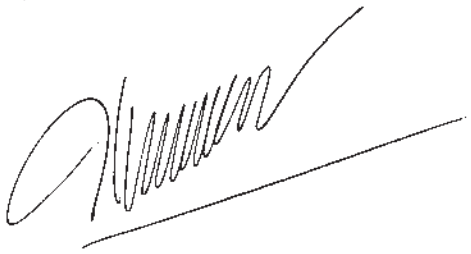
NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI) 2012

COUNTRY: VIET NAM

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Madame **Nguyen Thi Kim Tien**
Associate Professor, PhD, MD, Minister of Health

Signature:



Postal address: Ministry of Health 138A Giang Vo, Ha Noi, Viet Nam
Tel: +84 462732273
Fax: +84 438464051
E-mail: byt@moh.gov.vn

Date of submission: 31.03.2012

PART A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed any national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as Health, Finance, Education, Justice, Planning and Finance, Tourism, Social Works)

☑ Yes ☐ No

If YES, what was the period covered *[write in]*: 2011-2020

If YES, briefly describe key developments/modifications between the current national strategy and the prior one.

If NO or NOT APPLICABLE, briefly explain why.

The new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* has been developed in line with a new commitment to the UNAIDS "Getting to Zero" strategy.

Objectives are more clear, feasible, and based on evidence.

The new strategy has recognized the role of civil society in HIV prevention and control and assigned VUSTA as an implementing agency to coordinate CSO activities.

More attention has been paid to MSM, who are included in the National Strategy as one of the vulnerable groups which should be prioritized. There are plans to expand the MSM programme.

Treatment programme: The new strategy includes a more comprehensive treatment, care and support programme, including a pilot of Treatment 2.0.

Action plan: Combine action plans into 4 main components: HIV prevention; comprehensive treatment, care and support; M&E programme; system strengthening to ensure sustainability.

Implementation: Assign more specific and detailed tasks and responsibilities to ministries, departments and social organizations.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]:*

Ministry of Health; Ministry of Public Security; Ministry of Labour, War Invalids and Social Affairs; Ministry of Education and Training; Ministry of Finance; Ministry of Planning and Investment; Ministry of Culture, Sport and Tourism; Ministry of Information and Communication; Ministry of Justice;, Ministry of Defense; mass organizations, committees of government officials, the Fatherland Front, social organizations.

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

List out ministries, committees, committee for ethnic minorities, association received implementation budget

SECTORS	Included in Strategy		Earmarked Budget	
Education	✓Yes	No	✓Yes	No
Health	✓Yes	No	✓Yes	No
Labour	✓Yes	No	✓Yes	No
Military/Police	✓Yes	No	✓Yes	No
Transportation	✓Yes	No	✓Yes	No
Women	✓Yes	No	✓Yes	No
Young People	✓Yes	No	✓Yes	No
Others [list out]:	Yes	No	Yes	No
Fatherland Front	✓Yes	No	✓Yes	No
Finance	✓Yes	No	✓Yes	No
Planning and Investment	✓Yes	No	✓Yes	No
Culture, tourism, sport	✓Yes	No	✓Yes	No
Communication	✓Yes	No	✓Yes	No
Justice	✓Yes	No	✓Yes	No
Fatherland Front	✓Yes	No	✓Yes	No
Farmer's Union	✓Yes	No	✓Yes	No
Committee for Ethnic Minority Affairs	✓Yes	No	✓Yes	No

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	✓Yes	No
Migrants/mobile populations	✓Yes	No
Orphans and other vulnerable children	✓Yes	No
People with disabilities	Yes	✓No
People who inject drugs	✓Yes	No
Sex workers	✓Yes	No
Transgendered people	Yes	✓No
Women and girls	✓Yes	No
Young women/young men	✓Yes	No
Other specific vulnerable subpopulations	✓Yes	No

SETTINGS		
Prisons	✓Yes	No
Schools	✓Yes	No
Workplace	✓Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	✓Yes	No
Gender empowerment and/or gender equality	✓Yes	No
HIV and poverty	✓Yes	No
Human rights protection	✓Yes	No
Involvement of people living with HIV	✓Yes	No

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country *[write in]*?

KEY POPULATIONS
- PWID - Sex workers - MSM - Pregnant women - Young people - OVC - PLHIV - People living in remote areas - Mobile groups - People with STIs - Pupils and students

1.5. Does the multisectoral strategy include an operational plan?

☑ Yes ☐ No

1.6. Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	✓Yes	No	N/A
b. Clear targets or milestones?	✓Yes	No	N/A
c. Detailed costs for each programmatic area?	✓Yes	No	N/A
d. An indication of funding sources to support programme implementation?	✓Yes	No	N/A
e. A monitoring and evaluation framework?	✓Yes	No	N/A

1.7. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?

☑ Active Involvement ☐ Moderate Involvement ☐ No Involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:

A draft version of the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* was posted on the websites of VAAC and MOH and the Government web portal.

In addition to the general technical group meeting, two separate meetings were held for civil society organizations to provide feedback:

- The first consultation meeting sought input from CSOs on the major concepts and general content of the strategy.
- The second meeting contributed to the draft of the strategy by the Viet Nam Union of Science and Technology (VUSTA).

CSOs were actively involved in the process of building the multisectoral strategy by providing comments on the draft strategy both in writing and directly at the meetings. The comments were then studied by the Drafting Committee for inclusion in the strategy. VUSTA also mobilized civil society, groups of PLHIV and members of key populations at higher risk through their network to provide comments.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

☑ Yes ☐ No ☐ N/A

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

☑ Yes, all partners ☐ Yes, some partners

☐ No ☐ N/A

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

☑ Yes ☐ No ☐ N/A

2.1. If YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development	✓Yes	No	N/A
Assistance Framework	✓Yes	No	N/A
National Development Plan	✓Yes	No	N/A
Poverty Reduction Strategy	✓Yes	No	N/A
Sector-wide approach	✓Yes	No	N/A
Others (write in): National Programme on Drugs and Prostitution Prevention and Control; National Programme on Child Protection 2011-2015; National Strategy on Gender Equality 2011-2020; National Health Programme; Strategy on Education Development 2011- 2020			

2.2. If YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
HIV impact alleviation	✓Yes	No	N/A
Reduction of gender inequity as they relate to	✓Yes	No	N/A
HIV prevention/treatment, care and/or support	✓Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	✓Yes	No	N/A
Reduction of stigma and discrimination	✓Yes	No	N/A
Treatment, care, and support (including social security or other schemes)	✓Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	✓Yes	No	N/A
Others (write in): Child care and protection; drug and prostitution prevention and control			

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

☐ Yes ☑ No ☐ N/A

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

☑ Yes ☐ No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?

☑ Yes ☐ No

5.1. Have the national strategy and national HIV budget been revised accordingly?

☑ Yes ☐ No

5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

☑ Estimate of current and future need ☐ Only estimate of current need ☐ N/A

5.3. Is HIV programme coverage being monitored?

☑ Yes ☐ No

a. **If YES,** is coverage monitored by sex (male, female)?

☑ Yes ☐ No

b. **If YES,** is coverage monitored by population groups?

☑ Yes ☐ No

If YES, for which population groups?

- PWID
- Sex workers
- Pregnant women
- AIDS patients
- PLHIV
- MSM

Briefly explain how this information is used:

- Data is entered into projection software, analysed by international and national consultants, and used to develop policies or intervention plans.
- The information is also used to assess effectiveness and identify obstacles in implementing intervention activities, as well as to set priorities for interventions.
- The information is used to develop targets for national HIV programmes.
- The information is used to provide the basis for policy making and resource coordination.

c. Is coverage monitored by geographical area?

☑ Yes ☐ No

If YES, at which geographical levels (provincial, district, other)?

- Provincial level
- District level
- Commune level

Briefly explain how this information is used:

- The information is used for policy making, planning, and resource coordination in order to focus on locations with high prevalence, and is also used for estimations and projections.

5.4. Has the country developed a plan to strengthen health systems?

☑ Yes ☐ No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

Government *Decision 1107/QĐ-TTg*, dated 28/7/2009, approved the proposal to improve the capacity of the HIV prevention and control system at the provincial level during the period 2011-2015. The Government annually allocates funding to the construction of HIV-prevention centres and equipment purchase for HIV-prevention activities.

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	8	✓9	10

Since 2009, what have been key achievements in this area:

- Maintenance of the national HIV prevalence rate at under 0.3%.
- The *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* is currently being finalized. The strategy is evidence-based, with greater detail than the previous strategy and clear objectives; and was developed with the involvement of multisectoral government agencies/ branches, mass organizations, the UN, INGOs and civil society.with the involvement of various governments, departments, unions, and civil society.
- The annual plans of ministries and departments at different local levels were sent to VAAC on time.
- There is an HIV and AIDS M&E logframe to measure and assess intervention activities, providing evidence for policymaking, resource coordination, and intervention planning.
- The budget was disbursed as planned.
- The rate of use of out-of-date ARV medicines was low due to effective planning, coordination and use.
- Improved capacity of functional staff in most provinces.
- Strengthened resources for activities.

What challenges remain in this area:

- It is difficult to predict the budget committed to the HIV prevention and control programme in coming years. The draft National Strategy does not yet include a plan to allocate funding to implementing agencies.
- Lack of resources prevents the expansion of intervention programmes.
- Limited planning and management capacity of provincial HIV-prevention staff due to lack of responsible staff, or new and junior staff.
- Limited awareness of local people and authorities at several levels
- Limited quantity and quality of data.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

Government ministers

☑ Yes ☐ No

Other high officials at sub-national level

☑ Yes ☐ No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

☑ Yes ☐ No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

Over the past two years, the chairman of the National Committee for AIDS, drugs and prostitution prevention and control and other ministries/sectors have issued a variety of instructions and conclusions. Notably, during the Review Conferences on HIV prevention and control, ministries and sectors were requested to develop their HIV prevention plans in line with the new situation, to allocate appropriate funds to complete programmes, to finalize related legal documents and to increase intersectoral collaboration to implement comprehensive interventions and enhance international cooperation. In December 2011, at a meeting with international donors, Deputy Prime MInister Nguyen Xuan Phuc, the current chairman of the National Committee, affirmed his commitment to continue improving the political framework for HIV prevention and control to bring about favourable conditions for the implementation of the HIV prevention and control programme. The Ministry of Health was assigned by the Government to develop the Programme on AIDS, drugs and prostitution prevention and control for the period 2011-2020; to consolidate the Committee at the central and provincial levels to ensure consistent coordination and performance; and to appeal for the involvement of the whole political system in activities.

In June 2011, high-ranking leaders attended the UN High-Level Meeting on AIDS in New York, and committed to the new Political Declaration: "Intensifying our Efforts to Eliminate HIV/AIDS", which aims to bolster national political commitment and the engagement of leaders in a comprehensive response at the community, local, national, regional and international levels to halt and reverse the HIV epidemic and mitigate its impacts.

Deputy Prime Minister Truong Vinh Trong – the former chairman of the National Committee, who retired in 2011 – and leaders from different ministries visited a variety of methadone maintenance therapy and ART facilities for adults and children, as well as self-help groups and PLHIV in the community.

In March 2012, Deputy Prime Minister Nguyen Xuan Phuc convened a National Conference to review the implementation of activities in 2011 and plan for 2012. The conference was attended by leaders at the ministerial/sectoral level, People's Committees from 63 provinces/cities and heads of international organizations in Viet Nam.

2. Does the country have an officially recognized national multisectoral HIV coordination body(i.e., a National HIV Council or equivalent)?

☑ Yes ☐ No

2.1. If YES:

If YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	✓Yes	No
Have active government leadership and participation?	✓Yes	No
Have an official chair person?	✓Yes	No
If YES, *what is his/her name and position title?*	Deputy Prime Minister Nguyen Xuan Phuc	
Have a defined membership?	✓Yes	No
If YES, *how many members?*	28 members	
Include civil society representatives?	✓Yes	No
If YES, *how many?*	7 (Fatherland Front, Youth Union, Women's Union, Veterans Association, Committee of Ethnic Minority Affairs, VUSTA	
Include people living with HIV?	Yes	✓No
If YES, *how many?*		
Include the private sector?	Yes	✓No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	✓Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

☑ Yes ☐ No ☐ N/A

If YES, briefly describe the main achievements:

- The Government promulgated many regulations to guide and improve intersectoral collaboration with regard to HIV/AIDS prevention and control; to encourage organizations and individuals to be involved in HIV/AIDS prevention and control; and to allocate funds for related activities. The provinces have their own mechanisms for intersectoral collaboration.
- There is increasing and efficient involvement of civil society organizations in HIV/AIDS prevention and control. These organizations are invited by the Government to take part in the development of new policies and strategies for HIV prevention and control and provide technical assistance to projects.
- Some HIV-related activities, such as treatment and care, are now the responsibility of local NGOs.
- Social organizations, coordinated by VUSTA, are actively involved in Global Fund Round 9 projects.
- PLHIV receive better treatment and care.
- The private and business sectors are mobilized in the HIV response.
- The Country Coordination Mechanism of the Global Fund in Viet Nam includes members from civil society organizations and the private sector.

What challenges remain in this area:

- The exchange of information for policy framework development is only a formality; sufficient feedback is not provided regularly.
- Lack of operational budget.
- Limited capacity of civil society.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past years?

No data available

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	✓Yes	No
Coordination with other implementing partners	✓Yes	No
Information on priority needs	✓Yes	No
Procurement and distribution of medications or other supplies	✓Yes	No
Technical guidance	✓Yes	No
Others *[write in]*:	✓Yes	No
Development of policies which facilitate civil society involvement in HIV-prevention programmes. Involvement of civil society in national TWG meetings.		

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

☑ Yes ☐ No

6.1. If YES, were policies and laws amended to be consistent with the National HIV Control policies?

☑ Yes ☐ No

If YES, name and describe how the policies / laws were amended

- A new Decree (122/2011/ND-CP) has been issued to replace Decree 124/2008/ND-CP, which provides for exemptions from corporate income tax for HIV-related activities in the workplace.
- Approval of *Decree 69/2011/ND-CP* on handling administrative violations in health prevention, the medical environment and HIV/AIDS prevention and control, which provides crucial support to the enforcement of the Law on HIV. The Ordinance on sex work is currently being revised to support the implementation of harm-reduction interventions.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

- Despite provisions in the Law on HIV enabling greater access to prevention services for key populations at higher risk, Viet Nam still faces considerable policy barriers in establishing and scaling up effective interventions such as the Needle and Syringe Programme and the Condom Use Programme at the local level.
- While the Law on Drug Prevention and Control No.16/2008/QH12 (Law on Drugs) has been amended to decriminalize drug use, under the Ordinance on Administrative Violations, drug use still remains an administrative violation and results in detention for up to two years in 06 Centres.
- Decision 96 mandates the provision of HIV prevention, treatment and care in correctional facilities and 05/06 centres; however under Decree 108, the provision of opiate substitution therapy is prohibited in these facilities.
- There are also difficulties in implementing Decree 13/2010/ND-CP due to administrative procedures and changes in the definition of poverty.

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	8	✓9	10

Since 2009, what have been key achievements in this area:

- Revision and issue of legal documents consistent with the Law on HIV.
- Ministries and sectors work closely with the Ministry of Health to prepare legal documents and policies for HIV/AIDS prevention and control.
- Enhancement of National Committee monitoring of HIV-prevention activities in provinces.
- Strong commitment of the Party and Government.
- Support provided to and engagement of civil society organizations in HIV prevention and control.

What challenges remain in this area:
- Funds for HIV/AIDS prevention and control are not sufficient to expand the scope of prevention activities and treatment services for PLHIV. - Some legal documents are still being developed or revised, and are not yet finalized. - Discrimination against PLHIV still exists.

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	✓Yes	No
Men who have sex with men	✓ Yes	No
Migrants/mobile populations	✓Yes	No
Orphans and other vulnerable children	✓Yes	No
People with disabilities	✓Yes	No
People who inject drugs	✓Yes	No
Prison inmates	✓Yes	No
Sex workers	✓Yes	No
Transgendered people	Yes	✓No
Women and girls	✓Yes	No
Young women/young men	✓Yes	No
Other specific vulnerable subpopulations *[write in]:*	Yes	✓No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non- discrimination?

☑ Yes ☐ No

If YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
The Constitution of the Socialist Republic of Viet Nam provides all citizens with economic, politic and social equality, and forbids all discrimination.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
The Constitution is supported by various policy documents.
Briefly comment on the degree to which they are currently implemented:
Implementation is moderate.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

☑ Yes ☐ No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	✓Yes	No
Men who have sex with men	✓Yes	No
Migrants/mobile populations	✓Yes	No
Orphans and other vulnerable children	Yes	✓No
People with disabilities	Yes	✓No
People who inject drugs	✓Yes	No
Prison inmates	✓Yes	No
Sex workers	Yes	✓No
Transgendered people	✓Yes	No
Women and girls	Yes	✓No
Young women/young men	Yes	✓No
Other specific vulnerable populations *[write in below]:*	Yes	✓No

Briefly describe the content of these laws, regulations or policies:

There are no regulations that facilitate access to health services for transgender and mobile groups. Under the Ordinance on Administrative Violations, drug use still remains an administrative violation and results in detention for up to two years in 06 Centres. Under Decree 94, which guides the implementation of the Law on Drugs, drug users are subject to an additional period of 'post-detoxification management' for between one and two years. Due to limited access to HIV services, including treatment, in 06 Centres, this is a barrier to PWIDs accessing effective HIV prevention, treatment, care and support services.

The Ordinance on Prostitution Prevention and Combat 2003 prohibits "availing oneself of business service to carry out commercial sex work" or "lending a hand to commercial sex work". Anyone selling sex is subject to administrative detention in 05 Centres. Due to limited access to HIV services, including treatment, in 05 Centres, this is a barrier to FSWs accessing effective HIV prevention, treatment, care and support services. A recent draft amendment to the law prevents sex workers from being detained without judicial process. Under Decree 108, the provision of opiate substitution therapy is prohibited in closed settings.

As residency in the district of a treatment centre is one of the eligibility criteria for the current national pilot methadone maintenance therapy (MMT) programme, migrants without official residency are not able to access these services. Decree 67 requires disclosure to social security and people cannot access social services and benefits unless HIV status is disclosed. Stigma and discrimination prevent PLHIV from disclosure and therefore from receiving social support.

There are also difficulties in implementing Decree 13/2010/ND-CP due to the administrative definition of poverty.

Briefly comment on how they pose barriers:
Since 2010, restrictive policies have been added to the Law on Drugs Prevention and Control requiring drug users to be undergo compulsory treatment (with a compulsory period of 2 years in an 06 Centre and another compulsory 2 years after that in a rehabilitation centre). Access to treatment in these centres is very limited and confidentiality is not normally respected. PLHIV who are also drug users or sex workers are affected by the amendments to the Law on Drugs Prevention and Control and the Ordinance on Prostitution Prevention and Control. In addition to this legislation, the laws on sex work and drugs mentioned above prevent PLHIV from accessing services.

IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

☑ Yes ☐ No

If YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	✓Yes	No
Avoid commercial sex	✓ Yes	No
Avoid inter-generational sex	Yes	✓ No
Be faithful	✓Yes	No
Be sexually abstinent	Yes	✓No
Delay sexual debut	✓Yes	No
Engage in safe(r) sex	✓Yes	No
Fight against violence against women	✓Yes	No
Greater acceptance and involvement of people living with HIV	✓Yes	No
Greater involvement of men in reproductive health programmes	✓Yes	No
Know your HIV status	✓Yes	No
Males to get circumcised under medical supervision	Yes	✓No
Prevent mother-to-child transmission of HIV	✓Yes	No
Promote greater equality between men and women	✓Yes	No
Reduce the number of sexual partners	✓Yes	No
Use clean needles and syringes	✓Yes	No
Use condoms consistently	✓Yes	No
Other *[write in below]:*	✓Yes	No
No stigma and discrimination against PLHIV Avoid exposure to blood and body fluids		

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

☑ Yes ☐ No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

☑ Yes ☐ No

2.1. Is HIV education part of the curriculum in:

Primary schools?	✓Yes	No
Secondary schools?	✓Yes	No
Teacher training?	✓Yes	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

☑ Yes ☐ No

2.3. Nước bạn đã có chiến lược giáo dục về HIV cho thanh thiếu niên ngòai trường học chưa?

☑ Yes ☐ No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

☑ Yes ☐ No

Briefly describe the content of this policy or strategy:

- The Law on HIV includes a chapter on IEC/BCC and harm reduction as technical contributions to HIV prevention and control.
- Decree No. 108/2007/NĐ-CP guides the implementation of harm-reduction programmes for HIV prevention.
- An IEC/BCC national action plan is included in the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*
- The regulations of multisectoral coordination assign tasks to different ministries and departments for the implementation of the IEC/BCC national action plan.
- The National Strategy also includes plans to strengthen the direction of the Party, departments and organizations at different levels, as well as increase community involvement, in relation to the implementation of the IEC/BCC programme.
- The development of the *Strategic action plan for the education sector on HIV/AIDS prevention 2011-2020 with a vision to 2030* also demonstrates national commitment to the HIV response in the context of complicated developments in the epidemic and reducing funding for HIV from the international community.

3.1. If YES, which populations and what elements of HIV prevention does the policy/ strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex worker	Customers of Sex Workers	Prison inmates	Other populations PLHIV, people of mobile groups, sex partners of members of the above groups, STI patients, pregnant women, young people
Condom promotion	✓	✓	✓	✓		✓
Drug substitution therapy	✓					
HIV testing and counselling	✓	✓	✓	✓	✓	✓
Needle & syringe exchange	✓					
Reproductive health, including sexually transmitted infections prevention and treatment	✓	✓	✓	✓		✓
Stigma and discrimination reduction	✓	✓	✓	✓	✓	✓
Targeted information on risk reduction and HIV education	✓	✓	✓	✓	✓	✓
Vulnerability reduction (e.g. income generation)	✓		✓			✓

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	✓8	9	10

Since 2009, what have been key achievements in this area:

- More instructions from the Party and Government, increased budget and intersectoral collaboration.
- High levels of consensus among communities and in the implementation of prevention programmes by intersectoral bodies.
- Issue of a joint circular on information dissemination through the mass media.
- Development of documents on prevention.
- HIV prevention and control are integrated into the general national development plan.
- Discrimination against PLHIV by employees has significantly decreased compared to 2005.
- Sympathy and better support from the community for workers living with HIV, which better addresses their needs.
- Increase of methadone maintenance therapy for drug users.
- The organizational system with regard to HIV in the education sector has been consolidated and is functioning. It ensures that knowledge and information appropriate to HIV prevention and control are communicated and focuses on the elimination of stigma and discrimination against PLHIV and children affected by HIV in education establishments. HIV activities have also been integrated into other educational activities.

What challenges remain in this area:

- Public knowledge about HIV prevention is still limited.
- Some provinces have not yet paid enough attention to prevention activities; the limited budget holds back the expansion of prevention services.
- Discrimination against PLHIV and MSM still needs to be addressed. The awareness of managers and policymakers of sensitive issues, such as man-on-man sex, should be improved so that appropriate harm-reduction policies and interventions can be implemented.
- There are insufficient funds to expand coverage.
- Ineffective staff performance.
- The number of migrant workers in industrial zones has dramatically increased, resulting in increased needs for HIV prevention, while resource and capacity are still limited.
- IEC on HIV is still not targeted at specific populations. In addition, some Directing Committees of Education and Training Provincial Departments and education establishments have not performed effectively. As staff working on HIV are only part-time, they do not have much time for HIV activities; the capacity of staff is also not uniform, with many staff lacking experience. Some unit leaders have not paid enough attention to HIV, and some implemented programmes and projects still overlap and lack overall coordination.

4. Has the country indentured specific needs for HIV prevention programmes?

☑ Yes ☐ No

If YES, how were these specific needs determined?

Needs are determined based on:

- Identification of the programme target groups and the number of beneficiaries of prevention activities.
- Results of the HIV case reporting system, sentinel surveillance, HSS+ and IBBS.

- Needs assessment surveys.
- Programme routine reports.
- Financial and human resources capacity to meet demands
- The feasibility of prevention activities.
- The setting of specific targets, based on evidence, relating to HIV-prevention knowledge, attitudes and practices.

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)	N/A
Blood safety				✓	
Condom promotion				✓	
Harm reduction for people who inject drugs				✓	
HIV prevention for out-of-school young people			✓		
HIV prevention in the workplace			✓		
HIV testing and counselling				✓	
IEC on risk reduction				✓	
IEC on stigma and discrimination reduction				✓	
Prevention of mother-to-child transmission of HIV				✓	
Prevention for people living with HIV				✓	
Reproductive health services including sexually transmitted infections prevention and treatment			✓		
Risk reduction for intimate partners of key populations			✓		
Risk reduction for men who have sex with men			✓		
Risk reduction for sex workers			✓		
School-based HIV education for young people				✓	
Universal precautions in health care settings			✓		
Other*[write in]*:					✓

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	✓8	9	10

Since 2009, what have been key achievements in this area:

- Increase in communication activities and in the involvement of Ministries, sectors and other political and social agencies
- Successful control of the number of newly infected people. This number has not increased as fast as in previous years and the prevalence rate is kept under 0.3%.
- Prevention services have been continuously expanded, especially methadone-based treatment programmes and education about reproductive and sexual health for young people.
- HIV prevention and control reached more workplaces and financial resources began to be mobilized for HIV-related activities targeting employees.
- Information dissemination and education for key populations at higher risk.
- Reduction of discrimination against PLHIV.

What challenges remain in this area:

- Lack of budget and competent staff.
- The coverage of prevention services has not yet met demand.
- Prevention projects rely heavily on funding from international donors.

V. TREATMENT, CARE, AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

☑ Yes ☐ No

If YES, Briefly identify the elements and what has been prioritized:

Elements:

- ART, OI treatment
- Nutrition care
- STI, family planning care
- Home-based care
- Pain management
- VCT
- TB screening for PLHIV
- TB preventive treatment for PLHIV
- TB control at HIV treatment clinic
- Universal precautions
- HIV screening of blood transfusions

Prioritized elements:

- PMTCT
- TB treatment
- OVC care and treatment
- Health insurance for PLHIV

Briefly identify how HIV treatment, care and support services are being scaled-up?

- Expansion and implementation of HIV treatment and care services at all levels, from the local to the central, in:
    a. OPCs at national hospitals at the central level
    b. OPCs at provincial general hospitals at the provincial level
    c. OPCs at district general hospitals, preventive health care centres, and preventive HIV centres at the district level
    d. Communal health centres and village health systems, where a number of PLHIV receive treatment and care. Some home-based care groups have been organized at this level in some locations.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)	N/A
Antiretroviral therapy			✓		
ART for TB patients			✓		
Cotrimoxazole prophylaxis in people living with HIV				✓	
Early infant diagnosis			✓		
HIV care and support in the workplace (including alternative working arrangements)		✓			
HIV testing and counselling for people with TB				✓	
HIV treatment services in the workplace or treatment referral systems through the workplace		✓			
Nutritional care			✓		
Pediatric AIDS treatment			✓		
Post-delivery ART provision to women			✓		
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)		✓			
Post-exposure prophylaxis for occupational exposures to HIV				✓	
Psychosocial support for people living with HIV and their families			✓		
Sexually transmitted infection management			✓		
TB infection control in HIV treatment and care facilities		✓			
TB preventive therapy for people living with HIV		✓			
TB screening for people living with HIV				✓	
Treatment of common HIV-related infections			✓		
Other *[write in]:*					✓

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

☑ Yes ☐ No

Please clarify which social and economic support is provided:

- Children living with HIV from poor households, PLHIV who are unable to work and from poor households, families or individuals who adopt children living with HIV and people who are raising PLHIV under 18 years old receive monthly social benefits, health insurance, exemptions from tuition fees when attending training programmes or vocational training and funeral expenses.
- People living with HIV at social protection centres also receive financial support to buy clothes and medicines for everyday illnesses, treatment for opportunistic infections and menstruation-related supplies.
- The aid fund for PLHIV also provides financial support, offers loans and creates jobs for disadvantaged people.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

☑ Yes ☐ No ☐ N/A

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

☑ Yes ☐ No ☐ N/A

If YES, for which commodities?

- ART medication: through the Supply Chain Management System (SCMS) and Voluntary Pooled Procurement (VPP)
- Methadone: through SCMS

For ART: currently 5% of ART medications are purchased in-country, while 95% are imported through foreign-funded programmes/projects, such as PEPFAR (through SCMS) and the Global Fund (through VPP). These projects and programmes use international procurement mechanisms.

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	✓8	9	10

Since 2009, what have been key achievements in this area:

- Enhanced access to ART: 318 medical facilities (PKNT) have been established (of which 289 facilities for adults, 118 facilities for children, 89 integrated facilities, 4 OPC at the national level, 155 OPC at the provincial level and 195 OPC at the district level); 60,924 patients have undergone ART (of whom 57,663 adults and 3,261 children).
- Management of ART distribution to ensure that recipients receive the medicine regularly.
- Management and coordination of testing and medical equipment for treatment, including the Early Infant Diagnosis test of viral load.
- Prevention of mother-to-child transmission: 38% of pregnant women took an HIV test and received their result, of whom 0.26% received a positive result; 49% of pregnant women living with HIV received ARV medicines for PMTCT prophylaxis; 46% of children born to women living with HIV received ARV medicines for prophylaxis; 45% of children born to women living with HIV were treated with Cotrimoxazole to prevent opportunistic infections.
- Treatment and care services for children: The PKNT system is established in 54 out of 63 provinces, and 3,121 children have been able to access ART (by September 2011); 1,601 children living with HIV in 45 provinces have been provided with a health insurance card.
- HIV/Tuberculosis (TB): 35 provinces and 341 districts are implementing the integration of HIV and TB services. The number of PLHIV also being treated for TB every year is between 2,500 to 2,700 persons.
- Health insurance: VAAC is collaborating with the Department of Health Insurance to draft a Circular on Guidelines for Health Insurance for PLHIV.
- Pilot of Treatment 2.0 and the introduction of quality improvement(QI) activities for care and treatment services.

What challenges remain in this area:

- The sustainability of ART provision in the context of reductions in funds from international donors.
- The guidelines on health insurance for PLHIV have not yet been issued.
- An e-reporting and management system has not yet been developed
- There is not a wide coverage of PMTCT.
- Staff capacity at district level is limited.

6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

☑ Yes ☐ No ☐ N/A

If YES, is there an operational definition for orphans and vulnerable children in the country?

☑ Yes ☐ No

If YES, does the country have a national action plan specifically for orphans and vulnerable children?

☑ Yes ☐ No

If YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

☐ Yes ☑ No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	✓8	9	10

Since 2009, what have been key achievements in this area:

- Many policies on treatment and support for children and adults living with HIV have been developed.
- Treatment and care services have continuously expanded. The number of OVC receiving treatment care services has increased.
- A policy on health insurance for children living with HIV is being developed.
- More children born women living with HIV receive preventive treatment.

What challenges remain in this area:

- Coverage of care and support services for children is not broad enough.
- Sustainability of ART in the context of decreasing donor resources.
- Discrimination against children living with HIV has had negative consequences, with some children not be able to attend school.
- Lack of statistics about OVC and children benefiting from interventions.

VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

☑ Yes ☐ No ☐ N/A

Briefly describe any challenges in development or implementation:

Difficulties in reaching consensus on the measured indicators and M&E tools and to get commitment to sharing and submitting data across ministries, agencies and projects.

1.1. If YES, years covered *[write in]:*

5 years

1.2 If YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

☑ Yes, all partners ☐ Yes, some partners

☐ No ☐ N/A

Briefly describe what the issues are:
Donor and government requirements for and definition of indicators are different and change over time.

2. Does the national Monitoring and Evaluation plan include?

If YES, which main messages were clearly facilitated?		
A data collection strategy	✓Yes	No
If YES, does it address:		
Behavioural surveys	✓Yes	No
Evaluation / research studies	✓Yes	No
HIV Drug resistance surveillance	Yes	✓No
HIV surveillance	✓Yes	No
Routine programme monitoring	✓Yes	No
A data analysis strategy	✓Yes	No
A data dissemination and use strategy	✓Yes	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	✓Yes	No
Guidelines on tools for data collection	✓Yes	No

3. Is there a budget for implementation of the M&E plan?

☑ Yes ☐ In Progress ☐ No

3.1. If YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

No data available

4. Is there a functional national M&E Unit?

☑ Yes ☐ In Progress ☐ No

Briefly describe any obstacles:
Lack of staff; existing staff lack capacity.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?	✓Yes	No
In the National HIV Commission (or equivalent)?	Yes	✓No
Elsewhere *[write in]?*	Yes	✓No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces below]	**Fulltime**	**Part time**	**Since when?**
Permanent Staff [Add as many as needed] 12 staff	✓		
2	✓		2005
2	✓		2007
1	✓		2008
5	✓		2010
2	✓		2011
Temporary Staff [Add as many as needed]			

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

☑ Yes ☐ No

Briefly describe the data-sharing mechanisms:
The data-sharing mechanism operates through: - The National HIV Prevention System submits reports following routine reporting. - Internationally funded programmes submit reports to PACs. PACs then report to VAAC. - Information-sharing takes place through the National M&E Technical Working Group, where updates are provided on M&E activities undertaken by various organizations and donors.

What are the major challenges in this area:
- The national M&E unit has not yet been able to harmonize the project-funded M&E system with the national M&E system - Some data have not been collected as required. - Reports were not submitted in time, the duplication of statistics in the reports among different projects still exist. Lack of M&E staff, and in some organizations their capacity is limited. - Limited budget for M&E.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

☑ Yes ☐ No

6. Is there a central national database with HIV- related data?

☑ Yes ☐ No

If YES, briefly describe the national database and who manages it.
- HIV case report and sentinel surveillance results are recorded and managed by HIV Info software - Reports on HIV prevention and control are periodically updated through online reporting software. - VCT statistics are reported using specialized VCT management software. - VAAC currently manages the databases for the abovementioned datasets.

6.1. If YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

☑ Yes, all of the above ☐ Yes ☐ But only some of the above

6.2 Is there a functional Health Information System?

At national level	✓Yes	No
At subnational level	✓Yes	No
If YES, at what level(s)? *[write in]* National, provincial, district and commune		

7. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

☑ Yes ☐ No

8. How are M&E data used?

For programme improvement?	✓Yes	No
In developing / revising the national HIV response?	✓Yes	No
For resource allocation?	✓Yes	No
Other *[write in]:*	Yes	✓No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

- To develop annual plans and provide recommendations to improve interventions
- To provide recommendations to the Government on budgetary increases.

Provincial AIDS Centres do not pay sufficient attention to data, as limited budgets mean that they cannot use the data to improve programme performance.

9. In the last year, was training in M&E conducted

At national level?	✓Yes	No
If YES, what was the number trained:	10	
At subnational level?	✓Yes	No
If YES, what was the number trained	154	
At service delivery level including civil society?	✓Yes	No
If YES, how many?	No data available	

9.1. Were other M&E capacity-building activities conducted other than training?

☑ Yes ☐ No

If YES, describe what types of activities

More support was provided to the provinces to assist in evaluating the quality of statistics.

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	8	✓9	10

Since 2011, what have been key achievements in this area:
- Provision of an overview on HIV prevalence in the country and an evaluation of the efficiency of policies and strategies. - Improved analysis of prevalence by location and key population at higher risk.
What challenges remain in this area:
- The capacity of M&E staff in some organizations is still limited. A high turnover of staff has led to an increase in demand for training. - Lack of budget and resources for M&E activities.

PART B

[to be administered to representatives from civil society organizations, bilateral agencies and UN organizations]

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5, where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Very Poor					Excellent
0	1	2	✓3	4	5

Comments and examples

Areas of improvement:

There has been a notable increase in the recognition of civil society by the Government since 2010. Civil society is now invited to events and planning, and has been encouraged by PACs to participate in HIV programmes from the commune to the district levels. For example, CSOs were invited to all workshops held by the HCMC PAC, and were also invited to participate in the advisory board, network for care and support, vocational training and loan programmes.

VNP+ continues to play a role in policy advocacy and the number of groups and networks of MSM, SW and PWID has increased with Global Fund support, especially in provinces. There has also been more positive recognition from leaders of these groups, and a change in attitude from considering that members of these groups are committing 'social evils' to focusing on solving social issues. For example, the Government consulted with the community of people who use drugs in the development of Decree 94 on community-based detoxification at the commune level in HCMC.

Civil society was also invited to provide inputs into the National HIV and AIDS Strategy, and two consultation meetings were organized, giving CSOs the opportunity to provide comments.

VUSTA has become an official member of the National Committee, and will now be in a better position to promote the voice of civil society. The Viet Nam Civil Society Partnership Platform on AIDS (VCSPA), established in 2007, has also contributed to a stronger CSO voice.

There has been an increase in participation from organizations representing workers, which have participated in the Technical Working Group on Migrants and HIV in the Workplace alongside government, CSO, business and donor representatives. The Technical Working Group on Law conducts joint HIV and AIDS efforts and its contributions are valued by the Government.

CSOs were also included as official members of the delegation that attended the UN General Assembly High-Level Meeting on AIDS in New York in June 2011.

Challenges:

Despite increased recognition from the Government in recent years, Vietnamese civil society contributions to strengthening political commitment remain limited, and civil society lacks real and meaningful involvement, particularly when compared to other countries.

Unfortunately the achievements noted in the last report have not sustained, with VNP+ unable to provide a strong voice in the current political environment and the Global Fund Round 9 dual track process failing, as civil society was not found to be strong enough to take on the role of PR.

Legal barriers and a lack of government funding remain challenges for CSOs in Viet Nam, and the CSOs that do operate are dependent for financing and protection on the international donor community. As Viet Nam is now a middle-income country, donors are phasing out their support and thus the sustainability of civil society participation is a concern.

Civil society also requires capacity building in strategic and lobbying skills in order to influence political commitment and processes.

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

LOW					HIGH
0	1	✓2	3	4	5

Comments and examples

Planning:

There was a consultation process with civil society in the planning and development of the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* in 2010 and 2011: CSOs were invited to a brainstorming session at the outset of the process, as well as to meetings of Technical Working Groups to discuss specific sections of the report. They were also involved in two meetings that took place towards the end of the process and were consulted on the fifth draft of the Strategy. However, not all issues raised by CSOs have been addressed. VUSTA has recently become a member of the National Committee and will therefore have a chance to participate in planning and be allocated funds from the national budget.

Whilst there is some degree of civil society involvement in planning at the provincial level in some provinces, there has been none at all in other provinces. As the provincial plans feed into the national plans, there is thus also a (very limited) civil society involvement in national planning.

Budgeting:

Civil society has had no real involvement in the budgeting process at the national level. The limited involvement includes the participation of CSOs in the development of the Global Fund Round 9 budget plan, while in some provinces CSOs were consulted and informed about project financial issues.

It should be noted that the budgeting process for budgeting makes it difficult for civil society to participate, as it takes place within the Ministry of Planning and Finance and the National Assembly makes final decisions (representing all people in Viet Nam).

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					HIGH
0	1	✓2	3	4	5

b. The national HIV budget?

LOW					HIGH
0	✓1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	✓2	3	4	5

Comments and examples

Despite the increase in Government dialogue with civil society, there has been no real change in terms of meaningful participation, and the extent to which civil society has been involved in the strategy, budgeting and reports has not changed much.

Strategy:

The *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* includes a role for civil society in providing services, and this is gradually receiving greater acknowledgement, albeit in very general terms, e.g. "community-based treatment and care". Some mass organizations, such as the Women's Union, and VUSTA were identified as implementing partners. CSOs are requesting a further section of the report to be devoted to their role. It is hoped that the new Strategy will be revised after VUSTA make their official contributions. CSOs requested a chapter in the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* on their participation but have not yet received feedback.

Budget:

While the State budget for the HIV programme has increased annually, there is no budget allocated to CSOs, and CSO activities remain funded by international organizations.

While the government does recognize civil society, there is still no clear definition of civil society and no mechanism to direct budgets to organizations that do not officially 'exist'. It is therefore important to note barriers to legal registration and the importance of defining civil society.

Reports:

Government reporting remains focused on government activities, not the general HIV response, and therefore civil society activities are not captured. A report on 20 years of the response released in 2011 contains no examples of civil society activities.

The M&E framework also does not target civil society, only the government sector.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

LOW					HIGH
0	1	2	✓3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	✓2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	✓2	3	4	5

Comments and examples

There has not been any national M&E plan developed in the reporting period. Whilst the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* does specify the role of civil society organizations in evaluation and supervision, it does not clarify the mechanism for participation in this process. There is little provincial planning and civil society is also not involved in this process.

Whilst INGOs are very involved in national- and local-level monitoring and evaluation, local NGO participation in M&E activities is largely limited to the community level, though local NGOs are playing an increasing role in some provinces. HCMC and Hai Phong city, for example, involve various groups in their M&E processes. In general, however, participation in M&E is limited to the role of CSOs in monitoring their own project work, they often record and report M&E in order to protect themselves and to adhere to donor requirements. M&E project-based activities carried out by CSOs are not fed into the national M&E system.

In addition, project data obtained from M&E activities conducted by CSOs have not yet been used for planning or decision-making. Whilst PACs have working relationships with peer networks and are exposed to their opinions, their participation in data use for decision making is passive and not clear.

In 2011, one CSO (the Institute for Social Development Studies, ISDS) participated in the National M&E Technical Working Group (TWG) meetings and was also involved in surveillance and the development of tools. CSO involvement in the M&E TWG has otherwise been limited. Whilst the TWG welcomes local CSO participation, their lack of technical M&E capacity makes it difficult for them to participate. There is therefore a need to strengthen this capacity, and to ensure that CSOs are aware of the roles they can have in, and contributions they can make to, national M&E activities.

International NGOs play a crucial role in M&E in Viet Nam, but more effort is needed to improve the capacity of local civil society on monitoring and evaluation.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organisations)?

LOW					HIGH
0	1	2	3	✓4	5

Comments and examples

The level of CSO representation has increased and there are a number of capacity-building activities supported by PEPFAR and the Global Fund. There has also been an increase in the number of CSOs, particularly in HCMC, Binh Duong, Vung Tau, Vinh Long, Can Tho, Vinh Phuc, and in the participation of faith-based organizations (faiths include: Buddhism, Hoa Hao, Cao Dai and Catholicism).

The representation of PLHIV has been improving steadily and the national network (VNP+) is increasingly vocal and influential. However, whilst PLHIV representation in particular has improved, the representation of different constituencies and key affected populations has not, and the types and mechanisms of inclusion are not meaningful. There has to date been almost no real involvement of sex workers and drug users and members of these groups remain highly stigmatized as a result of committing "social evils". In addition, legal registration and regulations continue to exclude meaningful participation of these groups.

MSM networks have continued to grow, but meaningful participation of this group is also limited.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	✓3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	✓3	4	5

Comments and examples
Financial support The majority of funding comes from donors, predominantly PEPFAR, the Global Fund and DFID/the World Bank. International donor funding, however, is decreasing, making it much more difficult for civil society organizations to access funds. There is still no budget allocation for CSOs from the government as the budget law does not allow government funds to be allocated to civil society. Administrative barriers to accessing funds for self-help groups and civil society organizations are a significant obstacle, as many groups find it difficult to comply with the requirements needed to legally register. Some CSOs received small one-off grants from the HCMC PAC to organize events such as on World AIDS day. There is also only minor participation by the private sector, and more efforts to engage the private sector in providing funding and other resources are needed. Whilst the Viet Nam Chamber of Commerce and Industry has shown interest in participating, and Decree 122 provides for corporate tax exemptions for HIV-related activities, guidelines on the application of the Decree have not yet been developed. *Technical support* There is no structure or programme to improve the technical capacity of local CSOs. Technical support for organizational capacity strengthening is very limited, and comes from INGOs to hand-picked local CSOs. Technical support will also decrease with the overall reduction in international funding.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations	<25%	25-50%	51–75%	>75%
People living with HIV		✓		
Men who have sex with men			✓	
People who inject drugs	✓			
Sex workers	✓			
Transgendered people		✓		
Testing and Counselling	✓			
Reduction of Stigma and Discrimination			✓	
Clinical services (ART/OI)*	✓			
Home-based care			✓	
Programmes for OVC**		✓		

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	✓8	9	10

Since 2009, what have been key achievements in this area:

- Government bodies have a greater recognition of the role of CSOs in the HIV response and CSOs have a stronger voice. For example, they were invited to participate in the development of the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*.
- The expansion of networks, in particular PLHIV networks (for example, the membership of VNP+ has increased from 70 to 150) and networks of PWID, FSW and MSM, and improved coverage. There is also a new network of sexual partners of PWIDs, MSM working groups continue to grow and efforts to increase the participation of sex workers also increased. The capacity, collaboration and coordination of these groups have improved.
- VUSTA has become the 28th member of National Committee and represents civil society.
- Implementation of the civil society component of Global Fund Round 9.
- CSO representatives were part of the high-profile delegation that participated in the UN General Assembly High-Level Meeting in New York in June 2011.
- The number of CSOs with legal entity status has increased, and a small but growing number of local NGOs have demonstrated increased capacity for national advocacy, technical leadership and implementation.
- Increased recognition of and/or resource allocation to self-help groups by local AIDS administrations and authorities in some provinces
- Efforts to increase participation by civil society and the international community have been particularly strong.

What challenges remain in this area:

Whilst there has been some progress, there is no significant change from the previous reporting period, and challenges and limitations remain, with civil society still unable to participate meaningfully:

- There is still no government budget allocation for CSOs, and the Government still does not recognize CSOs as partners in planning, budgeting or implementing activities in the HIV response.
- CSO networks have increased in quantity, but not in diversity, and there remains a notable lack in representation of key populations at higher risk, particularly PWID and sex workers, but including other vulnerable groups such as people with a disability and people living in remote areas. CSOs also continue to lack a common voice and advocacy strategies.
- The existing legal framework and difficulties in legal registration are important barriers to civil society involvement. Furthermore, widespread stigma and discrimination and the lack of entitlement to form a legal entity due to their illegal status limits the participation of MSM, PWID and sex workers in the national response and groups from forming their own organizations.
- The capacity of CSOs in organizational development, financial management, programme management and monitoring and evaluation needs to be strengthened.
- The majority of financial and technical support to civil society comes from international donors. This is a significant issue as donors reduce their support.

It is also important to note the lack of clarity around the definition of civil society in the Vietnamese context. The government considers that mass organizations (such as the Women's Union and Youth Union) represent civil society; however, these organizations are not entirely separated from the government and thus do not genuinely represent civil society.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

☑ Yes ☐ No

If YES, describe some examples of when and how this has happened:

In 2010-2011, CSOs had some participation in the development of:

- Guidelines on reproductive health and sexual health for PLHIV
- *Decree 69/2011/ND-CP* on administrative sanctions
- *Decree 61/2011/ND-CP* on medical treatment establishments
- A draft *Decree on Substitution Treatment for Opioid Addiction* which elaborates the conditions for the recipients and delivery of MMT.
- Guideline on Substitution Treatment by Methadone and Implementation Instructions, as approved by *Decision 3140/QD-BYT*.
- Decree 122/2011/ND-CP on corporate income tax
- *Decree 13/2010/ND-CP* on social protection for OVC and people in difficult situations

However decision-making and planning are still top-down and not yet based on the reality in Viet Nam. Government engagement is case by case, passive, disconnected and informal. There is still a lack of opportunities for dialogue with the relevant government bodies, and authorities still stigmatize and discriminate against PLHIV and vulnerable groups. There is some limited engagement of PLHIV in consultation processes to develop strategies and policies, although this is usually facilitated (and always financed) by international donors, and the selection of people to represent PLHIV often happens without a fair nomination process. However, the authorities are now also beginning to engage MSM networks in programme design.

There is relatively limited involvement of PLHIV in the implementation of Government programmes, which is mostly conducted at the local level by provincial and district authorities.

II. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS	Yes	No
People living with HIV	✓	
Men who have sex with men		✓
Migrants/mobile populations	✓	
Orphans and other vulnerable children	✓	
People with disabilities	✓	
People who inject drugs		✓

Prison inmates		✓
Sex workers		✓
Transgendered people		✓
Women and girls	✓	
Young women/young men	✓	
Other specific vulnerable subpopulations *[write in]:*	✓	
Sexual partners of PWID/SW/MSM	No	

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

☑ Yes ☐ No

If Yes to question 1.1 or 1.2, briefly describe the contents of these laws:

In the Constitution of the Socialist Republic of Viet Nam from 1992, amended in 2001, the chapter on the rights and obligations of citizens has a provision that all citizens have equal rights without discrimination.

Non-discrimination has also been included in the following policy documents and laws:

- Decree 108/2008: endorses harm-reduction interventions, including the provision of needles and syringes, condoms and opiate substitution treatment. The following subpopulations are entitled to harm-reduction interventions under the Decree: sex workers and their clients, people who use drugs, PLHIV, homosexual people, migrant and mobile populations and sexual partners of all these subpopulations.
- Law on disability 51/2010/QH12 Article 14: forbidden activities include the stigmatization of and discrimination against people with a disability.
- Under national labour law, all people have the right to work, and to choose a job, career and vocational training, without being discriminated against on the grounds of gender, ethnicity, social class, religion or belief.
- National laws on domestic violence forbid domestic violence of all kinds and protect and provide support to victims.
- Under Article 4 of the Law on child protection, care and education (25/2004/QH11), children are protected, provided with care and education and enjoy the rights prescribed by law, irrespective of sex, legitimacy, adoptive status, race, creed, religion, social class, or the opinions of their parents or guardians.
- Decree 69/2011/ND-CP, updating Decree 45/2005/ND-CP, which makes provisions for administrative sanctions against those who discriminate against PLHIV or people affected by HIV in the fields of education, employment and health care.
- Law on Gender Equity (dated 29/11/2006 of the 10th National Assembly meeting 73/2006/QH11): under Article 10, forbidden activities include gender-related discrimination in all types of situation.
- Under the 1989 Law on the care and protection of people's health, people shall enjoy the right to health care when they are sick. In emergencies, people have the right to seek health care at any health facility, which has to receive patients and provide medical treatment in all cases.
- Decree 96/2007/QD-TTg of the Prime Minister includes provisions on the rights of prisoners to access to HIV treatment.

Some gaps in non-discrimination laws for some populations are also noted. There are provisions regarding HIV prevention for mobile people, particularly for mobile populations that are employed; however, there are no provisions for non-discrimination and protection of mobile populations who are not employed. Furthermore, transgender is a term that has not been included in any regulation, and there are therefore no laws or policies specifying the protection of this group.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Laws are implemented after the Government issues a Decree and the relevant Ministry issues instructions. However, the Government often delays the promulgation of laws and decrees generally from 6 months to 1 year. For example, while Decree 108/2008 mentions interventions for MSM and harm reduction for PWID, such as needle and syringe distribution, the implementation of the Decree has been limited in some provinces and some sectors (e.g. public security), and also differs from province to province depending on funding levels. There is also limited knowledge about Decree 69/2011/ND-CP (on administrative sanctions for discrimination against PLHIV) among people at the commune level, or in health facilities and enterprises etc., and thus it is not effectively implemented. There are also difficulties in implementing Decree 13/2010/ND-CP due to administrative procedures and changes in the definition of poverty. It has also been found that mechanisms to ensure the implementation of laws vary from group to group. In general, PLHIV enjoy the full benefits of the law, as do women and children, especially orphans. However, prisoners cannot always access their entitlements (e.g. timely and appropriate treatment), and anyone who falls into the "social evils" category (e.g. sex workers and people who use drugs) are often discriminated against. There are also no mechanisms for CSOs to monitor or give feedback to help ensure that laws are enforced.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Barriers to the implementation of laws include delays in promulgating decrees and in disseminating the law to law-enforcement agencies and the public, as well as a generally insufficient knowledge of laws among law-enforcement agencies and officers. The mechanisms of law enforcement are very weak, with the vast majority of issues related to legal sanctions not taken seriously; overall mechanisms for law-enforcement monitoring are weak.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

☑ Yes ☐ No

2.1. If YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS	Yes	No
People living with HIV		✓
Men who have sex with men		✓
Migrants/mobile populations	✓	
Orphans and other vulnerable children		✓
People with disabilities		✓
People who inject drugs	✓	
Prison inmates	✓	
Sex workers	✓	

Transgendered people		✓
Women and girls		✓
Young women/young men		✓
Other specific vulnerable populations[43] *[write in]:*		

Briefly describe the content of these laws, regulations or policies:

There remain inconsistencies between public security measures to control drug use and sex work and public health messages to reach the populations engaged in these activities.

- While the Law on Drug Prevention and Control No.16/2008/QH12 (Law on Drugs) has been amended to decriminalise drug use, under the Ordinance on Administrative Violations, drug use still remains an administrative violation and results in detention for up to two years in 06 centres.
- While the amendment of the Law on Drugs improves its overall consistency with the Law on HIV, contradictions remain. Under Decree 94, which guides the implementation of the Law on Drugs, drug users are subject to an additional period of 'post-detoxification management' for between one and two years. This is after completing compulsory detoxification in 06 centres for a period of up to two years. Due to the limited access to HIV services including treatment in 06 centres, this is a barrier to PWIDs accessing effective HIV prevention, treatment, care and support services.
- The Ordinance on Prostitution Prevention and Combat 2003 prohibits "availing oneself of business service to carry out commercial sex work" or "lending a hand to commercial sex work". Anyone selling sex is subject to administrative detention in 05 centres. Due to the limited access to HIV services including treatment in 05 centres, this is a barrier to PWIDs accessing effective HIV prevention, treatment, care and support services. Recent draft amendment to the law however would stop sex workers from being detained without judicial process.

Decision 96 mandates the provision of HIV prevention, treatment and care in correctional facilities and 05/06 centres however under Decree 108 the provision of opiate substitution therapy is prohibited in these facilities. Currently, antiretroviral therapy (ART) is not available in any prisons, and only a few are providing tuberculosis (TB) treatment.

As residency in the specific district of the treatment centre is one of the eligibility criteria for the current national pilot methadone maintenance therapy (MMT) programme, migrants without official residency are not able to access these services.

Legal provision on confidentiality regarding HIV conflicts with regulations in other sectors; for example, the regulation on carrying ID which prevents access to services.

Briefly comment on how they pose barriers:

- Under the Law on Social Evils, sex work and drug use are classified as social evils. The associated stigma and discrimination prevent or delay drug users and sex workers from accessing drug-treatment, harm-reduction and other social services. The fear of being detained also poses a barrier.
- Access to HIV prevention, treatment and care services (particularly harm-reduction interventions such as condoms, needles/syringes and opiate substitution therapy) is essentially non-existent in prisons. By 2011, ART had been provided in 05/06 Centres in 29 provinces through Global Fund project activities implemented by MOLISA. Voluntary counselling and testing (VCT) and information, education and communication (IEC) services are provided in 05/06 Centres in 31 provinces through Global Fund and HAARP projects.

- Migrants and mobile populations continue to experience difficulties accessing treatment and care as a result of their mobility, long work hours, location of work sites and lack of official residency. While it is not official policy, there have been reports of PLHIV having to provide their identity card and proof of household registration before they can access treatment and there is the perception among PLHIV that this is the official policy. In addition, provincial budgets and services are planned using the household registration system. Therefore, migrants and mobile populations are often not included in local HIV plans and/or may need to pay more for services.
- Decree 67 requires disclosure to social security and people cannot access social services and benefits unless HIV status is disclosed. Stigma and discrimination constrain PLHIV from receiving social support.
- Although carrying needles, syringes and condoms is not illegal, in some provinces local authorities still consider this practice unlawful.
- Policies that require parents to disclose children's HIV status in order to access support threaten confidentiality and the protection of HIV-positive children.
- The absence of laws can also be a barrier. For example, there are no employment rights for MSM, so if they disclose they are at risk of being fired. In addition, there are no laws that mention lesbians and transgender persons.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

☑ Yes ☐ No

Briefly describe the content of the policy, law or regulation and the populations included:

The laws on domestic violence and gender equality have general provisions on domestic violence and sexual violence.

The 2011 anti-trafficking law and the regulations on the prevention of cross-border trafficking mention the protection of women with HIV.

However, women in vulnerable groups are not treated equally and sanctions for disadvantaged groups such as sex workers are more severe than for other people. There is also no specific article mentioning the protection of women living with HIV and FSW.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

☑ Yes ☐ No

If YES, briefly describe how human rights are mentioned in the HIV policy or strategy:

The newly developed *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* states clearly that respect for human rights needs to be ensured; stigma and discrimination countered; the responsibility of families and society for taking care of PLHIV increased; equity in treatment and care for PLHIV ensured; gender equity ensured; and care for children and vulnerable groups, as well as ethnic minorities and people living in remote areas provided.

Under Article 4 of the Law on HIV, PLHIV have the right to live within the community and society; to receive medical treatment, care, education and employment; to keep private their HIV status; to refuse medical examination and treatment for full-blown AIDS [sic] and other rights as stipulated in the Law on HIV and other related laws.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

☑ Yes ☐ No

If YES, briefly describe this mechanism:

Decree 07/2007/ND-CP provides guidance on legal aid legislation, and article 3 states that PLHIV are eligible to free legal aid.

Under the Decree on administrative sanctions for violations in the health sector, fines can be issued if provisions in the Law on HIV are violated.

Five donor-funded legal aid clinics exist to provide free or reduced-cost legal support services for PLHIV whose rights have been violated under the Law on HIV. In addition, support is provided by the Government at Centres for Legal Support under the Department of Justice. A policy document states that the Department will provide this support free of charge in some provinces where PLHIV are a target group for receiving legal assistance.

There continued to be increased efforts to improve PLHIV's awareness of their rights in the reporting period.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment			Yes			
HIV prevention services			Yes			
HIV-related care and support interventions			Yes			

If applicable, which populations have been identified as priority, and for which services?

The Law on HIV stipulates that the State should provide ART free for charge to the following groups of PLHIV: 'people who have been exposed to or infected with HIV due to occupation, people who have been infected with HIV due to risks of medical techniques, HIV-infected pregnant women and HIV-infected under-six children'. It also stipulates that government- and donor-funded ART should be provided to these groups as a priority, with other PLHIV receiving ART once these populations have been treated. This means that some PLHIV do still pay for treatment.

Currently, most of the funding for ARV medicines comes from international sources. As international organizations gradually withdraw their aid, there is a concern that access to medicines and other services will no longer be free.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

☑ Yes ☐ No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the *context of pregnancy and childbirth?*

☑ Yes ☐ No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

☑ Yes ☐ No

If YES, Briefly describe the content of this policy/strategy and the populations included:

The Law on HIV mandates the equitable access to prevention, treatment and care to all populations in need of these services, regardless of their socio-economic status.

8.1. If YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

☑ Yes ☐ No

If YES, briefly explain the different types of approaches to ensure equal access for different populations:

Under the Law on HIV, key populations at higher risk are given priority with regards to access to IEC on HIV prevention and control (Article 11); and harm reduction interventions (Article 21).

However, the Law on HIV does not specify targeted approaches for the following key populations at higher risk: MSM, female PWIDs, prisoners, people in administrative detention, and migrant and populations.

The eight Programmes of Action (POA) provide guidance on the needs of key populations at higher risk. For example the Harm Reduction POA provides specific guidance for PWIDs, SW and detainees in 05/06 centres. Decree 108 stipulates harm reduction services for all key populations at higher risk.

Decision 96 on support to PLHIV in prisons and administrative detention centres provides for the provision of HIV prevention, treatment and care in these settings. However, access to HIV prevention, treatment and care services (particularly harm-reduction interventions such as condoms, needles/syringes and opiate substitution therapy) is basically non-existent in prisons. ART services in closed setting are improving slightly: by 2011, ART had been provided in 05/06 Centres in 29 provinces through Global Fund project activities implemented by MOLISA. Voluntary counselling and testing (VCT) and information, education and communication (IEC) services are provided in 05/06 Centres in 31 provinces through Global Fund and HAARP projects.

PWID and SW are discriminated against under other legislation (see above). This means in practice that they do not have equal access.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

☑ Yes ☐ No

If YES, briefly describe the content of the policy or law:

The Law on HIV and Decree 108 contain provisions that HIV tests are not required for recruitment, with the exception of pilots and a number of special careers in national security and defense (under Article 20 of Decree 108). However, in practice there are instances where HIV screening does occur.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

☐ Yes ☑ No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

☐ Yes ☑ No

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key popula- tions concerning their rights (in the context of HIV)?

☑ Yes ☐ No

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?

☑ Yes ☐ No

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

☑ Yes ☐ No

b. Private sector law firms or university-based centres to provide free or reduced cost legal services to people living with HIV

☑ Yes ☐ No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

☑ Yes ☐ No

If YES, what types of programmes?	Yes	No
Programmes for health care workers	✓	
Programmes for the media	✓	
Programmes in the work place	✓	
Other *[write in]:*	✓	
Ambassadors (prominent people who use their role to reduce stigma and discrimination)		

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor									Excellent
0	1	2	3	5	6	✓7	8	9	10

Since 2009, what have been key achievements in this area:

There are several newly passed laws on human rights issues related to HIV and existing laws were updated and revised in the reporting period, including: the 2011 anti-trafficking law (66/2011/QH12); the Law on Disability *(51/2010/QH12); Decree No. 69/2011/ND- CP* on administrative sanctions in health care; *Decree 91/2011/ND-CP* on administrative sanctions in the field of protection, care and education for children; and *Decree No.13/2010/ND-CP* on school-fee exemptions for children with special circumstances. There has also been some noticeable progress on the decriminalization of sex work.

There is also an increased recognition of drug users as patients who require medical assistance, and a small reduction in drug users in 06 Centres.

What challenges remain in this area:

While there has been progress, with new laws promulgated and existing laws amended, inconsistencies between laws and their effective implementation remains a challenge. All key populations at higher risk remain highly stigmatized despite legal documents.

Despite the amendment to the Law on Drugs in the previous reporting period, the following issues remain of concern:

- Although drug use has been decriminalized, drug users are still subject to administrative detention for up to two years.
- Under Decree 94, drug users can be detained for an additional one to two years after they have already served up to two years in 06 Centres.

Although a review of the implementation of the Ordinance on Sex Work is underway, the Ordinance as it currently stands poses a barrier to SW accessing HIV services as they are subject to administrative detention in 05 Centres.

There also continues to be a basic lack of human rights, including HIV treatment, care and prevention services, for people in closed settings.

Low compliance with the Law on HIV, especially in the area of stigma and discrimination, continues.

Compliance with regulations is low among law-enforcement agencies and monitoring mechanisms and sanctions are very weak.

Decree 45 (2010) guides the development of social associations but creates a barrier to the establishment of associations of vulnerable groups, as a group cannot register with a name or terms of reference which overlap with those of an existing organization. As the Viet Nam HIV/AIDS Association has been formally established, no PLHIV self-help group is able to register.

Under Decree 12/2003/ND-CP, PLHIV are currently barred from accessing fertility treatment, including "sperm washing" and IVF, making it more difficult for them to conceive children safely.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor									Excellent
0	1	2	3	✓5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

There is increased knowledge within civil society about the law in general and human rights in particular compared with the previous reporting period (which has led to greater criticism of the national response). Efforts to reduce stigma and discrimination in schools and health care systems have also improved.

However, while the Government increasingly enshrines human rights issues relating to HIV in law and policy, compliance with the law is not universal, and stigma and discrimination still exist.

What challenges remain in this area:

The implementation of laws remains weak due to:

- The late introduction of developed policies to commune authorities, law enforcement agencies and the community, and a limited understanding of HIV-related policies among those who implement them.
- The remaining inconsistencies between public security measures to control drug use and sex work and public health measures to reach the populations engaged in these activities.
- Stigmatization of and discrimination against key populations at higher risk and PLHIV continues.
- A lack of remedies and penalties for violations of the law.

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

☑ Yes ☐ No

If YES, how were these specific needs determined?
Specific prevention programme needs are determined by reviewing available epidemiological data and ensuring geographical prioritization in close collaboration with key partners. This is an ongoing process that happens at national/provincial/district/commune level and takes into account the current epidemiological situation as well as evidence to ensure the scale-up of effective prevention services. However, there need to be greater efforts to prioritize and scale up HIV-prevention services and ensure they are sustainables.
If NO, how are HIV prevention programmes being scaled up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)	N/A
Blood safety				✓	
Condom promotion			✓		
Harm reduction for people who inject drugs			✓		
HIV prevention for out-of-school young people		✓			
HIV prevention in the workplace		✓			
HIV testing and counselling			✓		
IEC on risk reduction			✓		
IEC on stigma and discrimination reduction			✓		
Prevention of mother-to-child transmission of HIV			✓		
Prevention for people living with HIV			✓		
Reproductive health services including sexually transmitted infections prevention and treatment			✓		

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)	N/A
Risk reduction for intimate partners of key populations		✓			
Risk reduction for men who have sex with men		✓			
Risk reduction for sex workers			✓		
School-based HIV education for young people			✓		
Universal precautions in health care settings		✓			
Other *[write in]:*					
Prevention services in closed settings; Prevention services for mobile groups (truck drivers, seasonal migrant workers and migrant workers in industry)		✓ ✓			

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very Poor									Excellent
0	1	2	3	5	6	7	✓8	9	10

Since 2009, what have been the key achievements in this area:

There have been a number of notable achievements in the reporting period:

- Prevention programmes for key populations at higher risk have been included in the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030.*
- Prevention programmes for youth in schools were officially introduced in curricula at secondary schools.
- The methadone maintenance therapy programme has been expanded to 11 provinces.
- In recognition of the rising incidence among MSM, a problem that until recently was largely hidden except in the larger cities, many provinces are now implementing programmes explicitly targeted at prevention among MSM. Prevention programmes for MSM have been included in the *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030* and the National MSM Technical Working Group continues to grow.
- Business law has encouraged enterprises to recruit PLHIV by reducing tax and HIV prevention strategies in the workplace are obligatory, thereby also strengthening HIV prevention measures in enterprises.
- Networks of PLHIV, PWID, SW and MSM have been recognized and mobilized to be more active in the HIV response.

- The incidence of new cases among PWIDs has been declining steadily and incidence/prevalence among SWs has remained low. This indicates a degree of success of the prevention programmes, and is largely due to large-scale (donor-funded) needle and syringe programmes and 100% condom use programmes among PWIDs and SWs.
- Surveys now show very high rates of condom use among SWs and indicate quite a high level of awareness about the risk of HIV and how to prevent infection.
- PMTCT, HIV testing and counselling and blood transfusion have also improved.

What are remaining challenges in this area:

Whilst prevention programmes in the past two years have made notable achievements they have yet to fulfill the needs of the community:

- Whilst there has been a scale up of harm reduction and there is a greater recognition that people who use drugs need medical care, services are still limited and PWID do not access services due to fear of being detained in compulsory 06 Centres.
- Prevention programmes for sexual partners of PLHIV and people who use drugs were not formally included in the new *National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030*.
- Whilst there has been progress in the response for MSM, rising incidence among MSM remains a concern. Challenges remain in accessing prevention services, in particular for MSM located in rural areas.
- Testing and counselling services differ in availability and quality from province to province, and with little availability in rural areas. In general, counselling services are of particularly low quality.
- IEC for risk reduction is mostly project oriented, targeting just some key populations at higher risk and not necessarily reaching all people in need.
- There is a lack of integration of reproductive health/STI and HIV services and there is no separate HIV prevention programme for PLHIV as it is integrated with testing and counselling.
- There are significant differences throughout the country in terms of HIV prevention programmes; provinces with greater donor support have a better quality of services.

As there is significant dependence on international donor support, the sustainability of HIV prevention activities is a concern.

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

☑ Yes ☐ No

If YES, how were these specific needs determined?

Treatment guidelines specify the package of services.

Existing support for PLHIV includes: psychological support; legal and social support; support for OPC registration; stigma- and discrimination-reduction activities; economic development: loans, job creation; group meetings for capacity building; nutrition support, particularly for children; home-based care; education support; OVC programme; palliative care; sexual and reproductive health; TB treatment; OI prophylaxis; treatment for STIs and other infections. There are also national guidelines for the early treatment of hepatitis B and for PMTCT.

Treatment, care and support services have expanded in recent years.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)	N/A
Antiretroviral therapy			✓		
ART for TB patients			✓		
Cotrimoxazole prophylaxis in people living with HIV			✓		
Early infant diagnosis		✓			
HIV care and support in the workplace (including alternative working arrangements)		✓			
HIV testing and counselling for people with TB			✓		
HIV treatment services in the workplace or treatment referral systems through		✓			
Nutritional care			✓		
Paediatric AIDS treatment			✓		
Post-delivery ART provision to women			✓		
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)		✓			
Post-exposure prophylaxis for occupational exposures to HIV			✓		
Psychosocial support for people living with HIV and their families			✓		
Sexually transmitted infection management			✓		
TB infection control in HIV treatment and care facilities			✓		
TB preventive therapy for people living with HIV			✓		
TB screening for people living with HIV			✓		
Treatment of common HIV-related infections			✓		
Other *[write in]:*					
Home based care			✓		
Palliative care			✓		
Treatment in closed settings		✓			

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor									Excellent
0	1	2	3	5	6	✓7	8	9	10

Since 2009, what have been key achievements in this area:

The coverage of services (such as ART, PMTCT, livelihoods support and STI treatment) has expanded, and the services provided are more comprehensive, with an increase in programmes that recognize the value of a holistic response to treatment and care, including for families affected by HIV. Care and support services have been expanded, with an increased number of CSO support groups; the capacity and knowledge of CSOs to provide these services has also increased. Steps have also been taken to work across government ministries and departments to ensure cooperation and a coordinated response.

Treatment 2.0 will be piloted in Viet Nam, helping to increase the number of people able to access treatment and care services. TB screening for PLHIV is also now available in almost all provinces and an Early Infant Diagnosis Test for children has also been initiated.

What challenges remain in this area:

Whilst there has been significant progress, a number of treatment-related challenges remain:

- Stigma and discrimination still exist, with health service staff particularly guilty. Stigma and discrimination are challenges for ART access as many patients refuse treatment because of the risks of unintended disclosure. In addition, some PLHIV do not want to start ART because of associated financial costs and the perceived complication of ART.
- TB treatment services for PLHIV are still not adequate and in most provinces, ART regimens are not changed when patients undertake TB treatment; in addition, many TB patients are unable to access ART early enough. In some provinces, 2-line regimen ARV medicines or medications for HepB/C treatment are unavailable.
- Post-exposure prophylaxis is only available to some professionals (such as military and health staff) and in the case of rape no treatment is provided. While early testing for infants is provided in some provinces, in others only some infants get tested, while others do not know their results.
- Treatment inside 05/06 Centres and prisons remains very limited. PLHIV often have to transfer medicine from outside, which costs a considerable amount, or interrupt their treatment, which increases the risk of drug resistance.
- Whilst it is foreseen that the Treatment 2.0 pilot will increase the number of patients on ART, there are concerns that as medicine provision will be decentralized to wards/communes, patients will be afraid to disclose their HIV status. The capacity of staff at the commune level is also a concern.
- The role of CSOs in treatment, care and support has not been fully recognized. The obstacles faced by CSOs, such as difficulties in legal registration, make it difficult for them to provide services.
- Sustainability is an issue in light of reductions in international funding. In addition, when Viet Nam signs the Asia-Pacific Trade Agreement, which will mean that generic ARV medications are no longer available due to rules on intellectual property rights, patients will face more difficulties in accessing treatment because of increased prices of ART.

Improving the quality of services requires a comprehensive solution, including professional training to enhance the quality of the workforce, retaining health professionals working in HIV, institutional reform for better management (such as relocating OPC to hospitals), etc.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

☑ Yes ☐ No

2.1. If YES, is there an operational definition for orphans and vulnerable children in the country?

☑ Yes ☐ No

2.2. If YES, does the country have a national action plan specifically for orphans and vulnerable children?

☑ Yes ☐ No

2.3 If YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

☐ Yes ☑ No

2.4. If YES, what percentage of orphans and vulnerable children is being reached?

N/A

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor									Excellent
0	1	2	3	5	6	✓7	8	9	10

Since 2009, what have been key achievement in this area:

- The number of HIV-positive infants born to HIV-positive mothers has reduced significantly due to the expansion of PMTCT, and early testing for infants born to mothers with HIV has been initiated. There has also been an expansion of nutritional support, and infants born to HIV-positive mothers receive formula milk. The accessibility and coverage of ART for OVC is high.Better collaboration between the Government and CSOs in the provision of treatment, care and support for OVC and the expansion of CSOs providing these services. There is continued commitment to the National Plan of Action on Children affected by HIV (NPA), despite a rapid decline in international donor funding for OVC.

What are remaining challenges in this area:

- There is still strong stigma and discrimination, which poses a barrier to school attendance for many children.
- Some families prevent children from accessing treatment due to poor knowledge.
- There is a lack of data on OVC, which makes planning and evaluation of OVC programmes difficult.
- The ongoing institutionalization of OVC and the limited development of alternative models, such as foster care and community-based care, other than small-scale pilots and the commitment in the NPA.
- The NPA remains unfunded.

CONSULTATION LIST FOR NCPI PART B

Civil Society Organizations

1. Accompany - Da Nang
2. ACP+ (VNP+)
3. ACP+ (VNP+) - Hai Duong
4. Adamzone - Can Thơ
5. AIDS Association - Viet Nam Buddism Institute- HCMC
6. Alo Ban Me
7. Blue belief - Hai Duong
8. Bright Future - Bac Giang
9. Bright Future - Ha Noi
10. Bright Future - Thai Nguyên
11. Bright Future - Vinh Phuc
12. Bullet point
13. Care group - Long An
14. Caritas Viet Nam
15. CCIHP
16. CCLPHH
17. CCRD
18. CEPHAD
19. Children's sun - Ha Noi
20. CHP
21. CKT - Nha Trang
22. COHED
23. Collective actions - Vinh Phuc
24. Countryside - Cam Giang - Hai Duong
25. Empathy Cluc - Thanh Xuan Trung
26. Flamboyant - Hai Phong
27. Future Centre of Community Research and Development
28. G-Link – HCMC
29. Green Pinetree - Ha Noi
30. Home - Ha Noi
31. Hope - An Giang
32. Hope - Da Nang
33. Hope - Long An
34. Hope network - Bac Kan
35. Hope network Bach Thong - Bac Kan
36. Hope network - Thai Binh
37. HTX Sông Lam Xanh
38. HTX Sông Lam Xanh
39. Immortal flowers - Van Don - Quang Ninh
40. ISDS
41. Light
42. Lotus scent Phap Van
43. Love and serve - Da Nang
44. Mai Hoa charity clinic - Dong Nai
45. Moon - Hai Duong
46. Moving forward - HCMC
47. Nang cuoi troi - Vinh Phuc
48. New life - Can Tho
49. New Life – HCMC
50. Online – HCMC
51. Outreach to MSMS - Can Tho
52. Peaceful place - Ha Noi
53. PLHIV self-help group network - Can Tho
54. PSN MSM Youth Leadership Fellow/ Ha Noi focal point for National MSM Working Group (PSI)
55. PUSTA Binh Duong
56. PUSTA HCMC
57. PUSTA Vinh Long
58. PUSTA Vung Tau
59. Quang Hanh Mine Land Club
60. Quang Ninh Young Women Network
61. REACOM
62. Safe living – HCMC
63. Sea love - Hai phong
64. Self-help group network - Hai Phong
65. Self help group network - Tan Thanh - Ba Ria Vung Tau
66. Spirit programme - HCMC
67. SPN+ (VNP+)

68. Sunshine network - Daklak
69. The moon - Ha Noi
70. VCSPA
71. VCSPA – HCMC
72. VICOMC
73. VNP+
74. VUSTA
75. VUSTA - Hai Duong
76. VUSTA Project Management Unit - Global Fund Project on HIV/AIDS
77. We are students/MSM network in the North
78. White sand
79. Women living with HIV in the South - Nha Trang - Khanh Hoa
80. Women's Health Centre - Ha Noi
81. You and I - Dong Nai
82. You, I, and We - HCMC

Business Enterprises

1. Vinatex
2. VCCI

Bilaterals

1. AusAID - Embassy of Australia
2. DFID
3. PEPFAR

International Non-Governmental Organizations

1. Abt Associates
2. Care International
3. Catholic Relief Services
4. Medical Committee Netherlands Viet Nam (MCNV)
5. Family Health International (FHI)
6. Healthright International
7. Pact Viet Nam
8. Save the Children
9. World Vision

United Nations Agencies

1. International Labour Organization (ILO)
2. International Organization for Migration (IOM)
3. The Joint United Nations Programme on HIV/AIDS (UNAIDS)
4. United Nations Population Fund (UNFPA)
5. The United Nations Children's Fund (UNICEF)
6. The United Nations Office on Drugs and Crime (UNODC)
7. World Health Organization (WHO)

ANNEX 3

NATIONAL AIDS SPENDING ASSESSMENT (NASA)

Indicator 6.1: Domestic and international AIDS spending by category and financing source for the period 2009-2010

1. Methodology

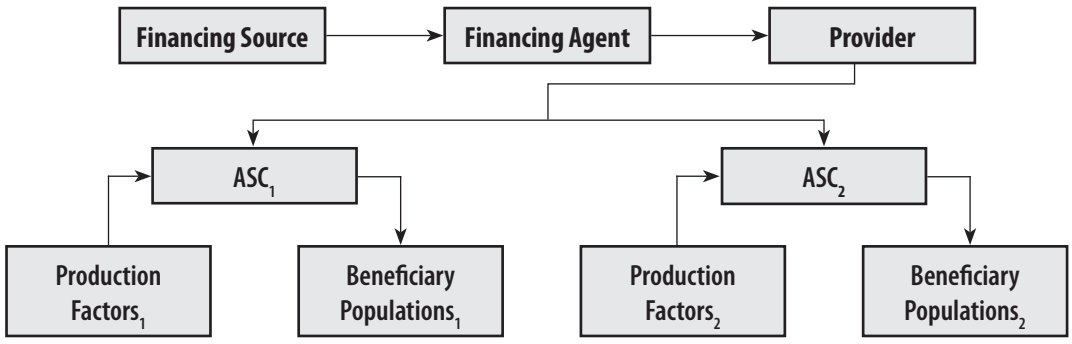
In order to report against indicator 6.1: Domestic and international AIDS spending by category and financing source for the period 2009-2010, a second round of the National AIDS Spending Assessment (NASA) was conducted in 2011.

The National AIDS Spending Assessment (NASA) approach to resource tracking uses a comprehensive and systematic methodology to determine the flow of resources intended to support the national HIV response. The tool tracks actual expenditure (public, private and international) in both the health and the non-health sectors (social mitigation, education, labour and justice) which comprise the national response to HIV.[66]

The NASA systematically captures the flow of financial resources from their origin to their ultimate beneficiaries via various sources and service providers, and as delivered through a range of transactional mechanisms. The NASA defines a transaction as comprising the flow of financial resources from their initial transfer to an HIV service provider to their final administrative or programmatic expenditure in support of a beneficiary population (see Figure 1).

The methodology applies both top-down and bottom-up resource-tracking techniques to obtain and consolidate expenditure information. The top-down approach tracks sources of HIV funding from donor reports, commitment reports and Government budgets; bottom-up

Figure 1
Financial flow scheme



[66] National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV financing flows and expenditure at country level. UNAIDS, 2006.

tracking captures HIV expenditure from service providers' expenditure records, facility-level records and governmental department expenditure accounts.

The NASA classification follows internationally accepted standard accounting methods and procedures, including the framework of the National Health Accounts (NHA) system. Tracked financial flows and AIDS expenditure are organized across three dimensions: financing; the provision of HIV services; and the use of HIV services. These dimensions incorporate six categories: [67]

Financing

1. Financing Agents (FA) (also known as Purchaser Agents) are entities that pool financial resources to finance service provision and make programmatic decisions regarding the type of activities and the specific service provider involved in actual service delivery.
2. Financing Sources (FS) are entities that allocate funding to HIV in general and provide money to financing agents

Provision of HIV services

3. Providers (PS) are entities that engage in the production, provision and delivery of HIV services.
4. Production factors/resource costs (PF) are inputs (labour, capital, natural resources, "know-how" and entrepreneurial resources).

Use

5. AIDS spending categories (ASC) are HIV-related interventions and activities.
6. Beneficiary populations (BP) are groups targeted with services, such as PLHIV and people who inject drugs

The first NASA was conducted in 2010 by the Viet Nam Authority of HIV/AIDS Control (VAAC). It captured AIDS expenditure by nearly all national and international funding sources in Viet Nam over the two-year period 2008-2009. The second NASA followed the same methodology and was conducted in late 2011 to provide data for the Country Progress Report..

2. Preparatory phase and data collection

A NASA orientation workshop was jointly organized by VAAC and UNAIDS Viet Nam on 12 December 2011 for all key national and international partners in the HIV response, including Government officials, civil society organizations, UN representatives and bilateral agencies. Following the workshop, VAAC formally sent information and a request letter to all relevant ministries, institutions, donor agencies, international non-profit organizations and other stakeholders, asking them to support the NASA process and provide data.

The NASA data-collection form (see Appendix 3c below) was prepared based on the NASA Manual guidelines and lessons learned from the previous NASA round.[68]

---

[67] For more detail please refer to National AIDS Spending Assessment (NASA) Classification and Definition. UNAIDS, 2009

[68] For more detail please see the "Guide to produce National AIDS Spending Assessment". UNAIDS, 2009.

The data-collection process often required several visits to each relevant organization, including follow-up visits to clarify areas of confusion relating to the classification and recording of AIDS expenditure by category, or when inconsistencies were found in the data received. To the greatest extent possible, individual materials were collected from each funding source to improve understanding of the different types of intervention, implementation modalities and beneficiaries, project documents, annual reports, progress reports, annual work plans and budgets associated with the various funding entities. The NASA data-collection process lasted approximately three months.

3. Secondary data sources and estimationh

Secondary data were used to provide estimated expenditure when actual expenditure reports were unavailable, including: :

- Human resources: VAAC routine reporting data were used to estimate expenditure on human resources in both the health and non-health sectors – the latter including staff of Provincial AIDS Committees and those working on HIV within Departments of Labour, War Invalids and Social Affairs; Education and Training; Public Security; and Information and Communication. Human resources include full-time and part-time staff at the provincial, district and commune levels.
- Out-of-pocket expenditure by PLHIV and their families: the findings from the USAID Health Policy Initiative (HPI) survey of out-of-pocket expenditure, conducted in 2010, were used.
- For household expenditure on HIV testing, the information collected during the first NASA round was used.
- Expenditure in the labour sector on AIDS-related services, including: support for children and adults living with HIV in public orphanages and social welfare centres; the payment of incentives to staff who care for AIDS patients; and the payment of basic health care support for detainees in rehabilitation centres. Information on this expenditure was based on monitoring data provided by the Ministry of Labour, War Invalids and Social Affairs collected during the first round of the NASA.
- Overhead expenditure by PACs: the average of the overheads expenditure reported by some PACs was used to estimate expenditure by the PACs that did not report against this requirement.

4. Data processing and analysis

The data processing process consisted of four stages.

Stage 1: Upon receipt, all data were immediately checked for consistency, clarity and detail. If any data inconsistency was discovered, the submitting organization was contacted for clarification.

Stage 2: Once the data were deemed complete and consistent, NASA financial transactions were reconstructed using a pre-designed Excel sheet. This necessitated assigning a particular

NASA classification to each expenditure item. This stage also entailed cleaning the data, as well as triangulating the three dimensions (source, provision and use) and five vectors (source, agent, providers, AIDS expenditure category and beneficiary population) to ensure consistency.

Stage 3: Given the large volume of data involved, the NASA team used Stata software to complete the analysis.

Stage 4: Stata was used to generate the NASA tables.

5. Assumptions, limitations and challenges

There were a number of limitations and challenges associated with conducting the second round of the NASA in Viet Nam.

Firstly, there are significant variations in accounting systems, fiscal years and the classification of spending categories among national institutions and donor-supported projects. For example, the PEPFAR fiscal year starts on 1 October and ends on 30 September the following year, while the Government fiscal year follows the calendar year. Adjustments were therefore made where appropriate.

Secondly, reported financial expenditure was taken as actual expenditure when there was no other available information. This may have resulted in overestimation of actual expenditure.

Thirdly, as mentioned above, it was necessary to estimate AIDS expenses for certain items based on secondary data and costing estimations, potentially leading to overestimation of expenditure in certain spending categories.

6. Overview of AIDS expenditure in 2009-2010

To ensure the most comprehensive possible scope, the NASA sought to collect AIDS expenditure data from all organizations involved in supporting the HIV response in Viet Nam, including the public sector, bilateral donors, multilateral institutions, international non-profit organizations and the private sector.

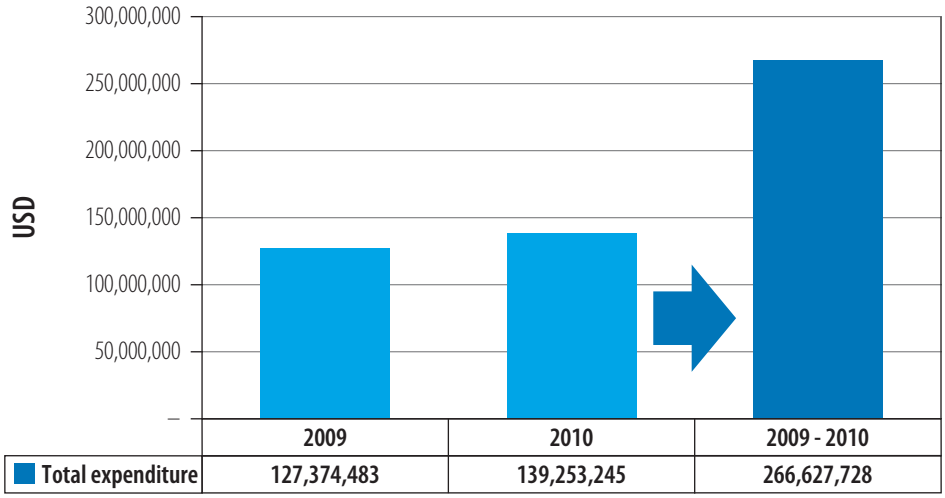
Figure 2
Type and number of organizations providing AIDS expenditure data

Type of respondent organization	Number of respondent organizations
Public organizations	44
Bilateral organizations	9
Multilateral organizations	7
International non-profit organizations	10
International for-profit organizations	1
Total	**71**

Total national AIDS expenditure 2009-2010

According to the NASA findings, US$266.6 million were spent on supporting the national HIV response in the period 2009-2010.

Figure 3
Total national AIDS expenditure, 2009-2010



AIDS expenditure accounted for 0.13% of GDP, while per capita AIDS expenditure was US$1.54

AIDS expenditure by financing source

The NASA defines financing sources as "entities that provide money to financing agents". HIV-related activities in Viet Nam were supported in 2009-2010 by three major sources: public, private and international funds. Total expenditure by, and the proportional share of, each major financing source in 2009-10 are illustrated in Figures 4 and 5.

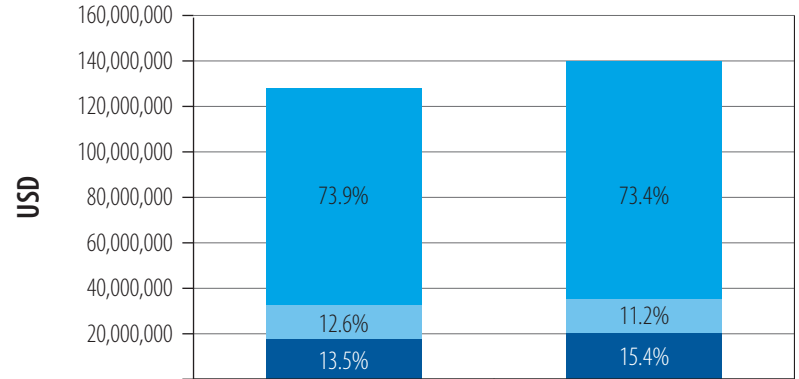
Figure 4
Summary of AIDS expenditure in Viet Nam by financing source, 2009-10 (US$)

SOURCES	2009	2010	TOTAL 2009-10	%
PUBLIC SOURCES	**17,176,061**	**21,431,087**	**38,607,148**	**14.5%**
Central Government (including National Targeted Programme)	6,737,254	9,193,116	15,930,370	6.0%
Provincial Government	10,438,807	12,237,971	22,676,778	8.5%
PRIVATE SOURCES	**16,036,519**	**15,600,379**	**31,636,898**	**11.9%**
For-profit institutions	144,812		144,812	0.1%
Households	15,891,707	15,600,379	31,492,086	11.8%
INTERNATIONAL SOURCES	**94,161,903**	**102,221,779**	**196,383,682**	**73.7%**
Bilateral organizations	70,785,002	84,013,483	154,798,484	58.1%
Government of Australia	2,471,859	1,502,842	3,974,701	1.5%
Government of Canada	137,207	300,000	437,207	0.2%

Government of Denmark		4,176,787	4,176,787	1.6%
Government of France	598,866	321,443	920,309	0.3%
Government of United Kingdom	2,256,690	7,534,127	9,790,817	3.7%
Government of United States (PEPFAR)	63,926,353	69,340,357	133,266,710	50.0%
Government of Germany	158,083		158,083	0.1%
Government of Ireland	398,397	117,000	515,397	0.2%
Government of Netherlands	385,379	502,195	887,574	0.3%
Government of Sweden	448,912	159,897	608,809	0.2%
Other Governments (Japan, Luxembourg, Norway)	3,255	58,835	62,090	0.0%
Multilateral organizations	22,975,232	17,512,495	40,487,727	15.2%
Asian Development Bank (ADB)	6,320,161	6,152,088	12,472,249	4.7%
Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	5,829,561	6,650,517	12,480,078	4.7%
UN agencies	1,670,997	1,343,508	3,014,505	1.1%
World Bank	8,443,611	1,849,216	10,292,827	3.9%
Multilateral funds or development funds n.e.c.	710,902	1,517,166	2,228,068	0.8%
International non-profit organizations	401,670	695,801	1,097,471	0.4%
The Bill and Melinda Gates Foundation	46,697	20,887	67,584	0.0%
Ford Foundation	14,880		14,880	0.0%
Other international non-profit organizations	340,093	674,914	1,015,007	0.4%
TOTAL	**127,374,483**	**139,253,245**	**266,627,728**	**100.0%**

In 2009-2010, the Government contributed a total of US$38.6 million towards the national HIV response; US$154.8 million came from bilateral donors (including US$133 million from PEPFAR); and US$40.5 million came from multilateral organizations. Households paid about US$31.6 million, while international non-profit organizations provided approximately US$1.1 million.

Figure 5
National AIDS spending by 3 main financing sources 2009 - 2010



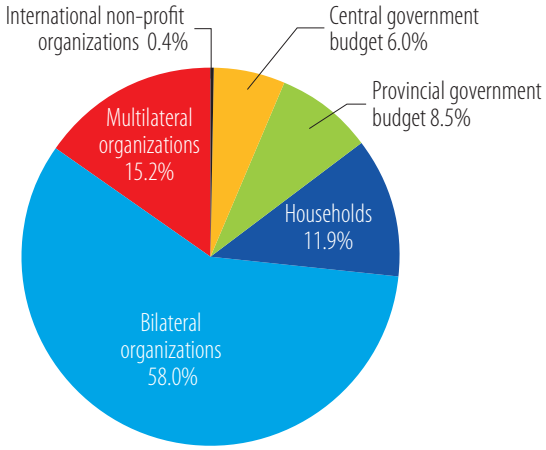
	2009	2010
International	94,161,903	102,221,779
Private	16,036,519	15,600,379
Public	17,190,707	21,445,732

International sources contributed 73.7% of total AIDS resources in 2009 and 2010, of which 58% came from bilateral grants and 15.2% from multilateral sources.

PEPFAR alone contributed around 50% of total AIDS resources in Viet Nam, these funds constituting 86% of all bilateral contributions in the period 2009-2010. International non-profit organizations contributed 0.4% to all expenditure.

The Government budget, including the central and provincial budgets, provided for 14.5% of the overall AIDS expenditure, while households contributed around 12%.

Figure 6
Share of major sources in total national AIDS expenditure, 2009 - 2010



AIDS expenditure by spending category

The NASA also allows for the tracking of AIDS expenditure by programmatic area. The NASA categorises such expenditure across eight core areas of HIV intervention. The distribution of expenditure by AIDS spending category (ASC) is summarised in Figure 8.

Figure 7
Share of major ASC in total expenditure, 2009-2010

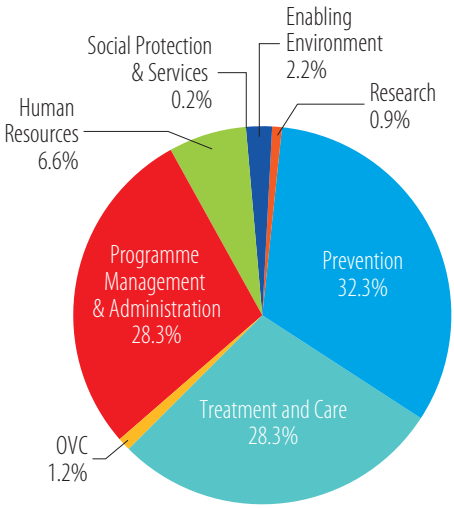
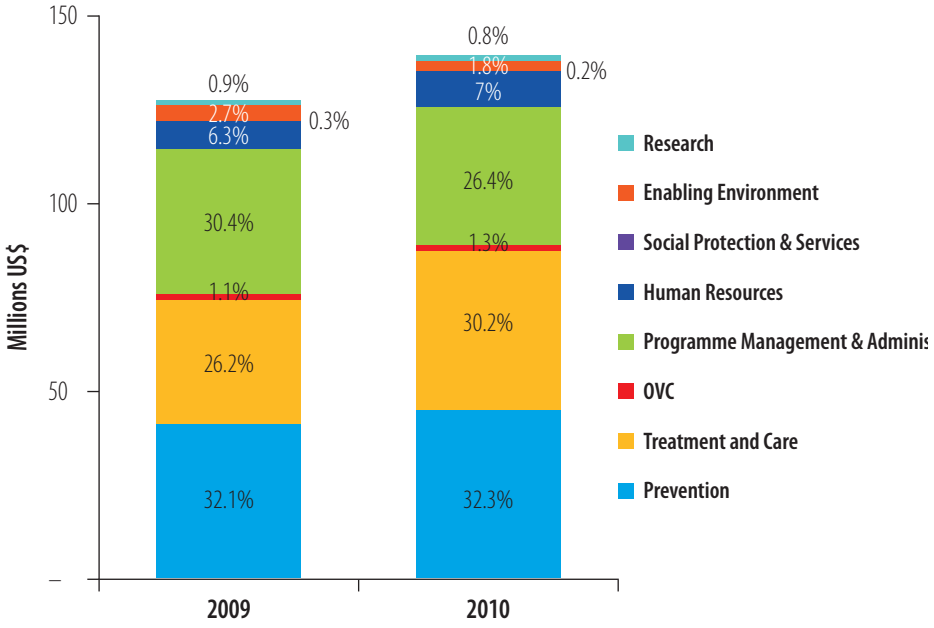


Figure 8
Distribution of expenditure by ASC, 2009 - 2010



In 2009 and 2010, three spending categories received the majority of resources: prevention (32%); treatment and care (28%); and programme management and administration strengthening (29%). Human resources accounted for 7% of the overall expenditure, the enabling environment for 2%, orphans and vulnerable children (OVC) and research for 1% each and social protection for less than 1%.

Absolute figures for prevention expenditure increased from US$41 million in 2009 to US$45 million in 2010, but the proportion of spending on prevention compared to overall spending remained the same (32%). Spending on treatment and care expanded in 2010 both in absolute figures and proportionally – from US$33.8 million (26%) in 2009 to US$42.6 million (30%). However, programme management and administration strengthening expenditure reduced slightly in this period, from US$38.8 million (30%) in 2009 to US$36.8 (26%) in 2010.

Expenditure on OVC was small in volume, but increased from US$1.4 million in 2009 to US$1.8 million in 2010. Spending on human resources also increased slightly in both absolute figures and proportionally, while social protection and services, the enabling environment and research have seen a decline in expenditure.

AIDS expenditure by beneficiary population

The NASA also allows for the classification of AIDS expenditure by beneficiary population. The NASA methodology classifies beneficiary populations into six major categories: the general population; people living with HIV (PLHIV); most-at-risk populations; specific "accessible" populations; other key populations; and non-targeted interventions. Figures 9 and 10 itemize annual AIDS expenditure by the six categories of beneficiary in 2009-2010.

During 2009-2010, 31% of AIDS expenditure benefited PLHIV. Activities targeting most-at-risk populations (including people who inject drugs, men who have sex with men and female sex workers) received 16% of total AIDS expenditure. Other key population groups, including OVC, pregnant women, migrants, prisoners, partners of PLHIV and recipients of blood or blood products, benefited from 5% of total AIDS expenditure. Activities for specific "accessible" populations, including people attending STI clinics, factory employees, the military and students, received 2% of total AIDS expenditure. The general population benefited from 10% of total AIDS expenditure, while 36% of total expenditure supported non-targeted activities, including training, programme management and administration, monitoring and evaluation and investment in infrastructure.

Figure 9
Disaggregation of AIDS expenditure by six beneficiary population groups, 2009 -2010

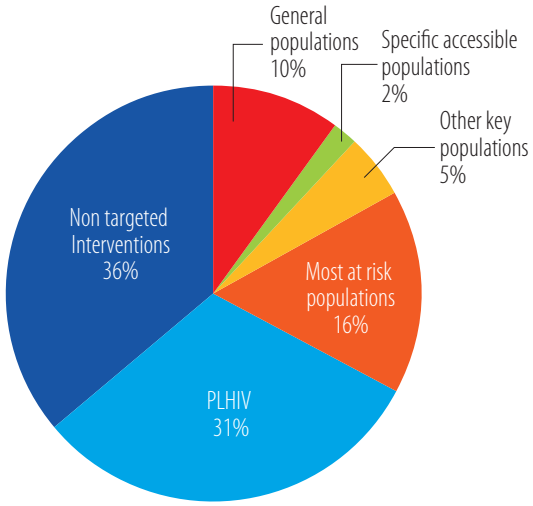


Figure 10
Disaggregation of AIDS expenditure by six beneficiary population groups, 2009 - 2010

BENEFICIARY POPULATION	2009	2010	2009-2010	%
People living with HIV	35,694,752	46,594,814	82,289,566	31%
Most-at-risk populations	21,164,259	20,522,932	41,687,191	16%
Other key populations	6,471,014	6,787,652	13,258,666	5%
Specific "accessible" populations	2,841,871	3,547,015	6,388,886	2%
General population	11,023,664	15,190,698	26,214,362	10%
Non-targeted interventions	50,178,923	46,610,134	96,789,058	36%
Total	**127,374,483**	**139,253,245**	**266,627,728**	**100%**

AIDS expenditure in 2009

According to the NASA results, US$127.4 million were spent to support the national HIV response in 2009. AIDS expenditure accounted for 0.13% of GDP; US$1.48 were spent per capita.

In 2009, public sources, including both central and local Government budgets, contributed US$17.1 million to the HIV response. Of this, US$6.7 million (39%) came from the central budget, mostly though the National Targeted Programme on HIV (US$6.3 million), while US$10.4 million (61%) came from local (provincial) budgets, which mainly support the operational and investment costs of PAC activities. In 2009, the total Government spending on HIV accounted for 1.06% of total Government expenditure on health.

International sources provided funds for 74% of total AIDS spending, while domestic sources covered the remaining 26%. Of all recorded AIDS expenditure, 55.6% was financed through bilateral grants and 18% from multilateral sources.

PEPFAR was the largest bilateral donor, providing 50.2% of resources for national AIDS expenditure, or US$64 million. The World Bank, Asian Development Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria contributed the funds for 6.6%, 4.9% and 4.6% of national AIDS expenditure respectively. The detailed breakdown of AIDS expenditure by source is summarised in Figure 11.

Figure 11
Summary of AIDS expenditure in Viet Nam by financing source, 2009

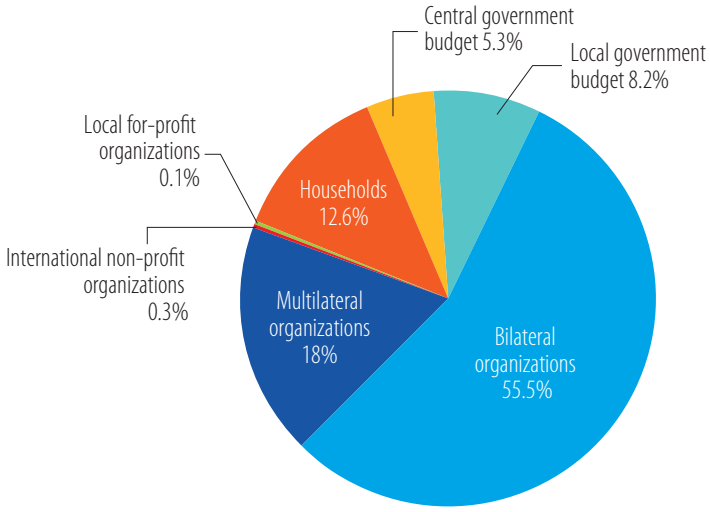
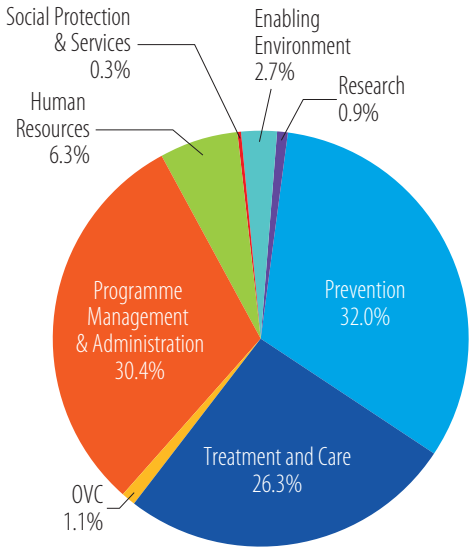


Figure 12 describes AIDS expenditure under eight major AIDS spending categories (ASC). The majority of resources are allocated to prevention (32% of all resources), programme management and administration strengthening (30.4%) and treatment and care (26.3%). In 2009, US$40.8 million were spent on prevention and US$33.4 million on treatment and care. A total of 6.3% of all funds were spent on human resources and 2.7% on the enabling environment. Of total AIDS expenditure in 2009, OVC and research received about 1% each, while social protection and services received 0.3%. The detailed breakdown of national AIDS expenditure by ASC in 2009 is included in Appendix 3a.

Figure 12
Total AIDS spending by ASC, 2009



The detailed breakdown of spending by financial source and ASC (Figure 13) shows that Government expenditure was concentrated on programme management and administration strengthening (49%). Bilateral sources likewise focused on programme management and administration strengthening (37%), but also invested in prevention (29%) and treatment and care (22%). Prevention was the primary focus for multilateral sources, attracting 55% of resources, followed by programme management and administration strengthening (19%). A total of 45% of resources from international non-profit organizations were spent on research, while households spent their funds on treatment and care (77%) and prevention (23%).

Figure 13
Distribution of spending by source and ASC, 2009

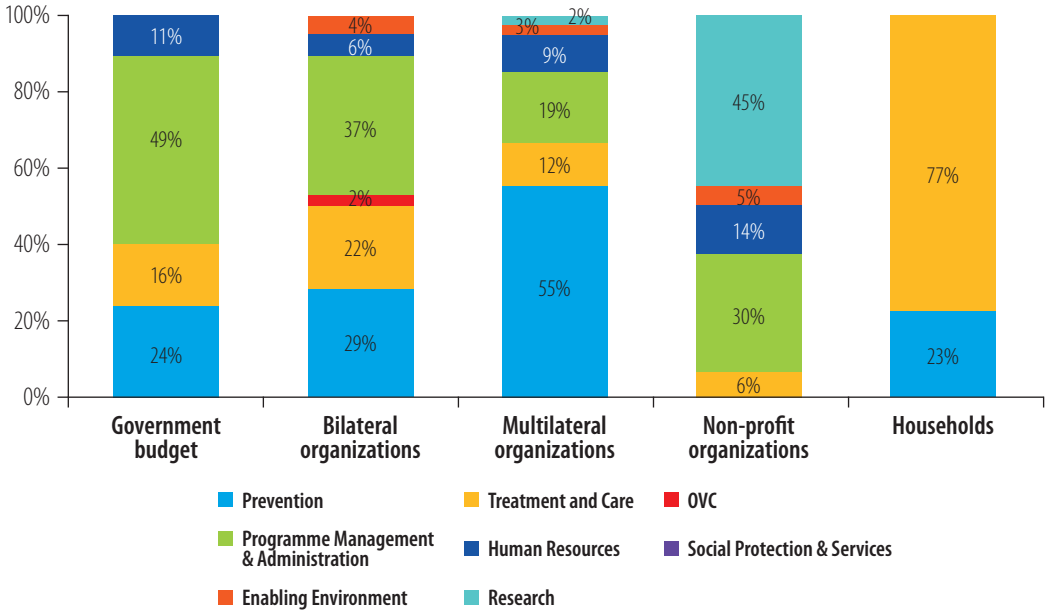
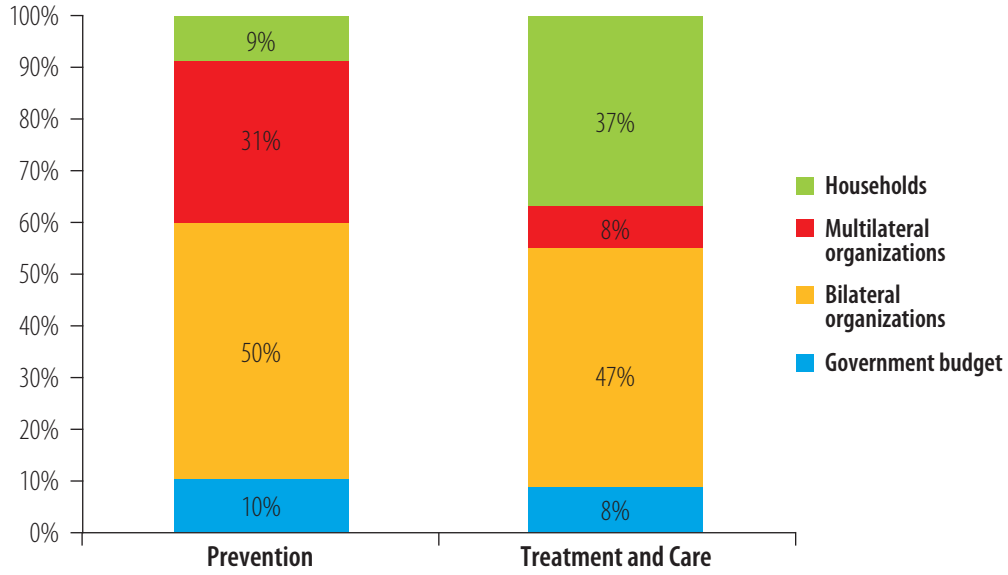


Figure 14 illustrates the contribution of various financial sources to the prevention and treatment and care spending categories. Both prevention and treatment and care were heavily financed by international sources, which provided 81% of total prevention resources and 55% of total treatment and care resources. The Government budget paid for 10% of prevention costs and 8% of treatment and care costs, while 37% of treatment and care costs and 9% of prevention were covered by household out-of-pocket payments.

Figure 14
Spending on prevention, treatment and care by different financial sources, 2009



AIDS expenditure in 2010

According to the recorded expenditure for 2010, national AIDS expenditure continued to grow, reaching US$139.3 million in 2010, an increase of 9% compared to 2009. The share of AIDS expenditure as a proportion of GDP remained at 0.13%, but expenditure per capita increased to US$1.68 (from US$1.48 in 2009).

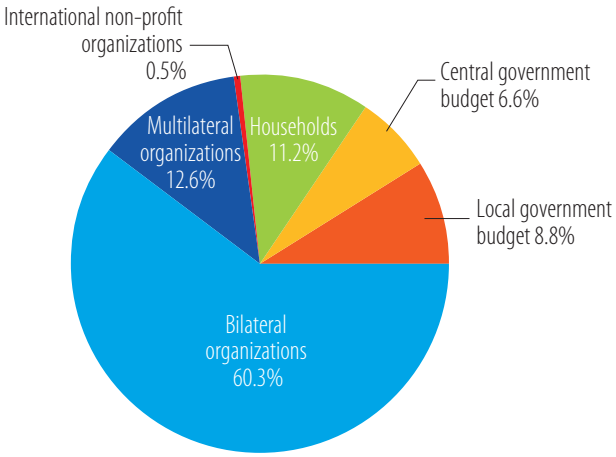
The Government spent US$21.4 million on AIDS in 2010, an increase of 24% compared to 2009. Of the total Government AIDS expenditure, US$9.2 million came from the central budget (43% of Government spending), including US$8.2 million through the National Targeted Programme, and US$12.2 million from the local (provincial) budget (56.7%).

Figure 15 summarizes the main financial sources for AIDS programming in 2010 and their contributions to total national expenditure. The figure shows that 73.4% of national AIDS expenditure was financed by international sources in 2010, 15.4% was paid for by the Government budget and 11.2% was covered by households.

Bilateral donors continued to be the main financial source for AIDS programming, contributing US$84 million in 2010. PEPFAR was the largest bilateral donor, with US$69.3 million contributed, accounting for 49.8% of all AIDS expenditure. The United Kingdom's Department for International Development (DFID) was the second largest bilateral donor, paying US$7.5 million, and the Danish International Development Agency (DANIDA) the third largest, at US$4.2 million.

Multilateral sources paid for 11.8% of AIDS expenditure, with the largest donors being the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Asian Development Bank (ADB). For the detailed breakdown of AIDS expenditure by source, see Figure 15.

Figure 15
Main financial sources for AIDS spending in Viet Nam, 2010



As in 2009, the majority of AIDS expenditure (89% in 2010) was concentrated on three spending categories: 1. prevention; 2. treatment and care; and 3. programme management and administration strengthening.

Prevention programmes continued to receive 32% of all AIDS resources; funding for treatment and care programmes increased to 30% of resources from 26% in 2009; however, funds for programme management and administration strengthening initiatives reduced to 26% of resources (from 30% in 2009).

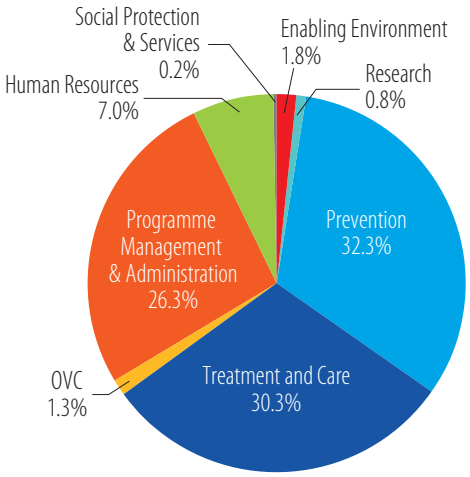
Human resources received 7% of all expenditure, while 2% of resources were spent on the enabling environment. OVC and research received 1% of resources each.

Compared to 2009, spending on OVC services increased by 26% in real terms, from US$1,425,733 to US$1,800,891. (please see Figure 16). Details of expenditure broken down by ASC can be found in Appendix 3b, below.

In 2010, one third (35%) of Government resources were spent on prevention, while 13% were spent on treatment and care. Programme management and administration strengthening attracted 44% of public expenditure.

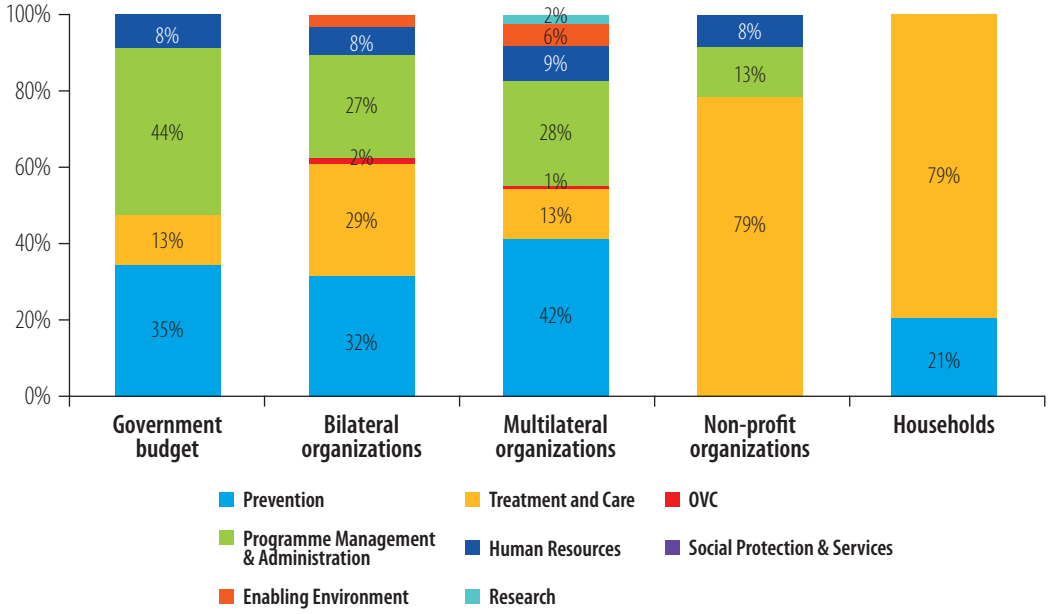
Bilateral resources were distributed more evenly across the spending categories, with almost a third of the funds focused on prevention (32% of all expenditure), followed by treatment and care (29%), programme management and administration strengthening (27%) and human resources activities (8%).

Figure 16
Total spending by ASC, 2010



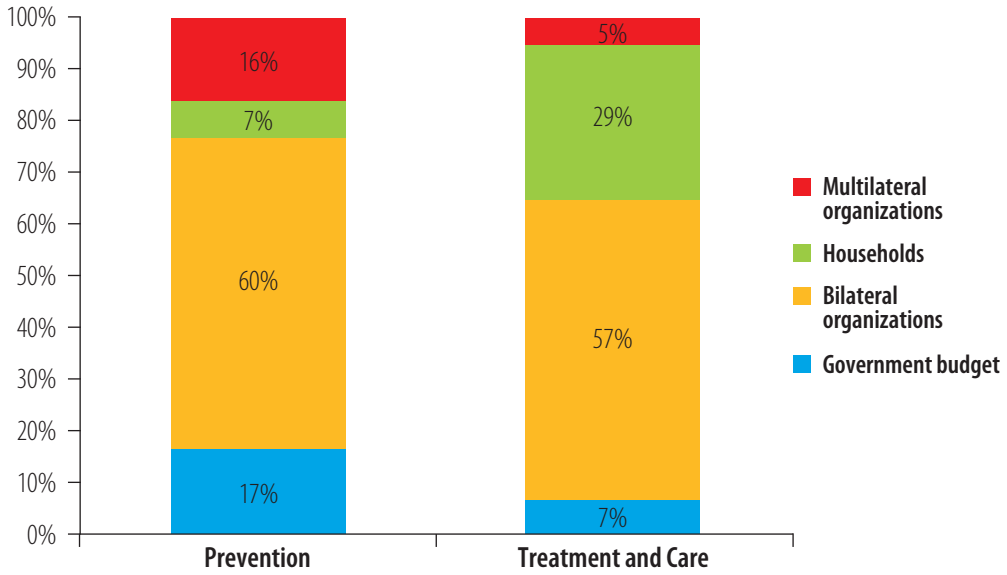
Spending patterns among multilateral sources were similar to Government spending – 42% of all resources were spent on prevention, 28% on programme management and administration strengthening and 13% on treatment and care. Both international non-profit organization and household resources were primarily spent on treatment and care – 78% and 79% respectively. (see Figure 17)

Figure 17
Distribution of spending by financial source and ASC, 2010



Overall, international sources covered 76% of prevention and 62% of treatment and care costs; bilateral donors alone were responsible for 60% of prevention and 57% of treatment and care funding (Figure 18). The Government budget at different levels paid for 17% of prevention and 7% of treatment and care costs, while the remainder – 26% of treatment and care and 7% of prevention costs – were covered by household out-of-pocket payments.

Figure 18
Spending on prevention, treatment and care by financial source, 2010



LIST OF PARTNERS CONTRIBUTING DATA TO THIS SURVEY

Bilateral organizations

1 Australian Agency for International Development (AusAid)
2 Danish International Development Agency (DANIDA)
3 Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (ESTHER)
4 Irish Aid
5 United Kingdom Department for International Development (DFID)
6 United States Centers for Disease Control and Prevention (CDC)
7 United States Department of Defense (DoD)
8 United States Agency for International Development (USAID)
9 United States Substance Abuse and Mental Health Services Administration (SAMHSA)

Multilateral Organizations

10 The Joint United Nations Programme on HIV/AIDS (UNAIDS)
11 United Nations Educational, Scientific and Cultural Organization (UNESCO)
12 United Nations Children's Fund (UNICEF)
13 United Nations Office on Drugs and Crime (UNODC)
14 United Nations Population Fund (UNFPA)
15 United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
16 The World Health Organization (WHO)

International non-profit organizations and foundations

17 AIDS Healthcare Foundation (AHF)
18 Beth Israel Deaconess Medical Center
19 Clinton HIV/AIDS Initiative (CHAI)
20 Chemonics
21 FHI 360
22 Management Sciences for Health (MSH)
23 MEASURE
24 Medisch Comite Nederland-Viet Nam (MCNV)
25 Pact
26 PSI

International for-profit organizations

27 Abt Associates

Public organizations

28 Central Women's Union
29 Central Project Management Unit (CPMU) of Life-Gap Project, Ministry of Health (MOH)
30 CPMU of the Global Fund to Fight AIDS, Tuberculosis and Malaria Project on HIV/AIDS, MOH
31 CPMU of the World Bank Project on HIV/AIDS, MOH
32 CPMU of the HIV/AIDS Asia Regional Program (HAARP), MOH
33 General Department of Social Evils Prevention, MOLISA
34 HCMC AIDS Committee
35 HCMC Pasteur Institute
36 Harvard School of Public Health (HSPH), MOH
37 National Institute of Hygiene and Epidemiology (NIHE), MOH
38 Viet Nam Authority of HIV/AIDS Control (VAAC)
39 Bac Giang Provincial AIDS Committee (PAC)
40 Bac Ninh PAC
41 Binh Duong PAC
42 Binh Phuoc PAC
43 Binh Thuan PAC
44 Ba Ria – Vung Tau PAC
45 Can Tho PAC
46 Cao Bang PAC
47 Da Nang PAC
48 Dac Nong PAC
49 Dak Lak PAC
50 Dien Bien PAC
51 Dong Nai PAC
52 Ha Tinh PAC
53 Hau Giang PAC
54 Khanh Hoa PAC
55 Lai Chau PAC
56 Lao Cai PAC
57 Long An PAC
58 Nghe An PAC
59 Ninh Binh PAC
60 Ninh Thuan PAC
61 Phu Tho PAC
62 Quang Binh PAC
63 Quang Nam PAC
64 Quang Ngai PAC
65 Quang Ninh PAC
66 Quang Tri PAC
67 Thai Binh PAC
68 Thanh Hoa PAC
69 Tien Giang PAC
70 Tra Vinh PAC
71 Tuyen Quang PAC

ANNEX 4

KEY REPORTED INDICATORS

Indicator 1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

1. Method of data collection

- **Data source:** National Survey on Adolescents and Youth in Viet Nam from 15-24 years old (SAVY)
- **Target population:** Youth aged 15-24
- **Study sites:** 63 provinces/cities
- **Study method:** Cross-sectional household survey

2. Method of measurement

- **Numerator:** Number of respondents aged 15-24 who gave correct answers to all 5 questions
  1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
  2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
  3. Can a healthy-looking person have HIV?
  4. Can a person get HIV from mosquito bites?
  5. Can a person get HIV by sharing food with someone who is infected?
- **Denominator:** Number of all respondents aged 15-24

3. Results

- The survey shows 42.5% of people aged 15-24 both correctly identify ways of preventing the transmission of HIV through sexual intercourse and reject major misconceptions about HIV transmission. This percentage is almost the same as that found in 2005.
- The percentage of people aged 20-24 (47%) who both correctly identify ways of preventing the transmission of HIV through sexual intercourse and reject major misconceptions about HIV transmission was slightly higher than that of those aged 15-19 (40%).
- This percentage was slightly higher among men (44%) than among women (40.8%).
- However, according to the MICS4 survey conducted in 2010-2011, the percentage of young women was slightly higher (49.9%) than that found in the SAVY 2009 survey (40.8%).

4. Limitations of the data

- Missing data accounted for 2.3% of all respondents aged 15-24.

Indicator 1.2 Percentage of young women and men who have had sexual intercourse before the age of 15

1. Method of data collection

- **Data source:** National Survey on Adolescents and Youth in Viet Nam from 15-24 years old (SAVY)
- **Target population:** Youth aged 15-24
- **Study sites:** 63 provinces/cities
- **Study method:** Cross-sectional household survey

2. Method of measurement

- **Numerator:** Number of young women and men aged 15-24 who have had sexual intercourse before the age of 15
- **Denominator:** Number of all respondents aged 15–24

3. Results

- The survey indicates that only 0.11% of youth aged 15-24 reported having sex before the age of 15. This percentage is 3.6 times lower than 2005 (0.4%).
- This percentage was higher among men (0.16%) than women (0.07%).
- This percentage was higher among people aged 20-24 (0.19%) than among people aged 15-19 (0.07%).
- However, according to the MICS4 survey conducted in 2010-2011, while the percentage of young women was still low at 0.32%, it was higher than that found by the SAVY 2009 survey (0.07%).

4. Limitations of the data

- As cultural norms in Viet Nam limit the discussion of sexual activity, respondents may have been prevented from truthfully answering sensitive survey questions regarding sexual activity at an early age. In addition, SAVY was conducted in a household setting that limited the respondents' privacy when answering sensitive questions. This may have further increased the likelihood of underreporting sexual activity.

Indicator 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

1. Method of data collection

- **Data source:** National Survey on Adolescents and Youth in Viet Nam from 15-24 years old (SAVY)
- **Target population:** Youth aged 15-24
- **Study sites:** 63 provinces/cities
- **Study method:** Cross-sectional household survey

2. Method of measurement

- **Numerator:** Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
- **Denominator:** Number of all respondents aged 15-49

3. Results

- Reporting of multiple partners is extremely uncommon. Only 1.28% of respondents aged 15-24 report having had sex with more than one partner in the last 12 months. This percentage is higher than that in 2005 (0.77%).
- The percentage of men (2.44%) was much higher than that of women (0.11%). Compared to 2007, the proportions of both men and women were significantly higher.
- The results of the MICS4 survey among young women in 2010-2011 are similar to those of the SAVY 2009 survey.

4. Limitations of the data

- Data for the age group 25-49 are not available.
- Members of groups whose behaviours put them at highest risk for HIV were less likely to be found at home at the time the survey was undertaken, potentially influencing the representativeness of the results.
- As cultural norms in Viet Nam limit the discussion of sexual activity, respondents may have been prevented from truthfully answering sensitive survey questions regarding sexual activity at an early age. In addition, SAVY was conducted in a household setting that limited the respondents' privacy when answering sensitive questions. This may have further increased the likelihood of underreporting sexual activity.

Indicator 1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse

1. Method of data collection

- **Data source:** National Survey on Adolescents and Youth in Viet Nam from 15-24 years old (SAVY)
- **Target population:** Youth aged 15-24
- **Study sites:** 63 provinces/cities
- **Study method:** Cross-sectional household survey

2. Method of measurement

- **Numerator:** Number of respondents aged 15-49 who have had more than one sexual partner in the past 12 months who also reported that a condom was used the last time they had sex
- **Denominator:** Number of all respondents aged 15–49 who reported having had more than one sexual partner in the last 12 months

3. Results

- The percentage of males aged 15-24 reporting the use of a condom the last time they had sex with a sex worker was 93%.
- The percentage was not significantly different among men aged 15-19 (100%) and men aged 20-24 (90%); however, the total number of young men who reported ever having had sex with a sex worker (56) was too small to allow accurate comparison and interpretation.

4. Limitations of the data

- Data for the age group 25-49 are not available.
- The numerator was different to that in the GARPR guidelines. The numerator used in this report was "Number of young men aged 15-24 who reported using a condom the last time they had sex with a sex worker".
- The denominator was different to that in the GARPR guidelines. The denominator used in this report was "Number of young men aged 15-24 who reported ever having had sex with a sex worker".
- In this survey, members of groups whose behaviours put them at highest risk for HIV were less likely to be found at home at the time the survey was undertaken, potentially influencing the representativeness of the results.
- As cultural norms in Viet Nam limit the discussion of sexual activity, respondents may have been prevented from truthfully answering sensitive survey questions regarding sexual activity at an early age. In addition, SAVY was conducted in a household setting that limited the respondents' privacy when answering sensitive questions. This may have further increased the likelihood of underreporting sexual activity.

Indicator 1.7 Percentage of sex workers reached with HIV prevention programmes

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam, 2009.
- **Target population:** Female sex workers (FSW) (women who were 18 years or older, who reported having sex for money at least once in the month prior to the survey, who were working on the street or in establishments and who agreed to be tested for HIV/STI and reproductive tract infections (RTI)).
- **Study sites:** The IBBS was conducted in 10 provinces/cities: Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, HCMC, Can Tho and An Giang. In each city or province, districts considered "hot spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the IBBS questionnaire applying cluster sampling methods.

2. Method of measurement

- **Numerator:** Number of sex workers who were reached by intervention programmes for HIV prevention, including knowing where to get an HIV test and receiving condoms in the last 12 months
- **Denominator:** Total number of sex workers surveyed

3. Results

- The IBBS results showed that 47.3% of FSW were reached by HIV prevention programmes.
- The IBBS results indicate that approximately 57.7% of FSW know where to get a HIV test and 69.7% received condoms in the last 12 months.
- FSW older than 25 are more likely to be reached by HIV-prevention programmes (53.3%) than those younger than 25 (37.3%).

4. Limitations of the data

- The data is not representative of the national population because it was only collected at sex worker "hot spots" in provinces/cities with high HIV prevalence.
- Data on male sex workers are not available.

Indicator 1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client

1. Method of data collection

- **Data source:** Results of behavioural surveillance integrated into sentinel surveillance (HSS+) in Viet Nam, 2011.
- **Target population:** FSW (women who were 16 years old or above and who reported having vaginal or anal sex for money at least once in the month prior to the survey).
- **Study sites:** The HSS+ was conducted in 12 provinces/cities: An Giang, Binh Duong, Ca Mau, Da Nang, Dien Bien, Ha Noi, Hai Duong, Hue, Nghe An, Quang Tri, Thanh Hoa and HCMC. In each city or province, FSW were selected at "hot spots" through introduction by collaborators, peer educators or "hot spot" owners.
- **Study method:** A cross-sectional survey was conducted in 2011 using the integrated behavioural surveillance questionnaire and the sentinel surveillance survey (HSS+), applying cluster sampling methods, with each "hot spot" a cluster.

2. Method of measurement

- **Numerator:** Number of sex workers reporting the use of a condom with their most recent client
- **Denominator:** Number of sex workers who reported having commercial sex in the last 12 months

3. Results

- The survey showed that 88.6% of FSW reported using a condom with their most recent client in the last month. This percentage is slightly higher than that found in IBBS 2009 (77.7%).
- There was no significant difference between FSW younger than 25 and those older than 25.

4. Limitations of the data

- The data are not representative of the national population because they were only collected at sex-worker "hot spots" in provinces/cities with high HIV prevalence.
- Data on male sex workers are not available.
- The HSS+ interviewed FSW who reported undertaking sex work in the last month, while the GARPR guidelines requested reporting on FSW who reported undertaking sex work in the last 12 months.

Indicator 1.9 Percentage of sex workers who have received an HIV test in the last 12 months and who know the results

1. Method of data collection

- **Data source:** Results of behavioural surveillance integrated into sentinel surveillance (HSS+) in Viet Nam 2011.
- **Target population:** FSW (women who were 16 years old or older and who reported having vaginal or anal sex for money at least once in the month prior to the survey).
- **Study sites:** The HSS+ was conducted in 12 provinces/cities: An Giang, Binh Duong, Ca Mau, Da Nang, Dien Bien, Ha Noi, Hai Duong, Hue, Nghe An, Quang Tri, Thanh Hoa and HCMC. In each city or province, FSW were selected at "hot spots" through introduction by collaborators, peer educators or "hot spot" owners.
- **Study method:** A cross-sectional survey was conducted in 2011 using the integrated behavioural surveillance questionnaire and the sentinel surveillance survey (HSS+), applying cluster sampling methods, with each "hot spot" a cluster.

2. Method of measurement

- **Numerator:** Number of sex workers who were tested for HIV in the last 12 months and who know their results
- **Denominator:** Number of sex workers included in the sample

3. Results

- The 2011 survey indicates that 43.8% of FSW received an HIV test in the last 12 months and knew their results.
- The proportion of FSW younger than 25 (50%) is higher than of FSW older than 25 (38.8%).

4. Limitations of the data

- The data are not nationally representative because they were only collected from sex-worker "hot spots" in provinces/cities with high HIV prevalence.
- Data on male sex workers are not available.

Indicator 1.10 Percentage of sex workers who are living with HIV

1. Method of data collection

- **Data source:** HIV sentinel surveillance
- **Target population:** Female SW in communities[69]
- **Study sites:** 39 out of 63 provinces/cities in Viet Nam
- **Study method:** Sentinel surveillance is conducted by the Ministry of Health annually between May and August. HIV testing (strategy II) is performed as per the national guidelines.

2. Method of measurement

- **Numerator:** Number of sex workers who tested positive for HIV
- **Denominator:** Number of sex workers tested for HIV

3. Results

- HIV prevalence among FSW in 39 provinces in 2011 was 3.0%. HIV prevalence among this population was 3.2% in 2009 according to sentinel surveillance.
- In 2011, the highest HIV prevalence among FSW was found in Ha Noi (22.5%), Lang Son (17.1%), Can Tho (10.7%), Dien Bien (8%) and Soc Trang (6%).
- The IBBS conducted in 10 provinces/cities in 2009 showed HIV prevalence among FSW was 9.1%, much higher than the national figure.

4. Limitations of the data

- The sentinel surveillance results reflect the trend of HIV prevalence in sentinel sites, but they are not representative of the targeted population nationwide. In addition, as most of the sentinel sites are in urban settings, the data may not be representative of rural, remote and mountainous areas.
- Data disaggregated by age are not available.
- Data on male sex workers are not available.

[69] FSW not in 05 Centres

Indicator 1.11 Percentage of men who have sex with men (MSM) reached with HIV prevention programmes

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam 2009.
- **Target population:** MSM (men aged 15 years or above, who engaged in sex with men at least once in the previous 12 months, agreed to be tested for HIV/STI and RTI, and had an active referral card given by another survey respondent).
- **Study sites:** The IBBS was conducted in four provinces/cities: Ha Noi, Hai Phong, HCMC and Can Tho. In each city or province, districts considered "hot spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the IBBS questionnaire. Respondents were selected using respondent-driven sampling (RDS).

2. Method of measurement

- **Numerator:** Number of MSM who were reached by intervention programmes for HIV prevention, including knowing where to get an HIV test and receiving condoms in the last 12 months
- **Denominator:** Total number of MSM surveyed

3. Results

- The IBBS results indicate that between 38.5% and 47.4% of MSM know where to get an HIV test, and 24.2% to 48.6% received condoms in the last 12 months. However, only 12.8% to 30% know both where to get a HIV test and received condoms.
- MSM older than 25 are more likely to be reached by HIV prevention programmes (30.2%) than those younger than 25 (17.7%).

4. Limitations of the data

- The data are not representative of the national MSM population because they were only collected at MSM "hot spots" in four cities with high HIV prevalence.
- This indicator only looks at the coverage of prevention programmes. The quality and frequency of programme interventions are not measured.

Indicator 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

1. Method of data collection

- **Data source:** Results of behavioural surveillance integrated into sentinel surveillance (HSS+) in Viet Nam 2011.
- **Target population:** MSM (men aged 16 years or above, who engaged in sex with men at least once in the previous 12 months).
- **Study sites:** The HSS+ was conducted among MSM in five provinces/cities: An Giang, Da Nang, Ha Noi, Hai Duong and HCMC. In each city or province, MSM were selected using the "snowballing" method.
- **Study method:** A cross-sectional survey was conducted in 2011 using the integrated behavioural surveillance questionnaire and the sentinel surveillance survey (HSS+).

2. Method of measurement

- **Numerator:** Number of men reporting using a condom the last time they had anal sex with a male partner
- **Denominator:** Number of respondents who reported having had anal sex with a male partner in the last six months

3. Results

- The study indicates that 75.6% of respondents reported using a condom the last time they had anal sex with a consensual partner.
- There is no significant difference between MSM under 25 (74.5%) and those over 25 (77%).

4. Limitations of the data

- The data are not representative of the national MSM population because they were only collected among MSM in five cities with high HIV prevalence.
- The HSS+ selected MSM who reported having had anal sex with a male partner in the last 12 months, while the GARPR guidelines requested reporting on MSM who reported having had anal sex with a male partner in the last six months.

Indicator 1.13 Percentage of men who have sex with men (MSM) who have received an HIV test in the last 12 months and who know the results

1. Method of data collection

- **Data source:** Results of behavioural surveillance integrated into sentinel surveillance (HSS+) in Viet Nam 2011.
- **Target population:** MSM (men 16 years or older who engaged in sex with men at least once in the previous 12 months).
- **Study sites:** The HSS+ was conducted among MSM in five provinces/cities: An Giang, Da Nang, Ha Noi, Hai Duong, and HCMC. In each city or province, MSM were selected using the "snowballing" method.
- **Study method:** A cross-sectional survey was conducted in 2011 using the integrated behavioural surveillance and sentinel surveillance questionnaire (HSS+).

2. Method of measurement

- **Numerator:** Number of MSM who have been tested for HIV during the last 12 months and who know their results
- **Denominator:** Number of MSM included in the sample

3. Results

- The survey results indicate that only 30.2% of MSM received a HIV test in the last 12 months and know their results.
- There is no significant difference in this indicator between MSM younger than 25 (30.6%) and those older than 25 (29.7%).

4. Limitations of the data

- The data are not representative of the national MSM population because they were only collected among MSM in five cities with high HIV prevalence.

Indicator 1.14 Percentage of men who have sex with men who are living with HIV

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam 2009.
- **Target population:** MSM (men 15 years or older, who engaged in sex with men at least once in the previous 12 months, agreed to be tested for HIV/STI and RTI, and had an active referral card given by another survey respondent).
- **Study sites:** The IBBS was conducted in four provinces/cities; Ha Noi, Hai Phong, HCMC and Can Tho. In each city or province, districts considered "hot spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the IBBS questionnaire. Respondents were selected using respondent-driven sampling (RDS).

2. Method of measurement

- **Numerator:** Number of MSM who tested positive for HIV
- **Denominator:** Number of MSM tested for HIV

3. Results

- HIV prevalence among MSM in the survey ranged from 6.7% to 26.1%. This prevalence is higher than that in 2006.
- HIV prevalence among MSM who were younger than 25 is much lower than that among those older than 25.

4. Limitations of the data

- The data are not representative of the national MSM population because they were only collected at MSM "hot spots" in four cities with high HIV prevalence.

Indicator 2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

1. Method of data collection

- **Data source:** Routine reporting on the national AIDS programme using the D28 form and size estimates for PWID according to the 2011 Viet Nam HIV/AIDS Estimations and Projections.
- **Target population:** PWID
- **Study sites:** Nationwide
- **Study method:**

- The numerator was taken from routine reporting on the national AIDS programme using the D28 form
- The denominator was taken from the medium scenario of the size estimates for PWID according to the 2011 Viet Nam HIV/AIDS Estimates and Projections.

2. Method of measurement

- **Numerator:** Number of syringes distributed in past 12 months by needle and syringe programmes
- **Denominator:** Number of people who inject drugs in the country

3. Results

- More than 30.3 million needles and syringes were distributed by needle and syringe programmes in 2011. On average, each PWID received 140 clean needles and syringes in 2011.

4. Limitations of the data

Indicator 2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam 2009.
- **Target population:** PWID (men 18 years or older, who reported drug injection in the month prior the survey, agreed to be tested for HIV/STI and RTI, and had an active referral card given by another survey respondent).
- **Study sites:** The IBBS was conducted in 10 provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, HCMC, Can Tho, and An Giang. In each city or province, districts considered "hot spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the IBBS questionnaire. Respondent-driven sampling (RDS) was used to select respondents in Ha Noi, Da Nang, HCMC, and Can Tho. In the other six provinces, respondents were selected using cluster sampling methods.

2. Method of measurement

- **Numerator:** Calculated by multiplying the sample size by the median of the 10 percentages calculated (estimated from the range of percentages of PWID in the 10 target provinces who reported using a condom the last time they had sexual intercourse)
- **Denominator:** Number of respondents who reported having had sexual intercourse in the last month

3. Results

- The survey indicates that between 26.1% and 93.9% of respondents reported that a condom was used the last time they had sex with a regular partner.
- There is no significant difference in this indicator between male PWID younger than 25 and those older than 25.

4. Limitations of the data

- The data are not representative of the national PWID population because they were only collected at PWID "hot spots" in provinces/cities with high HIV prevalence.
- Data on female PWID are not available.

Indicator 2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

1. Method of data collection

- **Data source:** Results of behavioural surveillance integrated into sentinel surveillance (HSS+) in Viet Nam 2011.
- **Target population:** PWID (men 16 years or older, who reported drug injection in the month prior to the survey)
- **Study sites:** The HSS+ was conducted in 12 provinces/cities: An Giang, Binh Duong, Ca Mau, Da Nang, Dien Bien, Ha Noi, Hai Duong, Hue, Nghe An, Quang Tri, Thanh Hoa and HCMC. In each city or province, PWID were selected at "hot spots" through introduction by collaborators, peer educators or other study respondents.
- **Study method:** A cross-sectional survey was conducted in 2011 using the integrated behavioural surveillance questionnaire and the sentinel surveillance survey (HSS+).

2. Method of measurement

- **Numerator:** Number of PWID who report using sterile injecting equipment the last time they injected drugs
- **Denominator:** Number of PWID who report injecting drugs in the last month

3. Results

- The survey indicates that 95.3% of male PWID reported the use of sterile injecting needles/syringes the last time they injected.
- The proportions of male PWID younger than 25 and those older than 25 are the same.

4. Limitations of the data

- The data are not representative of the national PWID population because they were only collected at PWID "hot spots" in provinces/cities with high HIV prevalence.
- Data on female PWID are not available.

Indicator 2.4 Percentage of people who inject drugs who have received an HIV test in the last 12 months and who know the results

1. Method of data collection

- **Data source:** Results of behavioural surveillance integrated into sentinel surveillance (HSS+) in Viet Nam 2011.
- **Target population:** PWID (men 16 years or older who reported drug injection in the month prior to the survey).
- **Study sites:** The HSS+ was conducted in 12 provinces/cities: An Giang, Binh Duong, Ca Mau, Da Nang, Dien Bien, Ha Noi, Hai Duong, Hue, Nghe An, Quang Tri, Thanh Hoa and HCMC. In each city or province, PWID were selected at "hot spots" through introduction by collaborators, peer educators or other study respondents.
- **Study method:** A cross-sectional survey was conducted in 2011 using the integrated behavioural surveillance questionnaire and sentinel surveillance survey (HSS+).

2. Method of measurement

- **Numerator:** Number of PWID who have been tested for HIV during the last 12 months and who know their results
- **Denominator:** Number of PWID included in the sample

3. Results

- The survey results indicate that 29.1% of men who inject drugs received a HIV test in the last 12 months and know their results.
- There is no significant difference between PWID under 25 (25.8%) and over 25 (30.6%).

4. Limitations of the data

- The data are not representative of the national PWID population because they were only collected at PWID "hot spots" in provinces/cities with high HIV prevalence.
- Data on female PWID are not available.

Indicator 2.5 Percentage of people who inject drugs who are living with HIV

1. Method of data collection

- **Data source:** HIV sentinel surveillance
- **Target population**: PWID in communities[70]
- **Study sites:** 39 out of 63 provinces/cities in Viet Nam
- **Study method:** Sentinel surveillance is conducted annually by the Ministry of Health annually between May and August. HIV testing (strategy II) is performed as per the national guidelines.

2. Method of measurement

- **Numerator:** Number of PWID who tested positive for HIV
- **Denominator:** Number of PWID tested for HIV

3. Results

- HIV prevalence among PWID in 39 provinces in 2011 was 13.4%. HIV prevalence among this population was 18.4% in 2009.
- In 2011, the highest HIV prevalence rates among PWID were found in Dien Bien (45.7%), HCMC (39.3%), Thai Nguyen (25.9%), Quang Ninh (24.8%), Ha Noi (20.7%), and Can Tho (20%).
- IBBS 2009 conducted in 10 provinces/cities showed HIV prevalence among PWID was between 1% and 56%.

4. Limitations of the data

- The sentinel surveillance results reflect HIV infection trends at sentinel sites, but they are not representative of the targeted population nationwide. In addition, most sentinel sites are in urban settings and the data may therefore not be representative of rural, remote, and mountainous areas.

[70] PWID not in 06 Centres.

Indicator 3.1 Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission

1. Method of data collection

- **Data source:** Routine reporting of the National HIV/AIDS Programme 2011 and estimates of PMTCT needs using Spectrum dated 22/7/2011.
- **Target population:** Pregnant women living with HIV
- **Study sites:** Nationwide
- **Study method:** Secondary data were collected from programme reports

2. Method of measurement

- **Numerator:** Number of HIV-positive pregnant women who received antiretroviral medicines during the last 12 months to reduce mother-to-child transmission
- **Denominator:** Estimated number of HIV-positive pregnant women in the last 12 months

3. Results

- Over the last two years, the Government of Viet Nam has made big efforts to scale up the PMTCT programme. In 2010 and 2011, 49.1% and 44.0% of pregnant women, respectively, received ARV medicines to reduce the risk of mother-to-child transmission; this is a considerable increase compared to 2009 (32.3%).
- Among those receiving ARV medicines to reduce the risk of mother-to-child transmission:
  - 27.9% received single dose NVP only
  - 35.5% received Zidovudine
  - 35.8% received ART for HIV-positive pregnant women eligible for treatment
  - 0.4% received maternal triple ARV prophylaxis
  - 0.4% received other regimens

4. Limitations of the data

The classification of women who received different treatment regimens in this report is different to that in the GARPR guidelines. There were a number of HIV-positive pregnant women who received sd-NVP plus AZT and 3TC for 7-day postpartum who were classified as belonging to the "single dose NVP only" group.

Indicator 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

1. Method of data collection

- **Data source:** Routine reporting of the National HIV/AIDS Programme 2011 and estimates of PMTCT needs using Spectrum dated 22/7/2011.
- **Target population:** Infants born to HIV-positive women
- **Study sites:** Nationwide
- **Study method:** Secondary data were collected from programme reports

2. Method of measurement

- **Numerator:** Number of infants who received an HIV test within 2 months of birth, during the reporting period. Infants tested should only be counted once.
- **Denominator:** Number of HIV-positive pregnant women giving birth in the last 12 months

3. Results

- The virological test for infants was performed by only two institutes: the National Institute for Hygiene and Epidemiology and the HCMC Pasteur Institute. However, blood samples were collected from various provincial hospitals and transferred to these institutes to perform the test.
- The results of the 2011 reporting show that of 1,804 infants being tested using PCR, 999 of them were tested within 2 months of birth. The percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth is 25.8%.

4. Limitations of the data

The denominator was estimated using the Spectrum output "the number of pregnant women needing PMTCT" as a proxy. There is no reported number of HIV-positive pregnant women giving birth in the last 12 months.

Indicator 3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months

1. Method of data collection

- **Data source:** Spectrum dated 22/7/2011
- **Target population:** Children born to HIV-positive women
- **Study sites:** Nationwide
- **Study method:** Estimates using Spectrum

2. Method of measurement

- **Numerator:** Estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women
- **Denominator:** Estimated number of HIV-positive women who delivered in the previous 12 months

3. Results

- The percentage of child HIV infections from HIV-positive women delivering in the previous 12 months was estimated to be 17.7% in 2010, slightly decreasing to 16.3% in 2011.

4. Limitations of the data

Indicator 4.1 Percentage of eligible adults and children receiving antiretroviral therapy

1. Method of data collection

- **Data source:**
  - 2010 and 2011 treatment programme reports
  - Estimations and Projections of HIV/AIDS in Viet Nam conducted in 2011
- **Target population:** Adults and children with advanced HIV infection who are currently receiving ART
- **Study sites:** Nationwide
- **Study method:**
  - Numerator was taken from the treatment programme reports
  - Denominator was taken from the 2011 Viet Nam HIV/AIDS Estimations and Projections

2. Method of measurement

- **Numerator:** Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period
- **Denominator:** Estimated number of adults and children with advanced HIV infection

3. Results

- In the last few years, the Government of Viet Nam, with support from PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria, has made big efforts to scale up the ART programme.
- The percentage of people with advanced HIV infection receiving ART reached 47.7% (46.6% of adults and 83.2% of children) in 2010 and 54% (53% of adults and 82.9% of children) in 2011.

4. Limitations of the data

Data disaggregated by gender are not available.

Indicator 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

1. Method of data collection

- **Data source:** Annual data collection on ART cohorts outcome and early warning indicators for HIV drug resistance, 2011
- **Target population:** Adults and children with advanced HIV infection who are currently receiving ART
- **Study sites:** 62 treatment sites
- **Study method:** Cohort study

2. Method of measurement

- **Numerator:** Number of adults and children who are still alive and on ART at 12 months after initiating treatment
- **Denominator:** Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up

3. Results

- According to Ministry of Health routine reporting data, 82.1% of adults and 82.8% of children were still alive and on ART 12 months after the initiation of the treatment. This percentage was slightly lower among adults compared to 2009 (84.4%) but slightly higher among children (80.6% in 2009).

4. Limitations of the data

- Data disaggregated by gender are not available.

Indicator 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

1. Method of data collection

- **Data source:**
  - Annual D28 routine report, VAAC 2011
  - WHO estimated number of incident TB cases in PLHIV 2010 (http://www.who.int/tb/country/en)
- **Target population:** Incident TB cases in PLHIV
- **Study sites:** Nationwide
- **Study method:** Secondary data were collected from programme reports

2. Method of measurement

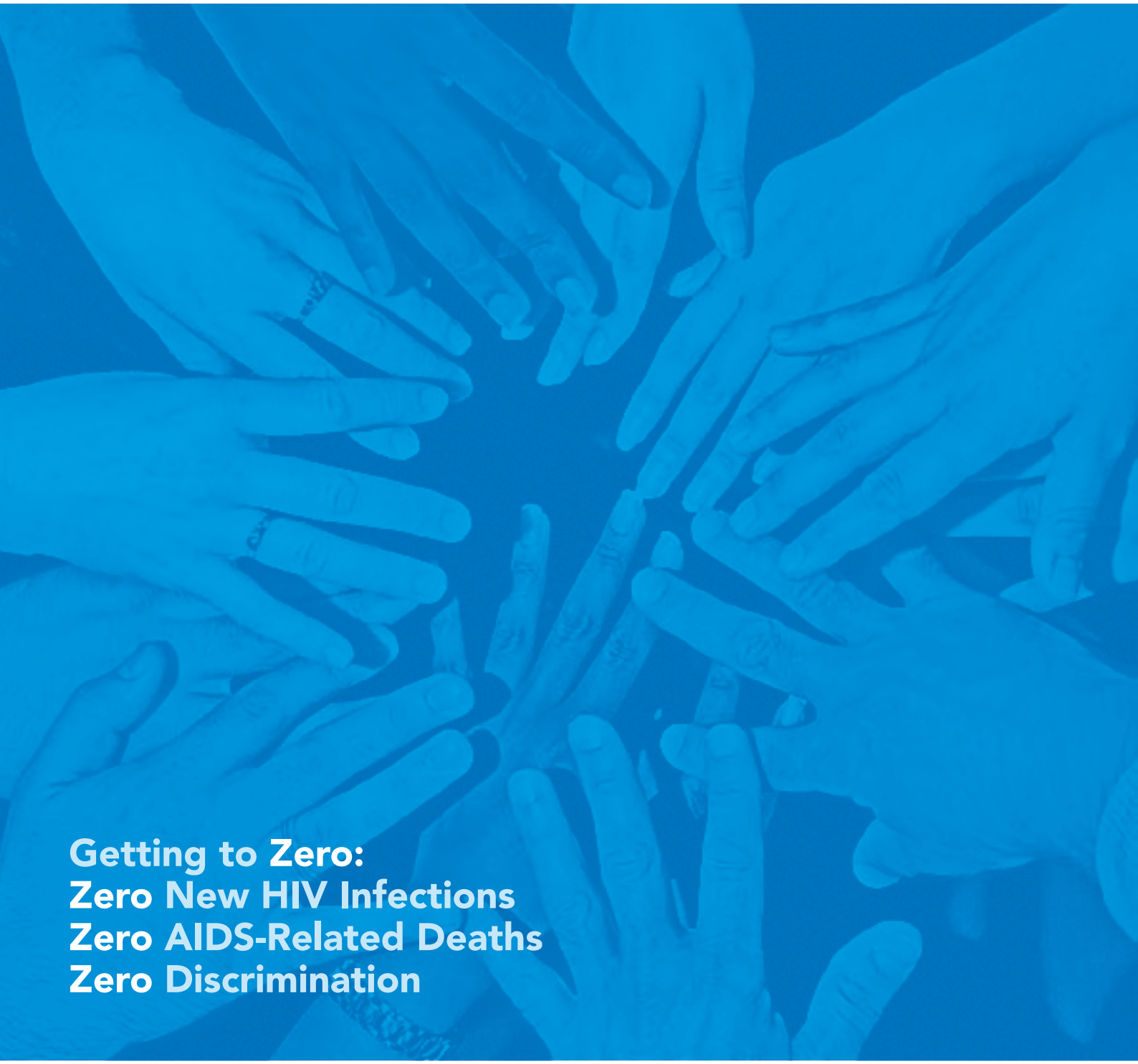
- **Numerator:** Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the MOH approved treatment protocol and who had started on TB treatment in accordance with national TB programme guidelines within the reporting year
- **Denominator:** Estimated number of incident TB cases in PLHIV

3. Results

- By the end of 2011, there were 2,162 adults and 123 children with advanced HIV infection who were receiving ART in accordance with the nationally approved treatment protocol and who had started TB treatment. Among those, 77.7% were male.
- It is estimated that by the end of 2011, 30.1% of estimated HIV-positive incident TB adults in Viet Nam would be receiving treatment for TB and HIV.

4. Limitations of the data

- The estimated number of incident TB cases in PLHIV in 2011 is not available. This indicator was calculated using the reported number in 2011 for the numerator and estimated number in 2010 for the denominator.



Getting to Zero:
Zero New HIV Infections
Zero AIDS-Related Deaths
Zero Discrimination